Waikato District Health Board

2021/22 ANNUAL REPORT

For the year ended 30 June 2022

Waikato District Health Board

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

Statement of responsibility for the 12 months ended 30 June 2022

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

This Annual Report has been prepared to meet the requirements of the Crown Entities Act 2004 (see Section 150 of the Act) and the Public Finance Act 1989 (see Section 43 of the Act). This report presents information on our performance over the 2021/22 year with ratings on the outputs and impacts we intended to deliver in terms of national, regional and local priorities and as stated in the Waikato DHB's 2021/22 Annual Plan.

Name of DHB:
Waikato District Health Board

Address:
Private Bag 3200, Hamilton 3240

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07 834 3646

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www.waikatodhb.health.nz

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

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Waikato DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Waikato District Health Board Group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Waikato DHB group under section 19A of the Public Finance Act.

We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Waikato District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board

Naomi Ferguson
Acting Chair
23 March 2023

Hon Amy Adams
Board Member
23 March 2023

Mihi

He Honore, he kororia ki te Atua, he Maungarongo ki te whenua, he whakaaro pai ki ngā tangata katoa.

Ko ona tomairangi atawhai ki runga i a Kiingi Tuuheitia Pootatau Te Wherowhero te tuawhitu, e noho mai rā ki te torona tapu o ana Mātua Tūpuna. Kei tona taha tika ko te whare Kāhui Ariki, Pai Marie ki a rātou!!

Heke nei te taumata kōrero ki ngā whānau, ngā hapū me ngā iwi o tēnei takiwā, ko te reo whakamiha ki a koutou.

Kau hoki ēnei mihi ki te hunga tangata e manaaki te iwi ki ngā whare hauora o tō tātou takiwā.

Kei ngā ringaringa waewae o te whare, tēnā koutou, tēnā koutou, tēnā koutou katoa.

Ko tēnei pūrongo, he kohinga kōrero nō te tau i hori ake, i roto tonu i te whitinga o ngā Poari Hauora, ki a Te Whatu Ora, e tū ake nei. Noo reira kei aku nui, kei aku rahi, kei aku whakatiketike, tēnā koutou.

I was deeply impressed by the care I received from all staff and at every level. Staff were friendly, efficient, professional and reassuring. My stay (and now my recovery) was made more pleasantly possible because of the care I experienced. Ngā mihi nui.

Ward M7 – Burns, Plastics, Maxillofacial and Urology

Foreword from the chief executive for the period under review

Dr Kevin Snee
Chief Executive

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

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

This is the final annual report to be produced as Waikato DHB as from 1 July, 2022 all 20 DHBs and associated shared services were amalgamated under Te Whatu Ora – Health New Zealand.

It has been a privilege to be part of the DHB's leadership in recent years as our people have time and again demonstrated their strength, skill, resilience, and dedication in support of our community.

It has been a period of significant challenges as we have responded to major events including the Whakaari/White Island eruption, a disruptive cyber-attack, and the ongoing COVID-19 pandemic. I am immensely proud of how DHB teams, and our primary care and community partners have worked to support and protect our community at all times.

While responding to these external events, we have also continued to focus on delivering a series of change programmes internally to strengthen our leadership and implement new structures which better support our clinical delivery, improve transparency and support clear decision-making processes. In this time the organisation has also made significant progress building a culture which embraces a Māori world view and is focused on delivering quality improvement across the board.

The organisation is now also in a stronger financial position than it was in 2019, at which time we were facing a deficit of around $100 million if clear steps were not taken to ensure we were able to operate more efficiently to continue delivering high levels of quality care while remaining within our budgets. Key to this has been the focus on quality care which is not only the best path for our patient's experience and outcomes, but also delivers better efficiency and cost-savings in the longer term as we see fewer return visits and fewer patients requiring ongoing support.

Across the Te Manawa Taki region and nationally there has been an increasing move towards operating as a more integrated system with DHBs and partner organisations coordinating to deliver patient-centric services. The pandemic accelerated this work as an 'all hands' approach was needed to reach all areas of our community. This has helped to position us very favourably as we undertake the transition to a new system as Te Whatu Ora – Health New Zealand and Te Aka Whai Ora Māori Health Authority.

Considerable progress has been made in a short time and I am confident that the many outstanding people working across the health system have the ability and drive to continue this progress within the new system.

Commissioner interests

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

The Waikato DHB commissioner and deputy commissioner roles were disestablished when Waikato DHB ceased to exist as a legal entity (as per the Pae Ora (Healthy Futures) Act 2022 provisions), and on the establishment of Te Whatu Ora – Health New Zealand on 1 July 2022.

Agendas and minutes of Commissioner meetings are not publically available.

Dame Karen Poutasi

Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Member, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Deputy Chair, Network for Learning
- Son, Health Manager, Worksafe
- Chair, Wellington Uni-Professional Board
- Chair, Taumata Arowai
- Member, Interim Health NZ Board
- Co-Chair, Joint Mental Health and Addictions Governance Group, Waikato DHB

Mr Chad Paraone

Deputy Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Member, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Māori Health Director, Precision Driven Health (stepped down from role from October 2020 to December 2021)
- Committee of Management Member and Chair, Parengarenga A Incorporation
- Director/Shareholder, Finora Management Services Ltd
- Member, Joint Mental Health and Addictions Governance Group, Waikato DHB
- Chief Advisor, Hauora Māori and Equity, Health Transition Unit, Department of Prime Minister and Cabinet

Mr Andrew Connolly

Deputy Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Chair, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Board member, Health Quality and Safety Commission (position non-active whilst Acting Chief Medical Officer, Ministry of Health)
- Employee, Counties Manukau DHB
- Clinical Advisor to Chair, Southern DHB
- Member, Ministry of Health Planned Care Advisory Group
- Member, Joint Mental Health and Addictions Governance Group, Waikato DHB

Emeritus Professor Margaret Wilson

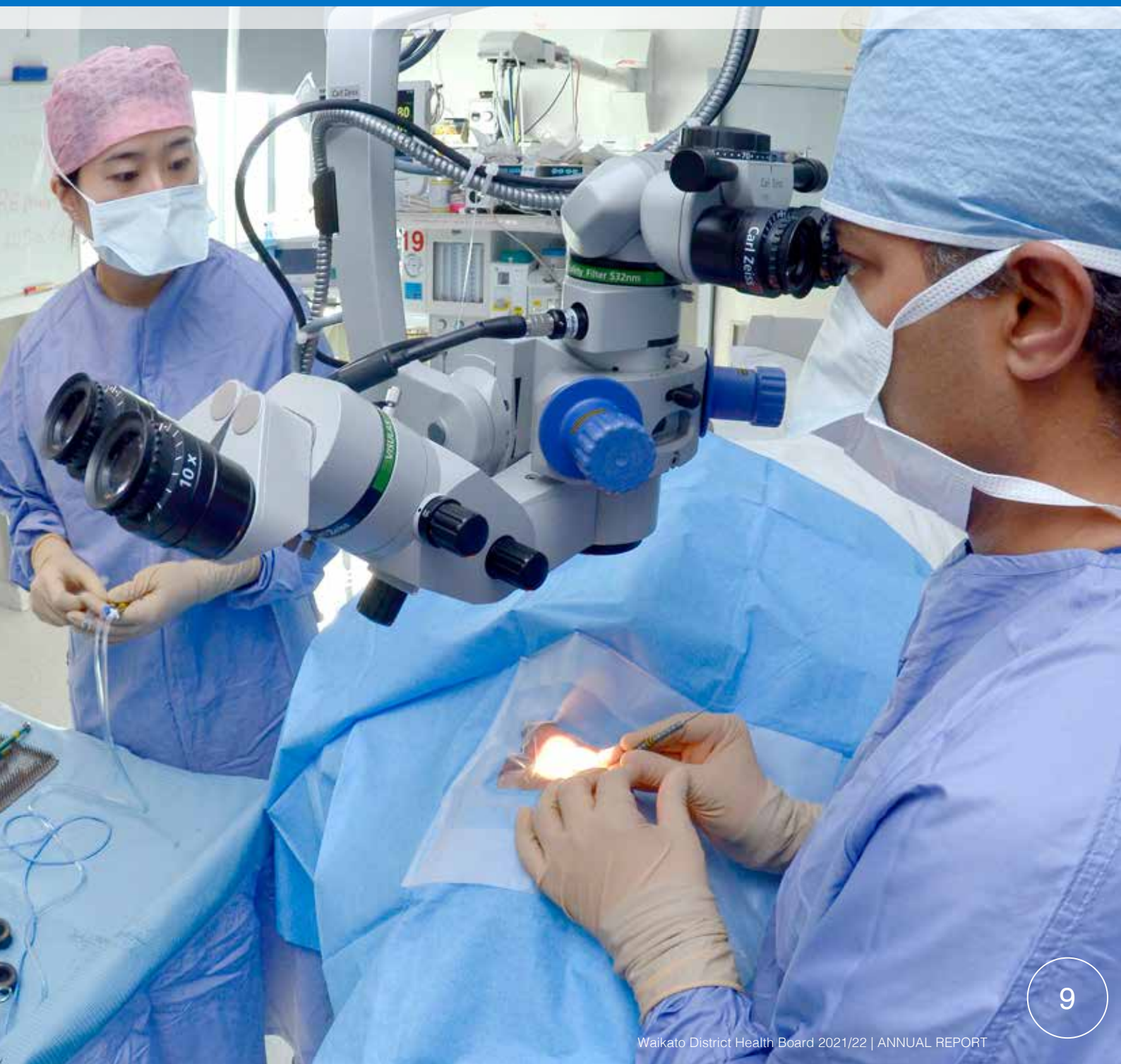
Deputy Commissioner

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

Such an amazing team! They have restored my life with the surgical procedure I had. Everyone was highly efficient, yet very personal and caring. I loved the way each one of the team introduced themselves to me, it made me feel so at ease. To everyone from the initial booking team to the surgical team and the after-care team, a huge thank you for the wonderful change you have brought to my life! .

Cardiology

Part one: Overview



Introduction

Who we are and what we do

This Annual Report outlines our financial and non-financial performance for the year ended 30 June 2022. In the Statement of Performance (part three), we present our actual performance results against the non-financial measures and targets contained in our Statement of Performance Expectations 2021/22.

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

We have both funded and provided health services this year. For the 2021/22 year, we received approximately $1.8 billion in funding from Government and Crown agencies for health and disability services for the Waikato population. The amount of funding we receive is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status.

During 2021/22 approximately 70 percent of funding received by Waikato DHB was used to directly provide hospital services. The remaining 30 percent was used to fund contracted health services provided by non-government organisations (NGOs), primary health care organisations (PHOs), Māori health providers, Pacific health providers, aged residential care, other DHBs, pharmacies and laboratories. These services were monitored, audited, and evaluated for the level of service delivery.

As well as the strategic direction at a local, regional and national level, the following performance story diagram shows the links between what we do to enable and support our performance (stewardship), and our service performance (output classes, outputs and impacts).

Functions of a DHB

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

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

Health System Review – Transition period

An interim Health New Zealand organisation was established in September 2021 to help drive the development of the permanent entity and its role within a newly transformed system. This was transitioned to Te Whatu Ora – Health New Zealand on 1 July 2022 when the Pae Ora – Healthy Futures Act received Royal Assent. Te Whatu Ora will lead the day-to-day running of the health system across New Zealand, with functions delivered at local, district, regional and national levels. It will weave the functions of the 20 former DHBs into its regional divisions and district offices, ensuring continuity of services in the health system. Te Whatu Ora will manage all health services, including hospital and specialist services, and primary and community care. Hospital and specialist services are planned nationally so they can be delivered more consistently across the country. It will manage national contracts.

Te Aka Whai Ora – Māori Health Authority is an equal partner to Te Whatu Ora and their role is to lead and monitor transformational change in the way the entire health system understands and responds to the health and wellbeing needs of whānau Māori. Te Aka Whai Ora will work with Iwi-Māori Partnership Boards, Māori health providers and professionals, iwi, hapū and Māori communities to understand Māori health needs and aspirations across New Zealand. They will ensure these are reflected in the priorities and plans of the health system, and how services are designed and delivered to meet those needs, including through the use of kaupapa Māori models and the application of mātauranga Māori in the system.

Providing health and disability services

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

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

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

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

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

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

Mental health rebuild – Te Pae Tawhiti

In early 2021, Ministers approved the indicative business case for the much needed new adult acute mental health inpatient facility for Waikato. The indicative business case provided decision makers with an early indication of the preferred way forward, confirmed the need for investment and case for change, and approval provided development to be undertaken on the next approval step – the detailed business case.

Throughout 2021, there was significant work undertaken on site investigation, concept design and preliminary design phases for the new facility. We also extensively reworked our model of care and designed a culturally led and clinically underpinned approach to the delivery of care within the new facility. System transformation activities are underway across the mental health continuum of care, to improve health outcomes and modify patient flows to ensure the new facility is right-sized and delivers optimal value.

The preferred location for the new adult acute mental health inpatient facility is the Ryburn 'ridge' site. This site is currently occupied by Puna Whiti, the old ICT Ryburn Building, the Ryburn Building accommodating rheumatology and pain services, and the Waikato Regional Renal Centre. After extensive analysis into relocation options for renal, the decision was made to progress the preferred option for a new renal facility on the site currently occupied by the squash courts. As a critical enabling project, the new renal facility was also outlined in the detailed business case. The purpose of the detailed business case is to recommend the preferred option that optimises value for money and seeks approval to finalise the arrangements for successful implementation.

In June 2022, Ministers approved the detailed business case for:

- a new 64 bed adult acute mental health inpatient facility on the Ryburn 'ridge' site with a budget of $115m. Construction to be complete around mid-2025
- a new 53 chair Waikato Regional Renal facility on the squash courts site with a budget of $40m. Construction to be complete around mid-2024

Design phases for both facilities will continue throughout 2022, including ongoing engagement with our mana whenua group – Te Haa o te Whenua o Kirikiriroa. Market sounding is underway as the first step in the process to engaging construction contractors. And work is now underway on the final Treasury approval step – an implementation business case. The implementation business case recommends a preferred supplier and seeks approval from decision-makers to enter into commercial contracts. It is planned that construction will commence on both facilities around mid-2023.

Getting to this point has taken the work and input of many staff, service users, and their whānau who use services, mana whenua, community stakeholders and others. The successful and timely delivery of this large building programme is important for Waikato.

A sneak peek at the new concept designs

Adult acute inpatient facility: Front façade provides multiple entry points and supports a welcoming accessible and reassuring arrival into the facility.

Adult acute inpatient facility: Living room shows light and spacious lounges with seamless flow into courtyards.

Regional renal facility: The facility will be located at a main entry of the hospital campus, it will be one of the first buildings seen on arrival, and the last on departure. Front façade (above). Reception (right) where an open airy reception space will welcome people into the facility.

COVID-19 response

Waikato DHB's response to the COVID-19 pandemic has been equity-led and driven by community need. We have worked in partnership with iwi, kaupapa Māori and Pacific providers, embracing the tongikura that was gifted by Kiingi Tuuheitia Pootatau Te Wherowhero te tuawhitu:
Amohia ake te ora o te iwi, ka puta ki te wheiao.
To protect the wellbeing of our people is paramount.

This tongikura was the driver for the establishment of 'The Waikato Way', the ethos and principles by which all our response has been built, alongside our obligations under Te Tiriti o Waitangi.

The Waikato district took a system-wide approach in its response, working across all areas of the DHB, to ensure we could meet local need, while reducing the impact on the healthcare system and protecting our most vulnerable populations.

The focus of our efforts has been on our priority populations (approximately 30 percent) who would be hardest hit by both the pandemic and winter illnesses. The national response adequately served the general population (approximately 70 percent).

The Waikato Way

Our purpose

To provide a safe and welcoming COVID-19 vaccination programme to protect the wellbeing of our community

We achieve this by...

1. **Kawea ake**
   – being prepared for what is ahead (whether immediate, medium or long term action is required) and we are ready to take up the tasks before us
2. **Manaakitanga**
   – uplifting the mana of others – our care, respect and empathy for others will ensure that their mana will be enhanced and uplifted
3. **Mahitahi**
   – demonstrating collective, collaborative and cooperative efforts of all working in unison

Managed isolation

A significant part of the Waikato COVID-19 response for nearly two years were the multi-agency managed isolation and quarantine facilities llocated across three sites in Hamilton (Distinction Hotel, Ibis Tainui, and Jet Park Hotel). Ensuring whānau with COVID-19 and those returning from overseas had safe accommodation to isolate was crucial to protecting our communities prior to the vaccine becoming available and the ability for whānau to isolate at home.

The Waikato Way developed at the beginning of the Managed Isolation Facilities (MIFs) laid out our approach to managed isolation, ensuring manaakitanga was at the forefront for all whānau required to isolate. By providing outstanding hospitality and warmth of spirit shown daily by those working across our facilities to welcome and care for all guests, the challenges for whānau were eased.

In October of 2021 Amohia opened, the Community Isolation and Quarantine (CIQ) facility located at Distinction Hotel Hamilton. This was a direct response to the Delta outbreak and the Government's elimination strategy at the time. The CIQ later relocated to the Jet Park Hotel Hamilton in February 2022.

The total number of returnees undertaking managed isolation at Hamilton facilities over the past two years was 8457 with the first arriving at Distinction Hamilton on 28 June 2020 and the last leaving from Ibis Tainui on 3 March 2022.

A total of 200 people needing support while isolating passed through the Amohia facility at Jet Park Hotel Hamilton since that time.

All three facilities won a Waiora Waikato Matariki Award in 2021 for their innovative service and the Jet Park Hotel Hamilton team won the People's Choice Award in the 2021 Waikato Chamber of Commerce Business Awards.

One of the unique features of the Waikato isolation response was the inclusion of the pou tiaki role at each site. Pou tiaki were leaders in embracing The Waikato Way and provided culturally responsive support to both public and staff.

Hospital and community services

All aspects of patient care for both hospital and community services had to be reviewed and modified to respond to and meet the demands of COVID-19. At the peak over 120 patients were being actively treated within Waikato hospitals, whilst a greater number were being cared for within their homes.

As a result new systems, processes and clinical considerations were adopted to care for our patients. Alongside heightened use of PPE, yellow zones and corridors were introduced within emergency departments and throughout hospitals respectively to support the management of suspected COVID-19 positive patients.

COVID-19 wards were created where patients across disciplines were cared for, which required in turn flexibility across all wards to accept patients outside of their specialty. Engagement with patients and whānau was heightened and supported by increased use of kaitiaki and the creation of COVID-19 discharge coordinators who also connected with primary providers.

Through the Coordinated Incident Management System (CIMS) and the incident management team, greater coordination and communication was required to help facilitate both business as usual and the challenges of COVID-19.

Contingency plans were developed by all workgroups to mitigate risks and problem solve. It needs to be acknowledged that none of the above, or the response in any part of the organisation, could have been achieved without the wonderful people and teams who form Waikato DHB. Each workgroup changed the way it managed business to meet the needs of this challenge and to ensure the best patient care possible.

Care in the community

Early in our care in the community response, a specialised equity led team, Marangai Areare, was established to better engage with whānau mokemoke and those who needed more intensive and culturally responsive support. Following this, the COVID-19 Directorate was established to serve as an integrated response, pulling together the multiple operational delivery functions of the pandemic into one area, in order to improve communication, collaboration, efficiencies and create pace in an environment that required agility and cohesion to best serve the Waikato population.

As the Omicron outbreak approached and the impact this could have on the priority populations, it was important to identify those most at risk and ensure no one fell through the cracks. As a result, we undertook to identify and triage the entire population of the takiwā. Using a unique risk stratification tool, that considered not just health complexities, but also socio-economic and cultural factors, we identified those priority whānau who would be most at risk of serious illness or complex welfare needs should they test positive. This stratification process was central to our response as early identification enabled us to provide early manaaki support for whānau identified as having COVID-19. This included assessment of clinical safety, welfare needs, and mental wellbeing to prevent unnecessary presentation to emergency departments and acute care, as well as improved experiences and engagement with the healthcare system for whānau who at times had previously been disengaged. This process also gave visibility to whānau who were not enrolled in general practice and ensured clinical support was still enabled as required.

This was a collaborative effort, involving infrastructure established during the Delta and previous outbreaks and the learnings these provided. As the pandemic progressed, the need to ensure wrap-around manaaki support for our priority population living in our communities with COVID-19 and other winter illnesses meant we needed to establish a Waikato care in the community response.

Tākina – Care in the Community was an equity driven approach available seven days per week. Working closely with Marangai Areare this infrastructure pulled together the Primary Care Response Unit (PCRU), the Integrated Coordination Centre (ICC) and 12 Care Coordination Hubs across the takiwā. Of these 12 hubs, 10 were iwi led, one Pacific led and one ethnic community led. This was the only ethnic led hub set up in New Zealand and provided care to our refugee and migrant communities.

A key tool for Tākina was the expansion of the Here to Help U platform which enabled both the public and providers to request support across a large range of social and health services directly.

Collectively these different functions were the engine room for the response. The PCRU provided the expert interface across the care continuum, with particular focus on ensuring clinical oversight of community based COVID-19 cases. Liaison with all local providers and the Care Coordination Hubs ensured appropriate clinical oversight existed for all Waikato COVID-19 cases. This required case visibility and knowledge of the capacity within general practice to provide oversight, and the ability to rapidly adapt our response to emerging risks on a daily basis.

The PCRU enabled key linkages between existing systems, supporting patient care by recognising and mitigating systemic risks within the health delivery response. While initially this largely involved supporting primary care, as the pandemic evolved the interface broadened to support core communications and information transfer between secondary care and the community locally.

To support the clinical aspects of care in the community, the Care Coordination Hubs focused on the needs of the person with COVID-19 in their local community rather than the needs of the provider organisations. This was a joined-up approach across health, iwi and social services organisations. A key factor to the success of this approach was removing barriers of access by ensuring a community led, localised, holistic and whānau centred approach.

The ICC provided the supporting functions for the clinical and community responses, the single point of entry for any COVID-19 and immunisation related queries as well as winter illness queries from consumers, providers and Care Coordination Hubs. The ICC also undertook outbound calling campaigns to support immunisation uptake and delivery.

The key outbreaks were Delta from August to December moving to mainly Omicron from January to June. Over the financial year, a total of 718 people with mainly Delta and 108,391 people with mainly Omicon were supported through our Tākina response. With more than 70 percent of those requiring support identifying as Māori, it is clear that the risk stratification process was a positive early preparation step to take.

Total number of cases by variant and ethnicity (July 2021-June 2022)

	Year	Month	Māori	Pacific peoples	Asian	European or other	Total
Delta variant period	2021	July	-	-	3	-	3
		August	-	-	1	-	1
		September	-	-	-	1	1
		October	54	-	1	68	123
		November	265	12	13	49	339
		December	184	11	3	53	251
Omicron variant period	2022	January	41	9	57	32	139
		February	2931	1052	1419	4159	9561
		March	14,655	2274	5430	27,571	49,930
		April	4625	576	2271	12,718	20,190
		May	2630	437	1751	11,720	16,538
		June	1620	252	1389	8369	11,630
		Total	27,005	4623	12,338	64,740	108,706

Vaccination

The COVID-19 vaccine continued to be our best defence in the pandemic. Given that vaccination rates, particularly for the 30 percent priority populations, have been a problem long before the COVID-19 pandemic, our focus remained on closing the equity gap.

To do this, the vaccination programme relied heavily on regular detailed data, which enabled an agile delivery model.

Providers and Waikato DHB used this data to ensure we were taking vaccine to where the unvaccinated people were and leveraging timely outreach campaigns to let whānau know when and where they could receive their vaccination.

Testing

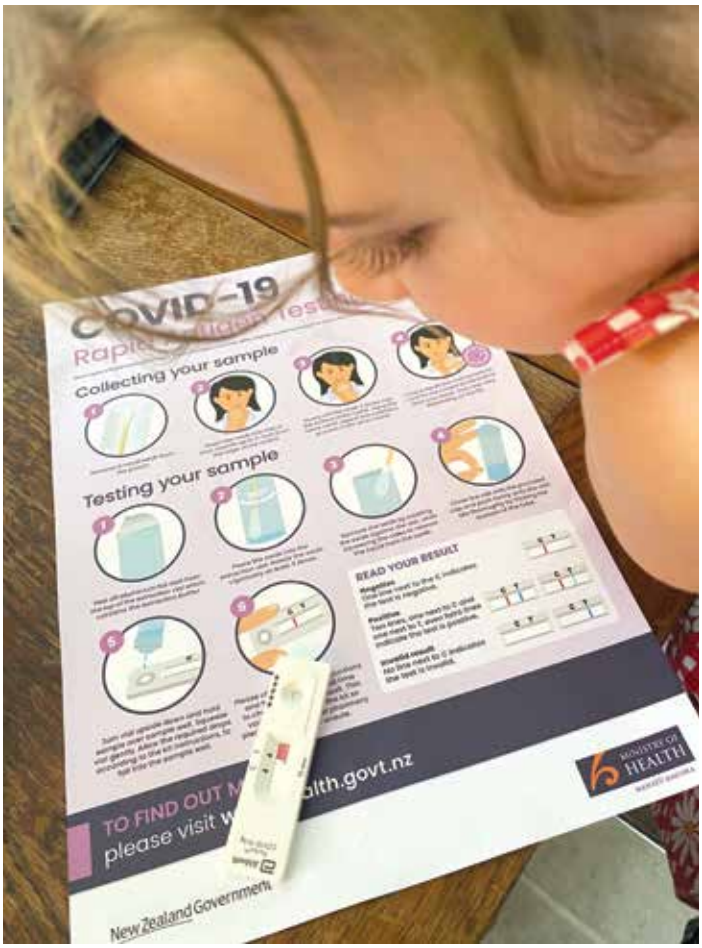
The Waikato testing response has evolved dramatically over the course of the pandemic with the last year seeing a significant shift in the delivery model for testing nationally. The focus for the first half of the year was on the delivery of PCR testing. There was substantial demand at our community and primary care sites which required an additional workforce to be trained in the PCR testing process and placed significant demand on the lab capacity.

Our equity led response was developed in partnership with iwi, kaupapa Māori and Pacific providers to ensure access for our 30 percent priority population with many of the providers standing up testing sites as localised outbreaks occurred.

Following the introduction of Rapid Antigen Tests (RATs), the country moved to a click-and-collect model with test kits distributed to consumers to administer and record at home. We continued to ensure iwi, kaupapa Māori and Pacific providers had adequate supplies early to ensure those whānau who needed extra support could access tests.

PCR tests delivered by Waikato DHB (July 2021-June 2022)

Total	391,864
Māori	99,798
Pacific Peoples	17,430
Asian	43,917
MELAA	6153
European or Other	219,352
Unkown	5214



The Waikato's agile and responsive approach to supporting whānau with COVID-19 has been built on robust cross-sector relationships and a shared vision to protect our communities. The foundations established to deliver locally-led solutions strongly align with the future direction of the health sector.

Workforce

The COVID-19 response saw rapid growth within the health sector at time of critical workforce shortages. There was a significant focus on recruitment of Māori and Pacific staff to ensure our workforce reflected the communities it was serving.

The COVID Directorate employed around 40 percent Māori staff, substantially growing Waikato DHB's Māori workforce.

One key role, which supported this growth, is the kai manaaki position. Originally established to facilitate culturally responsive journeys through vaccination sites for whānau, the role has since expanded with many kai manaaki training to deliver COVID vaccinations, testing, contact tracing, outreach and engagement campaigns, health screening, and support to both the Care Coordination Hubs and ICC.

Local performance story

Our vision

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

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

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

Our strategic imperatives and priorities

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

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

WAIKATO Health System Plan Te Korowai Waiora

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

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

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

Te Korowai Waiora		
Seven goals		Examples of 2021/22 achievements
goal 1	Partner with Māori in the planning and delivery of health services	Seven Māori Needs Assessment and Service Coordination (NASC) venues were established across the Waikato district in partnership with local iwi. The Māori NASC team will be based at these venues enabling clients and whānau to access culturally appropriate support that meets their needs. Improving access to community support is part of a community admission avoidance model that links in with the other community approaches including; acute support, supported rehab, allied health, primary care and aged residential care.
goal 2	Empower whānau to achieve wellbeing	Waikato DHB has driven community solutions and enhanced models of care by working in partnership with a key stakeholder to implement oranga (wellbeing) assessment tools (WHĀ, WHRAP, Harti Hauora) to connect Māori and Pacific whānau to wider holistic health, wellbeing and social services. The assessment tools will be used at Tokoroa Emergency Department when people present. This approach will also ensure continuity of care.
goal 3	Support community aspirations to address the determinants of health	The Alcohol and Other Drug Treatment Court (AODTC) commenced this year. All people who present to the Hamilton Court House will be given the opportunity for wellbeing hauora screening. Through lawyers, individuals who meet the criteria for Te Whare Whakapiki Wairua ki Kirikiriroa will be screened if not already screened by corrections, and offered a comprehensive assessment.
goal 4	Improve access to services	Waikato DHB is committed to supporting the reconfiguration of the national air ambulance service project. The successful delivery of this project will ensure that there is a nationally consistent framework that ensures regardless of location, people will have access to ambulance services. With our diverse and often rural population, this is essential in ensuring equitable access to services no matter where you live.

goal 5	Enhance the capacity and capability of primary and community health care	The COVID-19 response demonstrated that community care, primary care and secondary care could work together to develop better processes for patients. In 2021/22 the DHB, community and primary care continued to work together to identify and address barriers to access colonoscopy and bowel cancer screening. This involved relationship building, no blame listening, prioritisation, troubleshooting, focused actions, and a willingness to modify institutional behaviour to allow better pathway flow.
goal 6	Strengthen intermediate care	There was increased use of the Frailty Admission Avoidance pathway to provide GPs with direct access to community supports through a telephone triage system. GPs can be confident that their patients are able to access the right care at the right time; supported rehabilitation at home, increased home supports, emergency respite, and planned admission if needed.
goal 7	Enhance the connectedness and sustainability of specialist care	The Māori rural initiative team are locally screening identified patients to prevent emergency cardiac events and hospital admissions where clinically appropriate. This has released scarce resource to be available for high and complex cases.

Locality development

Overview

Locality development In Waikato DHB was a 'flagship' for the implementation programme for Te Korowai Waiora. Early in 2021/22, the interim Health New Zealand Transition Unit (iHNZ TU) signalled to DHBs that there would be a process to select 'Locality Prototypes' across the country. The Waikato DHB approach until this time had been focused on seven main localities within the DHB area and in particular the areas with highest deprivation and poorest health outcomes. The seven localities are six predominantly rural areas – North Ruapehu, South Waikato, Waitomo, North Waikato, Hauraki-Thames-Coromandel and Matamata-Piako and one urban area (Greater Hamilton including Morrinsville, Cambridge and Te Awamutu).

Challenges

A commitment to a principled approach and desire to work closely with mana whenua leadership and approval as a first step to locality development in each area meant progress was very slow where these relationships had to be embedded. Changes in DHB leadership with accountability for locality development over the previous year continued to be an impact in 2021/22.

Locality development as at 30 June 2022

Led by Hauraki Māori Trust Board, the Hauraki Rural Healthcare Partnership proposal 'Te Tara o Te Whai' was selected in April 2022 as one of nine Locality Prototypes across Aotearoa. Waikato DHB endorsed the proposal based on an existing productive partnership with Te Korowai Waiora and Hauraki PHO noting that "The Prototype proposal is not a plan to start – this is a plan to continue and grow. The Prototype signals a clear direction and expectations for further collaboration between iwi, the DHB and partners in the locality."

Te Tara o Te Whai
Mo tatou o Hauraki

The Pae Ora (Healthy Futures) Bill was given the royal assent in June 2022 and legislated requirements for the establishment of Iwi Māori Partnership Boards and Localities as a key component of the health system reforms.

The South Waikato proposal led by Raukawa Charitable Trust was in the final stages of development, having agreed with the Transition Unit to present their locality approach to the Transition Unit in July 2022.

Interim Health New Zealand signalled that innovation in other localities would be welcome but that in the first phase of the programme the focus will be on the nine prototypes and those areas with high deprivation and poor health outcomes. In future other areas will be able to benefit from the learning and insights from the prototypes, and be able to use the guidelines and templates being developed – but will not be allocated any specific resources.

Alongside the focus on supporting Pare Hauraki and South Waikato locality development, the DHB continued to support and partner with initiatives across the district such as the Hauraki Rural Healthcare Partnership and the co-location of DHB community services and mana whenua-led healthcare in the Raahui-Pookeka area.

Whilst not specifically a 'locality activity', DHB activity continued to apply the 'locality lens' on proposed and planned opportunities to understand and engage more in those localities where data showed health outcomes were poorest. For example research into the use of the WHĀ tool (Whānau Health Assessment) with children under five years presenting to emergency care included the research team being sited in the Tokoroa Hospital Emergency Department as well as the Waikato Hospital Emergency Department.

Opportunities

The advent of the iHNZ TU-led process and the impending legislative changes in the Pae Ora Bill provided opportunity for the DHB in the development of localities because of the strengthening of the governance structures which were enshrined in legislation provided a strong platform on which to further build relationships.

Through Care Coordination Hubs, the DHB built upon the strong mana whenua leadership, iwi provider relationships, and community connectedness that emerged from the Waikato DHB COVID-19 response. The development of an equity based COVID-19 response that is mana whenua led in each locality has

been a significant game-changer to 'opening the doors' for relationship growth with the DHB to move forwards to address overall health priorities including equity and access.

There are opportunities to align the iwi-specific initiatives in their own rohe and the health priorities identified by Health New Zealand and the Māori Health Authority. Moving from a community hub approach to an integrated health response at a locality level is a key opportunity.

The excellent work that has been done by the Waikato DHB teams in developing fit-for-purpose data processes to enable risk stratification for purposes of wrap around services to our high risk populations will provide a very useful platform going forwards. Value is being added through the development and training of a kai manaaki / non-regulated workforce that would otherwise not have been available without the pressures of needing to quickly build a care in the community response.

Continuing challenges

Mechanisms for funding locality plan development with Pare Hauraki Tranche one have been identified. Clarification of funding available to support Raukawa/South Waikato Tranche two, and to implement emerging Locality Plan service initiatives as agreed with Iwi Māori Partnership Boards is needed going forwards.

Locality boundaries currently identified by Waikato DHB will change and evolve as the Iwi Māori Partnership Boards inform and endorse boundaries across each district. This will necessitate Te Whatu Ora Waikato working closely with neighbouring Te Whatu Ora districts where these areas overlap.

Risks

The risks include taking too long to move into the locality programme across the whole takiwā and losing the gains from the COVID-19 response. Timeframes need to be aligned and sufficient resourcing provided to progress planning and implementation. Other significant risks to developing fully integrated healthcare systems at a local level are the consequences of COVID-19 stress on our primary care workforce, for example the early retirement of general practitioners as a result of COVID-19 response burn out; and the impact of prolonged border closures on the availability of healthcare workforce.

Future expectations

We expect that over 2022/23 there will be increasing national and regional leadership from both Te Aka Wai Ora and Te Whatu Ora in the development of localities. Significant landmarks will be the finalisation of the Iwi Māori Partnership Boards with expected clarifications of locality boundaries and sign-off of locality plans in their area, as well as the embedding of the promised tools and enabling functions to guide the vision to reality.

Community Health Forums

The Community Health Forums (CHFs) are one of the ways Waikato DHB engages with its consumers and communities. We run up to 30 hui a year – either face-to-face or online – rotating meetings across our urban and rural localities to engage with communities in up to thirteen different towns across our DHB area. These towns include Raahui Pookeka/Huntly, Coromandel, Meremere, Taumarunui and Tokoroa. These public forums are facilitated every three to four months and up until 1 July 2022 had representation from our DHB commissioner group. They provide an opportunity to hear about what matters to local communities in regards to health, and enable communities to receive updates on what's happening in terms of Waikato DHB, and health service improvements. Understanding the unique characteristics of each community is important in order to tailor responses to meet locally identified needs.

A lack of local access to some services, physical access as a barrier (i.e. transport) and mental health and wellbeing matters continue to be regularly identified as issues by participants at forums in rural areas. Social isolation and mental wellbeing concerns for both rangatahi/youth and older people are limited remote access to health services are emerging issues across all the forums. A new regional whānau hauā/disability forum has been established and is being hosted by 'My Life, My Voice Waikato', or the Waikato Disabled Persons Assembly.

Regional performance story

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

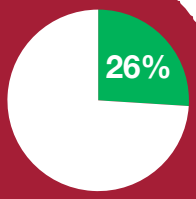
Te Manawa Taki vision	He kapa kī tahi – a singular pursuit of Māori health equity			
Te Manawa Taki values	Tautoko – mutual support	Auahatanga – innovation	Hauora – Māori health and wellbeing	Ihi – power of our integrity
Te Manawa Taki mission	C3: Co-design, Co-decide, Co-implement			

Regional Equity Plan

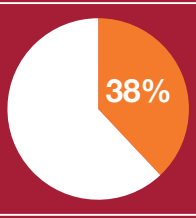
Te Manawa Taki Governance produce annually a Regional Equity Plan. Te Manawa Taki Governance Group comprises the four Board chairs and one commissioner of Te Manawa Taki DHBs as well as the five chairs of Te Manawa Taki Iwi Relationship Board. This 50:50 composition reflects a Te Tiriti o Waitangi-based partnership. The Regional Equity Plan aligns DHB priorities with shared regional objectives and vision He kapa kī tahi – a singular pursuit of Māori health equity.

Te Manawa Taki iwi

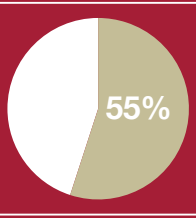
Bay of Plenty DHB
Ngai Te Rangi, Ngāti Ranginui, Te Whānau ā Te Ēhutu, Ngāti Rangitihi, Te Whānau ā Apanui, Ngāti Awa, Tūhoe, Ngāti Mākino, Ngāti Whakaue ki Maketū, Ngāti Manawa, Ngāti Whare, Waitahā, Tapuika, Whakatōhea, Ngāti Pūkenga, Ngai Tai, Ngāti Whakahemo, Tūwharetoa ki Kawerau



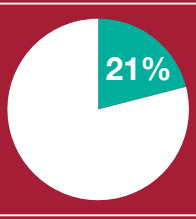
Lakes DHB
Te Arawa, Ngāti Tūwharetoa, Ngāti Kahungunu ki Wairarapa



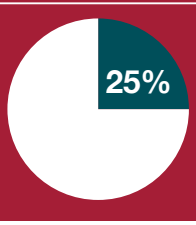
Hauora Tairāwhiti DHB
Ngāti Porou, Ngāi Tamanuhiri, Rongowhakaata, Te Aitanga-a-Mahaki, Ngāti Kahungunu, Ngā Ariki Kaiputahi, Te Aitanga-a-Hauiti

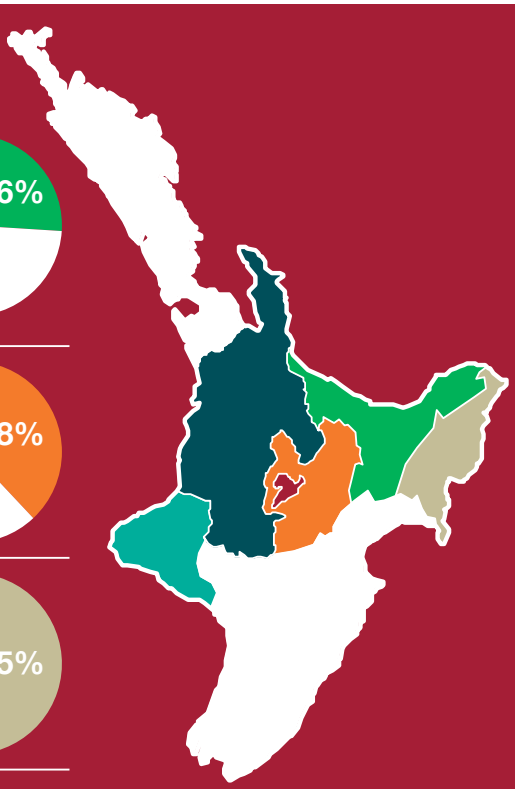


Taranaki DHB
Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngāruahine, Ngāti Ruanui, Ngā Rauru Kiitahi



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





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

About **Te Manawa Taki**

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

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

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

1,007,405 people (2021/22 population projections), including 280,170 Māori (28 percent)

Te Manawa Taki values

The values of Te Manawa Taki are represented by the acronym T.A.H.I, which is also the Māori kupu (word) for the number one. T.A.H.I reflects our commitment to achieve equity, Māori health gain and a successful Te Tiriti embedded partnership. These issues and those in the Regional Equity Plan are our combined number one priority.

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

It is through these values that we can continue to improve outcomes for Māori, where Māori have at least the same health outcomes as non-Māori. T.A.H.I also aligns with our vision statement, which reflects our singular commitment.

Strategic plan

The Regional Equity Plan 2021-2022 consolidates the approach of the 2020-2023 Regional Equity Plan, and previous Regional Services Plans. There is significant national work underway both to continue an ongoing response to COVID-19 and to begin to implement the changes directed by the Health and Disability System Review (HDSR). Therefore this plan has a one-year rather than three-year focus.

Within Te Manawa Taki, DHBs are working collectively on strategic equity priorities, in order to complete strategic actions over the next 12 months.

Additionally, five health equity outcome priorities have been agreed within the region – equitable immunisation rates for tamariki, mental health and addiction, planned care, home and community support, and cardiovascular services. These priorities and will be a focus of local/DHB and regional collective activity throughout 2021/22.

<table>
<tr><th colspan="2">Regional Equity Plan</th></tr>
<tr><th>Strategic plan with 12-month actions</th><th>Priority health equity outcomes</th></tr>
<tr><td rowspan="4">• Equity position statement
• Equitable funding strategies action plans
• Māori workforce framework regional data collection
• Provider development COVID-19

Priorities to advocate for, with incoming health authorities
• Equity strategies
• Regional plan to eliminate institutional racism/bias</td><td>• Cardiovascular services (cardiac and stroke services)
• Child health (tamariki immunisations)
• Healthy ageing (home and community support services)
• Mental health and addiction
• Planned care services</td></tr>
<tr><td>Other regional clinical services</td></tr>
<tr><td>• Cancer – via Te Aho o Te Kahu – Cancer Control agency
• Screening services – bowel cancer, hepatitis C, HPV and cervical screening
• Trauma services</td></tr>
<tr><td>Enablers</td></tr>
<tr><td></td><td>• Data and digital services
• Pathways of care
• Quality
• Workforce</td></tr>
</table>

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

National performance story

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

Accountability

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

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

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

Our performance story

National performance story

Health system future direction	All New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system				
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			
Te Manawa Taki values	Tautoko – mutual support	Auahatanga – innovation	Hauora – Māori health and wellbeing	Ihi – power of our integrity
Te Manawa Taki mission	C3: Co-design, Co-decide, Co-implement			

Waikato DHB performance story

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

Service performance

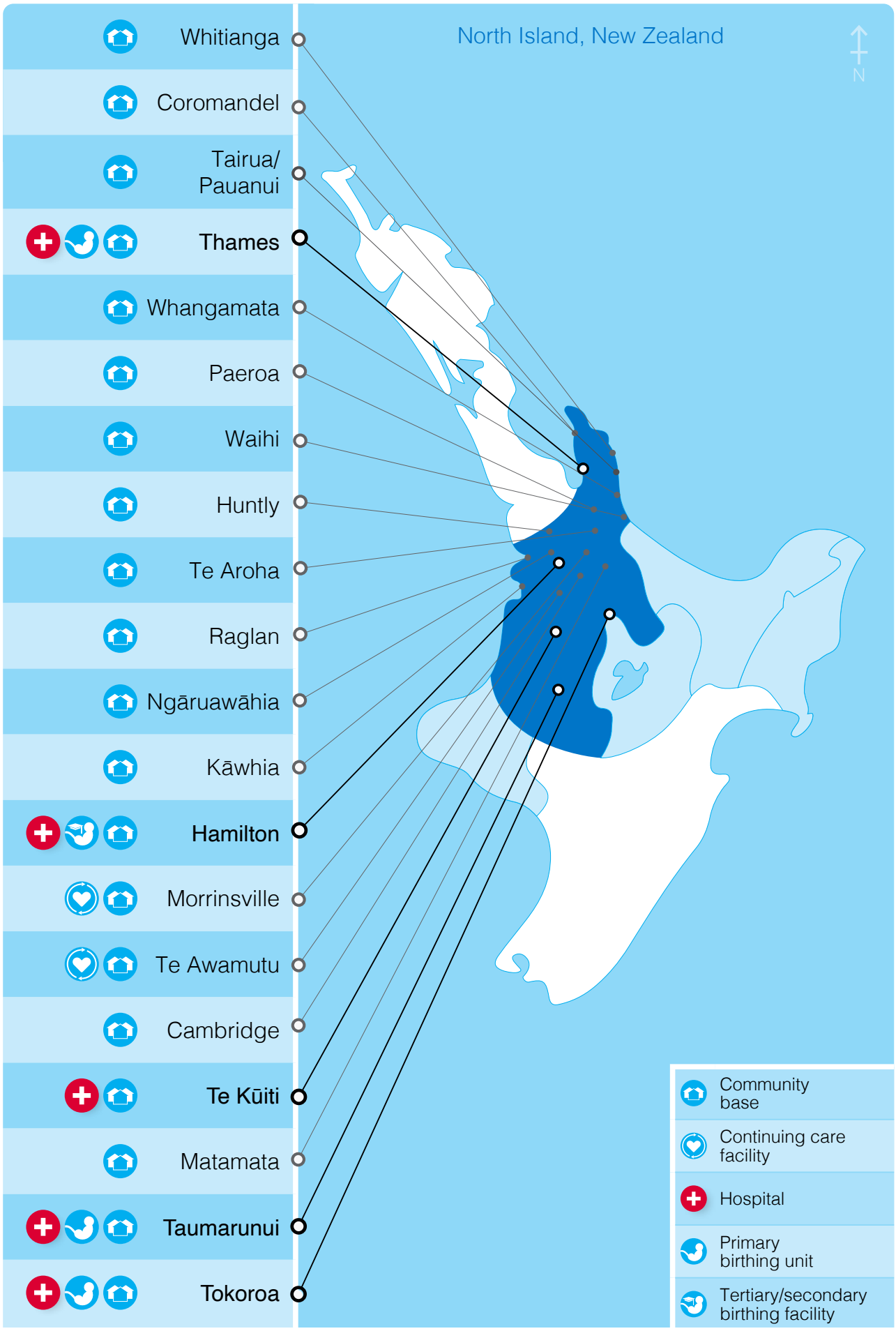
Long-term impacts	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours	An improvement in childhood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

Stewardship

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

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

Waikato DHB profile



Location and population at a glance

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

7 localities within our boundary

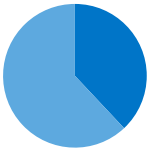
Our population in 2021/22 is 449,598

59% Urban

41% Rural

127,817

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



51,347 40% **Māori**

76,470 60% **non-Māori**

High deprivation as a percentage of total locality population

- **75%** South Waikato
- **59%** North Ruapehu
- **49%** North Waikato
- **42%** Waitomo-Ōtorohanga
- **35%** Thames-Coromandel-Hauraki
- **21%** Greater Hamilton
- **12%** Matamata-Piako

50% Female  **50% Male**

17.1% of our population is aged 65 years or over

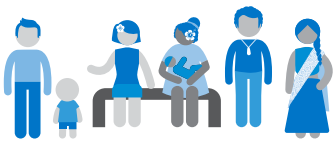
25% **Māori population** compared to national average of 17%

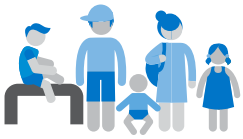
Our ethnicity population make up

25% Māori

72% Other

3% Pacific





26.7% of our population are under 20 years

Population growth in the next 10 years

+10% Total

+20% Māori

+35% 65 or older

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

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

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

Seventeen percent of the Waikato population is aged 65 or over. Our population will continue to get proportionately older (the 65 and over age group is projected to comprise 21 percent of our population by 2032). This, coupled with the increase in chronic and complex health conditions, help to direct strategies and plans being put in place to meet future health needs.

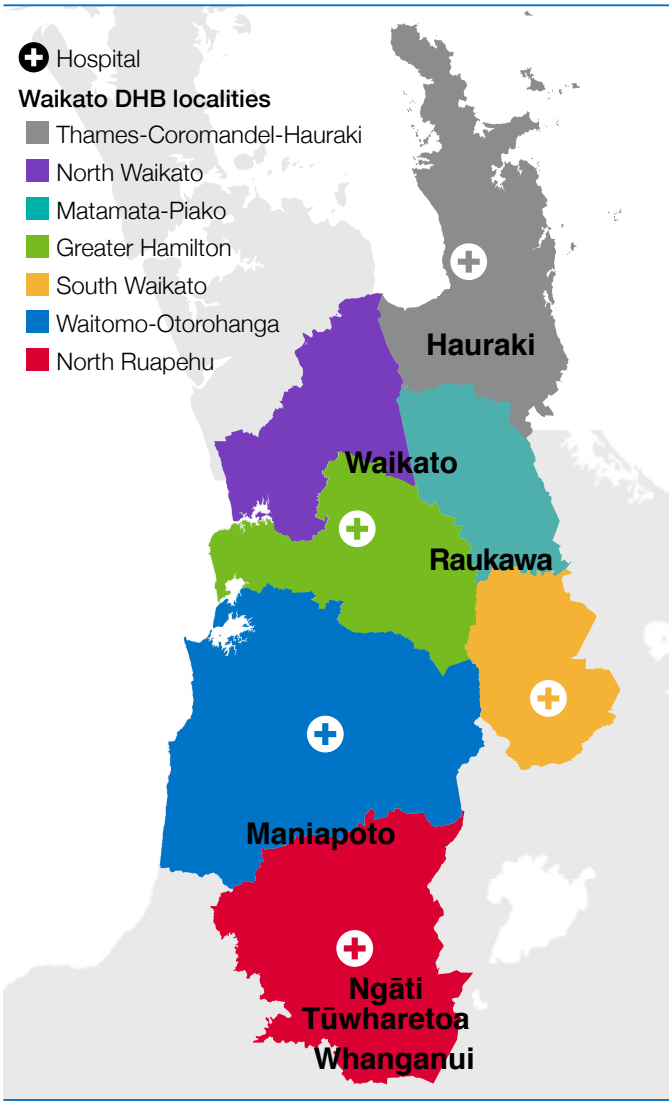
Twenty-five percent of the Waikato population are Māori. The Māori population is significantly impacted by many chronic conditions and are disproportionately represented in adverse health statistics. These facts, alongside the acknowledgement of the status of iwi in the Waikato, gives us a strong commitment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

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

Waikato DHB iwi

Waikato DHB serves the highest population of Māori of any DHB.

Iwi in the Waikato DHB region include Hauraki, Maniapoto, Raukawa, Waikato, Ngāti Tūwharetoa and Whanganui. A significant number of Māori living here affiliate to iwi outside the district. The map shows the overlap between iwi rohe and the seven DHB localities.



Iwi rohe and Waikato DHB localities

Our workforce at a glance

Understanding the workforce composition is essential to delivering equal employment opportunities (EEO). Without such knowledge, progress towards a diverse workforce cannot be accurately measured. The numbers are as at 30 June 2022 and include all active employees with the exclusion of parked employees (i.e. those on parental leave, yet to start, and those on career break leave) and contingent workers. As at 30 June 2022, Waikato DHB had 8455 employees with 6959 full time equivalents.

8455 Total employees

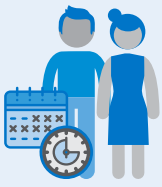
Employee diversity

41.9% NZ European
11.4% Māori
2.4% Pacific
44.3% Other

Employee age range

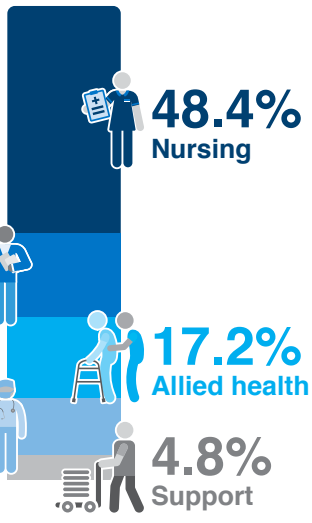
6.9% <25
24.5% 25-34
23.1% 35-44
19.9% 45-54
19.9% 55-64
5.7% 65 and over

Employment status



47.3% Full-time
46.9% Part-time
5.8% Casual

Employee type



48.4% Nursing
17.9% Management/ administration
17.2% Allied health
11.7% Medical
4.8% Support

Employee diversity

New Zealand European is 41.93 percent of the workforce and Māori is 11.39 percent.

Ethnic group	Headcount	Percent
NZ European	3545	41.93%
Asian	2406	28.46%
Other European	1096	12.96%
Māori	963	11.39%
Pacific Peoples	206	2.44%
Other ethnicity	106	1.25%
African	68	0.80%
Middle Eastern	39	0.46%
Latin American	26	0.31%
Total	8455	100%

Age range

The average age of all Waikato DHB employees is 43.4 years. The age distribution is shown below

Age range	Total	Percent
24 and under	581	6.87%
25-34	2072	24.51%
35-44	1954	23.11%
45-54	1684	19.92%
55-64	1686	19.94%
65 and over	478	5.65%
Total	8455	100%

Employment status

The majority of our employees are full-time (47.31 percent) and 46.88 percent are part-time. 5.81 percent are casual employees.

Status	Headcount	Percent
Full-time	4000	47.31%
Part-time	3964	46.88%
Casual	491	5.81%
Total	8455	100%

Employee type

Type	Headcount	Percent
Nursing	4088	48.34%
Management/administration	1514	17.91%
Allied health	1455	17.21%
Resident Medical Officer (RMO)	508	6.01%
Senior Medical Officer (SMO)	482	5.70%
Support	408	4.83%
Total	8455	100%

Employee exiting information

The table below shows the number of terminations for the past 12 months and the reasons for leaving recorded in the system (1 July 2021 to 30 June 2022, source: OurKaimahi). The top five reasons for why people left over 2021/22 have changed since 2020/21.

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

- relocation
- career progression
- end of temporary employment
- personal reasons
- family reasons

Reason for leaving	Total
Relocation	410
Career progression	331
End temporary employment	289
Personal reasons	248
Family reasons	165
Career change	144
Retirement	105
COVID-19 vaccine health order	104
Health reasons	88
Changed status to casual	62
Further study	48
Dissatisfied with work conditions	31
Offer declined	26
Reason unknown	17
Resigned from parental leave	14
Dissatisfied with type of work	12
Travel	10
Dissatisfied with manager/supervisor	8
Dissatisfied with hours	7
Dissatisfied with pay	6
Elimination of position	4
Failure to return from leave	4
Serious misconduct	4
Death	2
Misconduct	2
Dissatisfied with company policies	1
Mutual consent	1
Parental leave	1
Unsatisfactory work relationship	1
Total	2145

Organisational and workforce development

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

'Healthy People. Excellent Care' is the vision of Waikato DHB. Waikato DHB also has a set of values that reflect a more supportive, inclusive, positive and respectful culture.

We strive to

- build a workforce that is representative of our community, with a specific focus on increasing our Māori workforce
- provide an organisational culture, with strong leadership and accountability, where everyone is able to contribute to the way the organisation develops and delivers
- ensure that the values of the organisation are demonstrated at all levels
- provide a healthy and safe workplace. COVID-19 and psychological safety have been areas of focus this past year
- build the capability for all our employees, enhancing their career development, job satisfaction and retention as well as enabling them to perform at the top of their scope – clinical or otherwise.

Leadership, accountability and culture

Waikato DHB continues focus on organisational culture and levers for development in that regard, including leadership, policy and processes, communication, technology and resourcing. Over the last 12 months we have worked alongside our leaders and managers to support them through a number of somewhat unique circumstances and events, including COVID-19. We have introduced an organisational culture and staff engagement survey tool, (available on demand), psychometrics for leadership and team development, workshops and webinars on wellbeing (e.g. psychological safety, resilience and personal financial management) and leadership development training.

Waikato DHB has an evolving self-service model, and this involved an upgrade to our PeopleSoft HRIS system in 2022. We introduced manager and employee self-service in this system and further developments are currently underway, which will support transparency of information, workflow-enabled processes and simpler, faster accurate human resources processes.

Recruitment, selection and induction

The DHB has a centralised recruitment function ensuring robust recruitment and selection processes are consistently managed across the DHB. Those responsible for recruitment within the DHB must make fair, objective and informed selection decisions. Waikato DHB also complies with all relevant provisions contained in the legislation when conducting recruitment activities. Our recruitment processes comply fully with safety checking regulations and the Public Service Commission Workforce Assurance Standards. A new area of focus this year has been ensuring compliance with the COVID-19 vaccination order applicable to health care workers.

The Taleo applicant management system ensures consistent candidate care and the DHB has a particular focus on increasing Māori and Pacific uptake into health careers. There has been a focus this year on Māori workforce development action plans, which has increased participation of Māori in our workforce. This has included an in-house careers fair to support retention and growth of our Māori staff, support for CV and interview preparation etc.

Orientation and onboarding are being continuously improved, and with COVID-19 Te Hono Whakataki – Our First Meeting moved quickly online to ensure this important activity could still take place for our new staff.

Employee development, promotion and exit

Waikato DHB has a fair and equitable performance appraisal system in place which supports performance, development, retention and engagement.

The health workforce is a diverse, highly qualified and often highly specialised workforce. The training and development needs reflect this diversity. The DHB is committed to supporting all staff to access appropriate training in accordance with their needs and career plans. This is in multiple forms including face-to-face, tertiary study, assessments and online learning through our online learning system, Ko Awatea. This blended approach provides the DHB greater ability to provide training opportunities which are more effective and efficient for our clinical and non-clinical staff, particularly as some roles have moved to a more 'hybrid' way of working over the past year.

SMOs are able to take sabbatical leave for the purposes of strengthening or acquiring clinical knowledge or skills or undertaking an approved course of study or research in matters relevant to their clinical practice.

Flexibility and work design

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

Waikato DHB's Human Resources service also works closely with managers and our union partners as required to implement change in work practice that meets the needs of staff and assists the organisation to achieve its service and financial performance objectives. This includes new roles, ways of working, service sizing reviews and other organisational culture and service developments.

Remuneration, recognition and conditions

Employee remuneration

Remuneration	2022 Actual	2021 Actual
Employee remuneration over $100,000 ($10,000 bands)		
100,000 - 110,000	561	453
110,000 - 120,000	433	230
120,000 - 130,000	253	139
130,000 - 140,000	128	99
140,000 - 150,000	94	77
150,000 - 160,000	90	50
160,000 - 170,000	44	31
170,000 - 180,000	32	30
180,000 - 190,000	34	40
190,000 - 200,000	28	19
200,000 - 210,000	30	14
210,000 - 220,000	21	24
220,000 - 230,000	18	23
230,000 - 240,000	24	22
240,000 - 250,000	28	29
250,000 - 260,000	27	31
260,000 - 270,000	25	23
270,000 - 280,000	27	28
280,000 - 290,000	18	20
290,000 - 300,000	24	15
300,000 - 310,000	20	31
310,001 - 320,000	23	18
320,001 - 330,000	23	17
330,001 - 340,000	20	13
340,001 - 350,000	14	8
350,001 - 360,000	16	16
360,001 - 370,000	12	9

Remuneration	2022 Actual	2021 Actual
Employee remuneration over $100,000 ($10,000 bands)		
370,001 - 380,000	15	15
380,001 - 390,000	11	8
390,001 - 400,000	7	6
400,001 - 410,000	9	7
410,001 - 420,000	2	2
420,001 - 430,000	6	4
430,001 - 440,000	3	5
440,001 - 450,000	1	2
450,001 - 460,000	5	4
460,001 - 470,000	4	4
470,001 - 480,000	1	2
480,001 - 490,000	1	0
490,001 - 500,000	1	0
500,001 - 510,000	2	1
520,001 - 530,000	-	0
530,001 - 540,000	-	0
540,001 - 550,000	3	1
560,001 - 570,000	-	0
570,001 - 580,000	1	1
580,001 - 590,000	1	1
600,001 - 610,000	1	0
610,001 - 620,000	-	1
620,001 - 630,000	1	0
640,001 - 650,000	1	0
660,001 - 670,000	1	0
670,001 - 680,000	-	1
Total	2144	1574

Between the 2021 to 2022 fiscal years the number of employees earning over $100,000 increased by 570, which related mainly to clinical staff classifications.

Waikato DHB recognises the valuable contribution our employees make to patient care through recognition programmes and/or awards, including long service awards. We have a number of scholarships, study support, leave above statutory requirements and other more informal informs of recognition.

Remuneration and rewards are decided fairly and equitably within the boundaries of the Collective Agreements for the vast majority of employees or in line with relevant employment agreements and the Waikato DHB Remuneration – Individual Employment Agreement Employees policy. This year has seen labour market conditions tighten considerably, and we have experienced pressure on remuneration for all groups. We initiated the move to the 2022 Living Wage for our employees not currently at that level in terms of base hourly rate.

The DHB has regular meetings with its union partners where views are exchanged and information shared. This has been particularly important this year, with COVID-19.

Key management personnel remuneration

Key management personnel

The aggregate value of transactions and outstanding balances relating to governors and executives and the entities which they have control or significant influence were as follows:

Compensations

There were no loans to commissioners during the year ended 30 June 2022 (2021:$Nil)

The Waikato DHB has a standard Directors and Officers Insurance Policy. No claims were made under this policy during the year ended 30 June 2022 (2021:$Nil).

Remuneration

Key management includes the commissioners and executive management including the chief executive. Key management compensation for the period was as follows:

Commissioner and deputy commissioners	2022 Actual	2021 Actual
Commissioner	$	$
Dame Karen Poutasi	203,600	224,692
Deputy commissioners		
Andrew Connolly	-	9,500
Chad Paraone	21,500	40,400
Prof Margaret Wilson	81,500	81,500
	306,600	**356,092**

Executive management team	2022 Actual $000	2021 Actual $000
Salaries and other short-term benefits	3,650	3,586
Contributions to superannuation schemes	140	145
Full-time equivalent members	10	10

Total remuneration and compensation to close members of the family of key management personnel occurred within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those which it is reasonable to expect the Waikato DHB would have adopted if dealing with that individual at arm's length in the same circumstances.

Non-Board members who attended committee meetings	No. of meetings eligible to attend 2022	No. of meetings actually attended* 2022	Remuneration 2022 Actual	Remuneration 2021 Actual
			$	$
Judy Small	8	6	1,500	1,500
Rachel Karalus	8	6	1,500	1,125
David Slone	8	8	2,000	2,000
John McIntosh	8	4	1,000	1,500
Gerri Pomeroy	8	8	2,000	1,500
Te Pora Thompson-Evans (ceased 30/11/2021)	9	9	2,000	5,250
Kataraina Hodge (commenced 1/12/2021)	5	4	500	-
Glen Tupuhi	8	1	250	1,000
Paul Malpass	8	8	2,000	2,500
Fungai Mhlanga	8	8	2,000	2,000
			14,750	**18,375**

Termination payments to employees

During the year payments were made to 12 employees (2021:17) in respect of the termination of employment with Waikato DHB.

	2022 Actual $000	2021 Actual $000
Amount paid	183	596

Harassment and bullying prevention

The Speaking Up For Safety programme has been running for three years and is designed to support all employees to speak up when they experience or witness behaviour that may harm patient safety. Speaking Up For Safety was developed by the Cognitive Institute and has already been rolled out internationally as well as at other New Zealand DHBs. To date over 75 percent of our workforce have attended the training. This is currently being further developed to more directly support psychological safety of staff in addition to patient safety.

Safe and healthy environment

In the past 12 months, the focus of Health, Safety and Wellbeing has needed to pivot somewhat, to support the risks and workplace requirements of COVID-19. Vaccination information, mask fit testing, safe working environments and a safe return to work after more significant illnesses has been an important area of focus.

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

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

We currently have a focus on addressing violence and aggression (from patients and visitors) in the workplace, with an accredited training for identified roles taking place late this financial year. This role, part of in service positions, will enable us to more effectively deescalate and address instances of violence and aggression in the workplace.

Systems are utilised by Waikato DHB to ensure that our ‘workers’, including employees, contractors, locums and healthcare students are assessed, screened and vaccinated against infectious diseases prior to commencing employment or clinical placement.

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

Governance and accountabilities

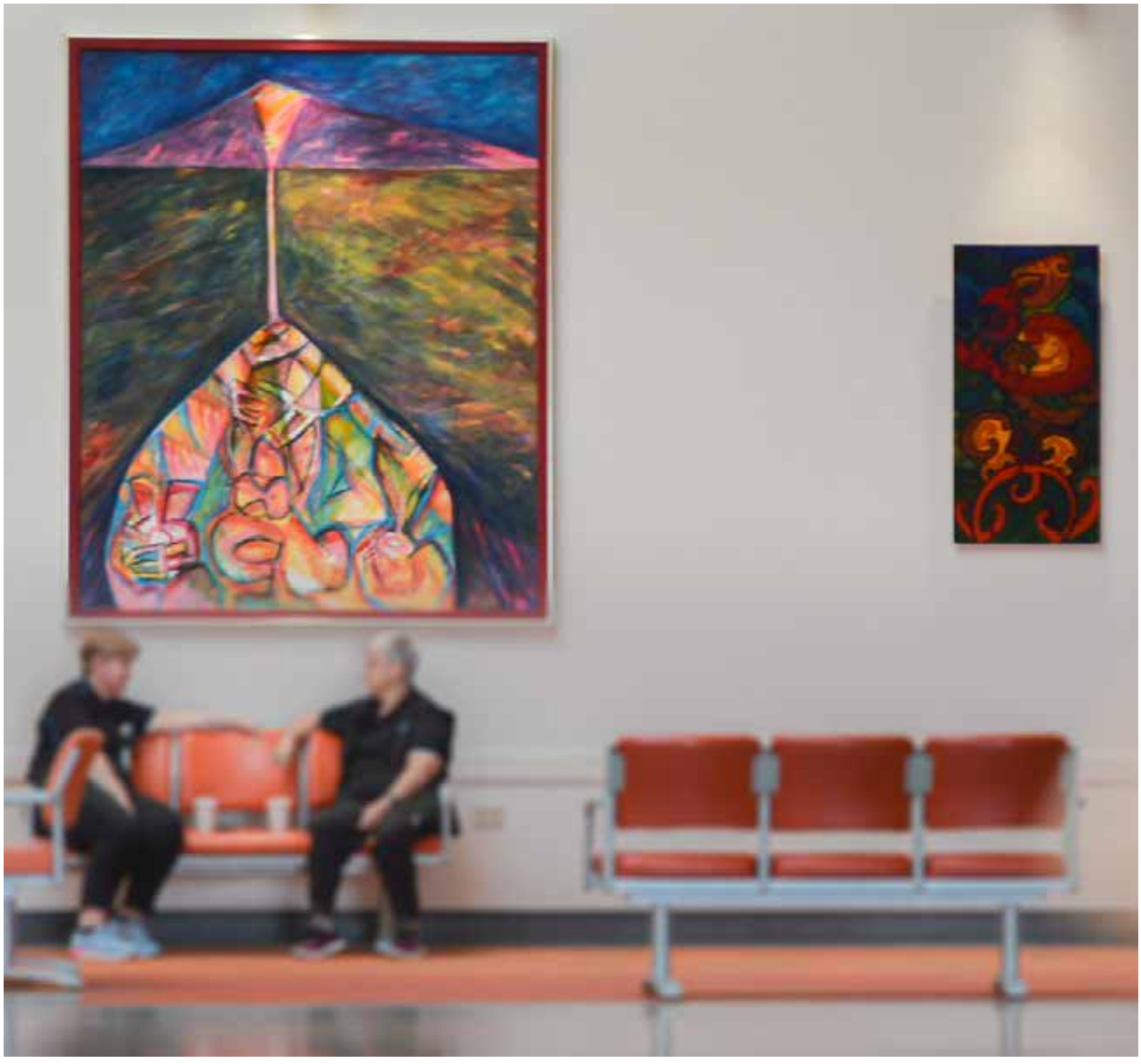
Waikato DHB has three statutory committees; the Community Public Health Advisory Committee, the Disability Support Advisory Committee and the Hospitals Advisory Committee, which are made up of commissioner representation, members of Iwi Māori Council and members from the community.

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

Ministerial directions

Directions issued by a Minister during the 2021/22 year, or that remain current are as follows

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



Some highlights from the year

L-R: Patumahoe Leaf-Wright nurse specialist cardiology, community māori liaison, Dr Micaela Victoria Molinero, specialist cardiologist, Dr Faeez Mohamad Ali, specialist cardiologist, Dr Rajesh Nair, specialist cardiologist.

Hāpaitia te Hauora Manawa Mobile cardiac screening

To the home – for the heart is the ethos of an innovative programme that sees cardiac screening services move from the hospital to the home among Waikato rural and Māori communities.

Hāpaitia te Hauora Manawa was launched in May 2022 by Kiingi Tuuheitia Pootatau Te Wherowhero te tuawhitu and co-chair of the Māori Health Authority, Tipa Mahuta, at Kirikiriroa Marae.

Hāpaitia Te Hauora Manawa will see an outreach nurse hitting the road to visit isolated areas, taking specialist care into people's homes, kōhanga, kura, community centres and marae. Its ultimate aim, is to close a significant equity gap.

Waikato DHB head of Cardiology, Dr Rajesh Nair, described the Hāpaitia te Hauora Manawa programme, as a real game changer. "It centres on specialist cardiologists at Waikato Hospital supporting outreach nurse specialists and an echo-sonographer by way of telehealth as they travel out to remote rural and Māori communities conducting lifesaving heart screening of patients in their own homes."

A bi-lingual (English – te reo Māori) remote health management platform with telehealth capabilities is used to support the programme, a NZ first for heart health.

"The programme's strength is in its innovative approach that sees us head out to see those deemed most at risk in the community instead of waiting for them to come and see us. It's a collaborative approach involving GPs, NGOs, and Māori community leaders identifying those most in need."

With Māori having some of the highest incidences of heart related diseases in the country and being nearly 10 times more likely to be admitted with heart failure, Dr Nair said a prevention first approach is key to turning the tide.

"Māori are also nearly three times more likely to be admitted due to a heart attack so reaching out with a more culturally appropriate approach allows us to better engage with patients who might be reluctant to engage with more traditional health facilities and practices."

Building up trust and confidence in the patients with this different approach will make a real difference said Dr Nair.

Kiingi Tuuheitia (centre), Waikato DHB chief executive Dr Kevin Snee (centre right) and other dignitaries with Waikato DHB COVID-19 vaccination staff.

Te Awa COVID-19 Vaccination Centre supports campaign roll out

Te Awa COVID-19 Vaccination Centre, the largest community vaccination clinic in the Waikato, marked a big step forward in Waikato DHB's COVID-19 vaccination programme when it opened on 20 July 2021.

A whakamanawatanga (blessing) was held at the site on 19 July, attended by Kiingi Tuuheitia, dignitaries from Waikato-Tainui iwi, local MPs, Deputy Mayor Geoff Taylor and DHB vaccination staff.

Subsequent community vaccination centres were established in Hamilton, Thames, Te Kūiti, Taumarunui, Morrinsville, Matamata, Te Awamutu, Cambridge and Tokoroa.

Te Awa COVID-19 Vaccination Centre remained open seven days a week until it closed on 16 June 2022. During operation 82,400 COVID-19 and 696 flu vaccinations were administered at the site. The closure was part of the DHBs transition to replacing the community vaccination centres with mobile vaccination clinics throughout the Waikato, except for one remaining centre in Tokoroa where additional vaccination capacity is needed to support primary care providers.

The site at Te Awa was run in partnership with Waikato-Tainui and Dr Snee says the collaboration is an example of the shared purpose of the DHB, iwi, Māori and Pacific health providers, PHOs, pharmacies and general practice to protect our community from COVID-19. He says partnering with many organisations across the Waikato DHB takiwā has meant the vaccination programme has been tailored to the unique needs of communities, keeping them at the heart of the process. Dr Snee says he is grateful for the DHB's healthcare partners who signed up to become part of the vaccination programme and for the important role they play.

Vaccination team at Te Awa Vaccination Centre.

Shining stars at the inaugural Waiora Waikato Matariki Awards

Waikato DHB hosted selected staff and service providers at the inaugural Waiora Waikato Matariki Awards event on 15 July 2021. The awards have been created to recognise the unsung heroes who have gone above and beyond in supporting the delivery of healthcare across Waikato.

The evening was also a Hiki Wairua activity to help boost wellbeing. With the goal to lift up the spirits of our staff and to celebrate those who have faced many difficult challenges over the past 18 months, including the Whakaari/White Island eruption, COVID-19, and the impacts of the cyber security incident.

The event was timed to coincide with Matariki, known as the Māori New Year, which is a special time to reflect on and celebrate our achievements, spend time together, and look ahead to the future. The awards were named after nine of the stars which make up the Matariki/Pleiades cluster. A tenth, overall award, the Amohia Ake Award acknowledges those who bring to life the tongikura of Kiingi Tuuheitia – "Amohia ake te ora o te iwi, ka puta ki te wheiao (to protect the wellbeing of our people is paramount)".

The majority of award winners were acknowledged for their tireless efforts during the initial COVID-19 response. The overall Amohia Ake Award was presented to specialist cardiologist Dr Rajesh Nair, the head of Cardiology at Waikato Hospital. In this role Dr Nair has championed clinical quality and safety and heart health, with a particular dedication and passion for health equity for Māori.

Dr Rajesh Nair (left) wins overall Amohia Ake Award.

WAIORA WAIKATO MATARIKI AWARDS 2021

WAIPUNA-Ā-RANGI – *acknowledges those who remained steadfast in the face of challenging times*

Awarded to hospital support services (Distribution team, Taylors laundry, kitchen, cleaning and security staff)

URURANGI – *acknowledges problem-solvers, outside-the-box thinkers, the unflappable and those who persevere in the face of adversity*

Awarded to COVID-19 response nursing staff

TUPU-Ā-RANGI – *acknowledges those who go above and beyond to support and empowering others to achieve their best*

Awarded to rural hospitals (Thames, Te Kūiti, Taumarunui and Tokoroa)

TUPU-Ā-NUKU – *acknowledges those who nourish and grow the skills of our people*

Awarded to Media and Communications team

HIWA-I-TE-RANGI – *acknowledges those who are a steady hand, show wisdom and reliability as well having a non-judgmental and compassionate approach to others*

Awarded to Managed Isolation Facilities (Ibis Tainui, Distinction Hamilton and Jet Park Hamilton Airport)

WAITĪ – *acknowledges those who make strong connections, bring people together and listen respectfully to others*

Awarded to Tainui Waka Alliance (Waikato Tainui, Maniapoto, Raukawa and Hauraki)

WAITĀ – *acknowledges those who treat people as a taonga and value diversity and inclusion*

Awarded to Mental Health and Addictions

PŌHUTUKAWA – *acknowledges those who have found innovative ways to continue with traditions and customs*

Awarded to Chaplains

MATARIKI – *acknowledges those with a focus on new beginnings and a vision for the future*

Awarded to COVID-19 Vaccination Programme

AMOHIA AKE – *This overall award acknowledges extraordinary work to protect and support the wellbeing of our people regardless of challenges*

Awarded to Dr Rajesh Nair

Waipuna-ā-rangi award – Distribution team

Ururangi award – COVID-19 response nursing staff

Tupu-ā-rangi award – Rural hospitals teams (Tokoroa, Thames, Te Kūiti and Taumarunui)

Tupu-ā-nuku award – Media and Communications team

Hiwa-i-te-Rangi award – Managed Isolation Facilities (Ibis Tainui, Distinction Hamilton and Jet Park Hamilton Airport)

Waitī award – Tainui Waka Alliance (Waikato Tainui, Maniapoto, Raukawa and Hauraki)

Pōhutukawa award – Chaplains

Waitā award – Mental Health and Addictions

Matariki award – COVID-19 Vaccination Programme

Waikato Bowel Screening Programme celebrates first anniversary

One year on, the Waikato National Bowel Screening Programme has changed the lives of many Waikato whānau for good. Real results delivered for real people, by a team that never lost focus was how clinical lead, Dr Liz Phillips described the first 12 months of the Waikato National Bowel Screening Programme (NBSP) during a ceremony celebrating its first year of operation.

Dr Liz Phillips cuts cake.

Over the past year, despite the challenges thrown up by COVID-19 and restrictions on how they could engage with the community, over 40,000 people were invited to take part in the programme, with over 20,000 using the DIY kits provided.

Phillips said, from that group

- 607 underwent a colonoscopy and 18 a CT colonography
- 45 people were diagnosed with cancer with most discovered at an early stage
- eight more people had cancers confined to a polyp and were cured by a polyp removal on the day of their screening
- four people were diagnosed with advanced disease despite having no symptoms.

“All of those in the group are real people- fathers/sons, mothers/daughters, husbands/wives and grandparents/grandchildren. Participating in the NBSP enables us to detect cancer at an early stage when it can often be successfully treated,” said Phillips.

“For the group of four people with advanced disease the diagnosis, although unwelcome and life changing, allowed them to make decisions about how to spend time on what matters to them. Over the next year the team will continue looking at how to improve the screening programme, removing any barriers which can prevent people from taking part in screening services.”


Tipa Mahuta receiving her flu vaccination from registered nurse Meghan O’Leary at the event.

Kaumātua Wellbeing and Housing Expo in Te Rapa well attended

There were 108 kaumātua at the first Kaumātua Wellbeing and Housing Expo held in Te Rapa on 10 June 2021 with 183 people attending the event.

A collaboration between Rauawaawa Kaumātua Charitable Trust (RKCT), University of Waikato, Te Runanga o Kirikiriroa, Community Enterprise Leadership Foundation and Waikato DHB, it held a range of presentations on wellbeing and housing from a range of experts.

Rangimahora Reddy, chief executive of RKCT said it was a real privilege to have Tipa Mahuta, co-chair of the Māori Health Authority, Te Rehia Papesch – Ministry of Social Development, Whaea Tilly Turner and Rangita Wilson – Te Puni Kokiri, Dr Kay Saville-Smith – Ministry of Housing and Urban Development, Yvonne Wilson – Te Runanga o Kirikiriroa, Professor John Oetzel and Dr Sophie Nock – University of Waikato at the event.

She said feedback from kaumātua on the event had been extremely positive with high praise for the stall providers, presenters, and the entertainment and experiences.

Launch of Pito Hauora – Te Korowai Hauora o Hauraki, Thames.
L-R: Julia Carr (Waikato DHB), Riki Nia Nia (Waikato DHB), Tammy Dehar (Te Korowai Hauora o Hauraki), Taima Campbell (Te Puna Hauora Matua o Hauraki), Chris Lowry (Waikato DHB), Maree Pierce (BreastScreen Aotearoa), Lu-ana Ngatai (Waikato DHB), Luke Wilson (Waikato DHB), Riana Manuel (Māori Health Authority), Mike Brosnan (Waikato DHB), Dr Korohere Ngapo (Te Korowai Hauora o Hauraki), John McEnteer (Hauraki Māori Trust Board).

A new health service, Pito Hauora launches for everyone in the Hauraki rohe

This new preventative and health screening hub has been introduced by Te Korowai Hauora o Hauraki and the Waikato DHB to help create greater access to hauora services closer to home for whānau in the Thames – Coromandel – Hauraki rohe.

Pito Hauora launched on 20 June 2022 with karakia and whakatau led by Dr Korohere Ngapo.

Pito Hauora is a health and wellbeing hub for everyone in the rohe and the aim is to reduce barriers by providing access to health screening and other intervention services closer to home. As the only iwi health provider within Pare Hauraki and the largest provider of holistic whānau-centred services within the rohe, Te Korowai Hauora o Hauraki deliver hauora services in a way that is uniquely Māori yet inclusive of all peoples who choose to engage with their services – including the newly launched Pito Hauora hub.

The name Pito Hauora was gifted to the service by Dr Korohere Ngapo and symbolises the potential of growth and in this context, refers to the promise of a healthier pathway.

Riana Manuel, Chief executive of Māori Health Authority, was there to celebrate the launch as she recognised this health gap and was instrumental in bringing the services together.

“This is a great milestone for Māori health as this is the first mammography service in New Zealand to be incorporated into a Māori health provider and it is also the first combination of a dental health facility and a mammography service in a Māori health provider.” said Manuel.

Chief executive of Te Puna Hauora Matua o Hauraki, Taima Campbell said the opening of the Pito Hauora service is another step towards transformation in the health sector and the establishment of localities, a key part of the health system change.

Waikato DHB chief executive Dr Kevin Snee says the model Pito Hauora is an important partnership between the DHB and Te Korowai Hauora o Hauraki for the Hauraki community and is an excellent example of the new national plan aimed at delivering health that is equitable and accessible for all.

“We are excited at what the locality prototype can achieve and are committed to being part of this work. Screening services save lives through early detection and treatment.” said Snee.

“I was in hospital for a number of hours with a family member – what a fantastic team you have. They were so very kind and caring whilst also being very busy with a number of challenging people. They were very professional, had great communication and were really respectful.”

Emergency Department, Waikato Hospital

Part two: Quality and patient safety

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

Quality and Patient Safety at Waikato DHB underwent a restructure late in 2020/21. The major focus of the restructure was to coordinate the four arms of Quality and Patient Safety – consumer engagement, risk management, clinical effectiveness and infection prevention and control in a model of delivery that enhanced the collaboration between Quality and Patient Safety and clinical services. In 2021/22 the implementation of the new structure began with the recruitment of the Quality and Patient Safety team. A new role of Quality and Patient Safety Business Partner was established, with these quality leads working alongside services to enhance quality and patient safety and ensure that all services in the Waikato DHB are functioning with a focus on provision of care that is equitable and of a high quality in alignment with all regulatory requirements and expectations of consumers and their whānau.

Preparation has been underway for the Waikato DHBs triennial survey of healthcare facilities. This survey will be undertaken using the new Ngā Paerewa Health and Disability Services Standard and whilst scheduled for late 2021, the survey was postponed due to COVID-19 and will be undertaken in the second half of 2022.

Accurate collection and analysis of data is a key to ensuring the provision of quality healthcare and Quality and Patient Safety is in the process of reviewing and analysing all data collection and analysis to ensure it is robust and enables us to ensure that care provided is equitable, effective and uses appropriate resources. Many in the Waikato Quality and Patient Safety team have been providing input into work streams for the change to the new national health provision model on 1 July and we look forward to this collaboration improving the quality and safety of the care provided.

Current priorities and achievements

Risk

Risk management at Waikato DHB supports the delivery of our objectives. A structured approach to risk management enables the DHB to proactively respond to, mitigate and manage risks, as well as looking to improvement opportunities as they may arise. There is clear ownership and delegation of responsibility for the management and oversight of risk to support the appropriate flow of information.

Despite ongoing challenges, such as the COVID-19 pandemic, our performance in risk continues to highlight the resilience of our people.

The risk management process is embedded across the organisation and incorporates a group-wide top down and bottom-up evaluation to determine the likelihood of occurrence and potential impact of risks. New and emerging risks are added as they are identified and are assessed. A standard risk scoring methodology is used to ensure consistency in reporting and evaluating of risks.

Risk reports are completed for the Executive Leadership Team meetings and the commissioners, and are monitored as part of the ongoing risk management processes.

Serious adverse events

An adverse event is an incident which results in unintended harm to a consumer, and a serious adverse event is one that leads to significant additional treatment, is life threatening, results in an unexpected death or major loss of function. The review process is not one of blame and retribution, but of learning and focus on systems and processes. Adverse event reviews are carried out to seek to understand what happened, why it happened and what can be done to try to prevent or lessen the impact.

We have a robust system, which has an open and collaborative person-centred approach which listens to, and involves, patients and/or their whānau. The team leading the review works with clinicians to identify opportunities for staff education and learning and ensure that reviews are system focused.

There were 76 serious adverse events reported in the 2021/22 year, including eight always report and review events that Waikato DHB is required to report to the Health Quality and Safety Commission (HQSC), which are managed in the same way as serious adverse events.

There have been some pressures to meet the required timeframes for reviews, due to COVID-19 resurgence (Omicron), however this is not a long-term impact, and reviews that were delayed are now being finalised.

Patient safety

Deteriorating patient programme

This programme is about improving the recognition and response to patients who are deteriorating, allowing early and appropriate response and treatment to be put in place. Terms of reference for the **Early Recognition of the Deteriorating Patient Committee** are being reviewed and updated.

The **National Early Warning Score** Quality and Safety Marker data collection methods have recently been updated to improve processes. Data improvement work, in conjunction with the HQSC, is ongoing.

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

The national **Paediatric Early Warning Score** chart has been trialled by some sites and final modifications are occurring. There are four versions for different ages and roll out is planned nationally next year. Waikato DHB has formed a project group who will oversee this locally including representation from across the DHB.

The **Shared Goals of Care** is the last element of the deteriorating patient programme, and representatives attend the national hui. Implementing this at Waikato DHB is in the discussion phase.

Sepsis Governance Group

The Sepsis Steering Group (SSG) successfully implemented the Sepsis Ready programme in 2018. Pre-and post-implementation auditing showed improvements in several key metrics, including overall use of the bundle, reduced times to recognition and treatment of sepsis, shorter Intensive Care Unit (ICU) length of stay and reduced inpatient mortality.

In early 2022, the focus of the SSG evolved from the introduction and implementation stage and the Sepsis Governance Group (SGG) was established.

The SGG continue to monitor the (now rebranded) Raise the Flag programme to ensure ongoing success, sustainability and growth. The SGG terms of reference and primary and secondary drivers sit in line with the New Zealand Sepsis Trust national plan to reduce harm associated to sepsis.

Ongoing quality improvement work includes

- developing a Sepsis/Infection data reporting platform
- ensuring current versions of clinical tools have an equity focus (resulting from previous data indicating Māori and Pacific ethnicity are overrepresented in both sepsis presentations and mortality)
- actively engaging and welcoming governance group membership with a strong equity focus
- rolling out the new version of clinical tools and recent changes made
- implementation of new pathways
- morbidity and mortality reviews of significant sepsis events to help identify system/clinical areas of growth required

Patient experience

Kōrero mai – Talk to me

Kōrero mai
Talk to me

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

Kōrero Mai is a communication process that enables a patient or their family/whānau to escalate their concerns through a series of steps. The first two steps encourage the patient or whānau to talk with their nurse or nurse in charge, with the final step being to call a phone number and activate an independent review through the 'Patient at Risk' team.

Kōrero Mai has been in place at Waikato Hospital for two years and an evaluation of the programme shows the following

- There is an average of two calls per month being escalated to the 'Patient at Risk' team, with nearly half of the calls being made by Māori patients or whānau
- Calls are being made to Kōrero Mai to make a complaint about staff or service, to raise questions/concerns about condition or treatment plan, or to request nursing or medical care
- Following evaluation there is now work to be done on strengthening the process including consistent advertising and utilisation across the hospital and how to improve responses and support to patient and whānau

Consumer engagement

Last year Waikato DHB developed a Consumer and Community Engagement Framework to define and support the way in which the DHB engages with our consumers and communities. This sets out the importance of partnership with iwi, the role of consumers in service improvement, and the role of communities in determining the delivery of healthcare in their locality. This is now being used to drive and support increasing partnership with our consumers and their whānau.

The quality safety marker (QSM) that has been developed to assess consumer engagement provides a way to rate and measure progress. Working with consumers to agree these ratings assures accountability to our communities. Waikato DHB has determined good performance in consulting and involving consumers but has identified the need to move towards partnership.

Examples of ways that we engage

- Our Consumer Council, made up of members of our community, and with representation from our priority populations of Māori, rural populations, and those living with disability
- Community Health Forums throughout the Waikato where communities can communicate directly with Waikato DHB about the things that matter to them
- Use of feedback received through phone calls, mail, emails and from forms and surveys throughout the hospitals and clinics
- Forums such as the 37 'Let's Talk' hui that engaged over 1000 community members to understand the needs of those with mental health concerns

Consumer voice

Consumer voice and insights are being used in many ways

- Providing feedback regarding the COVID-19 response
- Engaging consumer representatives on work such as the transport plan
- Driving improvement activities such as the replacement of signage in the Thames Hospital Inpatient Unit to include te reo Māori
- Better reporting of feedback and compliments to ensure that we understand where things are working well for patients and whānau

Consumer Council

Waikato DHB's Consumer Council have focused on the support that has been given to priority communities during the COVID-19 pandemic response, ensuring that they engage with those leading the response. They have advocated for Māori, rural communities, and those living with disability.

The Consumer Council have highlighted the needs of rural communities, and the importance of accessible vaccines, tests, and support packages. The COVID-19 response team have shared how they are responding to these needs and have used the information from the Consumer Council to help guide their delivery.

Quality safety markers for consumer engagement

Waikato DHB has used the quality safety marker (QSM) as an opportunity to put a spotlight on consumer and community engagement and reviewing how effective this has been in designing or developing our services. Examples of this in the last year are

- the Hapori Hauora health screening and promotion event that was organised with the Northern Ruapehu community
- increasing partnership with pre-schools in the Matamata region to form a relationship with an aim to improve pre-school enrolment numbers in dental healthcare
- a new Community Health Forum developed specifically for the disability community to provide a safe place for discussion about the needs of those living with disability

Quality improvement around the organisation

Infection Prevention and Control annual report

Waikato DHB Infection Prevention and Control team provides a service to

- Waikato Hospital
- Mental Health and Addictions
- the four rural hospitals – Thames, Te Kūiti, Taumarunui and Tokoroa
- community services
- continuing care – Rhoda Read and Matariki
- contracted services – cleaning, laundry and waste management services.

The Infection Prevention and Control team is responsible for maintaining a comprehensive programme that ensures a coordinated response in minimising infection control risks to ensure patient safety.

This work has increased significantly in the last 24 months due to the COVID-19 pandemic.

COVID-19 pandemic response

Activities have been focused on ensuring that the management of COVID-19 adheres to national and organisational requirements and guidelines. This includes use of personal protective equipment (PPE), effective isolation of patients, and contact tracing activities for affected staff and inpatients.

There has been a significant requirement for reporting on COVID-19 activities, both internally, and to the Ministry of Health. The Infection Prevention and Control team have been involved with providing advice and contact tracing from the first COVID-19 case in February 2020 to date.

A key focus was ensuring the risk of transmission within the DHB premises was minimised, and as a result, there were no outbreaks from hospital transmission in 2021.

Other activities

Infection Prevention and Control are involved in the three national patient safety programmes

- Hand hygiene
- Surgical Site Infection Improvement Programmes (SSIIP) for cardiac and orthopaedic hip and knee joint surgeries
- Hospital Acquired Staphylococcus aureus Bacteraemia (HA SAB)

These are ongoing into 2022 and are led by the HQSC.

Infection Prevention and Control structure

The need for extra resources due to the COVID-19 pandemic response gave the Infection Prevention and Control team a chance to consider the way DHB services are supported. This has led to a functional structure, with Infection Prevention and Control nursing teams aligned to specific portfolios to enable specialist partnerships to develop, with a deep understanding of the requirements for the services. This supports a transition to normal work streams such as hand hygiene, education, hospital surveillance as business as usual, alongside the COVID-19 requirements.

Priorities for 2022/23

Clinical governance

Collaborate with Te Whatu Ora Waikato leadership team on the implementation of a robust clinical governance programme with aligned structures across Te Whatu Ora Waikato to support the provision of high-quality services that are consistent with the key principles of clinical governance as described in the HQSC Clinical Governance – guidance for health and disability providers (2017).

Listening to our patients and community

Ongoing work to improve the partnership between providers and consumers in line with the newly created code of expectations for consumer engagement. Delivery of the consumer engagement quality and safety marker by continuing to improve the information coming from complaints, feedback and compliments, to ensure it drives improvement.

Risk focus

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

Patient safety data

Continue to review data collection processes, including the reporting of data by ethnicity, and collaborate across Waikato DHB to strengthen analysis.

Kōrero mai / Talk to me

Following evaluation, focus to strengthen the process and ensure consistent utilisation across the hospital.

Raise the Flag – Could it be sepsis?

Continue to highlight sepsis throughout the hospital and in the community in various ways i.e. World Sepsis Day, Fieldays. Continue to help identify and give better outcomes for all patients.

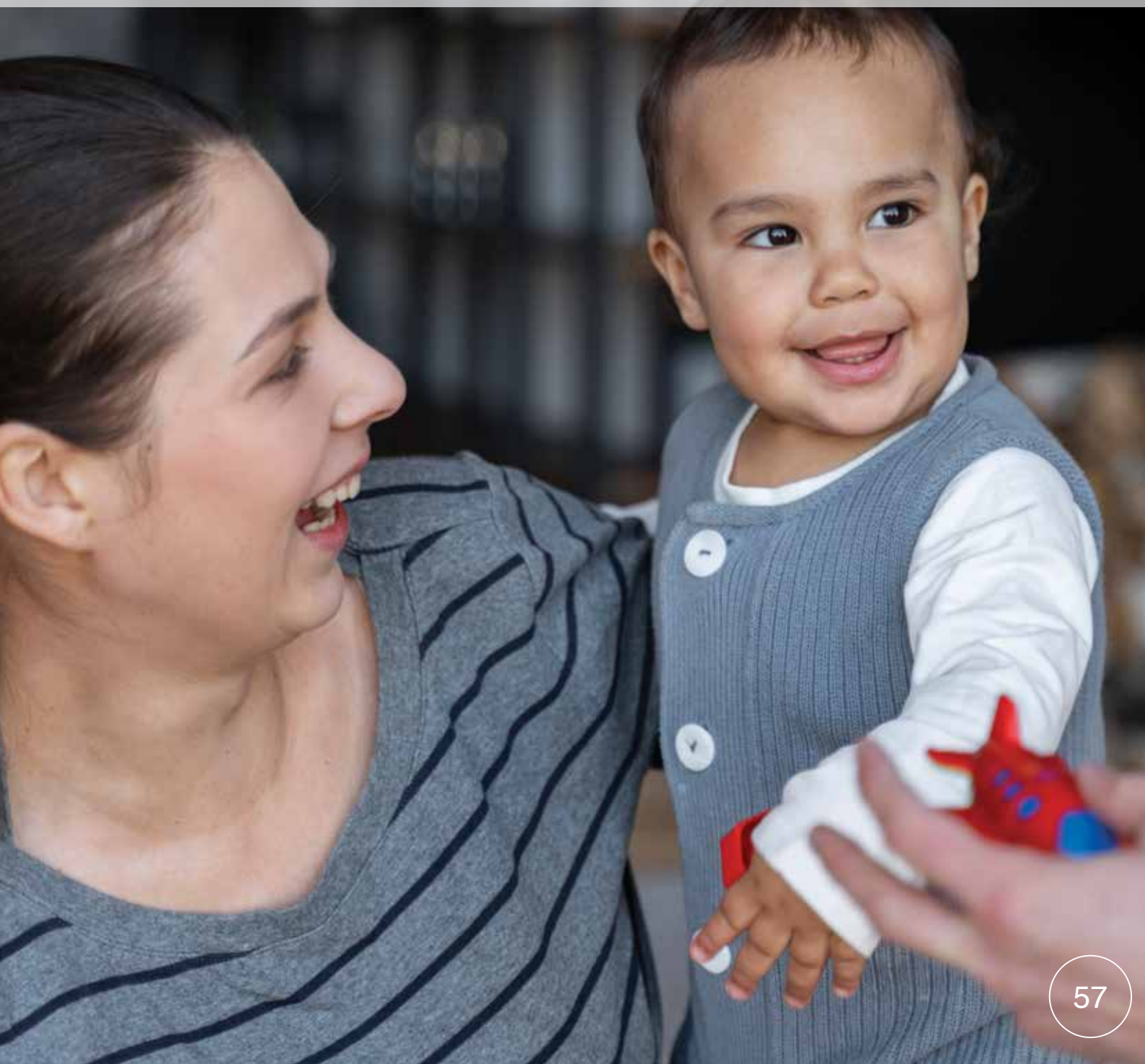
Paediatric Early Warning Score (PEWS)

A version of the PEWS early warning system has been implemented in Waikato DHB with an escalation pathway in place for the past nine years. The HQSC is leading a national programme to implement and standardise the PEWS system across all paediatric services. A project group has started to coordinate implementation of the HQSC PEWS framework in the Waikato.

> Just want to say a huge thankyou to the people on the ward who looked after my moko and I. Thanks for the donations of clothes and the manaaki. We stayed two stressful nights and I can't say enough about how this experienced has changed my moko and built her trust in the health workers that helped her.

Ward E5 – Waikids Medical

Part three: Statement of performance



Introduction

People are supported to take greater responsibility for their health

People stay well in their homes and communities

People receive timely and appropriate specialist care

Our service performance

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

Performance disclosure

2021/22 has been a year of challenges. We are exceptionally proud of the way Waikato DHB faced these challenges and of the way that our staff coped and worked together to overcome these as a team. The COVID-19 pandemic saw outbreaks within our district and once again we saw our frontline essential service staff working together, committed to help those affected and focused on the delivery of care to our population. Many existing employees were redeployed to help in both clinical and non-clinical roles.

Another big challenge for 2021/22 was the ongoing recovery from the unprecedented cyber-attack that affected our DHB IT system starting 18 May 2021. Waikato DHB is confident that the restored data is of the same quality as pre-incident and continued to complete checks while working with the Ministry of Health auditors to provide validity of the data. Waikato DHB engaged with external providers Ernst and Young and Microsoft to undertake an independent assessment on the system recovery activities. This included assessment of current risk management, and what new protocols and implementation guidance the DHB requires to ensure future risks were mitigated. These were managed and reviewed alongside the commissioners, chief executive and chief financial officer and from there we are able to confirm that our back-up was restored, systems are up to date and our results are accurate. While delivery of some of our services was impacted by the outage this was managed by transferring patients to neighbouring DHBs for treatment where necessary and deferring some non-urgent appointments. Our core services were able to continue during the outage and this is further explored under some measures throughout this section.

Our impacts

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

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

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

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

Our outputs

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

The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health impacts we are seeking over the intermediate and longer term. Additionally they cover areas where we are developing new services and expect to see a change in activity levels or settings over the 2021/22 year – and therefore reflect a reasonable picture of activity across the whole of the Waikato health system.

Our service performance – funding

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

The budget figures are based on the Ministry of Health data dictionary definitions that were used to calculate the budget as presented in the Waikato DHB Annual Plan for 2021/22. Output class allocations are based on specific rules to separate and assign costs resulting in total revenue and total expenses that will be different to the statement of comprehensive revenue and expense.

Output class reporting is a different way of slicing information. We do not have embedded variance analysis in place, making it difficult to explain any variance and/or trends. The output class financial reporting for 2021/22 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code.

Cost of service statement by output class for the year ended 30 June 2022

	Group 2022 ACTUAL	Group 2022 BUDGET	Group 2021 ACTUAL
Revenue			
Prevention	136,210	35,984	31,680
Early detection and management	411,267	363,179	347,158
Intensive assessment and treatment	1,389,179	1,306,163	1,254,737
Rehabilitation and support	162,695	158,311	144,180
Total revenue	2,099,351	1,863,637	1,777,755
Expenditure			
Prevention	134,478	34,865	30,745
Early detection and management	408,410	369,087	355,115
Intensive assessment and treatment	1,448,309	1,315,218	1,301,293
Rehabilitation and support	179,895	174,467	160,048
Total expenses	2,171,092	1,893,637	1,847,201
Share of joint venture surplus/(deficit)	(360)		244
Surplus/(deficit)	(72,101)	(30,000)	(69,202)

People are supported to take greater responsibility for their health

Long-term impact	Intermediate impacts	Impact and outputs
People are supported to take greater responsibility for their health	Fewer people smoke	Babies who live in smokefree homes at six weeks Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer (LMC) are offered brief advice and support to quit smoking
	Reduction in vaccine preventable diseases	Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds Percentage of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time Percentage of two year olds are fully immunised and coverage is maintained Percentage of eligible children fully immunised at five years of age Percentage of eligible 12 year olds have received HPV dose two Seasonal influenza immunisation rates in the eligible population (65 years and over)
	Improving health behaviours	95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2021) Newborn GP enrolment rate at six weeks Newborn GP enrolment rate at three months

Why does this matter?

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

The likelihood of developing long-term conditions increases with age and these conditions are more prevalent amongst Māori and Pacific populations. With our higher than average Māori population (25 percent) and a predicted 35 percent increase in 65+ year olds in the Waikato DHB over the next 10 years, it is crucial that people are supported to take control of their health and help prevent illness to ensure the sustainability of our health services.

Māori are underrepresented in preventative primary care and overrepresented in acute services. It is essential that this changes to ensure that Māori experience the best health outcomes possible. By shifting our focus from treatment to prevention, proactively promoting wellness and increasing health literacy we will enable our population to live well and stay well.

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

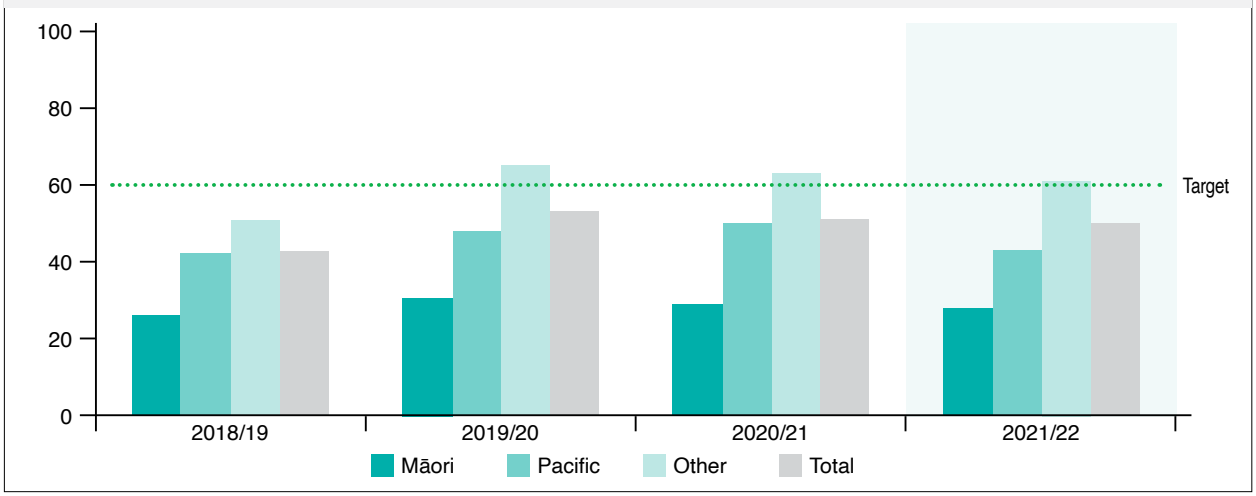
● We achieved the target	● We almost met the target (within 10 percent)	● We have not met the target

Fewer people smoke

Impact measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Babies who live in smokefree homes at six weeks	Māori 31% Pacific 48% Other 65% Total 53%	Māori 29% Pacific 50% Other 63% Total 51%	Māori 60% Pacific 60% Other 60% Total 60%	Māori 28% Pacific 43% Other 61% Total 50%	

Our performance

Percentage of babies who live in smokefree homes at six weeks



The data for this measure is based on the 2021 calendar year and sourced from the Well Child Tamariki Ora quality improvement programme.

Waikato DHB has not achieved the babies living in smokefree homes target for 2021/22. Meeting this target is crucial in achieving the Smokefree Aotearoa 2025 target and ensuring our tamariki have the best possible start to life. There remains a high number of babies experiencing avoidable harm that can lead to poor health outcomes and an unacceptably high equity gap. The second half of 2021 was disrupted with COVID-19 alert level three and four restrictions across significant areas of the DHB. The lack of movement on this indicator is from a combination of disruptions in the health system as part of the COVID-19 response and continued high COVID-19 related stress and anxiety.

Current initiatives continue in Waikato Hospital to support people who birth there to be smokefree, with ward staff trained in screening and referral to readily available smoking cessation services and nicotine replacement therapy.

Changes have been made at a strategic level to ensure greater leadership and coordination across the smokefree work in the Waikato DHB region. The smokefree community coordinator role has expanded to coordinate across key service areas including primary care, mental health and addictions, and maternity. As these areas intersect with our goal of increasing babies who live in smokefree homes, greater coordination and consistency will contribute positively to the target.

The core planned activities of 2022/23 will support the responsiveness of LMCs to be able to actively work with pregnant māmā to stop smoking in pregnancy. In addition, we will work in partnership with the nine primary birth centres in the region to provide training and resources to improve interventions for smokefree pregnancies. The use of Tupeka Kore, a change management framework that allows birth centres and midwives to set self-identified goals in the process of improving interventions for pregnant people who smoke, will be reinvigorated.

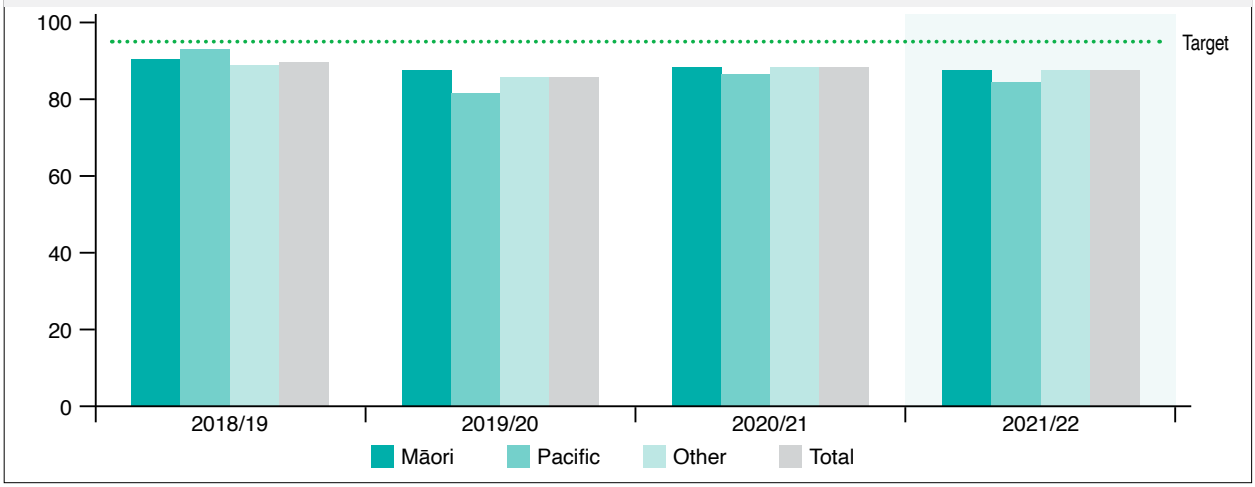
Additionally, the Hapū Wānanga team will provide training and support to Māori and Pacific focused midwives in the region, to ensure there is specialist support addressing the equity gap for Māori and Pacific in maternal smoking prevalence and babies living in smokefree homes. By improving maternal smoking interventions, this will have a positive effect on the rates of babies living in smokefree homes.

People are supported to take greater responsibility for their health

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	Māori 87% Pacific 82% Other 86% Total 86%	Māori 88% Pacific 86% Other 88% Total 88%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 87% Pacific 84% Other 87% Total 87%	

Our performance

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



In the past year, 87 percent of inpatients patients who smoke at Waikato DHB hospitals (Waikato, Thames, Tokoroa, Te Kūiti and Taumarunui) received brief advice and support to quit smoking which was below the 95 percent target. No significant equity gap is noted. Maintaining support for our people who smoke in secondary care services has continued throughout a very challenging year.

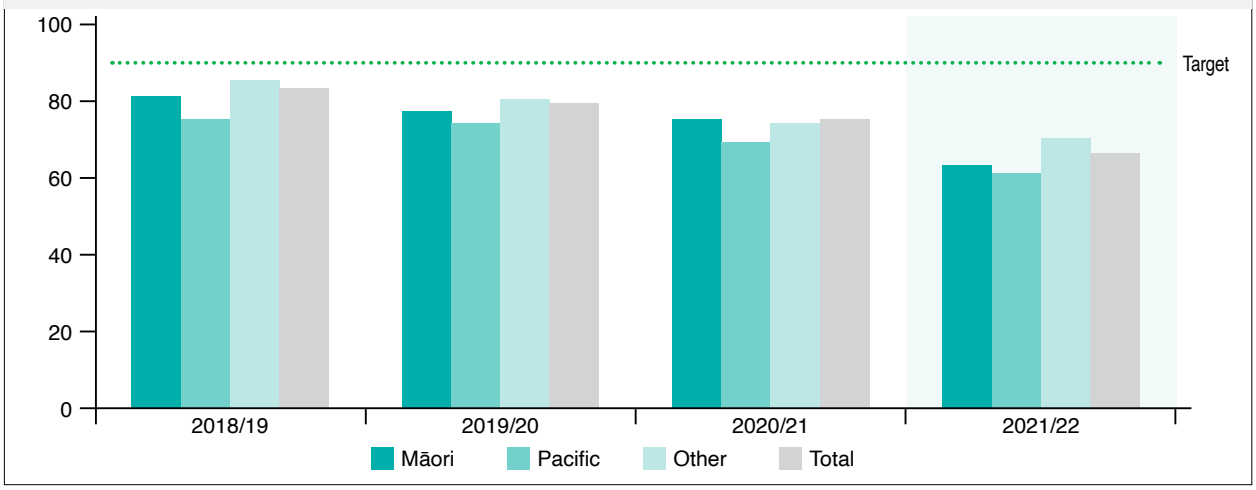
Planning for 2022/23 includes; a smokefree education plan in each ward using nursing educators and champions and a new online education course for new staff explaining what we do at ward level (nicotine standing orders and referral pathways). Rewards will continue for wards, areas, units which consistently undertake smokefree interventions. Actions included in Smokefree Aotearoa 2025 Action Plan are being promoted in trainings including

- very low nicotine cigarettes (VLNCs)
- reducing the retail availability of tobacco
- smokefree generation

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a healthcare practitioner in the last 15 months	Māori 92% Pacific 91% Other 89% Total 90%	Māori 75% Pacific 69% Other 74% Total 75%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 63% Pacific 61% Other 70% Total 66%	

Our performance

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



Waikato DHB has not met the target for the number of PHO enrolled patients who smoke that received advice and support to quit compared to last years result, particularly for Māori and Pacific. A key factor influencing this decline is the reality of COVID-19 pressure on front line primary care staff in both meeting and completing reporting against the target. The target remains a priority for Waikato DHB and work is underway to ensure better outcomes going forward.

Key actions in 2022/23 to improve the outcomes against this target include a greater focus on supporting PHOs to meet the target for Māori and Pacfic. The Smokefree community coordinator is working with key relationship managers to develop working relationships with each PHO, with the goal of co-designing and implementing strategies to improve on the smoking cessation target. This will include identifying barriers and corresponding solutions to meeting the target, supporting the establishment of staff training plan to increase knowledge and confidence in smoking cessation referral, and supporting smokefree practice champions within the clinics from all community services. Specific support will also be tailored for our kaupapa Māori and Pacific providers to ensure an equitable approach to smoking harm. Community pharmacies continue to provide brief smoking cessation advice, this approach has been used previously and appears to have good outcomes.

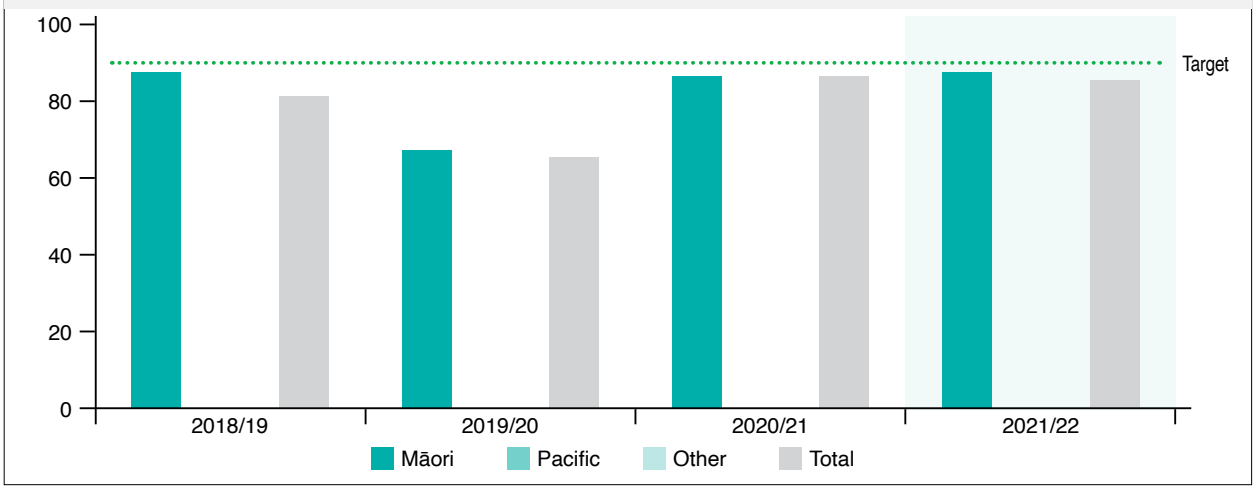
Waikato DHB will monitor and evaluate these actions and consider their effectiveness in improving performance through 2022/23.

People are supported to take greater responsibility for their health

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC are offered brief advice and support to quit smoking	Māori 64% Pacific N/A* Other 70% Total 66%	Māori 86% Pacific N/A* Other N/A* Total 86%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 87% Pacific N/A* Other N/A* Total 85%	● ●

Our performance

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



**The 2021/22 data is for Māori and Total only as this is what the Ministry of Health collates.*

Waikato DHB has not met the target for the percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC are offered brief advice and support to quit smoking and an equity gap still exists.

The 2021/22 data for smoking cessation interventions by midwives and LMCs reflects disruption by COVID-19 to the Tupeka Kore initiative which provides training, resources and support for midwives and LMCs to reach self-identified goals supporting wāhine hapū to be smokefree. Frontline maternity services have also been impacted by the COVID-19 response.

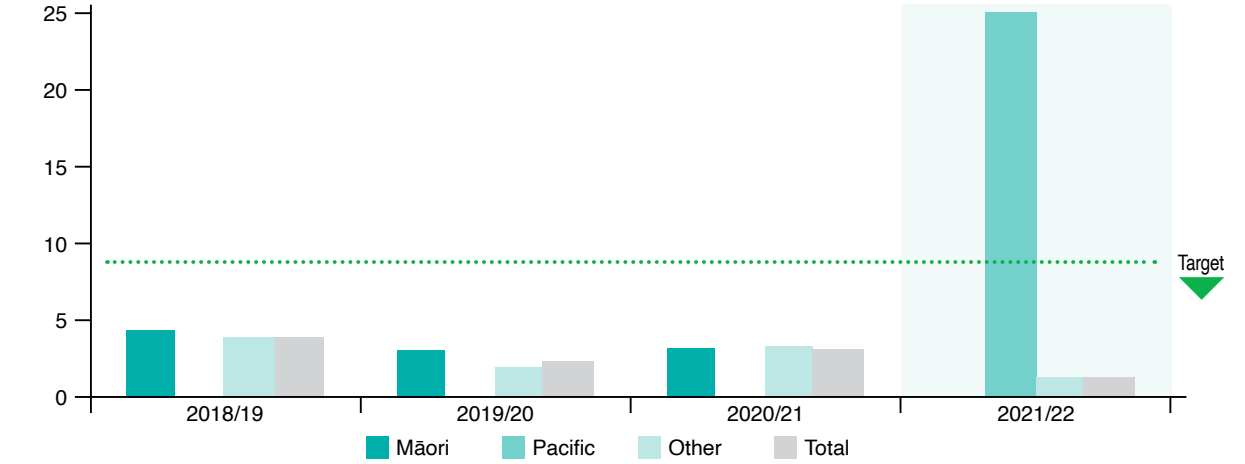
The core planned activities of 2022/23 to improve the outcome for this target are to work in partnership with the nine birth centres in the region to provide training and resources to improve interventions for smokefree pregnancies. The Tupeka Kore framework will be reinvigorated. In conjunction with this work, the Hapū Wānanga team will provide training and support to Māori and Pacific focused midwives in the region which will ensure there is specialist support to address the equity gap for Māori and Pacific in maternal smoking prevalence. The Smokefree hospital coordinator continues support for women's health wards to provide quality interventions and referral for patients who smoke. Both Waikato Whānau Āwhina Plunket Whirihia and Waikato Hapū Wānanga include tobacco and pregnancy in their pregnancy and birth education programmes. These programmes include kaupapa Māori led specialist stop smoking support for women and their whānau to be smokefree.

Reduction in vaccine preventable diseases

Impact measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	Māori 3.1 Pacific 0.0 Other 2.0 Total 2.3	Māori 3.2 Pacific 0.0 Other 3.3 Total 3.1	Māori <8.8 Pacific <8.8 Other <8.8 Total <8.8	Māori 0.0 Pacific 25.0 Other 1.3 Total 2.6	

Our performance

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



For all populations except Pacific, the rate of vaccine preventable disease continues to be significantly better than the required target.

Over the last three years there have been seven vaccine preventable hospitalisations for 0-14 year olds, three of these cases were members of our Pacific community. We note that due to the relatively smaller Pacific population in Waikato, any change in the numbers of 0-14 hospitalised with a vaccine preventative disease will lead to a significant change in the rate per 100,000.

Although the low case numbers are very pleasing, it must be seen against a background of relatively low immunisation rates in the Waikato and across New Zealand, particularly for Māori where there has been a sustained decline in immunisation rates over the last two years. The risk of outbreaks of vaccine preventable diseases is increasing as borders open and increasing international travel to countries that also have lowered immunisation rates and increased risks of outbreaks.

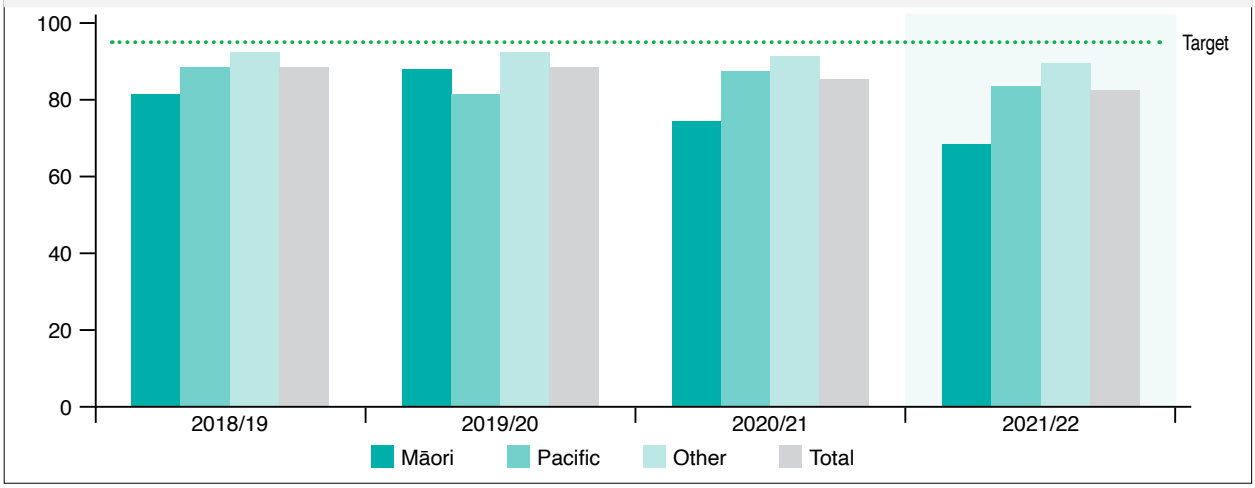
Significant work continues with all our partners to help raise the immunisation rates and reduce the risks of serious diseases which can have deadly consequences for particularly the young, elderly and immune compromised in our community.

People are supported to take greater responsibility for their health

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Māori 82% Pacific 91% Other 92% Total 88%	Māori 74% Pacific 87% Other 91% Total 85%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 68% Pacific 83% Other 89% Total 82%	

Our performance

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



Waikato DHB has not met the target of 95 percent eligible population being fully vaccinated by eight months of age, with the most significant decrease being in Māori.

Like much of New Zealand, and much of the world, child immunisation rates have fallen over the last two years as COVID-19 focused our attention towards protection in our 'bubbles' and then COVID-19 immunisations. The plan is now to mobilise the health workforce back toward 'business as usual' and start to tackle the low immunisation rates, particularly for Māori.

Newborns are amongst the most vulnerable in our communities and need the most support to grow and thrive. Our focus is to better integrate all our vaccination services (COVID-19, flu, MMR catch-up and childhood) to provide comprehensive approaches to meet the various needs of our communities. We are also focusing on removing the barriers that currently prevent immunisations occurring on time.

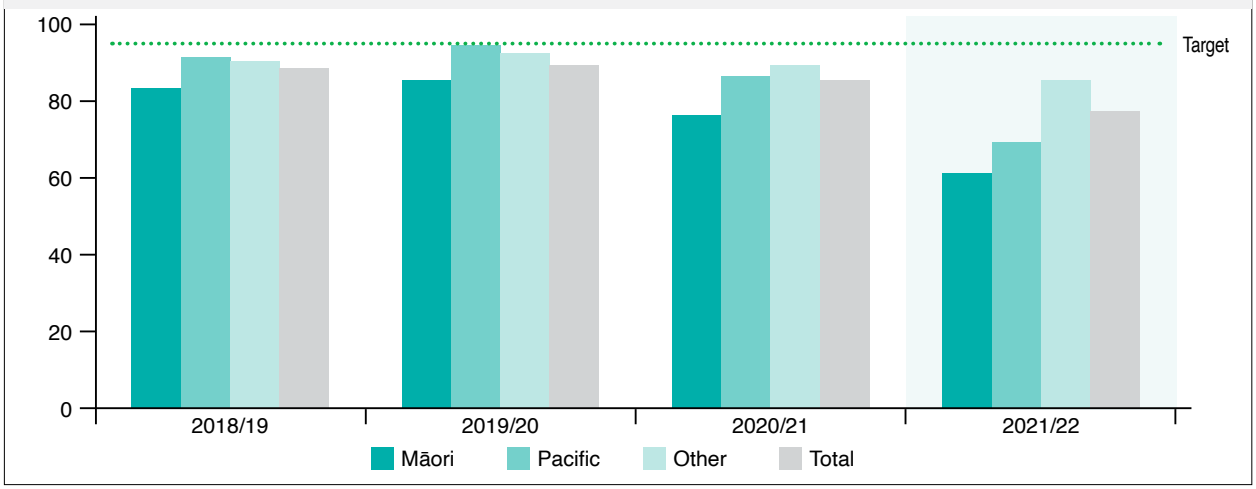
Most childhood immunisations occur at a general practice. Improving access and processes will be key to improving immunisation rates. A key action is to speed up the enrolment of children with a GP. This has been shown to improve immunisation rates and provide a healthier start for babies.

We will look at improved outreach services and better integration across the sector for those parents that find that general practice is not a good option for vaccinations. Waikato DHB is currently trialing a joint approach to immunisations with Whānau Āwhina Plunket. The Whānau Āwhina Plunket nurses already have relationships and trust with whānau which means it is much faster than the outreach nurse cold calling whānau and having to build a relationship.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of two year olds are fully immunised and coverage is maintained	Māori 85% Pacific 94% Other 92% Total 89%	Māori 76% Pacific 86% Other 89% Total 85%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 61% Pacific 69% Other 85% Total 77%	

Our performance

Percentage of two year olds are fully immunised



Waikato DHB's performance for the percentage of two year olds that are fully immunised has continued to decline and not meet the required target.

The impacts of COVID-19 appear to be impacting all vaccination rates. Increasing misinformation is creating hesitancy and scepticism towards a wide range of proven safe vaccines.

The performance against this measure has been impacted by the changes to when MMR vaccinations are administered. Previously MMR vaccinations were completed at four years old. MMR is now administered at 12 and 15 months. We have identified a large number of parents that are not aware of the change. Previously these children would have been classed as fully immunised at two years, but now are 'missing' their second MMR vaccination and are not fully vaccinated.

In coming years Waikato DHB will require programmed integration of services to better meet the needs of our communities. We will work with the national immunisation taskforce to embed learnings from other districts and communities into our local response.

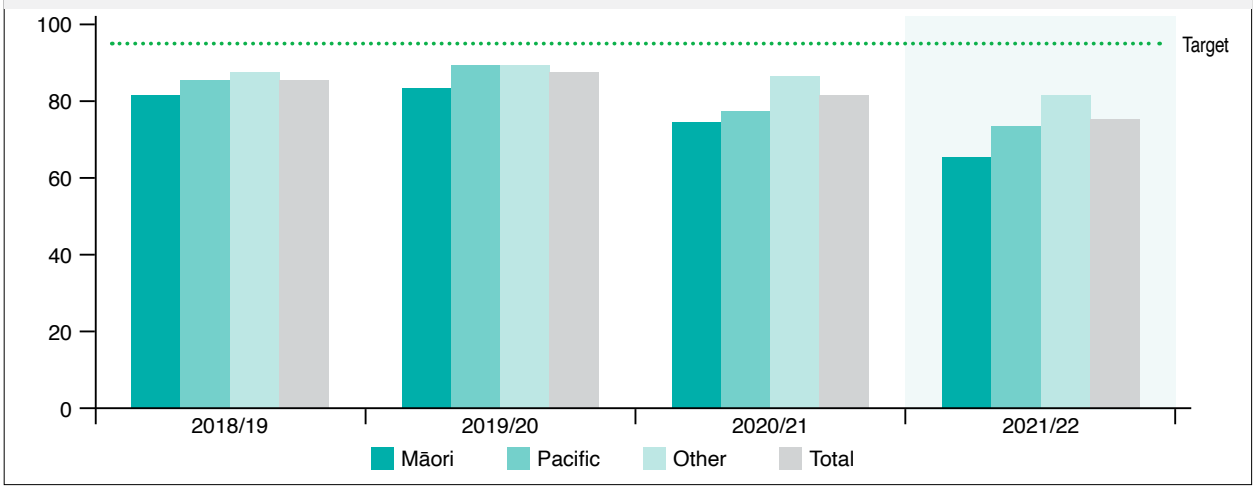
Our COVID-19 call centre has phoned parents of all two to five year olds who are under vaccinated for MMR. This is in tandem with our PHOs having a focus on MMR, plus pop-up clinics/immunisation centres offering MMR immunisation has led to a significant increase in MMR immunisations during the last quarter of 2021/22.

People are supported to take greater responsibility for their health

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of eligible children fully immunised at five years of age	Māori 83% Pacific 89% Other 89% Total 87%	Māori 74% Pacific 77% Other 86% Total 81%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 65% Pacific 73% Other 81% Total 75%	●

Our performance

Percentage of five year olds are fully immunised



Waikato DHB has not met the target for the percentage of five year olds that are fully immunised. Waikato DHB immunisation rates continue to decline across the whole population, particularly in the Māori and Pacific communities. The most significant impact on this measure has been COVID-19. The response to COVID-19 has put pressure on every part of the health sector and has resulted in resources being redirected from the normal day-to-day activities.

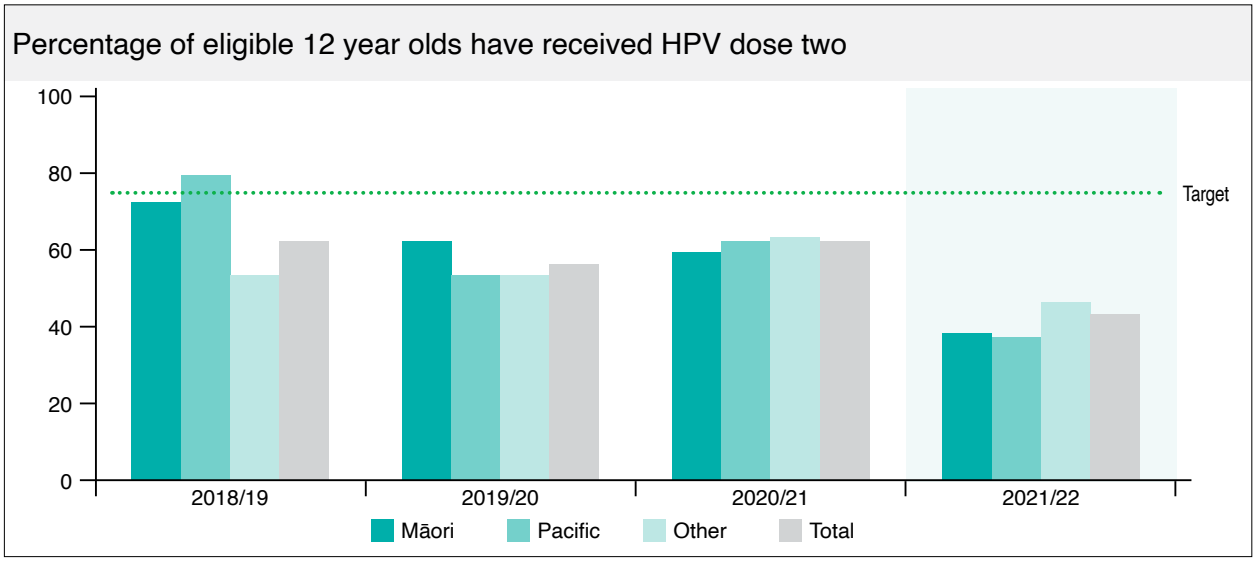
We will continue to work with all our key partners in this work to embed a more holistic approach across all immunisations; COVID-19, flu, MMR catch-up, and childhood. This will include working with the National Immunisation Taskforce to implement learnings from other communities into our local service model in a planned and structured approach.

Our COVID-19 call centre is phoning all parents who have a child that is under immunised for MMR in the two to five year age group. Many of these parents were not aware of the October 2020 schedule change or that their child has missed MMR vaccination and the calls prompted parents to arranged immunisation. Parents of children over three years are given the option of making an appointment at an immunisation clinic or immunisation event happening near their home. Alternatively whānau can choose to contact the general practice for an appointment. Our PHO teams have also had a focus on MMR catch-up for two to five year olds and have been working with practices with lower MMR rates to increase coverage.

As a result of these efforts in quarter four of 2021/22 we have seen a significant monthly increase in the number of two to five year olds receiving MMR, with a total of 1289 MMR vaccinations being administered to the cohort in quarter four, 433 of which were to Māori tamariki. This intervention has not contributed significantly to the five year immunisation milestone in this quarter, but is assisting in putting tamariki back on schedule to achieve full immunisation by their fifth birthday over the coming months and years. More importantly, it is increasing MMR coverage in our community which provides more protection for our tamariki. This is an ongoing initiative that will be completed in quarter one of 2022/23.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of eligible 12 year olds have received HPV dose two	Māori 62% Pacific 53% Other 53% Total 56%	Māori 59% Pacific 62% Other 63% Total 62%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 38% Pacific 37% Other 46% Total 43%	

Our performance



This measure was incorrectly published as dose three in the Annual Plan. We are reporting on dose two as per previous reports.

Waikato DHB has not met the HPV vaccination target for 2021/22 and the ongoing COVID-19 response continues to impact the school vaccination programme.

During the period 1 July 2021-30 June 2022, the public health nursing service was engaged for several months in support work for Public Health and the COVID-19 Directorate including contact tracing, swabbing and vaccination. Although one section of the public health nurse team was allocated to vaccinate in schools during this time, they were unable to do so as COVID-19 alert level restrictions saw schools closed, effectively putting the HPV programme on hold.

Low immunisation coverage for HPV dose one in 2022 meant that public health nurses returned several times to schools to ensure there was every opportunity for students to receive the HPV vaccination. It was hoped that by returning to schools, this would give students the opportunity to complete dose two within the required timeframe before schools closed in December 2021. This proved to be time consuming with schools endeavouring to return to business as usual but closing during COVID-19 alert levels and students using online learning. Other barriers also included staff vacancies and high sick rates across the district.

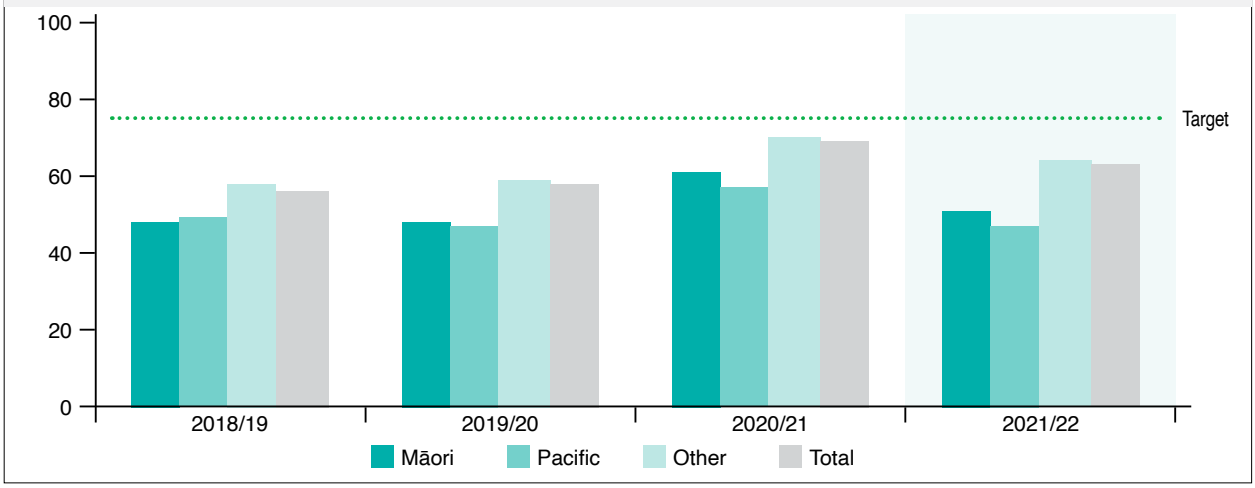
Looking forward, the public health nurse service will use the minimum timeframe (five month gap between dose one and two) again this year to ensure all consented students are able to have HPV dose two before school concludes in December 2022. As a result of the public health nursing service mainly supporting the COVID-19 response, the small number of public health nurses available to work in the programme were unable to home visit to follow-up outstanding consents. This method will be encouraged going forward to help achieve equitable outcomes for our Māori and Pacific students.

People are supported to take greater responsibility for their health

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Seasonal influenza immunisation rates in the eligible population (65 years and over)	Māori 48% Pacific 47% Other 59% Total 58%	Māori 61% Pacific 57% Other 70% Total 69%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 51% Pacific 47% Other 64% Total 63%	

Our performance

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



There has been an overall decrease in the seasonal immunisation uptake in the eligible population and the target has not been met by Waikato DHB. Inequities reported in previous years continue although overall for Māori and Other there has been a small increase from baseline. The impact of COVID-19 on our results and the impact of alert level restrictions in the Waikato district should be taken into account when reviewing this report.

We have maintained our focus on increasing the workforce to deliver influenza immunisations with an increasing number of pharmacies across the district offering to opt in to this service. Some pharmacies do not require an appointment and are open at weekends which further reduces barriers to access. We will also work with PHOs to proactively recall all people over 65 for their annual influenza immunisations.

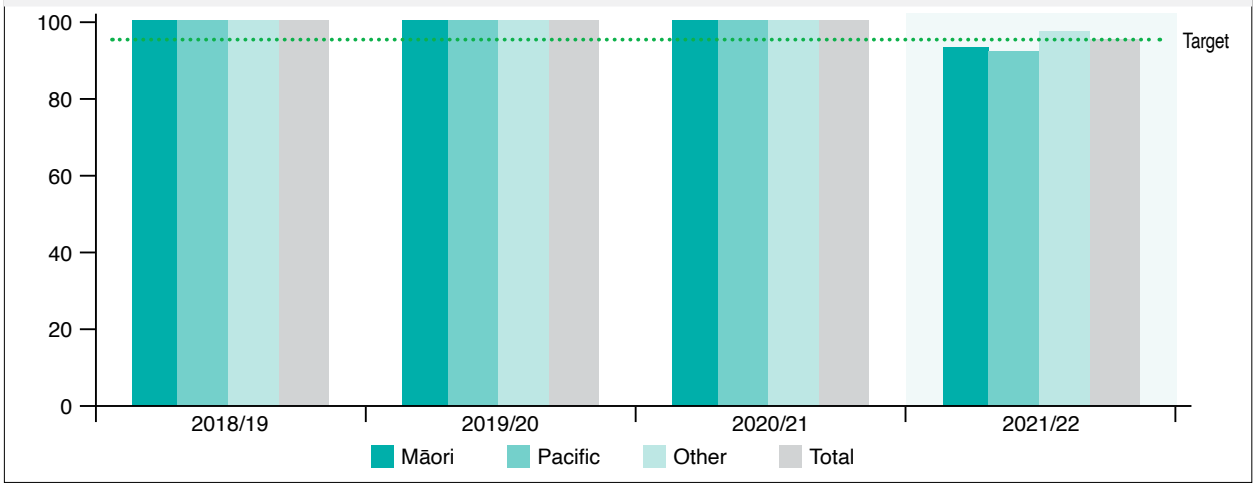
Targeted activities undertaken by Māori and Pacific providers continue to support whānau to access services such as free annual influenza immunisations. These targeted activities will continue to have a positive impact on our uptake in the future.

Improving health behaviours

Impact measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2021)	Māori 100% Pacific 100% Other 100% Total 100%	Māori 100% Pacific 100% Other 100% Total 100%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 93% Pacific 92% Other 97% Total 95%	

Our performance

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



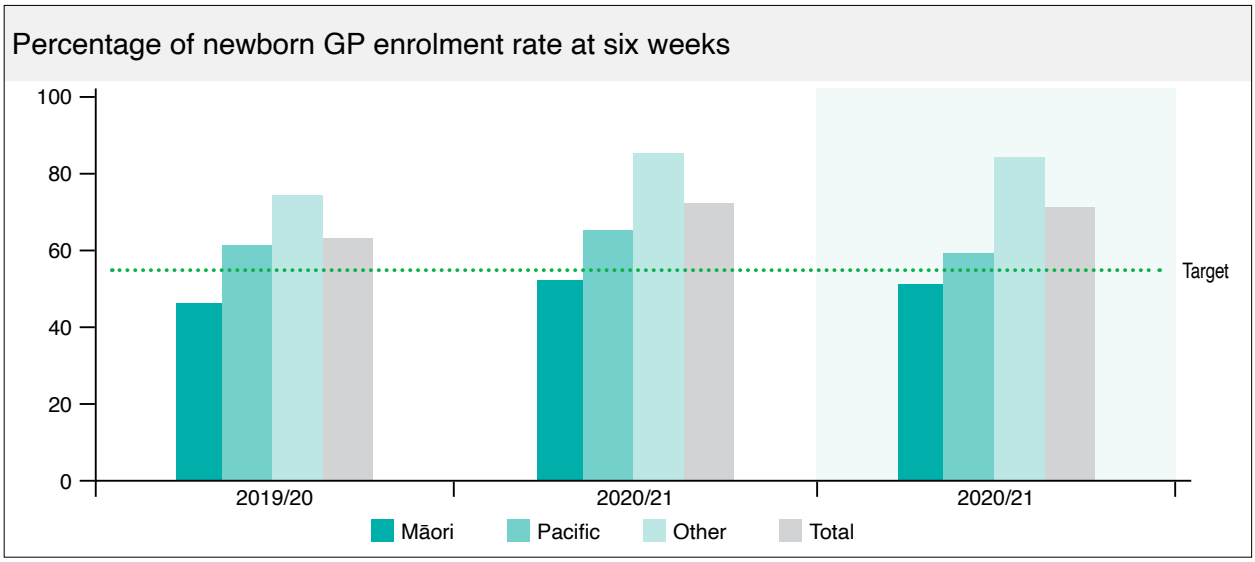
Waikato DHB exceeded the overall target of 95 percent B4 School Checks for Total and Other population groups but has not achieved the target for both Māori and Pacific children. Cohort numbers are relatively low and a further two Māori and one Pacific referral would have allowed all targets to have been achieved.

Process improvements have already been made which resulted in 100 percent of children being referred in the second half of 2021/22. We would expect this trend to continue in the coming year.

People are supported to take greater responsibility for their health

Output measure	Baseline Q4 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Newborn GP enrolment rate at six weeks	Māori 46% Pacific 61% Other 74% Total 63%	Māori 52% Pacific 65% Other 85% Total 72%	Māori 55% Pacific 55% Other 55% Total 55%	Māori 51% Pacific 59% Other 84% Total 71%	

Our performance



Waikato DHB has met the 55 percent target for newborn GP enrolment for all population groups except Māori. To meet the 55 percent target for tamariki Māori we would have required two additional children each week to have been enrolled by six weeks.

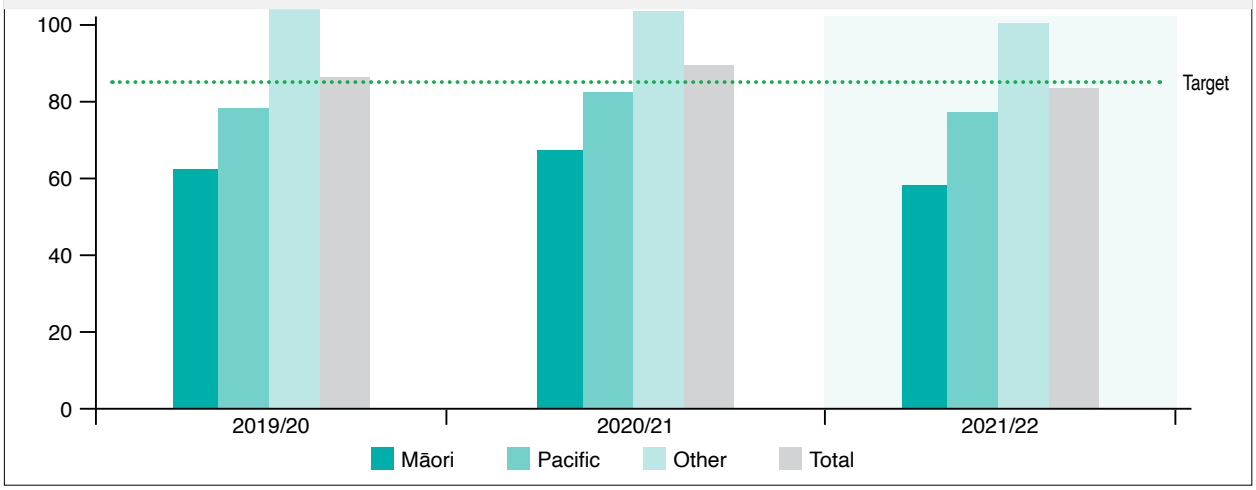
We are building early newborn enrolment activity into our immunisation response plan as it is key for improved immunisation rates and wider child health outcomes. We have had notable success in using our call centre resource to contact parents about overdue MMR vaccinations. We will be deploying this resource to contact the caregivers of those who are not enrolled with a GP. Tamariki Māori will be prioritised first to proactively address the equity gap. The aim will be to find individualised solutions to assist with enrolment. This could be paying for a birth certificate, advice about local GP services, advocating for a family or referral to other local services that can assist and advocate.

Over the coming year we will be working with all three PHOs in the district to understand the barriers to early enrolment and create solutions that eliminate the equity gap for all ethnicities. This is crucial for providing a good healthy start in life for children in the Waikato. Providing immunisations and general healthcare that is appropriate, close to home and accessible is vitally important.

Output measure	Baseline Q4 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Newborn GP enrolment rate at three months	Māori 62% Pacific 78% Other 106% Total 86%	Māori 67% Pacific 82% Other 103% Total 89%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 58% Pacific 77% Other 100% Total 83%	

Our performance

Percentage of newborn GP enrolment rate at three months



Waikato DHB has not acheived the target of 85 percent of newborns enrolled with a GP and have deteriorated in performance across all four measures. The results have been impacted by the COVID-19 response provided by primary care.

This measure can been seen as an enabler. Early enrolment is particularly important to achieving timely immunisation and general good child health. Those tamariki enrolled with a general practice have high immunisation rates.

As part of our immunisation plan we will be monitoring children more closely as they access the health system. Those that are not enrolled with a general practice will be contacted by our call centre to help with enrolment. This support may include paying for a birth certificate, providing advice about local GP services, advocating for a family or referral to other local services that can assist and advocate. Māori tamariki will be prioritised as a direct targeted approach to eliminating the current equity gap.

A new inner city service has been established to provide free access to GP and pharmaceuticals for those families living in emergency or transitional housing. Temporary housing makes it more difficult to make connections with local services and enrol with a GP. By providing more support to these families we aim to improve access to health services and improve enrolment rates. Increasing the number of tamariki being enrolled early with a GP helps to provide the best start possible and allow our little ones to thrive.

People stay well in their homes and communities

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

Why does this matter?

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

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

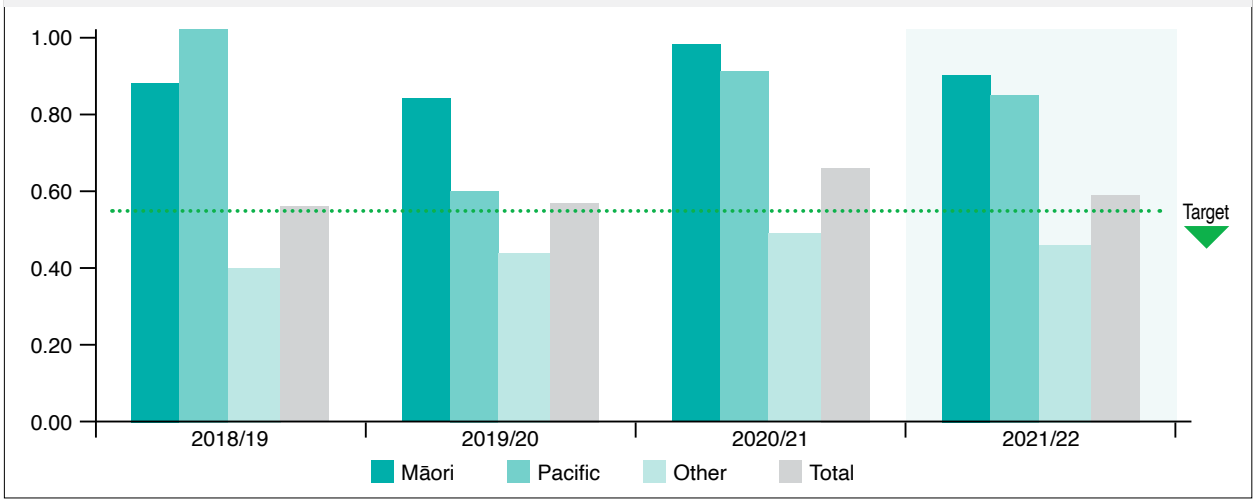
● We achieved the target	● We almost met the target (within 10 percent)	● We have not met the target

Children and adolescents have better oral health

Impact measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Mean decayed missing and filled teeth (DMFT) score of Year 8 children	Māori 0.84 Pacific 0.60 Other 0.44 Total 0.57	Māori 0.98 Pacific 0.91 Other 0.49 Total 0.66	Māori <0.55 Pacific <0.55 Other <0.55 Total <0.55	Māori 0.90 Pacific 0.85 Other 0.46 Total 0.59	

Our performance

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



The above results are based on the 2021 calendar year and represent the measure of the mean number of decayed, missing and filled permanent teeth for 12-13 year olds in the Waikato DHB region.

Waikato DHB has not met the target for this year. The cohort of Pacific children is relatively small therefore a small change in actual numbers can result in what appears to be a significant percentage change from year to year.

The decrease in the mean DMFT for year eight children in 2021 compared to 2020 is largely due to the impact of the COVID-19 response which reduced dental care to emergency treatments only and closed schools during the higher alert levels. In addition to this, the Waikato DHB cyber-attack impacted 20,000 records, the retrospective data loading has affected the DMFT results for some patients.

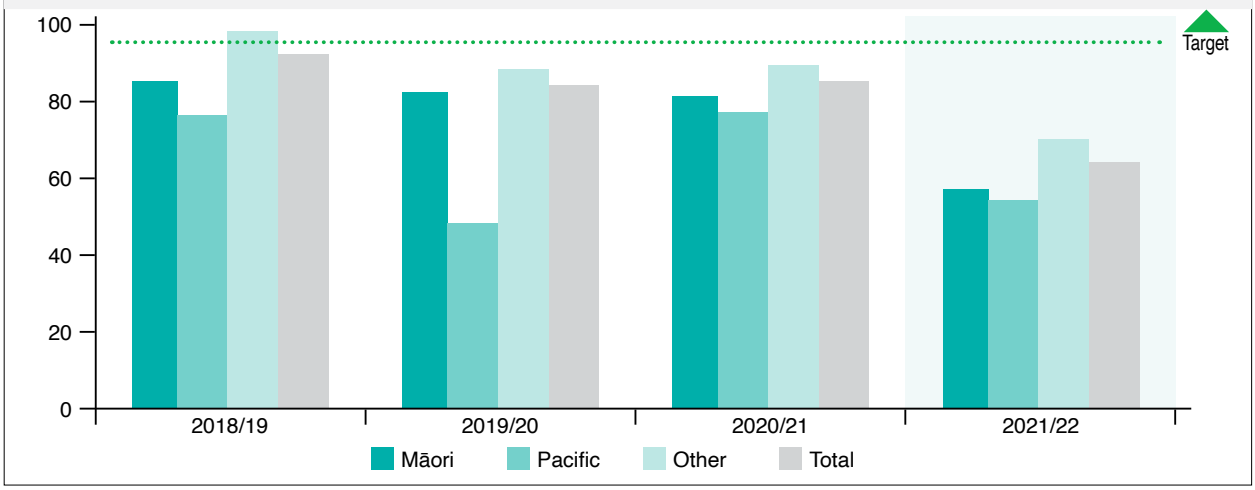
The growing inequality for Māori and Pacific children is of concern and will remain a focus during the coming year as the service moves to better meet the needs of children and their whānau.

People stay well in their homes and communities

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of children (0-4) enrolled in DHB-funded dental services	Māori 82% Pacific 48% Other 88% Total 84%	Māori 81% Pacific 77% Other 89% Total 85%	Māori ≥95% Pacific ≥95% Other ≥95% Total ≥95%	Māori 57% Pacific 54% Other 70% Total 64%	● ● ● ●

Our performance

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



The above results are based on the 2021 calendar year and represent the number of children (0-4) enrolled in the Waikato DHB funded dental service.

Waikato DHB has not achieved the targets against this measure in 2021 with a decrease in Māori enrolments and a decrease across the wider population. The cohort of Pacific children is relatively small therefore a small change in actual numbers can result in what appears to be a significant percentage change from year to year.

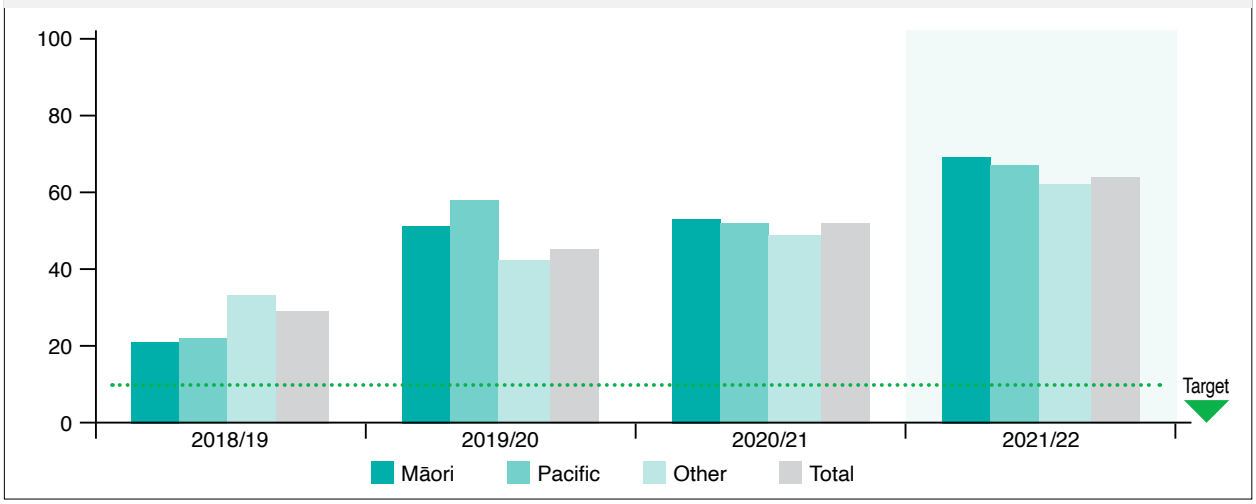
This measure has lagged due to several data/cyber-attack disruptions to Waikato DHB – specifically in 2021. These issues have recently been resolved and a specific targeted programme has been designed and is ready for implementation. The service expects significant improvement in this measure from quarter two of 2022.

Early engagement provides opportunities to provide good quality education, prevention and treatment which will improve the oral health of tamariki in the long term. Improvements in enrolment rates will remain a focus for 2022/23 as early enrolment is key to prevention and early intervention.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Māori 51% Pacific 58% Other 42% Total 45%	Māori 54% Pacific 52% Other 49% Total 52%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%	Māori 69% Pacific 67% Other 62% Total 64%	

Our performance

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



The above results for 2021/22 are based on the quarter four 2022 April-June Performance report and represent the number of children aged 12 and under who are overdue their scheduled dental examination in Waikato DHB.

The results have deteriorated further in 2021/22 against results in 2020/21 and Waikato DHB has not met the target for this year. The COVID-19 response had a significant impact on the oral health service. Significant time was lost during alert levels three and four where dental treatment was restricted to emergency treatment only. COVID-19 illness, vaccination mandates and COVID-19 redeployment impacted on staffing levels and availability for service delivery. This reduced the number of children that were able to be seen and increased the number that were overdue an examination by 15 percent.

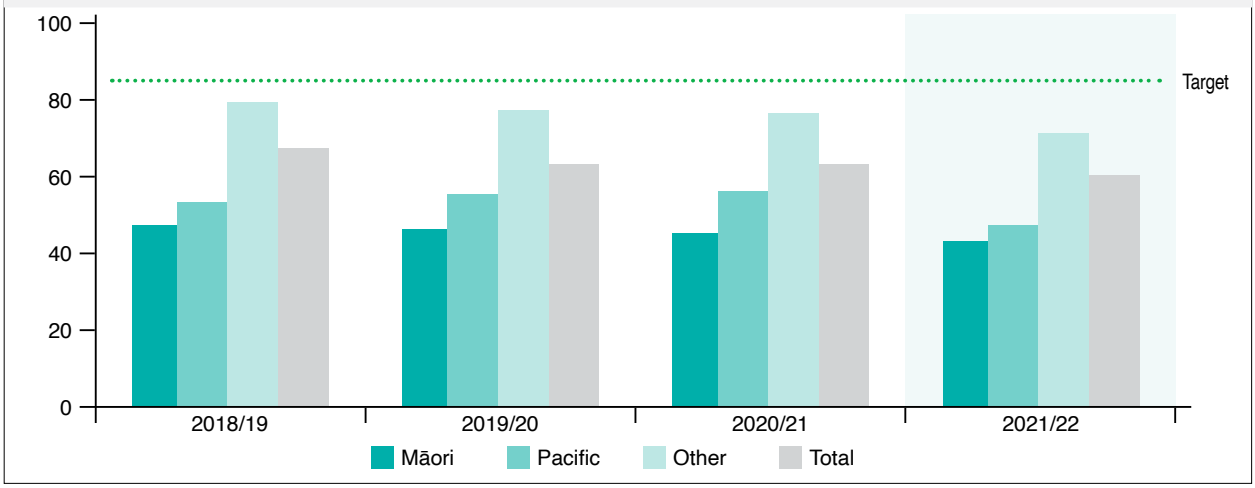
Significant planning and restructuring of the service is underway to provide better education and prevention that will allow resources to be better targeted for whānau where children have a higher risk of poor oral health.

People stay well in their homes and communities

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of adolescent utilisation of DHB-funded dental services	Māori 46% Pacific 55% Other 77% Total 65%	Māori 45% Pacific 56% Other 76% Total 63%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 43% Pacific 47% Other 71% Total 60%	

Our performance

Percentage of adolescent utilisation of DHB funded dental services



The results above are based on the 2021 calendar year to align with the school year.

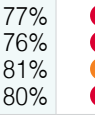
Waikato DHB has not met the 85 percent target and performance has deteriorated against all measures in 2021/22. Our performance is aligned to the worsening performance nationally, but with performance slightly higher than national for Māori and Other.

Adolescent engagement with dental services remains a challenge across New Zealand. The Waikato district was particularly hard hit by alert level three and four restrictions during the second half of the 2021. These restrictions disrupted dental services and the ability to function at full capacity.

Additional investment is being made in dental practices to encourage engagement with rangatahi and improve up take of this free service. We also continue to work as part of regional and national forums which provide opportunities for sharing approaches, successes, challenges, and opportunities to learn from each other about how uptake can be improved.

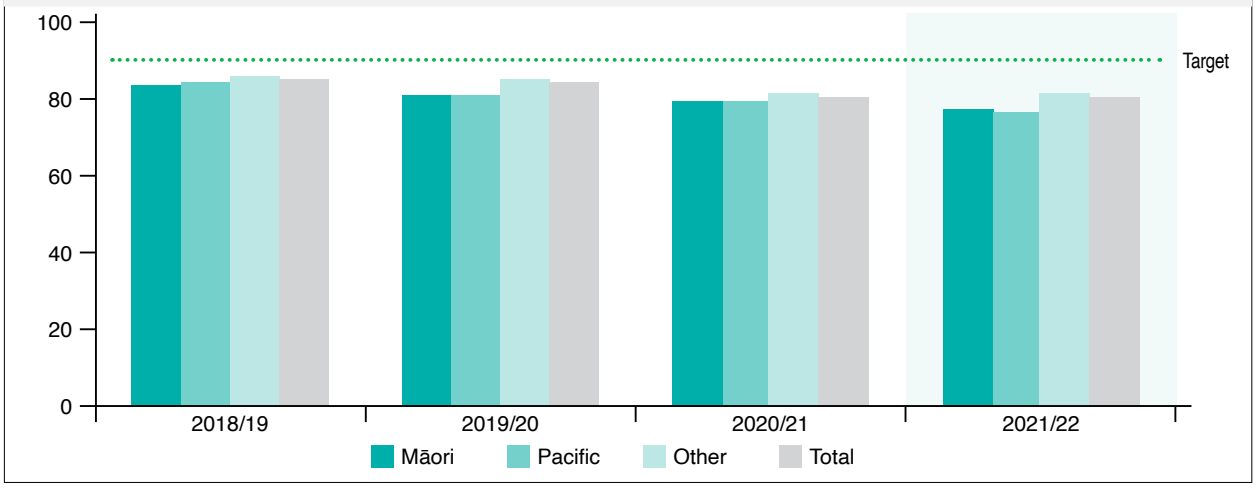
We remain committed to increasing adolescent utilisation funded services knowing that good oral health during childhood and adolescence is an important indicator for good lifelong oral health and will continue to focus on improving our results in the coming year.

Long-term conditions are detected early and managed well

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percent of the eligible population who have had their cardiovascular risk assessment in the last five years	Māori 81% Pacific 81% Other 85% Total 84%	Māori 79% Pacific 79% Other 81% Total 80%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 77% Pacific 76% Other 81% Total 80%	

Our performance

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



Waikato DHB has not met the cardiovascular risk assessment target and results have declined compared to the previous year. All PHOs have reported there were significant events that required a shift in focus away from preventative care such as heart health. Patients and front line resources continued to be adversely impacted by alert level three and four restrictions and increased illness in the Waikato. Accordingly, COVID-19 care in the community and vaccination programmes have taken priority and affected planned activity through the requirement to re-prioritise workforce and resources.

In the Waikato district, cardiovascular disease accounts for a high proportion of amenable mortality (avoidable death) rates, particularly for Māori. It has been a key focus for PHOs and general practices to work alongside Te Puna Oranga (Waikato DHB Māori Health), local iwi and the wider Waikato network to reach high needs and vulnerable populations, with a focus on Māori whānau, to achieve the 90 percent target. This collaborative approach will remain the focus in the coming year as it is well known that supported general practices, connected to their communities and with the right systems in place, have the best opportunity to identify and engage with eligible patients.

All PHOs have a range of IT systems in place including interactive dashboards, Mohio, patient prompts, and up to date performance statistics to assist their general practices to identify current and new eligible patients and offer a cardiovascular risk assessments.

To improve results, Waikato DHB will continue to fund all Māori and Pacific providers with a range of agreements that include additional wellbeing supports to identify and assist Māori and Pacific people with long term conditions improve their health outcomes. These include Whānau Ora services, long term conditions nurses, Pacific nursing services, mobile nursing and kaiāwhina services.

People stay well in their homes and communities

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the past five years	65%	61%	90%	44%	●

Our performance

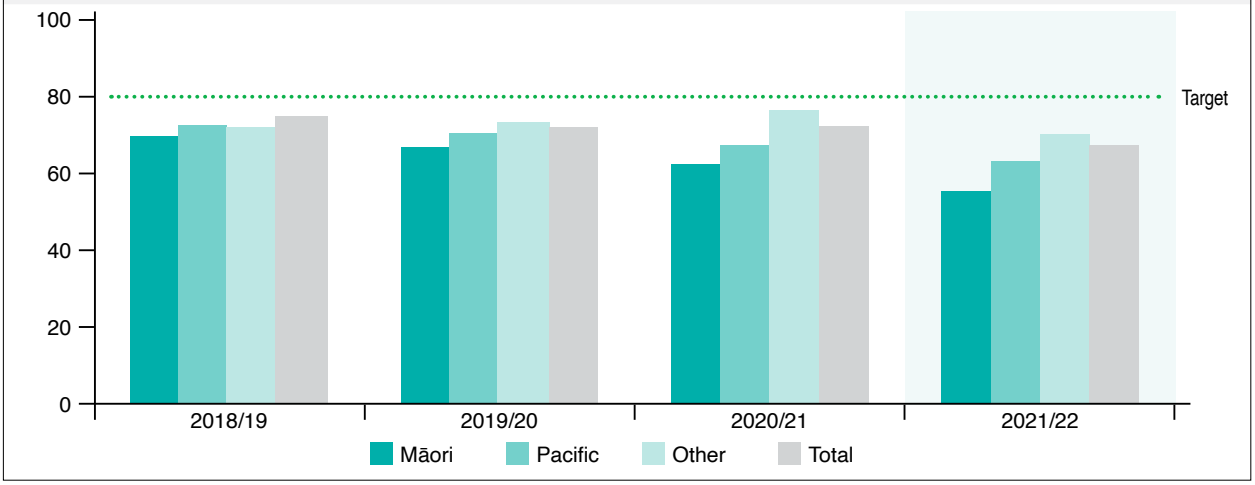
Please note that the data includes results from Hauraki PHO and National Hauora Coalition only. Pinnacle Midlands Health Network were unable to extract the data due to a cyber-attack after the reporting period.

Waikato DHB has not met the target for percentage of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the past five years. Our three PHOs have Heart Health Agreements in place and work with general practices and Whānau Ora teams to improve access to cardiovascular risk assessments and appropriate medical management for the eligible population. PHOs incentivise general practices to contact and see high needs patients including Māori men aged 30 to 44 years old. All PHOs have reported their performance has been significantly impacted by COVID-19, especially given blood lipids are required to complete patient assessment as well as examining the patient kanohi ki te kanohi. The use of kaitiaki could make a significant improvement to the rates for Māori, but are not available in primary care as yet. We will continue to work with our Māori and PHO partners to explore ways to improve outcomes in the coming year.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months	Māori 66% Pacific 70% Other 73% Total 71%	Māori 62% Pacific 67% Other 76% Total 72%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 55% Pacific 63% Other 70% Total 67%	

Our performance

Percentage of eligible women who had a cervical screening event in the past 36 months



Waikato DHB has not met the 80 percent cervical screening target for 2021/22. It is also concerning that results have deteriorated from the previous year.

Key initiatives that we have in place and will support improved performance for the coming year include

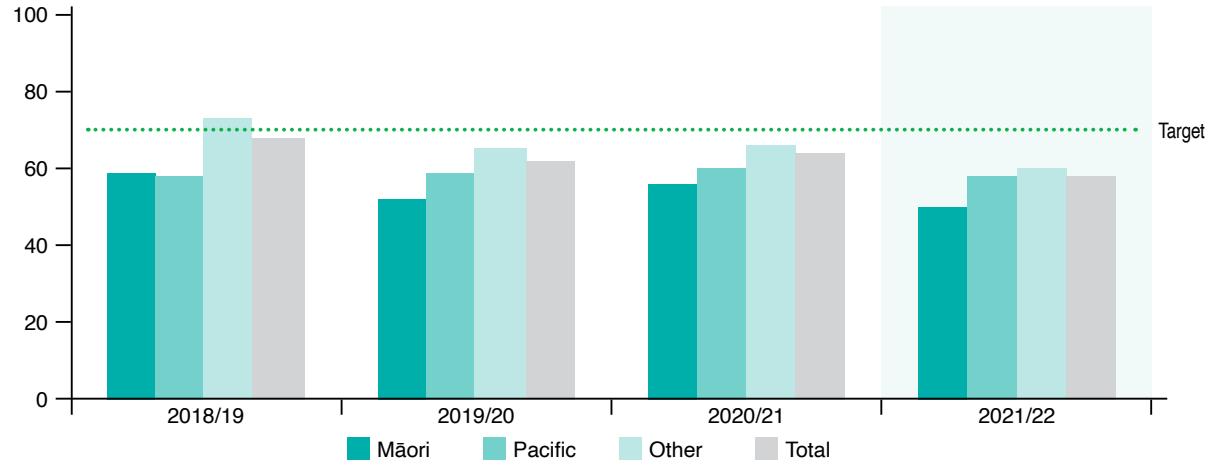
- Attend events and screening onsite with the mobile van where possible. Waikato DHB community coordination group which includes screening services, NGO and other community group representatives meets online monthly and have an events calendar to collectively co-ordinate attendance at events
- Dual screening alongside the mobile breast screening unit has been arranged for July-November 2022 to provide additional screening options in rural and higher need regions
- Planning around mobility and screening within the community that are outside clinic hours with the aim to capture priority group women
- Waikato DHB continues to fund local PHO practices for priority women to access a free smear. Priority criteria also extends to free smears for women who are aged 30 years plus and significantly overdue longer than five years or who have never had a smear. Encouraging home screening and after hours clinics within practices will continue
- Facebook/social media is a strong influencing forum and a connection point to share, educate and kōrero. Waikato DHB is the administrator of the Cervical Screening Waikato page which highlights awareness on cervical screening, HPV, local clinics and events.

People stay well in their homes and communities

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of eligible women aged 50-69 who have a BreastScreen Aotearoa mammogram every two years	Māori 52% Pacific 59% Other 65% Total 62%	Māori 56% Pacific 60% Other 66% Total 64%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 50% Pacific 58% Other 60% Total 58%	

Our performance

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



Waikato DHB has not achieved the breast screening target this year despite a concentrated effort in supporting priority group wāhine to screen and this resulted in an increase in the actual numbers of priority women screened in the period. In addition, we have increased access to screening at a fixed site by relocating one of our mammogram machines from the Breast Care Centre to Te Korowai o Hauraki in Thames in May 2022. This is the first partnership model between a Māori provider and a DHB in New Zealand. Since May 2022 this partnership has provided additional screening services to over 700 women in the Thames region and they are currently fully booked two months in advance. Having a Māori service provider available has also attracted more Māori in the region to screen. This provision is in addition to the current mobile unit cycle which services the Thames, Coromandel and Hauraki regions.

Overall, capacity and demand constraints have been the number one contributor to the under delivery and under achievement of screening services in the wider Waikato region. This is closely followed by workforce constraints in our Medical Imaging Technician (MIT) workforce. In 2021, the workforce constraints were addressed; seeing an increase in MIT capacity by 4.0 FTE, however workforce shortages have meant that the service is still trying to recruit 3.0 FTE.

In addition, staff sickness (MITs, radiologists and administration) at the Breast Care Centre and at Hamilton Radiology meant there has been a considerable reduction in bookings at these two sites over a four month period. Despite these challenges, with the increase in MIT workforce BreastScreen Midland has implemented

- weekend breast screening and cervical screening opportunities with targeted priority population appointments being made by call centre staff
- increased service delivery through providing two MITs per mammogram machine adding an additional 12 patients per day
- cold calling Māori and Pacific women and offering them dual screening prior to engagement with non-Māori women. Cold calling has been our most successful initiative to increase Māori participation in 2021
- Utilisation of the early release of the mobile van from Thames has allowed BreastScreen Midland increased access for the Hamilton City region where there is a large volume of Māori identified.

Fewer people admitted to hospital for avoidable conditions

Impact measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Ambulatory sensitive hospitalisation rate per 100,000 for 0-4 year olds	Māori 8387 Pacific 8852 Total 7008	Māori 6591 Pacific 7008 Total 5662	Māori 9927 Pacific 10,924 Total 6423	Māori 6845 Pacific 8250 Total 6297	
Impact measure	**Baseline 2019/20**	**Previous year 2020/21**	**Target 2021/22**	**Result 2021/22**	**Rating**
Ambulatory sensitive hospitalisation rate per 100,000 for 45-64 year olds	Māori 8726 Pacific 9000 Total 4335	Māori 7914 Pacific 7258 Total 3770	Māori 9384 Pacific 9999 Total 3858	Māori 7716 Pacific 6830 Total 4111	

Our performance

It is pleasing to see that Waikato DHB has met most of the targets for ambulatory sensitive hospitalisation rates.

For the 45-64 age group, the total rate is slightly above the threshold. In order to improve this, we have successfully implemented a number of services to provide care closer to home and to redirect the patients to their GPs or urgent care clinics, for example, community based nurse led COPD clinics. We have revised the POAC (Primary Options for Acute Care) service which was implemented in July 2019, this allows the GPs to manage patients in the community and volumes continue to grow.

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

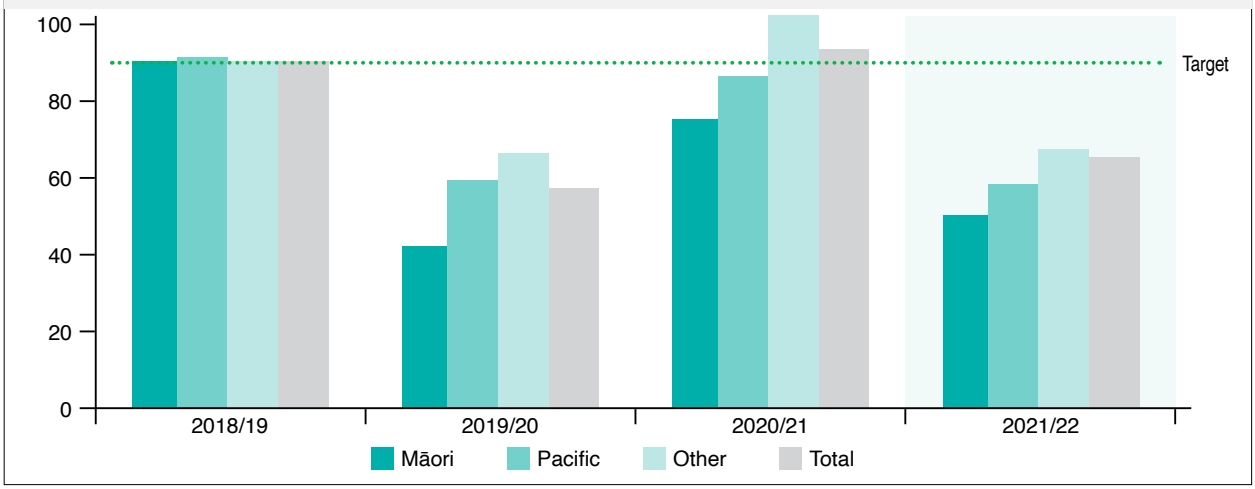
EmergencyQ, Waikato Hospital ED's app based patient redirection service volumes have continued to grow for Triage category 4 and 5 presentation. This has resulted in redirecting a significant proportion of ED presentations to urgent care clinics or local GPs.

People stay well in their homes and communities

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of eligible population who have had their B4 School Check completed	Māori 42% Pacific 59% Other 66% Total 57%	Māori 75% Pacific 86% Other 107% Total 93%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 50% Pacific 58% Other 67% Total 65%	● ● ● ●

Our performance

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



The last year has been challenging for B4 School Check services which is demonstrated by the performance in Waikato DHB where the gains made in 2020/21 have been lost and no targets were achieved in 2021/22. The B4 School Check is an important Ministry of Health programme which aims to identify health, behavioural and developmental issues before a child starts school. This is a crucial check to allow children to have the best possible start to their formal education.

Our achievement has been adversely affected by the COVID-19 pandemic where face-to-face contact for the B4 School Check was not possible during alert levels three and four. While our performance was one percent ahead of the national average in August 2021, when the country moved to alert level four in September we started to experience a significant reduction in completed checks, a trend that continued as alert level restrictions in large parts of the Waikato continued for the remainder of 2021.

Training and a renewed focus has been placed on the B4 School Check during 2022. This is already showing signs of improvement with the performance in June 2022 ahead of the monthly target.

Although this was another poor year overall, in challenging environments, the June performance provides early momentum to take us into the 2022/23 year and gives some confidence, COVID-19 permitting, that we can expect improvements moving forward. The focus for 2022/23 will be to once again eliminate the equity gap for this measure to ensure tamariki start school well set for formal education and lifelong learning.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)	3.5/100,000	3.3/100,000	1.2/100,000	1.8/100,000	●

Our performance

During the 2021/22 reporting year, there were eight notified cases of acute rheumatic fever in the Waikato district – this includes all confirmed, probable, and under investigation cases so may be subject to modification (reduction) following clinical review (six month follow up). This is a reasonable decrease on last year's number (14 cases) without clear cause. Acute rheumatic fever remains one of many diseases of inequity – with our numbers reflecting ongoing inequities in health care quality and access, and also varying access to social determinants of health.

While eight cases may not seem like a large number, the impact an episode of acute rheumatic fever has on an individual and on their whānau is immense and lifelong, which is why it is important to resource and prioritise rheumatic fever prevention and management initiatives sufficiently.

Dedicated Ministry of Health funding in acute rheumatic fever prevention has ceased, however Waikato has continued to fund pharmacy led sore throat management services as the barriers to adequate GP access continue. Sore throat management is also commencing within COVID-19 community hubs and respiratory assessment clinics. A major determinant of acute rheumatic fever (housing) continues to be a priority but under resourced area (Whare Ora). In the coming year Waikato will collaborate regionally in Te Manawa Taki (other high incidence areas) to determine where further improvements can be shared.

People stay well in their homes and communities

More people maintain their functional independence

Impact measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Average age-of-entry to aged residential care:					
• Rest home	84 years	86 years	>84 years	87 years	
• Dementia	81 years	82 years	>80 years	83 years	
• Hospital	85 years	84 years	>85 years	86 years	

Our performance

Waikato DHB has met the targets for entry to all levels of aged residential care. They have tracked consistently with the prior year. We have an ongoing focus on the overarching goal that aligns to the Healthy Ageing Strategy – older people will live well, age well and have a respectful end of life in age friendly communities.

Alongside being able to offer aged residential care in people's locations of choice, alternative options, enabling equity of access are available to allow people to remain in their community for as long as they are able with the right supports. With decreasing access to specialised care for psychogeriatric clients we considered a second care facility in the district that opened in May 2022. This facility offers 30 beds in the rural town of Morrinsville.

In the Waikato district we have a well-established model of care, Supported Transfer and Accelerated Rehabilitation Therapy (START) that provides individuals with targeted rehabilitation in their home up to four times a day, seven days a week. A project has also been underway for the past six months supporting a transition to home model of care. Transition to home offers a pathway of care for post-acute patients. This model offers older people that are medically stable (following a recent acute event and who require ongoing professional care, including nursing and daily medical oversight outside of the acute setting) to successfully transition home to their community of choice. The older person will be provided with up to two weeks short term care in an aged care facility with the involvement of the community START team providing rehabilitation. As the project continues data will be collected to determine the effectiveness of residents being able to successfully transition to live well within their home and community.

Localities are under review to create community hubs within local communities with the focus on removing some barriers to access services. In terms of continuous development of community based rehabilitative support, we recognise the need to grow the START service to enable older people in all localities to access community support to remain living well in their homes. Modelling will be undertaken to understand local demand.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of needs assessment and service coordination waiting times for new assessment within 20 working days	94%	91%	Māori 100% Pacific 100% Other 100% Total 100%	86%	●

Our performance

The target for the needs assessment and service coordination waiting times was not met for 2021/22. Our timeframe reports are not set up to differentiate between ethnicity.

COVID-19 has impacted significantly on the ability for Needs Assessment and Services Coordination (NASC) to complete assessments within the target timeframe of 100 percent. This is due to reduced staffing and numbers of clients unavailable because of isolation. Additionally, with the completion of the transition of non-complex clients to the Home and Community Support Service (HCSS) providers, all NASC clients are now complex requiring a higher levels of input from the team.

Waikato DHB have a dedicated Māori NASC team who complete assessments for Māori. For our non-complex Māori clients, all referrals are sent to one of our two kaupapa Māori providers.

One of the highlights for the year is that NASC has formed stronger relationships with all of the HCSS providers through the work that has been done collaboratively with the transition of non-complex clients.

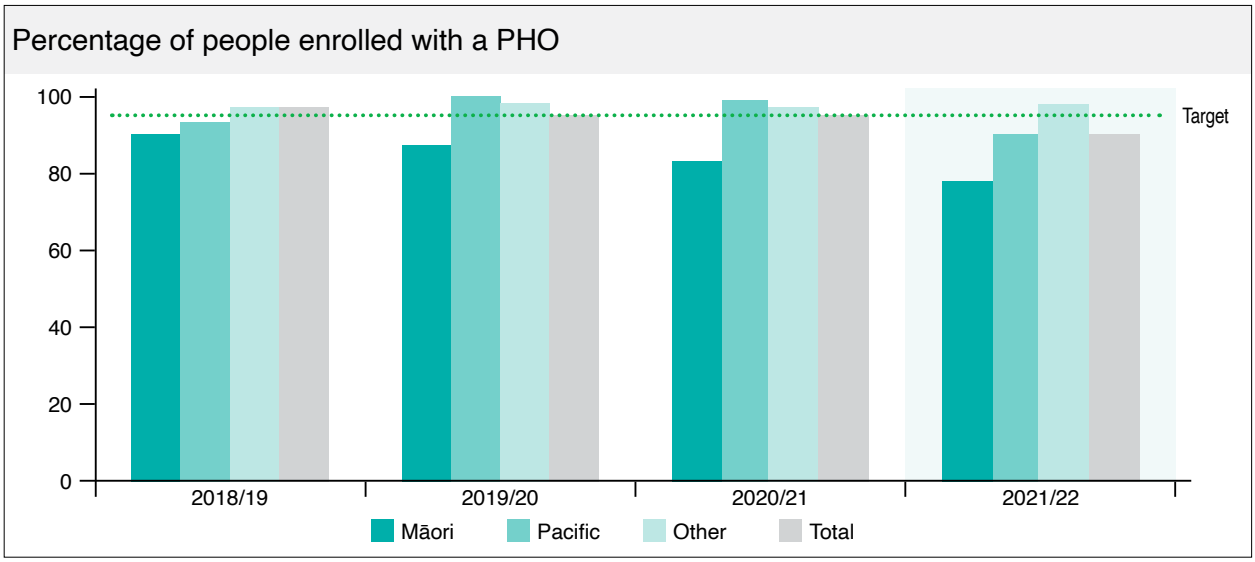
The continuous improvements for 2022/23 are to

- build on the care management model where clients are proactively managed with increased frequency of reassessment and reviews
- right size the NASC workforce to enable care management to be fully implemented
- establish an alert system where NASC care managers are notified when one of their clients present to ED enabling them to proactively follow-up
- assess the majority of clients for long-term aged residential care in the community rather than as an inpatient following an acute event
- develop a clinical triage team where referrals can seamless be transferred across services for the older person.

People stay well in their homes and communities

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of people enrolled with a PHO	Māori 87% Pacific 100% Other 98% Total 95%	Māori 83% Pacific 99% Other 97% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 78% Pacific 90% Other 94% Total 90%	

Our performance



Waikato DHB has not met the PHO enrolment target for 2021/22 and the result has deteriorated since last year. Patients with a Māori primary ethnicity have decreased by five percent from 2021/22 and are well below the baseline result. Patients with a Pacific primary ethnicity have decreased by 9 percent from 2021/22 and are also well below baseline.

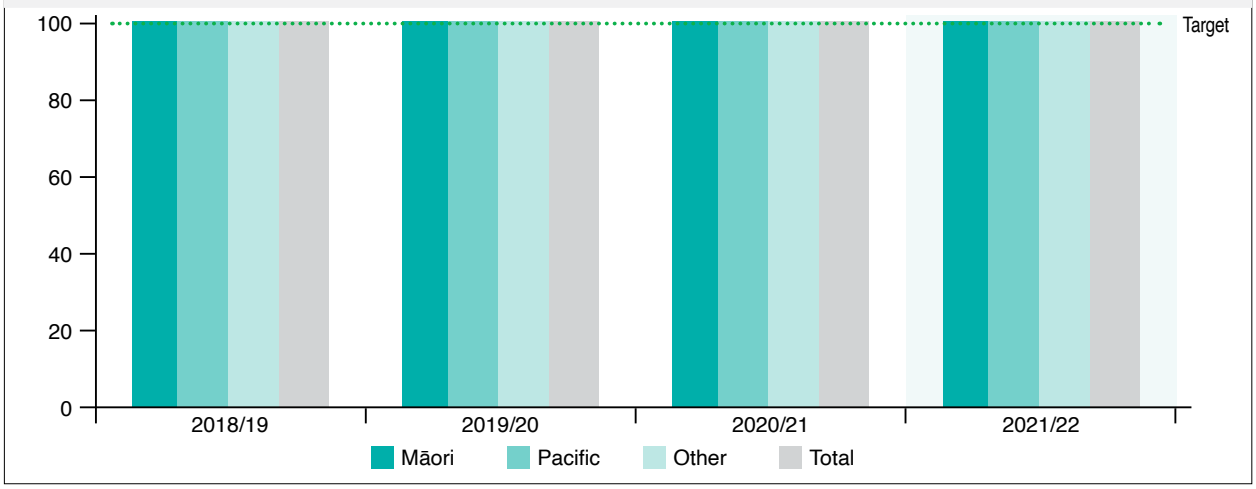
We are anticipating increases in our enrolments in the future as our iwi and Māori providers have played a very significant role throughout the region in our COVID-19 response and have engaged closely and effectively with local primary care providers and PHOs. Issues related to enrolment and service access will be a focus in the coming year and actions include

- continuing to work with our partner PHOs to reduce barriers to access
- supporting PHOs, iwi and locality developed plans to transform the culture and workface of general practice using a co-design process
- strengthening the roles of iwi led engagement, Māori provider outreach and locality hubs to facilitate enrolment in primary care
- analysing cost as a barrier to access including to very low-cost access (VLCA) practices
- adding the target to the Waikato equity plan for 2022/23

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of older people receiving long-term home-based support have a comprehensive clinical assessment and an individual care plan	Māori 100% Pacific 100% Other 100% Total 100%	Māori 100% Pacific 100% Other 100% Total 100%	Māori 100% Pacific 100% Other 100% Total 100%	Māori 100% Pacific 100% Other 100% Total 100%	

Our performance

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



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

With the direction of the new national framework for home and community support services (HCSS) being implemented in the Waikato, clients are screened using the screening assessment tool to determine a pathway for assessment. Non-complex clients now have a contact assessment completed by the community based provider. If deemed complex an InterRAI comprehensive clinical assessment is undertaken for all clients by Disability Support Link (DSL). Both assessments enable staff to select appropriate support requirements for older people needing home-based support services. Any care plan that is put in place is tailored to the individual needs and enables the older person to access the assistance they need while maintaining their independence.

COVID-19 and workforce shortages have presented challenges in completing review of initial assessments within the timeframe guidelines. Reviews tend to be undertaken at this time when an individual's needs trigger a requirement to do so. With the current registered nursing shortage it would be beneficial to explore what role a competent health care assistant could support in the review of client processes.

People receive timely and appropriate specialist care

Long-term impact	Intermediate impacts	Impact and outputs
People receive timely and appropriate specialist care	People receive prompt and appropriate acute and arranged care	Percentage of patients admitted, discharged, or transferred from emergency departments within six hours 90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks
	People have appropriate access to elective services	Standardised intervention rates (per 10,000) Percentage of patients waiting longer than four months for their first specialist assessment Number of planned care interventions completed Did-not-attend (DNA) percentage for outpatient services Acute inpatient average length of stay Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates Percentage of young people aged 0-24 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks Mental health clients discharged have a transitional (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 referrals 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

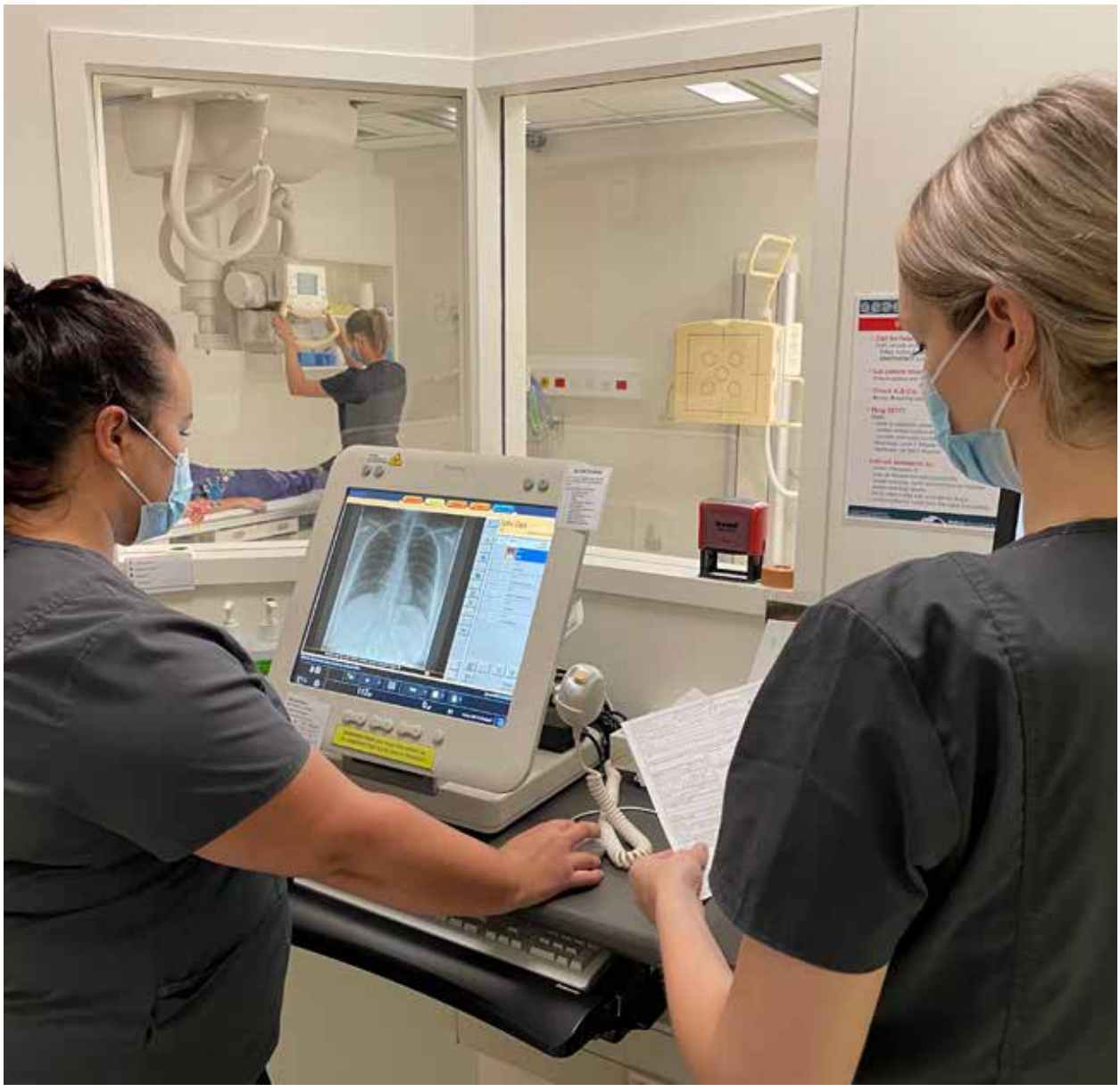
We achieved the target	We almost met the target (within 10 percent)	We have not met the target

Why does this matter?

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

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

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



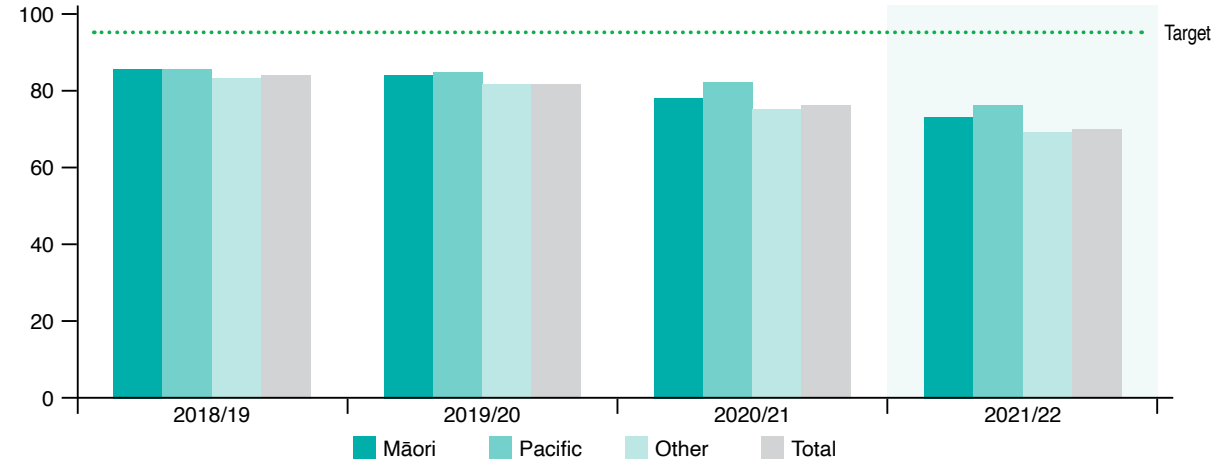
People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Impact measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	Māori 84% Pacific 85% Other 82% Total 82%	Māori 78% Pacific 82% Other 75% Total 76%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 73% Pacific 76% Other 69% Total 70%	● ● ● ●

Our performance

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



Waikato DHB has not met the target set for 2021/22 with a decline in performance compared to the previous year. Overall presentations have been less than previous years however the complexity of running a separate COVID-19 zone makes the service less efficient. Whilst a COVID-19 zone was operational in the previous year, the volumes through that area have been significantly higher. This has resulted in a loss of our short stay unit which is accountable for nearly 100 percent of our decrease in performance. This has impacted on all patients attending ED with very similar reductions in the percentage meeting the time frame for all ethnicities.

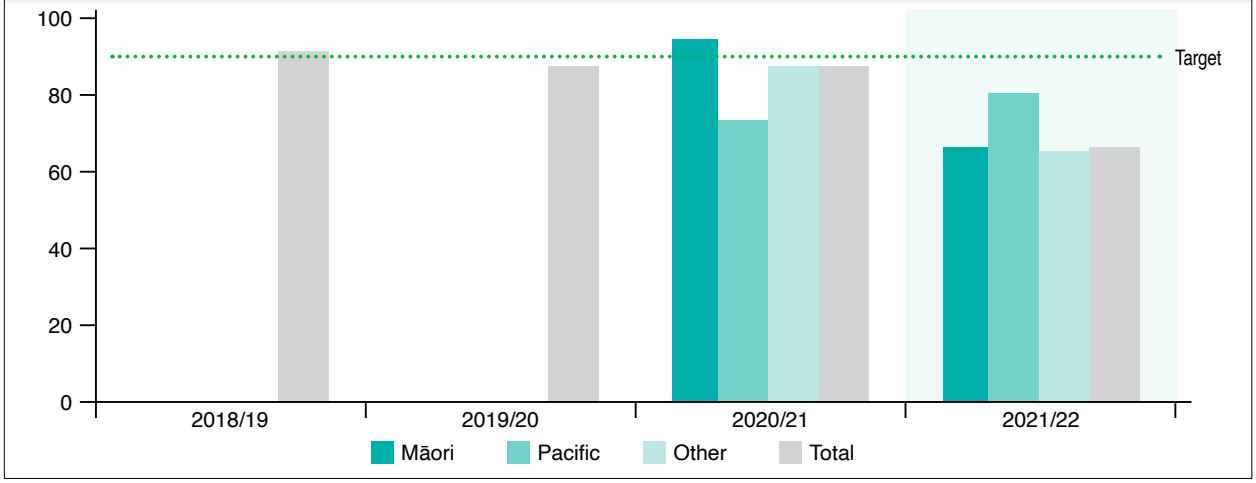
Successes

- EmergencyQ – safely redirected more than 6000 lower need patients to urgent care clinics
- GPs access – direct calls to a SMO in General Medicine and Cardiology, 20+ calls per day – advice so patients can be supported by primary care, "hot" clinics that mean patients bypass ED and when required a planned admission occurs. Access to Frailty Admission Avoidance Pathway means support is provided same day in the home, or planned respite arranged, that prevent an ED presentation and unplanned admission
- St John – redirecting lower need patients to urgent care clinics and also accessing the Frailty Admission Avoidance Pathway
- Approved business case that "right sizes" Waikato ED, leading to the recruitment of additional SMOs, RMOs, registered nurses and health care assistants
- ED front of house redesign underway – $3.3 million investment
- ED – The Australasian College for Emergency Medicine (ACEM) accreditation achieved
- The work undertaken by the 'admission avoidance' PhD student is underway and starting to bear fruition. This will be expanded on in 2023. Modelling has already been provided that supports the management of Plastics, Orthopaedic and Gynaecology patients. A business case will be developed using this work that will identify 'non-urgent care' at the front door, identify alternative options for care reserving ED for true emergency care. This work links in with the work of seven other PhD students taking a whole of patient continuum approach to coordinate acute care.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	87%	Māori 94% Pacific 73% Other 87% Total 87%	90%	Māori 66% Pacific 80% Other 65% Total 66%	

Our performance

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



Waikato DHB was not able to achieve the faster cancer treatment 62 day target in the 2021/22 financial year. Despite numerous efforts undertaken by the services, the achievement against the indicator dropped from 87 percent in the 2022/21 year to 66 percent in the 2021/22 year. Achievement was impacted by

- backlogs created due to the cyber-attack in May 2021 and restrictions related to COVID-19 alert levels that were in effect between August and November 2021
- staff deficits, COVID-19 and winter illness among staff leading to theatre cancellations
- deficits in radiology staffing leading to significant delays in diagnostic pathways
- capacity constraints, COVID-19 and staff sickness delaying outpatient appointments.

Achievement for Māori was slightly higher at 66 percent compared to the achievement for non-Māori at 65 percent. There is ongoing focus on achieving equity by monitoring of the patient pathways as they get worked through to a diagnosis and treatment and in the reporting of the indicator achievement by ethnicity. The clinical nurse specialist for equity and access continues to work on access issues for Māori and Pacific patients, monitoring did-not-attends (DNAs) and assisting patients to attend hospital appointments by finding solutions that work for each individual patient.

The clinical nurse specialist also helps to re-engage patients and whānau, who are reluctant to pursue diagnostics or treatment.

Waikato Clinical Equity team also introduced a Whānau Hauora Integrated Response Initiative (WHIRI) to help care coordination for patients identified as having high clinical and equity risk.

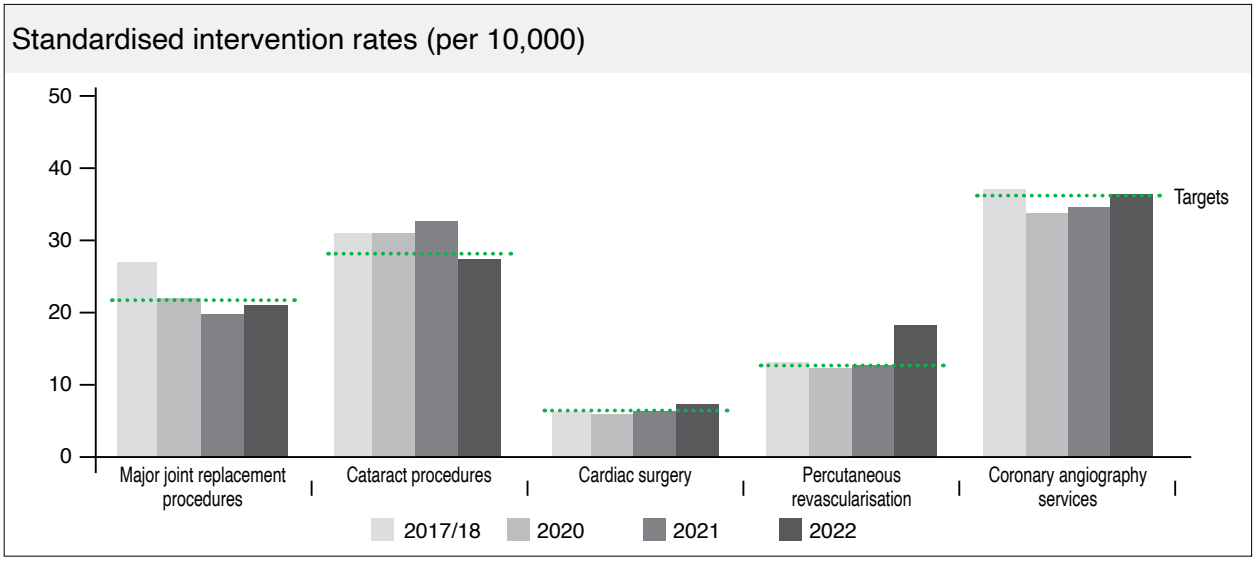
Several other service improvement initiatives are underway to improve the cancer pathway and outcomes for patients.

People receive timely and appropriate specialist care

People have appropriate access to elective services

Impact measure	Baseline September 2020	Previous year September 2021	Target September 2022	Result September 2022	Rating
Standardised intervention rates (per 10,000):					
• Major joint replacement procedures	22	19.8	22	21	
• Cataract procedures	31	32.6	28.4	27.4	
• Cardiac surgery	5.9	6.4	6.8	7.4	
• Percutaneous revascularisation	12.4	12.8	13	18.2	
• Coronary angiography services	33.8	34.5	36.4	36.3	

Our performance



Timely access to the above specialist services is a minimum expectation measure of the health system. Elective surgery, now referred to as Planned Care Intervention (PCI) is important to the wellbeing of populations that require surgery to reduce pain and discomfort improving their independence. Waikato DHB has attained two of the five targets and has not attained three.

The 2020/21 cyber-attack, industrial actions and COVID-19 disruption over the course of 2021/22 have impacted target delivery as evident in the result. This has meant a select number of patients have had timelines extended well beyond the four month required timelines. The planned care intervention recovery plans (reset/restore) have been crafted and put in place to help with delayed patient journeys. In May 2022, the "PCI Task Force" was set up at the national level to help establish a robust plan to resolve excessively long wait patients, (those in excess of 12 months) obtain access to intervention swiftly.

Waikato DHB's focus on a locality based model as defined in Te Korowai Waiora has also been adopted nationally. An example of this has been improving access to diagnostics that enhance patient pathways to care, which may also include other options than surgery. This has resulted in an increase in primary care options for care without requiring referral to secondary and or tertiary services. The planned care interventions plan during 2022/23 will be enhanced with the future locality opportunities. These will be co-crafted and co-created in partnership with communities which is a catalyst for reducing health disparity and improving equity of access and health/wellbeing outcomes.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of patients waiting longer than four months for their first specialist assessment	19%	33%	0%	24%	

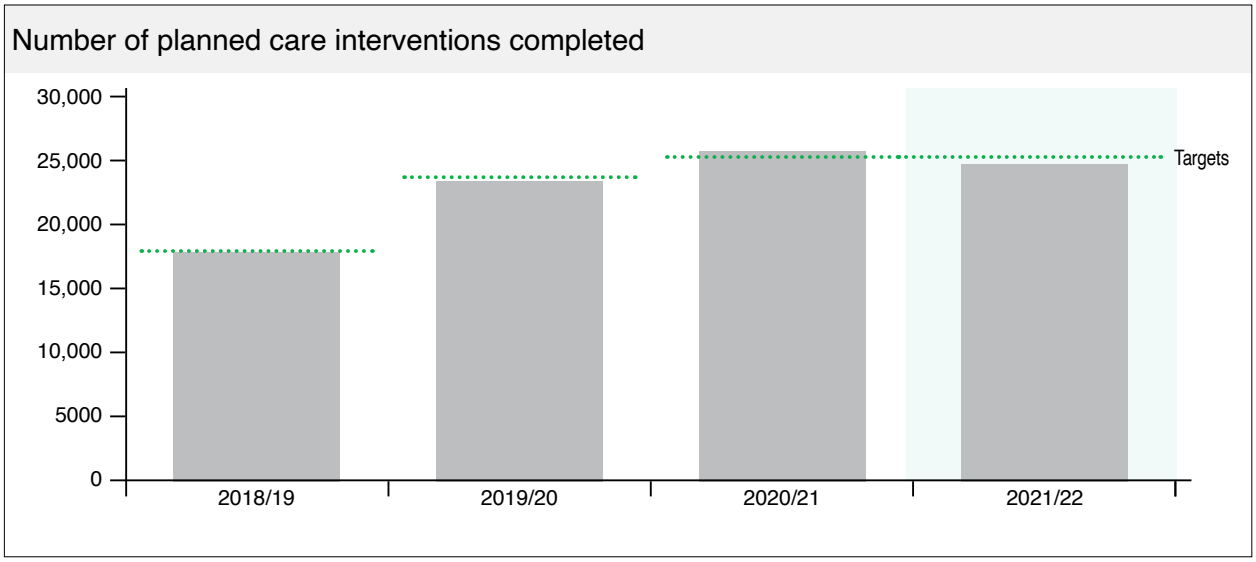
Our performance

Waikato DHB has not met the target for the percentage of patients waiting longer than four months for their FSA, but is pleased to have improved compared to last year. The result reflects the impact of both the cyber-attack on Waikato information systems along with COVID-19. Consequently, for a considerable period of time only cancer and time critical patients were seen in clinic with staff being redirected to inpatient areas affected by staffing shortages.

Recovery plans will be focusing prioritisation of scheduling the longest waiting, Māori and Pacific and the urgent/time critical patients. The production planning team are working on reporting and models that provide the ability to model and monitor demand against capacity.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Number of planned care interventions completed	23,257	25,758	25,459	24,681	

Our performance



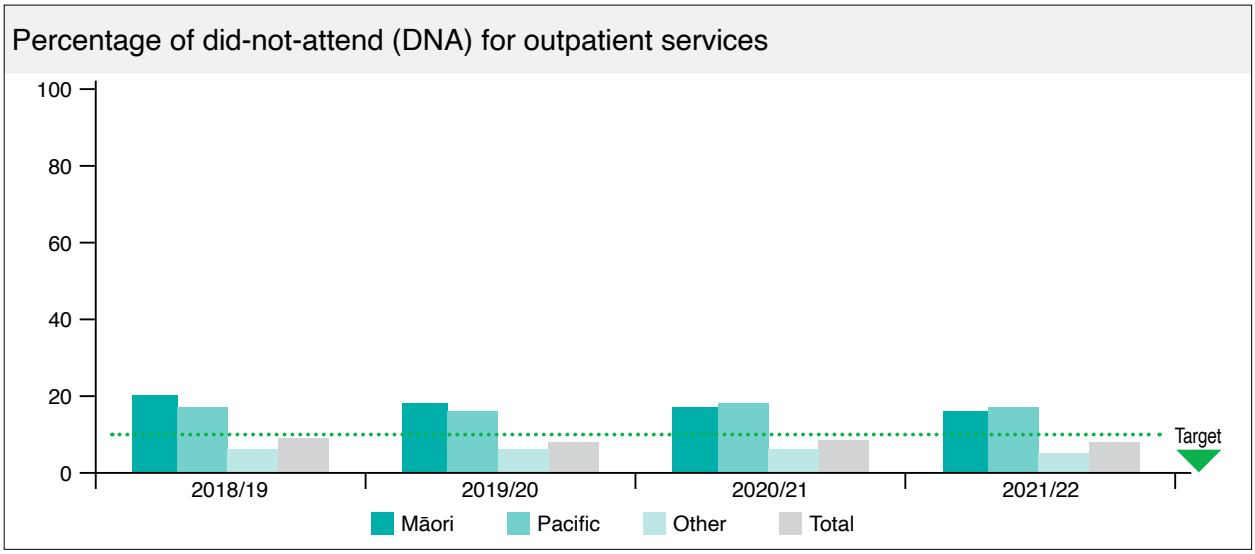
Whilst slightly below the target for 2021/22, Waikato DHB's ability to continue with outsourcing of planned care to private providers supported our capacity to deliver on planned care interventions.

Theatre capacity has been significantly affected due to staffing shortages (theatre nursing personnel and anaesthetic technicians), often only having the capacity to staff acute and time critical patients. We continue to work through the backlog (wait lists) and reschedule appointments. Recovery plans are being developed at service level.

People receive timely and appropriate specialist care

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Did-not-attend (DNA) percentage for outpatient services	Māori 18% Pacific 16% Other 6% Total 8%	Māori 17% Pacific 18% Other 6% Total 9%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 16% Pacific 17% Other 5% Total 8%	

Our performance



Waikato DHB has met the overall target for did-not-attend (DNA) percentage but has not met it for our priority populations.

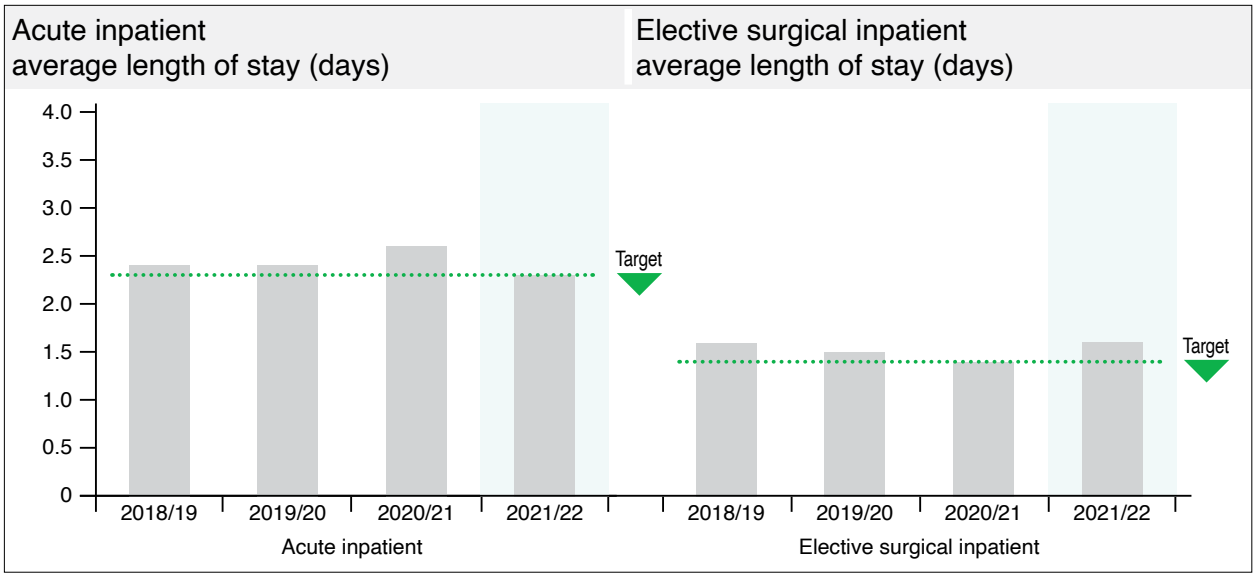
The overall percentage of DNA rates for the Cancer and Chronic Conditions Directorate for 2021/22 is six percent, well below the 10 percent target. The directorate reviews it's DNA rates on a regular basis and reports on them as part of the monthly performance review process to the Executive Leadership Team, chaired by the executive director for Hospital and Community Services. The directorate has a dedicated Equity and Access clinical nurse specialist for cancer services who is actively involved in working with our Māori patients to ensure they are able to attend the hospital and all their appointments. This has proved to be a very effective arrangement, ensuring that DNA rates are maintained at a relatively low levels for Māori cancer patients, as reflected in medical oncology (two percent) and radiation oncology (three percent), which is well below the national average. DNA rates in diabetes, though falling, remain an area of focus. For the new financial year the service will be piloting an initiative through the employment of a Māori staff member contacting all patients prior to their appointment to arrange convenient times and dates for their appointments. The role is currently being appointed to and we will track the impact of this initiative, with a view to potentially extending into endocrinology and renal services if it proves to have a positive impact.

The Medicine and Older Persons Rehabilitation Directorate performance result was four percent which is considerably lower than the 10 percent target. This can be partially attributed to the large volume of patients via the dermatology virtual lesion clinic which in reality does not require the patient to physically attend. The directorate is working closely with the Director of Equity to monitor and identify opportunities to improve whānau engagement and reduce the equity gap.

Meade Clinical Centre clinics were running at less than 75 percent capacity for much of 2021/22 due to COVID-19 restrictions. Meade Clinical Centre continues to phone all Māori and Pacific patients and liaise with the equity team when applicable for clinics run out of Meade Clinical Centre managed by clinical and operational support. From 20 September 2021 we introduced the could-not-attend measure and this has reduced the amount of incorrectly recorded DNAs.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Acute inpatient average length of stay	2.5 days	2.7 days	2.3 days	2.7 days	●
Elective surgical inpatient average length of stay	1.5 days	1.5 days	1.5 days	1.6 days	●

Our performance



Waikato DHB has met the target for acute inpatient average length of stay. Average length of stay continues to be impacted by COVID-19, with COVID-19 inpatients having longer, more complex stays and problematic discharge planning. Overall the medical specialties have been sustaining a consistent, though slightly increasing length of stay.

General Medicine – The service has been impacted by taking on increased patients (COVID-19 General Medicine and other specialty areas) with no associated increase in medical resourcing. Initiatives such as having dedicated COVID-19 discharge planners, seven days per week discharging, weekend coordinators and outsourcing some activity such as PICC lines has helped to mitigate the impact. Daily rounding, frequent long stay reviews and optimising community services and early supported discharge has resulted in a very small increase in length of stay from 1.62 to 1.66 days.

Respiratory – Length of stay is down from last year but higher than the previous three years. This reflects the change in the model of care as a result of COVID-19 bed occupancy, plus a return to business as usual with general respiratory presentations compared with last year.

Gastroenterology and Neurology – Both services have a reduced length of stay. The implementation of a ward team has supported earlier decision making in Gastroenterology. Neurology is often influenced by the varied length of stay that its patients have, but access to community models such as START supports an earlier return home.

Surgery – The increases in this area are attributable to Cardiology and General Surgery. This is mainly impacted by the constraining of elective admissions, which is then leading to an increase in acute admissions due to delayed elective surgery. As well as the ongoing monitoring and reviewing of patients with extended length of stay the following initiatives are underway

- Enhanced Recovery After Surgery (ERAS) – project implemented for colorectal patients which has been shown to reduce length of stay
- As per General Medicine – outsourcing PICC lines

Women's and Children's – Whilst there has been some variability during the year the overall length of stay has reduced from 2.70 to 2.55 days. The use of nearby motels for clinically stable patients from out of region while they gain gestational maturity has been effective.

People receive timely and appropriate specialist care

Cancer and chronic conditions – A review of the average acute length of stay across cancer and chronic conditions shows that it has

- a lower length of stay than comparable DHBs in the larger specialties of haematology (2.94 days vs 4.41 average) and oncology (3.54 days vs 3.86 average)
- a comparable rate for renal (4.16 days vs 4.16 average), and
- a slightly higher rate in the smaller specialties, of endocrinology (1.3 days vs 1.1 average) and rheumatology (2.90 vs 2.79 average)

Active work is on-going to ensure the directorate stays within its bed allocation as much as possible and to protect the oncology ward from general admissions to reduce the risk of COVID-19 to this vulnerable patient cohort.

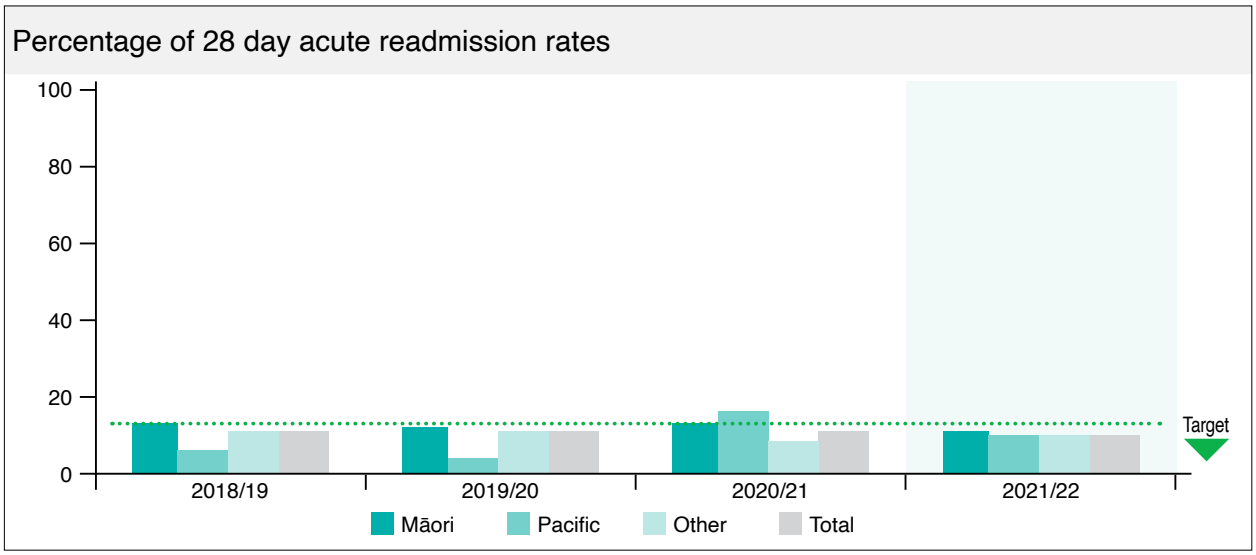
Rural hospitals – Thames Hospital have in place an acute general medicine clinic where patients can be referred directly from Thames Hospital ED to an outpatient environment where appropriate rather than inpatient admission. As for Waikato Hospital average length of stay has been significantly impacted by COVID-19 admissions and COVID-19 complexities in community services, including aged residential care facilities.

The increase in elective surgical inpatient length of stay of 0.1 from 2020/21 highlights the impact of a reduction in planned care and an increase in acute patients who present with greater clinical complexity. Cardiac surgery length of stay decreased from 9.79 in 2020/21 to 8.96 in 2021/22. There are no areas of significant variance in length of stay for the remaining surgical specialties.

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

Impact measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
28 day acute readmission rates	Māori 12% Pacific 4% Other 11% Total 11%	Māori 13% Pacific 16% Other 9% Total 11%	Māori <13% Pacific <13% Other <13% Total <13%	Māori 11% Pacific 10% Other 10% Total 10%	● ● ● ●

Our performance



The overall 28 day readmission rate for Waikato DHB in 2021/22 was 12 percent. While this fell within the target range overall there was a slight increase on the previous year's readmission rates.

Continuing high demand and the level of acuity of admissions has played a part in this, but by far the largest impacts on our ability to consistently reduce occupancy, length of stay and readmission have been the resurgence of COVID-19 in our community and the availability of appropriate community placements and housing options for tangata whaiora.

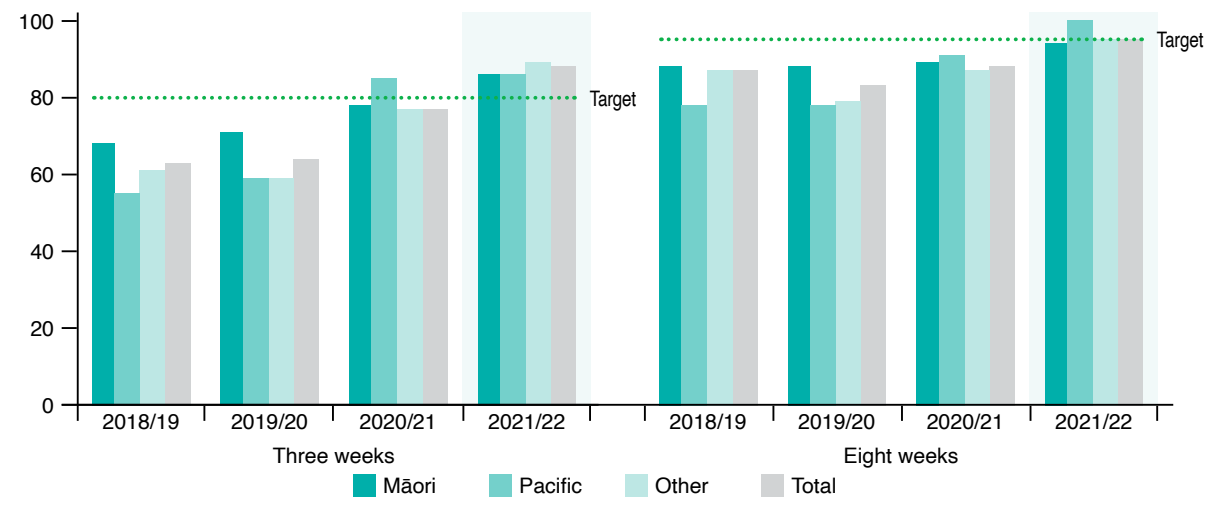
Work across the mental health and addictions sector in our district to develop models of care that better support tangata whaiora in the community has continued and is now part of an overall transformation programme for mental health and addictions services. Much of this work is in partnership with community providers (NGOs). This has in some cases been slowed and impacted by the issues arising from the COVID-19 resurgence in 2022.

People receive timely and appropriate specialist care

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of young people aged 0-24 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks	**3 weeks** Māori 71% Pacific 59% Other 59% Total 64%	**3 weeks** Māori 78% Pacific 85% Other 77% Total 77%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80%	**3 weeks** Māori 86% Pacific 86% Other 89% Total 89%	● ● ● ●
	8 weeks Māori 88% Pacific 78% Other 79% Total 83%	**8 weeks** Māori 89% Pacific 91% Other 87% Total 88%	**8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	**8 weeks** Māori 94% Pacific 100% Other 95% Total 95%	● ● ● ●

Our performance

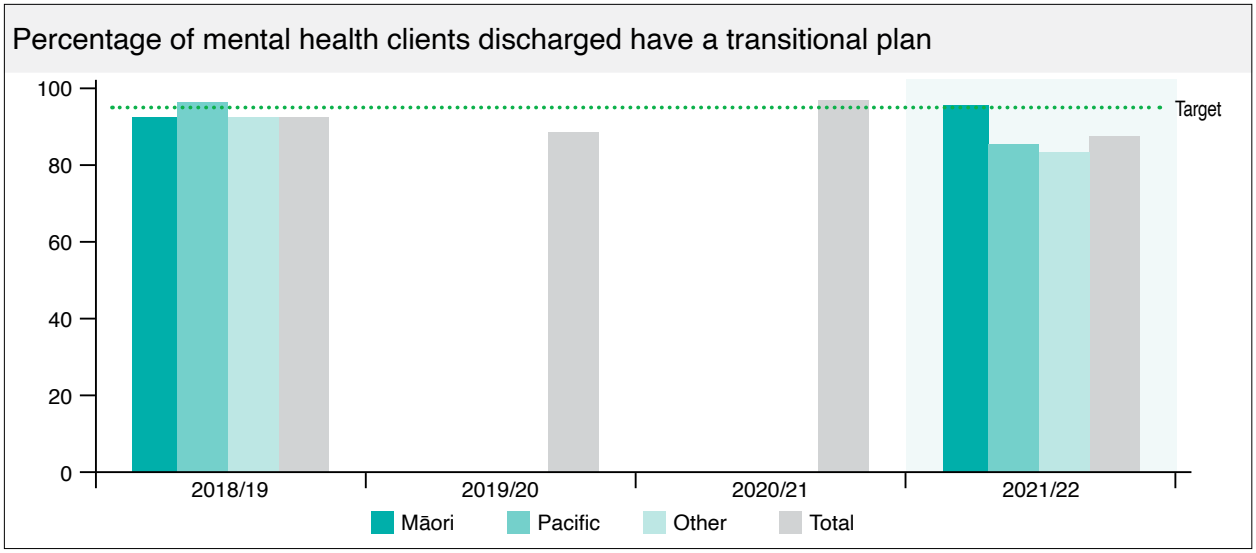
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks



Despite meeting most of the targets, child and youth mental health services continue to face very high demand for their services and this is reflected in the wait times reported by the provider arm for three and eight week categories. A number of the recommendations from the review of the Infant, Child and Adolescent Mental Health Service (ICAMHS) have been implemented, and the sector continued to work on these during 2021/22. Primary mental health options continued in 2021/22 to help reduce pressure on secondary services by offering alternative access points for youth.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Mental health clients discharged have a transitional (discharge) plan	Māori 92% Pacific 96% Other 92% Total 92%	Māori N/A Pacific N/A Other N/A Total 96%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 85% Other 83% Total 87%	

Our performance

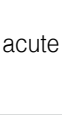


Waikato DHB has not met the overall target of 95 percent but is pleased to have met the target for tangata whaiora Māori.

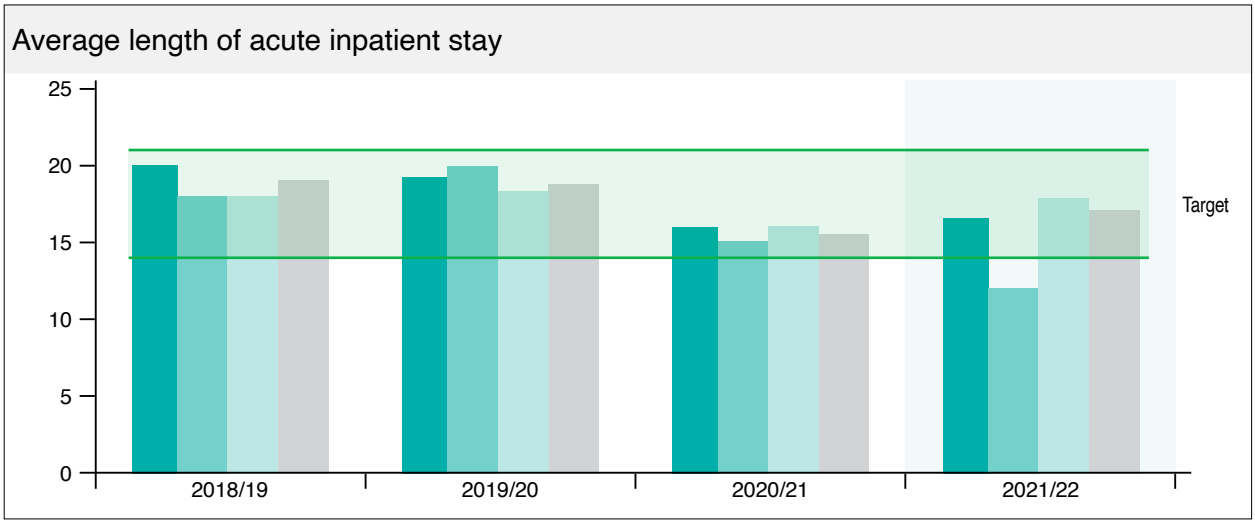
The 2021/22 year has not been without challenges for all mental health services. Already carrying a vacancy rate of 10 percent (mean), services have been significantly impacted by sickness and unplanned leave. At the same time, in the Waikato district, we continue to see an increase in the number of service users remaining in services and no reduction in demand for access to services, resulting in the need to prioritise caseloads and in some areas, carry waiting lists.

Collaborative planning for service user's journeys, including community and NGO providers, involving whānau and all involved in the provision of care, has been hampered historically by siloed working arrangements and lack of ability to share data and information across services. As part of the system transformation in the Waikato, we are currently collaborating with a number of providers to move to a more integrated model of care, with the goal of sharing one plan for our tangata whaiora. At the same time we are focusing a specific workstream on the review and revision of the content of the recovery plan and the way it is developed, to ensure the service user is at the centre of planning for their care, supported by whānau and with the right service providers identified and involved/aware of plans. This may take some time to accomplish in full, therefore in the meantime, we will be working to improve both the compliance and quality of plans.

People receive timely and appropriate specialist care

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Average length of acute inpatient stay	Māori 19.19 days Pacific 19.91 days Other 18.28 days Total 18.74 days	Māori 15.95 days Pacific 15.10 days Other 16.05 days Total 15.55 days	14 and 21 days	Māori 16.59 days Pacific 12.00 days Other 17.83 days Total 17.11 days	

Our performance

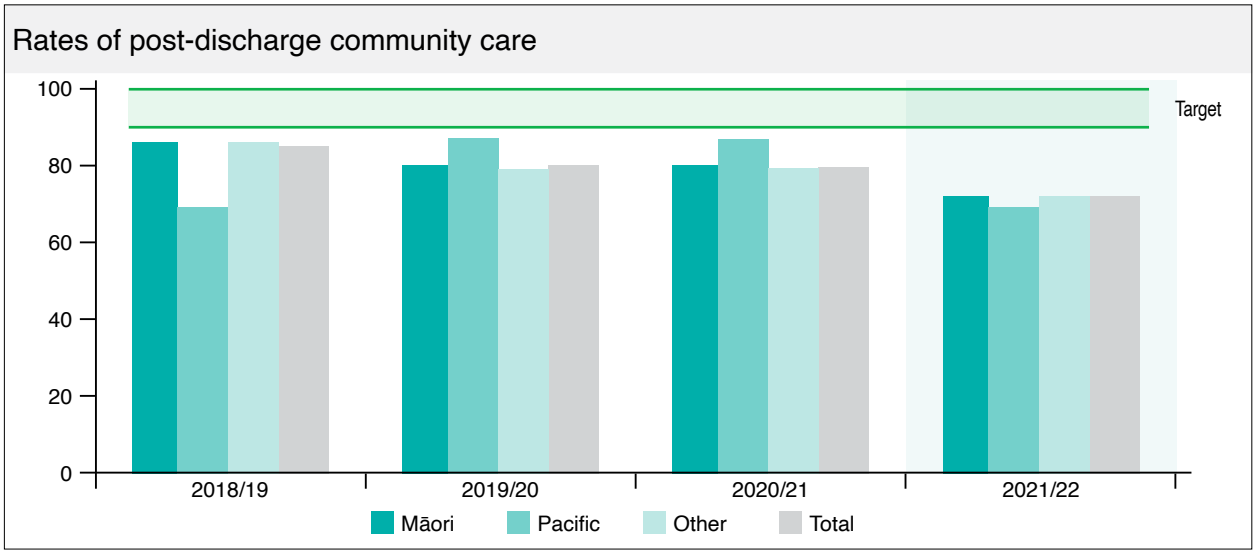


Waikato DHB has met the target for average length of acute inpatient stay for 2021/22. Although there was a small decrease for Māori and Pacific tangata whaiora, total length of stay has increased slightly in 2021/22. This increase in length of stay is a clear reflection of the number of tangata whaiora, for whom appropriate discharge options from hospital are limited. Waikato DHB Mental Health and Addictions does not turn away people in need of hospital admission or discharge people to homelessness. For many of our tangata whairoa there are barriers to safe, recovery focused, community living and recovery.

The whole of system transformation for mental health and addictions services in the Waikato district includes projects specifically focused on community accommodation and the development of an appropriate alternative to inpatient care for those identified as having particularly high and/or complex needs. These two groups are largely the drivers of long length of stay and the inability to discharge to appropriate settings impacts occupancy levels within the inpatient facility, effectively reducing available bed stock for others requiring admission and resulting in overcrowding. Equally, these groups tend to include a higher percentage of Māori and Pacific services users who are often disconnected from whānau supports and face multiple co-existing health and social challenges. Long term hospitalisation does not represent good care or a focus on recovery and rehabilitation. The models currently in development focus on putting tangata whaiora and whānau at the centre of their care.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Rates of post-discharge community care	Māori 80% Pacific 87% Other 79% Total 80%	Māori 80% Pacific 87% Other 79% Total 80%	90% and 100%	Māori 72% Pacific 69% Other 72% Total 72%	

Our performance



Waikato DHB Mental Health and Addictions has not met the target for post discharge community care which is based on face to face contacts undertaken within seven days of discharge from our inpatient facility. 2021/22 results show a marked decrease in face-to-face contact undertaken during this time across all measures.

Although there have been occasions where contact has not occurred within the post seven day discharge window, were we to include the phone contact follow up with tangata whaiora, the actual contact figure would be at 97 percent, well within the target range.

This is a significant area of focus for service delivery. COVID-19 resurgence in 2022 severely impacted our ability to connect in person and face-to-face with all those discharged from the inpatient facility. However where face-to-face follow-up has not been possible we have made every effort to connect by phone with tangata whaiora within the immediate period post discharge.

In every case where contact within seven days has not been possible, efforts have continued to make contact with the tangata whaiora and any missed contacts require manager level review of the discharge process.

People receive timely and appropriate specialist care

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Improving the health status of people with severe mental illness through improved access: 0-19 years 20-64 years 65 plus years	**0-19 years** Māori 5.07% Pacific 3.21% Other 4.72% Total 4.78%	**0-19 years** Māori 5.07% Pacific 3.21% Other 4.72% Total 4.78%	**0-19 years** Māori 5.17% Pacific 3.36% Other 4.72% Total 4.82%	**0-19 years** Māori 3.77% Pacific 2.49% Other 4.22% Total 3.97%	● ● ● ●
	20-64 years Māori 9.67% Pacific 4.59% Other 3.92% Total 5.12%	**20-64 years** Māori 9.67% Pacific 4.59% Other 3.92% Total 5.12%	**20-64 years** Māori 10.05% Pacific 5.17% Other 4.05% Total 5.31%	**20-64 years** Māori 6.94% Pacific 3.36% Other 3.01% Total 3.94%	● ● ● ●
	65+ years Māori 2.44% Pacific 3.10% Other 2.35% Total 2.37%	**65+ years** Māori 2.44% Pacific 3.10% Other 2.35% Total 2.37%	**65+ years** Māori 2.65% Pacific 3.43% Other 2.39% Total 2.43%	**65+ years** Māori 1.83% Pacific 2.15% Other 1.55% Total 1.58%	● ● ● ●

Our performance

Specialist mental health and addictions services are funded for those people who are most severely affected by mental illness or addictions. Waikato DHB continues to place a focus on continually improving access but the reported results for 2021/22 show all targets have not been met.

A significant workstream for mental health and addictions system transformation commenced in 2021/22 to re-orientate service delivery based on Me Kōrero Tātou, community and consumer voices. The adult mental health service in particular has been a focus. As the sector continues to face very high demand within both the DHB provider arm and NGO services, interfaces between the providers within the service continuum remain critical to ensure access continues to improve. Primary mental health options continued in 2021/22 to reduce future secondary mental health presentations, in particular the integrated primary mental health and addictions programme continued to roll out (COVID-19 permitting).

More people with end stage conditions are supported appropriately

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of aged residential care facilities utilising advance directives	100%	100%	100%	100%	●

Our performance

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

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

Waikato also promotes and utilises the Advance Care Plan (ACP) service model delivered with support from a community provider. The ACP is an alternative to an advanced directive and provides greater detail on a person's wishes.

Aged residential care facilities adopt a shared goals of care approach and utilise the Te Ara Whakapiri tools and resources to provide best practice end of life care.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Number of new patients seen by the Waikato Hospital Palliative Care service	740	741	727	877	●

Our performance

Waikato continues to meet target for this measure and was performing 20 percent above target during 2021/22. The Palliative Care team at Waikato Hospital is a consult liaison service that provides care for patients with life limiting or life threatening illness. We provide physical, psychosocial, spiritual and cultural care for patients, their whānau and other significant caregivers. The team work very closely with Hospice Waikato (a third party district provider) in a one service two provider model.

The consult liaison service has seen 877 new patients during the year, (19 percent Māori, 3 percent Pacific and 78 percent Other) with a total of 5173 face-to-face patient visits.

The service continues to develop the midland training group (including Waikato, Bay of Plenty and Taranaki) supporting palliative care advanced trainees and SMOs across the region.

The independent Waikato Palliative Care review was completed in late 2020 to inform the future model of care. There continues to be ongoing consideration of those recommendations. The Palliative Care strategic leadership group and hospital senior management continue to work towards improving palliative care. Their priority is focused on workforce and service specification clarity with the changing landscape of care at locality level.

People receive timely and appropriate specialist care

Support services

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	49%	59%	95%	43%	●

Our performance

Waikato DHB has not met the 95 percent target for coronary angiography procedures. Challenges have included high volumes of acute patients putting pressure on inpatient bed capacity and then being unable to bring patients in from the waitlist in a timely way, staffing shortages due to COVID-19 and reduced capacity due to the replacement of one cardiac catheterisation laboratory (cath lab).

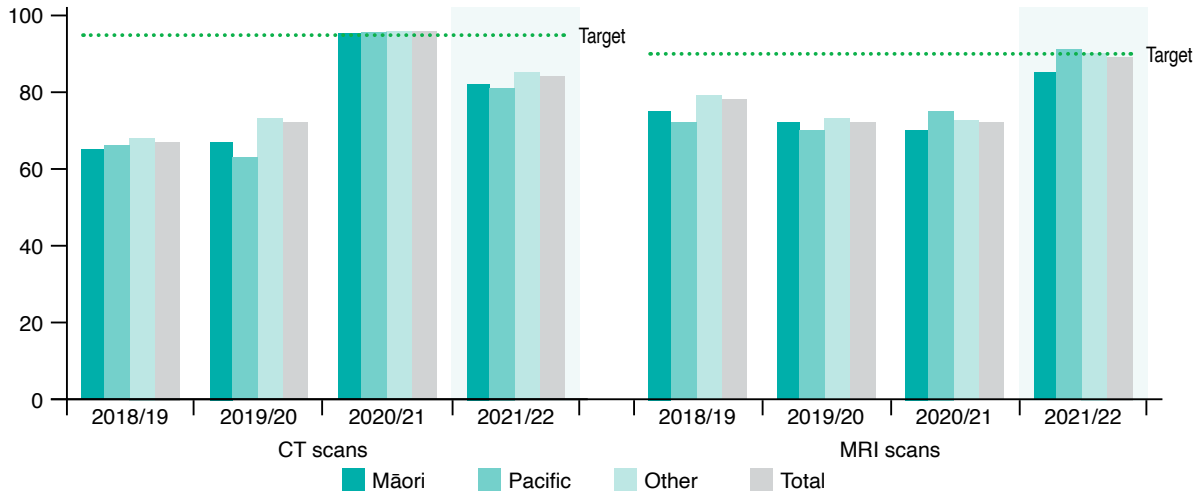
We have been continuing to book elective patients whenever possible however there is a high on the day cancellation rate. We have been outsourcing elective lists to a private facility utilising the maximum capacity they have available.

Output measures	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)	Māori 67% Pacific 63% Other 73% Total 72%	Māori 95% Pacific 95% Other 96% Total 96%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 82% Pacific 81% Other 85% Total 84%	
Percentage of accepted referrals for MRI scans will receive their scan within six weeks (42 days)	Māori 72% Pacific 70% Other 73% Total 72%	Māori 70% Pacific 75% Other 73% Total 72%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 85% Pacific 91% Other 90% Total 89%	

Our performance

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

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



Waikato DHB has not met the CT or MRI targets for this year. Despite staffing challenges due to COVID-19, overall capacity has increased from the previous year.

We successfully installed a third CT scanner on site at Waikato Hospital (October 2021) which now gives us the capacity to increase our volume of outpatients to allow us to meet the target. Due to staff vacancies and absences from the ongoing COVID-19 pandemic we have been unable to run the additional scanner at capacity.

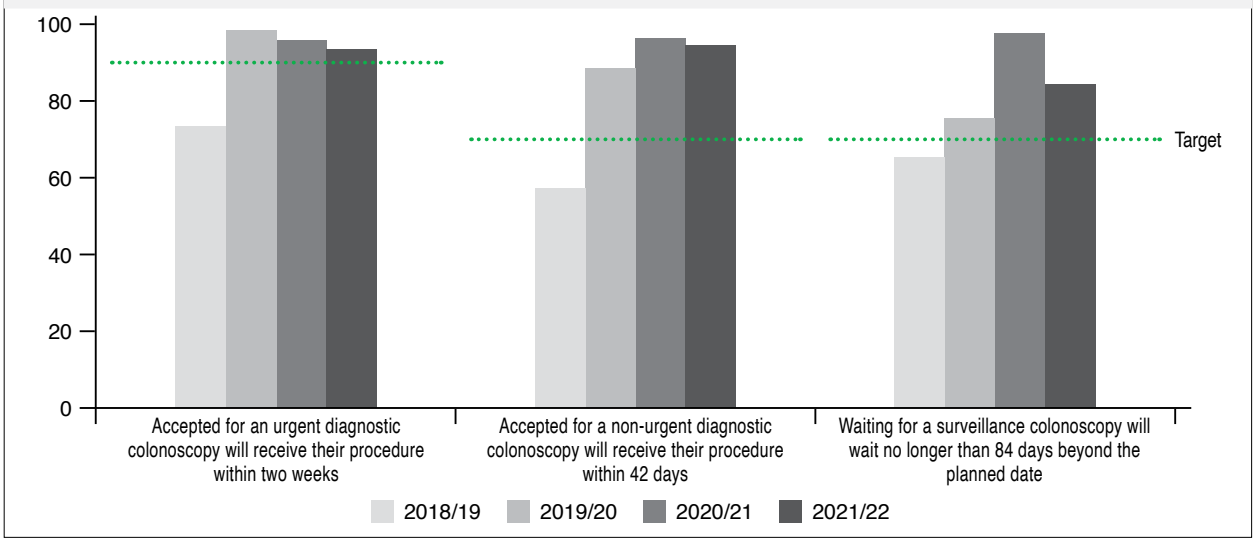
Whilst we continue to recruit for both MITs and radiologists, throughout the year we have continued to outsource 100 patients per week to help meet targets. Despite this outsourcing it has not allowed us to keep up with demand. The lack of radiologists continues to result in some CTs going unreported for longer. A range of mitigations are in place ranging from active recruitment through to the use of offshore reporting for CT and basic radiology to ensure the target for CT can be maintained in future.

People receive timely and appropriate specialist care

Output measures	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	98%	95%	90%	93%	●
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	88%	96%	70%	94%	●
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date	75%	97%	70%	84%	●

Our performance

Percentage of people waiting for colonoscopy procedures



Waikato DHB achieved compliance against all three colonoscopy targets for the 2021/22 year. There were some patients that waited longer than the planned target timeframes but most of those were due to patients recovering from COVID-19 and/or flu-like symptoms, and some delays due to staff sickness.

From a systems perspective, COVID-19 and the Waikato DHB cyber-attack has given us the opportunity to fine tune our booking processes. In 2021/22, we anticipated the need to have contracts in place with our private providers to support and anticipate any further impacts on service delivery.

Equity frameworks have been in place within the endoscopy department for more than two years which includes cold calling all Māori and Pacific patients and booking into scheduled sessions as priority, non-cancellation of priority population unless for clinical reasons and referrals to our WHĀ equity team for priority populations who continue to cancel their appointments.

Output measure	Baseline 2019/20	Previous year 2020/21	Target 2021/22	Result 2021/22	Rating
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	100%	100%	100%	100%	●

Our performance

Our community laboratory services both report 100 percent of laboratory tests are completed and communicated to referring practitioners within 48 hours for patients who present for referred tests at a laboratory collection site. There are collection sites within 2.5 km of almost every general practice in the Waikato district. Training, consumables and courier collection services are available for isolated rural general practices. Pathlab is the main provider of community referred laboratory tests in the Waikato. Waikato Hospital Laboratory undertakes these tests for our southern localities including Te Kūiti, Tokoroa and Taumarunui

Despite the significant impact of COVID-19 on laboratory services over the last two years, patients presenting at Pathlab collection sites have reported high levels of satisfaction with the service through annual surveys.

COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a PHO, or if they received health services in a given calendar year.

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were

- alive on 31 December 2021
- enrolled with a PHO or received health services in the 2021 calendar year

HSU 2020

People are included if they were

- alive on 1 July 2020
- enrolled with a PHO or received health services in the 2020 calendar year

During 2021/22, the Ministry of Health reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30 June 2022 are counted in their current DHB as at 23:59 13 December 2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Waikato DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022[1]. Percentages over 100 percent occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100 percent can occur.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[2] (HSU 2021 vs HSU 2020)

Year[3]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	8.45%	8.91%
2021/2022	80.85%	85.21%
Total	**89.31%**	**94.12%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 89 percent, compared with 94 percent using HSU 2020 as at 30 June 2022. The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Waikato DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

COVID-19 vaccine doses administered by dose type and year (HSU 2020)

Year[4]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[5]
2020/21	46,962	31,623	0	0	**78,585**
2021/22	313,736	311,772	208,595	1065	**835,168**
Total	**360,698**	**343,395**	**208,595**	**1065**	**913,753**

By 30 June 2022, a total of 913,753 COVID-19 vaccinations had been administered, of which 91 percent were administered in 2021/22.

There are two similar but distinct metrics used within the following tables: Doses administered and people vaccinated. Doses administered focuses on vaccination programme activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

1 – www.stats.govt.nz/reports/review-of-health-service-user-population-methodology
2 – Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report
3 – Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22
4 – Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June
5 – Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination

COVID-19 vaccinations and mortality

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by dose age group [6]

Age group (years) [7]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total [8]
0 to 11	20,865	8754	–	–	29,619
12 to 15	23,421	22,260	18	–	45,699
16 to 19	19,384	19,200	4,996	1	43,581
20 to 24	23,517	23,370	10,483	1	57,371
25 to 29	24,826	24,741	12,341	2	61,910
30 to 34	25,434	25,494	14,711	18	65,657
35 to 39	22,750	22,969	14,859	19	60,597
40 to 44	21,049	21,266	14,837	27	57,179
45 to 49	21,286	21,590	16,150	17	59,043
50 to 54	21,848	22,346	18,456	44	62,694
55 to 59	20,710	21,446	18,761	68	60,985
60 to 64	19,807	20,926	19,853	114	60,700
65 to 69	16,029	18,228	18,518	175	52,950
70 to 74	13,462	15,907	16,915	204	46,488
75 to 79	9099	10,864	12,410	183	32,556
80 to 84	5846	7073	8420	126	21,465
85 to 89	3016	3596	4399	48	11,059
90+	1387	1742	2468	18	5615
Total	313,736	311,772	208,595	1065	835,168

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

6 – Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022
7 – Age groupings in this table reflect the age of the person at the time of the vaccination being administered
8 – Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the previous table (COVID-19 doses administered by age group).

COVID-19 people vaccinated by age group during 2021/22 [9]

Age group (years) [10]	Partial [11]		Primary course [12]		Booster course			
	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed primary course (12+)	Completed primary course (12+) (% eligible)	Received first booster (18+)	First booster (18+) (% eligible)	Received second booster (50+)	Received second booster (50+) (% eligible)
0 to 11	17,597	24%	7509	10%	0	0%	0	0%
12 to 15	20,118	80%	17,543	70%	0	0%	0	0%
16 to 19	20,266	91%	19,954	89%	2759	37%	0	0%
20 to 24	23,475	83%	23,313	82%	10,263	42%	0	0%
25 to 29	24,380	77%	24,361	77%	11,918	45%	0	0%
30 to 34	25,988	80%	26,145	80%	14,461	51%	0	0%
35 to 39	23,282	81%	23,512	81%	14,807	57%	0	0%
40 to 44	21,450	81%	21,688	82%	14,788	63%	0	0%
45 to 49	20,766	78%	21,125	80%	15,672	68%	0	0%
50 to 54	22,189	80%	22,654	82%	18,292	73%	38	2%
55 to 59	20,549	78%	21,238	80%	18,427	78%	70	4%
60 to 64	20,322	78%	21,333	82%	19,945	83%	112	5%
65 to 69	16,955	74%	18,840	83%	18,758	88%	163	8%
70 to 74	13,832	70%	16,137	81%	17,001	91%	198	10%
75 to 79	10,228	72%	12,249	86%	13,490	94%	191	11%
80 to 84	6618	69%	7974	84%	8980	96%	127	11%
85 to 89	3484	69%	4105	82%	4838	98%	60	8%
90+	1797	62%	2185	76%	2844	103%	18	3%
Total	313,296	70%	311,865	69%	207,243	68%	977	7%

9 – Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022
10 – Age groupings in this table reflect age of the persons at end of financial year
11 – Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022)
12 – Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2)

COVID-19 vaccinations and mortality

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses [13] administered by ethnicity [14] (1 July 2021–30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Māori	61,423	58,798	27,524	101	147,846
Pacific peoples	9905	9682	5521	10	25,118
Asian	34,909	34,396	24,601	50	93,956
European/other	203,706	204,975	147,721	883	557,285
Unknown	3793	3921	3228	21	10,963
Total	313,736	311,772	208,595	1065	835,168

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the CVIP database).

COVID-19 people vaccinated by ethnicity during 2021/22 [15]

Ethnicity (Note 1)	Partial		Primary course		Booster course			
	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed primary course (12+)	Completed primary course (12+) (% eligible)	Received first booster (18+)	First booster (18+) (% eligible)	Received second booster (50+)	Received second booster (50+) (% eligible)
Māori	57,371	77%	57,420	77%	27,304	51%	92	5%
Pacific peoples	9103	78%	9426	81%	5505	60%	9	3%
Asian	31,803	79%	33,090	82%	24,535	70%	35	5%
European/other	193,582	79%	200,335	82%	146,661	73%	822	8%
Unknown	3840	73%	4085	78%	3238	70%	19	9%
Total	295,699	79%	304,356	81%	207,243	68%	977	7%

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

13 – This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster

14 – Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022

15 – Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partial		Primary course		Booster course			
	Partially vaccinated (12+)	Partially vaccinated (12+) (% of HSU2021)	Completed primary course (12+)	Completed primary course (12+) (% of HSU2021)	Received first booster (18+)	First booster (18+) (% eligible)	Received second booster (50+)	Received second booster (50+) (% eligible)
Māori	65,001	87%	62,207	84%	27,304	51%	92	5%
Pacific peoples	10,800	93%	10,515	90%	5505	60%	9	3%
Asian	38,785	96%	38,317	95%	24,536	70%	35	5%
European/other	223,799	91%	220,427	90%	146,662	73%	822	8%
Unknown	4797	91%	4716	90%	3238	70%	19	9%
Total	**343,182**	**91%**	**336,182**	**89%**	**207,245**	**68%**	**977**	**7%**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30 June 2022)
Completed Primary Course counted for 12+ years old (age as at 30 June 2022)
Received First Booster counted for 18+ years old (age as at 30 June 2022)
Received Second Booster counted for 18+ years old (age as at 30 June 2022)
50+ age determined as at 30 June 2022
Basis of population is HSU2021 for 12+ years old
All counts exclude those who died prior to 30 June 2022.

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ[16]

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
   a. National population estimates (produced quarterly)
   b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
   a. Official national and subnational projections
   b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

16 – www.stats.govt.nz/methods/population-statistics-user-guide

COVID-19 vaccinations and mortality

Differences between the HSU and Stats NZ population statistics arise because the population measures are

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

Stats NZ

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [17]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

17 – More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there is an estimated 449,439 health service users in the HSU 2021. This is an increase of 19,133 people from the HSU 2020 (an approximate 4 percent increase), and 4239 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison [18]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	99,227	109,800	10,573
Pacific peoples	14,824	13,800	-1024
Asian	49,873	50,000	127
European/other	280,063	271,600	-8463
Unknown	5452	0	-5452
Total (Note 1)	**449,439**	**445,200**	**-4239**

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 5,233,600. This is 111,000 above the Stats NZ total projected population of 5,122,600 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021.

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison.

DHB population by ethnicity: HSU 2020 and Stats NZ PRP [19]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	94,395	107,000	12,605
Pacific peoples	13,855	13,550	-305
Asian	42,865	49,200	6335
European/other	273,821	270,800	-3021
Unknown	5370	0	-5370
Total (Note 1)	**430,306**	**440,500**	**10,194**

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 5,000,500. This is 89,700 below the Stats NZ total projected population of 5,090,200 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

18 – HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021
19 – HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020

COVID-19 vaccinations and mortality

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv [20] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry of Health now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

> 'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry of Health.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

20 – EpiSurv is a secure national system used by primary health units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

COVID-19 deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Waikato DHB by age group at the time of death (as at 30 June 2022).

COVID-19 deaths by age group as at 30 June 2022

Age group (years)	Deaths
<10	–
10 to 19	–
20 to 29	–
30 to 39	–
40 to 49	–
50 to 59	5
60 to 69	11
70 to 79	34
80 to 89	40
90+	33
Total	**123**

COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Waikato DHB by the ethnicity of the individual (as at 30 June 2022).

COVID-19 deaths by ethnicity as at 30 June 2022

Ethnicity	Deaths
Māori	18
Pacific peoples	1
Asian	4
European/other	99
Unknown [21]	1
Total	**123**

21 – 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined

Amazing nursing, medical and supporting staff! Everyone was kind, attentive, professional and ensured I felt that I mattered. I was truly touched at how genuine the team was despite being run off their feet. They were very knowledgeable and always had a kind word to say. The doctor was really caring and gave me the best advice. Everything was perfect. Timely service, regular check-ins, safe and professionalism to the highest standard.

Thames Hospital

Part four:
Asset management

Asset performance information

Asset numbers

Our fixed assets

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

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

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

The following table summarises our three portfolios

Asset portfolio	Assets class within portfolios	Asset purpose	2019/20 Net Book Value	2020/21 Net Book Value	2021/22 Net Book Value
Property	Land, buildings, plant and equipment, fixture and fittings, vehicles	To facilitate the delivery of hospital services through the establishment of purpose-built infrastructure	$701 million	$896 million	$978 million
Equipment	Clinical equipment	To facilitate the delivery of hospital services through the provision of fit for purpose clinical equipment	$57 million	$56 million	$69 million
Information and communication technology	Computer hardware and software, other communication systems and devices	To facilitate the delivery of hospital services through the establishment of fit for purpose Information technology and communication systems	$35 million	$29 million	$32 million

The 2021/22 asset performance indicators (APIs) identified for each portfolio are set out below along with targets which have been agreed at clinical, management and commissioner level.

Asset performance indicators

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

Property portfolio performance

Asset performance indicators	Indicator class	2018/19 Result	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Rating
The percentage of Waikato DHB IL3 and IL4 buildings that have a seismic rating of less than 34% of the NBS. Note 1	Condition	6%	6%	7%	0%	0%	●
Waiora Waikato hospital campus building core services down time as a percentage of total operating hours, per annum. Note 2	Utilisation	99%	100%	100%	<99%	99.4%	●
Waiora Waikato campus disabled carparks as a percentage of total public car parking. Note 3	Functionality	13.3%	13%	14%	>13%	14%	●
Waiora Waikato hospital campus building energy efficiency savings as a percentage of targeted energy consumption. Note 4	Functionality	14%	21%	7%	>7%	17%	●
Percentage of Waiora Waikato hospital campus buildings with vaild Building Warrant of Fitness (BWoF)	Condition	N/A	N/A	100%	100%	100%	●
Percentage of Waikato DHB rural hospitals and community facilities with valid BWoF	Condition	N/A	N/A	94%	100%	94%	●

Clinical portfolio performance

Asset performance indicators	Indicator class	2018/19 Result	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Rating
Percentage CT scanners (Radiology) compliant with the requirements of the Radiation Safety Act 2016	Condition	100%	100%	100%	100%	100%	●
Percentage linear accelerators (Oncology) compliant with the requirements of the Radiation Safety Act 2016	Condition	100%	100%	100%	100%	100%	●
Waiora Waikato hospital campus Radiology, actual CT scanned patients versus planned patient scans	Utilisation	100%	120%	113%	>90%	82%	●
Percentage of the available time linear accelerators (Oncology) are used to carry out radiation treatment on patients	Utilisation	85%	72%	65%	>86%	75%	●
Waiora Waikato hospital campus, planned theatre usage versus actual usage. Note 5	Utilisation	73%	73%	74%	>75%	71%	●
Waikato DHB planned outpatient services to be delivered versus actual outpatient attendances	Utilisation	98%	94%	107%	>90%	92%	●
Waiora Waikato hospital campus actual beds occupied (days) as a percentage of planned bed occupancy over the last 12 months. Note 6	Utilisation	88%	86%	101%	>85% and <95%	89%	●
Waikato DHB elective surgery completed as a percentage of Ministry of Health elective surgery targets for last 12 months. Note 7	Utilisation	99%	92%	103%	100%	97%	●
Waikato DHB weighted average age of clinical fixed assets versus suppliers weighted average life expectancy	Condition / Functionality	8.9 years	8.9 years	7.2 years	<7 years	7.2 years	●
Percentage of diagnostic monitors meeting Quality Assurance (QA) requirements	Functionality (fit for purpose)	N/A	N/A	100%	100%	100%	●
Percentage of diagnostic ultrasound machines meeting the International Accreditation New Zealand (IANZ) specified industry accepted standards	Functionality (fit for purpose)	N/A	N/A	76%	100%	81%	●

Information communication and technology (ICT) portfolio performance

Asset performance indicators	Indicator class	2018/19 Result	2019/20 Result	2020/21 Result	2021/22 Target	2021/22 Result	Rating
Availability of critical clinical systems (iPM, CWS, iSL, PACS) to the Emergency Department. Note 8	Utilisation	99.7%	99.4%	90.6%	>99.5%	98.2%	●
User devices with the latest vendor-provided level of critical and security patching. Note 9	Condition	N/A	N/A	75%	>=85%	90%	●
Percentage of server devices with critical and security patches, to latest vendor-provided level. Note 10	Condition	N/A	N/A	65%	100%	91%	●
Access to results in Clinical Workstation (CWS)	Utilisation	N/A	N/A	N/A	100% (>7980 sessions per day)	102%	●

Addendum

1. Measuring earthquake risk against current building design and detail
2. Usage of core building services, including Lifts and Boilers
3. There are 148 carparks designated for disabled parking at the Waikato DHB (30 June 2022)
4. Measured as Kwh /m2 per annum
5. For theatre day session Monday to Friday and includes acute list
6. Includes all inpatient wards within CCTV/IM/Surgery/Orthopaedics/Oncology/Paediatrics/Women's Health but excludes Critical Care
7. As defined by the Planned Care Initiatives, Waikato facilities only, excludes Waikato domiciled patients receiving treatment at other DHBs
8. Change in measure specifically identifies critical clinical systems at ED only
9. IS System security effectiveness
10. IS System security effectiveness. Covers owned assets only.

> I want to say how impressed I was with all the employees there who dealt with my father.
>
> The team were wonderful. It always felt like it was more than just a job to them, I could feel their passion and empathy and it gave me great relief knowing that my father was under their care.

START (Supported Transfer and Accelerated Rehabilitation Therapy)

Part five:
Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2022

	Note	Group			Parent	
		2022 Budget	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
		$000	$000	$000	$000	$000
Revenue						
Patient care revenue	2/36	1,840,568	2,048,707	1,748,399	2,048,707	1,748,399
Other revenue	3	22,706	49,466	28,676	48,848	27,736
Finance revenue	4	363	1,178	680	1,075	560
Total income		**1,863,637**	**2,099,351**	**1,777,755**	**2,098,630**	**1,776,695**
Expenses						
Personnel costs	5/36	801,305	896,658	779,204	896,658	779,204
Depreciation	6	55,959	57,458	52,330	57,458	52,330
Amortisation and impairment cost	7	7,694	6,914	6,632	6,914	6,632
Outsourced services and personnel		76,663	151,952	94,610	151,952	94,610
Clinical supplies		182,333	211,153	187,809	211,153	187,809
Infrastructure and non-clinical expenses		79,259	110,404	84,448	110,404	84,448
Other district health boards		72,459	74,520	68,346	74,520	68,346
Non-health board providers		568,778	611,174	531,152	611,174	531,152
Other operating expenses	8	11,633	13,304	11,765	13,287	11,747
Finance costs	9	21	78	81	78	81
Capital charge	10	37,533	37,477	30,824	37,477	30,824
Total expenses		**1,893,637**	**2,171,092**	**1,847,201**	**2,171,075**	**1,847,183**
Share of joint venture surplus/(deficit)	11	-	(360)	244	-	-
Surplus/(deficit)		**(30,000)**	**(72,101)**	**(69,202)**	**(72,445)**	**(70,488)**
Other comprehensive revenue and expense						
Increase/(decrease) in revaluation reserve	12	-	113,553	240,318	113,553	240,318
Other comprehensive revenue and expense for the year		**-**	**113,553**	**240,318**	**113,553**	**240,318**
Total comprehensive revenue and expense for the year		**(30,000)**	**41,452**	**171,116**	**41,108**	**169,830**

Explanations of major variances to budget are provided in note 37.
Prior year figures were restated as detailed in note 36.
The accompanying notes form part of the financial statements.

Statement of changes in equity for the year ended 30 June 2022

	Note	Group			Parent	
		2022 Budget	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
		$000	$000	$000	$000	$000
Balance at 1 July		**763,352**	**729,364**	**561,455**	**728,120**	**560,484**
Total comprehensive revenue and expense for the year						
Surplus/(deficit) for the year		(30,000)	(72,101)	(69,202)	(72,445)	(70,488)
Other comprehensive income/(expense)		-	113,553	240,318	113,553	240,318
Total comprehensive revenue and expense for the year		**(30,000)**	**41,452**	**171,116**	**41,108**	**169,830**
Owner transactions						
Capital contribution		25,254	50,176	-	50,176	-
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other equity movement	23	60	(744)	(1,014)	-	-
Balance at 30 June	**12/36**	**756,472**	**818,053**	**729,363**	**817,210**	**728,120**

Explanations of major variances to budget are provided in note 37.
Prior year figures were restated as detailed in note 36.
The accompanying notes form part of the financial statements.

Statement of financial position as at 30 June 2022

	Note	Group			Parent	
		2022 Budget	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
Assets		$000	$000	$000	$000	$000
Current assets						
Cash and cash equivalents	13	9,460	55,279	28,034	44,677	18,170
Receivables	14/36	66,560	127,064	80,150	127,060	80,112
Prepayments	15	10,500	12,868	7,846	12,868	7,846
Inventories	16	12,571	11,724	12,516	11,724	12,516
Non-current assets held for sale	17	-	1,381	1,381	1,381	1,381
Total current assets		**99,091**	**208,316**	**129,927**	**197,710**	**120,025**
Non-current assets						
Property, plant and equipment	6	1,009,892	1,089,014	972,560	1,089,014	972,560
Intangible assets	7	42,820	22,865	42,116	22,865	42,116
Investment in joint venture accounted for using the equity method	11	673	313	673	-	-
Prepayments	15	13,187	14,182	15,027	14,182	15,027
Total non-current assets		1,066,572	1,126,374	1,030,376	1,126,061	1,029,703
Total assets		**1,165,663**	**1,334,690**	**1,160,303**	**1,323,771**	**1,149,728**
Liabilities						
Current liabilities						
Cash and cash equivalents	13	28,823	-	-	-	-
Borrowings	19	-	-	50	-	50
Employee entitlements	20/36	279,727	370,078	304,370	370,078	304,370
Trade and other payables under exchange transactions	21	81,800	114,736	95,641	114,718	95,623
Trade and other payables under non-exchange transactions	21		13,561	12,111	13,561	12,111
Provisions	22	1,374	1,613	1,065	1,613	1,065
Total current liabilities		**391,724**	**499,988**	**413,237**	**499,970**	**413,219**
Non-current liabilities						
Employee entitlements	20	8,473	6,328	7,991	6,328	7,991
Provisions	22	270	263	398	263	398
Restricted trust funds	23	8,724	10,058	9,314	-	-
Total non-current liabilities		17,467	16,649	17,703	6,591	8,389
Total liabilities		409,191	516,637	430,940	506,561	421,608
Net assets		**756,472**	**818,053**	**729,364**	**817,210**	**728,120**
Equity						
Crown equity (Contributed capital)	12	450,121	475,043	427,061	475,043	427,061
Revaluation reserve	12	591,806	705,359	591,806	705,359	591,806
Retained earnings (Accumulated deficit)		(286,084)	(362,880)	(290,074)	(363,192)	(290,747)
Trust funds	12	629	531	571	-	-
Total equity		**756,472**	**818,053**	**729,364**	**817,210**	**728,120**

Explanations of major variances to budget are provided in note 37.
Prior year figures were restated as detailed in note 36.
The accompanying notes form part of the financial statements.

Statement of cash flows for the year ended 30 June 2022

	Note	Group			Parent	
		2022 Budget	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
		$000	$000	$000	$000	$000
Cash flows from operating activities						
Operating receipts		1,875,951	2,029,665	1,759,629	2,029,045	1,758,736
Interest received		362	1,212	709	1,075	560
Payments to suppliers		(1,000,391)	(1,139,314)	(962,233)	(1,139,295)	(962,215)
Payments to employees		(805,464)	(832,612)	(727,497)	(832,612)	(727,497)
Interest paid		(547)	(78)	(81)	(78)	(81)
Payments for capital charge		(37,533)	(37,477)	(30,824)	(37,477)	(30,824)
Goods and services tax (net)		(2,286)	1,404	3,672	1,404	3,672
Net cash flows from operating activities	24	30,092	22,800	43,375	22,062	42,351
Cash flows from investing activities						
Purchase of property, plant and equipment		(89,799)	(38,875)	(26,162)	(38,875)	(26,162)
Purchase of intangible assets		(11,549)	(4,612)	(13,908)	(4,612)	(13,908)
Receipts from sale of property, plant and equipment		1,381	-	-	-	-
Net cash flows from investing activities		(99,967)	(43,487)	(40,070)	(43,487)	(40,070)
Cash flows from financing activities						
Capital contribution from the Crown		25,254	50,176	-	50,176	-
Repayment of capital to the Crown		-	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowings		(2,727)	-	-	-	-
Repayment of borrowings		(50)	(50)	(135)	(50)	(135)
Net cash flows from financing activities		22,477	47,932	(2,329)	47,932	(2,329)
Net increase/(decrease) in cash and equivalents		(47,398)	27,245	976	26,507	(48)
Cash and cash equivalents at beginning of year		28,035	28,034	27,058	18,170	18,218
Cash and cash equivalents at end of year	13	(19,363)	55,279	28,034	44,677	18,170

Explanations of major variances to budget are provided in note 37.
The accompanying notes form part of the financial statements.

1. 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. The entities are incorporated and domiciled in New Zealand.

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

The financial statements are for the year ended 30 June 2022, and were authorised for issue by the Board of Te Whatu Ora – Health New Zealand on 23 March 2023.

Basis of preparation

Health sector reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms replace all 20 DHBs and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities – the Māori Health Authority (Te Aka Whai Ora) to monitor the state of Māori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred the Waikato DHB Group assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

Statement of compliance

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

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

Presentation currency and rounding

The financial statements are presented in NZ dollars and all values are rounded to the nearest thousand dollars ($000), other than remuneration disclosed in accordance with section 152 of the Crown Entities Act 2004 and the related party transaction disclosures in Note 30, which are rounded to the nearest dollar.

Changes in accounting policies

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

1. Statement of accounting policies (continued)

Standards issued and not yet effective and not early adopted

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

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. Waikato DHB has assessed the effect of the new standard and it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

PBR FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation and presentation of service performance information.

Summary of significant accounting policies

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

Subsidiaries

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

Basis of consolidation

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

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

Budget figures

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

Income tax

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

Goods and services tax (GST)

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

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

Commitments and contingencies are disclosed exclusive of GST.

1. Statement of accounting policies (continued)

Foreign currency transactions

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

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

In preparing these financial statements, the DHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations

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

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

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

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

Retirement gratuities and long service leave

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

Holidays Act 2003

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

Critical judgements in applying accounting policies

Agency relationship

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

2. Patient care revenue

Accounting policies

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

Ministry of Health population-based revenue

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

Ministry of Health contract revenue

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

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

ACC contract revenue

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

Revenue from other district health boards

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

	Group		Parent	
Patient care revenue breakdown	2022 Actual $000	2021 Restated Actual $000	2022 Actual $000	2021 Restated Actual $000
Non-exchange transactions				
Health and disability services (Crown appropriation revenue) [22]	1,634,413	1,457,231	1,634,413	1,457,231
Other Ministry of Health and government revenue	66,228	48,842	66,228	48,842
Patient co-payments	963	1,360	963	1,360
Exchange transactions				
Health and disability services (Ministry of Health)	123,048	32,113	123,048	32,113
ACC contract revenue	19,423	20,452	19,423	20,452
Inter district revenue from other district health boards	175,526	159,213	175,526	159,213
Clinical Training Agency revenue	12,244	12,120	12,244	12,120
Other patient care related revenue	16,862	17,068	16,862	17,068
Total patient care revenue	2,048,707	1,748,399	2,048,707	1,748,399

22 – Performance against this appropriation is reported in the Statement of Performance on pages 57-119. The appropriation revenue received by Waikato DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act. The budgeted appropriation amount from the Ministry of Health relating to personal and public health services and management outputs for the current year is $1,526,760,000 (2021: $1,404,976,000)

3. Other revenue

Accounting policies

Rental revenue

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

Provision of services

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

Grants revenue

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.

Other revenue breakdown	Group 2022 Actual $000	Group 2021 Actual $000	Parent 2022 Actual $000	Parent 2021 Actual $000
Non-exchange transactions				
Donations and bequests received	22,633	4,907	21,252	3,199
Grants received	-	-	763	768
Exchange transactions				
Rental revenue	1,564	1,742	1,564	1,742
Gain on sale of property, plant and equipment	199	-	199	-
Other revenue [1]	25,070	22,027	25,070	22,027
Total other revenue	49,466	28,676	48,848	27,736

1 - Other revenue includes revenue from parking, cafeterias, research grants, drug trials, tutoring, cyber attack insurance claim and bad debts recovered.

4. Finance revenue

Accounting policy

Interest revenue

Interest revenue is recognised using the effective interest method.

Finance revenue (exchange transactions) breakdown	Group 2022 Actual $000	Group 2021 Actual $000	Parent 2022 Actual $000	Parent 2021 Actual $000
Interest revenue	1,178	680	1,075	560
Total finance revenue	1,178	680	1,075	560

5. Personnel costs

Accounting policy

Salaries and wages

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit plan contributors scheme

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

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

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

		Group		Parent	
	Note	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
Personnel costs breakdown		$000	$000	$000	$000
Salaries and wages		807,336	704,734	807,336	704,734
Increase/(decrease) in liability for employee entitlements		64,045	31,728	64,045	31,728
Restatement of prior year liability for employee entitlements	36	-	19,979	-	19,979
Defined contribution plan employer contributions		25,277	22,763	25,277	22,763
Total personnel cost		896,658	779,204	896,658	779,204

6. Property, plant and equipment

Accounting policy

Classes of property, plant and equipment

Property, plant and equipment consists of the following asset classes:

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

Land and buildings

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

6. Property, plant and equipment (continued)

Revaluations

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

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

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

Additions

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

Subsequent costs

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

Disposals

Gain and loss on disposal is determined by comparing the proceeds with the carrying amount of the asset. Net gains and losses on disposals are reported 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 are not depreciated. Depreciation is set at rates that will write off the cost or valuation of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of the major classes of property, plant and equipment have been estimated as:

Class of asset	Estimated life	Depreciation rate
Buildings	2.5 - 58 years	1.7 - 40.0%
Clinical assets	2 - 20 years	5.0 - 50.0%
General assets	3 - 35 years	2.9 - 33.3%
Motor vehicles	5 - 11 years	9.1 - 20.0%

The residual value and useful life of assets are reviewed and adjusted if applicable, at each financial year-end.

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.

6. Property, plant and equipment (continued)

Value in use is determined using an approach based on either a depreciated replacement cost approach, a 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 revenue in the surplus or deficit.

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

Group Actual Cost	Freehold land $000	Freehold buildings $000	Leasehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Balance at 1 July 2020	48,989	651,649	-	254,527	20,233	975,398
Additions	-	-	-	-	26,541	26,541
Transfers	-	(1,709)	15,788	20,805	(34,884)	-
Reclassified to intangible assets	-	(822)	482	281	-	(59)
Disposals	-	-	-	(19,469)	-	(19,469)
Revaluation	44,637	129,554	-	-	-	174,191
Prior year adjustment	-	-	-	(42)	-	(42)
Balance at 30 June 2021	**93,626**	**778,672**	**16,270**	**256,102**	**11,890**	**1,156,560**
Balance at 1 July 2021	93,626	778,672	16,270	256,102	11,890	1,156,560
Additions	-	-	-	-	43,603	43,603
Transfer from intangible assets				16,783		16,783
Transfers	-	8,091	131	18,945	(27,167)	-
Reclassified to intangible assets	-	1,795	(1,586)	(208)	(1)	-
Disposals	-	(221)	(21)	(50,754)	-	(50,996)
Revaluation	8,542	65,410	979	-	-	74,931
Balance at 30 June 2022	**102,168**	**853,747**	**15,773**	**240,868**	**28,325**	**1,240,881**
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000	$000
Balance at 1 July 2020	-	33,587	-	183,597	-	217,184
Depreciation charge and impairment losses for the year	-	33,355	756	18,219	-	52,330
Disposals	-	-	-	(19,386)	-	(19,386)
Revaluation adjustment	-	(66,127)	-	-	-	(66,127)
Reclassification adjustment	-	335	(352)	16	-	(1)
Balance at 30 June 2021	**-**	**1,150**	**404**	**182,446**	**-**	**184,000**
Balance at 1 July 2021	-	1,150	404	182,446	-	184,000
Depreciation charge and impairment losses for the year	-	37,724	833	18,901	-	57,458
Disposals	-	(221)	(21)	(50,592)	-	(50,834)
Revaluation adjustment	-	(37,680)	(1,077)	-	-	(38,757)
Reclassification adjustment	-	116	(140)	24	-	-
Balance at 30 June 2022	**-**	**1,089**	**(1)**	**150,779**	**-**	**151,867**

6. Property, plant and equipment (continued)

Group Actual	Freehold land	Freehold buildings	Leasehold buildings	Plant, equipment and vehicles	Work in progress	Total
Carrying amounts	$000	$000	$000	$000	$000	$000
At 1 July 2020	48,989	618,062	0	70,930	20,233	758,214
At 30 June 2021	**93,626**	**777,522**	**15,866**	**73,656**	**11,890**	**972,560**
At 1 July 2021	93,626	777,522	15,866	73,656	11,890	972,560
At 30 June 2022	**102,168**	**852,658**	**15,774**	**90,089**	**28,325**	**1,089,014**

Parent Actual	Freehold land	Freehold buildings	Leasehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000	$000
Balance at 1 July 2020	48,989	651,649	-	254,527	20,233	975,398
Additions					26,541	26,541
Transfers		(1,709)	15788	20,805	(34,884)	-
Transferred to intangible assets		(822)	482	281		(59)
Disposals				(19,469)		(19,469)
Revaluation	44,637	129,554				174,191
Prior year adjustment				(42)		(42)
Balance at 30 June 2021	**93,626**	**778,672**	**16,270**	**256,102**	**11,890**	**1,156,560**
Balance at 1 July 2021	93,626	778,672	16,270	256,102	11,890	1,156,560
Additions					43,603	43,603
Transfer from intangible assets	-	-	-	16,783	-	16,783
Transfers		8,091	131	18,945	(27,167)	-
Reclassification		1,795	(1,586)	(208)	(1)	-
Disposals		(221)	(21)	(50,754)		(50,996)
Revaluation	8,542	65,410	979			74,931
Prior year adjustment				-		-
Balance at 30 June 2022	**102,168**	**853,747**	**15,773**	**240,868**	**28,325**	**1,240,881**
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000	$000
Balance at 1 July 2020	-	33,587		183,597	-	217,184
Depreciation charge and impairment losses for the year		33,355	756	18,219		52,330
Disposals				(19,386)		(19,386)
Revaluation adjustment		(66,127)	0			(66,127)
Reclassification adjustment		335	(352)	16		(1)
Balance at 30 June 2020	**-**	**1,150**	**404**	**182,446**	**-**	**184,000**
Balance at 1 July 2021	-	1,150	404	182,446	-	184,000
Depreciation charge and impairment losses for the year		37,724	833	18,901		57,458
Disposals		(221)	(21)	(50,592)		(50,834)
Revaluation		(37,680)	(1,077)			(38,757)
Reclassification adjustment		116	(140)	24		-
Balance at 30 June 2022	**-**	**1,089**	**(1)**	**150,779**	**-**	**151,867**
Carrying amounts	$000	$000	$000	$000	$000	$000
At 1 July 2020	48,989	618,062	-	70,930	20,233	758,214
At 30 June 2021	**93,626**	**777,522**	**15,866**	**73,656**	**11,890**	**972,560**
At 1 July 2021	93,626	777,522	15,866	73,656	11,890	972,560
At 30 June 2022	**102,168**	**852,658**	**15,774**	**90,089**	**28,325**	**1,089,014**

6. Property, plant and equipment (continued)

Valuation

The most recent comprehensive valuation of land and buildings was carried out by P.D. Todd, an independent registered valuer and a member of the New Zealand Institute of Valuers. The valuation was carried out as at 30 June 2022.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Where appropriate, 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.

Land values were determined using a number of significant assumptions. Significant assumptions used in the 30 June 2022 valuation include:

- The land values that have been applied across the sites range from $11 to $1,146 (2021: $10 to $1,060) per square metre across all sites

As there have been no direct sales of land comparable to the size of the main Hamilton hospital site which is over 185,000 square metres, land sales have been analysed taking size variation, zoning, contour and related factors into account.

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

Buildings

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

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings. Depreciated replacement cost is determined using a number of significant assumptions, these assumptions underpinning the valuation have been arrived at during uncertain times with labour and material cost and have been performed based on evidence currently available and include:

- The replacement asset is based on the replacement with modern equivalent assets with adjustments where appropriate for optimisation due to over-design or surplus capacity. Optimisation has been applied in this valuation where the building can be built smaller due to changes in technology, building use or other factors. For example where a boiler house can be built smaller due to the redundancy of coal boilers
- Replacement cost is primarily derived from recent construction contracts of similar assets
- For Waikato DHB's earthquake prone buildings that are expected to be strengthened, the fair value has been reduced, after considering the estimated earthquake strengthening costs
- The DHB is not aware of any significant asbestos issues associated with the buildings and therefore no allowance has been made for deferred maintenance in this regard
- The remaining useful life of assets is estimated
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Comparable sales, market rents and capitalisation rates were applied, where appropriate, to reflect market value. These valuations included adjustments for estimated building strengthening costs for earthquake prone buildings.

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

The Waiora Waikato Centre has been valued based on a range of costs per square metre ranging from approximately $7,000 per square metre for offices facilities, to laboratories at over $10,000 per square metre.

The Meade Medical Centre has been valued based on a range of costs per square metre including the higher value areas at over $12,000 per square metre. The assumptions underpinning the valuation have been arrived at during uncertain times with labour and material cost and have been performed based on evidence currently available.

6. Property, plant and equipment (continued)

Restrictions on title

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

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

Finance leases

The net carrying amount of plant, equipment and vehicles held under finance lease is $0 (2021: $0.06 million). Note 19 provides further information about finance leases.

Property, plant and equipment under construction

Buildings work in progress at 30 June 2022 is $7.2 million (2021: $3.0 million) and capital commitments is $5.0 million (2021: $3.2 million). Plant, equipment and vehicles work in progress at 30 June 2022 is $21.2 million (2021: $8.9 million) and capital commitments is $16.4 million (2021: $11.1 million).

7. Intangible assets

Accounting policy

Software acquisition and development

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

Information technology shared services rights

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

Amortisation

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

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

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

Impairment of intangible assets

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

Movements for intangible assets are as follows:

Group 2022 Actual Cost	Internally generated $000	Software and development $000	Work in progress $000	Total $000
Balance at 1 July 2020	4,672	76,689	17,716	99,077
Additions	-	-	13,908	13,908
Disposals	-	(10)	-	(10)
Transfers	330	8,999	(9,329)	-
Transfer from fixed assets	-	59	-	59
Balance at 30 June 2021	**5,002**	**85,737**	**22,295**	**113,034**

7. Intangible assets (continued)

Group 2022 Actual Cost	Internally generated $000	Software and development $000	Work in progress $000	Total $000
Balance at 1 July 2021	5,002	85,737	22,295	113,034
Additions	-	-	4,612	4,612
Disposals	-	(51,639)		(51,639)
Transfers	(330)	5,842	(5,512)	-
Transfer to fixed assets	-	-	(16,784)	(16,784)
Balance at 30 June 2022	**4,672**	**39,940**	**4,611**	**49,223**
Accumulated amortisation and impairment losses				
Balance at 1 July 2020	1,020	63,275	-	64,295
Amortisation and impairment charge for the year	32	6,600	-	6,632
Disposals		(10)	-	(10)
Reclassifications	-	1	-	1
Balance at 30 June 2021	**1,052**	**69,866**	**-**	**70,918**
Balance at 1 July 2021	1,052	69,866	-	70,918
Amortisation and impairment charge for the year	77	6,837	-	6,914
Disposals		(51,474)	-	(51,474)
Reclassifications	(110)	110	-	-
Balance at 30 June 2022	1,019	25,339	-	26,358
Carrying amounts				
At 1 July 2020	3,652	13,414	17,716	34,782
At 30 June 2021	**3,950**	**15,871**	**22,295**	**42,116**
At 1 July 2021	3,950	15,871	22,295	42,116
At 30 June 2022	**3,653**	**14,601**	**4,611**	**22,865**

Parent 2022 Actual Cost	Internally generated $000	Software and development $000	Work in progress $000	Total $000
Balance at 1 July 2020	4,672	76,689	17,716	99,077
Additions	-	-	13,908	13,908
Transfers	330	8,999	(9,329)	-
Transfer from fixed assets	-	59	-	59
Disposals	-	(10)	-	(10)
Balance at 30 June 2021	**5,002**	**85,737**	**22,295**	**113,034**
Balance at 1 July 2021	5,002	85,737	22,295	113,034
Additions	-	-	4,612	4,612
Transfers	(330)	5,842	(5,512)	-
Transfer to fixed assets	-	-	(16,784)	(16,784)
Disposals	-	(51,639)	-	(51,639)
Balance at 30 June 2022	**4,672**	**39,940**	**4,611**	**49,223**
Accumulated amortisation and impairment losses				
Balance at 1 July 2020	1,020	63,275	-	64,295
Amortisation and impairment charge for the year	32	6,600	-	6,632
Disposals		(10)	-	(10)
Reclassifications	-	1	-	1
Balance at 30 June 2021	1,052	69,866	-	70,918
Balance at 1 July 2021	1,052	69,866	-	70,918
Amortisation and impairment charge for the year	77	6,837	-	6,914
Disposals		(51,474)	-	(51,474)
Reclassifications	(110)	110	-	-
Balance at 30 June 2022	1,019	25,339	-	26,358

7. Intangible assets (continued)

Parent 2022 Actual Carrying amounts	Internally generated $000	Software and development $000	Work in progress $000	Total $000
At 1 July 2020	3,652	13,414	17,716	34,782
At 30 June 2021	3,950	15,871	22,295	42,116
At 1 July 2021	3,950	15,871	22,295	42,116
At 30 June 2022	3,653	14,601	4,611	22,865

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

Impairments

The value of impairments in the current year is $nil (2021: $nil).

8. Other operating expenses

Accounting policy

Leases

Waikato DHB as lessee

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

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

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

Waikato DHB as lessor

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

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

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

	Group		Parent	
Breakdown of other expenses	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Allowance for credit losses on receivables	371	527	371	527
Audit fees for the audit of the financial statements – 2021/22	352	-	335	-
Audit fees for the audit of the financial statements – 2020/21	126	286	126	268
Audit related fees for assurance and internal audits	-	5	-	5
Board and committee members' remuneration and expenses	71	91	71	91
Koha and donations	286	212	286	212
Operating lease expenses	11,706	10,562	11,706	10,562
Loss on disposal of property, plant and equipment	392	82	392	82
Total other operating expenses	13,304	11,765	13,287	11,747

9. Finance costs

Accounting policy

Borrowing costs

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

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Interest and financing expenses	78	81	78	81
Total finance cost	**78**	**81**	**78**	**81**

10. Capital charge

Accounting policy

Capital charge

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

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Capital charge	37,477	30,824	37,477	30,824
Total capital charge	**37,477**	**30,824**	**37,477**	**30,824**

Waikato DHB pays a capital charge to the Crown every six months. This charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the period ended 30 June 2022 was 5% (2021: 5%).

11. Investments in joint venture

Accounting policy

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

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

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

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

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

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

11. Investments in joint venture (continued)

a) General information

Name of entity	Principal activities	Interest held at 30 June 2022	Balance date
HealthShare Limited	Provision of clinical regional services	20%	30 June

b) Carrying amount of investment

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Opening balance	673	429	-	-
Share of joint venture surplus/(deficit)	(360)	244	-	-
Correction – prior year equity accounting joint venture	-	-	-	-
Closing balance	**313**	**673**	**-**	**-**

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

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Current assets	1,362	1,920	-	-
Non-current assets	5,550	5,535	-	-
Current liabilities	(1,931)	(828)	-	-
Non-current liabilities	(4,668)	(5,954)	-	-
Net assets	**313**	**673**	**-**	**-**
Revenue	4090	4,270	-	-
Expenses	(4,450)	(4,026)	-	-
Share of surplus/(deficit) of joint venture	**(360)**	**244**	**-**	**-**

12. Equity

Accounting policy

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

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

Revaluation reserves

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

Trust funds

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

12. Equity (continued)

Group Reconciliation of movement in equity	Trust funds $000	Crown equity $000	Revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 2020	543	429,255	351,488	(219,831)	561,455
Total comprehensive revenue/(expense)	1,042	-	240,318	(70,244)	171,116
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted trust fund	(1,014)	-	-	-	(1,014)
Balance at 30 June 2021	**571**	**427,061**	**591,806**	**(290,075)**	**729,363**
Balance at 1 July 2021	571	427,061	591,806	(290,075)	729,363
Total comprehensive revenue/(expense)	704	-	113,553	(72,805)	41,452
Contributed capital – deficit support funding	-	50,176	-	-	50,176
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted trust fund	(744)	-	-	-	(744)
Balance at 30 June 2022	**531**	**475,043**	**705,359**	(362,880)	**818,053**

Trust funds

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

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

Parent Reconciliation of movement in equity	Crown equity $000	Revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 2020	429,255	351,488	(220,259)	560,484
Total comprehensive revenue/(expense)	-	240,318	(70,488)	169,830
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Balance at 30 June 2021	**427,061**	**591,806**	**(290,747)**	**728,120**
Balance at 1 July 2021	427,061	591,806	(290,747)	728,120
Total comprehensive revenue/(expense)	-	113,553	(72,445)	41,108
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Contributed capital - Deficit support funding	50,176	-	-	50,176
Balance at 30 June 2022	**475,043**	**705,359**	**(363,192)**	**817,210**

13. Cash and cash equivalents

Accounting policy

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

While cash and cash equivalents at 30 June 2022 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

13. Cash and cash equivalents (continued)

Financial assets recognised subject to restrictions

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

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Cash at bank/(overdraft) and cash on hand	29	48	29	48
Advance to/(from) New Zealand Health Partnerships Limited	44,648	18,122	44,648	18,122
Trust funds	10,602	9,864	-	-
Total cash and cash equivalents	**55,279**	**28,034**	**44,677**	**18,170**

14. Receivables

Accounting policy

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

In measuring expected credit losses, receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the shared credit risk characteristics and days past due. The expected loss rates are based on the payment profile of transaction over a period of 24 months before 30 June 2022 and the corresponding historical credit losses experienced within this period.

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

	Group		Parent	
	2022 Actual $000	2021 Restated Actual $000	2022 Actual $000	2021 Restated Actual $000
Ministry of Health trade receivables	16,535	13,783	16,535	13,783
Other trade receivables	14,006	14,542	14,006	14,542
Less: Allowance for credit losses	(1,859)	(1,547)	(1,859)	(1,547)
Total trade receivables	**28,682**	**26,778**	**28,682**	**26,778**
Ministry of Health accrued revenue	51,777	21,473	51,777	21,473
Other accrued revenue	46,605	31,899	46,601	31,861
Total receivables	**127,064**	**80,150**	**127,060**	**80,112**
Total receivables comprises:				
Receivables from non-exchange transactions	4,324	13,491	4,324	13,491
Receivables from exchange transactions	122,740	66,659	122,736	66,621

The expected credit loss rates for receivables at 30 June 2022 are based on the payment profile of invoices issued over the past 2 years at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forward looking macroeconomic factors that might affect the recoverability of receivables.

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

14. Receivables (continued)

The allowance for credit losses at 30 June 2022 was determined as follows:

Group	Receivables days past due				
	Current	More than 30 days	More than 60 days	More than 90 days	TOTAL
30 June 2022					
Expected credit loss rate	0.17%	21.69%	27.48%	19.57%	
Gross carrying amount ($000)	120,642	461	242	7,578	128,923
Lifetime expected credit loss ($000)	210	100	66	1,483	1,859
30 June 2021 Restated					
Expected credit loss rate	0.08%	4.07%	9.10%	17.32%	
Gross carrying amount ($000)	71,705	1,156	1,187	7,649	81,697
Lifetime expected credit loss ($000)	67	47	108	1,325	1,547
Parent					
30 June 2022					
Expected credit loss rate	0.17%	21.69%	27.48%	19.57%	
Gross carrying amount ($000)	120,637	461	242	7,578	128,918
Lifetime expected credit loss ($000)	210	100	66	1,483	1,859
30 June 2021 Restated					
Expected credit loss rate	0.08%	4.07%	9.10%	17.32%	
Gross carrying amount ($000)	71,667	1,156	1,187	7,649	81,659
Lifetime expected credit loss ($000)	67	47	108	1,325	1,547

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

	Group		Parent	
	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
	$000	$000	$000	$000
Opening allowance for credit losses at 1 July	1,547	1,397	1,547	1,397
Increase in loss allowance made during the year	316	364	316	364
Receivables written off during the year	(59)	(377)	(59)	(377)
Receivables recovered during the year	55	163	55	163
Balance at 30 June	**1,859**	**1,547**	**1,859**	**1,547**

15. Prepayments

	Group		Parent	
	2022 Actual	2021 Actual	2022 Actual	2021 Actual
Current portion	$000	$000	$000	$000
Prepayments	12,868	7,846	12,868	7,846
Total prepayments	**12,868**	**7,846**	**12,868**	**7,846**
Non-current portion				
Prepayments	14,182	15,027	14,182	15,027
Total prepayments	**14,182**	**15,027**	**14,182**	**15,027**

16. Inventories

Accounting policy

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

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Pharmaceuticals	1,507	1,426	1,507	1,426
Surgical and medical supplies	6,686	6,956	6,686	6,956
Other supplies	3,531	4,134	3,531	4,134
Total inventories	11,724	12,516	11,724	12,516

The amount of inventories recognised as expense due to change in stock value during the year was $2,948 (2021:$2,660), which is included in the clinical supplies line item in the statement of comprehensive revenue and expense.

Write-down of inventories amounted to $26,357 for 2022 (2021: $2,552). There have been no reversals of write-downs. The provision for obsolete inventories adjustment recognised in the statement of comprehensive revenue and expense for the year ended 30 June 2022 was $Nil (2021: $Nil). No inventories are pledged as security for liabilities.

No inventories are pledged as security for liabilities (2021: $Nil). However, some inventories are subject to retention of title clauses.

17. Non-current assets held for sale

Accounting policy

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

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

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

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

	Group		Parent	
Breakdown of non-current assets held for sale	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Non-current assets held for resale include:				
Land	1,050	1,050	1,050	1,050
Buildings	331	331	331	331
Total non-current assets held for sale	1,381	1,381	1,381	1,381

The group owns land and buildings which have been classified as held for sale following the commissioner and Ministry of Health approval to sell the properties as they will provide no future use to the group. The sale is expected to be completed in the 2022/23 financial year.

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

18. Derivative financial instruments

Accounting policy

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

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

Forward foreign exchange derivatives are classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives is classified as non-current. The notional principal amount of outstanding forward foreign exchange contracts in NZ$ was $ Nil (2021: $Nil). The foreign currency principal amounts were $ Nil (2021: USD Nil).

19. Borrowings

Accounting policy

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

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

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Current portion				
Finance leases	-	50	-	50
	-	**50**	**-**	**50**
Analysis of finance leases				
Minimum lease payments payable:				
No later than one year	-	50	-	50
Total minimum lease payments	**-**	**50**	**-**	**50**
Future finance charges	-	-	-	-
Present value of minimum lease payments	**-**	**50**	**-**	**50**
Present value of minimum lease payments payable:				
No later than one year	(0)	50	(0)	50
Later than one year and not later than five years	0	-	0	-
Total present value of minimum lease payments	**-**	**50**	**-**	**50**

Finance Leases

Finance lease liabilities are effectively secured because the rights to the asset revert to the lessor on default. The fair value of finance leases is $0 (2021: $50,000). Fair value has been determined by using a discount rate of 0.38% in 2021.

Description of finance leases

The DHB has entered into contracts for the supply of consumables and reagents which includes the use of clinical equipment. At expiration of the agreements, the ownership of the equipment will transfer to Waikato DHB, so has been deemed to be finance leases.

20. Employee entitlements

Accounting policy

Short-term employee entitlements

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

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

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

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

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employees render 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 employees, based on years of service, years to entitlement, the likelihood that employees 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 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

	Note	Group 2022 Actual	Group 2021 Restated Actual	Parent 2022 Actual	Parent 2021 Restated Actual
Current portion		$000	$000	$000	$000
Liability for long service leave		4,613	3,665	4,613	3,665
Liability for retirement gratuities		3,418	3,809	3,418	3,809
Liability for annual leave		269,754	210,648	269,754	210,648
Nursing MECA pay equity adjustment to prior year	36	-	19,979	-	19,979
Liability for sick and sabbatical leave		2,320	2,184	2,320	2,184
Liability for continuing medical education leave and expenses		24,197	19,962	24,197	19,962
PAYE payable		8,359	19,047	8,359	19,047
Overpayment recovery		(1,422)	(4,955)	(1,422)	(4,955)
Salary and wages accrual		58,839	30,031	58,839	30,031
		370,078	**304,370**	**370,078**	**304,370**
Non-current portion					
Liability for long service leave		2,048	1,963	2,048	1,963
Liability for retirement gratuities		4,280	6,028	4,280	6,028
		6,328	**7,991**	**6,328**	**7,991**

20. Employee entitlements (continued)

Key assumptions in measuring retirement and long service leave obligations

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Two discount rates for retirement and long service leave are used, 3.7% and 3.4%, respectively. (2021: 1.31% and 0.59% respectively) and a salary inflation factor of 3.0% (2021: 3.0%) was used.

If the discount rate was to differ by 1% from that used, with all the other factors held constant, the carrying amount of the retirement and long service leave obligations would be an estimated $0.3 million higher/lower

If the salary inflation factor was to differ by 1% from that used, with all the other factors held constant, the carrying amount of the retirement and long service leave obligations would be an estimated $0.3 million higher/lower.

Holidays Act 2003 remediation

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 Holidays 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 Holidays 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 2022/23 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2022, in preparing these financial statements, Waikato DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

The current estimate of the liability is $152.06 million (2021: $111.48 million). However, until the project has progressed further, there remain uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the provision liability within the next financial year or payments to current and former employees that differ significantly from the estimation of the liability.

21. Payables and deferred revenue

Accounting policy

Short-term payables are recorded at their face value.

	Group		Parent	
	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
Payables under exchange transactions	$000	$000	$000	$000
Creditors	107,546	87,605	107,528	87,587
Revenue received in advance	7,190	8,036	7,190	8,036
Total payables under exchange transactions	**114,736**	**95,641**	**114,718**	**95,623**
Payables under non-exchange transactions				
ACC levy payable	1,137	1,091	1,137	1,091
GST payable	11,213	9,809	11,213	9,809
Accrual – non-exchange expenses	1,211	1,211	1,211	1,211
Total payables under non-exchange transactions	**13,561**	**12,111**	**13,561**	**12,111**
Total payables	**128,297**	**107,752**	**128,279**	**107,734**

Creditors and other payables are non-interest bearing and are normally settled on 10 to 30-day terms. Therefore the carrying value of creditors and other payables approximates their fair value.

22. Provisions

Accounting policy

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

ACC Partnership Programme

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

Repairs to motor vehicles provision

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

Restructuring

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

	Group		Parent	
	2022 Actual	2021 Actual	2022 Actual	2021 Actual
Current liabilities	$000	$000	$000	$000
ACC Partnership Programme	1,370	1,042	1,370	1,042
Motor vehicle repairs on disposal	243	23	243	23
	1,613	**1,065**	**1,613**	**1,065**
Non-current liabilities				
Motor vehicle repairs on disposal	263	398	263	398
	263	**398**	**263**	**398**

22. Provisions (continued)

Movements for each class of provision are as follows:

	ACC Partnership Programme	Motor vehicle repairs on disposal	Total
	$000	$000	$000
Balance at 1 July 2020	957	399	1,356
Additional provisions made/released	1,475	122	1,597
Amounts used	(1,390)	(100)	(1,490)
Balance at 30 June 2021	**1,042**	**421**	**1,463**
Balance at 1 July 2021	1,042	421	1,463
Additional provisions made/released	1,931	88	2,020
Amounts used	(1,603)	(4)	(1,607)
Balance at 30 June 2022	**1,370**	**505**	**1,876**

ACC Partnership Programme

Waikato DHB belongs to the ACC Accredited Employers Programme (the "Full Self Cover Plan") whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, it is liable for all claims costs for a period of four years and up to a specified maximum amount. At the end of the four year period, Waikato DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

Exposures arising from the programme are managed by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies
- induction training on health and safety
- actively managing workplace injuries to ensure that employees return to work as soon as practical
- recording and monitoring workplace injuries and near misses to identify risk areas and implementing mitigating actions; and
- identifying workplace hazards and implementation of appropriate safety procedures.

Waikato DHB is not exposed to any significant concentrations of insurance risk, as work-related injuries are generally the result of an isolated event involving an individual employee.

An external independent actuarial valuer, Simon Ferry from Aon New Zealand, provided the ACC actuarials valuation to 30 June 2022. The valuer has attested that they are satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the valuer's report.

A prudent margin of 11.1% (2021: 11.6%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. This is the rate used by ACC. The key assumptions used in determining the outstanding claims liability are

- pre valuation date claim inflation of 50% of movements in the Consumer Price Index and 50% of the movements in the Average Weekly Earnings index
- post valuation date claim inflation of 2.23% per annum (2021: 1.85%); and
- a discount factor of 2.47% for 30 June 2022 (2021: 0.50%).

Any changes in liability valuation assumptions will not have a material effect on the financial statements.

Motor vehicle repairs on disposal

In respect of a number of its leased vehicles, Waikato DHB is required to make provision for motor vehicles repairs for return to owner at the end of the lease of the motor vehicles.

23. Restricted trust funds

Movements are as follows:	Group 2022 Actual $000 Waikato Health Trust	Group 2021 Actual $000 Waikato Health Trust
Balance at 1 July	9,314	8,300
Transfer from accumulated funds	744	1,014
Balance at 30 June	**10,058**	**9,314**

The restricted trust funds represent the reserved funds held by the Waikato Health Trust. Reserved and partially reserved funds are donated or bequeathed for specific purposes. The Trustees are required to manage these funds in accordance with the trust deed or the wishes of the donor. Partially reserved funds are externally bequeathed and bound by specific governing statements. Fully reserved funds are funds externally bequeathed that are held in perpetuity. The fund is not reduced and interest earned is transferred to a general fund where distributions can be made.

The receipt of and investment revenue earned on, restricted trust funds is recognised as revenue and then transferred to the trust fund from accumulated surpluses/(deficits). Application of restricted trust funds on the specified purpose is recognised as an expense, with an equivalent amount transferred to accumulated surpluses/(deficits).

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

24. Reconciliation of surplus/(deficit) for the period with net cash flows from operating activities

	Note	Group 2022 Actual $000	Group 2021 Restated Actual $000	Parent 2022 Actual $000	Parent 2021 Restated Actual $000
Net surplus/(deficit)		(72,101)	(69,202)	(72,445)	(70,488)
Add/(less) non-cash items:					
Depreciation	6	57,458	52,330	57,458	52,330
Amortisation	7	6,914	6,632	6,914	6,632
Bad and doubtful debts	14	316	364	316	364
Share of joint venture (surplus)/deficit	11	360	(244)	-	-
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	8	193	82	193	82
Add/(less) movements is statement of financial position items:					
(Increase)/decrease in inventories	16	792	133	792	133
(Increase)/decrease in gross receivables	14	(47,230)	(29,295)	(47,264)	(29,277)
(Increase)/decrease in prepayments	15	(4,177)	(2,325)	(4,177)	(2,325)
Increase/(decrease) in employee entitlements	20	64,045	51,707	64,045	51,707
Increase/(decrease) in trade and other payables	21	15,817	33,086	15,817	33,086
Increase/(decrease) in other provisions	22	413	107	413	107
Increase/(decrease) in derivative financial instruments	18	-	-	-	-
Net cash flows from operating activities		**22,800**	**43,375**	**22,062**	**42,351**

25. Capital commitments and operating leases

Capital commitments	Group 2022 Actual $000	Group 2021 Actual $000	Parent 2022 Actual $000	Parent 2021 Actual $000
Buildings	4,980	3,194	4,980	3,194
Plant, equipment and vehicles	16,264	11,174	16,264	11,174
Intangible assets	137	1,795	137	1,795
Total capital commitments	**21,381**	**16,163**	**21,381**	**16,163**

The capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

Non-cancellable operating lease commitments

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Group 2022 Actual $000	Group 2021 Actual $000	Parent 2022 Actual $000	Parent 2021 Actual $000
Not later than one year	8,098	8,096	8,098	8,096
Later than one year and not later than five years	25,120	27,691	25,120	27,691
Later than five years	8,086	13,904	8,086	13,904
	41,304	**49,691**	**41,304**	**49,691**

Waikato DHB leases a number of buildings, vehicles and office equipment under operating leases. The leases typically run for a period of 1 - 30 years for buildings, 1 - 3 years for office equipment and 6 years for vehicles. In the case of leased buildings, lease payments are adjusted every 1 - 7 years to reflect market rentals. None of the leases includes contingent rentals.

A portion of the total non-cancellable operating lease expense relates to the lease of motor vehicles. Waikato DHB does not have an option to purchase the assets at the end of the lease term. There are no restrictions placed on Waikato DHB by its leasing arrangements.

26. Contingencies

Contingent liabilities	Group 2022 Actual $000	Group 2021 Actual $000	Parent 2022 Actual $000	Parent 2021 Actual $000
Personal grievances	336	330	336	330
Legal proceedings and disputes by third parties	170	75	170	75
	506	**405**	**506**	**405**

The contingent liabilities relate to a number of claims involving third party and employment issues which may result in legal action, or legal action is in progress. The actual timing and amounts will be determined by the outcome of personal grievance processes and legal proceedings. Where a claim is covered by insurance, the value declared as a contingent liability is limited to the insurance excess.

Compliance with Holidays Act 2003

Many public and private sector entities, including the DHB, have considered and continue to investigate historic underpayment of holiday entitlements.

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

Waikato DHB has recognised a provision at balance date based on a reasonable estimate of the potential liability.

Contingent assets

Waikato DHB has no contingent assets at 30 June 2022 (2021:$Nil).

27. Client funds

Waikato DHB administers certain funds on behalf of clients. These funds are held in a separate bank account and any interest earned is allocated to the individual client balances. Therefore, the transactions during the year and the balance at 30 June are not recognised in the Statement of Comprehensive revenue and expense, Statement of Financial Position or Statement of Cash Flows.

	2022 Actual $000	2021 Actual $000
Balance at 1 July	44	57
Receipts	57	80
Payments	(46)	(93)
Balance at 30 June	**55**	**44**

28. Financial instruments

The carrying amounts of financial assets and liabilities in each of the financial instrument categories are as follows:

	Group		Parent	
Financial instrument categories	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
Financial assets measured at amortised cost	$000	$000	$000	$000
Cash and cash equivalents	55,279	28,034	44,677	18,170
Receivables – credit impaired	127,064	80,151	127,060	80,112
Total financial assets measured at amortised cost	**182,343**	**108,185**	**171,737**	**98,282**
Fair value through surplus or deficit				
Derivative financial instrument	-	-	-	-
Total derivative financial instrument	**-**	**-**	**-**	**-**
Financial liabilities measured at amortised cost				
Trade and other payables (excluding income in advance)	121,107	100,562	121,089	99,698
Borrowings – loans	-	50	-	50
Total other financial liabilities	121,107	**100,612**	121,089	**99,748**

Financial assets are measured on an amortised cost basis using the expected credit risk model.

Financial instrument risks

Waikato DHB's activities expose it to a variety of financial instrument risks. Waikato DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Credit risk

Credit risk is the risk that a third party will default on its obligation to Waikato DHB, causing it to incur a loss.

Waikato DHB places its cash balances with high-quality financial institutions via a national DHB shared banking arrangement facilitated by New Zealand Health Partnerships Limited.

Concentrations of credit risk from trade receivables are limited due to ACC and Ministry of Health being the largest single debtors (17% and 65% respectively, at 30 June 2022). They are assessed to be a low risk and high-quality entity due to their nature as the government funded purchaser of health and disability support services.

The impact of the COVID-19 pandemic on the collectability of trade receivables was considered, and as a high proportion of receivables are Crown entities (90% at 30 June 2022), the risk of higher expected credit loss rate is considered low.

No collateral or other credit enhancements are held for financial assets that give rise to credit risk.

Cash and cash equivalents (note 13) and receivables (note 14) are subject to the expected credit loss model. The notes for these items provide relevant information on impairment

The impact of the COVID-19 pandemic on credit loss history relating to receivables is minimal due to the customer type and nature of the receivable balances.

28. Financial instruments (continued)

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings or to historical information about counterparty default rates.

	Group		Parent	
	2022 Actual	2021 Restated Actual	2022 Actual	2021 Restated Actual
Counterparties with credit ratings	$000	$000	$000	$000
Cash and cash equivalents				
AA	29	48	29	48
AA-	10,602	9,864	-	-
Total cash and cash equivalents	10,631	9,912	29	48
Counterparties without credit ratings				
New Zealand Health Partnership Limited	44,648	18,122	44,648	18,122
Receivables				
Counterparty with no defaults in the past	126,794	79,881	126,790	79,842
Counterparty with defaults in the past	270	270	270	270
Total receivables – credit impaired	127,064	80,151	127,060	80,112

Liquidity risk

Liquidity risk represents the ability for Waikato DHB to meet its contractual obligations and its liquidity requirements on an ongoing basis. Waikato DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the management of loan facilities.

The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are contractual undiscounted cash flows.

	Group 2022 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Finance leases	-	-	-	-	-	-	-
Trade and other payables	121,107	121,107	121,107	-	-	-	-
	121,107	121,107	121,107	-	-	-	-

	Parent 2022 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Finance leases	-	-	-	-	-	-	-
Trade and other payables	121,089	121,089	121,089	-	-	-	-
	121,089	121,089	121,089	-	-	-	-

	Group 2021 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Finance leases	50	50	25	25	-	-	-
Trade and other payables	100,562	100,562	100,562	-	-	-	-
	100,612	100,612	100,587	25	-	-	-

	Parent 2021 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Finance leases	50	50	25	25	-	-	-
Trade and other payables	99,698	99,698	99,698	-	-	-	-
	99,748	99,748	99,723	25	-	-	-

Market price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. Waikato DHB has no financial instruments that give rise to price risk.

28. Financial instruments (continued)

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in market interest rates. Waikato DHB's exposure to fair value interest rate risk is limited to its cash balance held under a contract with New Zealand Health Partnership Limited (NZHPL) through a national DHB shared banking arrangement. NZHPL actively manages this risk. The exposure to fair value interest rate risk for long term borrowings is low due to long term borrowings generally being held to maturity.

Fair value interest rate sensitivity analysis

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate because of changes in market interest rates.

In managing fair value interest rate risks Waikato DHB aims to reduce the impact of short-term fluctuations on revenue and expenses. Over the longer-term, however, permanent changes in interest rates would have an impact on revenue and expenses.

Sensitivity analysis

For the year ended 30 June 2022, if floating interest rates had been 1% higher/lower, with all other variables held constant, the result for the year would have been approximately $832,000 higher/lower (2021: $868,000 lower/higher).

Currency risk

Currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Waikato DHB's currency risk is mainly limited to large purchases of clinical equipment from overseas and licence payments. Waikato DHB uses forward currency contracts or options to hedge its foreign currency risk. Waikato DHB hedges trade payables denominated in a foreign exchange currency for large transactions and where necessary the forward exchange contracts or options are rolled over at maturity.

The group has no unhedged foreign-denominated payables at balance date (2021: $ Nil).

It is estimated that a general increase of one percentage point in the value of NZD against other foreign currencies would not have a material effect on the net result.

29. Capital management

Waikato DHB's capital is its equity, which comprises Crown equity, accumulated surpluses/deficits, revaluation reserves and trust funds. Equity is represented by net assets.

Waikato DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives. Waikato DHB has complied with the financial management requirements of the Crown Entities Act 2004 during the year. Waikato DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments and general financial dealings to ensure that it effectively achieves its objectives and purposes, while remaining a going concern.

30. Related parties

Ownership

Waikato DHB is a crown entity in terms of the Crown Entities Act 2004, and is a wholly owned entity of the Crown. The Crown significantly influences the role of Waikato DHB as well as being its major source of revenue. During the year Waikato DHB received $1.82 billion (2021:$1.55 billion) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2022 was $68.31 million (2021:$46.12 million). Waikato DHB incurred a capital charge of $37.5 million (2021:$30.8 million) to the Government during the year.

Identity of related parties

Waikato DHB has a related party relationship with the Waikato Health Trust, HealthShare Limited, New Zealand Health Partnership Limited and with its commissioners.

Transactions with the Waikato Health Trust, HealthShare Limited and New Zealand Health Partnership Limited are priced on an arm's length basis.

30. Related parties (continued)

Significant transactions with government-related entities

Waikato DHB has received funding from ACC for the year ended 30 June 2022 of $19.4 million (2021:$20.5 million) to provide health services.

Revenue earned from other DHBs for the care of patients outside of the Waikato DHB district for the year ended 30 June 2022 was $175.5 million (2021:$159.2 million). Expenditure to other DHBs for their care of patients from Waikato DHB's district for the year ended 30 June 2022 was $74.5 million (2021:$68.3 million).

Collective, but not individually significant, transactions with government-related entities

In conducting its activities, Waikato DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies is based on the standard terms and conditions that apply to all tax and levy payers. Waikato DHB is exempt from paying income tax.

Waikato DHB also purchased goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended the 30 June 2022 totalled $31.6 million (2021 $30.0 million). These purchases included the purchase of electricity from Genesis and Meridian Power NZ, air travel from Air New Zealand, postal services from New Zealand Post and blood products from NZ Blood Service.

HealthShare Limited

HealthShare Limited is a company, established in February 2001 by the five DHBs in the Midland region under a joint venture agreement, which provides regional services for these DHBs. No dividends have been received from HealthShare Limited.

As at 30 June 2022, HealthShare Limited had total assets of $34.561 million (2021:$37.274 million) and total liabilities of $32.994 million (2021:$33.908 million).

During the year Waikato DHB received $1,181,702 (2021: $1,583,252) from HealthShare Limited for services provided. Waikato DHB incurred expenses from HealthShare Limited of $5,100,425 (2021:$10,765,597) for services provided.

As at 30 June 2022 Waikato DHB owed HealthShare Limited $18,094 (2021: $644,586) and HealthShare Limited owed Waikato DHB $630,292 (2021: $69,586).

The Group's investment in HealthShare Limited has been accounted for using the equity method.

Waikato Health Trust

Waikato Health Trust (formerly the Health Waikato Charitable Trust) was incorporated in 1993 as a charitable trust in accordance with the provisions of the Charitable Trust Act 1957. Under the Trust Deed the trustees are appointed by the Waikato DHB, these trustees acting independently in accordance with their fiduciary responsibilities under trust law. The trustees at 30 June 2022 are Mark Cawthorne and Margaret Wilson.

The purpose of the Trust is to fund health or disability services, related services or projects, health research or education and other appropriate health related purposes within the communities served by Waikato DHB.

Administration costs of the trust are borne by Waikato DHB. Revenue received from the Trust during the period was $0.763 million (2021:$0.768 million). There was $Nil owing to Waikato DHB at 30 June 2022 (2021:$Nil).

New Zealand Health Partnerships Limited

NZ Health Partnerships Limited was incorporated on 16 June 2015. Waikato DHB owns 6,948,005 (2021:6,948,005) shares being 10.17% (2021:10.17%). Waikato DHB does not have a controlling interest in New Zealand Health Partnership Limited.

31. Waikids early childhood centre – Waikato Hospital

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Summary of transactions relating to Waikids:				
Subsidy funding – Ministry of Education	258	197	258	197
Equity funding – Ministry of Education	37	41	37	41
Equity funding – Ministry of Education – In advance	(52)		(52)	
Other funding – Ministry of Education	-	11	-	11
Other income	-	1	-	1
Personnel costs	(243)	(341)	(243)	(341)
Minor equipment purchases	(12)	(12)	(12)	(12)
Administration costs	(12)	(17)	(12)	(17)
Surplus/(Deficit) for the year	(26)	(120)	(26)	(120)
Accumulated surplus attributed to Waikato early childhood centre				
Balance at 1 July	42	162	42	162
Surplus/(Deficit) for the year	(26)	(120)	(26)	(120)
Accumulated surplus attributed to Waikato early childhood centre	16	42	16	42
Income in advance – Equity funding	52	-	52	-
Accrued income	48	13	48	13
Net current assets	100	13	100	13

Waikids early childhood centre is a hospital based play specialist service operated by the Waikato DHB within the Waikato Hospital, funded primarily by the Ministry of Education.

Waikato DHB supports the centre through provision of building, facilities and general administration.

Waikato DHB contributed to personnel costs to the extent of the work done in relation to inpatient care.

$360,744 of the personnel costs are offset from the total of $604,071.

Approved project costs of $25,552 for personnel expenses have been funded from retained earnings/ accumulated surplus attributed to Waikids Early Childhood Centre.

The income held in advance relates to unspent equity funding received from Ministry of Education from prior and current year that will be used future project/s per Equity Funding guidelines.

32. Impact of COVID-19 on Waikato DHB

On 11 March 2020, the World Health Organisation declared the outbreak of COVID-19 a pandemic. During the ensuing years, the country was in lockdown or subject to restrictions for a number of weeks, impacting service delivery. In the current financial year, as well as rescheduled recovery activity, the DHB has participated in Managed Isolation and Quarantine facilities and COVID-19 vaccination and testing programmes.

An assessment of the impact of COVID-19 on the results of Waikato DHB at 30 June 2022 and its future viability has been performed and the effect on our operations is reflected in these financial statements, based on the information available to the date these financial statements are signed.

- Land and Buildings: An independent valuer carried out a valuation of Land and Buildings at year end and the resulting upward revaluation adjustment of $113.6 million processed.
- Revenue: The bulk of Patient Care revenue is secured from funding from the Ministry of Health. Additional funding to assist with the COVID-19 response was approved.
- Expenses: Additional direct costs incurred associated with supporting the response to the pandemic include payroll, community health providers and other clinical expenses and have been funded by the Ministry of Health.

33. Impact of criminal cyber-attack on Waikato DHB

On 18 May 2021, Waikato DHB was subject to a criminal cyber-attack which disrupted the computer network and systems. No ransom was paid.

The immediate focus was on minimising the disruption to patients, with business continuity plans to keep patient care and clinical support services running. Urgent work was commenced on the secure restoration of digital systems followed by a recovery phase. Most systems have been restored.

Waikato DHB has increased its resilience to cyber security threats following the cyber-attack.

Systems, including the financial accounting system, have been online for most of the financial year under review. Material accounting estimates arising as a result of the cyber-attack were not required in the current or prior years.

There were no material financial impacts on Waikato DHB due to the cyber-attack. While the cyber-attack caused considerable temporary disruption to the organisation, the costs of systems recovery and return to full service are the subject of a claim under our and broader government insurance policies.

34. Subsequent event

On 1 July 2022 Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority were established with all 20 DHBs being amalgamated into Te Whatu Ora – Health New Zealand .

Te Whatu Ora – Health New Zealand is responsible for running hospitals and commissioning primary and community health services. As a result of the health reforms, responsibility for public health issues will rest with this new entity.

Te Aka Whai Ora – Māori Health Authority is responsible for monitoring the state of Māori health and can commission services directly.

There were no other significant events after the balance date.

35. Comparative information

Comparative figures have been restated where necessary to align with current year disclosures.

36. Restatement of comparative figures

The DHB NZHO Nursing and Midwifery MECA settlement which included terms relating to the 2020/21 financial year was agreed after the 2020/21 year end. As the 2020/21 annual financial statements were due for approval at the time, the adjustment amounting to $19.979 million was not able to be recognised and incorporated.

The adjustment was subsequently completed, and balances at 30 June 2021 restated as follows:

- an increase to employee entitlement liability of $19.979 million
- an increase to personnel costs of $19.979 million

In addition, the Ministry of Health reduced Waikato DHB PCI funding $9.451 million for the 2020/21 financial year and recognition of the adjustment could not be achieved prior to finalisation of the annual financial statements.

The adjustment was subsequently completed and balances restated as follows:

- a decrease in receivables of $10.869 million
- a decrease in GST liability of $1.418 million
- a decrease in patient revenue of $9.451 million

36. Restatement of comparative figures (continued)

The following table summarises the impact on the Waikato DHB Group consolidated and parent financial statements:

	Group			Parent		
	As previously reported	Adjustment	As restated	As previously reported	Adjustment	As restated
	$000	$000	$000	$000		
Statement of comprehensive revenue and expense for the year ended 30 June 2021						
Patient revenue	1,757,850	(9,451)	1,748,399	1,757,850	(9,451)	1,748,399
Personnel costs	(759,225)	(19,979)	(779,204)	(759,225)	(19,979)	(779,204)
Line items not impacted by restatement	(798,079)	-	(798,079)	(799,365)	-	-799,365
Total comprehensive revenue for the year	**200,546**	**(29,430)**	**171,116**	**199,260**	**(29,430)**	**169,830**
Statement of Financial Position as at 30 June 2021						
Receivables	91,019	(10,869)	80,151	90,981	(10,869)	80,112
Total assets	**1,171,172**	**(10,869)**	**1,160,304**	**1,160,597**	**(10,869)**	**1,149,728**
Employee entitlements – current	284,391	19,979	304,370	187,831	19,979	207,810
Trade and other payables under non-exchange transactions	13,475	(1,418)	12,057	215,216	(1,418)	213,798
Total liabilities	412,379	**18,561**	430,940	**403,047**	**18,561**	**421,608**
Retained earnings	(260,645)	(29,430)	(290,074)	(261,317)	(29,430)	(290,747)
Total equity	758,793	**(29,430)**	729,364	**757,550**	**(29,430)**	**728,120**

There is no impact on the Waikato DHB Group and parent total operating, investing or financing cash flows for the year ending 30 June 2021.

37. Explanation of financial variances from budget

Waikato DHB Group recorded a net group deficit of $72.1 million against a budgeted deficit of $30.0 million with an unfavourable variance against budget of $42.1 million.

An unbudgeted increase in revaluation reserve resulted in an favourable variance of $71.5 million against budgeted comprehensive revenue.

Variances in group deficit

The unfavourable group deficit against budget of $42.1 million includes:

- revenue is $235.7 million favourable which includes additional funding for extra health services delivered together with reimbursement of specific costs incurred (materially offset in expenses). This includes $155.8 million in respect of funding to cover COVID-19 costs, COVID-19 consumables donated by Ministry of Health $20.4 million and $42.9 million funding to cover pay equity settlements.
- personnel costs are $95.4 million unfavourable to budget which includes the unbudgeted increase of estimated potential liability relating to Holidays Act 2003 remediation of $30.6 million, COVID-19 related costs of $38.6 million (offset in revenue), pay equity settlements $47.8 million (partly offset in revenue). Higher costs were also part offset by favourable vacancy variances.
- outsourced services and personnel are $75.3million unfavourable. Variances include outsourced costs of COVID-19 recovery $49.3 million and higher than planned use of outsourced personnel to cover for vacancies.
- clinical supplies expense is $28.8 million unfavourable mainly due to COVID-19 lab testing costs.
- infrastructure costs $31.1 million unfavourable which includes COVID-19 and Holidays Act rectification and remediation costs.
- non-health board provider expenses are $42.4 million unfavourable mainly due to COVID-19 costs (offset in revenue).

37. Explanation of financial variances from budget (continued)

Variances in statement of changes in equity

Total equity is $61.6 million favourable to budget. This includes:

- Revaluation Reserve $113.6 million higher than budget as a result of a revaluation of land and buildings at 30 June 2022.
- Unfavourable group deficit variance of $42.1 million.
- Crown Equity is $24.9 million higher than budget due to higher than budgeted equity contribution received.

Variances in financial position

Current assets are $109.2 million higher than budget mainly due to higher receivables balances $60.5 million arising mainly from the unbudgeted debtor accrual of COVID-19 and ACC revenue. In addition, the bank balance was higher than total budget $74.6 million as a result of the underspend on fixed assets, higher than budgeted deficit support received together with receipt and payment timing differences. The bank balance was budgeted as an overdraft $28.8 million – see current liabilities below.

Non current assets are $59.8 million higher than budget. This due to the impact of the revaluation of land and buildings $113.6 million offset by lower than planned capital spend $56.5 million. The revaluation is based on a number of assumptions as described in note 6. The significant increase is in part attributed to large increases in construction costs which have been impacted by the disruptions and restitutions over supply chains resulting in greater demands and limited capacity for building materials.

Current liabilities are $108.3 million higher than budget. This include:

- Employee entitlements are $90.4 million higher than budget mainly due to the recognition of an additional Holidays Act remediation liability together with lower than budgeted annual leave taken, accrual of expired collective employment agreements and impact of unbudgeted pay equity payments on annual leave earned rates.
- Trade and other payables are $46.5 million higher than budgeted which includes unbudgeted accrual for Holidays Act remediation costs, higher than budgeted goods and services received but not yet invoiced and higher income in advance received from the Ministry of Health.
- Bank balance was budgeted to be an overdraft of $28.8 million which did not eventuate – see current assets.

Non current liabilities are close to budget.

Variances in cash flows

- Net cash cash outflows from operating activities are $7.3 million lower than budget due mainly to timing variances.
- Net cash outflows from investing activities are $56.5 million lower than budget due to lower than planned capital spend.
- Net cash inflows from financing activities are $25.5 million higher than budget due to higher than budgeted equity contributions received.

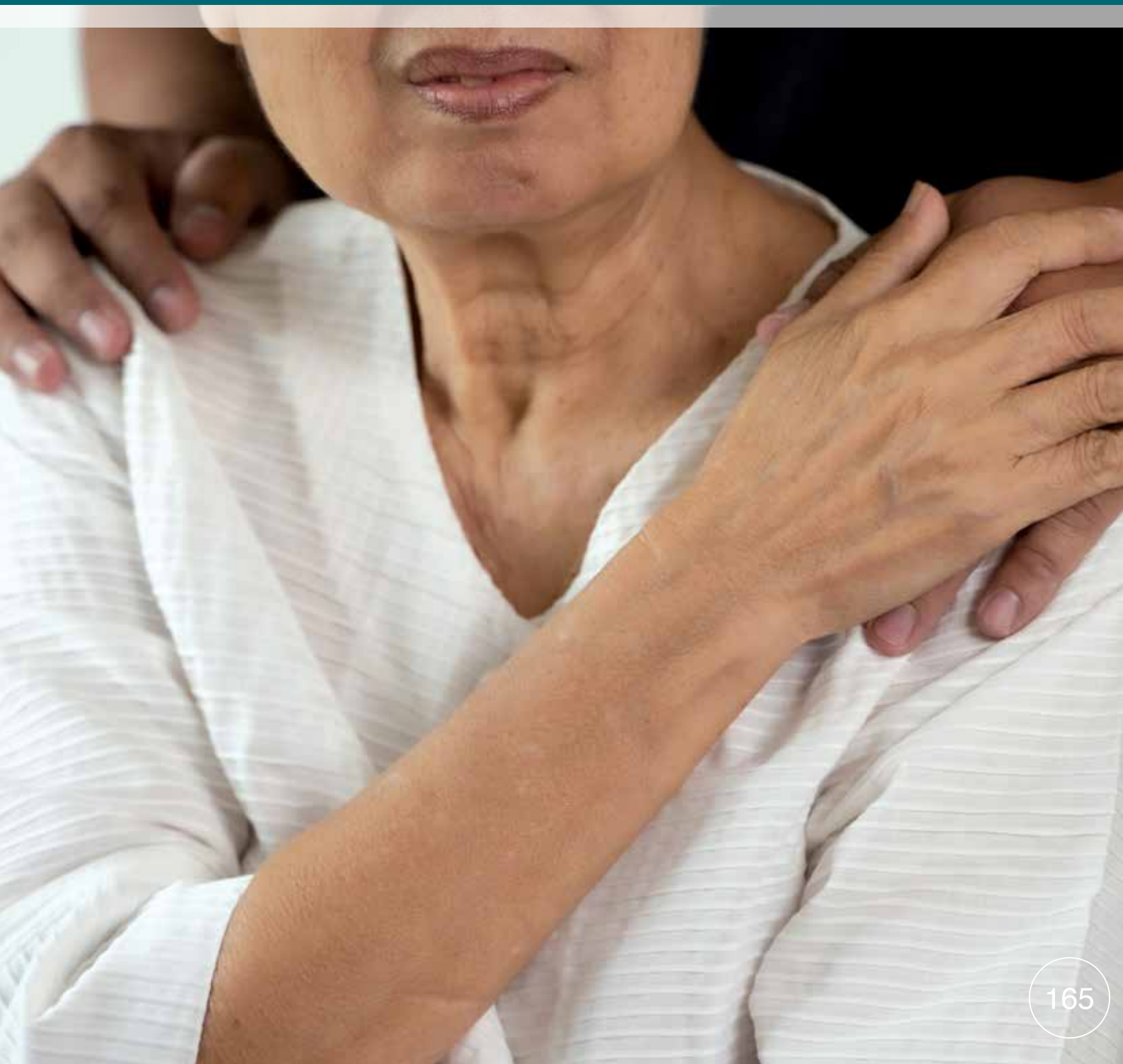
38. Breach of statutory reporting deadline

The 2021/22 annual report of Waikato DHB group was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

> Doctors were all so supportive and informative. They made an effort to acknowledge our culture by greeting us in te reo Māori, especially as three of them were non-Kiwis.

Ward OPR4 – Combined Stroke

Part six:
Audit report



AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Waikato District Health Board and Group's financial statements and performance information for the year ended 30 June 2022

The Auditor-General is the auditor of Waikato District Health Board (the Health Board) and Group. The Auditor-General has appointed me, Wikus Jansen van Rensburg, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health Board and Group on his behalf.

Opinion

We have audited:

- the financial statements of the Health Board and Group on pages 126 to 163, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board and Group on pages 58 to 119.

In our opinion:

- the financial statements of the Health Board and Group on pages 126 to 163, which have been prepared on a disestablishment basis:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2022; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board and Group on pages 58 to 119:
  - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2022, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and

- what has been achieved with the appropriation; and

- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

– complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 23 March 2023. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board of Te Whatu Ora – Health New Zealand and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been prepared on a disestablishment basis

Note 1 on page 130 outlines that the Health Board and Group have prepared its financial statements on a disestablishment basis because the Health Board and Group were disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board and Group's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 20 on page 151, which outlines that the Health Board and Group have been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board and Group has estimated a provision of $152 million, as at 30 June 2022 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Pages 110 to 119 of Part three outline the information used by the Health Board and Group to report on its Covid-19 vaccine coverage. The Health Board and Group use the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 115 to 116. The notes on page 117 outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board and Group have provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 32 on page 160 to the financial statements and pages 58 to 119 of the performance information, which outline the ongoing impact of Covid-19 on the Health Board and Group.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Board of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board and Group is the responsibility of the Board of Te Whatu Ora.

The Board of Te Whatu Ora is responsible on behalf of the Group for preparing the disestablishment financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

Up until 30 June 2022, the Health Board and Group were responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board and Group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board and Group's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board of Te Whatu Ora.
- We evaluate the appropriateness of the reported performance information within the Health Board and Group's framework for reporting its performance.
- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Board of Te Whatu Ora.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board and Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the Group audit. We remain solely responsible for our audit opinion.

We communicate with the Board of Te Whatu Ora regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 1 to 57; pages 120 to 125; pages 164 to 165 and pages 172 to 175, but does not include the financial statements and the performance information, and our auditor's report thereon.

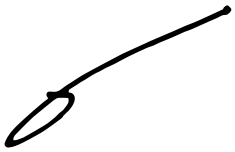
Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board and Group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than the audit, we have no relationship with, or interests in, the Health Board or any of its subsidiaries.



Wikus Jansen van Rensburg
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

> We went through a complex and emotional time. Our nurse was wonderful. Honest, professional, calm, supportive. She made what was an exceptionally tough time so much better just by being herself. My husband and I are exceptionally grateful.

Women's Health – Maternity

Part seven:
Glossary of acronyms

Glossary of acronyms

At Waikato DHB and across the health system we often use acronyms to refer to common terms or services. Some of the more commonly used are listed below.

Acronym	Meaning
ACC	Accident Compensation Corporation
ACEM	Australasian College for Emergency Medicine
ACP	Advance Care Plan
AODTC	Alcohol and Other Drug Treatment Court
API	Asset Performance Indicators
ASH	Ambulatory Sensitive Hospital Admissions – hospital admissions that are considered as avoidable
CHF	Community Health Forum
CIR	COVID Immunisation Register – Information record about COVID-19 immunisation/s
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus disease (formerly known as 2019-nCoV)
CT	Computed Tomography
CVD	Cardiovascular Disease
CVDRA	Cardiovascular Disease Risk Assessment
CVIP	COVID-19 Vaccination and Immunisation Programme
DHB	District Health Board
DMFT	Decayed, Missing, and Filled Teeth
DNA	Did Not Attend – when a patient does not attend their scheduled appointment without notification
DSL	Disability Support Link
ED	Emergency Department
EEO	Equal employment opportunities
ERAS	Enhanced Recovery After Surgery
ERP	Estimated resident population – an estimate of the population usually living (resident) in New Zealand at a point in time
FCT	Faster Cancer Treatment – a healthcare pathway
FSA	First specialist appointment
FTE	Full Time Equivalent – refers to staffing levels
GP	General practice
HCSS	Home and Community Support Services
HDU	High Dependency Unit
HPV	Human Papilloma Virus
HQSC	Health Quality and Safety Commission
HSCAN	High suspicion of cancer – patients referred with a high suspicion of cancer
HSU	Health service user – a measure of the population in New Zealand using (or potentially using) the health system at a point in time
ICT	Information communication and technology
ICU	Intensive Care Unit
InterRAI	International Resident Assessment Instrument • The primary assessment instrument in aged residential care and home and community services for older people living in the community
IT	Information Technology
KPI	Key Performance Indicators

Acronym	Meaning
LMC	Lead Maternity Carer
LOS	Length of Stay
MDM	Multi-Disciplinary Meeting
MDS-HC	Minimum Dataset Homecare Assessment Tool
MIT	Medical Imaging Technician
MMR	Measles, mumps and rubella
MOU	Memorandum of Understanding
MP	Member of Parliament
MRI	Magnetic Resonance Imaging
NASC	Needs Assessment and Service Coordination
NCTS	National Contact Tracing Solution – the national electronic database to support contact tracers to keep accurate and secure records of all contact tracing activity
NGO	Non-Government Organisation
NHI	National Health Index number – a unique identifier that is assigned to every person who uses health and disability services in New Zealand
NICU	Newborn Intensive Care Unit
NIR	National Immunisation Register
NRT	Nicotine Replacement Therapy
NZ	New Zealand
NZBN	New Zealand Business Number
NZPHD	New Zealand Public Health and Disability Act 2000
OPR	Older Persons and Rehabilitation
PCI	Planned Care Intervention
PHO	Primary Health Organisation
PICC	Peripherally inserted central catheter – tube used for administering intravenous fluids and medication
POAC	Primary Options for Acute Care
PPE	Personal Protective Equipment
PRP	Projected resident population
QPI	Quality performance improvement
QSM	Quality safety marker
RMO	Resident Medical Officer
RN	Registered Nurse
SMO	Senior Medical Officer
SPE	Statement of Performance Expectations
START	Supported Transfer and Accelerated Rehabilitation Therapy – Waikato district model of care that provides individuals with targeted rehabilitation in their home
VLCA	Very Low Cost Access – scheme supports general practices with high needs patients where the practice agrees to maintain patient fees at a low level
WHIRI	Whānau Hauora Integrated Response Initiative
WKTO	Whaanau Kori Tamariki Ora – Active Families, Healthy Kids





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