Waikato District Health Board

2019/20 ANNUAL PLAN

INCORPORATING THE 2019/20 STATEMENT OF PERFORMANCE EXPECTATIONS AND 2019/20-2022/23 STATEMENT OF INTENT

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

Contents

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Mihi

He honore, he kororia ki te Atua
He maungarongo ki te whenua
He whakaaro pai ki nga tāngata katoa
Ka tau te kei o te waka ki te Kiingi Tuheitia
me te whare o te Kahui ariki whānau whanui tonu
Paimarire.
Kahuri ki te korowai aitua
O ratou ko wehi ki te po
Takoto mai, moe mai koutou
Haere, haere, haere atu raa.
Noreira, ka puari te kuaha pounamu
Mahana kia taatou katoa.
“Mehemea ka moemoeā ahau
Ko au anake
Mehemeā ka moemoeā e tātou,
ka taea e tātou”

All honour and glory to God
Peace on earth
And good will to all mankind
Including Kiingi Tuheitia his family
And the royal household
Paimarire.
We turn to acknowledge those
Who have passed beyond the veil
Rest in peaceful slumber.
Haere, haere, haere atu raa
Therefore the green stone door
Opens wide with a very warm greeting to us all
“If I am to dream
I dream alone
If we all dream together
Then we will achieve”

Minister's letter of expectations to Waikato DHB

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Dear Chair

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

Fiscal responsibility
Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery
High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025
I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability
I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Updated Minister's Letter of expectations to Waikato DHB

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Tēnā koe (Chair)

UPDATE: Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out an update to the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20. This builds on my December 2018 letter, attached for your reference. I want to emphasise that my strong focus remains on the expectations set out in that letter.

I also want to acknowledge your engagement with the important conversations we have been having on improving financial sustainability and clinical performance.

While I recognise there are a number of challenges, it is my expectation that DHBs ensure their local communities can access high quality sustainable services that deliver equitable outcomes.

Wellbeing Budget

Budget 2019 is about delivering better wellbeing for all New Zealanders and driving intergenerational change. There are five key priorities – taking mental health seriously, improving child poverty, supporting Māori and Pasifika aspirations, building a productive nation, and transforming the economy.

Budget 2019 builds on last year's Vote Health investment. A record $19.871 billion is being invested for 2019/20 to support a stronger, more sustainable health and disability system.

Our Government has signalled a willingness not just to invest, but also to make the fundamental changes needed to deliver long term and sustainable change. Budget initiatives are also based around evidence on what will make the greatest contribution to the long term improvement of living standards and wellbeing.

Monitoring improved performance

High performing DHBs are needed to support the delivery of the Government's priorities. I am concerned about the sector's overall financial position, and some areas of service performance.

As you are aware I have worked with the Ministry of Health (Ministry) to ensure DHB performance is supported through a stronger performance programme. This will help DHBs to be more sustainable, and to improve financial and clinical performance to ensure better and more equitable outcomes for New Zealanders. I have made it clear that you have a responsibility to address the range of performance challenges in partnership with the Ministry.

Your DHB's performance will be reported to me regularly, and I support the use of data and benchmarking to identify variation as well as opportunities for improvement. This will also support collaboration across DHBs regionally and nationally to make the most of our

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collective capability. I expect all DHBs to contribute to, and participate in, such work to help ensure the system is safe, equitable, efficient, and maximises the resource use across the whole system.

Fiscal responsibility

I have made my expectations on improving financial performance very clear, and DHBs need to have a plan to return to financial sustainability.

You have been provided with your confirmed budget allocations for 2019/20 and I expect you to be considering ways to contain expenditure, including maximising available capability and resources in the system, tightly managing recruitment and staff leave, and improving consistency of clinical pathways and decision-making.

Continuing to do things in the same way as we are now is not sustainable operationally, clinically or financially. There will be a dedicated focus in 2019/20 on strengthening sustainability planning and establishing an on-going sustainability programme.

You will be aware that Budget 2019 invests an extra $94.7 million over four years to help improve DHB financial sustainability. This new funding will enable DHBs to work more collaboratively across your regions, to share and build on best practice, to implement new service models that transform the way we use workforce and facilities, and to make the best use of the available funding and capacity in your region.

Capital investment

Budget 2019 invests $1.7 billion over two years for capital investment projects, building on last year's investment to restore our hospitals and health facilities. This funding will be prioritised for mental health projects, high growth areas with increased demand, and health facilities that are no longer fit for purpose. I urge that in all investment, environmental sustainability be a significant consideration.

Some business cases for new infrastructure projects are already well advanced and have been indicatively prioritised for consideration. I expect this process to be completed with DHBs being advised of the outcomes in July/August 2019.

The Ministry of Business, Innovation and Employment is developing a new framework which will focus on skills development and training as a requirement of construction projects. New construction procurement guidelines will also be applied across government. I expect you to apply the changes to the procurement of new construction projects.

National Asset Management Plan

In the long term, we need to better map out future infrastructure requirements. This will enable the Government to make more informed decisions, and better prioritise remediation work and plan for new facilities.

I am pleased that you are actively supporting the National Asset Management Plan programme of work. I expect that any requests for information from the project team are responded to in a timely manner.

It is also my expectation that you will update your DHB's Asset Management Plans. These are a requirement of the Ministry, and will assist in the formulation of the capital investment pipeline, and the ongoing work on the National Asset Management Plan.

The Budget also provides some funding to lift capacity and capability within the Ministry, notably to establish a new health infrastructure unit that will provide better support to DHBs.

Update on my priority areas

Improving child wellbeing

As you know, child wellbeing is a key priority for this Government. I expect your annual plans to reflect how you are actively working to improve childhood immunisation coverage and eliminate inequity, especially for Māori.

As I have said in my earlier letter of expectations, I expect you to support the reduction of family violence and sexual violence through addressing abuse as a fundamental healthcare responsibility.

Improving mental wellbeing

Mental health and addiction is a top priority in the Wellbeing Budget with $1.9 billion over four years being invested into a range of mental wellbeing initiatives and mental health and addiction facilities. These strongly align with the Government's response to He Ara Oranga, the report of the independent inquiry into mental health and addiction.

We have a unique opportunity to improve the mental health and wellbeing of all New Zealanders. We need to embed a focus on wellbeing and equity at all points of the system. We also need to focus more on mental health promotion, prevention, identification, and early intervention.

It is my expectation that you will work closely with the Ministry and key partners in your region to help drive this transformation; your leadership is essential.

Improving wellbeing through prevention

Our Government's vision is for a welfare system that ensures people have an adequate income and standard of living, are treated with respect, can live in dignity and are able to participate meaningfully in their communities. DHBs have an important and ongoing role working alongside social sector partners to improve the welfare and health system outcomes for their population.

I have introduced a new priority section in DHB annual plans, given the considerable overlaps between people engaging with the welfare system as well as the health and disability support system. Over half the proportion of working age people receiving a main benefit have a health condition or a disability, or care for someone with a health condition or disability.

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

Planned Care

I am confident that the changes to how planned care is planned, funded and monitored will remove the current disincentives to developing better ways of delivering services.

The new planned care approach will enable DHBs to deliver more appropriate, timely, high quality services to support the health and wellbeing of New Zealanders. DHBs will be able to provide care in the most appropriate setting, with the right workforce.

There will also be a greater focus on equity, quality, and people's experience of our services. I expect DHBs to create robust plans for these services and to consistently meet volume, waiting time, and other quality expectations.

Cancer Action Plan

I have asked the Ministry to work with you and other stakeholders to develop a Cancer Action Plan. I expect you to support and drive the development of this important work, and to deliver on the local actions within your Plan.

Health Research Strategy Implementation

Research, evidence and innovation is critical to addressing inequities and in continuously improving the quality and outcomes of services provided.

I am aware that the Ministry is working with DHBs and other government agencies to develop a work programme to implement the Health Research Strategy. I encourage you to continue to work closely with the Ministry to progress this important work.

Workforce

DHBs have a key role in training our health and disability workforce. I expect that all DHBs continue to maintain a strong focus on this area to build capacity and capability, and to implement an equitable approach to funding professional development.

In your current annual plan I expect you to develop a sustainable approach to nursing career pathways, including actions to support equitable funding for professional development for nurse practitioners.

Care Capacity Demand Management

At the end of last year I outlined my expectation that DHBs are to implement Care Capacity Demand Management (CCDM) in line with the process and timetable set out in the 2018-2020 MECA.

I expect to see significant progress on CCDM implementation this year, as well as detailed planning to ensure full implementation by June 2021.

I expect you to confirm that you have met my expectation to include implementing CCDM in the performance expectations of your Chief Executive and that you are updating these expectations to include implementation in midwifery services.

Devolution of the pay equity appropriation

I have supported the devolution of the pay equity appropriation. I expect you to work with the Ministry to ensure a seamless transition of responsibilities.

The Ministry has an ongoing stewardship responsibility to ensure that Care and Support Workers (Pay Equity) Settlement Act obligations are met.

The Government's agenda to improve the health and wellbeing of New Zealanders is significant, as evidenced by the sizable investments being made. I am confident that DHBs will present strong plans to support delivery of our priorities and I am looking forward to seeing progress against both measures and activities during the year.

I have appreciated the willingness shown by DHB teams to focus on equity and outcomes, and have confidence that you will all embrace the direction and implement plans to deliver it.

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

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Minister's 2019/20 letter to Waikato DHB

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

18 DEC 2019

Dr Karen Poutasi
Commissioner
Waikato District Health Board
karen.poutasi@waikatodhb.health.nz

Dear Karen

Waikato District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed Waikato District Health Board's (DHB's) 2019/20 Annual Plan for one year together with the Minister of Finance.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan with the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

I am aware that you have advised the Ministry of Health (Ministry) of an improving out-years position. However, I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety, and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

I am aware you are planning a number of service reviews in the 2019/20 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute

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approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your Annual Plan.

I would like to thank you and your staff for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2019/20 Annual Plan. I look forward to seeing your achievements.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr David Clark
Minister of Health

Hon Grant Robertson
Minister of Finance

cc Dr Kevin Snee
Chief Executive
Waikato District Health Board
Kevin.snee@waikatodhb.health.nz

Introduction

The 2019/20 Waikato District Health Board (DHB) Annual Plan (2019/20 Plan) meets the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health. It is prepared in accordance with sections 100 and 141 of the Crown Entities Act 2004.

The 2019/20 Plan incorporates the 2019/20-2022/23 Waikato DHB Statement of Intent (Statement of Intent). The core components of the Statement of Intent can be extracted from the Annual Plan (sections 1, 2, 3 and 4) and tabled as a separate public accountability document.

Detailed planning and reporting components of the 2019/20 Plan, including Waikato DHBs Statement of Performance Expectations and System Level Measure Plan are contained in the appendices.

The 2019/20 Plan sets out the DHBs goals and objectives and what it intends to achieve, in terms of improving the health of the population it serves, and ensuring the sustainability of the health system over the coming year. It outlines our strong focus on health equity and access, financial viability, and improved service performance to meet legislative requirements.

It is important to note that, given the DHBs challenging financial position, a 2019/20 Savings Plan is being developed that may impact on the achievement of the 2019/20 Plan's goals, objectives and activities. Further areas of strategic focus for the DHB for the coming three years include reconfiguring models of care and a review of resourcing to support these models.

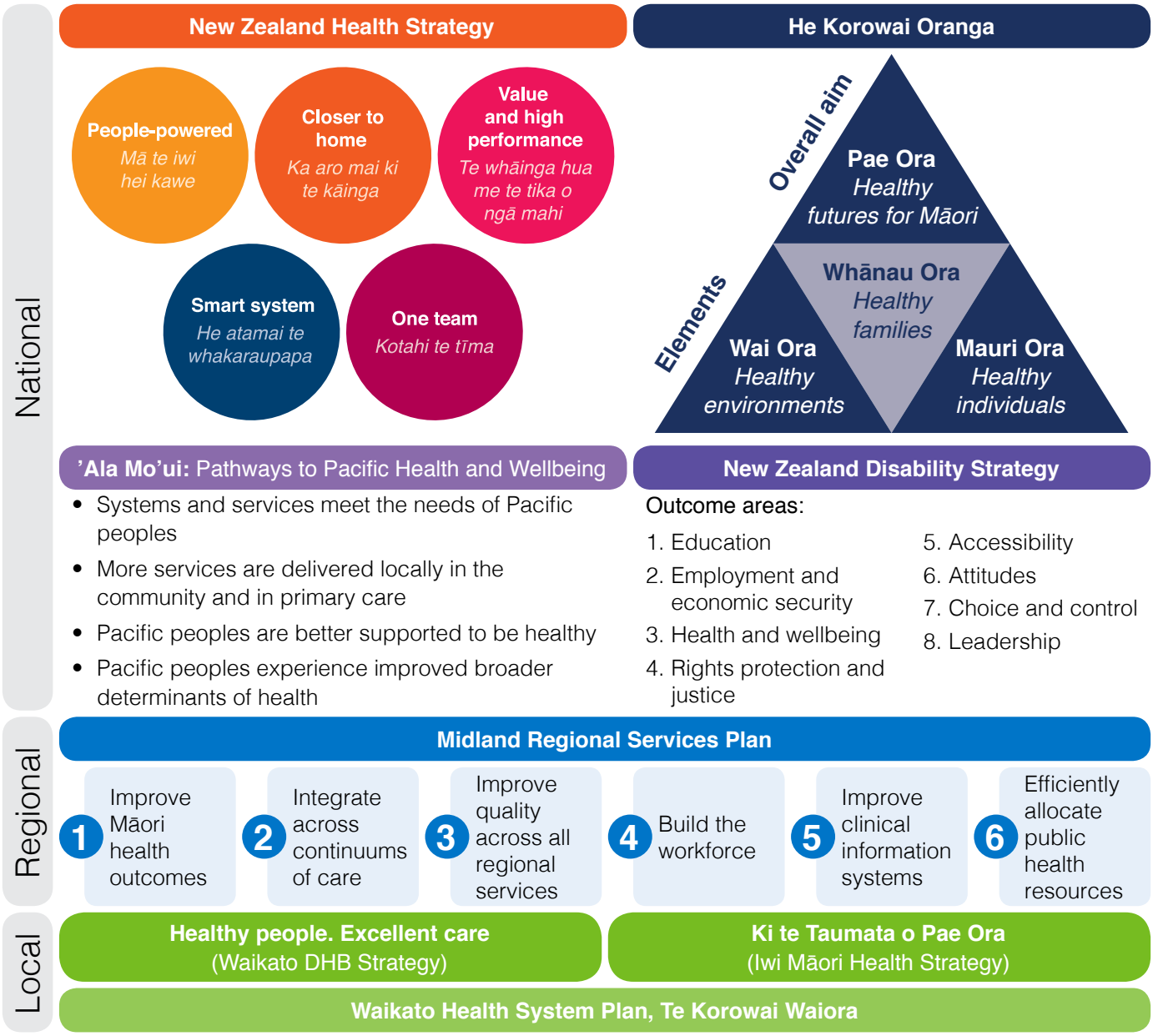


Figure 1: National, regional and local strategic intent

Strategic intentions

This 2019/20 Plan articulates the Waikato DHBs commitment to meeting the Minister's expectations, and our vision of "Healthy people. Excellent care" It makes clear links to national, regional and local agreed strategic priorities including the Waikato DHB Strategy (2016) and Waikato Health System Plan, Te Korowai Waiora (2019) (see figure 1).

The Waikato Health System Plan, Te Korowai Waiora will focus the DHBs work on what is needed to support our population to improve their health, make services easier to access and improve the way services are delivered over the next 10 years. the DHB is committed to working in partnership with local iwi, its community service providers and consumers, as well as with the other Midland region DHBs to achieve this.

National

The Treaty of Waitangi

The Treaty of Waitangi (Te Tiriti o Waitangi) is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Waikato DHB values the importance of the Treaty. Central to the implementation of the Treaty principles is a shared understanding that health is a 'taonga' (treasure).

The principles within the Treaty of partnership, protection and participation implicitly recognise the important role the health sector plays in recognising the indigenous rights of Māori to achieve radical improvements in health and eliminate health inequities.

New Zealand Health Strategy

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

He Korowai Oranga

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

The Healthy Ageing Strategy

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

The UN Convention on the Rights of Persons with Disabilities

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

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018

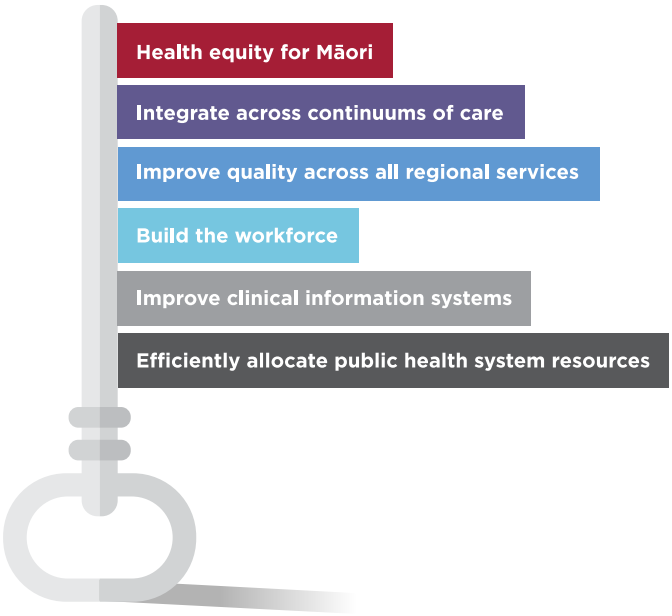
The purpose of Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018 is to facilitate the delivery of high-quality health services that meet the needs of Pacific peoples, 'Ala Mo'ui has been developed. This builds on the successes of the former plan, 'Ala Mo'ui 2010-2014. It sets out the strategic direction to address health needs of Pacific peoples and stipulates new actions, to be delivered from 2014 to 2018.

Regional

Legislation requires the DHBs to collaborate regionally and for each of the four regions of DHBs to develop a Regional Services Plan (RSP). The RSP is a companion plan to DHB Annual Plans. HealthShare Ltd, the Midland DHBs shared services agency, is tasked with developing the Midland RSP on our behalf. This work is carried out in consultation with the Midland DHBs Annual Plan writers group and DHB executive groups to ensure collaboration and alignment between the region and DHB planning.

The Midland region has identified six regional strategic objectives that inform and support the direction of regional efforts:

Our six regional objectives



In 2019/20 the Midland RSP has a particular focus on collaboration to achieve equity for Māori. This is being driven by a signed Memorandum of Understanding (MOU) between the Midland Regional Governance Group and the Midland Iwi Relationship Board. Work programmes are developed by the regional clinical networks and action groups, the regional enablers, and also by services provided by HealthShare Ltd. Alignment with national and regional strategic direction is provided against each work programme's initiatives i.e. the New Zealand Health Strategy's five strategic themes; the national System Level Measures, and Midland's six regional strategic objectives. Resourcing for delivery of approved work programmes is regionally agreed, budgeted and approved.

Full details can be found in the Regional Services Plan 2018-2021.

Local

Waikato DHB is the Government's funder and provider of health services to an estimated 426,137 residents, covering almost nine percent of New Zealand's population, the fifth largest DHB in the country. The DHBs population is part urban and part rural. It is also experiencing population growth, particularly in and around main urban centres such as Hamilton.

The DHB has a larger proportion of people living in areas of high deprivation than in areas of low deprivation. The population is becoming proportionally older (the 65 plus age group is projected to increase by 40 percent between 2018 and 2028). This will increase the prevalence of chronic and complex health conditions and informs many of the strategies being put in place to meet future health need.

Twenty three percent of the population are Māori compared with the national average of 16 percent. The Māori population are disproportionally represented in adverse health statistics, and are significantly impacted by many chronic conditions such as diabetes and smoking related diseases. This provides a strong driver to include and engage Māori in health service decision making, and to deliver health information and health services in a culturally appropriate way.

The Pacific population make up three percent of the DHB population and are a group that require targeted health initiatives. The Pacific community are also disproportionately represented in adverse health statistics. Improving the health and wellbeing of Pacific peoples will require mobilising all key stakeholders including the Pacific health sector, Pacific community and DHB to be responsible for growing and coordinating effective interventions that are responsive to Pacific needs.

Approximately one in four people living within the Waikato are experiencing a disability. Living with a disability impacts on peoples' quality of life and ability to fully contribute to communities. This means the DHB and other social sectors organisations need to work alongside those with a disability to determine how best to enable access and liveability.

Waikato Public Health

Waikato Public Health provides activities to promote, improve and protect health and wellbeing with a focus on achieving equity for the people it serves. Good health and wellbeing is about more than healthcare. A good start in life, education, employment, housing, and strong, supportive relationships and communities all play a part. For this reason, this 2019/20 Plan is aligned with the Waikato Public Health Annual Plan, where appropriate. This will strengthen work towards achieving better health outcomes for the DHBs population.

The key areas of alignment between the plans in 2019/20 are[1]:

- Māori health and equity
- Disability and equity
- First 1000 days
- Climate change and environmental sustainability
- Healthy food and drink
- Developing preventative capabilities in hard-to-reach communities
- Cross-sectoral collaboration.

[1] See appendix C, Waikato Public Health Annual Plan for activities that reinforce these focus areas

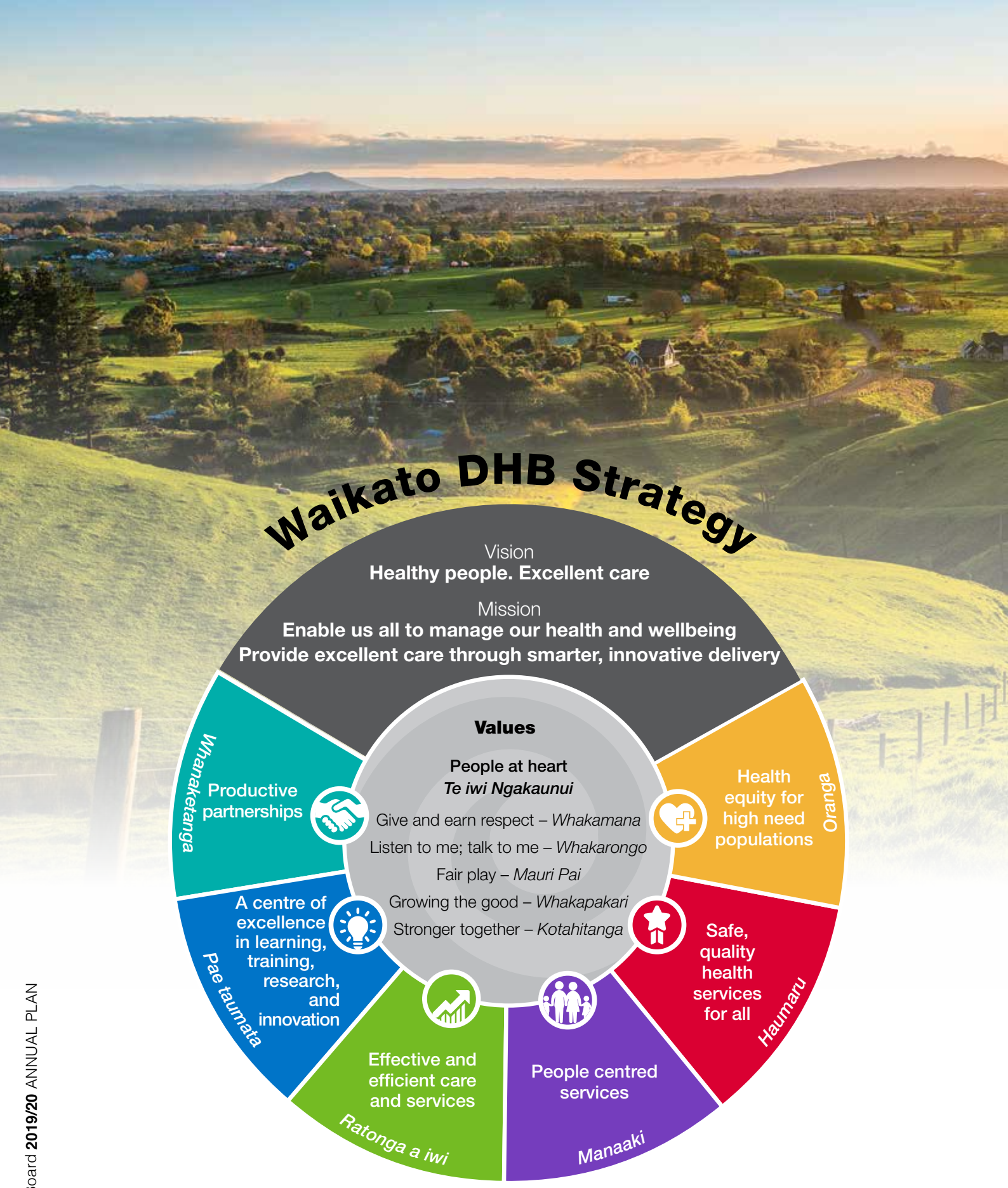
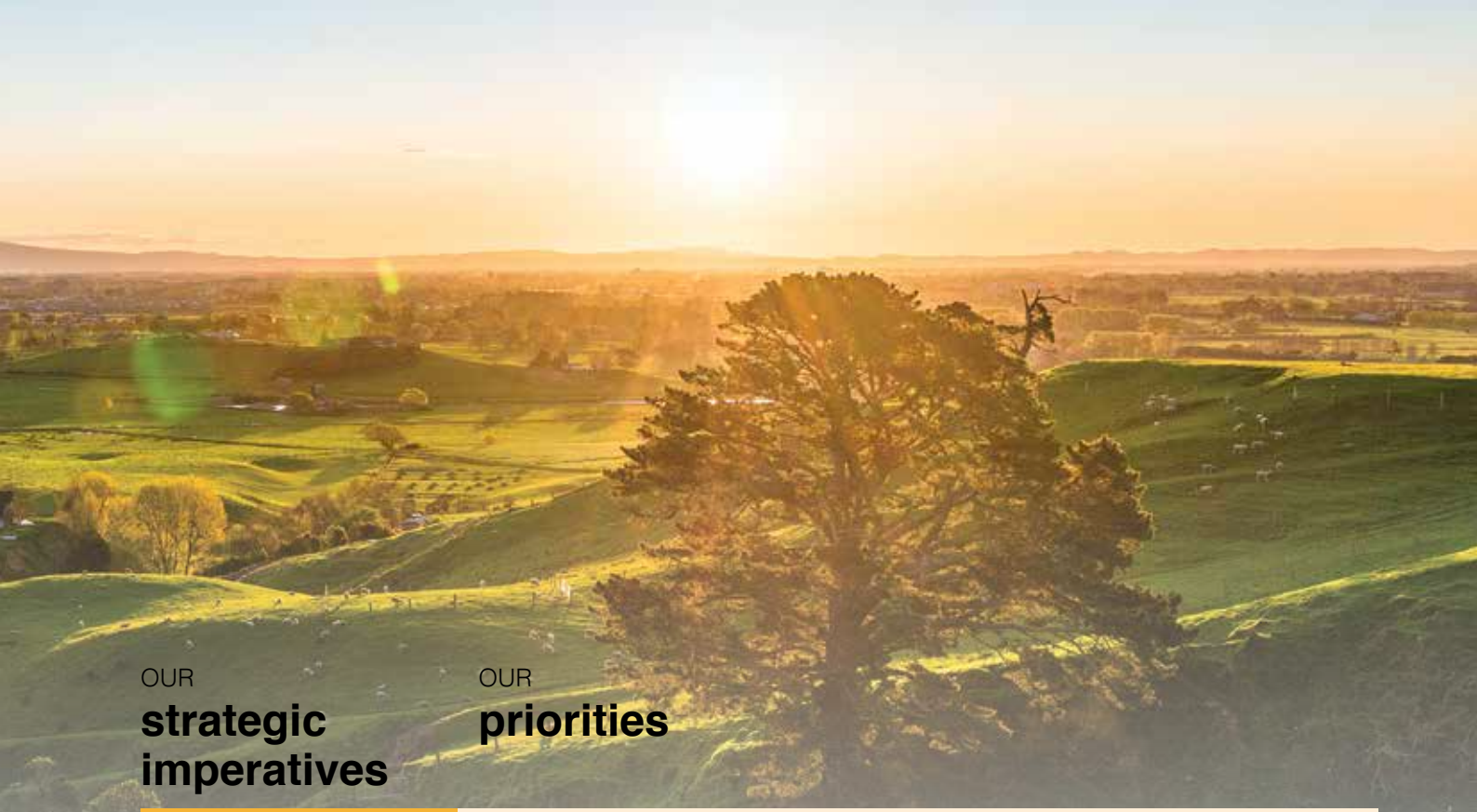


Figure 2: Waikato DHB Strategy summary

Waikato DHB Strategy

During 2016/17 Waikato DHB began implementation of a new strategy. The DHB Strategy recognises that there are some fundamental challenges that must be faced if we are to improve the health status of the population and to achieve health equity. It clearly articulates a future vision and set of strategic imperatives that provide a ten year overarching strategic framework that will drive all investment decisions within a priority hierarchy.



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

In 2018/19 the DHB developed a Waikato Health System Plan, Te Korowai Waiora (Waikato HSP) using co-design. The aim is to improve our health system and futureproof it for the challenges we expect in the coming years. The Waikato HSP translates the Waikato DHB Strategy's vision of **Healthy people. Excellent care** into a set of strategic goals and actions that will be implemented over the next ten years.

Through the co-design process, localities across the DHB clearly communicated they want health services that:

- Focus on wellness and wellbeing
- Focus on the needs of service users, not the services' needs
- Are equitable and fair for everyone
- Integrate health and social services; and
- Designed with the people who use them.

The community and whānau voices have been distilled into goals. These goals have underlying actions and enablers associated with the Waikato DHB vision: "Healthy people. Excellent care".

The goals identified in the Waikato HSP include:

goal 1	Waikato DHB and Māori partner in a way that is an example to others
goal 2	Give whānau and families the best opportunity to achieve wellbeing
goal 3	Support community aspirations to positively influence the determinants of health
goal 4	Improve access to services
goal 5	Enhance the capacity and capability of primary and community health care
goal 6	Strengthen intermediate care
goal 7	Enhance the connectedness and sustainability of specialist care

Enablers needed to achieve these goals include:

- Leadership and partnerships
- Commissioning
- Workforce development
- Technology and information; and
- Quality improvement

These goals and enablers will result in a range of Waikato health system desired outcomes (see figure 3).

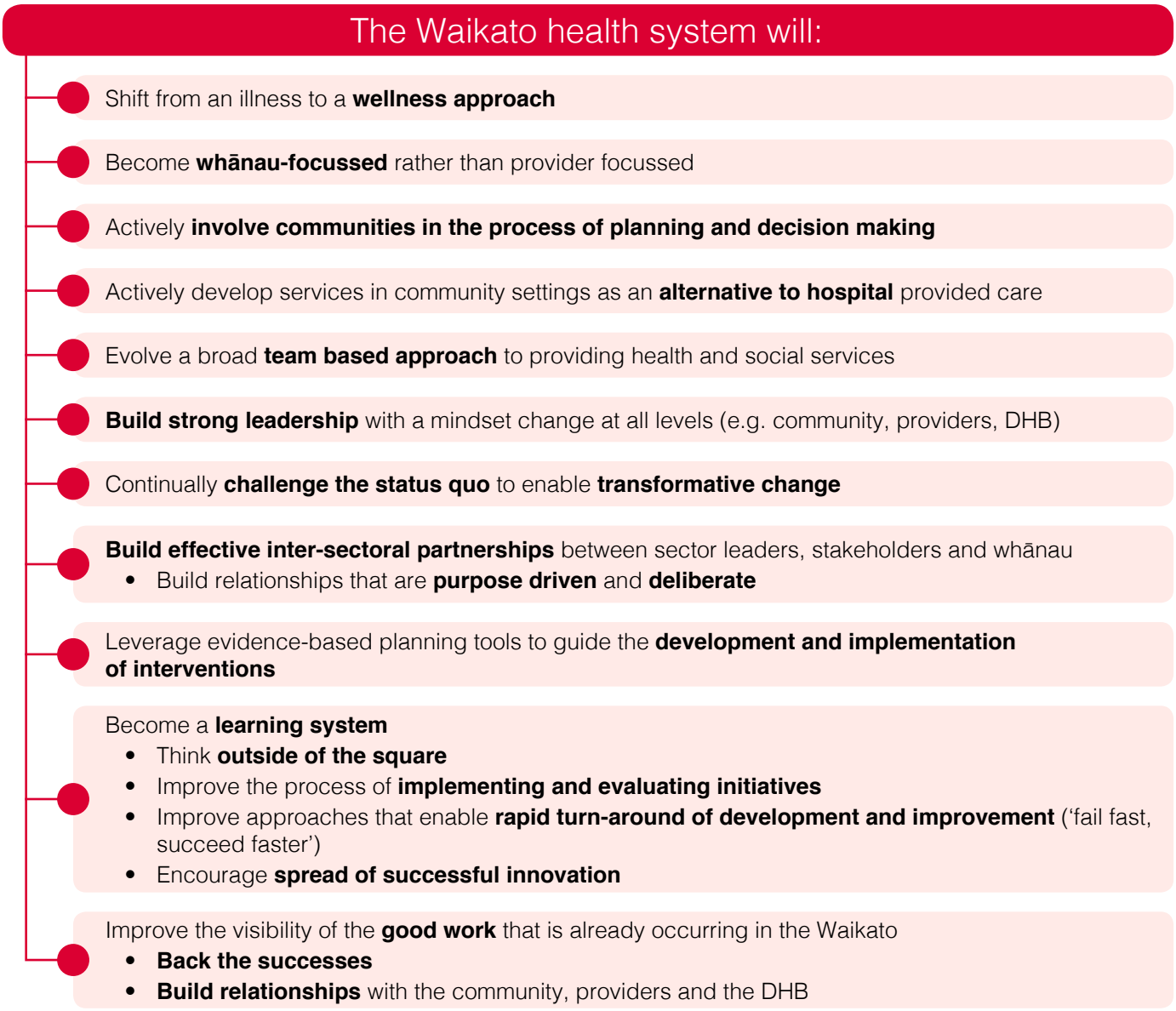


Figure 3: Waikato Health System Plan, Te Korowai Waiora desired outcomes

The process of engaging communities and the health sector on improving health and wellbeing has brought together a collective vision for the health system.

The vision for the health system in the Waikato is that within ten years:

- our people will enjoy good health and wellbeing supported by the communities they live in.
- communities will be supported to address the things they need for good health and wellbeing. Health and social services are part of the community.
- people will have easy access to information and services that are supported by technology and provided by health workers in a way that focuses on the needs of whānau and family.
- where possible, services will be provided in the communities where people live.
- providers will be well connected, communicate well and coordinate between themselves.
- all services in the health system are connected therefore people with multiple needs can access services through any part of their journey – 'any door is the right door.'
- irrespective of the type of care people need, all paths will lead them back to the support of their whānau, families and communities.

The Waikato HSP's vision for good health and wellbeing in the Waikato is illustrated on the following page (figure 4).

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

Figure 4: Waikato Health System Plan, Te Korowai Waiora 2019: Vision for good health and wellbeing in the Waikato


Waitomo - Otorohanga
North Ruapehu
Thames - Coromandel - Hauraki
Greater Hamilton
Matamata - Piako
PEOPLE AT HEART
HOSPITAL
HEALTH SERVICES
SOCIAL SERVICES
Support whānau as active participants in their health
x+y=
POLICE
Address determinants of health

Implementing the Waikato Health System Plan, Te Korowai Waiora

Implementation of the Waikato HSP will begin in 2019/20. To successfully achieve this new direction over the short to medium term, the organisation and other health system partners will need to consider changes to how it funds services, review the scope and nature of services provided and transform the DHBs culture.

Further planning

Waikato DHB is undertaking further planning over the next three years to support the implementation process. This planning will be guided by the Waikato DHB Strategy and Waikato HSP.

Initial further planning prioritised by the DHB for development in 2019/20 includes:

- Mental Health and Addictions Strategic Directions Framework[2]
- Tamariki Oranga Plan[3]
- A Disability Responsiveness Plan; and
- Clinical Services Planning.

This planning will be determined by equity and locality considerations and have a three to five year implementation timeframe.

Localities

The term locality is used in health to describe a geographical space, where stakeholders collaborate to address issues they are experiencing. Waikato DHB proposes using a locality approach for seven localities, using similar boundaries as the Territorial Local Authorities. The names of the localities used in this plan are temporary placeholders. A separate process with communities and stakeholders will be used to identify appropriate names for each locality. Larger localities may have neighbourhoods as subsets.

The DHB recognises the particular role that localities play in shaping health outcomes. It therefore makes sense to focus services and community action by locality. Services can be more responsive and accessible in the future if they are both close to home and in familiar surroundings.

The DHB has identified seven localities (see figure 5). It recognises the potential of localities as a means of supporting Waikato HSP implementation.

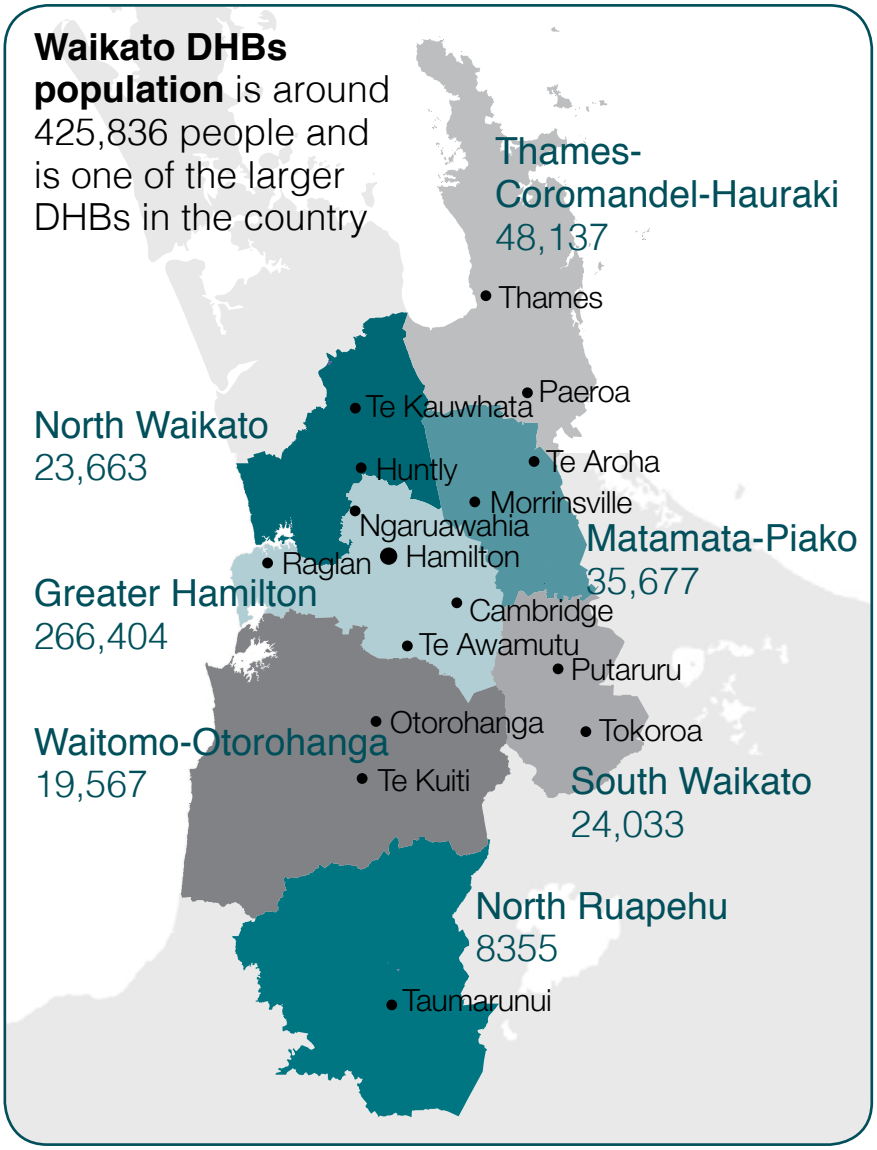


Figure 5: Waikato DHB localities[4]

[2] Plan is focused on mental health and wellbeing and addictions within the Waikato DHB geographic area
[3] Framework is focused on the health and wellbeing of Māori tamariki and their whānau within the Waikato DHB geographic area
[4] 2020 population count by locality (Statistics NZ)

Delivering on the strategic objectives

The DHB will deliver on its Statement of Intent strategic objectives through implementation of the Waikato HSP, and in part, through this 2019/20 Plan. This includes a focus on improving responsiveness to Māori, empowering local communities, enabling health and wellbeing and strengthening the provision of community care.

Strategic objectives

Waikato DHB has five key focus areas for 2019/20, as agreed with the Ministry of Health. Actions to support these priorities are highlighted through section 2 of this plan and summarised in table 1 below.

The areas of focus are:

- equity
- mental health
- child health
- workforce
- financial sustainability

The DHBs strategic objectives for the next three years are guided by the Waikato DHB Strategy, the Waikato HSP and have links to the Minister's identified expectations of DHBs for 2019/20. The DHB has identified five strategic objectives that will be a key focus for the next three years (see table 1) which have link to DHB strategic focus areas identified in DHB discussions with Ministry in late 2018/19.

Table 1: Waikato DHB objectives (2019/20-2022/23) and links to local goals and national expectations

Objective	Associated Waikato HSP, Te Korowai Waiora goal(s)	Strategic focus area	Associated expectations of the Minister (2019/20)
1. Begin Implementation of the Waikato HSP, Te Korowai Waiora with a particular focus on health equity for Māori through partnerships with Māori, and enabling whānau wellbeing.	All goals	• Identify opportunities to align implementation of Waikato HSP, Te Korowai Waiora and DHB Resource Review recommendations via the Transformation Programme • Reconfigure models of care	Achieving equity for Māori Devolution Workforce Unmet need Disability Rural health Integration across sectors Refreshed strategic direction
2. Reorient primary and community service delivery across the Waikato.	Goals 4-5	• Reconfigure models of care via the Transformation Programme • Review of resourcing to support new models of care	Primary health care –closer integration with secondary and community care
3. Implement the new model of service delivery for mental health and addictions services in line with the Government Inquiry into Mental Health and Addictions findings (Te Ara Oranga) and the Waikato DHB Mental Health and Addictions Strategic Directions Framework.	All goals	• Reconfigure models of care via the Transformation Programme • Review of resourcing and existing models to support new models of care	Mental health and addiction care Integration across sectors
4. Strengthen action to improve productivity and fiscal management across Waikato DHB.	All goals	• Implement DHB Savings Plan • Implement DHB Resource Review recommendations via the Transformation Programme • Improve control of recruitment requests • Improve process for outsourcing requests approvals • Re-budgeting to reflect DHB activity i.e. 'zero-based budgeting'	Fiscal responsibility Building infrastructure
5. Develop and implement a Waikato DHB Tamariki Oranga Plan.	All goals	• Reconfigure models of care via the Transformation Programme • Review of resourcing to support new models of care	Child wellbeing Maternity care and midwifery Integration across sectors

Financial sustainability

The DHB has had a growing deficit over the last two years, and anticipates a significant budgeted deficit for 2019/20 and will inform the 2019/20 Savings Plan and 'Recovery Plan' through until 2021/22. The DHB commissioned a 'Resource Review' project in 2019. The scope of this included how the DHB allocates its resources, the wider structures and FTE establishment of all services, and the function of governance and management structure within the organisation. Implementation of the 'Resource Review' recommendations is a priority for 2019/20-2021/22.

Commissioning

As noted above, five key enablers have been identified as critical in achieving the Waikato HSP goals. One of these key enablers is the commissioning approach that was adopted by Waikato DHB in 2018. The commissioning approach is founded on its commitment to working in partnership to improve population health and eliminate health inequities.

The principles that guide our approach to commissioning are:

- Equity for vulnerable populations: a focus on reducing and if possible eliminating inequities in health.
- Shared leadership: all the stakeholders in the local health system share leadership in achieving health gain for the population.
- Accountability: while each organisation has its own accountability mechanism, there will be shared accountability in Waikato for achieving health improvement.
- Whole of system, end to end care: commissioning of services will take into account the impact of any changes on the whole system of care. When commissioning new services or service changes, the principle will be to assess the improvement any service will bring to the end-to-end health experience of patients.

A number of commissioning models have been examined and as a result, Waikato DHB has developed the 'Commissioning Koru' (see figure 6).

Figure 6: Waikato DHB Commissioning Koru

What will commissioning look like?

Waikato DHB Strategy development

Developing the Waikato DHB Strategy provided an overarching strategic framework and is the first step in the commissioning process as it grounds all future decisions within a priority hierarchy.

Strategic position statements

Good planning requires clear definitions and descriptions of activities and areas of focus. Position statements will provide a solid foundation upon which engagement with wider stakeholder groups can take place and guide service development.

Health needs assessment

Knowing where to invest in services to maximise health gain and reduce inequalities is entirely dependent on understanding the health needs of the population. The DHB will run an active Health Needs Assessment Programme where aspects will be updated as new data becomes available.

Health system design

The Waikato HSP provides a schematic that outlines what a connected system of health services looks like at a future point in time. It will provide clear direction for on-going service planning and change management activity.

Investment prioritisation

Ensures investment in services that maximise health gain and eliminate inequalities by identifying where investment is most likely to have the greatest impact, and to prioritise our investments based on clear evidence and rationale.

Service development

Service development will be more collaborative and create better connections across the sector to ensure services are more people centred and are focussed on reducing inequalities, particularly for Māori. Services will be developed through co-design with stakeholders including our communities, Iwi Māori Council, the Consumer Council, commissioners group and committees.

Contracting for outcomes

We will collaborate with our service providers to reorientate contracts to be clearly linked to desired outcomes. This will allow for services to be developed around people and their whānau and ensure we deliver the right service to achieve the desired outcomes.

Monitoring and managing performance

There will be a strong focus on monitoring performance and working together to remediate issues and take advantage of opportunities. The Strategy and Funding directorate of the DHB will have a stronger focus on evaluation to ensure that services continue to successfully impact on our strategic imperatives.

Outcomes/value for money measurement

Consideration will be given to all performance and evaluation information to determine the relative value and outcomes of the service and investment.

Re-commission or decommission services

In addition to considering the relative value and contribution to outcomes a service has made, re-commissioning or decommissioning decisions will also be driven by: changes in organisational priorities determined by the Government of the day or commissioners group, the emergence of opportunities to deliver services in a more effective way, and the Government's Rules of Sourcing.

Foreword from the Waikato DHB Commissioner and Acting Chief Executive

The year 2019/20 represents a re-set year for Waikato DHB. The Board was in May 2019 succeeded by a Commissioner, and a new Chief Executive has been appointed commencing 12 August 2019.

Over the past year considerable effort has been placed into developing a Waikato Health System Plan, Te Korowai Waiora which will during the coming year begin to drive change in the way that services are delivered and our population is supported.

Waikato DHB is facing a challenge in addressing cost growth which over the past few years has exceeded revenue growth by a significant margin.

The first priority will be to adopt a budget which demonstrates that some stability has been brought to the organisation's financial situation.

From there, the Waikato DHB will move into a recovery phase which brings our deficit down over time, while looking at different models of care and more alignment with our community based partners.

In doing this work we need always to remind ourselves that we exist to deliver safe high-quality services to our population and to the individuals of which it is comprised. We will not allow budget pressures to undermine the standards we aspire to.

I want to stress in particular that the priority Waikato DHB gives to health equity is undiminished by recent leadership changes. Indeed, I wish even greater focus to be given to achieving equity for all population groups.

Essentially we subscribe fully to the principle that what is good for Māori in health is good for the entire population in that it represents the system accommodating itself to those in the greatest need.

Our focus in our decision-making in 2019/20 will also be on the whole system. We don't want the best-of-care occurring only in some parts of our people's journey across the system. By definition if the experience is only good in parts it is not good at all. We want everyone's journey to be safe, simple and effective. And by that means we will also reduce cost.

We are not blind to the challenge of the coming years, but now is the time to take up that challenge and do our best for the people of the Waikato.

Signatories

Agreement for the Waikato DHB 2019/20 Annual Plan and 2019/20-2022/23 Statement of Intent

between

Hon Dr David Clark Minister of Health	Hon Grant Robertson Minister of Finance
Date:	Date:

Dr Karen Poutasi Commissioner Waikato DHB	Prof Margaret Wilson Deputy Commissioner Waikato DHB	Neville Hablous Acting Chief Executive Waikato DHB
Date: 23 October 2019	Date: 23 October 2019	Date: 23 October 2019

SECTION TWO: Delivering on priorities

Waikato DHB is committed to delivering on the Minister's Letter of Expectations and to the agreed planning priorities in its 2019/20 Plan. These planning priorities include a particular focus on improving Māori health and health equity.

The DHB will have a significant savings plan for 2019/20 that may restrain the depth of activity and may impact on the achievements in the 2019/20 financial year. As part of this savings plan, the DHB will implement recommendations from the 'Resource Review' completed in June 2019.

Health equity

Health inequities are systematic, avoidable and unfair differences in health outcomes between different groups of people. This disparity in health outcomes affect how long people live in good health. They are often a result of differences in people's homes, education, childhood experiences, environments, jobs and employment prospects, access to good public services and habits.

Achieving equity within the New Zealand health system underpins all government priorities. The Waikato HSP supports this intent, and its implementation is underpinned by a commitment to health gain and equity for Waikato DHB priority populations.

The DHBs focus is on improving equity for Māori, people living in rural areas, people experiencing disabilities, and Pacific peoples. These population groups are very likely to experience inequity in both access to health services and health outcomes.

Health equity tools

The DHB utilises the following health equity tools to assess and identify disparities and outline activities for improving equitable access and outcomes:

- The Health Equity Assessment Tool (HEAT).
- Equity of Health Care for Māori: A Framework.
- 'Ala Mo' ui: Pathways to Pacific Health and Wellbeing 2014-2018 as guidance for service design and development.
- Health improvement process (Waikato Public Health) – a whānau ora centred consistent framework for implementing the settings based approach and has an intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities.

Waikato Public Health has significant expertise in understanding population needs. Work is currently underway to strengthen service activity integration to enhance system development and service responsiveness, particularly for Māori and other priority populations.

Māori health

Māori as a population group experience the poorest health outcomes, and the DHB has an explicit focus on achieving equity for Māori across their life course.

Ki te Taumata o Pae Ora is Waikato DHBs draft Māori Health Strategy. It identifies key elements required to improve Māori health across the DHB. The operative plan – Ki te Taumata o Pae Ora 2016-17 – is in the process of being updated. This revised Māori Strategy will support the DHBs broader planning for Māori health gain and achieving health equity for Māori. Ki te Taumata o Pae Ora means to reach the pinnacle of a healthy future and as He Korowai Oranga[5] outlines this encapsulates, healthy individuals, healthy whānau and healthy environments.

Māori whānau, hapū, and iwi want to have control over their own destinies, to live longer and enjoy a better quality of life, to confidently participate in te ao Māori and to feel valued as a member of their communities and environments. This aligns to the Waikato DHB value of Te iwi ngākaunui (People at heart).

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

Equitable Outcomes Actions (EOA)

There is a Ministry requirement that all equity actions specifically designed to reduce health outcome equity gaps be identified with 'EOA.' Any action marked with EOA should:

- Specify the equity gap that the action is targeting
- Identify the population group the action will improve equity for
- Specify how success will be measured and monitored.

In addition to the Ministry's EOA requirements, Waikato DHB is trialing a tool that will help prioritise investment based on whether it will drive radical improvements to Māori health.

The Radical Improvements to Māori Health Tool is based on the principles of Partnership (governance and decision-making), Participation (workforce and whānau), Protection (targeted approaches and services), and Pono (tikanga). It will support DHB planning and funding decisions that will enable the achievement of a key Waikato DHB strategic objective: Radical improvement in Māori health outcomes by eliminating health inequities for Māori.

This tool will be used across the activities in this plan to assess if an activity is an EOA for Māori i.e. activity marked (EOA Māori).

The DHB will aim to develop a similar tool for our remaining priority groups (Pacific peoples, people who experience disabilities and people living in rural areas) to help assess activities in the future.

Responding to the guidance

The 2019/20 Annual Plan is a further refinement of the 2018/19 Annual Plan, however the priorities have been updated to reflect the Minister's direction which in turn will contribute to achieving the Government's priorities.

The health and disability system outcomes framework supports a stable system by articulating what outcomes the system intends to achieve for New Zealanders, and the areas of focus through which to obtain those outcomes. Figure 7 shows the elements of the health and disability system outcomes framework.

In responding to this guidance, engagement with relevant stakeholders has been undertaken to support development of this document.

Regional Service Planning

The 2019/20 regional planning priorities identified by Government for 2019/20 regional service planning are:

- Data and digital
- Workforce
- Hepatitis C
- Cardiac and stroke services; and
- Implementation of the New Zealand Framework for Dementia Care.

Government planning priorities

Government priorities and desired outcomes for New Zealand include planning priorities for health, wellbeing and equity. The 2019/20 annual planning priorities for all DHBs are:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by a strong and equitable public health and disability system
- Better population health outcomes supported by primary health care; and
- Strong fiscal management.

[5] New Zealand Māori Health Strategy (2014)

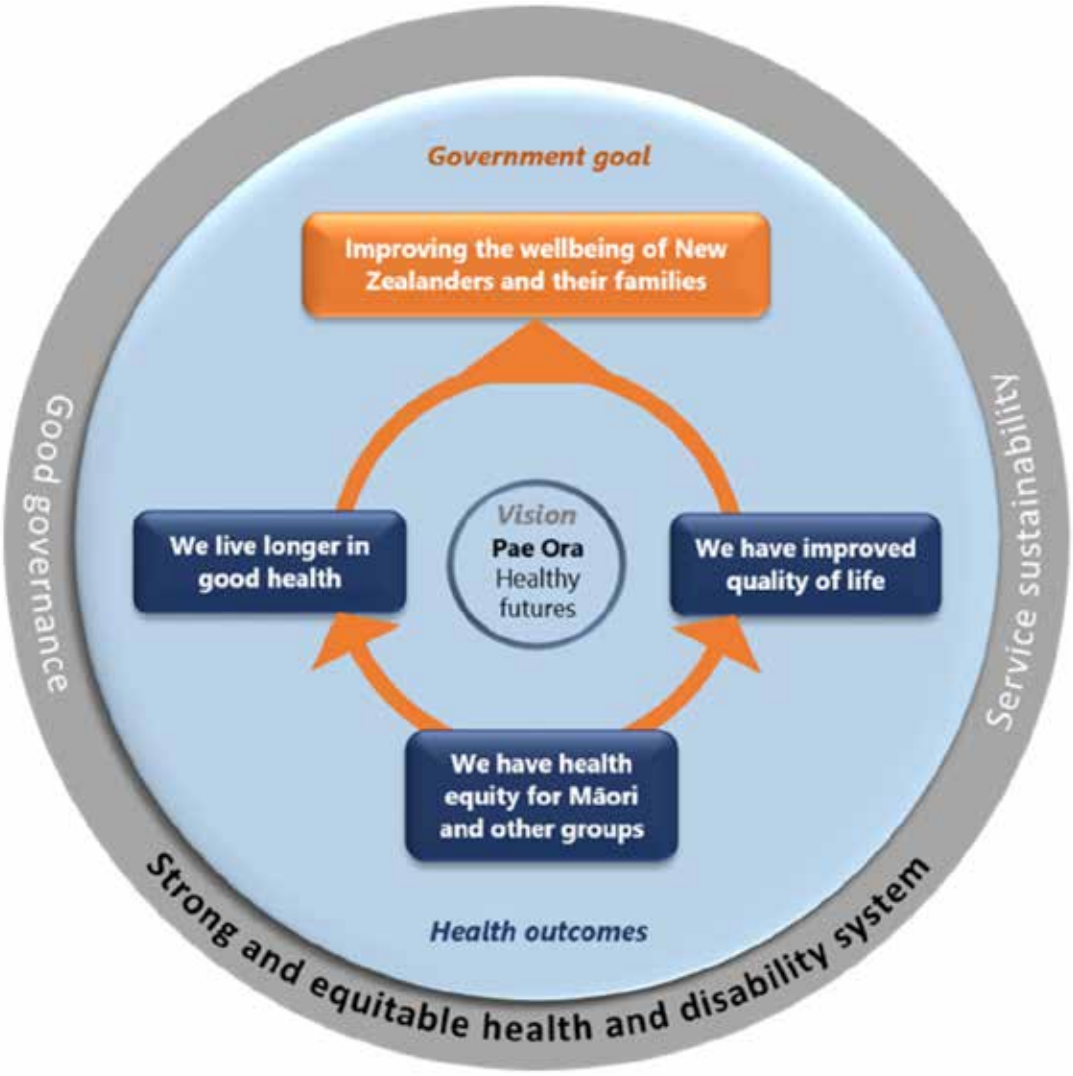


Figure 7: The health and disability system framework elements (Ministry of Health, 2019)

Table 2: Waikato DHB 2019/20 Annual Plan activities

Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
Improving child wellbeing	We have improved quality of life, We have improved health equity, for Māori and other groups, We live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	Productive partnerrships	**Immunisation** Waikato DHB continues to proactively work with all key partners to significantly improve the immunisation performance across all key milestone ages up to age 5 years and ensure at least 95 percent of children are immunised on time. To continue to progress towards this target in 2019/20 the DHB will: Implement the agreed immunisation action plan to achieve all key milestone immunisations until school age. Reconfigure the Outreach Immunisation services. (EOA Māori) Trial an expansion of outreach immunisation for high need/ Māori whānau in partnership with Waikato DHB funded Hapu Wananga pregnancy and parenting courses. Work with Māori providers of Well Child Tamariki Ora services to identify the reasons for lower immunisation rates within their cohort of children, and the potential solutions, support and resources required to lift on time immunisation rates for Māori. (EOA Māori) Provide immunisation teaching for medical students, practice nurses, public health nurses and GP registrars.[6] (EOA Māori) Support work on enabling a Māori community led approach to immunisation.[7] (EOA Māori) Support work on a pilot of pharmacy provided scheduled childhood vaccinations.[8]	 Q1 and ongoing Q4 Q1 Q1 Q1 and ongoing Q1 and ongoing Q1 and ongoing	CW05 CW08 Annual plan actions – status update reports
			Safe, quality health services for all	**School-based health services** Waikato DHB is committed to providing quality services to youth, to achieve this the DHB will: Monitor progress and provide quantitative reports in quarter two and four on the implementation of school based health services (SBHS) in decile one to four secondary schools, teen parent units and alternative education facilities. To implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS, the following activities will be completed: • Ensure there is a commitment to implementing the Quality Improvement Framework with our School Based Health Services within provider contracts. • Work with our providers to assist in establishing the framework in each school. • Ensure there are processes in place for regular consultation with youth, and particularly Māori youth to inform on-going service planning. To improve the responsiveness of primary care for our youth, the following activities will be completed: • Form a youth consumer advisory function to inform a Rangatahi Plan. • Provide quarterly narrative reports on the actions of this group to improve the health of our youth population. Ensure equity focused member representation on this group. • Review the process for signing up to e-Portal to make it easier for youth to access information and increase channels of communication in a more digitally appropriate/ youth friendly format. • Achieve a minimum 5 percent reduction in intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year olds through the Service Level Measures programme of work. Determine whether or not to carry out a Health Equity Assessment within SBHS in order to apply a health equity lens to the services, identify existing inequities along with service improvement opportunities to address inequities.	 Q2 and Q4 Ongoing Q3 Q1 Q4 Q4 Q4	CW11 CW12 Annual plan actions – status update reports

[6] Reporting for this activity will be completed by Waikato Public Health.
[7] Reporting for this activity will be completed by Waikato Public Health.
[8] Reporting for this activity will be completed by Waikato Public Health.

Table continues over page

Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
Improving child wellbeing	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	Effective and efficient care and services	**Midwifery workforce – hospital and Lead Maternity Carer (LMC)** Waikato DHB is committed to supporting its current and future midwifery workforce and will:		Annual plan actions – status update reports
				Continue implementation of the plan "Midwifery at Waikato DHB 2017-2021. Expectations, professional development frameworks and midwifery strategic aims." This plan outlines how the midwifery workforce capability, readiness and capacity will be built and key objectives that will ensure the needs of service users and communities are met.[9]	Q1 and ongoing	
				Encourage more Māori applicants by working with the Gateway Project to encourage Māori student interest in midwifery. (EOA Māori)	Q2	
				Progress towards the midwifery workforce being 23% Māori to reflect the demographics of our population.[10] (EOA Māori)	Ongoing	
				Offer all midwife applicants identifying as Māori an interview. (EOA Māori)	Q2	
				Engage with the WINTEC Employer Partnership Group to support students in order to reduce attrition rates.	Q2	
				Support employed graduate midwives through preceptorship, education and mentoring. This includes support for graduate LMCs when they access the secondary care facility.	Q1 and ongoing	
				Recognising that Māori midwives work with some of the most vulnerable and complex clients, develop supports for this workforce and enable Māori and Pasifika DHB employed midwives to culturally engage with Māori and Pasifika students. (EOA Māori and Pacific)	Q4	
				Identify what supports are required to allow registered midwives to work to the full breadth and depth of their scope.	Q3	
				Increase FTE to allow release time for midwives to access and participate in education and professional development.	Q4	
				Create Clinical Midwife Specialist roles for early pregnancy, vulnerable families and quality.	Q1	
				Build and strengthen alliances across and within the maternity sector, including education, non-government organisations (NGOs), primary, secondary and tertiary care.	Q1 and ongoing	
				Moving towards implementation of Care Capacity Demand Management (CCDM) for midwifery, Waikato DHB will:		
				Meet with the midwifery union to complete a CCDM plan that will then be included in work plans.	Q4	
				Ensure core data is consistent and actions against poor data quality are completed, this will include measuring Māori and Pacific retention and recruitment rates, using data, staff and patient satisfaction measures.	Q4	

[9] Full Midwifery at Waikato plan can be viewed at www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Strategies/105e6c7e66/Midwifery-at-Waikato-DHB.pdf

[10] Reported on via the workforce section

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Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
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				As part of a whole of system view, develop and commence implementation of Waikato DHB Tamariki Oranga Plan. **(EOA Māori)**	Q1 and ongoing	
				Consolidate the activity within the First 1000 Days into an integrated programme to provide a holistic, whānau centred care and support system for the parents, pēpi and whānau. This will focus on Māori, rural and parents with high needs. **(EOA Māori)**	Q4	
				Expand the Hapū Wānanga programme inclusive of the Harti mama assessment. **(EOA Māori)**	Q4	
				Launch the Waikato Community Breastfeeding Service into Hamilton and rural locations. This will be monitored and quality improvement methodology applied. **(EOA Māori and Rural)**	Q1	
				Develop healthy nutrition resources for the First 1000 Days.	Q2	
				Identify public health ways to respond to First 1000 Days mental wellbeing for hapū wahine (women), nga whaea and pāpara (new mothers and fathers), and pēpi (babies).[11] **(EOA Māori)**	Q1	
			Productive partnerships	**Family violence and sexual violence** **Waikato DHB is committed to reducing family violence and sexual violence by:**		Annual plan actions – status update reports
				Continue a Violence Intervention Programme (VIP) Advisory Group that includes senior clinicians, quality improvement, HR, Māori and Pacific staff, Oranga Tamariki, Police, Women's Refuge, and PHOs. This group will support the implementation of the VIP strategic service plan (2018/21); and take a broader DHB and community focus with the view to developing partnership opportunities with these agencies and community. The VIP advisory group will hold quarterly meetings where progress against the action plan will be monitored and reported. **(EOA Māori)**	Q1-Q4	
				VIP continue to provide staff training on how to respond to child abuse and neglect and intimate partner violence. This is supported by policy and monitored through the staff training plan. A report on staff training will be completed through the six monthly contract reports.	Q1 and ongoing	
				Promote a DHB Employee Assistance Programme (EAP) or equivalent as a means for offering support to DHB employees who are victims or perpetrators of violence and abuse. A report on promotion activities will be available six monthly.	Q2 and Q4	
				Improve health pathways for women and children known to Women's Refuge. A progress report will be completed by the VIP advisory group.	Q4	
				Embed the national child protection alert system enabling child protection alerts and birth plans to be generated in a timely way in collaboration with LMCs and Oranga Tamariki. The VIP action group will monitor progress and whether the system is successful. CPAs are reported quarterly to MoH. Any challenges identified will be raised with the Ministry through quarter four report.	Q4	
				Employ a permanent midwife specialist for the vulnerable unborn.	Q2	
				Cases of referred child sexual abuse will continue to be prioritised. Providing timely access for children to specialist services in collaboration with Police and Oranga Tamariki.	Q1 and ongoing	
				DHB VIP will take action to ensure VIP is culturally competent by: • Ensuring that Māori and Pacific staff are represented and contribute to the VIP Governance Group, staff training, implementation and audit processes. **(EOA Māori and Pacific)**	Q1 and ongoing	
				• Including cultural responsiveness as part of the VIP training programme. This will be evaluated as part of the evaluation activities domain of the VIP audit tool. **(EOA Māori)**	Q4	
				• Building relationships and referral pathways with iwi, Whānau Ora providers and Māori services. **(EOA Māori and Pacific)**	Q1 and ongoing	
				Waikato DHB will complete annual self-audits of our VIP programme using the current Delphi tool to provide information to the DHB, Auckland University of Technology and the Ministry on the 9 required domains including: organisational leadership, training, ViP practice, cultural responsiveness, collaboration etc.	Q2	

[11] Reporting for this activity will be completed by Waikato Public Health.

Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
			People centred services	**Sudden Unexplained Death in Infancy (SUDI)** Waikato DHB is committed to reducing the rate of SUDI and will:		Annual plan actions – status update reports
				A minimum of 1000 safe sleep devices will be distributed to appropriate families/whānau.	Q4	
				Expand Hapū Wānanga to cover a wider range of rural areas and reach the targeted population with key risk factor messages relating to safe sleeping, breastfeeding and smoking cessation. (EOA Māori)	Q4	
				Increase referrals from Hapū Wānanga to the *Once and For All* smoking cessation service. (EOA Māori)	Q1 and ongoing	
				Introduce Whare Ora refresher training on hospital wards and provide a presentation to Midwives, kohanga, daycare and attend community events to increase knowledge and referrals. (EOA Māori and Pacific)	Q1 and ongoing	
				Improve access to lactation support services in rural locations to increase breastfeeding rates.	Q1 and ongoing	
				Hold a workshop wānanga for Tamariki Ora Well Child providers to train, refresh and emphasise the SUDI risks and risk reduction techniques. These workshops will target Māori and Pacific communities. (EOA Māori and Pacific)	Q2	
				Develop and distribute a Māori breastfeeding resource package. (EOA Māori)	Q4	

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Improving mental wellbeing	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	**Health equity for high need populations**	**Inquiry into mental health and addiction** Waikato DHB is committed to implementing the agreed actions following the Mental Health and Addiction Inquiry Report and will: **Embedding a wellbeing focus** • Implement the DHB Mental Health and Addictions Strategic Directions Framework which includes a new model of care for mental health and addictions that has a focus on wellness. • Through the SLM 2019/20 Improvement Plan, primary healthcare organisations will educate general practice teams in Equally Well approaches to improve access for Māori men with serious mental health issues to CVRA. (EOA Māori) **Building the continuum / increasing access and choice** • Establish a new Mental Health and Addictions Alliance to oversee the implementation of services under the DHBs Mental Health and Addictions Framework will build on partnerships with Māori, Pacific people, young people, people with lived experience, NGOs, primary and community organisations, and other stakeholders to plan an integrated approach to mental health, addiction and wellbeing for the Waikato DHB. (EOA Māori and Pacific) • Work with local district councils to establish a community prevention and promotion focus for the Waikato Plan. • Implement revised primary mental health service specifications to broader the access to psychological therapies. **Suicide prevention** • Provide suicide prevention training tailored to specific audiences; coordinate suicide prevention activities for the Waikato DHB area, encourage suicide prevention work using a community development approach and working with the Mental Health and Addictions Services on community-based preventative initiatives such as the 'Let's Talk Wellbeing.' • Postvention work includes initiating the acute inter-agency postvention response and managing the bereavement counselling referrals. • Continue to contribute to the implementation of the Suicide Prevention Strategy. **Crisis response** • Grow the capacity of the crisis short term care pathway. • Establish overnight awake crisis staff. • Establish a consolidated acute response team on the Pembroke Street (Hamilton) site. **NGOs** • Apply the cost pressure funding to the NGO mental health and addictions agreements. **Workforce** • Pilot a Peer Support Training Programme. • Develop and implement a refreshed approach to recruitment to mental health and addictions which incorporates new branding, enhanced relationships with education providers engaging rangatahi/ youth in mental health and addictions as career options. • Create and implement an employee wellbeing programme. • Embed and refine mental health and addictions orientation. • Establish cultural competence framework for Mental Health and Addictions service. **Mental Health and Wellbeing Commission** • Work collaboratively with any new Commission, once it is established. **Forensics** • Contribute to the Forensics Framework.	Q1 and ongoing Q4 Q1 Q2 Q1 Q4 Q4 Q4 Q1 Q2 Q4 Q4 Q4 Q2 Q1 Q2 Q4 Q4	MH01 MH02 MH03 MH04 MH05 MH06 Annual plan actions – status update reports

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				Commence implementation of Waikato DHB Mental Health and Addictions Strategic Directions Framework including a new model of care.	Q1 and ongoing	
				Establish a Mental Health and Addictions Alliance to oversee the implementation of services under the DHBs Mental Health and Addictions Framework.	Q4 and ongoing	
				Develop a detailed business case for new acute inpatient mental health facilities.	Q1	
				Partner with Department of Corrections to develop mental health and forensic models of care in relation to the future Waikeria Prison expansion.	2019-2022	
				Improve capability of Waikato Public Health staff in the mental health and wellbeing area through increased literacy.[12]	Q1 and ongoing	
				Develop initiatives that focus on addressing the current high levels of adult inpatient occupancy and improving the patient flow:		
				• Undertake a procurement process for a new community based acute care alternatives to hospital based inpatient services.	Q2	
				• Undertake a full review of respite services.	Q1	
				• Develop and implement a programme to better support individualised solutions for complex clients living in the community.	Q1	
				• Design and develop a range of housing alternatives for the mental health service tangata whaiora. **(EOA Māori)**	Q3	
				• Establish a data set such as 'Knowing the People Planning' to better understand and respond to tangata whairoa needs.	Q1 and ongoing	
				• Re-establish a comprehensive approach to people with a complex borderline personality disorder (BPD) including a consistent approach to management and treatment planning and use of dialectical behavioural therapy (DBT).	Q2 and ongoing	
				• Support key community settings to destigmatise mental illness/issues; and raise awareness regarding mental wellbeing via the Waikato Plan.	Q3	
				• Implement the recommendations from the infant, child and adolescent mental health service (iCAMHS) review and identify activities to improve access and quality for children in the service.	Q1 and ongoing	

[12] Reporting for this activity will be completed by Waikato Public Health.

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				Enable a mechanism for counting discharge plans to be added to the adult community and inpatient electronic recovery plan forms. This will ensure accurate reporting of the number of patients with a discharge/transition plan.	Q1	
				Complete a co-design approach to seclusion elimination.	Q4	
				Remove one seclusion room in the intensive psychiatric care (IPC) area – ward 36.	Q2	
				Develop a flip chart that includes seclusion prevention strategies, alternatives to seclusion, de-escalation, sensory modulation, seclusion documentation criterion, care planning for secluded service users, risk assessment and decision making tools. Prompts for ending seclusion and post seclusion de-briefing will also be included.	Q4	
				Introduce the dynamic appraisal of situational aggression (DASA) across the inpatient setting to minimise the likelihood of aggression (due to early intervention), subsequent assault and restrictive practice. Ongoing promotion, role modelling and communication.	Q1 and ongoing	
				Complete a post seclusion review (staff member and service user interview) after each seclusion event to gather information that will inform acute care interventions and rebuild relationships through understanding.	Q1 and ongoing	
				Have Kaitakawaenga available on the wards across the Mental Health and Addictions service to provide cultural support, advocacy and education. **(EOA Māori)**	Q2	
				Work on more collaboration between inpatient and community services to develop interventions for managing deteriorating mental health and clear indications for when different treatment options are to be utilised.	Q2 and ongoing	
				Near complete roll out of safe practice effective communications (SPEC) across the inpatient setting – least restrictive approaches.	Q4	
				Introduce DASA across the inpatient setting to minimise the likelihood of aggression (due to early intervention), subsequent assault and restrictive practice. Ongoing promotion, role modelling and communication.	Q4	
				Continue plan-do-study-act (PDSA) cycles for post seclusion reviews.	Q4	
				Complete PDSA cycles for DASA scores and plans to manage potential aggression.	Q4	
				Complete de-escalation scenarios – SPEC instructors will provide ongoing sessions to clinical staff to build confidence when dealing with challenging situations.	Q4	

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				Implement equity tools to identify the most effective interventions for achieving Māori health equity. (EOA Māori)	Q2	
				Establish partnerships with Māori service providers and co-design mental health and addictions service (MH&A) service delivery closer to home. (EOA Māori)	Q1 and ongoing	
				In partnership with local iwi providers, improve local points of service access. This is a new initiative to have a mental health clinician, alcohol and drug worker providing support and access at the Waharoa Hauora Clinic on a weekly basis. (EOA Māori)	Q1 and ongoing	
				Co-design of new acute facility development in association with staff, tangata whaiora whānau and key stakeholders. (EOA Māori)	Q1 and ongoing	
				Ensure Me Kōrero Tātou Report from community hui is used to inform the provision of person centred and whānau inclusive care. (EOA Māori)	Q1 and ongoing	
				Establish links to local tertiary education institutions to inform tertiary education providers around the requirement of a workforce that is work ready and culturally competent. (EOA Māori)	Q1 and ongoing	
				Deliver community Mental Health and Addictions service closer to home working in partnership with primary and other community services. (EOA Rural)	Q4	
				Partner with the Department of Corrections for the development of new fit for purpose acute forensics and mental health services at Waikeria Prison.	Q4	
				As a result of the recent "Let's Talk" hui, the Mental Health and Addictions has received valuable input from LGBTIQ focus groups that were held. This input will be referred to and included in future service quality improvement initiatives.	Q1 and ongoing	
				Ensure Mental Health and Addictions service receives ongoing input from the LGBTIQ community through representation on the Creating Our Futures Advisory Group.	Q1 and ongoing	
				Maternal mental health services The Waikato DHB Maternal Mental Health service is committed to improving access and outcomes for our population, especially its Māori and Pacific women. This will include:		MH01 MH02 MH03 MH04 MH05 MH06 Annual plan actions – status update reports
				Work to improve the primary care response to maternal mental health need Improve response to the need of Māori and Pacific mothers in the community. (EOA Māori and Pacific)	Q4	
				Complete the Southern Rural maternity project. This will improve equity of access for rural women to specialist support services. (EOA Māori and Rural)	Q3	
				Fund 1.2 FTE psychiatrist support across all PHOs to provide advice, training and support to GPs. Women who present to their GP with primary maternity mental health needs will receive the right care from their primary care team, be referred to counselling and psychology services or be referred onto secondary care as appropriate.	Q1 and ongoing	
				Establish the Maternity Resource Centres at Taumarunui and Tokoroa. (EOA Māori, Pacific and Rural)	Q4	

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				Climate change Waikato DHB is committed to addressing climate change and will: Reduce hospital food wastage through the implementation of new integrated software that will help accurately forecast the amount of food to purchase and prepare based on trend information of actual patient meal orders. Develop and implement a transport plan for the Waikato Hospital campus that has a focus on travel demand management and sustainability. Develop a DHB Sustainability Position Statement with support from Waikato Public Health. [13]	 Q2 Q1 and ongoing Q4	Annual plan actions – status update reports
				Drinking water Waikato DHB recognises water as a taonga and a life sustaining resource. This is why it is committed to supporting Waikato Public Health's role in regard to drinking water standards and will: Support Waikato Public Health to undertake all duties and functions required by the Health Act 1956. Support Waikato Public Health to implement the requirements of the Drinking Water Standards for New Zealand. Support Waikato Public Health's participation in or input into national or other changes linked to drinking water as required on factors outside of Waikato Drinking Water Assessment Service's direct control.	 Q4 Q4 Q4	Annual plan actions – status update reports
			People centred services	**Healthy food and drink** Waikato DHB is committed to creating supportive environments for healthy eating and healthy weight, and will do so by undertaking the following activities: Review and implement an updated DHB Healthy Food and Drink Policy with support from Waikato Public Health. Contracts held between the DHB and provider organisations will include a clause stipulating the expectation they develop a Healthy Food and Drink Policy.[14] Develop a healthy weight programme that will include determining effective intervention opportunities that build on current activities i.e. across the continuum of care from prevention to specialist services. Engage and support key community settings (education, Māori and Pacific and workplaces) via the nutrition and physical activity strategy group to inquire, plan and transform food environments and physical activity levels.[15] Support iwi to develop and implement healthy food and drink policy on marae. (EOA Māori) Continue to support our settings (education, Māori and Pacific, and workplaces) in developing and implementing healthy food and drink policies including water only policies.[16] (EOA Māori and Pacific) Report in quarter 2 and quarter 4 on the number and proportion of schools, kura and early learning services that have a) a healthy food policy, and b) are water or plain milk only.	 Q4 Q4 Q3 Q1 and ongoing Q1 and ongoing Q1 and ongoing Q2 and Q4	Annual plan actions – status update reports

[13] Reporting for this activity will be completed by Waikato Public Health.
[14] Excluding inpatient meals and meals on wheels.
[15] Reporting for this activity will be completed by Waikato Public Health.
[16] Reporting for this activity will be completed by Waikato Public Health.

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Improving wellbeing through prevention	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	**Health equity for high need populations**	**Smokefree Aotearoa 2025** Waikato DHB is committed to Smokefree 2025 and will: Expand the Tupeka Kore programme, a stepwise, co-designed policy change management programme that has been successfully implemented in Waikato Hospital Maternity service to support women and whānau to be smoke free. (EOA Māori) Introduce new requirements that funded services actively contribute to eliminating smoking for Māori. New reporting and monitoring systems will also be introduced to support the move to Smokefree 2025. (EOA Māori) Actively support the expansion of Tupeka Kore to include LMCs, Primary Birthing Facilities, general practices, and community organisations, particularly those with significant engagement with Māori. (EOA Māori) Linked to the above, DHB will work with all government agencies and services operating within the DHB area to demonstrate the same active commitment to supporting Māori to be smoke free and provide support where appropriate and possible. (EOA Māori) Build on the DHB smoking cessation service directly funded by Ministry of Health by actively promoting the service to potential referrers. Redevelop the Smokefree Action Plan with a stronger focus to achieve the smokefree 2025 target.	 Q4 Q4 Q1 and ongoing Q1 and ongoing Q1 Q3	CW09 SS06 PH04 Annual plan actions – status update reports
				Breast screening Waikato DHB is committed to reducing mortality and morbidity from breast cancer and improving equitable access to screening and will: Breastscreen Midland and DHB activities: **Increase participation rates for Māori and Pacific Islands women** (EOA Māori and Pacific) • Implement recommendations from the 2018/19 invitation process review. • Continue to deliver on Māori first timer text project. • Extend first time text project out to Pacific Islands' women. • Implement a targeted initiative to improve Māori rescreening rates. • Continue to work with Bay of Plenty DHB on 'Test for Change' initiatives. • Extend out the 'test for change' initiatives into Waikato DHB • Provide a "WOF" day/Mana Wahine day in the Bay of Plenty and Waikato regions. • Complete a feasibility study on remote access to GP patient management system systems to provide able to contact women on behalf of the practice for breast screening. • Complete a promotion in Hamilton GP practices around Mother's Day or Matariki rewarding the practice with the most Māori enrolments. • Participate in the opportunity to facilitate Māori focus groups on improving rescreening to the programme with Ministry of Health / Breastscreen Aotearoa. • Develop and implement two targeted campaigns (including a repeat DNR project as one project) where there is higher Māori population. • Ensure Kaitiaki support is provided during the mobile visit in Te Kuiti and Tokoroa. **Deliver on actions within Breastscreen Midland Communications and engagement plan, focussing on Māori wahine** (EOA Māori) • Review and maintain a current communications and engagement plan which focuses on Māori participation awareness and promotion. **Improve engagement and awareness of the programme to key stakeholders** • Deliver a continuing nurse education – Nurse/primary care evening in South Waikato. • Deliver a continuing medical education – GP evening in Western Bay of Plenty area.	 Q2 Q4 Q3 Q3 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2	PV01 Annual plan actions – status update reports

Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
Improving wellbeing through prevention	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	**Health equity for high need populations**	**Cervical screening** Waikato DHB is committed to reducing mortality and morbidity from cervical cancer and improving equitable access to screening and will: **Achieving participation** Provide support to medical centres in Waikato with the lowest uptake and high numbers of eligible Māori and Asian women. Deliver an Asian centred awareness campaign in collaboration with PHOs and Family Planning. Work with PHOs on opportunities to promote and screen focussing on groups through Waikato settlement centre and other Asian communities. Work with and fund the PHOs to identify women who are significantly overdue, contact these women, provide education and support to the general practice for cervical screening. Provide dual breast and cervical screening clinics to overdue priority women. Support each practice to have a system in place and operating so woman are screened within three years. **Eliminate equity gaps** Provide cervical smears at no cost to all eligible Māori, Pacific Islands and Asian women. Work collaboratively on a project with PHOs: an initiative to recall women at least eight weeks before the test is due (more in priority group women, and with women with a history of being slow to respond). Work with the support to screening services providers to ensure support to colposcopy occurs in a timely manner with successful outcomes (in terms of support for the wahine). Support home based smear taking.	DHB selected milestone	PV02 Annual plan actions – status update reports

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Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
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Better population health outcomes supported by strong and equitable public health and disability system	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	**Productive partnerships**	**Engagement and obligations as a Treaty partner** Waikato DHB is committed to the principles of Partnership, Participation and Protection under the Treaty of Waitangi and will work to ensure that our Māori population experience equitable health outcomes. Some key activities include to:		SS12 Annual plan actions – status update reports
				Partnership Take account of the Memorandum of Understanding agreed between the DHB and Iwi.[17]	Q1	
				Include Māori leadership and expertise in appropriate governance groups.[18]	Q1 and ongoing	
				Include Māori representation on appropriate decision making groups.[19]	Q1 and ongoing	
				Present equity assessments for all projects and applications for funding.[20]	Q1 and ongoing	
				Focus on engagement and productive partnerships in Māori communities to improve Māori wellbeing (whānau ora) and health equity. (EOA Māori)	Q4	
				Participation Work with Māori to understand locality priorities, the resources they have, and agree on a plan to support the localities. (EOA Māori)	Q3	
				Protection Reduce the rate of outpatient appointment "did not attends" (DNAs) for Māori to ≤10%.	Q4	
				Support kaupapa Māori services to operate in the Waikato through targeted investment and co-designed service agreements.	Q4	
				Expand the supported transfer accelerated rehabilitation team (START) service to reduce avoidable ED presentations for Māori.	Q1	
				Develop an equity position statement. (EOA Māori)[21]	Q4	
				Develop agreed Māori equity KPIs that will be included in appropriate provider contracts for 2020/21.	Q3	
				All clinical service plans to include actions that are targeted to eliminate the inequitable health outcomes experienced by Māori.	Q4	
				In conjunction with the iHub service manager, set increased targets of Māori given opportunistic screening and immunisation at iHub and continue work to achieve those targets.	Q4	
				Incorporate tikanga principles into employment processes.	Q1 and ongoing	

[17] To view the full MoU visit https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/3ed11109ef/Iwi-Māori-Council-and-Waikato-DHB-memorandum-of-understanding.pdf
[18] Appropriate Governance groups include the DHB Community Public Health Advisory Committee (CPHAC).
[19] Appropriate decision making group includes the Executive Leadership Team.
[20] Reporting for this activity will be completed by Waikato Public Health.
[21] Reporting for this activity will be completed by Waikato Public Health.

Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
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Better population health outcomes supported by strong and equitable public health and disability system	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	Productive partnerships	**Delivery of Whānau Ora** **Waikato DHB will demonstrate commitment to the strategic change for Whānau Ora approaches by:** Establishing a Strategic Development Group to identify opportunities that **(EOA Māori)**: • support shared understanding of what whānau-centred approaches and whānau ora approaches mean across the DHB and how they contribute to health improvement • support provider development • support sustainability of Māori and Pacific providers and Māori models of practice • increase expectation of whānau-centred service provision with all providers • support service development • prioritise the expansion of whānau ora navigation services with Māori and Pacific providers • work to inform planning for next 3-5 years • start to review and reconfigure DHB systems and services to ensure they deliver whānau-centred approaches that contribute to Māori health advancement and also achieve health equity • ensure that the Clinical Services Implementation Plan includes some activities around whānau ora approaches. **Waikato DHB will support collaboration, including through investment, with the Whānau Ora Initiatives and its Commissioning Agencies and partners, to identify opportunities for alignment and will:** • Establish a formal working relationship with the Whānau Ora Initiatives and its Commissioning Agencies and partners to contribute to Māori and Pacific health advancement and to achieve health equity, including **(EOA Māori and Pacific)**: – Agreed working arrangements – Clear understanding of the strengths, weaknesses, opportunities and challenges facing parties, – Exploration of opportunities for alignment – Prioritise future investment/disinvestment to support Whānau Ora centred services and Whānau Ora approaches.	Q4 Q4	SS17 Annual plan actions – status update reports
				Care Capacity Demand Management (CCDM) **Waikato DHB will progress each of the five components of the CCDM programme with a key focus on:** **Governance** The CCDM council is in place and has been functioning for 18 months. In 2019/20 we will complete our partnership workshop and will implement the maternity MEARS and allied health streams of CCDM. Local data groups will run in all areas quarterly however, as more core data becomes available we aim to have these monthly by 2021. **Patient acuity data** Currently the assignment work load manager tool (AWM) is the acuity tool for Waikato DHB. This is mature having been in the DHB for over five years. All wards except for mental health have been rolled out and it has been used to assess and adjust FTE. A business case is in development, if this goes ahead we will move to 'TrendCare' with an implementation date of July 2020, to have a year's data by 2021 and be able to complete the FTE calculations using the tool within Safe Staffing Healthy Workplaces. **Core data set** We have employed a CCDM analyst, who currently has seven out of 23 measures in place. The time line is to have all 23 data sets available monthly by early 2020. We are using the 'Qlick' tool to assist with this. The core data working group is finalising data sources and process. **Variance response management (VRM)** The operations centre will move to using the CCDM tools within the centre. We have a culture of moving staff around to where they are needed so for the next year we will be focussing on the care essentials and Standard Operating Procedures to manage escalations. A business case for the hospital at a glance screens will be completed.	Q4 Q4 Q4 and ongoing Q4 Q4	Annual plan actions – status update reports

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				• Patients on wait lists at three months will be reviewed weekly to ensure intervention is received on time.	Q1 and ongoing	Annual plan actions – status update reports
				• Review options and work towards the introduction of an acuity tool to ensure all patients are seen at the appropriate clinical timeline.		
				• Work towards a single point of entry for all spine referrals to provide increased flexibility and capacity for spine surgeries within the DHB.	Q4	
				• Implement a musculo-skeletal programme to shift patients to a non-invasive treatment plan, avoiding surgical intervention where appropriate. This will help manage the wait times for spinal and orthopaedic work by reducing the number of patients requiring FSA to the musculo-skeletal programme by 420 per year (35 per month).	Q1 and ongoing	
				Delivery and improvements will be measured against the agreed Planned Care measures quarterly.	Q1-Q4	
				Waikato DHB will use the Wai 2575 report to identify gaps and equity issues across services and to inform change. A key focus will be to work towards reducing Māori DNA rates to <=10%. (EOA Māori)	Q4	
				Combine the current two hospital wait lists for colonoscopy (Waikato and Thames Hospital) to become one waitlist. This will support equitable wait times for the total population regardless of the patient's locality or hospital providing intervention.	Q4	
				Begin development of a three year plan for Planned Care based on Ministry's five guidance parameters:	Q1/Q2	
				• Draft plan to be available for consultation with key stakeholders.	Q2/Q3	
				• Final draft plan to be submitted to Ministry for approval.	Q3/Q4	
				• Begin implementation of the three year plan.	Q4 and ongoing	
				Disability Waikato DHB is committed to ensuring that all people who experience disability have a positive and equitable experience when interacting with the health system, to ensure this it will:		Annual plan actions – status update reports
				Provide staff training on how to interact with people experiencing disabilities through the "Supportive Employment" stream of work for 2019/20. Once the new HR information system (HRIS) has been implemented we will monitor training completions. (EOA Disability)	Q1 and ongoing	
				During a face-to-face patient interaction, if a patient discloses any disability, update the patient management system (iPM) to include a 'Patient Alert'. This information will also be populated into Clinical Work Station (CWS). All clinicians have access to CWS and administrators have access to iPM. (EOA Disability)	Ongoing	
				Develop the disability responsiveness plan and the disability profile for the Waikato DHB population. (EOA Disability)	Q4	
				Include a clause in provider contracts that specifies the requirement for them to have disability access. (EOA Disability)	Q4	
				Develop and implement a community health pathway for primary care to respond to the needs of people experiencing physical disabilities. (EOA Disability)	Q3	
				Improve access to health services for people experiencing disabilities, and progressively integrate health and disability services. (EOA Disability)	Q1 and ongoing	

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				Scope the required work for systematically organised collection of medical terms (SNOMED) coding in our emergency department (ED) during the FY20 year, including consideration of appropriate system development environment. As the DHB is scheduled to move onto the regional Midland Clinical Portal by 2021/22, careful consideration needs to be given to developing the solution for this requirement in the appropriate system, to avoid developing the functionality twice in both legacy and future systems. Additionally, the impact on required IT equipment in ED is likely to be significant.	2019-2021	
				Implement the System Level Measure (SLM) Improvement Plan which contains activities to improve management of patients who present to ED with long term conditions.[22]	Q4	
				Ensure that primary options for acute care (POAC) and urgent and emergency care lead to new arrangements with GPs and urgent care facilities to avoid acute admissions.	Q1 and ongoing	
				Establish a whole of system group[23] to address high and complex users of ED with the aim to put collaborative management plans in place with primary care partners.	Q1	
				Complete a review of our current advanced care planning (ACP) activity, and propose opportunities for change.	Q2	
				Implement the re-developed ACP activity approaches across clinical and community care.	Q4	
				Complete a minimum of 600 ACPs as a result of our new model.	Q4	
				Waikato DHB is committed to undertaking actions to improve ED patient flow and will: Adopt and implement the strategy Manaaki Mana: Excellence in Emergency Care for Māori in the Waikato Hospital Emergency Department. This strategy is to deliver equity for Māori in ED, led by the ACEM Manaaki Mana Steering Group. Actions will include EOA (Māori): • Te Reo training for all ED doctors and nurses, health care assistants (HCAs) and clerical to address patients correctly with correct pronunciation of names • care and decision making conducted in partnership with whānau • response to complaints will be culturally appropriate, taking place at face to face meetings with whānau rather than a response in writing.	Q4	
				Mental health presence in ED Continue to have a mental health nurse practitioner and team of mental health registered nurses based in ED seven days a week to provide an increased presence and service to patients. This service is not currently 24/7 and attendance will be measured against the shifts that they are not in attendance to ensure wait time reduction for those patients requiring mental health and/or addictions services.	Q2	
				Kaitiaki Increase Kaitiaki presence in the ED and work with Te Puna Oranga to have an on call resource outside of normal working hours seven days a week to help families/whānau in times of stress with support for families who have patients in resus/ trauma or critically unwell. (EOA Māori)	Q2	
				Family/whānau room Provide a space in the ED for patient's whānau to wait that is culturally appropriate and has resources available to support the families attending the ED.	Q2	

[22] See appendix B for 2019/20 SLM Improvement Plan

[23] This group is called the "High and complex user group" and includes the senior medical officers of the DHB provider arm, community services, primary care, St John and urgent care leadership.

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				Reorient primary and community health services to enable solutions to be delivered that meet the needs of local communities. (EOA Māori and Rural)	Q4	
				Work with Māori and other partners to understand locality priorities, the resources they have, and agree on a plan to support the localities. (EOA Māori)	Q4	
				Resource and support communities to facilitate community development and leadership.	Q3	
				Complete the Southern Rural Maternity Project which will include the refurbishment of the Tokoroa hospital primary birthing unit and implementation of a new roster that is supported by midwives and lead maternity caregivers working in the South Waikato. (EOA Māori)	Q3	
				Complete the refurbishment of Taumarunui hospital primary birthing unit. (EOA Rural)	Q3	
				Establish the Maternity Resource Centres at Taumarunui and Tokoroa. (EOA Māori and Rural)	Q4	
				Implement the Rural Lactation Consultant Service. (EOA Rural)	Q1	
				Improve equity of access for rural women to specialist support services by increasing community capability that supports breast feeding and provides mother to mother support groups. (EOA Māori)	Q4	
				Complete the single point of entry model of care in Taumarunui and move to business as usual. This project has been in partnership with Taumarunui Community Kokiriri Trust. (EOA Māori and Rural)	Q4	
				Whānau ora principles and approach are central to this model of care. As a result we expect: • a reduction in low acuity presentations to Taumarunui ED • re-engagement of people with their general practice or other primary care provider • ED being used for emergency care	Q1	
				Embed the locality framework and appoint locality leadership roles to lead local planning and improvement of health services. This will include locality networks with Māori, local providers and stakeholders to coordinate and improve health services and care. (EOA Māori and Rural)	Q3	

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				Continue to support the on-going delivery of the Kaumātua Day Programmes. This is a Māori cultural response to the Healthy Ageing Strategy framework. They vary from Community Day programmes as they are based on Māori principles of Manākitanga (looking after each other), Wairuatangata (spiritual growth), and whānautanga (importance of whānau) and allow kaumātua to whakawhānautanga (mix with their peers) in a culturally safe environment. (EOA Māori)	Q1 and ongoing	
				Work with ACC, Health Quality and Safety Commission (HQSC) and the Ministry of Health to promote and increase enrolment in strength and balance programmes and improvement of osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework (This expectation aligns most closely to the Government's 'Prevention and Early Detection' priority outcome; and the Ageing Well and Acute and Restorative Care goals of the Healthy Ageing Strategy).	Q1 and ongoing	
				Develop local protocols for working through the in-home strength and balance programme for cognitively impaired older people at risk of falls and fractures.	Q4	
				Regular communication with GP Practice nurses through Best Practice Advocacy Centre NZ (BPAC) to improve the programme's visibility.	Q1 and ongoing	
				The cross-sector Waikato DHB Falls Working Group to identify and understand the reasons for low referral volumes from ACC case managers.	Q3	
				Work with primary care providers to aged residential care with the aim to increase the prescribing of Vitamin D / cholecalciferol to age-related residential care residents – increase percentage of residents on Vitamin D from 65 percent to 75 percent.	Q1 and ongoing	
				Review the updated evidence (April 2019) on the HQSC website and map against current activity in Waikato DHB to identify opportunities.	Q1	
				Align local Waikato DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS (This expectation aligns most closely to the Government's 'Health Maintenance and Independence' priority outcome; and the Living Well with Long-Term Conditions goal of the Healthy Ageing Strategy).	Q3	
				Once the national framework and service specifications are made available to DHBs, implement a service development programme to identify actions needed across the HCSS sector.	Q4	
				Continue to support the multidisciplinary team[24] to review and manage older, frail and complex patients presenting to ED without a clear medical need for admission. This will review the needs of the patient and look towards alternatives to admission including the use of acute home based support, supported transfer and accelerated rehabilitation team (START), rest and recuperation and convalescent care.	Q1 and ongoing	
				Identify and implement alternative models for managing older patients who present to ED after a fall but do not need admission.	Q4	
				Increase the percentage of older people, of pacific island ethnicity, who have appointed an enduring power of attorney upon completion of a needs assessment. (EOA Pacific)	Q4	
				Focus on developing the Māori needs assessment and service coordination (NASC) services across the Waikato is to include a Pacific Island resource. This will enable a more culturally appropriate effective NASC for this Pacific population group.	Q4 and ongoing	

[24] Multi-disciplinary team led by an acute geriatrician and includes two clinical nurse specialists, an occupational therapist, a physiotherapist and a social worker

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[25] Reporting via the ambulatory sensitive hospitalisations (ASH) 0-4 SLM Improvement Plan 2019/20
[26] See full 2019/20 SLM Improvement Plan in appendix B

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				Complete a data cleanse and ensure systems are prepared for the DHB to join the National Bowel Screening Programme (NBSP) in 2021.	Q4	
				Work with primary care to establish NBSP pathway and promotion activity.	Q4	
				Monitor the Faster Cancer Treatment (FCT) achievement of the health target for patients on the lung cancer pathway, ensuring gains of the "one stop shop" model are embedded and maintained.	Q1 and ongoing	
				Increase resource for FCT nurse tracker (0.6 FTE increased to 1.0FTE), with a view to an increased focus on the 31 day target and pathway.	Q1	
				Engage with Te Puna Oranga and the cancer service's dedicated equity clinical nurse specialists to minimise inequity by addressing Did Not Attend appointments (DNAs and identifying barriers. This has been successful in reducing our Māori DNA rates to circa 6 percent, which is well below the DHB average. An on-going focus remains ensuring equity of access for Māori and Pasifika to complete their treatment. **(EOA Māori)**	Q1 and ongoing	
				Develop a building solution to the predicted capacity problem that will exist for both chemotherapy and outpatient department patients by 2021. The building proposal will include improved arrangements for handling acute admissions for patients experiencing complications with treatment. It will also include additional space to enable private confidential conversations, space for whānau to be with their loved ones, and a dedicated "education" area to enable proactive health education for lifestyle, treatment and on-going support options.	Business Case to Commissioners. Group in Q1.	
				Work with the national Breast Cancer Foundation to establish a pilot project for advanced breast cancer patients to self-report symptoms. The aim is to enable rapid access to specialist advice, rather than waiting for appointments, to ensure timely interventions, with the aim of improving current Breast cancer outcomes. If successful, it is envisaged that this project would be rolled out nationally. It will involve monitoring of ethnicity data and identifying any barriers to accessing health care.	Project initiation in Q1	

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Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
Better population health outcomes supported by strong and equitable public health and disability system	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	**Safe, quality health services for all**	**Bowel screening** **Waikato DHB is committed reducing rates of bowel cancer in its population, the key priorities for 2019/20 are to:** Ensure diagnostic colonoscopy wait time indicators are consistently met; this requires active management of demand, capacity and capability. • Implement a new patient focused booking system. • Develop and implement a new diagnostic report (refreshed daily) that identifies patients that are coming up to breach dates. • Train and educate booking clerks to use the new reports to better manage patient demand. • Manage and monitor capacity and demand through weekly audits of referrals received and patients treated. • Outsource contracts in place to enable additional capacity if required to manage capacity and demand. • Merge Waikato and Thames hospital waitlists into one waitlist and book to both site as demand and capacity allows. • Recruit a service manager specifically attached to endoscopy and bowel screening to support ongoing capacity and demand and equity of access across both screening and symptomatic pathways. Complete an analysis, with a focus on Māori, Pacific and rural peoples, of "Did Not Attend" (DNA) and cancelled appointments over the past six months to understand the reasons and patterns behind DNAs and cancellations. Once completed the results will help to identify and implement ways to reduce the number of DNAs and cancelled appointments. **(EOA Māori, Pacific and Rural)** • Endoscopy unit nurses record all patients that DNA and cancel on day of procedure. • Data is gathered monthly and information gathered on age, ethnicity and rurality and includes the cancellation reasons. • A paper analysis is undertaken quarterly to review DNA and "Could Not Attend" (CNA) including if the patient went on to have a colonoscopy. • Lessons learnt feedback to staff. Options for improving DNA and CNA sought from the team and implemented. Offer additional nursing support to Māori and rural patients who have had a DNA or cancelled their appointment following a confirmed date for procedure. • All patients that DNA or ring to cancel prior, and on the day of procedure are referred to the clinical nurse specialist (CNS) for endoscopy who will have a conversation with the patient to determine what the issues/barriers to attending are. • CNS will work with the patient to book them another appointment and to remove any identified barriers to access for the patient (note: due to patient booking these patients have already been contacted previously and had agreed to attend the appointment). • CNS to work alongside bowel cancer equity manager where patients are identified as rural or Māori where there are extremely difficult situations that need addressing before the patient can come in to have their procedure. Work towards meeting pre-assessment requirements of the National Bowel Screening team. • Endoscopy unit CNS will review and update all clinical information to patients. • EUG members to work through GRS requirements in readiness for bowel screening. • Discussions held with director of nursing and chief medical officer around nursing consenting. • Agreement reached on nurse consenting and will be implemented. • Review layout of pre-assessment areas to ensure there are two consult rooms available for pre-assessment checks and an additional room available for breaking bad news. • Move to a service model where all patients (excluding acute and frail) walk into the endoscopy scoping room. Ensure improved performance in diagnostic colonoscopy wait time indicators monitoring. • Monitoring through a diagnostic colonoscopy waiting times report that clearly identifies which patients are booked within the timeframes set by the ministry and which patients are at risk of breaching the wait time indicators. • Create and manage a report that clearly identifies inflows and outflows onto the waitlist. • Patient focused bookings to ensure that each patient is contacted and offered a date within the 14 day, 42 day and 84 day timeframes. • Increase capacity as required through outsourcing contracts.	 Q1 Q1 Q1 and ongoing Q1 and ongoing Q1 and ongoing Q1 Q3 Q4 and ongoing Q1 and ongoing Q1 and ongoing Q2, Q3 and Q4 Q1 and ongoing Q1 and ongoing Q1 and ongoing Q2 Q4 Q2 Q3 Q3 Q3 Q1 and ongoing Q1 and ongoing Q1 and ongoing Q1 and ongoing	SS15 Annual plan actions – status update reports

Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
Better population health outcomes supported by strong and equitable public health and disability system	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	Effective and efficient care and services	**Workforce**[27] **Waikato DHB is committed to delivering a strong and equitable health system, and its workforce activities will ensure this is achieved and will:**		Annual plan actions – status update reports
				Support staff to attend training in effective health literacy communication, training will include a particular focus on improving the health of Māori and Pacific.[28]	Q4	
				Have a defined and clear career pathway for nurses and midwives. The pathway will be aligned to service needs, and will include Nurse Practitioner development.	Q4	
				Ensure allocated funding received from the HW Directorate supports the post grad training, some funding for the nurse practitioner pathway is to be managed by universities.	Q4	
				Waikato DHB will develop and implement guidelines that indicate the level of support each service should consider before employing nurse practitioners.	Q4	
				In May 2019 the Safe Staffing Healthy Workplaces unit came and completed a standards assessment form. From this, complete work plans for each stream of work within CCDM.	Q2	
				To progress towards implementation of CCDM, ensure core data is consistent and actions against poor data sets will be completed, this will include measuring Māori and Pacific retention and recruitment rates using data, and staff and patient satisfaction measures for nursing.	Q2	
				Undertake a robust analysis of primary and community based workforce need across localities for the next ten years.		
				Develop a primary and community care workforce development strategy.	Q2	
				Identifying current workforce planning, supply issues and opportunities internally and externally.	Q4	
				Make progress towards having a workforce that is 23 percent Māori across all areas and levels to be reflective of the Waikato DHB population. **(EOA Māori)**	Q4	
				Complete workforce modelling and agree a workforce plan that shows anticipated composition (employee, alternative workforce types and automation), size and cost of the Waikato DHB workforce across 2019-2024.	Q1 and ongoing	
				Build an Employee Value Proposition (EVP).	Q4	
				Integrate Tikanga into all Human Resource processes. **(EOA Māori)**	Q4	
				Redesign the recruitment model for target/critical workforce groups with the aim to eliminate, automate or streamline the organisation's work, increasing speed to value while maintaining sufficient checks and balances.	Q4	
				Create governance of learning that will set the direction and make key decisions regarding learning and development across the organisation. Organisational capability needs analysis to identify the critical shared requirements of the organisation's workforce.	Q4	
				Implement the "Speaking Up for Safety" programme, requiring leaders to visibly role model the focus on wellbeing and inclusive behaviours.	Q4	
				Implement the "Supportive Employment" initiative.	Q4	
				Complete an organisation wide learning inventory stocktake and review to inform the organisation's current HR service review.	Q4	
				Prioritise the development of the Māori workforce through partnerships with education providers and training institutions. **(EOA Māori)**	Q4	
				Identify new workforce roles required to implement the Waikato Health System Plan strategic direction.	Q4	
				Expand the peer support workforce in mental health and addictions.	Q1 - Q4	
				Continue to support the Puna Waiora programme, a kaupapa Māori support system to empower and support rangatahi interested in pursuing a career in health. **(EOA Māori)**	Q1 - Q4 Q1 - Q4	

[27] For further details see section four: Managing our business

[28] Reporting for this activity will be completed by Waikato Public Health and DHB

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Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
Better population health outcomes supported by strong and equitable public health and disability system	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	Health equity for high need populations	**Data and digital**[29] **Waikato DHB will continue to support services through advancements in data and digital services, including to:**		Annual plan actions – status update reports
				Continue to provide multiple ways of contacting the DHB, including increased usage of telehealth and virtual health. These two services have proven popular with Māori patients, particularly renal services, which use telehealth. (EOA Māori and Rural)	Q1 and ongoing	
				Accelerate the achievement of equity for Māori by focusing on responsiveness in information systems that are used by the DHB to manage Māori and other patients' health, including systems in diabetes, women's health (breast and cervical screening, smoking cessation), oral health and breastfeeding services. (EOA Māori)	Q1 and ongoing	
				Improve the quality of ethnicity data collected at the DHB and by primary care, taking account of data sovereignty obligations. (EOA Māori)	Q4	
				Collaborate with GPs in evaluating booking systems to move towards same-day-access and next-available-appointment for patients.	Q4	
				Build prompts in IT systems to ensure that patient prompts, decision support and audit tools exist and are used to support Māori health.(EOA Māori)	Q1 and ongoing	
				Advance the Mobility Programme that has enabled clinicians with mobile devices. A number of clinical projects will be expanding the functionality and applications that are available on mobile devices.	Q3	
				Work with Police to triage people in Police care where there are mental health concerns with the purpose of ensuring these people access appropriate services in a timely manner.	Q1	
				Collective improvement programme **Waikato DHB is committed to supporting activities associated with the Collective Improvement Programme and will:**		SS16 Annual plan actions – status update reports
				Support development and implementation of a collective improvement programme.	Q4	
			Productive partnerships	**Delivery of regional service plan priorities and relevant national service plans** **Waikato DHB is committed to supporting activities to reduce hepatitis C and improve dementia care at a regional level, and will:**		SS02 Annual plan actions – status update reports
				Continue to support implementation of the regional hepatitis C clinical pathway by supporting the local MDT to develop and lead a local work plan for phase 2 of the programme. The local work plan will incorporate objectives and actions from the regional work plan to ensure that roll out of the programme is regionally consistent and the MDT approach will ensure an integrated approach to increasing access to care and promoting primary care prescribing of the new pangenotypic hepatitis C treatment.	Q1 and ongoing	
				Provide information and support to primary healthcare organisations to enable general practice teams to provide optimal hepatitis C care and support for the delivery of accessible PHARMAC funded direct acting antivirals (DAA) hepatitis C treatment for eligible patients.	Q1 and ongoing	
				Agree the approach to completing the stocktake with Midland DHBs.	Q1-Q2	
				Work with Midland DHBs to complete a stocktake of dementia services and related activity in the Midland region.	Q1-Q2	
				Identify priority areas for the Midland region to progress implementing the New Zealand Dementia Care Framework.	Q3	
				Develop an approach to implement the identified regional priorities.	Q4	

[29] For further details see section four: Managing our business

Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
Better population health outcomes supported by primary health care	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	People centred services	**Primary health care integration** Waikato DHB is committed to supporting primary health care integration and will:		PH01 Annual plan actions – status update reports
				Commence implementation of the Waikato Health System Plan, Te Korowai Waiora.	Q4	
				Enhance primary care practice models in localities that align nursing, pharmacy and other allied health services with GP practices (focus on southern localities).	Q4	
				Establish a sector wide health system leadership group (alliance) with priority area service level groups.	Q4	
				Reconfigure and refocus primary and community health services towards locality designed services that will meet the need and support the aspirations of those localities.	Q4	
				Develop data sharing agreements with primary and community care providers.	Q3	
				Develop a model of enhanced primary care inclusive of GPs, Pharmacy and St. John. This model will deliver better acute demand management, models of intermediate care and will re-develop our current urgent and emergency model of care.	Q4	
				Address equity through the enhancement of the whānau ora based approach to community care and general practice. This will help to strengthen networks and connections with other services and ensure services link effectively across the system. (EOA Māori)	Q4	
				Trial a messaging service between primary and secondary care to speed up the sharing of patient information.	Q4	
				Improve primary health care access to specialist diagnostic services (primary provided) under the 'choosing wisely' philosophy e.g. radiology.		
			Productive partnerships	**Pharmacy** Waikato DHB is committed to enhanced pharmacy services and will:		Annual plan actions - status update reports
				Pilot the pharmacy provided scheduled childhood immunisation in three pharmacies.	Q2	
				Implement via the Midland Community Pharmacy Group, a free minor ailment programme for tamariki Māori aged 0-4 to reduce ambulatory sensitive hospitalisations for skin conditions. (EOA Māori)	Q3	
				Establish a time limited workgroup with representation from general practitioners, pharmacists and New Zealand ePrescription Service (NZEPS) to progress NZEPS uptake in DHB general practice within primary care to support the national implementation process.	Q4	
				Offer support and advice to the national processes to separate medicine supply and clinical advice.	Q4	
				Work with the sector to develop a Pharmacy Action Plan aligned to the Waikato Health System Plan, Te Korowai Waiora.	Q3	
				Consider expanded roles for community pharmacists through our locality planning as part of enhanced service delivery approaches and identify opportunities where co-location may be beneficial particularly for pharmaceutical advice on the treatment of health conditions, self-management and early intervention.	Q4	
				Waikato Public Health to work with pharmacy on health literacy and messaging support DHB work to improve flu vaccine uptake for Māori and Pacific, those aged 65 and over and other priority groups including Asian.	Q1 and ongoing	

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Government planning priority	Health system outcome	Government priority outcome	Link to Waikato DHB Strategy	DHB key response activities to deliver improved performance		
				Activity	Milestones	Ministry reporting measure
Better population health outcomes supported by primary health care	We have improved quality of life, we have health equity for Māori and other groups, we live longer in good health.	Support healthier, safer and more connected communities. Make New Zealand the best place in the world to be a child. Ensure everyone who is able to, is earning, learning, caring or volunteering.	**People centred services**	**Diabetes and other long-term conditions** Waikato DHB is committed to addressing diabetes and other long-term conditions and will:		SS13 Annual plan actions – status update reports
				Through the diabetes collaborative group, focus on activity that will improve service delivery across primary and secondary care. Clinical service plans will be developed to align with the health system plan and its goals around equity for Māori including reducing health disparities.	Q2	
				Following the completion of the Waikato Health System Plan, Te Korowai Waiora, complete a road map of actions. This will include the development of a "Long Term Conditions Plan" for the DHB. This plan will have Māori health and wellbeing as a focus and will address the continuum of care from prevention to specialist services. (EOA Māori)	Q4	
				Implement via primary healthcare organisations the new consensus statement on cardiovascular disease risk assessment and management.	Q1	
				Extend investment for the diabetes retinal screening services in Tokoroa, a high need rural area. Delivering targeted care, close to home will increase the uptake of the most at risk population groups: Māori and Pacific people. If this is successful then the service may be rolled out in other high need rural areas. (EOA Māori, Pacific and Rural)	Q1	
				Begin to identify opportunities to help ensure all people with diabetes have equitable access to culturally appropriate diabetes self-management education and support services, by engaging with the 'unengaged population.'	Q1 and ongoing	
				Increase high risk foot clinic options linking into community settings with a particular focus on Māori. In addition to this the NZ Artificial Limb Service (NZALS) will work with the DHB and with the primary healthcare organisation, GP workforce to identify, refer and monitor feet related matters continuously.	Q4	

Financial performance summary

Table: Statement of Prospective Comprehensive Income

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

Forecast Statement of Comprehensive Income	2017/18 $000 ACTUAL	2018/19 $000 FORECAST	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
REVENUE						
Patient care revenue	1,422,904	1,499,835	1,568,734	1,631,483	1,696,742	1,764,612
Other operating income	18,244	19,448	21,250	22,205	23,200	24,136
Finance income	1,714	1,025	767	690	610	626
TOTAL REVENUE	**1,442,862**	**1,520,308**	**1,590,751**	**1,654,378**	**1,720,552**	**1,789,374**
EXPENSES						
Personnel costs	573,755	647,512	711,640	727,255	745,547	760,896
Depreciation	46,399	44,719	48,081	50,004	52,004	54,084
Amortisation	5,319	5,747	8,079	8,402	8,739	9,088
Outsourced services	92,926	99,199	69,930	66,675	59,494	56,520
Clinical supplies	144,983	158,612	161,075	170,419	167,789	165,166
Infrastructure and non-clinical expenses	84,669	90,696	91,082	98,156	101,521	104,963
Other district health boards	61,130	64,478	64,137	66,703	69,371	72,146
Non-health board provider expenses	433,663	448,167	470,522	489,341	508,915	529,272
Finance costs	116	311	1,035	1,077	1,120	1,165
Capital charge	37,124	34,174	37,595	36,493	36,118	35,991
TOTAL EXPENSES	**1,480,084**	**1,593,615**	**1,663,176**	**1,714,525**	**1,750,618**	**1,789,291**
Share of profit of Associates and Joint venture	72	-	-	-	-	-
SURPLUS/(DEFICIT)	**(37,150)**	**(73,307)**	**(72,425)**	**(60,147)**	**(30,066)**	**83**
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve	-	104,937	-	-	-	-
TOTAL COMPREHENSIVE INCOME (DEFICIT)	**(37,150)**	**31,630**	**(72,425)**	**(60,147)**	**(30,066)**	**83**

Table: Revenue and expenditure by Output class

Forecast Statement of Cost and Revenue	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
REVENUE				
Prevention	26,753	27,787	28,898	30,054
Early Detection and Management	320,335	332,708	346,017	359,857
Intensive Assessment and Treatment	1,111,611	1,154,547	1,200,729	1,248,757
Rehabilitation and Support	132,032	137,132	142,617	148,322
TOTAL REVENUE	**1,590,731**	**1,652,174**	**1,718,261**	**1,786,990**
EXPENDITURE				
Prevention	25,891	26,656	27,218	27,818
Early Detection and Management	319,343	328,784	335,697	343,105
Intensive Assessment and Treatment	1,172,345	1,207,001	1,232,380	1,259,575
Rehabilitation and Support	145,577	149,880	153,032	156,409
TOTAL EXPENSES	**1,663,156**	**1,712,321**	**1,748,327**	**1,786,907**
SURPLUS/DEFICIT	**(72,425)**	**(60,147)**	**(30,066)**	**83**

Service coverage

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

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

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

The DHB is not seeking any changes to the formal exemptions to the Service Coverage Schedule in 2019/20.

Service change

The table below describes all known at time of publication service reviews and service changes that have been approved or proposed for implementation in 2019/20. Given the challenging financial position of the DHB and the recent change in governance arrangements with the appointment of a Commissioner, there may be other service changes required throughout the year as part of the DHBs 2019/20 Savings Plan or 'Recovery Plan'. These service changes will be communicated to the Ministry as and when appropriate.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Cancer Adolescent and Young Adult Patients with Acute Lymphoblastic Leukaemia (AYA ALL)	Working with Auckland DHB for the future referral of AYA ALL patients through to Auckland DHB for inclusion in the COG trial programmes. This is considered to be best practice and to have better outcomes for patients that existed in the Midland Region prior to the proposed changes.	Midland AYA ALL patients have better outcomes, treatment path moves to current best practice	This change impacts all Midland DHB AYA ALL patients
Possible change in Hospice nursing model of care	Working with Hospice around possible changes to the mix of nursing service provided to palliative patients by both Hospice and district nursing services.	Hospice have requested a change as they currently provide an intensive service (Hospice at Home) to palliative patients in Hamilton, Cambridge and Ngaruawahia and a shared care service with the district nurses in the rest of the Waikato. Hospice would like to move resource out of the Hospice at Home service and into the rural services to provide the same level of service across the Waikato. This would have major impacts on district nursing resources in Hamilton, Cambridge and Ngaruawahia.	Local
Primary care lesion service	Funded removal of suspected skin cancers in the community, PHO run and operated, funded lesions triaged by Waikato DHB Teledermatology service.	Services closer to home and faster access to services for patients. Some potential cost savings.	Local

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Community based postmenopausal bleeding clinic	Exploration to set up community based postmenopausal bleeding clinic run by GPs in conjunction with DHB women's health service.	Allowing examination and scan to be done on the same day following agreed clinical pathway.	Local
Community COPD	Changes to community COPD initiative to ensure GPs have access to an admission avoidance scheme.	Patients are better supported to remain safe and well in the community and St John and Urgent Care work together to avoid ED presentations.	Local
Primary options	Review of primary options for acute care will lead to changes for general practice and PHOs.	This will ensure that all funded services available to general practice are clearly linked to hospital admission avoidance.	Local
Urgent and emergency care	Review of urgent and emergency care arrangements will lead to enhanced subacute service run by urgent care.	Help to avoid inappropriate hospital admissions.	Local
Primary care delivery model	Explore options for primary care delivery in line with outputs from the HSP.	System configured to meet the needs of consumers and their whānau as captured in the HSP consultation.	Local
Alliance structure	Implement broad primary and community care local alliance.	Consolidates existing alliancing structures into one broader alliance.	Local

SECTION FOUR: Managing our business

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

Organisational performance management

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

Table: External reporting framework

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

Funding and financial management

The DHBs key financial indicators are Revenue, Net Surplus/Deficit, Fixed Assets, Net Assets and Liabilities. These are assessed against and reported through Waikato DHBs performance management process to stakeholders on a monthly basis. Further information about DHBs planned financial position for 2019/20 and out years is contained in the Financial Performance Summary section of this document on page 59, and in appendix A: Statement of Performance Expectations on page 74.

Investment and asset management

The DHB has recently completed a Waikato HSP.

Shared service arrangements and ownership interests

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

Risk management

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

Quality assurance and improvement

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

Building capability

The DHB has developed a Waikato HSP across the whole of the DHB. The Waikato HSP takes a whole of health system and whole of DHB approach to building capability.

Capital and infrastructure development

The Capital Plan cash flow is set out below. It should be noted that this capital plan includes addressing the proven backlog in investments over the recent years.

New Capital Expenditure	2019/20 $M	2020/21 $M	2021/22 $M	2022/23 $M
Under $50,000	6	6	6	6
Over $50,000	47	51	54	57
Contingency	1	1	1	1
Total Capital Expenditure	54	58	61	64

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

Strategic capital spend includes:

Project Name	Business Case Start date	Business Case Completion date	Business Case Expected Approval date	Approx. $	Crown Cap requirement
Adult Mental Health	2016/17	2018/19	2019/20	$TBC	$TBC
CBD Building	2015/16	2016/17	2016/17	$8.3m	0
eSpace	2014/15	2014/15	2014/15	$29.1m	0
Oncology Building	2018/19	2019/20	2019/20	$9.5m	0
Renal Expansion	2020/21	2020/21	2021/22	$60.1m	0
Seismic Works (across DHB)	2019/20	2019/20	2019/20	$11.5m	0
Waiora, L2 - L4 development	2019/20	2019/20	2019/20	$6.72m	0
Ward Block A – Adult	2020/21	2020/21	2020/21	$126m	$74.4m

We have a working capital financing facility of no greater than 1/12th of crown revenue paid to Provider, as part of a Shared Banking arrangement with New Zealand Health Partnerships Limited, in order to manage our working capital requirements. We are well progressed in the evaluation of a request for proposal for access to lease financing. In addition, we have requested a Letter of Comfort and equity funding from the Ministry of Health for $56m deficit funding and $46.5m capital plan funding.

Information Technology (IT) and Communications Systems

Improving equity through IT

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

The DHB Information Services (IS) has met with the newly formed Waikato Consumer Council, including Māori representatives and formed a relationship with the Council to enable ongoing co-development of the IS strategy.

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

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

Provision of health services via digital technology

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

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

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

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

Access to regional patient notes is a pivotal part of healthcare provision, this is provided for by collaboration with eSPACE through HealthShare and a shared clinical portal. Currently, local primary care and community providers such as Lead Maternity Carers (LMC) have access to the DHBs Clinical Workstation (CWS) improving the accessibility of health information to health care providers and through them to patients. Current work with Health Alliance to access Starship patient notes is underway with a view to extend beyond paediatrics.

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

The DHB is progressing access for a wide group of primary and community care partners to the patient data within CWS. Partners with access to CWS include; GP's, Nurses, St John, Hospice, LMC's, Community Pharmacies, Mental Health Providers, Radiology Providers, DHBs/Private Hospitals, Corrections/Prison Services, and private clinics. During the 2019/20 year this solution is being enhanced by adding two factor authentication and expanding the solution to include regional radiology records. This is an interim tactical solution which will be replaced by the eSpace Orion based regional solution once it is available.

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

Aligning with national and regional IT initiatives

The DHB is committed to leveraging, where it is appropriate to do so, national and regional investments. Accordingly the DHB is midway through implementing the AoG IaaS solution, has previously confirmed its commitment to implement the national maternity solution, and has previously implemented Titanium, National Oracle Solution, ProVation and Dendrite. The DHB is also strongly committed to, and the major funder of, regional solutions.

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

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

Regional solutions utilised by the DHB include; MCPFP, Datix, ePharmacy and PACS/RIS. The objective of the regional eSpace Programme is to deliver a regional clinical information system. Waikato has limited development of its local system, CWS, to critical tactical changes only. The DHB has a significant investment commitment over the next three years to enhance the functionality within Midland Clinical Platform (MCP), including the delivery of eOrders, eReferrals, Results Management and Medication Management.

Local road mapping references national and regional plans, with national initiatives included in regional and local plans as appropriate.

Application Portfolio Management

The DHB plans to continue the work both locally and with the Ministry of Health on establishing a robust Application Portfolio Management Framework covering all classes of Information Communications Technology (ICT) asset, with a focus on appropriate lifecycle management of existing ICT assets. Historical funding for ICT has been constrained to annual depreciation, which has funded asset replacement, enhancements, and innovation. As per previous reporting to the Ministry of Health the DHB has, as a result of the historical funding mechanism and financial constraints, a ~$28m deferred maintenance (technical debt) which it has proposed to address through increased ICT capital funding over each of the next five years.

IT security maturity improvement

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

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

The DHB has a security manager in place and an active, positive, and constructive engagement with Nick Baty (Ministry of Health, Chief Security Advisor). All of which will continue.

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

Key IT Initiatives for 2019/20

Initiative	Key milestones 2019/20
HRIS	
Detailed Design	Q1 2019/20
Payroll – Build	Q2 2019/20
HealthShare payroll go-live	Q3 2019/20
Waikato DHB payroll go-live	Q4 2019/20
Learning Management System / Health and Safety functionality	Q4 2019/20
Decommission PeopleSoft	Q1 2020/21
Development and Performance Management functionality	Q2 2020/21
Succession Planning functionality	Q2 2020/21
DR	
Business Case Approval	Q1 2019/20
Detailed Design and Planning	Q1 2019/20
Infrastructure Implementation	Q2 2019/20
Network Implementation	Q2 2019/20
Application	Q3 2019/20
DR Plan Update and Test	Q4 2019/20
Project Closure	Q1 2020/21
iCNET (Infection Control Net Platform)	
The DHB is in the process of developing the Single Stage Better Business Case (BBC) for implementation of an Infection Control Net Platform. The investment proposal supports the national objective by recommending investment in an integrated electronic surveillance system which will enable increased data availability and automation (where possible) of analysis.	
Business Case Approval	Q1 2019/20
Go Live	Q4 2019/20
Nutrition and Food management	
This project aims to implement the CBORD integrated Nutrition and Food management system, so as to transform the DHBs ability to effectively manage, produce and deliver 1.386 million safe, suitable, nutritious and cost effective meals per annum. This includes meals for patients, Meals on Wheels, visitors and the Waikato Hospital workforce.	
Business Case Approval	Complete
Implement FSS	Q3
Implement NSS	Q3 2020/21
Trend AV SMX project	
The DHB is enhancing its Trend AV solution to deliver better levels of information security management for the Waikato DHB.	Complete
Business Case Approval	Q4 2018/19
Design and Planning	Q1
Go Live	

Initiative	Key milestones 2019/20
Observation platform The DHB is in the process of developing the Single Stage Better Business Case (BBC) for implementation of an electronic Observation and Early Warning System (EWS). The contract for this is not yet approved; however the proposed vendor has already delivered to other existing DHBs.	Q2
By digitising the EWS system we are removing any bias (perceived or otherwise) that may affect the equity of care for all patients. Rules of deteriorating patients can be centrally managed irrespective of race or gender and will ensure consistent timely escalations are handled as efficiently as possible, thereby creating a more efficient workforce.	Q4
This meets both Regional Service Plan strategic outcomes of improving the health of the midland population, eliminate health inequalities and addresses one of the three NZ Triple Aims by improved quality, safety and experience of care.	
As the BBC is currently under development the risk mitigations are under development.	
EObservations is being proposed as a regional solution with Waikato as the lead provider post. Risk mitigation is being included in the Better Business Case (BBC).	
The implementation of this solution will further the DHBs Electronic Medical Record Adoption Model (EMRAM) aspirations as it will enable vital signs and nursing documentation to be included through a subsequent phase.	Q1 2020/21 Q2 (decision on Nursing Assessment and therefore EMRAM alignment)
Once implemented this system will be added to the IS PMO Architectural Roadmap for inclusion in future years lifecycle maintenance.	Q4 2020/21
Anaesthesia Information System The DHB is in the process of developing the Single Stage BBC for implementation of an electronic Anaesthesia Information System enabling workflow through pre-operative assessment and planning, operating room processes, and post-operative care. The solution is seeking to improve patient outcomes, clinical efficiencies, and administrative efficiencies.	
Point of Entry Document Business Case Approval	Q1

Workforce

Future workforce development – Our People Strategy – will see evolving alignment and integration with the Ministry of Health's New Zealand Health Strategy: Future Direction, and the Waikato DHB Strategy. In summary the key areas are:

Organisational culture

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

Leadership

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

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

Workforce development

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

To make this a reality HR will be developing and implementing a workforce plan which will be used to inform which workforce capabilities are required and what development/ learning opportunities the organisation needs to provide for its workforce.

Over the 2019/20 year the organisation will be implementing a cultural component to Mental Health and Addictions service orientation for new staff. In the future all the DHB staff will attend cultural training with a view to ongoing cultural competency training through essential cultural skills based on 'the seven real skills' in "Let's Get Real Training."

The DHB has a commitment to adhere to the Medical Council's requirement for community-based attachments for post graduate year 1 and post graduate year 2 doctors.

Māori workforce development

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

HR will be integrating Tikanga into all HR processes and traditional Māori culture and language will be upheld and valued. This means that karakia, waiata, whakawhānaungatanga, powhiri and Te Reo Māori will be embedded into organisational practices to better support Māori staff. In addition, all services will need to develop a Māori health plan, which is included in the induction of all new staff. Training rates will also be reported by Māori and non-Māori so potential inequalities in the future workforce can be eliminated.

Co-operative developments

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

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

SECTION FIVE: Performance measures

The DHB monitoring framework and accountability measures have been updated for 2019/20 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance.

The DHB non-financial monitoring framework aims to provide a rounded view of performance in key areas using a range of performance markers. The measures are intended to cover a specific set of markers of DHB performance in key areas, rather than all health services or DHB activity. The five identified dimensions of DHB performance cover are:

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

Each performance measure has a nomenclature to assist with classification as follows:

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

Performance measure		Expectation			
CW01	Children caries free at 5 years of age	Year 1		Māori	62%
				Other	62%
				Total	62%
		Year 2		Māori	62%
				Other	62%
				Total	62%
CW02	Oral health: Mean DMFT score at year 8	Year 1		Māori	0.65
				Pacific	0.65
				Other	0.65
		Year 2		Māori	0.65
				Pacific	0.65
				Other	0.65
CW03	Improving the number of children enrolled and accessing the Community Oral Health service	Children (0-4) enrolled	Year 1	Māori	>=95%
				Other	>=95%
				Total	>=95%
			Year 2	Māori	>=95%
				Other	>=95%
				Total	>=95%
		Children (0-12) not examined according to planned recall	Year 1	Māori	>=10%
				Other	>=10%
				Total	>=10%
			Year 2	Māori	>=10%
				Other	>=10%
				Total	>=10%
CW04	Utilisation of DHB-funded dental services by adolescents from school Year 9 up to and including age 17 years	Year 1		Māori	>=85%
				Other	>=85%
				Total	>=85%
		Year 2		Māori	>=85%
				Other	>=85%
				Total	>=85%

Performance measure		Expectation	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.	
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five years of age.	
		75% of girls and boys fully immunised – HPV vaccine.	
		75% of 65+ year olds immunised – flu vaccine.	
CW06	Child Health (breastfeeding)	70% of infants are exclusively or fully breastfed at three months.	
CW07	Newborn enrolment with General Practice	55% of newborns enrolled in General Practice by six weeks of age.	
		85% of newborns enrolled in General Practice by three months of age.	
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years.	
CW09	Better help for smokers to quit (maternity)	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer are offered brief advice and support to quit smoking.	
CW10	Raising healthy kids	95% of obese children identified in the B4 School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	
CW11	Supporting child wellbeing	Provide report as per measure definition	
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement ***Youth Health Care in Secondary Schools: A framework for continuous quality improvement*** in each school (or group of schools) with SBHS.	
		Initiative 3: Youth Primary Mental Health.	
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHBs youth population.	
CW13	Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to ≤1.2 per 100,000	
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Māori, other and total	Māori 4.82%
			Pacific 3.28%
			Other 4.63%
			Total 4.64%
		Age (20-64) Māori, other and total	Māori 8.96%
			Pacific 4.04%
			Other 3.83%
			Total 4.88%
		Age (65+) Māori, other and total	Māori 2.48%
			Pacific 2.19%
			Other 2.29%
			Total 2.31%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.	
		95% of audited files meet accepted good practice.	
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within three weeks.
			95% of people seen within eight weeks.
		Addictions (Provider Arm and NGO)	80% of people seen within three weeks.
			95% of people seen within eight weeks.
MH04	Rising to the Challenge: The Mental Health and Addictions Service Development Plan	Provide reports as specified	
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	

Performance measure		Expectation		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical screening coverage	80% coverage for all ethnic groups and overall.		
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	Māori 9158/100,000 Pacific 8459/100,000 Other 3317/100,000 Total <=4508/100,000		
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	Only applies to specified DHBs	
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*	23,847 PCI including inpatient treatment, minor interventions and non- surgical alternatives	
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - no patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - no patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)

Performance measure		Expectation		
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within six weeks (42 days)
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within six weeks (42 days)
		Planned Care Measure 4: ***Ophthalmology Follow-up Waiting Times***	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 5: ***Cardiac Urgency Waiting Times***	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
		Planned Care Measure 6: ***Acute Readmissions***	Acute Readmission rate of 13.1% for 2019/20	
SS08	Planned care three year plan	Provide reports as specified		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	Recording of non-specific ethnicity in new NHI registration.	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value.	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1.	>76% and < or equal to 85%
			Invalid NHI data updates.	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95%
			National Collections completeness.	Greater than or equal to 94.5% and less than 97.5%
			Assessment of data reported to the NMDS.	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD).		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		

Performance measure		Expectation	
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified.	
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath –** Door to cath within three days for >70% of Acute Coronary Syndrome (ACS) patients undergoing coronary angiogram**.**
			Indicator 2a: Registry completion – of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within three months.
			Indicator 3: ACS LVEF assessment – ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator – in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - – Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and – LVEF<40% should also be on a beta-blocker (5-classes). **An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.*
			Indicator 5: Device registry completion – ≥99% of patients who have pacemaker or implantable cardiac defibrillator implantation/ replacement have completion of ANZACS QI Device forms within 2 months of the procedure.
		Focus Area 5: Stroke services	**Indicator 1** ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway
			Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7
			Indicator 3: Inpatient rehabilitation: 80% patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within seven days of acute admission
			Indicator 4: Community rehabilitation: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within seven calendar days of hospital discharge.

Performance measure		Expectation
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.
		95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.
SS16	Delivery of collective improvement plan	Deliverable TBC
SS17	Delivery of Whānau ora	Provide reports as specified
PH01	Delivery of actions to improve system integration and SLMs	Provide reports as specified
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	Provide reports as specified
PH03	Access to Care (PHO Enrolments)	Meet and/or maintain the national average enrolment rate of 90%
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
Annual plan actions – status update reports		Provide reports as specified

APPENDIX A: Statement of Performance Expectations including Financial Performance

Waikato District Health Board

2019/20 STATEMENT OF PERFORMANCE EXPECTATIONS

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

Contents

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Signatories

Agreement for the Waikato DHB 2019/20 Statement of Performance Expectations

between

Hon Dr David Clark Minister of Health	Dr Karen Poutasi Commissioner Waikato DHB	Professor Margaret Wilson Deputy Commissioner Waikato DHB
Date: 27 June 2019	Date: 27 June 2019	Date: 27 June 2019

Waikato DHB (the DHB) has worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Performance Expectations (SPE) in which it provides measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2019/20. The performance measures chosen are not an exhaustive list of all of the organisation's activity, but they do reflect a good representation of the range of outputs that the DHB fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, included with each measure is the past performance as baseline data.

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

National performance story

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

Regional performance story

Midland vision	All New Zealanders live well, stay well, get well					
Regional strategic outcomes	To improve the health of the Midland populations			To eliminate health inequalities		
Regional strategic objectives	Health Equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Improve clinical information systems	Build the workforce	Efficiently allocate public health system resources

Waikato DHB performance story

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

Service performance

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

Stewardship

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

Impacts

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

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

Impact measures – measure of performance

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

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

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

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

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

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

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

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

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

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

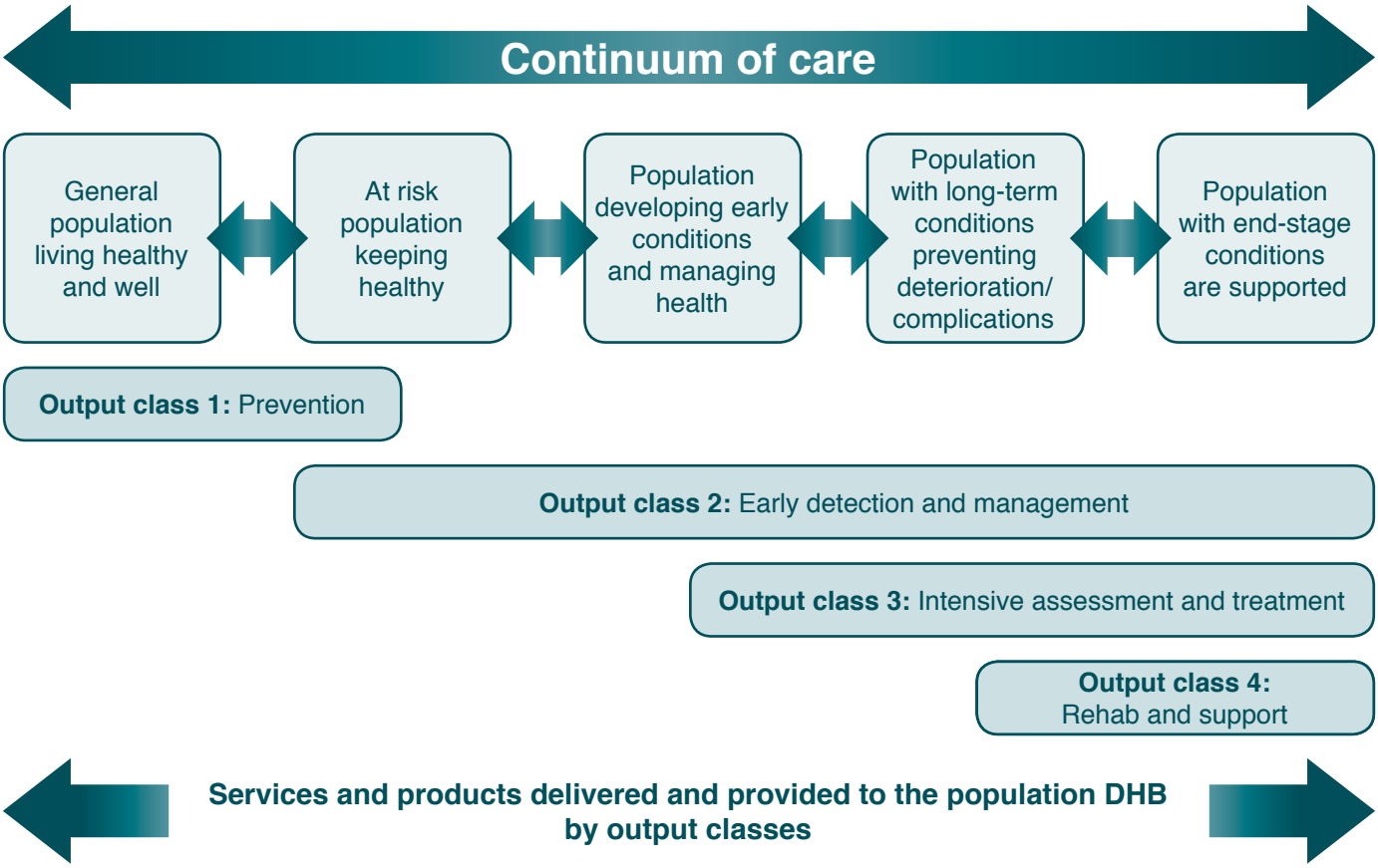
Providing timely care can slow the progression of health conditions and improve health outcomes. Ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions, and complications that have a negative impact on the health of our population, people's experience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

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

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

Output measures

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



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

Output class

Prevention

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

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

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

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

Early detection and management

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

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

Intensive assessment and treatment services

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

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

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

Rehabilitation and support

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

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

Setting targets

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

Where does the money go?

Table 1: Revenue and expenditure by Output class

Forecast Statement of Cost and Revenue	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
REVENUE				
Prevention	26,753	27,787	28,898	30,054
Early Detection and Management	320,335	332,708	346,017	359,857
Intensive Assessment and Treatment	1,111,611	1,154,547	1,200,729	1,248,757
Rehabilitation and Support	132,032	137,132	142,617	148,322
TOTAL REVENUE	1,590,731	1,652,174	1,718,261	1,786,990
EXPENDITURE				
Prevention	25,891	26,656	27,218	27,818
Early Detection and Management	319,343	328,784	335,697	343,105
Intensive Assessment and Treatment	1,172,345	1,207,001	1,232,380	1,259,575
Rehabilitation and Support	145,577	149,880	153,032	156,409
TOTAL EXPENSES	1,663,156	1,712,321	1,748,327	1,786,907
SURPLUS/DEFICIT	(72,425)	(60,147)	(30,066)	83

People are supported to take greater responsibility for their health

Long term impact	Intermediate impacts	Impact and outputs
People are supported to take greater responsibility for their health	Fewer people smoke	Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking
	Reduction in vaccine preventable diseases	Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time Percentage of two year olds are fully immunised and coverage is maintained Percentage of eligible children fully immunised at five years of age Percentage of eligible 12 year olds have received HPV dose three Seasonal influenza immunisation rates in the eligible population (65 years and over)
	Improving health behaviours	95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017) The number of people participating in Green Prescription programmes Percentage of Kura Kaupapa Māori primary schools participating in Project Energize Percentage of total primary schools participating in Project Energize

Fewer people smoke

Impact measure	Output class	Measure type	Baseline 2014/15	Target 2018/19	Target 2019/20
Percentage of babies living in smokefree homes at six weeks	1	Qn	Baseline (2018) Māori 26% Pacific 42% Other 51% Total 43%	New Measure in 2019/20	Māori 60% Pacific 60% Other 60% Total 60%

Output measure	Output class	Measure type	Baseline 2014/15	Target 2018/19	Target 2019/20
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	1	Qn	Māori 94% Pacific 100% Other 91% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	1	Qn	Māori 92% Pacific 91% Other 89% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	1	Qn	Māori 64% Pacific N/A Other 70% Total 66%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%

Reduction in vaccine preventable diseases

Impact measure	Output class	Measure type	Baseline 2014/15	Target 2018/19	Target 2019/20
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds			8.8	<8.8	<8.0

Output measure	Output class	Measure type	Baseline 2014/15	Target 2018/19	Target 2019/20
Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	1	Qn	Māori 90% Pacific 95% Other 83% Total 91%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of two year olds are fully immunised and coverage is maintained	1	Qn	Māori 91% Pacific 95% Other 91% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible children fully immunised at 5 years of age	1	Qn	Māori 73% Pacific 78% Other 76% Total 73%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible 12 year olds have received HPV dose three	1	Qn	Māori 70% Pacific 106% Other 62% Total 66%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 75% Pacific 75% Other 75% Total 75%
Seasonal influenza immunisation rates in the eligible population (65 years and over)	1	Qn/T	Māori 46% Pacific 49% Other 53% Total 52%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 75% Pacific 75% Other 75% Total 75%

Improving health behaviours

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
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 2017)			Māori 7% Pacific 19% Other 8% Total 9%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
The number of people participating in Green Prescription programmes	1	Qn	5802	6700	6700
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	1	Qn	100%	100%	100%
Percentage of total primary schools participating in Project Energize			100%	100%	100%

People stay well in their homes and communities

Long term impact	Intermediate impacts	Impact and outputs
People stay well in their homes and communities	An improvement in childhood oral health	Mean decayed missing and filled teeth score of Year 8 children Percentage of children (0-4) enrolled in DHB funded dental services Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination Percentage of adolescent utilisation of DHB funded dental services
	Long-term conditions are detected early and managed well	[To be confirmed] 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 5 years Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months Percentage of eligible women aged 50-69 who have a Breast Screen Aotearoa mammogram every two years
	Fewer people are admitted to hospital for avoidable conditions	Ambulatory sensitive hospitalisation rate per 100,000 for the following age group: 45-64 year olds Percentage of eligible population who have had their B4 School checks completed Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)
	More people maintain their functional independence	Average age of entry to aged related residential care Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days Percentage of people enrolled with a Primary Health Organisation Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan

An improvement in childhood oral health

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Mean decayed missing and filled teeth score of Year 8 children			Māori 1.65 Pacific 1.40 Other 0.87 Total 1.08	Māori 0.69 Pacific 0.69 Other 0.69 Total 0.69	Māori 0.65 Pacific 0.65 Other 0.65 Total 0.65

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percentage of children (0-4) enrolled in DHB funded dental services	2	Qn	Māori 72% Pacific 72% Other 72% Total 72%	Māori >=95% Pacific >=95% Other >=95% Total >=95%	Māori >=95% Pacific >=95% Other >=95% Total >=95%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	2	Qn/T	Māori 18% Pacific 20% Other 25% Total 18%	Māori <=10% Pacific <=10% Other <=10% Total <=10%	Māori <=10% Pacific <=10% Other <=10% Total <=10%
Percentage of adolescent utilisation of DHB funded dental services	2	Qn	Māori 45% Pacific 53% Other 80% Total 70%	Māori >=85% Pacific >=85% Other >=85% Total >=85%	Māori >=85% Pacific >=85% Other >=85% Total >=85%

Long-term conditions are detected early and managed well

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
[To be developed]				NA	

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percent of the eligible population who have had their cardiovascular risk assessed in the last five years	2	Qn	Māori 87% Pacific 88% Other 91% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of 'eligible Māori men in the PHO aged 30-44 years' who have had their cardiovascular risk assessed in the past five years	2	Qn	74%	90%	90%
Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months	2	Qn/T	Māori 60% Pacific 65% Other 80% Total 74%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 80% Pacific 80% Other 80% Total 80%
Percentage of eligible women aged 50-69 who have a Breast Screen Aotearoa mammogram every two years			Māori 58% Pacific 60% Other 70% Total 68%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 70% Pacific 70% Other 70% Total 70%

Fewer people are admitted to hospital for avoidable conditions

Impact measure	Output class	Measure type	Baseline (2018)	Target 2018/19 (45-64 year olds, total rather than per 100,000)	Target 2019/20
Ambulatory sensitive hospitalisation rate per 100,000 for the following age groups: 0-4 year olds 45-64 year olds			**0-4 year olds** Māori 10,531 per 100,000 Pacific 10,942 per 100,000 Total 9290 per 100,000 **45-64 year olds** Māori 9081 per 100,000 Pacific 7446 per 100,000 Total 4451 per 100,000	Māori 8942 Pacific 6371 Other 3357	**0-4 year olds** Māori <10,886 per 100,000 Pacific <10,670 per 100,000 Total <9572 per 100,000 **45-64 year olds** Māori <9158 per 100,000 Pacific <8459 per 100,000 Total <4355 per 100,000

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percentage of eligible population who have had their B4 School checks completed	1	Qn/T	Māori 77% Pacific 83% Other 98% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)			3.9/100,000	1.2/100,000	1.2/100,000

More people maintain their functional independence

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Average age of entry to aged related residential care: • Rest home • Dementia • Hospital			Resthome 85 years Dementia 83 years Hospital 86 years	Resthome >84 years Dementia >80 years Hospital >85 years	Resthome >84 years Dementia >80 years Hospital >85 years

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan	4	Qn/T	100%	100%	100%
Percentage of people enrolled with a Primary Health Organisation	2	Qn/T	Māori 91% Pacific 88% Other 96% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of needs assessment and service coordination waiting times for new assessment within 20 working days			62%	100%	100%

People receive timely and appropriate specialist care

Long term impact	Intermediate impacts	Impact and outputs
People receive timely and appropriate specialist care	People receive prompt and appropriate acute and arranged care	Percentage of patients admitted, discharged, or transferred from emergency departments within six hours
		90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks
		Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries
	People have appropriate access to elective services	Standardised intervention rates (per 10,000)
		Percentage of patients waiting longer than four months for their first specialist assessment
		Improved access to elective surgery, health target, agreed discharge volumes
		Did-not-attend percentage for outpatient services
		Acute inpatient average length of stay
		Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates
		Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks
		Percentage of child and youth with a transition (discharge) plan
		Average length of acute inpatient stay
		Rates of post-discharge community care
		Improving the health status of people with severe mental illness through improved access
	More people with end stage conditions are supported appropriately	Percentage of aged residential care facilities utilising advance directives
		Number of new patients seen by the Waikato hospital palliative care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
		Percentage of accepted referrals for CT scans will receive their scan within 6 weeks (42 days)
		Percentage of accepted referral for MRI scans will receive their scan within 6 weeks (42 days)
		Percentage of people accepted for an urgent diagnostic colonoscopy will
		receive their procedure within two weeks (14 calendar days, inclusive)
		Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days
		Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date
		Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

People have prompt and appropriate acute and arranged care

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours			Māori 92% Pacific 91% Other 91% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	3	Qn/T	56%	90%	90%

People have appropriate access to elective services

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Standardised intervention rates (per 10,000):					
• Major joint replacement procedures			27	21	21
• Cataract procedures			25	27	27
• Cardiac surgery			7.3	6.5	6.5
• Percutaneous Revascularisation			11.4	12.5	12.5
• Coronary Angiography Services			33.9	34.7	34.7

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percentage of patients waiting longer than four months for their first specialist assessment	3	Qn/T	2.7%	0%	0%
Improved access to elective surgery, health target, agreed discharge volumes	3	Qn/T	15,693	18,037	23,772
Did-not-attend percentage for outpatient services	3	Qn/T	Māori 21% Pacific 18% Other 7% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%
Elective surgical inpatient average length of stay	3	Qn/T	1.71 days	1.5 days	1.5 days
Acute inpatient average length of stay	3	Qn/T	3.89 days	2.3 days	2.3 days

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

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
28 day acute readmission rates			Māori 14% Pacific 8% Other 12% Total 12%	Māori <13% Pacific <13% Other <13% Total <13%	Māori <13% Pacific <13% Other <13% Total <13%

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks			**3 weeks** Māori 82% Pacific 86% Other 72% Total 75% **8 weeks** Māori 93% Pacific 95% Other 90% Total 91%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80% **8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80% **8 weeks** Māori 95% Pacific 95% Other 95% Total 95%
Mental health clients discharged have a transitional (discharge) plan	3	Qn/T	37%	95%	95%
Average length of acute inpatient stay	3	Qn/T/QI	Māori 14.51 days Pacific 10.79 days Other 13.16 days Total 14.41 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days
Rates of post-discharge community care	3	Qn/T/QI	Māori 69% Pacific 73% Other 72% Total 87%	Māori 90% to 100% Pacific 90% to 100% Other 90% to 100% Total 90% to 100%	Māori 90% to 100% Pacific 90% to 100% Other 90% to 100% Total 90% to 100%
Improving the health status of people with severe mental illness through improved access: 0-19 years 20-64 years 65 plus years	3	Qn	**0-19 years** Māori 2.89% Pacific 1.96% Other 3.07% Total 2.97% **20-64 years** Māori 7.12% Pacific 4.34% Other 4.34% Total 4.33% **65+ years** Māori 2.12% Pacific 2.13% Other 2.28% Total 2.27%	**0-19 years** Māori 4.73% Pacific 3.13% Other 4.23% Total 4.36% **20-64 years** Māori 8.77% Pacific 4.07% Other 3.78% Total 4.81% **65+ years** Māori 2.39% Pacific 1.69% Other 2.09% Total 2.11%	**0-19 years** Māori 4.82% Pacific 3.28% Other 4.63% Total 4.64% **20-64 years** Māori 8.96% Pacific 4.04% Other 3.83% Total 4.88% **65+ years** Māori 2.48% Pacific 2.19% Other 2.29% Total 2.31%

More people with end stage conditions are supported appropriately

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
[Measure to be developed]					

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percentage of aged residential care facilities utilising advance directives	3	Qn	100%	100%	100%
Number of new patients seen by the Waikato hospital palliative care service	3	Qn	652 original *1085 revised*	1000	727

Support services

Impact measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
[Measure to be developed]					

Output measure	Output class	Measure type	Baseline	Target 2018/19	Target 2019/20
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	3	Qn/T	94%	95%	95%
Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)	2	T	Māori 92% Pacific 100% Other 90% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days)	2	T	Māori 55% Pacific 53% Other 52% Total 48%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	2	T	78%	90%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	2	T	49%	70%	70%
Percentage of people waiting for a **surveillance** colonoscopy will wait no longer than 84 days beyond the planned date	2	T	70%	70%	70%
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	2	T	100%	100%	100%

Financial performance

Table: Statement of Prospective Comprehensive Income

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

Forecast Statement of Comprehensive Income	2017/18 $000 ACTUAL	2018/19 $000 FORECAST	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
REVENUE						
Patient care revenue	1,422,904	1,499,835	1,568,734	1,631,483	1,696,742	1,764,612
Other operating income	18,244	19,448	21,250	22,205	23,200	24,136
Finance income	1,714	1,025	767	690	610	626
TOTAL REVENUE	1,442,862	1,520,308	1,590,751	1,654,378	1,720,552	1,789,374
EXPENSES						
Personnel costs	573,755	647,512	711,640	727,255	745,547	760,896
Depreciation	46,399	44,719	48,081	50,004	52,004	54,084
Amortisation	5,319	5,747	8,079	8,402	8,739	9,088
Outsourced services	92,926	99,199	69,930	66,675	59,494	56,520
Clinical supplies	144,983	158,612	161,075	170,419	167,789	165,166
Infrastructure and non-clinical expenses	84,669	90,696	91,082	98,156	101,521	104,963
Other district health boards	61,130	64,478	64,137	66,703	69,371	72,146
Non-health board provider expenses	433,663	448,167	470,522	489,341	508,915	529,272
Finance costs	116	311	1,035	1,077	1,120	1,165
Capital charge	37,124	34,174	37,595	36,493	36,118	35,991
TOTAL EXPENSES	1,480,084	1,593,615	1,663,176	1,714,525	1,750,618	1,789,291
Share of profit of Associates and Joint venture	72	-	-	-	-	-
SURPLUS/(DEFICIT)	(37,150)	(73,307)	(72,425)	(60,147)	(30,066)	83
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve	-	104,937	-	-	-	-
TOTAL COMPREHENSIVE INCOME (DEFICIT)	(37,150)	31,630	(72,425)	(60,147)	(30,066)	83

The underlying trend in cost growth applying to the Waikato DHB heading into 2019/20 would have taken the organisation to a deficit of around $100m for the 2019/20 year. Please see Graph: Result trajectory below which shows a result of $110m deficit in 2019/20 based on a linear projection.

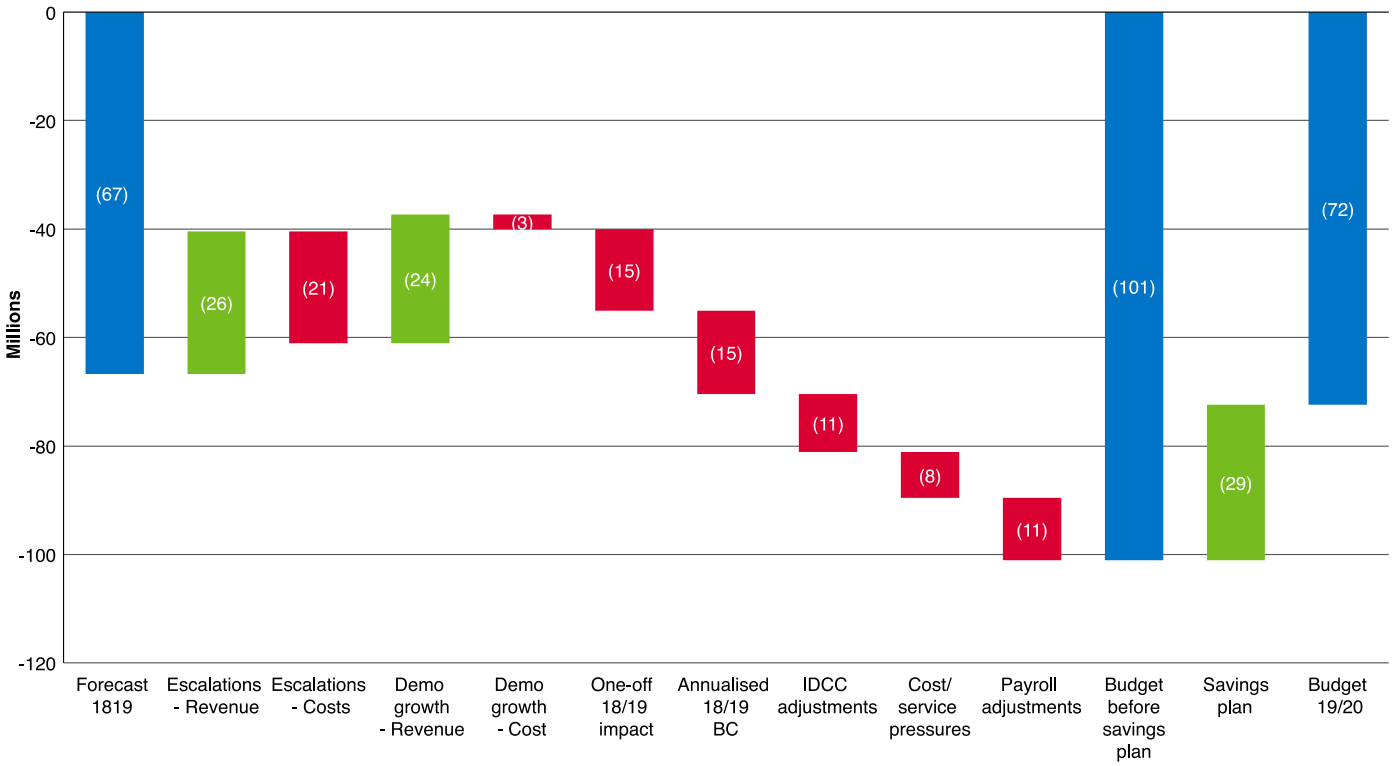
A concerted effort has been made to develop a budget based on checking this growth. This has involved identifying $31.5m of required cost exclusions from the budget outcome to which Waikato DHB was headed.

2019/20 budget has been developed based on the cost of service delivery for the expected volumes for the year, and funding estimates provided by the Ministry of Health. A structured process is in place to ensure that any requests for extra expenditure are challenged. The $31.5m in cost exclusions already referred to, include some savings from the implementation of the Resource Review which was developed to identify areas where efficiencies can be found.

We have a number of downside risks including: Multi Employer Collective Agreement (MECA) increases above budget not covered by the Ministry of Health salary support, any flow on effect of MECA changes to NGO providers and contracted out services, further nursing acuity related costs, pharmaceutical savings not being realised, unfavourable wash ups on 2018/19 NGO accruals, impairments of assets including FPIM and failure to achieve a reduction in outsourced services. Every effort will be made to mitigate these risks.

The chart below shows this diagrammatically. Please note that the latest forecast for the 2018/19 full year is a $73.3m deficit, however the budget commitment for 2019/20 is to deliver a $72.4m deficit result regardless of this move in forecast deficit for 2018/19.

Graph: 2018/19 Forecast transition to 2019/20 budget



Aspects of note

- the demographic growth has assumed no FTE growth for the provider – to the extent that FTE growth is considered unavoidable, it is covered under the cost/service pressures or payroll adjustments
- the one-off 2018/19 impact relates to items that occurred in 2018/19 that are not expected to re-occur in 2019/20
- the annualised 2018/19 is the reflection of the full year cost of approved growth items that occurred part way through 2018/19
- the IDCC adjustment includes $6m related to the revaluation of property as at 30 June 2019
- the cost/service pressures reflects items of cost growth that have been considered unavoidable
- payroll Adjustments is a reflection of vacancies and have an obvious connection to the Savings Plan – the two aspects are being considered separately in order to ensure we apply resources appropriately across the DHB.

The Waikato DHB has budgeted deficits for the 202019/20 to 2021/22 years with breakeven planned to be achieved in 2022/23. Our demand is not expected to reduce and thus both capital and operating expenditure will be constrained in 2019/20 and outer years. In response to these issues, Waikato DHB will focus on:

- defining, actioning and monitoring the required $31.5m of cost exclusions through formal savings plans
- prioritising capital expenditure investment for 2019/20 in order to focus on investing in the right things to reduce risk and improve efficiency and effectiveness (and thus clinical outcomes). Based on the current material investment backlog and capital expenditure constraint, our overall risk profile will increase as assets age and deteriorate. The 2018/19 capital under-spend has been carried over into 2019/20. Subject to cash availability we will apply available resources to reducing the backlog of capital investment.
- implementing a new portfolio based capital investment process based on a robust evaluation process aligned to our agreed strategic priorities
- implementing a commissioning approach to ensure that services we invest in and continue to invest in are the most appropriate ones
- implementing the relevant recommendations from the Resource Review project currently in progress
- continuing to leverage off and extend work done to improve surgical services throughput
- continuing to leverage off and extend the work done to improve patient flow.

Work now underway has the challenge of embedding the revised trajectory for future years.

It should be noted that we cannot predict the Ministry of Health response to any deficit support requests in the future, thus the equity injections reflected below should be considered as placeholders only.

Table: Statement of Prospective Position

Forecast Statement of Financial Position	2017/18 $000 ACTUAL	2018/19 $000 FORECAST	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
CROWN EQUITY	582,389	641,230	610,554	608,214	601,960	599,856
CURRENT ASSETS:						
Bank balances, deposits and cash	7,855	7,877	7,877	7,932	7,988	8,044
Receivables	60,622	65,084	71,529	74,745	76,015	77,308
Inventory	11,452	11,070	11,339	11,532	11,729	11,928
	79,929	84,031	90,745	94,209	95,732	97,280
CURRENT LIABILITIES:						
Bank overdraft	10,829	29,275	57,724	59,745	61,836	59,574
Short term loans	313	223	69	70	71	73
Payables and accruals	67,235	84,426	88,970	90,261	93,414	96,750
Employee entitlements	118,924	124,351	127,210	129,373	131,572	133,809
Provisions	680	680	714	726	738	751
	197,981	238,955	274,687	280,175	287,631	290,957
Net Working Capital	(118,052)	(154,924)	(183,942)	(185,966)	(191,899)	(193,677)
NON CURRENT ASSETS:						
Fixed assets	722,189	819,516	817,354	817,354	817,354	817,353
Investments	375	375	491	499	508	516
	722,564	819,891	817,845	817,853	817,862	817,869
NON CURRENT LIABILITIES:						
Borrowings	366	185	50	51	52	53
Employee entitlements	13,738	15,923	15,625	15,890	16,161	16,434
Provisions	474	422	408	415	422	429
Restricted trust funds	7,545	7,207	7,266	7,317	7,368	7,420
	22,123	23,737	23,349	23,673	24,003	24,336
NET ASSETS	582,389	641,230	610,554	608,214	601,960	599,856

Graph: Result trajectory *– Waikato DHB Net Result 2016/17 to 2022/23 Actuals vs DAP Projection*

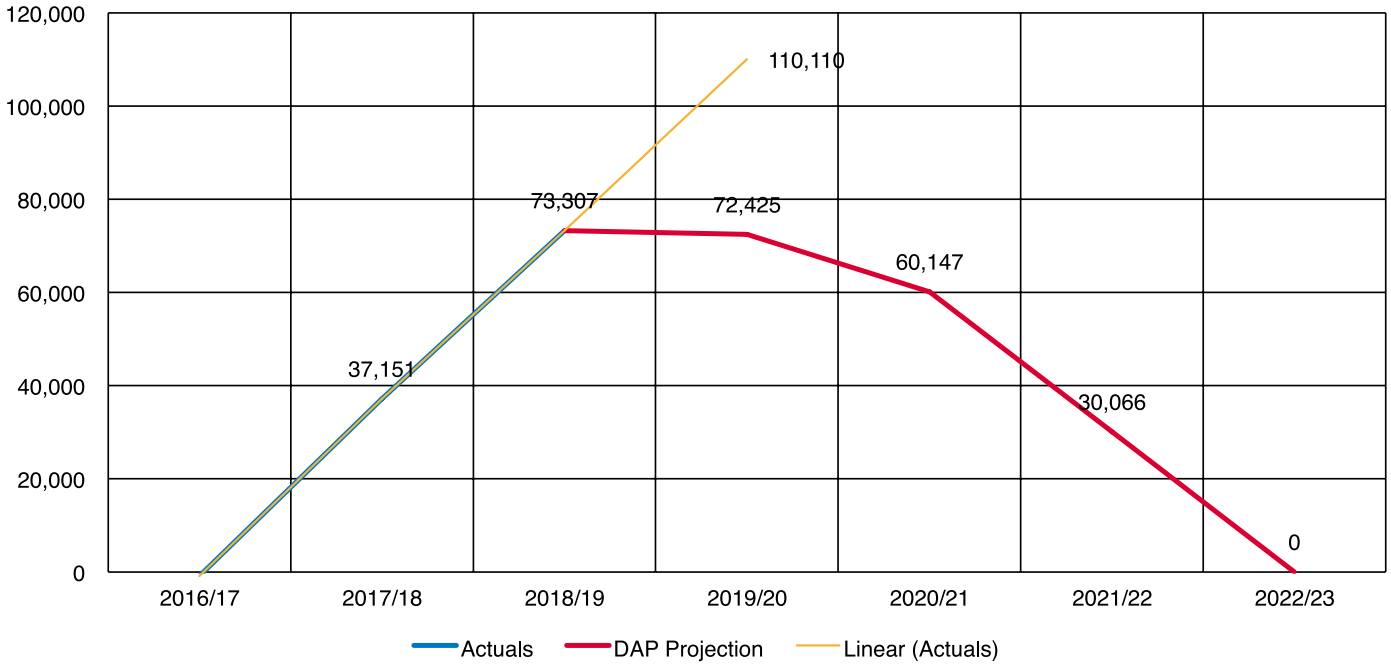


Table: Statement of Prospective Movements in Equity

Forecast Statement of Movements in Equity	2017/18 $000 ACTUAL	2018/19 $000 FORECAST	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
Crown equity at start of period	622,676	582,389	641,230	610,554	608,214	601,960
Surplus/(deficit) for the period	(37,150)	(73,307)	(72,425)	(60,147)	(30,066)	83
Increase in revaluation reserve	-	104,937	-	-	-	-
Equity injection from Crown	-	29,100	44,000	60,000	26,000	-
Repayment of capital to the Crown	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other movements in equity	(943)	305	(57)	1	6	7
Crown equity at end of period	582,389	641,230	610,554	608,214	601,960	599,856

Table: Statement of Prospective Cashflow

Forecast Statement of Cashflows	2017/18 $000 ACTUAL	2018/19 $000 FORECAST	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
OPERATING CASHFLOWS						
Cash was provided from Crown agencies and other income sources	1,439,182	1,515,608	1,583,528	1,650,660	1,718,871	1,787,658
Cash was disbursed to employees, suppliers and finance charges	(1,413,240)	(1,516,437)	(1,600,344)	(1,652,768)	(1,684,632)	(1,720,651)
	25,942	(829)	(16,816)	(2,108)	34,239	67,007
INVESTING CASHFLOWS						
Cash was provided from interest	1,747	1,125	767	690	610	626
Cash was disbursed to purchase of assets	(37,722)	(44,967)	(53,999)	(58,415)	(60,751)	(63,181)
	(35,975)	(43,842)	(53,232)	(57,725)	(60,141)	(62,555)
FINANCING CASHFLOWS						
Cash was provided from proceeds of borrowings and equity	1	29,100	43,999	60,060	26,060	60
Cash was disbursed to repayment of borrowings and equity	(2,519)	(2,853)	(2,400)	(2,193)	(2,194)	(2,194)
	(2,518)	26,247	41,599	57,867	23,866	(2,134)
Net increase/(decrease) in cash held	(12,551)	(18,424)	(28,449)	(1,966)	(2,035)	2,318
Add Opening cash balance	9,577	(2,974)	(21,398)	(49,847)	(51,813)	(53,848)
CLOSING CASH BALANCE	(2,974)	(21,398)	(49,847)	(51,813)	(53,848)	(51,530)
Made up from:						
Bank balances, deposits and cash	(2,974)	(21,398)	(49,847)	(51,813)	(53,848)	(51,530)

1.1 Fixed Assets

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

1.1.1 Disposal of Land

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

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

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

1.2 Capital Expenditure / Investment

The Capital Plan cash flow is set out below:

New Capital Expenditure	2019/20 $M	2020/21 $M	2021/22 $M	2022/23 $M
Under $50,000	6	6	6	6
Over $50,000	47	51	54	56
Contingency	1	1	1	1
Total Capital Expenditure	54	58	61	63

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

Potential strategic capital spend includes:

Project Name	Business Case Start date	Business Case Completion date	Business Case Expected Approval date	Approx. $	Crown Cap requirement
Adult Mental Health	2016/17	2018/19	2019/20	$TBC	$TBC
CBD Building	2015/16	2016/17	2016/17	$8.3m	0
eSpace	2014/15	2014/15	2014/15	$29.1m	0
Oncology Building	2018/19	2019/20	2019/20	$9.5m	0
Renal Expansion	2020/21	2020/21	2021/22	$60.1m	0
Seismic Works (across DHB)	2019/20	2019/20	2019/20	$11.5m	0
Waiora, L2 - L4 development	2019/20	2019/20	2019/20	$6.72m	0
Ward Block A – Adult	2020/21	2020/21	2020/21	$126m	$74.4m

We have a working capital financing facility of no greater than 1/12th of crown revenue, including GST, paid to the provider, as part of a shared banking arrangement with New Zealand Health Partnerships Limited, in order to manage our working capital requirements. In addition, we will need deficit support and a Letter of Comfort from the Ministry of Health.

1.3 Planned financial performance by division.

Please note: Because of the work required to out the Waikato DHB on a sustainable footing, these extrapolations must be considered highly conditional.

Table: Prospective Financial Targets and Measures DHB Provider

DHB Provider Forecast Statement of Financial Performance	2017/18 $000 ACTUAL	2018/19 $000 FORECAST	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
REVENUE						
Patient care revenue	896,012	939,022	984,643	1,024,029	1,064,990	1,107,590
Other operating income	18,298	19,434	21,238	22,194	23,189	24,124
Finance income	1,714	1,025	767	690	610	626
TOTAL REVENUE	916,024	959,481	1,006,648	1,046,913	1,088,789	1,132,340
EXPENSES						
Personnel costs	571,563	644,024	707,319	723,043	741,181	756,368
Outsourced services	92,386	97,814	69,309	66,030	58,822	55,822
Clinical supplies and patient costs	156,568	170,506	174,108	183,974	181,886	179,827
Infrastructure and non-clinical supplies	161,546	163,124	171,815	179,886	184,688	189,884
Internal recharges	(2,322)	(2,331)	(2,309)	(2,401)	(2,497)	(2,597)
TOTAL EXPENSES	979,741	1,073,137	1,120,242	1,150,532	1,164,080	1,179,304
SURPLUS/(DEFICIT)	(63,717)	(113,656)	(113,594)	(103,619)	(75,291)	(46,964)

Table: Prospective Financial Targets and Measures DHB Governance

DHB Governance Forecast Statement of Financial Performance	2017/18 $000 ACTUAL	2018/19 $000 FORECAST	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
REVENUE						
Patient care revenue	5,466	5,574	7,903	8,219	8,548	8,890
Other operating income	18	10	13	11	11	11
Finance income	-	-	-	-	-	-
TOTAL REVENUE	5,484	5,584	7,916	8,230	8,559	8,901
EXPENSES						
Personnel costs	2,194	3,488	4,321	4,212	4,366	4,527
Outsourced services	540	1,385	621	646	672	699
Clinical supplies and patient costs	-	1	-	-	-	-
Infrastructure and non-clinical supplies	495	628	1,025	689	717	745
Internal recharges	2,322	2,331	2,309	2,401	2,497	2,598
TOTAL EXPENSES	5,551	7,833	8,276	7,948	8,252	8,569
SURPLUS/(DEFICIT)	(67)	(2,249)	(360)	282	307	332

Table: Prospective Financial Targets and Measures DHB Funding

DHB Funding Forecast Statement of Financial Performance	2017/18 $000 ACTUAL	2018/19 $000 FORECAST	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED
REVENUE						
Patient care revenue	1,356,115	1,432,918	1,495,769	1,555,599	1,617,823	1,682,536
Other operating income	-	4	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	1,356,115	1,432,922	1,495,769	1,555,599	1,617,823	1,682,536
EXPENSES						
Governance administration	5,466	5,574	7,903	8,219	8,548	8,890
Personal health	1,018,371	1,064,592	1,114,838	1,159,431	1,205,808	1,254,041
Mental health	133,918	144,193	148,903	154,859	161,053	167,495
Disability support	163,468	166,901	173,607	180,551	187,773	195,284
Public health	2,661	3,246	3,005	3,125	3,250	3,380
Maori services	5,597	5,818	5,984	6,223	6,472	6,731
TOTAL EXPENSES	1,329,481	1,390,324	1,454,240	1,512,408	1,572,904	1,635,821
SURPLUS/(DEFICIT)	26,634	42,598	41,529	43,191	44,919	46,715

1.4 Significant Assumptions

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

Key Assumptions	2019/20	2020/21	2021/22
CFA revenue growth assumptions are in line with information provided in the funding envelope and includes cost pressure and demographic growth	4.25%	4.18%	4.18%
Employee agreement assumptions	3.70%	3.70%	3.70%
Payments to NGO's (cost pressure)	1.99%	1.99%	1.99%
Payments to suppliers	0.40%	0.40%	0.40%
Capital charge – fixed rate	6.00%	6.00%	6.00%

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

Major risks	Mitigation strategy
The $31.5m savings plan and the effort required to move to sustainability require considerable focus which may be challenging in the face of day to day pressures.	• Seek savings within the framework of the Resource Review which makes a considerable number of recommendations as to where savings and efficiencies may be found. • Bring in specialist assistance to help drive the achievement of the Resource Review.
The employee relations environment presents uncertainty in terms of potential increases in employee remuneration packages, especially as a flow on from MECA settlements. A one percent increase or decrease in wage rates equates to approximately $7.2 million in additional payroll costs.	• Actively engage in national processes around relevant settlements. • Ensure stakeholders, including the Ministry of Health, are aware of the local "total cost of settlement".

Major risks	Mitigation strategy
Impact of the interpretation of the Holidays Act 2003: A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act"). Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance. For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated. The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 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. Due to this complexity the accrual in our annual accounts of $34.8m and the ongoing accrual from July 2019 onwards of $332k per month, has been based on estimates extracted from fairly small samples of employees. Thus, it should be noted that once the complex detail has been fully worked through, the actual costs may be quite different, upside or downside.	• Actively engage in national processes around relevant settlements. • Ensure stakeholders, including the Ministry of Health, are aware of the local "total cost of settlement".
There is risk that cost increases for the goods and services will exceed the assumed percentage increases based on the inherent uncertainty of future inflationary pressures. A one per cent increase or decrease in the cost of provider arm goods and services equates to approximately $3.2 million in additional expenditure.	• Review contracting arrangements and negotiate more favourable terms. • Participate in national procurement initiatives to take advantage of bulk purchasing. • Take opportunities noted in the Resource Review.

1.5 Additional Information and Explanations to Fairly Reflect the Operations and Position of the DHB

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

1.6 Subsidiaries

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

APPENDIX B:
System Level Measures Improvement Plan

Waikato District Health Board

2019/20

SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

Pinnacle Midlands Health Network

HAURAKI PHO HAURAKI PRIMARY HEALTH ORGANISATION NETWORK

National Hauora Coalition

Contents

Introduction

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

The 2018/2019 milestones, contributory measures and activities have been decided and agreed by the below parties.

Neville Hablous
Acting Chief Executive Officer
Waikato DHB

David Oldershaw
Chief Executive Officer
Pinnacle Midlands Health Network

Hugh Kininmonth
Chief Executive Officer
Hauraki PHO

Simon Royal
Chief Executive Officer
National Hauora Coalition

Executive summary

Waikato DHB, Pinnacle Midland Health Network, Hauraki PHO and National Hauora Coalition have jointly developed a 2019/20 System Level Measure (SLM) Improvement Plan. Quality improvement is at the heart of this plan with continuous improvement in the quality of care delivered and health outcomes experienced by our population being the main goal. We know we can improve health system performance through focusing on making the health care delivery effective, efficient and sustainable.

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

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

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

Purpose

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

Background

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

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

The current nationally set SLMs include:

0-4 Ambulatory Sensitive Hospitalisation

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

Acute bed days

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

Patient experience of care

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

Amenable mortality

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

Babies living in smokefree households

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

Youth access to health services

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

Development of the plan

To ensure that perspectives from all relevant parts of the health system were captured a workshop with representatives from the Ministry, PHOs, Waikato DHB, Analysts, Strategy and Funding, Community Pharmacy was held in late 2018. At this workshop Ministry expectations were clarified and the approach to be taken was communicated, the group was then guided with this approach to identify and agree activities and contributory measures for each of the six SLMs. Activities have a clear line of sight to the improvement milestone, and the agreed contributory measures will allow progress to be monitored.

In this plan there is a strong commitment to Māori and Pacific health gain and eliminating health inequities. To ensure we make real progress towards this each group has focused on an achievable number of activities that can be done well in the knowledge that new measures and activities can be agreed in future SLM plans. The joint approach to SLMs allows the development of a plan that will enable quality improvement across the sector and ensure we are improving health outcomes for our population as one cohesive team.

Structure

Previously the development and implementation of the SLM plan was completed by six working groups each containing a clinical lead, project manager, technical reference group and an overarching SLM programme manager based within Strategy and Funding. The groups met regularly (monthly or quarterly) to monitor implementation.

Based on growing experience with SLMs this structure has been reviewed and a new approach will be taken in 2019-2020. Areas of focus in each of the six SLM groups often interrelate or overlap. For this reason, the six groups have agreed that they will combine to create one large SLM steering group that meets quarterly for monitoring purposes.

Smaller expert working groups will be formed with a lead for each of the SLMs contributory and system measures and associated activity. The lead will assemble and follow any process they decide is required to implement the activities they are responsible for.

Steering group will be responsible for:

- Oversee and monitor implementation of the SLM plan
- Analyses of the national and local data
- Refine priorities and contributory measures for our district
- Lead communication, engagement with providers across the system in a collective system wide response.

Expert groups will be responsible for:

- Access and analyse the relevant data
- Agree on specific actions to achieve the priorities and establish an annual work plan
- Progress any service redesign or development required
- Monitor/report on their work plan including actions contributing to improvements in the measures. This will be done quarterly and reported to the SLM steering group and Ministry of Health (via PP22 SLM Report).

System Level Measure 1:

ASH rates in 0-4 year olds: Reduce hospital admissions rates for conditions avoidable through prevention or management in primary care

Improvement milestones:

- Annual 5% reduction in ASH rate for Māori and 7.5% for Pacific

Baseline data analysis:

- ASH rates have increased throughout the year for all ethnicities except Pacific
- Respiratory Infections and Gastroenteritis/Dehydration being the top issues for this cohort.
- 'Other' shows a lower ASH rate than Māori for most conditions

ASH rate per 100,000 0-4 year olds	12 months June 2018	12 months September 2018
Māori	10,531	11,769
Pacific	10,942	11,232
Other	8,327	8,315
Total	9,290	9,767

- Annual 5% reduction for Māori and 7.5% for Pacific would see the equity gap eliminated in 2023

Respiratory

	Rationale	Activity	Contributory measure
1.	Respiratory conditions have been identified as one of five key areas that can contribute to Iwi and Government Whānau Ora aspirations. New Zealand has high rates of asthma with symptom severity greatest among Māori and Pacific children. Individual level interventions have been shown to be effective in reducing avoidable hospitalisations due to asthma.	Increase uptake of children's influenza vaccination to prevent respiratory admissions by: • Improving vaccination rates in primary care of children aged 0-4 years with previous respiratory admissions through the provision of data, practice-level improvement activities, and following up reporting of vaccination update provided throughout the season. • Prioritising vaccination of eligible Māori and Pacific children. Support a decrease in respiratory admissions with social determinants by: • Developing a partnership between Primary Care and Waikato DHB to develop referral pathways to healthy housing options. • Establishing an accurate baseline for Whare Ora/healthy housing referrals.	Influenza vaccination rates for eligible Māori children. Target 25% Baseline measurement of referrals to healthy housing established by December 2019.

Enrolment			
	Rationale	Activity	Contributory measure
2.	We know from NCHIP data that infants who are enrolled early in general practice are less likely to be admitted to the emergency department, or to be subject to an ambulatory sensitive hospital admission. Early enrolment and engagement with primary care gives opportunity for timely immunisation, support with breastfeeding and smoking cessation services. It enables maternal and child health to be accessible, and supports whānau to access services when needed through precall and recall activities. Early enrolment has more impact on Māori whānau than others, a universal process is needed to capture all Māori infants.	PHOs will implement electronic enrolment of all newborn infants in primary care across all Waikato birth sites.	Newborns enrolled in a primary health organisation by three months. Eligible population – Infants aged up to three months. Number of infants under three months enrolled with a PHO Goal: 98% Māori and Non-Māori. Current rates: Māori 84% Pacific 82% Other 75%

System Level Measure 2:

Acute bed days: Improved management of demand for acute care

Improvement milestones:

- 3% reduction for Māori populations by 30 June 2020
- 3% reduction for Pacific populations by 30 June 2020

Baseline data analysis:

- The overall top issues by bed duration are stroke, respiratory, hip fractures and heart failure.
- Top issues for Māori include chronic obstructive pulmonary disease and smoking.
- Current Acute Bed Day rate:

	Standardised Acute Bed Days per 1000 Population		
Year	**Year to Dec 2016**	**Year to Dec 2017**	**Year to Dec 2018**
Māori	664	677	701
Pacific	628	514	599
Other	437	432	432
Total	477	471	478

Care Management

	Rationale	Activity	Contributory measure
1.	Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of care, in the hospital and/or primary care, ensuring that people receive better health and disability services. Māori are overrepresented in ASH conditions.	A new COPD pathway will be established to support patients in the community and avoid hospital admissions. This programme will target Māori and Pacific patients who would otherwise be seen in ED. Māori patients with ASH conditions (e.g. CHF, CVD,COPD, AF/ Stroke and Cellulitis) receive appropriate clinical support: • Māori patients who are eligible for a flu vaccine are targeted. • Management of Māori patients with raised CVD risk as appropriate clinical practice should result in fewer IHD and CVD admissions.	Number of 75+ year olds 'Other' with two or more emergency admissions. Number of 65+ year old Māori and pacific with two or more emergency admissions. Seasonal target of 75% of eligible Māori patients receive the flu vaccine. ASH rate for Māori adults aged 45-64 years old. Target 2% reduction.

Smoking			
	Rationale	Activity	Contributory measure
2.	Respiratory illness and its complications are a key issue for acute bed day use that we expect to be impacted by activities in smoking cessation and adult vaccination in particular for influenza in eligible populations.	Public Health Unit to work with Primary Care to partner around health literacy and messaging to improve flu vaccine uptake. PHOs and Community Pharmacy will refresh their focus on smoking cessation with new resources to support practices. Patient outcomes related to harm from smoking will be improved by: • Regular reporting rates and referrals to cessation support and rates of medication therapy in primary care. • Use of a surveillance report to monitor smoking prevalence by ethnicity and age. The importance of smoking cessation as an intervention will be promoted by: • Continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services • Further development of smoking indicators for quality, to inform primary care approaches and interventions from PMS.	Flu vaccination rates in eligible population. Baseline influenza vaccine coverage for patients with an eligible ASH condition and establish an improvement target. 15 to 74 year old PHO enrolled population who have had a smoking status of current smoker within the last 15 months. ASH rate for Māori adults aged 45-64 years old. Target 2% reduction. PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

Acute demand management programme			
	Rationale	Activity	Contributory measure
3.	Acute Demand is driven by a range of conditions. A strategic approach to acute demand management requires continual demand/capacity oversight and continuous quality improvement across our system of delivery.	As a result of the review of POAC, a cross sectoral Quality Improvement Group has been established to drive improvements across the POAC programme in real time to improve admission avoidance. This group will: Systematically review ED presentations and ASH data to improve patient care pathways through the POAC quality improvement group. • Establish baseline data. • Seek quality improvement across services. • Add or delete activity aligned with acute demand.	Decrease in ASH by 5% for Māori and Pacific.

System Level Measure 3:

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

Improvement milestones:

- Improve same day response in primary care to 8.5 for all patients
- Improve understanding of medication use by patients (by ethnicity) by 10% for national patient survey

Baseline data analysis:

- PHO patient portal access – Total patients **registered** / Total patients enrolled 10.2%
- Patient survey results show
  - 7.6 same day response for Māori and 8 for non-Māori
  - 9 for purpose of medications explained 9 for Māori and non-Māori (PHO)

Primary Care

	Rationale	Activity	Contributory measures
1.	Patient experience is a vital but complex area. Growing evidence tells us that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centered care have been linked to improved health, clinical, financial, service and satisfaction outcomes. Patient e-portals are secure online sites provided by GPs where people can access their health information and interact with their general practice. Using a patient e-portal, people can better manage their own health care.	Obtain baseline data for current numbers and usage. Baseline data has not been used to date when looking at PES data across the PHOs. Evidence shows that to have an effective portal 40% utility is required. Review the process for signing up to the relevant primary care portal, to make it easy for consumers noting that My Health requires consumers. Improvements will be made where required (easy access, less cost). Develop an integrated communication plan (with PHO, GP practices, community pharmacy, NGOs, Māori providers, inpatient and outpatient services (Waikato and rural hospitals) – a separate plan will be required for consumers and staff.	Increased patient portal. Number of patients registered to use general practice portals. Total patients registered/Total patients enrolled.

Primary Care (continued)			
	Rationale	Activity	Contributory measures
1.		Messaging, as part of the communications plan, will show benefits of using the system for consumers / make them excited to use. Likely to include: • Answer phone message • Social media campaigns • Newspaper adverts • ED campaigns (on discharge ask 'have you signed up') • Community providers • Hauora ihub Publicise the portal at planned wellness expo. Target Waikato DHB and PHO staff to join the portal.	

Medicines knowledge			
	Rationale	Activity	Contributory measures
2.	One of the consistently low scoring questions in the patient experience survey is that patients are not being told of the side effects of prescribed medications. This is an opportunity to improve.	Using a PDSA cycle with measures incorporated will allow us to test a number of interventions that might improve the patients understanding of medication. Establish a multidisciplinary working group (Primary care, pharmacy, secondary care, consumers, Māori providers) to: • Develop terms of reference and scope of an improvement project. • Review data – ethnicity/age etc. • Review international innovation best practice. • Define roles for medication safety – who does what from prescribing through to taking. Develop improvement plan by 30 November 2019. Pilot improvement project in chosen community setting e.g. Thames or Tokoroa. Utilise HQSC leaflets and posters (5 questions to ask about your medications).	Pilot results.

System Level Measure 4:

Amenable mortality: Reduction in the number of avoidable deaths and reduced variation for population groups

Improvement milestones (age standardised):

- For Māori and Pacific reduce amenable mortality rates by a total of 4% and sustain by 30 June 2023 (*this is when 2019/20 data will be available)
- For other reduce total amenable mortality rates by 2% and sustain by 30 June 2023

Baseline data analysis:

- Milestone baseline data from 2014/15
- Increase the proportion of patients assessed for risk of suicide in primary care
- Risk management in those with a CVD RA score of ≥ 15%

Coronary/CVD

	Rationale	Activity	Contributory measures
1.	Amenable mortality in the latest figures available (2015) shows Māori inequity at its starkest. In Waikato Māori amenable mortality numbers show a preponderance towards cardiovascular diseases. Well supported practices that are connected to their communities and have the right systems in place have the best opportunity to identify and engage with eligible patients, particularly Māori in their communities. With Māori men being at high risk for CVD this work will specifically target this population group. Modification of risk factors through self-management, lifestyle and pharmaceutical interventions has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD and diabetes.	Clinical Health pathways are implemented and accessed. PHOs will provide information to their practices that will enable GPs to see their population more clearly. PHOs will incentivise GP practices to provide CVRA. PHOs will educate general practice teams in Equally Well approaches to improve access for Māori men with serious mental health issues to CVRA. Implement a process to ensure all PHOs have an electronic decision support tool that will have the ability to calculate and update CVD risk consistent with the National Consensus Statement for Assessment and Management of CVD in Primary Care.	Clinical Health pathways rates of access. CVRA rates Māori males 30-44+ and rate of those with a > 15% risk with a management plan. CVRA rates for Māori. Target 90% Percentage of Māori with a previous CVD event who are prescribed triple therapy. Target 60%

Diabetes			
	Rationale	Activity	Contributory measures
2.	Diabetes affects 6% of the enrolled population with Māori and Pacific disproportionately represented at 6% and 11% respectively. Only 42% of diabetics have their HbA1c levels managed adequately and Māori and Pacific are once again overrepresented in these figures. (Figures as at Q3 2018/19) Focusing on diabetes management through the following activities will reduce these inequities as well as overall morbidity and mortality.	Incentivising the improvement activity at practice level around diabetes management through a quality plan. These plans will incorporate the following initial activity: • Upskilling of practice nurses to help manage more complex diabetic patients. • Provision of prioritised lists to practice of patients who need to be targeted for better control of diabetes with Māori and Pacific prioritised. • Referral of Māori to culturally appropriate providers for self-management and support.	Reducing the equity gap between Māori and non-Māori in respect to HbA1c result less than 64mmol/mol. Target: Total population should be >60%. Equity gap between Māori and non-Māori and wider population no greater than 10%.

System Level Measure 5:

Babies living in smoke free homes: Reduction in the number of maternal smoking as well as the home and whānau/family environment

Improvement milestones:

- A reduction in the equity gap between Māori and non-Māori living in a smoke free household at 6 weeks from 34% to 17%.
- Increase referrals to maternal incentives smoking cessation programmes by 10% for pregnant women and whānau.

Baseline data analysis:

- While the overall percentage of babies living in a smoke-free household hovers around 72%-74% for the Waikato, huge inequity exists in this measure. As little as 50% of Māori babies in the Waikato live in a smoke-free household as opposed to 84% of non-Māori, non-Pacific babies.
- This SLM is important because it focuses attention on maternal smoking as well as the home and whānau/family environment. For these to be a success, stop smoking support and services need to be available across the lifespan and therefore our contributory measures are focused across the different stages of the pregnancy pathway.

Pregnancy

	Rationale	Activity	Contributory measures
1.	Equity: Significant equity gap between Māori and NZ European. This measure targets Māori results to enhance equity focus for monitoring and activity. Utilisation and access: Low numbers accepting referrals to smoking services. Smoking during pregnancy leads to increased carbon monoxide concentration in the blood of both the mother and her baby, resulting in reduced oxygen and nourishment available to the baby. This increases the risk of babies being born with a low birth weight and increases the risk of neonatal mortality, sudden and unexpected death in infancy and long-term respiratory problems for the child.	Develop a robust process for referral of pregnant women to smoking cessation programmes from LMC/GP/WCTO. Develop a toolkit that would enable the use of the Tupeka Kore framework to be rolled out in primary care (LMCs/GPs/Well Child Tamariki Ora). Hapu Mama (our District wide maternity support programme for pregnant Māori women) will have increased capacity for smoking cessation support for pregnant mums. Initial activity will include: • Increased focus on being smoke free during pregnancy and providing stop smoking support and/or referral to Once and for All Stop Smoking Service. • Provide incentives to stop smoking for hapū mama.	Smoking cessation referral rates for Māori and Pacific. Target 10% increase. Enrolment rates into smoking cessation programme. Smoking rates of postnatal women and households at 6 weeks (by Māori, Pacific, Other and Total). Smoking cessation programme completion rates for Māori and Pacific will increase by 25%.

Lifespan			
	Rationale	Activity	Contributory measures
2.	Placing the spot-light on particular data sets has resulted in data quality improvement in the past and it is anticipated this will occur for these datasets as well. Locally we have limited across sector access to regular robust data and the focus for 2019/20 activity is on data quality and monitoring to capture our denominator data accurately.	The DHB will roll out training to Tamariki Ora providers and monitor their smoking cessation referral rates.	Smoking rates of postnatal women and households at 6 weeks (by Māori, Pacific, Other and Total). Referral and programme completion rates to be audited by DHB.

System Level Measure 6:

Youth: Intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year olds'.

Improvement milestone:

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

Baseline data analysis:

- Waikato rates are generally increasing and Waikato's rate is higher than the national rate

Ethnicity	Waikato rate (per 10,000)	National rate (per 10,000)
Māori	72.3	67
Pacific	25.7	35.3
Other	61.2	49.8
Total	63.3	52.2

	Rationale	Activity	Contributory measures
1.	Poor understanding of current youth service availability and quality. To achieve health equity for youth, primary to tertiary services need to be accessible, appropriate and effective. The Waikato DHB region has no up to date needs assessment for youth in our region. Improved access to quality of care is required for youth in the Waikato region. Focus is on increased collaboration, enhanced understanding of youth needs and youth service provision, and increasing opportunities for alignment.	Waikato DHB to provide workforce development for school based nurses and GPs on identification and referral pathways for self-harm.	10% increase in referrals to youth primary mental health services.

Appendix

2019/20 SYSTEM LEVEL MEASURES (SLM) WORKING GROUP TERMS OF REFERENCE

Purpose

The purpose of the SLM working group is to bring together local experts across the sector to collaborate and recommend the following for the 2019/20 measure

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

Specific responsibilities

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

Outside of scope

- Funding related decisions

Linkages

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

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

Formation details

The working group were established in May 2017

Terms of membership

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

Meetings

The SLM working group will meet quarterly for the purpose of monitoring implementation.
Smaller working groups responsible for implementation will meet at the leads discretion.

Accountability

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

Waikato Child Health Network and DMG make final recommendations to Inter-Alliance.

Governance

Waikato DHB's executive leads for SLM are:

- Damian Tomic – Clinical Director, Primary and Integrated Care
- Tanya Maloney – Executive Director, Strategy and Funding.

The Waikato Inter-alliance will have oversight for Waikato system level measures.

The working group will all report to one of the two following groups or straight to Inter-Alliance

1. Waikato Child and Youth Health Network
   Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
   Proportion of babies who live in a smoke-free household at six weeks post-natal
   Youth access to and utilisation of youth-appropriate health services

2. Demand Management Advisory
   Acute hospital bed days per capita
   Amenable mortality

3. Inter-Alliance
   Patient Experience of Care

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

APPENDIX C: Waikato Public Health Annual Plan

Public Health

1 July 2019 – 30 June 2020

Public Health

Waikato District Health Board

Author: Public Health Unit
Last updated: 31 May 2019
Version: v3.0 Final

Date	Author	Summary of changes	Version
04/03/2019	Dyfed Thomas	Document creation	1.0 Final
19/03/2019	Dyfed Thomas	Incorporate feedback from across PHU	1.1 Final
29/03/2019	Dyfed Thomas	Incorporate Strategy and Funding feedback	2.0 Final
23/05/2019	Dyfed Thomas	Incorporate feedback from Ministry of Health	2.1 Final
24/05/2019	Dyfed Thomas	Incorporate feedback from Executive Director, Strategy, Funding and Public Health	2.2 Final
31/05/2019	Dyfed Thomas	Final version for submission to Ministry of Health	3.0 Final

mihi

Ka tū whera te tatau pounamu o te Ao
E takoto te whā riki o te Atua ki mua i a tātou
He hō nore, he korōria ki te Atua
He maungārongo ki te whenua
He whakaaro pai ki ngā tāngata katoa
Ka huri te kei o te waka ki te Kīngi a Tūheitia
Me te whare Kāhui Ariki whānau whānui tonu
Māte Atua e tiaki, e manaaki i a rātou
Me ngā whakaaro tonu ki ngā mate o te wā
Takoto mai, moe mai koutou, haere, haere, haere
Kāti rātou ki a rātou, tātou ki a tātou
Nō reira, he korowai rau whero o te whare Waiora o Waikato
Haere mai, Haere mai
Nau mai

The green stone door to the world opens
The whariki of God is laid before us
All honour and glory be to God
May there be peace on Earth
And good will to all people
The keel of our waka turns to King Tuheitia
And the household of the Kahui Ariki
May God care and bless them
Our thoughts turn to those who have passed on recently
Rest in peace sleep in peace depart journey on
Let the dead be separated from us the living
Therefore to our distinguished guests gathered here
Welcome, welcome,
Welcome.

Contents

1. Introduction

The annual plan is presented in relation to our core functions, which are outlined in Figure 2. Recently the Public Health Unit (PHU) was merged with the Strategy and Funding arm of the Waikato District Health Board (DHB) to form Public Health, Strategy and Funding. With this formal joining of the two groups, the PHU will be able to increase its collaboration and integration of public health action and effort across the DHB. The annual plan will highlight areas of alignment and support of wider DHB work and strategies. This plan was presented to Waikato DHB's Community and Public Health Advisory Committee (CPHAC) on 10 April 2019.

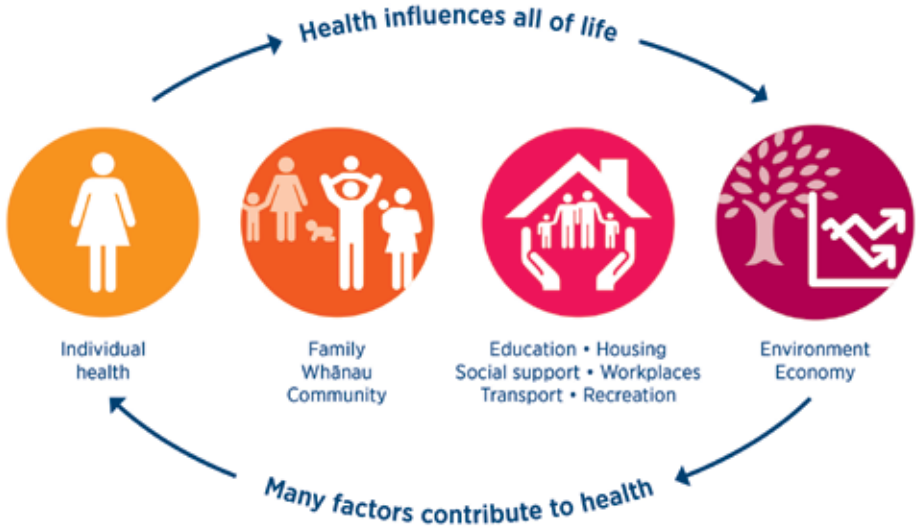
1.1 Why do we have an Annual plan?

The annual plan sets out the work to be covered by the PHU in the coming year, 2019/20. The Waikato DHB PHU provides public health services under the public health service specifications (tiers one, two and three) as agreed by the Ministry of Health. The annual plan outlines what we intend do to fulfil this contract as well as being mindful of the Ministry of Health's guidance for 2019/20 planning. The plan is also aligned with the Waikato DHB strategic imperatives (Waikato DHB, 2016) and the New Zealand Health Strategy themes (Ministry of Health, 2016).

1.2 Waikato Public Health Unit

In Public Health we strive to improve health across the life course of populations, from early life to older life. Waikato DHB prides itself on having an integrated public health service that prioritises its activities on promoting, improving and protecting health with a focus on achieving equity for people living in the Waikato DHB area. We work with communities such as Māori, those living in poverty, people in rural communities and those with disabilities to remove barriers that keep them from being well. Good health and wellbeing are about more than healthcare. A good start in life, education, decent work and housing, and strong, supportive relationships all play their part, which is why we take a broad look at health in our work covering many aspects as shown in Figure 1.

Figure 1: Health links with the wider environment.



(Ministry of Health, 2016)

The PHU's core functions, as outlined in Figure 2, underpin all we do. We fulfil regulatory and statutory functions relating to the public's health largely covered by the Health Protection Team and Medical Officers of Health. The Public Health Advisory and Development Team provide leadership through evidence based information, analysis, advice and practice. Reflecting the wider influences on health the Unit operates in a variety of settings which in turn shapes the way our Health Improvement Team works.

The Health Improvement Team (formerly Health Promotion) has adopted a settings based approach (see Figure 2). This allows us to work with key decision makers/leaders of community settings and to support them to provide an environment that is conducive to improving the health and wellbeing of our population. The team works in three settings; Healthy Education, Healthy Whānau with a focus on Māori and Pacific families and Healthy Workplaces. By working in this way, with the support of the Health Improvement Team, communities to lead and identify public health issues that require attention in their setting.

We deliver public health services across our communities and within settings using our public health process (bottom of Figure 2) as a guide. This process is a consistent framework for implementing the settings based approach and supports integration of public health core functions and change in practice. At the centre of our public health process is whānau ora. The settings based approach has an intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities. Te Pae Mahutonga is embedded within this process as our framework for engaging effectively with communities within our key settings.

Figure 2:

With a systems view in mind and consideration of a life course approach, targeted services are being negotiated with communities and organisations through the settings across the

Waikato DHB Rohe and ensures a strong equity focus as it allows assessment of current or future impacts on achieving health equity.

Healthy education

The education settings encompass early childhood education services (ECEs); years 1-8 in primary and intermediate schools[1] (previously covered by health promoting schools); and years 9-13 in secondary schools. To create a health promoting setting, health improvement advisors work with Ngā Manukura (leadership) within education settings, where they consider three levels of influence, which are organisational structures, environmental structures and whānau wellbeing.

Using the health improvement process to review these three levels of influence, the Health Improvement Advisors (HIA) facilitate a setting to support Ngā Manukura as health concerns and issues are identified, while at the same time they ensure Te Manawhakahaere (autonomy) to find and embed appropriate solutions.

Healthy whānau

Healthy whānau concentrates on social and cultural settings that whānau connect with. We acknowledge the need to address health equity for Māori and Pacific communities and understand that culture is a key determinant of health. We work in partnership with Māori and Pacific communities to influence healthy settings that support wellbeing, utilising tools and processes influenced by Māori and Pacific realities, practices and understandings.

Building on connections HIA's have, attention is given to engaging effectively with Māori and Pacific communities (particularly in rural areas) to inquire about and identify their holistic health and wellbeing needs and work together to determine ways to support and improve their health. The PATH tool is being used to advance the engagement and inquiry processes with great success to date.

Healthy workplaces

Healthy workplaces acknowledges that people spend at least one third of their life at work and therefore the workplace is a significant setting to improve, promote and protect the wellbeing of adults.

WorkWell is an evidence based programme developed by Toi Te Ora - Public Health service, delivered nationally and across the Waikato region. WorkWell operates on a continuous improvement cycle (Engage, Assess & Prioritise, Plan, Apply & Implement, Evaluate & Improve) and a stepped accreditation process (Bronze, Silver, Gold). A targeted engagement strategy determines the most appropriate industries and geographical locations for promotion or workplace wellbeing and active recruitment of WorkWell businesses. The workplaces team use a weighted; equity based scoring system to prioritise businesses as priority 1-5. This ensures equitable delivery of service across the enrolled WorkWell businesses.

[1] The Sport Waikato energizer contract offers District–wide coverage of primary schools (years 1-8).

1.3 An overview of the Waikato DHB area

The Waikato Public Health Unit covers a vast geographical area that stretches from northern Coromandel to close to Mount Ruapehu in the south, and from Raglan on the west coast to Waihi on the east and covers more than 21,000km^2.

The principal iwi (Māori tribal groups) in the Waikato DHB district are Hauraki, Ngāti Maniapoto, Ngāti Raukawa, and Waikato. Ngāti Tuuwharetoa and Whanganui iwi groups also reside within the district, and a significant number of Māori living here affiliate to iwi outside the district.

Waikato had an estimated resident population of 377,940 based on the 2013 Census. Of this total population, Māori made up 22.5% (or 85,000) which is a higher proportion than the national average of 14.4%. Pacific peoples made up 4.1% (or 15,610) which is a lower proportion than the national average of 7.8% (Statistics New Zealand, 2015). Projections for 2019/20 (based on the 2013 Census) show Waikato DHB serving a population of 426,400, with 22.9% (or 97,500) of the population identifying their primary ethnicity as Māori (Ministry of Health, 2018).

The Waikato region has a similar percentage of people aged 65 years compared to the national average (14.5% compared to 14.1% nationally), and slightly higher percentage of people aged under 15 years (21.7% compared to 20.5% nationally). While the non-Māori and non-Pacific population is projected to increase to 315,500 by 2034, an increase of 6%, the Māori and Pacific population is growing much faster. The projected increase for the Māori population is 28%, to 124,900, and the Pacific population is expected to grow by 38%, to 18,800. By 2033 Māori are projected to make up 26% and Pacific Peoples 4% of the total population (Ministry of Health, 2018).

There are 10 territorial local authorities within Waikato DHB boundaries – Hamilton City, Hauraki, Matamata-Piako, Otorohanga, (part of) Ruapehu, South Waikato, Thames-Coromandel, (part of) Waikato, Waipa, and Waitomo.

2. How our plan links to DHB, regional and national priorities

The PHU is also committed to working in partnership through our settings approach, Public health advice and development support and health protection arms with the DHB, the DHB's Consumer Council, local iwi and Māori providers, Pacific providers as well as the Midland Public Health Network. The Annual Plan is aligned with national, regional and local strategies.

All of the Waikato DHB strategic imperatives have relevance to the Waikato Public Health Unit as shown below.

Figure 3: Waikato District Health Board strategic imperatives along with how the PHU's work relates to them.

Waikato DHB Health System Plan

In 2018/19 Waikato DHB developed a Health System Plan to improve our health system and futureproof it for the challenges we expect in the coming years. It translates the DHB Strategy vision - 'Healthy people, excellent care' - into a set of strategic goals and actions for the Waikato health system for the next ten years.

During a series of wānanga, focus groups, and workshop sessions, over 600 members of our community (including health workers from the DHB and the broader health system) took

the opportunity to share their experience, knowledge and ideas. People said that they would like Waikato health services to be:

- Focussed on wellness and wellbeing
- Focussed on the needs of service users, not the services' needs
- Equitable and fair for everyone regardless of ethnicity, sex, age or where people live
- Joined up health services with smooth links between health and other social services
- Designed with the people who use them.

The community and whānau voices align strongly to key public health have been distilled into goals with underlying actions. At least two of these goals have clear links to recognised public health approaches.

Healthy People.

- Partner with Māori in the planning and delivery of health services
- Empower whānau to achieve wellbeing
- Support community aspirations and address determinants of health

Excellent Care.

- Improve access to services
- Enhance the capacity and capability of primary and community health care
- Strengthen intermediate care

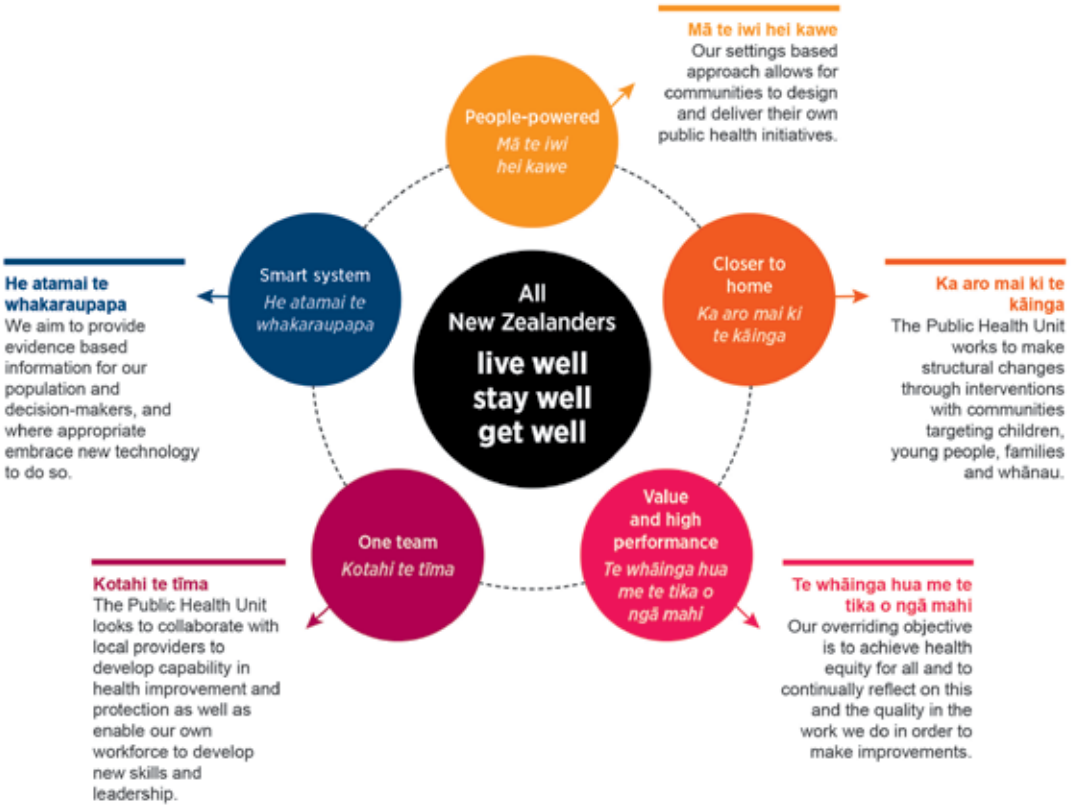
Key areas Public Health are working to support the DHB for 2019/20 includes:

- Māori health and equity.
- Disability and equity.
- First 1000 days.
- Climate change and environmental sustainability.
- Healthy eating – healthy weight.
- Developing preventative capabilities in hard-to-reach communities.
- Cross-sectoral collaboration.

New Zealand Health Strategy

The NZ Health Strategy: Future Direction (Ministry of Health, 2016) outlines the high-level direction for New Zealand's health system over the 10 years from 2016 to 2026. It has a vision and it lays out some of the challenges and opportunities the system faces; describes the future we want, including the culture and values that will underpin this future; and identifies five strategic themes for the changes that will take us toward this future (Figure 4).

Figure 4: New Zealand Health Strategy five strategic themes (2016).



The annual plan tables that follow will highlight (two left-hand columns) which strategic imperative (DHB) or strategic theme (NZHS) each action relates to. This is not done for the health protection section as the actions relate to specific legislation, which is noted.

3. Midland Public Health Regional Network

The Waikato PHU is part of the Midland Public Health Network, which also includes, Bay of Plenty and Lakes, Taranaki and Tairawhiti PHUs. The Network provides an opportunity for PHUs to work together on issues affecting the Midland region and this annual plan aligns with its goals, which are:

- Enhance the consistency, coordination and quality of public health service delivery across the region.
- Share innovative public health practice.
- Explore opportunities for increased efficiency through collaborative actions.
- Support and provide public health advice to other Midland clinical networks where they have a focus on upstream prevention.

Reflecting the Ministry of Health's expectations of continuing to share best-practice innovations with other PHUs, the region will support a commitment in the following areas for 2019/20:

a) Health equity

The Midland PHUs are committed to achieving health equity for high need populations and will share knowledge and practice that contributes for reducing differences which are unnecessary and avoidable, and are unfair and unjust.

b) HealthScape – Public Health Information Management system

The five regional PHUs are committed to adopting technology where a need is identified and its adoption will improve their service. HealthScape is currently being used by Toi Te Ora and Waikato PHU is currently implementing the system. Drinking Water operations will be the first area of implementation for Waikato. Taranaki and Tairawhiti PHUs are currently considering options for adoption. The Network recognises the value in adopting this system and will continue to share resources and knowledge on HealthScape.

c) Healthy Public Policy Network

In the last year this network has been established nationally, initiated by members of the Midland Region. The Midland Region will continue to promote and improve healthy public policy action through sharing knowledge, effective communications, improved consistency, improved capacity and reduced duplication of effort.

d) Health literacy

In order for people to stay healthy, improve their health and benefit from services we need health services to operate in a way that is appropriate, relevant and effective for them; this is a key area for all PHUs. This includes cultural competency so we can better communicate with Māori, Pacific peoples, disabled peoples and our migrant populations. The Network will continue to share knowledge and resources on health literacy for this purpose.

e) Sexual health

As noted in the Ministry of Health annual plan guidance the incidence of syphilis is increasing rapidly. The Network will collaborate and share resources and solutions in the effort to reduce incidence.

4. Population level indicators

We have included a set of population level indicators that broadly reflect the life course and can be impacted by a range of strategies the Unit work to. They are part of a wider body of work on developing a monitoring framework for the Waikato DHB Public Health Unit. They will be reported on in the annual report. They are:

- Gini coefficient.
- Percentage of children living in smokefree home.
- Percentage of newborns enrolled with a primary health organisation (PHO) by three months.
- Percentage of adults meeting vegetable and fruit intake guidelines.
- Percentage of adults experiencing psychological distress (high or very high probability of anxiety or depressive disorder, K10 score ≥12).
- Prevalence of adults who are smokefree.
- Rate of wholly alcohol-attributable hospitalisations.

5. Health assessment and surveillance 2019/20

Health assessment and surveillance support will provide the evidence to inform and drive service design, delivery and practice. We aim to:

- Develop and foster relationships with key partners that enable access and sharing of data to collaboratively discuss public health issues.
- Review and refine surveillance data management systems to ensure best quality data is collected, collated, analysed and reported.
- Explore opportunities to disseminate public health data with a focus on health determinants, in particular health inequities and the health of Māori and Pacific people.
- Engage with regional and national projects to develop and utilise consistent indicators that measure public health outcomes.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Public Health surveillance					
He atamai te whakara-upapa Ka aro mai ki te kāinga Te whāinga hua me te tika o ngā mahi	Pae taumata	Access and assess all available health related data. Explore additional data sources and the integration of health and social care data Continue indicator development and refinement for service in relation to the health status of the Waikato Population and the PHU strategy areas. Monitor and/or undertake regional or local analysis reports of alcohol intake, alcohol-related harm/disease, trends and highlight disparities.	No. of regional and/or local reports prepared and shared internally and externally as appropriate. No of: • Reports developed. • Reports analysed. Describe the scope, content and audience of regional or local analysis reports. No. of (CD): • Surveillance reports. • Reports disseminated to the sector and/or community groups that you have contributed to or produced.	Any documents produced are robust with high quality data and in line with peer review processes. Methodologies utilised are robust and culturally responsive. Describe how reports have considered: • Impact on specific population and health inequities. • Complied with relevant data collection, collation, analysis, and output protocols. • Any barriers to analysis of data by ethnicity.	Service direction and delivery is informed by quality epidemiological data and complemented with community-up information. Long-term project, therefore narrative of progress. Indicators clearly link through various strategies. No. and percentage of external service users report that they used the information disseminated to inform their planning, programme design and delivery of prevention and control services (BC, S). Describe how useful the report was for internal planning e.g. to develop submission on LAP. Provide a summary of outcomes of
He atamai te whakara-upapa	Haumaru	Conduct surveillance for the purpose of preventing, identifying and responding to emerging communicable disease issues. Report on communicable disease (CD) data. Produce and/or contribute to disease-specific reports for communicable diseases (CD) of concern.			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
			Description (CD) type of report and the stakeholders the reports were disseminated to.	Describe how well CD surveillance system is performing and any challenging or emerging issues. Describe emerging CD issues and how PHU is addressing these.	CD surveillance activities.
Population Health assessment					
Ka aro mai ki te kāinga	Whaneke-tanga	Submissions made, and advice provided to organisations (within and outside the health sector) on issues of interest to PH.	No. of: • Submissions made and captured in database. • Position statements developed. • Current position statements reviewed and updated. • Sections updated and developed. • Discussion documents promoted. • Strategic documents are developed or updated. • Impact assessments undertaken with stakeholders.	100% of submissions will be guided by evidence best practice and follow internal process and be collaborative. Percentage of submissions contributed to by DHB's Strategy and Funding Division PHU peer review and appropriate service procedures will be followed. Database updated regularly of all submissions made and their outcomes. Percentage of position statements submitted to DHB's Community	Service direction and delivery is informed by quality epidemiological data and complemented with community-up information. Number/percentage of recommendations made by PHU adopted by receiving authority. Narrative on barriers to adoption provided. Public health issues are raised with a view to positively influence decision-making. Stronger collaboration within the sector enables services to be streamlined and actively promoted. Extent to which PHU input is reflected in steering group decisions. Narrative of advocacy actions and results.
	Haumaru	Waikato DHB position statements on public health issues are developed and updated.			
	Ratonga a iwi	Work with Waikato DHB to develop position statements on sustainability and equity for the Waikato DHB region			
	Whaneke-tanga	Develop plan for the healthy policy (HiAP) function of the Unit.			
Kotahi te tīma	Haumaru	Support the Waikato DHB in further development of the DHB Healthy Food and Drink Policy.			
Mā te iwi hei kawe	Oranga	Continue to support our settings (education, whaanau, workplaces) in developing and implementing healthy food and drink policies including water only policies.			
He atamai te whakara-upapa	Haumaru	Continue to embed an internal strategic planning process for key identified priority areas			
Kotahi te tīma	Whaneke-tanga	Advocacy at national, regional, and local levels to support policies and practices that address PH issues.			
	Ratonga a iwi	Support the Waikato DHB in the development of the DHB Transport Policy			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Ka aro mai ki te kāinga	Haumaru	Identify opportunities and apply HIA as appropriate in response to organisation determined priority.		and Public Health Advisory Committee for approval. 100% of planning resources guided by evidence and best practice. Collaborative alliances are formed with stakeholders to enable the review and development of policies, processes and resources. Describe the extent to which the advice given by PHU promoted best practice.	HIA recommendations utilised where appropriately internally and externally.
Kotahi te tīma	Whaneke-tanga	Advocate for and offer to partner stakeholders to undertake impact assessments.			

6. Public health capacity development 2019/20

Within this core function we aim to:

- Develop and implement professional development pathway to provide access to appropriate training and professional development to all Population Health staff.
- Develop and implement an information and knowledge framework to strengthen programme planning and transferring knowledge to inform policy and service design and delivery.
- Use consistent approaches to research and evaluation.
- To foster and develop leadership across the service from management to service delivery.
- Strengthen key internal partnerships and develop opportunities for inter-sectoral collaboration to achieve equity in health.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Capacity and capability (Human Resource)					
Kotahi te tīma Te whāinga hua me te tika o	Pae taumata	Provide guidance and best practice advice for research and evaluation to PHU staff (TUK: 1.4, 1.6, 7.1).	Number of: • Staff receiving training and / or research and evaluation support. • Staff attending training. • Setting specific health promotion training by type (for HIT). One review completed to determine practicality of trainee position. Career and development plans in place for 100% of PH staff. Number of staff	Guidance and advice provided is aligned with PH best practice frameworks and processes. Appropriate guidelines and tools are developed to ensure staff can transfer knowledge into practice. Support training that has appropriate cultural frameworks embedded in the sessions. Responsive to needs and requests for training. PH continues to be an	Quality documentation produced by staff. Increase in staff confidence and skills to carry out PH activities, project and evaluation planning. Increase in staff professional development/improvement, confidence and skills to carry out PH activities. Increased number, and skills of, regulated and designated workforce. Designation and skills of existing regulated workforce maintained in line with best practice and requirements of regulatory
		Access to learning and development opportunities provided and or identified by DHB or PH. (TUK: 1.6).			
		Public health medicine registrar post provided and successful candidate supported. (TUK: 1.6, 4.2, 9.3)			
		Facilitate and support access to training and development opportunities. (TUK: 1.4, 1.6, 4.2).			
	Ratonga a iwi	Build Public Health leadership through supporting PHU staff to apply for and attend public health leadership training or equivalent (TUK: 1.6, 2.1).			
		PHU staff participates in orientation and annual performance reviews including cultural competencies (TUK: 1.1, 8.2, 8.5).			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
ngā mahi			participation reported. One induction and orientation process provided to each new staff member. Annual performance reviews held with 100% of staff. Number of mentoring/ coaching sessions provided by specialists in PH Unit. Service Improvement plan (SIP) (Māori / Pacific) in place Annual report on SIPs implementation completed. Advice provided on request. Access to study resources including but not limited to: Public Health Unit library, DHB libraries. No. of staff attending NPHAWG and other training workshops. No. of training activities (alcohol) or professional development activities delivered. Also, nature of	approved workplace for registrars. Registrars complete all activities required for competencies assessment. For training: • Evaluation following training sessions. • Staff engaged to develop training plan with manger. • Record of training and development for each PH staff member. Annual reviews: • Training and support needs identified and planned for. • Career development plans produced. • Leadership objectives reviewed. • Provided within a safe environment that encourages openness. • Advisors to evaluate roles after six months' time.	authorities. Increased awareness and uptake among staff of accessible professional development opportunities Public Health Unit staff engaged in professional planning processes. PHU support enhances the learning of the Public Health Unit workforce. Supportive workplace culture for building capability and capacity amongst the workforce. Local Māori and/or Pacific provider has increased capability and capacity for research, project and evaluation planning. Advance workforce planning and capacity building to grow public health workforce. Content of planning and evaluation advice/workshop enhanced. No. and percentage (alcohol) of: • Participants report an increase in the level of knowledge of the topic of the training activities (SK, S). • Participants report they can
Kotahi te tīma	Pae taumata	All staff will prepare learning and development plans (reviewed annually).			
		Support provided to staff undertaking relevant public health tertiary training. (TUK: 1.1, 1.6, 9.3)			
Te whāinga hua me te tika o ngā mahi	Oranga	Support the implementation of a service wide approach to improving the health of Māori and Pacific communities in the Waikato DHB area. (TUK: 1.3, 1.6, 2.2, 3.3, 5.1).			
Mā te iwi hei kawe	Manaaki	Provide planning, research, evaluation advice and support for Māori and Pacific public health providers. (TUK: 1.6, 2.1, 3.1, 7.1)			
Te whāinga hua me te tika o ngā mahi	Oranga	Support DHB initiatives to develop preventative capabilities in hard-to-reach communities			
Mā te iwi hei kawe	Whaneke-tanga	Undertake collaborative projects with key stakeholders (e.g. South Island Public Health Partnership Alcohol Working Group).			
Kotahi te tīma	Pae taumata	Support alcohol team staff to attend National Public Health Alcohol Working Group (NPHAWG) workshops and other training.			
		Provide training and professional development for relevant PHU staff on alcohol policy analysis, information systems and health promotion to reduce harm from alcohol.			
		Maintain a communicable diseases (CD) response capacity and support CD staff to attend ESR epidemiological skills courses			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		and other relevant courses.	training delivered and to whom. No. of: • CD staff attended at least 1 in 3 of ESR's epidemiological skills development programme core courses. • CD staff attended other relevant courses. • Education sessions delivered to health professionals external to the PHU. Description of non-core courses delivered to CD staff. No. of : • Trainings attended / completed by staff in effective health literacy communication. • Information resources produced/ provided for the target audience (partners and communities) including	Percentage (alcohol) of : • Participants report they are satisfied or very satisfied with training. • Training activities include a focus on improving health of Maori and Pacific, and fostering equity. • Training documents provided demonstrate high quality content and are responsive to the needs of staff. • Training reports/learnings shared at the service level by staff that attend • Documents or information resources produced include quality data and use plain language. • Type and extent of support/contributions made by MWSG members.	confidently apply the knowledge acquired to their alcohol and other drug work[2] (BC, S). Narrative of timely notifications occurring and if not, what will be done to address the issue. Narrative around: • Competency in communicating health information. • Stakeholders are accessing relevant mental wellbeing resources that are useful in their roles. • Whanau/communities/patients are enabled, through knowledge gain, to make informed and timely decisions around accessing mental health and related services. • Stakeholders engagement with the MWSG members and how that engagement has contributed to the de-stigmatisation of mental illness/issues and improved awareness of positive mental
		Maintain a planned programme annually to upskill investigating officers (CD)			
		Deliver education to health professionals (external to the PHU) and promote the importance of timely notification of CDs.			
Te whāinga hua me te tika o ngā mahi	Haumaru	Improve capability of Public Health staff in the mental health and wellbeing area through increased literacy.			
		Support key community settings to destigmatise mental illness / issues; and raise awareness regarding mental wellbeing.			
		Explore PH ways to respond to "First 1000 Days" mental wellbeing for hapu wahine (women), nga whaea (new mothers), and pepe (babies).			
Kotahi te tīma	Pae taumata	Immunisation teaching provided for medical students, practice nurses, PHNs, GP registrars			
		Support DHB work on enabling a Māori community led approach to immunisation			
		Support DHB work on a pilot of pharmacy provided scheduled childhood vaccinations			
		The nutrition and physical activity strategy group will engage and support key community settings (e.g. workplaces, schools, sport, local government, Māori and Pacific settings) to inquire, plan and transform food environments and physical activity levels.			
		Continue to grow Health Protection Officer			

3 Based on relevant assessment tool available within the organisation or from competency training provider.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		workforce by focussing on trainee possibilities where possible (currently at full capacity). Continue to focus on strengthening the Drinking Water Assessor and Technical Officer workforce by actively recruiting for both fields of expertise.	through a variety of media and technological approaches. • Networks supported / engaged with by MHW Strategy Group members. • Type of scoping activity (research, needs assessment, engagements) by PH that informs a "First 1000 days" mental wellbeing focus.	• The MWSG advocates that the explorative methods utilised are robust, culturally appropriate with a public health perspective evident. • Key priorities from "First 1000 Days" mental wellbeing literature are communicated across the service.	wellbeing. • The service direction and response are supported by the MWSG on identified/ prioritised first 1000 days initiatives and related activities. • Prepare a summary of actions (for initiation, delivery and evaluation) with a focus on MW during First 1000 days across PH teams and other service/regional groups to inform the PH leadership group. Narrative on immunisation activities. Narrative on how healthy nutrition and physical activity is supported by strategy group across settings
Information and knowledge services					
He atamai te whakara-upapa	Pae taumata	Provide research, analysis, interpretation and/or present evidence-based information on specific health and wellbeing issues.	No: of: • Analysis. • Advice. • Research. • Evaluations. Digital platform policy developed. No. of (alcohol):	Evidence-based information provided to inform strategic PH action across a wide range of sectors. Documents produced have been through internal peer review process.	Evidence based information utilised internally and externally to inform service design and delivery. Narrative on the process of development and application of digital platform policy. No. and Percentage of parents report increased knowledge of the
	Ratonga a iwi	Continue to implement HealthScape across the Unit on a team by team basis			
Mā te iwi hei kawe	Manaaki	Continue PHU wide process/policy on the use and communication through digital platforms. Raise awareness in communities of legislation relating to social supply to minors and alcohol-related harm.			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Manaaki	Alcohol harm strategy group to work with settings (e.g. workplaces, education whaanau) to develop evidence-based PH action (e.g. strategies and policies) which support the reduction of alcohol-related harm where there is an agreed priority for that setting. As appropriate we will prompt setting to consider alcohol as a priority.	• Awareness raising activities. • Communities provided with information on legislation relating to supply to minors. Description of communities assisted. No. of (alcohol): • Settings supported. • Support resources developed. • Key activities delivered. Description of organisations engaged with and advice and support (alcohol) given.	PHAD request form utilised to capture all requests. Percentage of communities supported (alcohol) that are in low SES/high number of Māori areas. Percentage of (alcohol): • Settings supported that are in low SES areas. • Settings supported that are kaupapa Maori settings.	legislation around social supply of alcohol to minors (SK, S). No. and Percentage of: • Organisations that have adopted evidence-based PH action to support the reduction of alcohol-related harm as a result of the PHU support activity (BC, S). • Organisations report increased knowledge about alcohol related harm and/or evidence to reduce alcohol related harm (SK, S). Impact of any PH action in settings as a result of PHU support/contribution. Narrative on reports and progress, networking and partnerships, submissions, hearings and other opportunities for advocating for nutrition and physical activity Narrative on engagement with LG and outcomes in relation to smokefree environments
		Nutrition and physical activity strategy group will advocate at local, regional and national levels through group representation to influence environmental opportunities for nutrition and physical activity			
		Tobacco control strategy group will support key community settings (workplaces, schools, sport, Māori and Pacific settings) to develop solutions to tobacco harm, with a focus on smokefree policies and environments, and access to cessation support.			
Ka aro mai ki te kāinga	Whaneke-tanga	Tobacco control strategy group will encourage Local Government to develop and expand smokefree environments through policies and/or bylaws			
Organisation and Infrastructure services					
Te whāinga hua me te tika o ngā mahi	Haumaru	Support the development and monitoring of service plans and indicators to ensure service improvement.	Plans are developed and reviewed / updated on a regular basis. A minimum of two “clinical”	Scheduled updates and/or reporting. Internal monitoring process is developed and	Infrastructure support systems maintained and developed with a focus on quality improvement; risk identification and minimisation; consistency of service.
		Quality linked plans / programmes developed and monitored include:			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		• Risk register (via Datix) • Coordinating hazards review (via Datix) • Audit programme • Service annual plan • Standard operating procedures (SOPs)	audits completed. Reports delivered to management monthly against annual plan deliverables through governance and strategy group. Resources will be provided in response to requests. Number and type of requests for graphic design support (internal and external).	implemented. Actions identified through audits are monitored for implementation and reflected in process updates. SOPs database monitored and updated regularly. Requests are fulfilled in a timely manner and database maintained. Documents produced have been through internal peer review process.	Effective and efficient health education resources distribution is maintained. Resources provided to meet regional demand. Narrative on effectiveness of public health information presented digitally and/or graphically, to key stakeholders and communities. Narrative on office move.
Kotahi te tīma	Ratonga a iwi	Manage office relocation to Hamilton CBD including any impacts.			
He atamai te whakara-upapa	Haumaru	Provide health education resources in accordance with authorised provider duties.			
		Provide high quality PH literacy focused information utilising digital and graphic formats to present key information for PH projects, programmes and strategies.			
Networks and partnerships services					
Kotahi te tīma	Whaneke-tanga	Active participation in forums / and workshops with relevant partners and stakeholders.	Number of relevant forums / networks participated in and actions delivered by the PHU. Number of forums/networks attended. Minimum of one leadership team member is represented on each Midland working group. No. of alcohol related collaborative projects. Partner organisations	Documented process in place to evidence PHU's contribution and the value provided. Encourage appropriate protocols are followed during the forums. Percentage of collaborative projects that are focused on health of: • Māori and Pacific communities. • Low socio-economic areas. • Youth.	PH issues are considered by decision makers. Public heath leadership, performance and sustainability are strengthened at a national and Midland level. Narrative of outcomes of the projects or initiatives. Extent to which PHU input is reflected in alcohol steering group decisions. No. and Percentage of external stakeholders report greater
		Actively participate as members of the Midland Regional Public Health Network governance group and sub-groups.			
		Participate in other relevant forums/networks to support the sharing of best practice.			
		Undertake collaborative projects with key alcohol working groups.			
		Contribute to steering group advising on screening for harmful use of alcohol and brief interventions.			
Mā te iwi hei kawe	Manaaki	Assess the feasibility of promoting alcohol screening and brief intervention strategies in Primary Care and Emergency			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		Departments.	(alcohol): • Description of partners. • Nature of collaboration. • Value added by PHU staff. Description of PHU contribution for alcohol screening and brief interventions. No. of (alcohol): • Feasibility studies carried out (Target =1). • Stakeholders approached to discuss screening and brief intervention strategies in Primary care and Emergency Departments. Details of stakeholders approached. No. of event organisers supported (alcohol). No. of national social marketing supported (alcohol) by PHU. No. of (alcohol): • Communities and other	Describe the extent to which the advice (alcohol) given by PHU promoted best practice. Summary of successes and barriers encountered in engaging with the event organisers (alcohol). Description of PHU role and the partners supporting alcohol marketing campaigns Percentage of (alcohol): • Communities and others supported that are in low SES/high number of Māori areas.	understanding of potential alcohol screening and brief intervention approaches (SK, S). No. and Percentage of event organisers that have implemented alcohol-free events as a result of provider support (BC, O). Extent to which LAPs reflect a PH perspective. Describe the successes, any barriers to success, PH impact and outcome of upstream/proactive work with stakeholders. No. and Percentage of: • Communities and other stakeholders that have adopted evidence-based PH action to support the reduction of alcohol-related harm as a result of the PHU support activity (BC, S). • Communities and other stakeholders report increased knowledge about alcohol related harm and/or evidence to reduce alcohol related harm (SK, S).
Kotahi te tīma	Whaneke-tanga	Work with event organisers and support them to adopt alcohol-free policies at events.			
Ka aro mai ki te kāinga		Support national social marketing campaigns related to reduction of alcohol related harm.			
Kotahi te tīma		Support TLAs to develop, implement and monitor their local alcohol policy (LAP).			
Mā te iwi hei kawe		Liaise with and where appropriate undertake joint projects to proactively influence other local authority alcohol-related policies and bylaws prior to the formal consultation process.			
		Work with communities and other stakeholders to develop evidence-based PH action which support the reduction of alcohol-related harm.			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
			stakeholders supported. • Key activities facilitated or delivered. Provide description of research or information summaries provided and community activities actively supported (alcohol). All TLAs visited.		

7. Health improvement 2019/20

The Health Improvement Team works through a setting based approach and the health improvement team will:

- Provide evidence of service delivery to support Waikato DHB priority of achieving radical improvement to Māori Health.
- Establish key communication messages to address the social determinants of health across settings and in communities.
- Showcase examples of the Health Improvement process.

The current three health improvement settings are:

Healthy Māori and Pacific Communities

Healthy Māori and Pacific Communities programme focuses on influencing socio-cultural environments and conditions to protect and improve health and wellbeing of whānau and communities. We acknowledge that culture is a key determinant of health – cultural identity, customs and traditions, and the beliefs of the family and community all affect wellbeing. We will work in partnership with Māori and Pacific communities to create healthy settings in ways that support and enhance whānau wellbeing.

Healthy Education

Healthy Education programme focuses on influencing education/school environments and conditions to protect and improve health and wellbeing of tamariki and rangatahi, whānau and communities. We acknowledge that education is a determinant of health, and not merely a setting for targeting populations. We will work in partnership with education leaders and key stakeholders in the Waikato to ensure wellbeing for learning is a shared outcome.

Healthy Workplaces

Healthy Workplaces programme focuses on influencing employment/workplace environments and conditions to protect and improve health and wellbeing of employees, whānau and communities. We acknowledge that employment is a determinant of health, and not merely a setting for targeting populations. We will work in partnership with employers and key industry players in the Waikato to ensure equitable opportunities and conditions in employment (and pre-employment).

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Healthy Māori and Pacific Communities					
Ka aro mai ki te kāinga	Whaneke-tanga	Focus on engagement and productive partnerships in Māori/Pacific communities to improve Māori/Pacific wellbeing (whānau ora) and health equity. Examples include in Marae and with Kaumatua	No of: • Partnership agreements/ MOUs. • Māori/Pacific communities engaged in Healthy settings (by type and locality). • Partnership activities completed by type. • Community outcomes profiled and opportunities to share successes / learnings. • Health improvement learning and development opportunities by type.	Percentage of: • Māori/Pacific communities engaged in Health Improvement Process. • Community members' feedback report satisfaction with health Improvement collaboration for wellbeing initiatives.	Narrative on productive partnerships developed and value of collaboration. Narrative of evidence of Māori/Pacific communities moving through the HI process and achievement of their identified health outcomes Narrative on capacity & capability initiatives and community feedback. Combined narrative on transformational outcomes for targeted Māori/Pacific communities.
Kotahi te tīma		Engage priority Māori/Pacific communities in the health improvement process as per targeted engagement strategy.			
Mā te iwi hei kawe	Oranga	Enable community leaders to facilitate inquiry process within the setting to understand needs and opportunities for health improvement.			
Te whāinga hua me te tika o ngā mahi	Manaaki	Enable community leaders to develop and implement action and evaluation plans to evaluate their health improvement strategies and monitor change over time.			
He atamai te whakara-upapa		Provide up to date evidence based PH information and advice to develop community leadership capability and capacity for health improvement.			
	Pae taumata	Provide opportunities to profile and celebrate good community leadership and successful initiatives aligned to the settings based approach for the development of other Māori/Pacific communities.			
Healthy Education					
Kotahi te tīma	Whaneke-tanga	Engage priority education services, ECE, Primary and secondary, in the settings based approach, as per targeted engagement strategy.	No of: • Type and locality of education settings engaged. • Type and locality of education settings engaged in the HI	Percentage of: • Education settings engaged with and meet prioritisation criteria. • Education settings engaged in the HI process meet	Narrative of evidence of settings moving through the HI process and the achievement/plan of attaining their identified health outcomes.
Mā te iwi hei kawe	Manaaki	Enable education leaders to facilitate inquiry process within the setting to understand needs and opportunities for health improvement; including a self-review of key child health issues.			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Te whāinga hua me te tika o ngā mahi		Enable Education leaders to develop and implement action and evaluation plans for health improvement, using evidence based tools. Enable education leaders to evaluate their health improvement strategies and monitor change over time, using evidence based tools.	process. • Type of Health and Wellbeing issues identified by settings. • Type of evidence provided to settings.	prioritization criteria. • Education settings using evidence based tools meeting prioritisation criteria.	
He atamai te whakara-upapa	Oranga	Provide up to date evidence based PH information and advice to develop education leadership capability/capacity for health improvement.	• Type of opportunities offered/ provided to settings.		Narrative on the value of capacity and capability developing activities delivered.
	Whaneke-tanga	Provide opportunities to profile and celebrate education leadership and initiatives aligned to the setting based approach. Provide opportunities for education leadership to share successes and learnings for the development of others in their sector.	• Type of key stakeholders engaged. • Type of engagement activities.		Narrative of evidence of leadership and success within settings. Narrative on value of stakeholder engagement.
Kotahi te tīma		Engage and maintain relationships with other health services/community organizations and seek a collaborative approach to working in the Education setting.			
Healthy Workplaces					
Kotahi te tīma	Whaneke-tanga	**Engagement:** Lead engagement and recruitment of businesses across Waikato rohe onto WorkWell program. Lead delivery of public health responses to workplace wellbeing enquiries from community and businesses across the Waikato rohe. Lead development of new and existing stakeholder relationships that are conducive to delivering workplace	Number of: • Workplaces engaged in workplace wellbeing program. • Communications with workplaces, by type. • Stakeholders engaged with.	Percentage of: • Registered workplaces meeting prioritisation level 1 or 2 criteria, as per targeted engagement strategy (TES).* *Our Workplaces TES works to address equity and accelerate Māori Health	Table depicting registered WorkWell businesses; industry, geographical location, number of staff and length of engagement / accreditation level). Narrative on value of engagement activities with non-WorkWell businesses.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		wellbeing initiatives across the Waikato rohe.		outcomes by targeting work with vulnerable communities (by TLA and NZDEP); low paying industries; industries with high numbers of Māori and Pacific peoples employed; and industries with minimal education levels required. • Participants who felt satisfied or very satisfied with the workplace wellbeing opportunity.	Narrative on value of stakeholder engagement and productive partnerships. Narrative on the public health issues identified as priority for businesses engaged in WorkWell. Narrative on success and benefits of workplace wellbeing opportunities. Narrative on businesses moving through accreditation process.
Mā te iwi hei kawe	Oranga	**Productive Partnerships:** Lead and work in partnership with key stakeholders to promote workplace wellbeing in the employment sector to advocate for and enable workplaces that support healthy choices and behaviors.	• And type of productive partnership activities completed.		
	Pae taumata	**Plan and Implement:** Enable Waikato businesses to facilitate their own inquiry, planning and evaluation processes to develop a wellbeing program, using evidence based tools (such as WorkWell or Good 4 Work) and other health improvement strategies. (Lead). (Where businesses have sites located outside our Waikato DHB boundaries, work in partnership with corresponding Public Health Units to identify the best response and way of working).	• Workplace initiatives/ outcomes profiled in local, regional or national communications. • Workplace sector opportunities to share successes / learnings. • Local public health enquiry templates developed or updated by topic. • Public Health enquiries responded to.		
		Lead the development of local, up to date, evidence based public health information and advice to employment industry, and /or key stakeholders, to develop their capability and capacity for health improvement.			
He atamai te whakara-upapa	Manaaki	**Build Public Health Capacity:** Lead and contribute to opportunities to profile and celebrate good industry/ workplace leadership and successful initiatives aligned to the setting based approach for the development of others in their sector.	• Businesses profiled		Narrative on enquiries for public health issues from non-registered businesses or outside of priority issues for WW businesses. Narrative on businesses profiled if applicable.
		Proactively feedback areas for Work Well and Good 4 Work development and improvement to Toi Te Ora (TTO) and HPA	• Feedback activities participated in or contributed to.		

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		Develop systems to inform service achievement and improvement including evaluation of WorkWell delivery. Workplaces team members are regularly upskilled by attending learning and development opportunities as identified in their WorkWell training needs assessments (TNA) and supported by objectives set in annual performance review. Capacity of team is monitored and discussed with management. Client to staff ratios. TTO recommends 5 at pre Bronze/ Bronze, an additional 5 at silver and/or gold to a maximum of 10 workplaces per FTE. Waikato will see its first businesses achieve silver in 2019. New staff will undergo a comprehensive orientation to workplaces team to increase their individual and team capacity.	• Evaluation tool is used with businesses during accreditation process. • TNA's completed for each staff member (6 monthly). • FTE ratios with WorkWell businesses at each accreditation level. • Orientation used and feedback given for evaluation.	Evaluation of orientation process	Narrative from businesses responses in evaluation of WorkWell delivery. For example, satisfaction with product being delivered and advisor capabilities. Number and/or percentage of employees demonstrating SK, AO or BC. Narrative on the value of learning and development activities by staff. Narrative on staff levels and capacity.
Te whāinga hua me te tika o ngā mahi	Oranga	**Poverty as a determinant of health: Living Wage:** Continue to participate and support Poverty Action Waikato and National Living Wage Movement stakeholders to increase awareness and understanding and support businesses whose employees are experiencing areas of poverty.			
Kotahi te tīma		**Industry response beyond the scope of WorkWell delivered as originally intended:** Lead implementation of WorkWell on a national scale using a 'national approach'. This will involve engagement with priority industry (as defined per TES). Identifying a business to progress national	• Engagement activities • Worksites and employees national project covers • Employees trained as WorkWell advisors		Narrative on HI process, the development of and level of service delivery achieved thus far.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		approach and brokering a partnership/MOU. Training staff from priority industry to be WorkWell representatives for their own worksites. Linking the trained business representatives with their local WorkWell advisor form around New Zealand to support the business and complete accreditation at the appropriate stage.		• Trained advisors implementing program at their worksite.	

8. Health protection 2019/20

The Health Protection core function:

- Supports, monitors and enforces compliance with legislation.
- Identifies, assesses, and reduces communicable disease risks, including management of people with communicable diseases and their contacts.
- Identifies, assesses and reduces environmental health risks, including biosecurity, air, food and water quality, sewage and waste disposal, and hazardous substances.
- Prepares for responding to public health emergencies, including natural disasters, hazardous substances emergencies, bioterrorism, disease outbreaks and pandemics.

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Border Health Protection	Undertake surveillance of mosquitoes at appropriate frequency for time of year. Provide mosquito interception response situation reports to the Environmental and Border Health Team. Respond promptly to interceptions of pests with a human health significance. Ensure designated points of entry achieve and maintain core capacities as required by the International Health Regulations 2005; audit core capacities annually. Identify and monitor border health protection risks from biological chemical and physical hazards. Develop/maintain contingency plans to deal with border health risks; work with border stakeholders to support the inclusion of PH response plans within sea and airport emergency response plans. Respond promptly to requests for pratique, inspections and certification.	No. of: • Interceptions. • Incursions. • Responses to other organisms • Authorized or accredited persons under the Biosecurity Act 1993. • Inter-sectoral meetings. • Responses to border public health incidents. • Maritime pratiques issued. • Maritime pratiques issued on arrival. • Aircraft met on arrival. • Ship sanitation exemption, extension and control certificates issued.	Percentage responses initiated within 30 minutes of notification. Narrative report on mosquito surveillance and whether it is occurring at appropriate frequency. Narrative report on requirements of a competent authority met by PHU. 100% of current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course.	No. and Percentage of: • Exotic mosquitoes that have crossed the border and established in your region (CC, O). • International points of entry that meets requirements of annual verification assessment under International Health Regulations 2005 (BC, O). • International points of entry that have contingency plans to deal with ill travelers and other border health responses that are interoperable with public health response plans (CC,

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Attend border and other inter-sectoral meetings with relevant agencies and organisations Provide sound technical and professional advice on PH issues that are related to border health protection objectives. Provide public health training to air and sea port staff. Contribute to or lead the preparation of health impact assessments in relation to border health protection threats and eradication and control activities. Maintain on-call roster to ensure appropriately trained staff are available at all times for any border responses.	• Public health training (e.g. advice, update, event) to air and sea port staff. • International points of entry that have contingency plans		O).
Communicable Diseases	Maintain an appropriate and efficient system for receiving, considering and responding to notifications and enquiries. Provide all information and manage the local operation of databases and information systems. Ensure there is a high level of accuracy and quality of data entered into databases and information systems and information is entered in a timely manner. Act on the deficiencies identified in the ESR Data Quality reports within two weeks of receipt of the reports. Conduct clinical review of completed case report forms by a Medical Officer of Health, Senior HPO or Communicable Diseases Nurse and feedback findings to staff. Enforce the Health Act 1956, Health (Infectious and Notifiable Diseases) Regulations 2016 and other relevant legislation.	No of: • Disease notifications received, including non-cases. • Significant outbreaks. • Confirmed and probable TB disease cases. • LTBI/cases on preventative treatment. • TB contacts followed up. • Vaccinator applications processed. • Authorised needle exchanges. • Observation visits. No of: • Large scale events provided	Percentage of: • Notifications entered into EpiSurv. • Significant outbreaks that are followed by a debrief. • Notified TB diseases cases (new and relapsed) that have been managed by the PHU. • TB contacts followed up. • Vaccinator applications processed according to Ministry of Health guidelines. • Authorisation visits completed using Ministry of Health-approved form. • Sore throats treated with appropriate antibiotic as per New Zealand Sore Throat Guideline, and	Narrative reporting: Describe whether debrief recommendations of significant outbreaks have/will be incorporated into future plans and Standard Operating Procedures, where applicable. Describe whether any longer term preventive measures are put in place to prevent similar outbreak/s. Narrative reporting: Describe outcomes of engagement in DHB Governance Group on Rheumatic Fever Prevention. Describe systemic issues or barriers that will be/are being

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Identify, investigate, assess, monitor, manage and report significant outbreaks and emergent risks to public health from communicable diseases. Take prompt and appropriate action to protect the public from communicable diseases. **Rheumatic Fever** Work with partners to raise public awareness about the importance of getting sore throats and skin infections checked and treated among the high risk population. Undertake gap analysis of notified rheumatic fever cases. Ensure that all diagnosed rheumatic fever cases are entered into the local rheumatic fever register. Engage with the DHB Governance Group to provide public health perspectives in relation to Rheumatic Fever Prevention. Work with the Child Health Action Group (CHAG) to advocate for a national register, and assist with implementation of regional or national register if initiated. Reporting on sore throat management to ascertain if processes in place are being effective **Tuberculosis** Provide BCG vaccination to children according to the Ministry of Health's eligibility criteria. Manage confirmed and probable TB disease cases. Manage and follow up TB contacts.	with advice and resources for rheumatic fever prevention. Specific narrative reporting: Describe nature of advice provided. Narrative reporting: Describe pro-active and reactive liaison with the mass media and on-line/social media, if applicable. No. of negative /positive throat swabs for Group A streptococcus	percentage given script on same day as positive result received.	addressed by various agencies to reduce rheumatic fever rates. Narrative reporting: Describe outcomes of the work you have carried out to support the delivery of the National Immunisation Schedule. Describe systemic issues or barriers that will be/are being addressed by various agencies to get the immunisation curve trending upwards. No. and Percentage: • Vaccinators that are authorised to practise (CC, O). • Needle exchanges operating in accordance with regulatory requirements. Narrative reporting: Describe outcomes of engagement with sore throat management providers Narrative on primary care engagement on syphilis

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Emergency Response: Develop communicable disease Emergency Response Plan. Maintain, exercise and regularly review Emergency Response Plan for responding effectively to a range of PH emergencies and emerging threats. Take appropriate emergency actions, as the need arises. Maintain civil defence and PH emergency planning and response capacity, and ensure there are appropriate numbers of staff trained in emergency management/CIMS. Ensure key health messages are available and up to date in both educational and promotional materials.			
	STIs and syphilis: Raise awareness, within primary care, of the increasing rate of syphilis and appropriate diagnosis and management of the disease. Raise clinician awareness of notifiable STIs and the process for notification. Support the DHB's Syphilis Action Plan with the Sexual Health Unit.			
	Immunisation: Provide vaccinator and programme authorisations. Support your respective DHBs/Primary Care Organisations (PHOs) towards achieving the current immunisation health targets and performance measures as agreed with the DHB. Provide clinical advice to your respective DHBs/PHOs to support the delivery of the National Immunisation Schedule. With support from the Ministry, implement			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	policy changes that will result in the national elimination of measles and rubella. Provide advice to the DHBs/PHOs on the management of individuals affected by cold chain failures and the local processes to address an immunisation provider's non-compliance to the requirements outlined in the National Standards.			
	Authorise needle exchange persons/premises, as required by the Needle Exchange Regulations.			
	Undertake observation visits to ensure needle and syringe exchange services operate in accordance with regulatory provisions and framework.			
	Provide objective advice, information and education about communicable diseases control and its significance.			
	Encourage and assist primary care providers, Crown entities, iwi, local authorities, other agencies and stakeholders to develop and implement policies to minimise control communicable diseases through processes.			
	Plan, implement and evaluate project-based activities that are aimed at providing evidence of effectiveness of PH action addressing specific communicable diseases control concerns and issues.			
	Inform and liaise with the mass media and on-line/social media about communicable diseases control issues and antimicrobial resistance.			
Drinking water	Identify and investigate incidents, complaints and notifications of adverse DW quality (or adequacy)	No. of DW Assessor FTEs. No. of investigations related to	% DW Assessors that maintain accreditation. % network drinking water	No. / Percentage of networked water supplies (broken down by class) compliant with sections

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Undertake all duties and functions required by the Health Act 1956.	incidents, complaints and notifications. No. of: • Water supplies surveyed in the annual review. • Water safety plans assessed. • Temporary drinking water supplies assessed and approved. No. of authorisations No. of investigations related to enforcement No. of assessments related to requirements of the DW Standards. No. of collaborative regional meetings/presentations (incl joint working groups) No. of district/regional council meetings	register entries verified or updated. % networked water supplies (by class of water supply) receiving at least one compliance inspection per annum with findings confirmed in writing. % water suppliers' water safety plans reported on within 20 working days 100% of network drinking water supplies with an approved WSP that have had an implementation completed in the last 3 years Percentage of networked water supplies (by class of water supply) where timely response was provided (transgressions, contamination or interruption)	69V and 69Z of the Health Act 1956 (BC, O). Percentage of networked water suppliers serving more than 100 people with approved water safety plans. No. / Percentage of water supplies serving 1000 people that are fluoridated (CC, O). Narrative on progress of improving drinking water quality system
	Certify the implementation of water safety plans.			
	Authorise organisations for the purposes of ensuring compliance with legislation, DW standards, and water safety plans			
	Report serious drinking water incidents to the Ministry of Health within 24 hours. Report suspected or confirmed waterborne disease outbreaks to the Ministry of Health within 2 hours.			
	Undertake enforcement activities in consultation with, and at the direction of, the Ministry of Health.			
	Refer issues and concerns with self-supplies to territorial authorities as required.			
	Implement the requirements of the DW Standards for New Zealand			
	Ensure activities are integrated with the DW technical advice services for networked supplies serving up to 5000 people.			
	Provide technical advice and information on public health aspects of DW supplies.			
	Ensure that the public health effects of DW supplies are considered and managed by making timely submissions on Regional and district plans, TLA assessments of DW supplies and resource consent applications.			
	Provide advice on the benefits of water fluoridation when it becomes a significant issue in the community.			
	Carry out public health grading of drinking-water supplies at the request of drinking-water suppliers.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Participate in collaborative arrangements with water suppliers, district councils and regional councils to share information about potential risks to drinking water catchments, drinking water supplies and other relevant issues.			
	Work to improve the drinking water quality system within the constraints of Ministry of Health and Wai Comply resource and support.			
	Implement and incorporate the HealthScape system to strengthen the quality of drinking water management			
	Prepare to meet any new accreditation and quality standards per the Health (Drinking Water) Amendment Bill.			
Hazardous substances	Develop hazardous substances programme plans.	No. of: • Public health HSNO enforcement officers. • Cases of hazardous substances injuries that are notified by GPs, hospitals and others. • Applications VTA permission received • Applications for VTA permission issued. • Desk top audits of 1080 operations. • Field audits of 1080 operations. • Desk top or field audits of non 1080 operations. • VTA complaint investigations	100% of debriefs/audits that show responses have been consistent with the Ministry's advice and guidelines. 100% routine applications for VTA permissions processed within 20 working days. 100% of 1080 operations with permissions audited, either by desktop or field audit, for compliance with permission conditions.	Narrative reporting: Promotion of the HSDIRT reporting process to GPs, hospitals and others. No. of and Percentage of audited VTA operations compliant with permit approval conditions (BC, O). Narrative reporting: Outcomes of hazmat meetings and exercises. Narrative reporting: Outcomes related to whether Local Authorities have been responding appropriately to public health risks from contaminated land.
	Report all notifications of hazardous substances injuries to the science provider in the format required, including GP notifications.			
	Promote hazardous substances injury notifications by GPs.			
	Participate in the Hazardous Substances Injury Surveillance System and other notifiable condition surveillance systems			
	Investigate notifications of lead poisoning, poisoning from chemical contamination of the environment, and hazardous substances injuries.			
	Process applications for Vertebrate Toxic Agent (VTA) operations that require public health permissions.			
	Ensure that the conditions imposed by the public health HSNO enforcement officer granting permits for the use of controlled			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	vertebrate toxic agents are complied with. Field or desktop audits of all permissions are required to ensure compliance.	received and investigated. • VTA complaints referred to another agency. • Hazmat incidents or emergencies attended. • Hazmat exercises attended. • Response plans reviewed and revised, if necessary, following responses and exercises. • Area hazmat coordination committee meetings attended. • Investigations/activities undertaken, by type (e.g. crayons, face paint, chemical spills).		
	Audit compliance with, investigate breaches of, and where appropriate, enforce the relevant Acts and Regulations.			
	Work with other HSNO enforcement agencies to support their regulatory roles and manage potential public health risk.			
	Receive annual reports on methyl bromide fumigations.			
	Maintain effective risk management strategies and response plans for hazmat incidents and emergencies.			
	Represent public health interests at meetings of the Area Hazmat Coordination Committee.			
	Promote public knowledge on the risks of environmental and non-occupational exposures to hazardous substances and products, including asbestos in the non-occupational environment.			
	Advise, encourage and/or assist territorial authorities and Regional Councils to: • Identify potentially contaminated sites and identify contaminants. • Implement HIA systems to ensure contaminated land is remedied. • Determine appropriate land use controls for contaminated sites. • Ensure appropriate advice is provided to manage any PH risk from sites and during any remediation processes.			
Illicit drugs and psychoactive substances	Employ statutory officers to identify, investigate, assess, monitor, manage and report significant and emergent risks to PH from psychoactive substances and the	No. of: • Psychoactive Substances Enforcement Officers.	Psychoactive Substances Enforcement Officers met and maintain competencies for statutory appointment	Number of Psychoactive Substances Officers employed are adequate to deliver the work programme and respond to

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	misuse of drugs.	• Trainings attended. • Complaints referred to the appropriate agency for action. • Advice given to the public about psychoactive substances. • Healthy public policies / Local plans on psychoactive substances and the misuse of drugs being developed or in place.	including attendance at Ministry of Health training as required. Complaints are referred onto appropriate agency within a suitable timeframe. Advice, information and education provided to the public is consistent with Ministry of Health policy, objective and evidence-based.	emergent issues in a timely manner. Formal system in place for receiving, considering and responding to complaints. Profiles established of activities, facilities or premises of significance to the psychoactive substances work programme. The level of advice, information and education provided to the public, including Māori, is maintained or increased. Reports are provided to the purchaser and regulator on psychoactive substances and the misuse of drugs programme activity. LAPPs in force.
	Maintain a response capacity to respond to issues relating to psychoactive substances and the misuse of drugs.			
	Ensure sufficient staffs are trained to meet the criteria for statutory appointment under the Psychoactive Substances Act 2013 and Misuse of Drugs Act 2005 and maintain awareness of factors influencing PH from the use of psychoactive substances and the misuse of drugs.			
	Collaboration with relevant enforcement agencies to enforce the relevant provisions of the Misuse of Drugs Act 2005 and the Psychoactive Substances Act 2013 and to protect PH.			
	Maintain an appropriate and efficient system for dealing with complaints from the public about the use of psychoactive substances and the misuse of drugs.			
	Maintain information systems for psychoactive substances and the misuse of drugs programme activity which has the capacity to serve as a basis for reporting to the purchaser and regulator and to assist with compliance audits.			
	Provide objective advice, information and education to the public, including Māori, about issues relating to the use of psychoactive substances and the misuse of drugs and their significance and to allow appropriate participation in the development of legislation relating to the use of psychoactive substances and the			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	misuse of drugs.			
	Support councils in developing policies on psychoactive substances.			
	Ensure interpretation and application of policies on reducing the harm from psychoactive substances and the misuse of drugs is consistent with Government policy, manuals and guidance.			
Public Health Emergency Planning and Response	Carry out all emergency management planning, preparedness and responses in collaboration with other relevant agencies.	No. of exercises	Percentage of: • Plans and Standard Operating Procedures updated each year (required 100%). • % plans tested, including emergency communications (required 100%). • Exercises and responses that are followed by a debrief (required 100%). • Debrief recommendations that are incorporated into plans and SOPs.	Narrative reporting: Outcomes of exercises. No. and Percentage of health protection officers and medical officers of health graduated from CIMS 4 or CIMS (Health) training (SK, O) Narrative reporting: If not 100%, please report on when they would be completing this training.
	There must be plans covering the following minimum areas - Border Health Response - Communicable Disease – Outbreak/Pandemic - Hazardous Substances. - Civil Defence/National Disaster.			
	Take appropriate emergency actions, as the need arises.			
	Maintain, exercise and regularly review plans for responding effectively to a range of public health emergencies.			
	Maintain civil defence and public health emergency planning and response capacity, and ensure there are appropriate numbers of staff trained in emergency management/CIMS.			
	Ensure key health messages are available in educational and promotional materials.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Sale and Supply of Alcohol Act 2012	Inquire into all on-, off-, club and special licence applications and provide Medical Officer of Health (MOsH) reports to District Licensing Committee (DLC) (for opposition or recommendations) Provide education as part of re-licensing and new licensing processes to staff Work with special licence event organisers and support them to adopt and implement appropriate alcohol management plans or alcohol harm reduction practices. Collaborate in police-led CPOs to reduce sale of alcohol to minors. Undertake or work with other agencies to undertake monitoring visits of high risk premises	No. of: • Applications and renewals • Received for each type. • Those were inquired into. • Had matters in opposition identified. • On-, club- and off-licences visited to provide education. • Formal training sessions of Duty Managers participated in. • Event organisers supported • CPO operations supported (conducted by NZ Police). • Premises visited during CPO ops. • Monitoring visits as part of multiagency efforts. • Monitoring visits as PHU.	100% reports provided to the licensing committee within 15 days. % premises located in low socioeconomic area where education was delivered. (Does not include formal training sessions of Duty Managers) 100% of high risk special licence application supported and an alcohol management plan is submitted within 15 working days to DLC. % high risk premises visited during CPO operations. 100% of inspections are recorded and noted in assessment database	No./ Percentage of oppositions accepted No./ Percentage licensee staff and volunteers report they know more about how to implement their responsibilities under Act No. / Percentage special licence event organisers that adopted and implemented appropriate alcohol management plans or alcohol harm reduction practices No. / Percentage of premises that are compliant at the time of CPO with the Act
Smokefree Environments Act 1990	Enforce the Smoke-free Environments Act 1990 and Smoke-free Environment Regulations 2007. Deliver tobacco control functions as per the Smoke-free Compliance and Enforcement Manual and advice and direction from the Ministry of Health. Regulatory activities undertaken to support compliance: • Carrying out retailer education	No of: • Education/compliance visits per recorded tobacco Industry premise. • Controlled purchase operations (CPO) conducted. • Standard operating procedures are consistent with Ministry of Health	No. and Percentage of: • Tobacco retailers that are compliant with Smokefree Environments Act. • Timeframes for summiting short form files to the Ministry in order for	90% retailers who are compliant with the SFEA. Number of tobacco retailer's compliance with the Smokefree Environments Act increases. The no. of media advisories and media statements on tobacco

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	• Conducting controlled purchase operations in priority areas. • Assessment of smoking areas in licensed premises • responding to complaints • Advertising and promotion • Providing advice to the public.	tobacco control and smoke-free policies. • Media statements and advisories. • Complaints received. • Training sessions provided.	infringement notices to be issued in a timely manner are met. Regulatory activities, CPOs and smoke free compliance inspections are carried out in accordance with Ministry of Health Smoke free Compliance Act and Enforcement manual. Advice, information and education provided to the public are consistent with Ministry of Health policy, objective and evidence-based. Appropriate regulatory advice is given in accordance with legislation, manual and best practice guidelines. 100% complaints are responded to within 20 days. 100% training sessions that are aligned with Ministry of Health guidelines and requirements. Staff has the necessary best practice approaches, skills, attitudes and knowledge.	control and smoke-free issues is maintained or increased. Improve attitudes of communities to minimise tobacco-related harm. Formal system in place for receiving, considering and responding to complaints100%. FTE of trained staff meets geographical spread of activities. Smokefree regulatory officers successfully complete Ministry of Health Smokefree Enforcement officer training programme. No. and Percentage of : • Staff with improved knowledge, skills and competencies as a result of training. • Smoke-free Enforcement Officers employed and trained are adequate to deliver the work programme and respond to emergent issues in a timely manner. Profiles established of activities,
	Ensure interpretation and application of national tobacco control and smoke-free policies is consistent with Ministry of Health Manuals and guidance.			
	Audit compliance with smoke-free legislation and tobacco control policies			
	Inform and liaise with the mass media about tobacco control and smoke-free issues.			
	Maintain an appropriate and efficient system for receiving, considering and responding to complaints from the public.			
	Take prompt and appropriate action to protect public health, and increase compliance with the smoke-free legislation.			
	Employ Smoke-free Enforcement Officers and ensure they attend all Ministry of Health training sessions. Maintain a response capacity.			
	Regulatory training is undertaken by staff to increase knowledge of legal responsibilities under the SFEA.			
	Training provided to ensure capacity to carry out smokefree and liquor regulatory activities.			
	Maintain profiles of activities, facilities or premises importing, manufacturing and selling (e.g. large growers, retailers and			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	wholesalers) tobacco products (the Industry).		Database up to date and maintained.	facilities or premises of significance to the tobacco control programme.
	Maintain an appropriate and efficient system for ensuring all sellers; including importer and manufacturers, of tobacco (where they can be identified) receive at least one education visit and one compliance visit at least every five years (more where non-compliance has been identified).			
	Maintain information systems for tobacco control programme activity which have the capacity to serve as a basis for reporting to the purchaser and regulator and to assist with compliance audits.			
	Tobacco control database.			
	Develop and maintain an up to date database of tobacco outlets to assist with planning of compliance and enforcement activities to be accessible by all partners.			
Stakeholder Planning, Submissions and Resource Management	Encourage and assist Councils to develop and implement policies through processes, such as the review of district plans, including variations or plan changes or Council Long Term Plans that address the wider determinants of health.	No. of: • Applications/plans/ statements/standards assessed for public health issues. • Submissions made. • Hearings where evidence presented. Narrative reporting: Brief description of proactive/upstream work with stakeholders (who and what).		Narrative reporting: Public Health impact (or expected impact) of submissions and/or proactive/upstream work with stakeholders (ie, key public health gains).
	Make timely and professional submissions on national and regional plans and policy statements, district long term and annual plans and, where appropriate, resource consent applications to ensure that the public health effects are considered and managed.			
	Monitor decisions made under the Resource Management Act 1991 to ensure that the health impacts of environmental hazards have been considered.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Make timely and professional submissions on local government assessments of sanitary works to ensure that the public health aspects are considered.			
	Comment, as appropriate, on territorial authority plans for sanitary works infrastructure planning.			
	Liaise and, where appropriate, undertake joint projects with consent authorities and affected communities to ensure that public health aspects of planning and resource management are considered.			
	Provide technical advice and information to regional councils and territorial authorities.			
	Inform other agencies and the public on the public health aspects of matters relating to sustainable resource management.			
Other Regulatory Issues	For the following PH issues: air quality; the disposal of the dead; environmental noise; ionising radiation; non-ionising fields; recreational waters; gaseous, liquid and solid waste and other environmental health issues; undertake the following: • Provide information and advice to other agencies, organisations and the public on their adverse effects. • Take appropriate action to minimise risks and protect from harmful exposure. • Monitor TLA actions. • Respond to public enquiries and investigate and/or redirect public complaints and queries on issues. • Support local government implementation of national policy statements and national environmental standards.	No of: • Ionising radiation source transports overseen. • Requests for advice or information responded to. • Complaints referred to the appropriate agency for action • Complaints investigated. • Sanitary surveys conducted by PHU. • Commercial solaria visited six-monthly – or at a frequency as determined by the Ministry • Pre-licensing inspections of early childhood centres. • Early childhood centre	100% activities and advice related to ionising radiation undertaken in consultation and with approval of the Ministry's Office of Radiation Safety. % visits to commercial solaria operators six monthly	No. / Percentage of known commercial solaria operators who report they are aware of the under-18 age ban (SK, S).

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Ensure applications for approvals are complete, and include the HPO's covering report and recommendations before forwarding to Ministry of Health for action.	inspections undertaken as a result of complaints. Narrative report: Nature of any significant work not reported elsewhere e.g. beauty industry work such as nail bars.		
	Supervise disinterments as required.			
	Advise and assist applicants to export cadavers to ensure PH concerns are addressed.			
	Conduct six-monthly visits to commercial solaria to encourage compliance with best practice guidelines.			
	Conduct and report on pre-licensing inspections of ECE. Investigate/inspect and report on ECEs in response to complaints.			
	Survey the availability of high-power laser pointers at retail outlets, provide advice on compliance and take compliance action as required by the Ministry of Health.			
	Encourage local authorities to clearly identify, and publically notify, existing or potential recreational waters, which do not meet minimum microbiological water quality guidelines.			
	Encourage the grading of bathing beaches.			
	Respond to recreational water incidents and inquiries as required, including toxic shellfish poisoning.			
	For recreational waters, provide: • Input into regional and local activities associated with quality. • Public and stakeholders with appropriate advice.			
	Liaise with councils and providers to verify that sewage overflows that pose a significant public health risk are: • Adequately responded to.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	• Ensure overflows are appropriately managed • Reduce overflows to high risk areas. • Promote improvements in public sewage collection and disposal systems. • Investigate clusters/cases of illnesses associated with non-occupational exposure to sewage or other waste.			
	Provide advice to schools and early childhood centres during an outbreak investigation and response.			
	Where appropriate, advocate the use of health impact assessment.			
	Where appropriate, promote the Healthy Cities/communities concept.			

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APPENDIX D: Accounting policies

Statement of accounting policies

Reporting entity

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

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

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

Basis of preparation

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

Statement of going concern

The going concern principle has been adopted in the preparation of these financial statements. The Board has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it consider is likely to affect the DHB, and to circumstances which it knows will occur in the next 12 months which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Operating and cash flow forecasts

The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that there will be sufficient cash flows generated from operating activities and either access to equity, lease financing or private debt to meet the investing and financing cash flow requirements of the DHB as set out in its current Statement of Intent and based on current trading terms and legislative requirements.

Borrowing covenants and forecast borrowing requirements

The forecast for the next year prepared by the DHB shows that the peak borrowing requirement will not exceed the available borrowing facilities if access to equity, lease financing or private debt is achieved. The Board has confidence that this can be achieved. The forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

Statement of compliance

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

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

Presentation currency and rounding

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

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective as at 30 June 2018 that have not been early adopted, and which are relevant to the Waikato DHB and group are:

Interests in other entities

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

These changes have no implication on the Waikato DHB and group

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces IPSAS 29 *Financial Instruments: Recognition and Measurement*. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. Waikato DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The Waikato DHB and group has not yet assessed the effects of the new standard. Based on initial assessment, Waikato DHB anticipates that the standard will not have a material effect on the Waikato DHBs financial statements.

Impairment of revalued assets

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

Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of-asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements with early adoption permitted. The timing of the Waikato DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

Service performance reporting

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

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

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

Summary of significant accounting policies

Subsidiaries

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

Associates

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

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

Joint ventures

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

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

Budget figures

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

Revenue

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

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

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

Ministry of Health (MoH) population-based revenue

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

Ministry of Health (MoH) contract revenue

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

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

in determining the timing of the revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled. Revenue from other district health boards

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of services

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

Grants received

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

Donations and bequests

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

Vested or donated assets

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

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

Capital charge

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

Finance costs

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

Leases

Waikato DHB as lessee

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

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

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

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

Waikato DHB as lessor

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

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

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

Foreign currency transactions

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

Cash and cash equivalents

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

Financial assets recognised subject to restrictions

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

Receivables

Short-term debtors and other receivables are recognised at their face value, less any provision for impairment. Bad debts are written off during the period in which they are identified.

A receivable is considered impaired when there is evidence that the group will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Derivative financial instruments

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

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

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

Inventories

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

Non-current assets held for sale

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

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

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

Property, plant and equipment

Classes of property, plant and equipment

The asset classes of property, plant and equipment are:

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

Land and buildings

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

Revaluations

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

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

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

Additions

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

Subsequent costs

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

Disposal

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

Depreciation

Class of asset	Estimated life	Depreciation rate
Buildings	3 - 85 years	1.2 - 33.3%
Plant, equipment and vehicles	2 - 35 years	2.5 - 50.0%

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

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

Impairment of property, plant, equipment and intangible assets

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

Non-cash generating assets

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

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

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

the statement of comprehensive revenue and expense. For assets not carried at a revalued amount, the total impairment loss is recognised as an expense in the surplus or deficit.

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

Intangible assets

Software acquisition and development

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

Amortisation

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

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

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

Impairment of intangible assets

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

Trade and other payables

Short term payables are recorded at their face value.

Borrowings

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

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

Finance Leases

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

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

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

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

Employee entitlements

Short-term employee entitlements

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

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

A liability 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 employee renders the related service, such as sick leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

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

Presentation of employee entitlements

Sick leave, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

Provisions

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

ACC Partnership Programme

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

Repairs to motor vehicles provision

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

Restructuring

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

Demolition

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

Equity

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

- Crown equity;
- accumulated surpluses/(deficits);
- property revaluation reserves; and
- trust funds.

Revaluation reserves

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

Trust funds

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

Income tax

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

Goods and services tax (GST)

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

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

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

Land and buildings revaluations

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

Land

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

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

Buildings:

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

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

Non-specialist buildings are valued at fair value using market-based evidence. Market rents and capitalisation rates are applied to reflect market value.

These valuations include adjustments for estimated building strengthening costs for earthquake prone buildings and the associated lost rental during the time to undertake the strengthening work.

Restrictions:

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

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

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

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

Retirement gratuities and long service leave

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

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

Critical judgements in applying accounting policies

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