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Waitematā District Health Board
Best Care for Everyone

2021/22 Annual Plan

Incorporating the 2019/20-2022/23 Statement of Intent and 2021/22 Statement of Performance Expectations

Waitematā District Health Board

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

Mihimihi

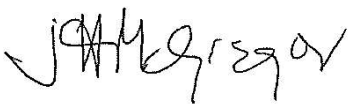
E ngā mana, e nga reo, e nga karangarangatanga tangata
E mihi atu nei ki a koutou
Tēnā koutou, tēnā koutou, tēnā koutou katoa
Ki wā tātou tini mate, kua tangihia, kua mihia kua ea
Rātou, ki a rātou, haere, haere, haere
Ko tātou ēnei ngā kanohi ora ki a tatou
Ko tēnei te kaupapa, 'Oranga Tika', mō te iti me te rahi
Hei huarahi puta hei hāpai tahi mō tātou katoa
Hei Oranga mō te Katoa
Nō reira tēnā koutou, tēnā koutou, tēnā koutou katoa

To the authority, and the voices, of all people within the communities
We send greetings to you all
We acknowledge the spirituality and wisdom of those who have crossed beyond the veil
We farewell them
We of today who continue the aspirations of yesterday to ensure a healthy tomorrow, greetings
This is the Annual Plan
Embarking on a journey through a pathway that requires your support to ensure success for all
Greetings, greetings, greetings

Kaua e mahue tētahi atu ki waho
Te Tihi Oranga O Ngāti Whātua

The Waitematā District Health Board Annual Plan for 2021/22 is signed for and on behalf of:

Waitematā District Health Board

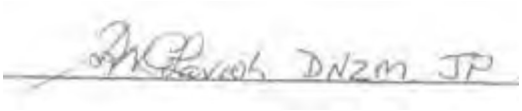


Dr Judy McGregor, CNZM
Chair

Kylie Clegg
Deputy Chair

Dr Dale Bramley
Chief Executive

Te Runanga o Ngati Whātua



Dame Rangimarie Naida Glavish, DNZM JP
Chair, Te Runanga o Ngati Whātua

Kōtui Hauora, Northern Iwi-DHB Partnership Board

Gwen Tepania-Palmer
Chair

And signed on behalf of:
The Crown

Hon Andrew Little
Minister of Health

Date
27 September 2021

Hon Grant Robertson
Minister of Finance

Date
26 September 2021

Hon Andrew Little

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

Judy McGregor
Chair
Waitematā District Health Board
chair@waitematadhb.govt.nz

30 SEP 2021

Tenā koe Judy

Waitematā District Health Board 2021/22 Annual Plan

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

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

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

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

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

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

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

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

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

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Dr Dale Bramley
Chief Executive

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Foreword from our Board Chair and Chief Executive

We continue to work through the latest phase of the COVID-19 pandemic response, the largest of its kind in our history, delivering a rollout of the Pfizer vaccine that offers everyone renewed hope of a less disruptive future.

The incredible team spirit and resilience of our staff was evident throughout the planning and implementation stages of this project, just as it was following the initial lockdown of March 2020 and during the various Alert Levels experienced since.

A drive to deliver the highest possible standard of service will continue to stand us in good stead over the coming months as we work closely with the Government to ensure as smooth a transition as possible to the planned new national health and disability system.

The new system is expected to be established by 1 July 2022. We will work hard to maximise any opportunities the reforms generate, both regionally and otherwise, to better serve our communities with the resources available to us.

That same service ethos is the reason why we are progressing a number of important developments:

- the old disused Pupuke and Taharoto buildings were deconstructed and removed from our North Shore campus to make way for the $267.1 million, four-storey Tōtara Haumaru facility, which is due for completion in late 2023. Tōtara Haumaru will create significant additional hospital capacity to meet the future health needs of our catchment and the broader region
- work began on a $6 million refurbishment and expansion of the Waitakere Hospital Special Care Baby Unit, boosting bed capacity from 12 to 18 to help meet projected regional growth by the time it opens in 2022. Importantly, the facility will enable parents to stay with their babies overnight
- design work on a building containing two new 15-bed inpatient units at Mason Clinic is now finished and construction is planned for completion in late 2023. The building will form half of the planned new E Tū Wairua Hinengaro facility to be built on a 2.8 ha block of land acquired in late 2019. Waitematā DHB also approved design work to start on the second half of the facility, a sister building containing another two 15-bed inpatient units. E Tū Wairua Hinengaro will be used to re-house service users who currently reside in Mason Clinic units that date back to the early 1990s. The old units will then be demolished, providing further space for expansion
- we hope to begin construction of a new 30-bed inpatient ward at Waitakere Hospital at the end of 2022. The Government agreed to provide $40 million in funding
- a major upgrade of the North Shore Hospital-based Central Sterile Services Department (CSSD) will help us achieve maximum efficiency while providing a safe and timely service delivery for our patients. We look forward to opening the new CSSD in 2023
- Waitematā DHB is embarking on master planning for the Waitakere Hospital site, creating an overarching strategy for the development of the campus and its various services from now until 2040
- we started work on new whānau accommodation at North Shore Hospital for people in need of somewhere to stay while supporting loved ones in our care. The modern facility is due to open in May 2022
- we are on track with plans to develop a $16.7 million addiction treatment centre, due to open within Auckland City Mission's HomeGround precinct later in 2021.

These initiatives follow a year of significant milestones, including:

- the opening of the Kia Ū Ora - Waitematā Breast Service at North Shore Hospital, improving breast cancer diagnosis and treatment times while removing barriers to care, in particular for Māori and Pacific women
- the opening of a new $22.46 million, 15-bed medium security E tū Tanekaha inpatient facility at our Regional Forensic Psychiatry Service (Mason Clinic), boosting the quality of buildings available for forensic care
- the launch of a newly expanded five-day intensive interventional radiology (IR) service at North Shore Hospital, offering Waitematā DHB patients a range of high tech treatment options closer to home
- the delivery of non-urgent specialist telehealth appointments to maintain safety and align with national visiting guidelines during various COVID-19 Alert Levels. Our Institute for Innovation and Improvement (i3) is developing more electronic tools to help us build and further enhance telehealth options for our patients.

We remain focused on reducing health inequities within our catchment, particularly in relation to Māori and our responsibilities under Te Tiriti o Waitangi to deliver effective and culturally appropriate models of care.

An example is the development of a lung cancer screening pilot with a special focus on improving health outcomes for Māori, whose mortality rates are three to four times higher than other ethnic groups.

The pilot is among a pipeline of projects, including plans for a kapa haka pulmonary screen prototype, targeted human papillomaviruses (HPV) self-testing cervical cancer initiatives, elimination of hepatitis C among Māori, and support to extend abdominal aortic aneurysm (AAA) screening for Māori to Northland DHB.

Waitematā is also working closely with community partners to reduce health inequities within our Pacific population. A strong emphasis on prevention and early intervention is evident through our continued work to boost immunisation rates, particularly among children, and improve access to oral health care.

We remain committed to achieving better Māori and Pacific representation of staff and have strong recruitment policies and processes in place to support ongoing improvement.

Our Māori workforce has already nearly doubled in the last five years and we aim to achieve parity with the proportion of Māori and Pacific people in our working-age population by 2025.

None of what we do would be possible without the extraordinary hospital and community-based staff whose hard work, dedication and tenacity combine to make our organisational values an everyday reality for the people we serve.

To every single one of you: a heartfelt thank you.

Dr Judy McGregor CNZM

Chair, Waitematā District Health Board

Dr Dale Bramley

Chief Executive, Waitematā District Health Board

Message from the Chair of Kōtui Hauora, our Iwi-DHB Partnership Board

E ngā iwi, e ngā karangatanga maha, tēnā koutou

E ngā mate kua mene ki te pō, haere, haere, haere

Ka huri matou ki te hunga ora, tēnā koutou katoa

Ngā mihi maha hoki ki a koutou, mānawatia a Matariki

Tēnā koutou, tēnā koutou, tēnā koutou katoa

Matariki 2021 brings us into the second year of Kōtui Hauora, a Tiriti-based partnership of mutual benefit between iwi across Te Tai Tokerau and the three northern most DHBs. Although we have a long journey ahead, I look back on the year that was with admiration for all involved and the work achieved for whānau and communities. It was truly inspiring to see how we, as a team, responded to the COVID-19 pandemic.

The impact from COVID-19 really put our partnership to the test and I am proud to say that we responded brilliantly. With the support of Kōtui Hauora, our iwi partners throughout the north provided necessities and home-based care to over 23,000 households, set up a COVID-19 coordination hub, and employed 90 Kaimanaaki as their frontline workforce to engage with whānau in the community. Ngā Kaimanaaki based with iwi conducted over 5,000 whānau wellbeing assessments and assisted them to access healthcare and social support. This massive effort was funded by a number of agencies, with Northland, Waitematā and Auckland DHBs providing a large part of this investment. The success was so great from these efforts that further support and investment will be made into Ngā Kaimanaaki services.

The wider sector response is also important to acknowledge. It was great to see Māori-led pop-up clinics in communities, outreach support services and testing sites across Te Tai Tokerau. In Auckland and Waitematā, Māori-led outreach services, supported by Kōtui Hauora, provided healthcare in vulnerable communities. A big part of this included influenza vaccinations for Māori. In 2020, the coverage for influenza vaccination for Māori aged 65 years and over increased by 7.7% in Auckland DHB and by 13.1% in Waitematā DHB compared with 2019 coverage. This is a good outcome, and shows that we need to continue to work together to engage and care for our communities.

Kōtui Hauora is about action in the face of need, and we firmly believe that this requires our collective resource, knowledge and influence to achieve. I am heartened to see that we are building on the progress we made in 2020 in the coming financial year. On behalf of Kōtui Hauora, I look forward to seeing the actions in the Annual Plan progress over the next 12 months and beyond.

Kia pūmau tā tātou hononga, kia haere tonu ā tātou mahi

(Our partnership will endure and our work will continue.)

Gwen Tepania-Palmer

Chair, Kōtui Hauora, Northern Iwi-DHB Partnership Board

Introduction

Waitematā DHB is the Government's funder and provider of health services to the estimated 650,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest DHB in the country and are experiencing rapid population growth.

Our population is diverse. Ten percent of Waitematā residents are Māori, 7% are Pacific, and 28% are Asian[1]. Our population is growing and projected to increase by 12% (76,000 people) over the next ten years.

Waitematā's population is generally healthier than that of New Zealand as a whole. We have the highest life expectancy in New Zealand at 83.9 years (2017-19), with an increase of 3.3 years since 2001.

Waitematā DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. We employ more than 8,600 people.

We have an estimated budget of $2.23 billion revenue in 2021/22.

We provide child disability, forensic psychiatric services, school dental services, and alcohol and drug services to the residents of the overall Auckland region on behalf of the other DHBs. Since 2013, the DHB has been the national provider of hyperbaric oxygen therapy services.

We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, and have contracts with approximately 600 other community providers.

DHBs act as planners, funders and providers of health services, as well as owners of Crown assets. Health needs assessment, along with input from key stakeholders, clinical leaders, service providers and the community, establishes the important areas of focus in our district. The identified needs are balanced alongside national and regional priorities and funding constraints to plan the optimum arrangement for effective and efficient delivery of health services.

These processes inform the Northern Region Long-Term Health Plan (NRLTHP), which sets the longer-term priorities for DHBs in the Northern Region and this Annual Plan.

This Annual Plan articulates Waitematā DHB's commitment to meeting the expectations of the Minister of Health in delivering improved wellbeing and equity, and our continued commitment to our Board's promise of **best care for everyone**, and to the expectations of the Minister of Health in delivering improved wellbeing and equity.

Section Two details the key activities we will deliver to address the planning priorities identified by the Minister for 2021/22.

Delivering equity and outcome improvements for our Māori, Pacific and other under-served populations will underpin all of our actions in 2021/22. We have a strong focus this year on prevention and population health, as well as improved and timely access. Sustainability and strong fiscal management are key to delivering these goals.

2021/22 will be a time of preparation and transition as we progress towards the new health service model, announced in April 2021 in response to the Health and Disability Services Review. Waitematā DHB will continue to deliver all of our usual services in 2021/22, but will begin to work towards the implementation of the new model. The short-term focus is on bringing Waitematā DHB back to a breakeven position, focusing on revenue optimisation, reducing waste, increasing productivity and containing costs. The medium term focus will enhance collaboration with the Northern Region DHBs on service and capital planning to ensure affordability and sustainability of services, while understanding and realigning service provision to meet the expectations of the Health Sector reforms.

This plan was prepared in accordance with Section 38 of the NZ Public Health and Disability Act 2000. A renewed Statement of Intent (SoI) is not required for 2021/22; we have therefore only made minor updates to our SoI, presented in Appendix A. Detailed reporting, including Financial Performance and the Statement of Performance Expectations for 2021/22, is also contained in the appendices.

COVID-19

COVID-19 has an immense impact on the way we plan and deliver services. Our challenges are to recover and grow from the outbreaks experienced in 2020, and continue to participate in the current COVID-19 response work and planning for the delivery of a comprehensive vaccination programme.

Our people are engaged in significant work programmes to clear the backlog of activity that was deferred during the 2020 lockdowns and return access and participation rates to levels seen prior to COVID-19.

Together with Northland DHB and the other

[1] Projected 2021/22 population; 2020 update.

metropolitan Auckland DHBs, we operate a regional response through the Northern Regional Health Coordination Centre (NRHCC). The NRHCC is responsible for community COVID-19 testing and outbreak control, surveillance testing of all border workers and the entire health component of the Managed Isolation and Quarantine system in the Northern Region.

DHBs are responsible for delivering New Zealand's largest ever immunisation roll out. The NRHCC oversees the set-up and operation of community vaccination centres all over Auckland, and Auckland DHB staff help to man both the community and staff vaccination clinics. As part of the regional work programme, Waitematā DHB is committed to completing the roll out of the COVID-19 vaccination programme and ensuring its success.

Our first large-scale COVID-19 vaccination clinic opened in South Auckland on 9 March 2021 to vaccinate household contacts of border staff and managed isolation and quarantine workers. Several more large-scale centres, capable of vaccinating up to 1,000 people a day, have opened across greater Auckland. There are Pacific-focused vaccination centres in Otara and West Auckland, and a Māori-led vaccination centre at Manurewa Marae. We are working in partnership with Māori and Pacific NGOs to set up more small, community-based vaccination centres.

Kaumātua were among the first people to be vaccinated at the Manurewa Marae clinic.

Vaccination of those living in aged residential care began in late April 2021, starting with those living in the South Auckland communities highlighted as a priority within the national vaccination programme.

Many GP practices and Urgent Care facilities are now delivering vaccines. The Waiheke Island Medical Centre was the first GP practice clinic to begin vaccinating its patients against COVID-19 in May 2021, with many more planned to open over the coming months.

The Waitematā DHB staff vaccination clinic opened in March 2021, in line with the Government's COVID-19 vaccination plan. As at 24 June 2021, 7980 staff were fully vaccinated, with a further 444 having received their first dose.

As at 20 June 2021, 352,000 vaccinations had been delivered across Metro Auckland, achieving 89% of the planned volume. 74,000 Waitematā DHB residents have received at least one dose. Vaccine delivery is expected to ramp up quickly between July and September 2021, and we are currently on track to deliver our planned vaccination volumes.

Equity

The health status of the majority of our population is very good and we are a relatively affluent population. Māori in our district have better health outcomes than Māori in other DHBs. However, some of our population experience inequalities in health outcomes. One in ten of our total population, 16% of our Māori population and 27% of our Pacific population live in areas ranked as highly deprived (NZDep2018), concentrated in West Auckland. Individuals living in these areas tend to experience poorer health outcomes than those living elsewhere.

All DHBs have a Te Tiriti o Waitangi responsibility for Māori health improvement and a legislative responsibility to reduce health inequalities. The Ministry of Health has developed a new Māori Health Action Plan, Whakamaua: Māori Health Action Plan 2020-2025, in response to the substantial challenges in achieving equitable health outcomes for Māori. The first part of Section 2 of our Annual Plan identifies our actions in furthering this work. We are also guided by the national Māori Health Strategy Korowai Oranga.

We also focus on achieving equitable health outcomes for Pacific (through delivering against the Ministry's Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025), Asian and other priority populations.

Equity is an over-arching priority in our performance framework, detailed in our SoI (Appendix A). We selected high-level outcome measures where equity gaps exist and we aim to reduce these gaps in the medium to long term.

We established a Te Tiriti o Waitangi-based partnership board with iwi from Tāmaki and Te Tai Tokerau to lead work to improve local and regional Māori health outcomes for Northland, Waitematā and Auckland DHBs. The current focus is on regional initiatives and major system change projects across the priority areas of child and youth health, mental health, and primary health care (prevention and screening).

We refreshed our current Pacific Health action plan (2016-2020) for 2020-2025 in consultation with our

Pacific communities, PHOs and representatives of Pacific providers, which includes jointly identified key priority areas to improve Pacific health outcomes.

We also refreshed our Asian, new migrant, former refugee and current asylum seeker health plan (2020-2023), based on our 2019 Health Needs Assessment, 2017 International Benchmarking of Asian Health Outcomes report and feedback from our partners and stakeholders.

We are focused on improving equity for disabled and older people. We are committed to the New Zealand Disability Strategy and the principles of the United Nations Convention on the Rights of Persons with Disabilities, and the Healthy Ageing Strategy.

Te Tiriti o Waitangi

Waitematā DHB recognises Te Tiriti o Waitangi (Te Tiriti) as the founding document of New Zealand. We commit to the intent of Te Tiriti that established Iwi as equal partners with the Crown.

We acknowledge and draw on the Ministry of Health's position on Te Tiriti expressed by Mana Whakahāere, Mana Motuhake, Mana Tangata and Mana Māori, as well as the invigorated Tiriti principles recommended by the Waitangi Tribunal's Hauora report (Wai 2575 stage one).

Te Tiriti provides a framework for developing a high performing and efficient health system that honours the beliefs and values of Māori patients, that is responsive to the needs of Māori communities, and achieves equitable health outcomes for Māori and other high priority members of our communities.

We recognise the importance of our Memoranda of Understanding (MOU) partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, in the planning and provision of healthcare services.

Article 1: Kawanatanga (governance)
Mana whakahāere: effective and appropriate stewardship or kaitiakitanga over the health and disability system. This relates to health system performance, particularly oversight and ownership of the processes necessary to reduce Māori health inequity. It provides active partnerships with mana whenua at a governance level. Providing for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services

Article 2: Tino Rangatiratanga (self-determination)
Mana motuhake: enabling the right for Māori to be Māori, exercise their authority over their lives and to live on Māori terms, according to Māori philosophies, values and practices, including Tikanga Māori. This is concerned with opportunities for Māori leadership, engagement, and participation in DHB activities. Further, to foster and develop the capacity of our MOU partners and Māori to have meaningful leadership and participation at every level of governance and operations within the DHB framework.

Article 3 – Oritetanga (equity)
Mana Tangata: achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness. This is concerned with achieving health equity, and thus with priorities directly linked to reducing systematic inequalities in health determinants, health outcomes and health service utilisation. Our MOU partners will hold the DHB to account and demand action to reduce health disparities in wellbeing that exist between Māori and non-Māori by improving health outcomes of Māori within their rohe, cognisant that 'wellbeing' is not simply the absence of illness and disease and that this will require dismantling systems and practices that have exasperated those health disparities.

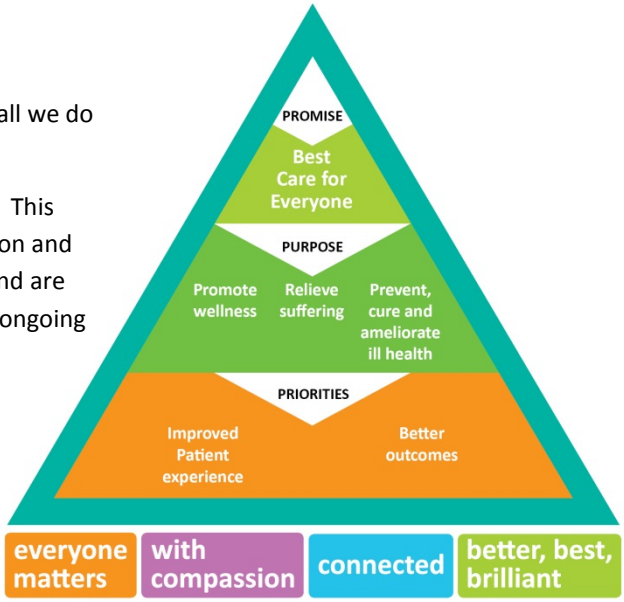
Article 4 – Te Ritenga (right to beliefs and values)
Mana Māori: enabling Ritenga Māori (Māori customary rituals), which are framed by te ao Māori (the Māori world), enacted through Tikanga Māori (Māori philosophy and customary practices) and encapsulated within māturanga Māori (Māori knowledge). This guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga. Waitematā DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities. Ensuring tikanga Māori is to the fore in the evolution of a more responsive model of care that prioritises Māori whānau, hapū, iwi and communities.

Our strategic direction

Best care for everyone

Our promise, purpose, priorities and values are the foundation for all we do as an organisation.

- Our **promise** is that we will deliver the **best care for everyone**. This means we strive to provide the best care possible to each person and their family engaged with our services. We put patients first and are relentless in the pursuit of fundamental standards of care and ongoing improvements, enhanced by clinical leadership.
- Our **purpose** defines what we strive to achieve, which is to:
  - promote wellness
  - prevent, cure and ameliorate ill health
  - relieve suffering of those entrusted to our care.
- We have two **priorities**:
  - better outcomes
  - patient experience.



The way we plan and make decisions and deliver services every day is based on our **values** of **everyone matters**; **with compassion**; **better, best, brilliant** and **connected**. Our values shape our behaviour, how we measure progress and continue to improve.

Delivering on our strategic direction

Our priorities are to achieve better and more equitable health outcomes for everyone in our community and enhance patient, family and whānau experience. We will do this by working with our communities and partners to deliver high quality, effective services that are patient-focused and compassionate.

We take a population-health perspective to improve the health of our entire population and achieve health equity for all groups, in particular for Māori. We will work with our Iwi Partnership Board Kōtui Hauora to plan and provide services to further Māori health gain. Our Waitematā DHB Consumer Council provides a strong voice for consumers on quality improvement and delivery of services that meet our population's needs.

We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services to ensure patients receive more effective and co-ordinated care.

Our Institute for Innovation and Improvement (i3) supports the design and implementation of new models of care and best practice processes to ensure the most effective and efficient delivery of health services. Examples include redesigning our outpatient and surgical services to improve patient experience, scaling telehealth and electronic tools in outpatients, building our e-data environment to support care redesign and redesigning hospital services in the community.

We recognise leadership is the most influential factor in shaping organisational culture and one of the key focuses of i3 is development of people with skills, experience and expertise needed to lead and champion healthcare redesign and innovation. Transforming Care is a clinical leadership programme to build innovation and improvement capability at Waitematā DHB.

We recently established a Staff Experience programme recognising that experiences at work are evolving, with staff increasingly wanting an overall experience that fits more seamlessly into their lives. Prioritised initiatives include: living our values and behaviours, wellbeing, leadership development, improving communications and growing a performance culture.

We expect our population to reach around 725,000 by 2031; this significant growth and increased demand for clinical and community services provide both challenges and opportunities. We have several major facilities developments planned for this year and we are working with the Northern Region DHBs on the NRLTHP to guide medium- to long-term planning decisions.

Environmental sustainability remains a priority. We have plans in place to reduce our carbon emissions and address the impact of climate change on health.

The financial challenge facing the broader health sector and Waitematā DHB is substantial. To ensure long-term sustainability, we need effective governance and strong clinical leadership to deliver the best evidence-based care

in a connected health system.

'Improving sustainability' in Section 2 identifies out-year planning activities that support system sustainability.

National, regional and sub-regional strategic direction

Waitematā DHB operates as part of the New Zealand health system. Our overall direction is set by the Minister's expectations and aligns with the health and disability system outcomes framework and the New Zealand Health Strategy.

The actions detailed in Section 2 of this plan align to the Minister's expectations and the Government's priority outcomes.

COVID-19

COVID-19 is a public health emergency and global pandemic. Aotearoa New Zealand's strategy is for the elimination of COVID-19. The aims are to eliminate chains of transmission in the community and contain any cases imported from overseas.

COVID-19 is fundamentally changing and challenging the way the New Zealand public health system responds, especially impacting how public health services are delivered. The COVID-19 response and associated activities delivered by the DHB-based public health units (PHUs) are now integrated with the Ministry of Health (led by the COVID-19 directorate), including the National Investigation and Tracing Centre (NITC) and the common IT platform in the National Contact Tracing Solution (NCTS).

Each outbreak is delivering significant learning opportunities for all parties, and the Ministry will ensure these learnings are shared across the sector and incorporated into future responses and activities.

The Ministry is engaging with DHBs/PHUs to design and implement a national public health response to more effectively share limited resources, standardise operating procedures, avoid duplication and increase the agility with which a surge response is mounted anywhere in the country and/or address future challenges.

The Northern Region 'whole of health system' response to COVID-19 is enabling rapid change and evolution in models of care across tier 1 and tier 2 services and has created an imperative to focus on faster, shorter, lifecycle projects and initiatives that will deliver change.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities and will be a key piece of work for the Health System in 2021/22.

Health and disability system reform

As a result of the findings of the 2018 Health and Disability Review, Aotearoa New Zealand's health system is changing. At the end of March 2021, Cabinet agreed a new operating model for the health and disability system.

The vision is for a health system delivering *pae ora* | *healthy futures* for all New Zealanders, where people live longer in good health and have an improved quality of life. To achieve this vision, the new system aims to achieve five outcomes above all others.

- Equity for all New Zealanders, so that people can achieve the same outcomes and have the same access to services and support, irrespective of who they are or where they live.
- Sustainability, through refocusing the system to prevent and reduce health needs and not just treat people when they are unwell: 'wellness not illness', and ensuring that we use resources to achieve the best value for money.
- Person and whānau-centred care, by empowering people to manage their own health and wellbeing and putting them in control of the support they receive.
- Partnership, through embedding the voice of Māori and other consumers into how the system plans and makes decisions, ensuring that Te Tiriti o Waitangi principles are meaningfully upheld.
- Excellence, ensuring consistent, high-quality care is available when people need it, and harnessing leadership, innovation and new technologies to the benefit of the whole population.

Improving outcomes for those traditionally underserved by our health system, Māori, Pacific and disabled people, our rural communities, and people with lower incomes (among others), is at the heart of these reforms.

To achieve *pae ora* and a more sustainable and better health system, there are five key shifts we must deliver.

1. The health system will reinforce Te Tiriti principles and obligations.
2. All people will be able to access a comprehensive range of support in their local communities to help them stay well.
3. Everyone will have access to high quality emergency or specialist care when they need it.
4. Digital services will provide more people with the care they need in their homes and local communities.
5. Health and care workers will be valued and well-trained for the future health system.

In 2022/23, all DHBs will be disestablished and their functions merged into a single entity, Health NZ.

Health NZ will manage all health services, including hospital and specialist services, and primary and community care. Hospital and specialist services will be planned nationally and delivered more consistently across the country. Primary and community services will be commissioned through four regional divisions, each of which will network with a range of district offices (Population Health and Wellbeing Networks) who will develop and implement locality plans to improve the health and wellbeing of communities.

A Māori Health Authority will work alongside Health NZ to improve services and achieve equitable health outcomes for Māori, and to directly commission tailored health services for Māori.

2021/22 will be a time of preparation and transition as we progress towards the new model. DHBs will continue to deliver all of our usual services, but will begin to establish national, regional and locality structures and functions.

Waitematā DHB is also engaging with the Transition Unit at various levels (i.e. CEO, CFO, Director of Funding, COOs) to provide input with planning.

Regional direction

The NRLTHP (previously Northern Region Long Term Investment Plan, or NRLTIP) was developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. The NRLTHP, together with the Ministry of Health's priorities, continues to be the foundation that sets the long term direction of the Northern Region work plans involving all the Northern Region DHBs.

Waitematā and Auckland DHBs have a bilateral agreement that joins governance and some activities. Furthermore, collaboration across the Northern Region is increasingly critical as we strive to deliver services for our whole population, invest across the health system, and increase coordination of care to improve access, equity and healthcare outcomes and reduce unnecessary duplication.

Strong clinical leadership is embedded at all levels of the organisation, enabling us to advocate for the health of our local population. We work with our District Alliance groups and other stakeholders to ensure a whole-of-system approach, working towards better integrated services and improved patient experience.

Regional and national networks with strong clinical leaders support work at both regional and national levels and focus DHB contribution to regional and national programmes.

Refer to Section 4 Stewardship, Northern Region Planning for further details.

Improving health outcomes for our population

Waitematā DHB's performance framework demonstrates how the services we fund or provide contribute to the health of our population and achieve our long-term outcomes and the Government's expectations.

Our performance framework reflects the key national and local priorities that inform this Annual Plan. There is considerable alignment between our performance framework, the System Level Measures framework set by the Ministry of Health, the Minister of Health's planning priorities, and the over-arching Government priorities.

We have two overall long-term population health outcome objectives:

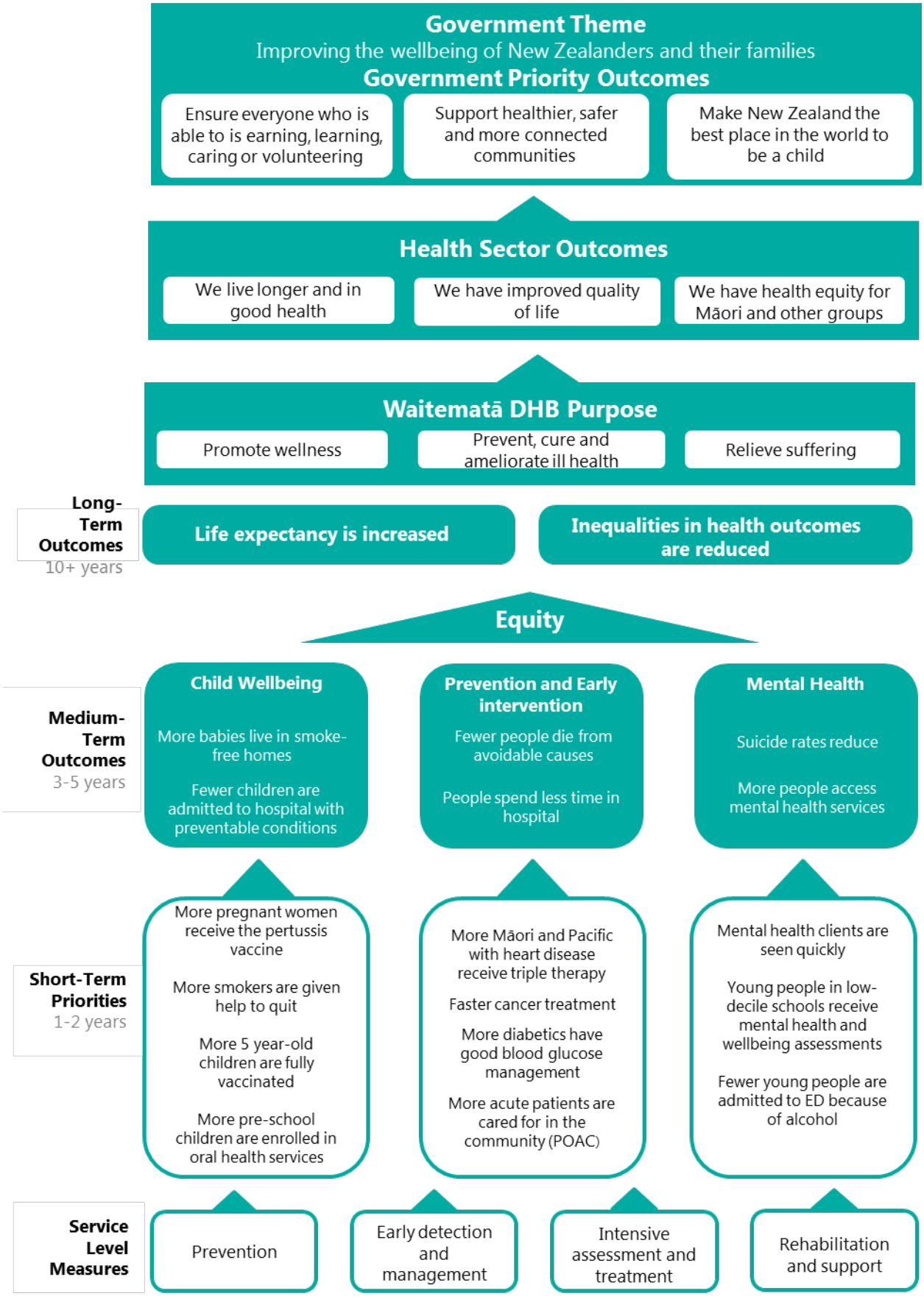
- life expectancy at birth continues to increase
- inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced.

The outcome measures are long-term indicators; the aim is for a measurable change in health status over time, rather than a fixed target.

Our medium-term outcome goals and short-term priorities will support achievement of these overall objectives. Our medium-term outcomes define our priorities for the next 3 to 5 years and allow us to measure the difference we are making for our population. Our short-term priorities are essential to the achievement of our outcome goals and are front-line measurements of the success of specific health processes or activities. Local progress against these indicators will be tracked throughout the year.

The Statement of Performance Expectations (Appendix B) details a list of service-level indicators that form part of our overall performance framework. We will report progress against these measures in our Annual Report.

Performance and intervention framework



SECTION 2: Delivering on Priorities

Introduction

On 10 February 2021, the Minister of Health set out DHB priorities for 2021/22. This section details our key programmes to deliver on these priorities. More information on the performance measures required by the Ministry is provided in Section 5.

Effective implementation of activities to meet these priorities and achieve milestones requires coordinated input and effort across multiple stakeholders to achieve real health gain for our communities. Overall leadership and accountability for the priority areas in this section generally sits within the Planning, Funding and Outcomes department, except where the focus is provider specific. Responsibility for delivery may sit across multiple stakeholders and collaborative priority setting and accountability is critical.

Several priority areas below benefit from, or are directly influenced by, the connections we share across the Northern Region. Many actions make sense to progress regionally just once, in a collaborative and consistent manner, rather than independently by each DHB. These were developed with significant contributions from the Region's clinical networks, clinical governance groups and other regional workgroups, and represent the thinking of clinicians and managers from both our hospital and community settings. Our NRLTHP provides the detail on this longer term regional work.

This is the second year that the annual plan of the region's public health unit (PHU) is incorporated into the DHB annual plan.

Focus for 2021/22

The Ministry of Health has directed that equity and the COVID-19 response are the focus for actions in 2021/22 DHB annual plans.

Actions to improve equity

Waitematā DHB is committed to helping all of our residents achieve equitable health outcomes. Specific activities designed to reduce health equity gaps for Māori, Pacific and other groups, such as disabled people, are identified as 'EOA'.

Actions related to COVID-19 response

Waitematā DHB is committed to supporting New Zealand's elimination approach to COVID-19. The COVID-19 outbreaks in 2020 had a significant impact on the way we delivered all of our services, and we continue to gather learnings from our response and the experiences of our health system partners.

We will use this experience to improve the way we plan and deliver a wide variety of services, not just those relating directly to COVID-19, and actions arising from these learnings are detailed in this annual plan. This plan also includes actions relating to our response to any future resurgence, and actions to aid our recovery from the impacts of the pandemic.

Government Planning Priorities

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

Whakamaua: the Māori Health Action Plan 2020-2025 was developed to achieve the vision of pae ora (healthy futures), set out in He Korowai Oranga, the Māori Health Strategy. Priorities include continuing to meet our responsibilities under Te Tiriti o Waitangi (the Treaty of Waitangi), to address and improve substantial health inequities, and to ensure all services for Māori are appropriate and safe.

Engagement and obligations as a Treaty partner
Actions to meet the Treaty of Waitangi obligations, as specified in the NZPHD Act

Action (all are EOA)	Milestone
Engagement and obligations as a Treaty partner Waitematā DHB has an existing relationship with Ngāti Whātua, and a relationship with Te Whānau o Waipareira representing Māori in West Auckland. We will work to increase the frequency of engagement between our Boards and the Boards of our partners, especially in light of the COVID-19 vaccine roll-out that will require strong engagement with our iwi and community partners • Host two Board-to-Board meetings with our iwi/Māori partners	Q2, Q4
Support the development and implementation of the Northern Region's Health Equity Plan	Q4
Host training sessions for Waitematā DHB Board, the topics will include (by quarter): Treaty of Waitangi, racism and bias within the health system, Māori health inequities, and Mātauranga Māori	Ongoing
Whakamaua Action 1.1 Work with Kōtui Hauora (the Northern Iwi-DHB Partnership Board) to implement the actions from their work plan. This includes aligned DHB and iwi priorities for Māori health development and gain. These actions need to be resourced by the DHBs to be completed	Q4
Whakamaua Action 2.3 Design and deliver training to Māori DHB Board members and Kōtui Hauora members to improve their understanding of the system and to identify where opportunities exist. We are committed to creating a proactive and accountable system where Māori health equity is at the core of everything that we do. These leaders will have the influence and mana to support this to occur	Q4
Support two Māori DHB Board members to take up formal governance training opportunities	Q4

Whakamaua: Māori Health Action Plan 2020-2025
Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems

Action (all are EOA)	Milestone
Accelerate and spread the delivery of Kaupapa Māori and whānau-centred services *Whakamaua Action 3.1* Implement the actions endorsed by Tumu Whakarae and the DHB Chief Executives, focused on: • Growing the Māori workforce to reflect the proportionality of the DHBs population - Increase Māori health workforce by 5% (baseline 564)	Q4
• Growing cultural competency (refer to the Health Workforce section)	Q4
• Measuring and reporting on recruitment and retention of Māori	Q1
Whakamaua Action 4.4 For the seven kaupapa general practices identified for support as part of Integrated Primary Mental Health and Addictions Services: • Review delivery against models and consider amendments/improvements to better align the models to appropriate cultural delivery	Q3
Whakamaua Action 6.1 Enable remote patient monitoring with feedback to patients for two priority groups where Māori are over-represented, congestive heart failure and renal medicine	Q3
Add human resource to support telehealth roll-out to rapidly shift delivery models from in-person to digitally enabled, with a focus on increased access and engagement in priority populations	Q1
Shift cultural and social norms *Whakamaua Action 3.3* Implement a refreshed approach to applying Te Tiriti o Waitangi in practice, in line with the Government's stronger approach to persistent Māori inequalities	Q4

Whakamaua: Māori Health Action Plan 2020-2025 Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems	
Action (all are EOA)	**Milestone**
To achieve more equitable outcomes for Māori, the DHB will work with Māori health providers/partners to improve the stability of their workforce, increase their collective attractiveness to Māori whānau and continue to build capacity and capability	Q4
Co-design a Māori staff wellbeing programme (refer to the Health Workforce section)	Q3
Reduce health inequities and health loss for Māori *Whakamaua Action 4.7* Refer to the Smokefree 2025, Immunisation, Breast Screening and Cervical Screening sections	
Whakamaua Action 8.2 Kōtui Hauora is our Tiriti-based partnership with our iwi partners. Plans across the Northern Region DHBs will be discussed in depth with iwi through this mechanism; local plans will follow existing local iwi/Māori partnership engagement processes. We will work with Kōtui Hauora to understand their priorities for the next 1-5 years, and start the development of a work plan and allocate necessary resources to achieve tasks linked to their priorities. • Engage with iwi to understand their health and wellbeing priorities • Develop a work plan to capture these priorities and agreed associated actions • Agree and allocate resources to complete these actions	 Q1 Q2 Q2
Strengthen system accountability settings *Whakamaua Action 1.4* Complete consultation with iwi and hapū to inform planning for the Warkworth community health service development project	Q4
Whakamaua Action 4.9 We are committed to supporting the Māori health sector to provide integrated and whānau-centred care that is accountable to the communities they serve. We need to ensure they are agile enough to respond to needs, and funded to achieve outcomes. We will align integrated Māori health contracts with Ngā Painga Hauora (the Auckland-Waitematā DHBs Health Outcomes framework), which includes: • Ensuring all Māori health providers have integrated contracts to allow for holistic models of care • Work with Māori health providers to reorient services to be better aligned with the needs in their community • Implement a sustainability process with Māori health providers	 Q1 Q4 Q4
Whakamaua Action 5.6 Work across the Northern Region to review the value of existing services to tāngata whaikaha and their whānau. In the first year, this review will focus on children's disability health services provided by DHBs to understand how responsive their model of care is to their patients and their whānau. This will include: • Refining data being recorded and reported by disability services for equity • Linkages with Māori health and whānau ora providers • Co-designing of new or enhanced services if necessary	 Q1 Q1 Q4
Whakamaua Action 8.5 Kōtui Hauora has the potential to provide oversight and guidance for major funding decisions within the Northern Region DHBs. This requires some critical pieces of work to occur: • Identify shared iwi and DHB priorities to focus resource and attention • Establish equity focused targets aligned to these priorities • Provide actions for each of these targets • Allocate resources to achieving these targets	 Q4

Improving sustainability

As New Zealand's population continues to grow and age, with more complex health needs, an enhanced focus on improving sustainability is required. This includes both immediate and medium term supports improvements in system sustainability, including significant consideration of models of care and the scope of practice of the workforce. We need to work collectively with our sector partners to deliver the Government's priorities and outcomes for the health and disability system while managing cost growth.

Short term focus 2021/22
Funding, analytics and production planning actions to support improved sustainability in 2021/22

Action	Milestone
The financial sustainability plan (FSP) for 2021/22 will continue in the same format as the 2020/21 plan. There is a commitment to deliver a $18m saving within the year. This is allocated between Hospital Services and Corporate, in line with the 2020/21 programme, with savings apportioned based on prior year spend. This equates to a 2.0% and 2.5% reduction in expenses, respectively. Community Services was added to the programme for 2021/22. The Hospital Services programme is expected to deliver $13.5m of savings, Corporate $2m in savings, with the balance of $2.5m in the Community Services programme. The programme has three clear themes, to which all identified initiatives will align: • remove clinical variation: 30% of total savings • remove waste within the DHB: 40% of total savings • address any duplication: 30% of total savings. A number of initiatives from the 2020/21 programme will continue to realise savings during the first half of the year, which will provide savings while the new initiatives reach benefit realisation. New initiatives will be added progressively throughout the year to ensure the $18m savings plan can be realised. The forecast for the delivery of savings assumes that $4.5m will be saved every quarter	
Identify and socialise savings initiatives	Q1
Estimate and evaluate benefits	Q1
Savings forecast charts created for monitoring benefits	Q1
Progressive implementation and benefit realisation	Q2, Q3
Deliver a $18m savings programme	Q4
Sustainability funding initiatives (funded by MoH; no savings element) Waitematā DHB has six projects underway as part of the Ministry funded sustainability fund, under the theme 'shifting the balance of care to the community'	
• Complete test of change	Q1
• Receive approval for implementation plan and execution is underway	Q2
• Embed changes throughout Waitematā DHB	Q3
• Complete project	Q4
National analytics (any identified benefits and associated saving will form part of FSP above) Review activity where Waitematā DHB is an outlier to National Price and identify opportunities for improvement	
• Identify outliers and validate benefits	Q1
• Execute improvement plan and begin to generate savings	Q2
• Monitor and report on benefit realisation	Q3
• Close initiatives and embed changes	Q4
Production planning (no associated saving) Improve the flow of acute patients through theatres and reduce waiting time on wards for acute patients. This will reduce disruption to elective lists as a result of acute demand, reduce length of stay (LOS) and improve flow through the hospital system. Benefits include avoided cost and improved efficiency	
• Analyse LOS reduction	Q2
• Minimise list cancellation rate	Q4

Medium term focus (three years) COVID-19 learnings, sustainable system improvements and quantified actions to achieve breakeven	
Action	**Milestone**
Innovative approaches from COVID-19 learnings Complete consumables rationalisation based on service criticality, to ensure sustainable service delivery and cost optimisation for both COVID-19 impacts and sustainable cost management	Q4
Sustainable system improvements over three years Focus on shifting the balance of care to the community as a continuation of the projects underway as proof-of-concept initiatives as part of the MoH sustainability funding. Initiate scaled-up project and complete detailed planning to enable a phased roll-out of a hospital-in-the-home model of care	
• Complete detailed planning for scale roll-out	Q2
• Execute new model of care	Q4
Quantified actions from the DHB's path to breakeven The programme will continue to have three clear themes, to which all identified initiatives will align: • Remove clinical variation: 30% of total savings • Remove waste within the DHB: 40% of total savings • Address any duplication: 30% of total savings There will also be an ongoing focus on enhancing operational efficiency across all areas of the organisation to manage the expected cost increases arising from demographic growth	
Action for each of years 1, 2, and 3: identify initiatives to reduce expenditure year on year by 2% to realise an annual saving of $16m across Waitematā DHB	
• Identify initiatives and evaluate benefits	Q1
• Execution underway	Q2
• Realise benefit	Q3
• Deliver 2% reduction in expense	Q4

Improving child wellbeing

We actively work to improve the health and wellbeing of infants, children, young people and their whānau, primarily through prevention and early intervention services, with a particular focus on improving equity of outcomes. For actions with a focus on ambulatory sensitive hospitalisations (ASH) in children aged 0-4 years, refer to the Maternity Care and Immunisation sections.

Maternity care Actions to meet the health needs of pregnant women, babies, children and their whānau, with a focus on equity	
Action	**Milestone**
Maternity care as a result of COVID-19 learnings During COVID-19 outbreaks, some women preferred to give birth at home. We will support and encourage LMCs to offer homebirth to well women with healthy pregnancies, via the distribution of homebirth packs and the provision of homebirth support	
• Engage with LMCs regarding the contents of homebirth packs	Q1
• Distribute 20 packs	Q2
• Obtain feedback from midwives	Q3
• Distribute 50 packs	Q4
During COVID-19 outbreaks and as agreed with MoH, earlier discharge from maternity is possible and, for some women, preferable with the right supports. In line with the CFA, we will develop a programme of supports to encourage optimal timing of discharge, increase satisfaction and reduce intervention rates	
• Establish a working group to examine what supports may be required	Q1
• Consult with stakeholders	Q2
• Trial early discharge for selected mothers and babies	Q3
• Analyse feedback and results	Q4
Developing integrated service models to improve access *Social services* Use summer student audit results of current performance to increase % of referrals of pregnant women to Noho Āhuru – Healthy Homes and maximise interventions prior to birth or discharge from hospital	
• Disseminate results to referrers	Q1

Maternity care
Actions to meet the health needs of pregnant women, babies, children and their whānau, with a focus on equity

Action	Milestone
• Increase the % of pregnant women referred (vs. those with an infant) from the 2019 baseline by 10%	Q3
Ultrasound Survey women postnatally regarding their primary maternity ultrasound experience to improve current understanding of the current state of the quality and quantity this service • Obtain approval for survey tool and method • Provide final report on findings	 Q1 Q3
Parenting education As Weaving Wānanga/Hapū Mama courses are effective in providing culturally acceptable information and support networks, we plan to improve access to this education for women and whānau by increasing the number of attendees and/or courses offered (EOA) • Review capacity in the courses to maximum participation • Establish baseline participation and set improvement target	 Ongoing Q1
WCTO WCTO Coordinator to use NCHIP, a new data source, to engage more whānau with a WCTO provider of their choice (EOA) • 95% of Māori infants enrolled with a provider at 4 weeks • 98% of all infants enrolled with a provider at 4 weeks	 Q1 Q3
Screening programme Consider learnings from COVID-19 catch-up to increase equity of service delivery across Newborn Metabolic Screening and Newborn Hearing Screening (EOA) • Complete review • Implement action plan	 Q1 From Q3
Support a sustainable workforce through a positive culture Ensure an engaged midwifery workforce by implementing the national Midwifery Career Pathway • Socialise the new pathway with midwives • Adjust roles and titles to align with the new pathway	 Q2 Q3
Perinatal and Maternity Mortality Review Committee recommendations (focus on ASH in children) Develop and implement a plan to promote the incentivised pregnancy stop smoking service, including actions to increase referrals from primary care, Lead Maternity Carers and other health services (EOA) • Develop the plan with specific actions and timeframes • Provide regular clinics in at least two general practices with high numbers of Māori and Pacific pregnancies to support the whānau to become smokefree • Build partnerships with the ten LMCs with the highest number of Māori and Pacific women who smoke to increase their referrals • Encourage smokefree conversations by health services (e.g. Well Child Tamariki Ora providers) to increase referrals to Stop Smoking Services	 Q1 Q2 Q3 Q4
General Practices are the most common early connection point for confirmation of pregnancy, but some women are not well informed on how to access LMC care; GPs need to have high quality information available to support engagement between pregnant women and an LMC. Review and improve information on Health Pathways to increase Early Engagement with a LMC, subject to MoH data provision (EOA) • Establish Health Pathways working group with primary care • Review information • Update information • Earlier engagement of Māori, Pacific and quintile 5 (NZDep2018)	 Q1 Q2 Q3 Q4

Immunisation (focus on ASH in children)
Actions to improve and maintain high childhood immunisation rates

Action	Milestone
Outreach Immunisation Services (OIS) Work with the OIS provider to establish and open at least one drop-in clinic per DHB that is open during whānau-friendly hours to improve access for those unable to attend during existing clinic hours	Q3
Work with regional colleagues on timing of referrals to the OIS for Māori, Pacific and quintile 5 (NZDep2018) tamariki (EOA)	

Immunisation (focus on ASH in children) Actions to improve and maintain high childhood immunisation rates	
Action	**Milestone**
• Review timing and process • Adapt referral processes, including testing a process for whānau PHO enrolment	Q1 Q2
Maintaining immunisation coverage during the COVID-19 immunisation programme • Work with Māori and Pacific mobile providers and WCTO providers (including Plunket) to agree a protocol for delivering vaccinations to children (EOA) • Work with the COVID-19 immunisation roll-out team to ensure that workforce for delivery of childhood immunisation is protected	 Ongoing Ongoing
Immunisation engagement and communications plan Key community influencers, as trusted sources of information, are identified and engaged to encourage immunisation and reduce decline rates. We will work with our Māori and Pacific provider network to identify immunisation concerns and work in partnership on messages to address these concerns, including testing with their consumer groups (EOA)	Ongoing
The tone of public health messages is important; we received feedback that not all of our messages are encouraging. We plan to review the suite of automated messages (e.g. NIR and text to remind) to ensure they are whānau-friendly and encourage access to services • Review NIR messages • Review primary care text messages • Update all whānau-directed messages	 Q1 Q2 Q4
Develop and trial a resource for new Māori and Pacific whānau that promotes the timing of childhood immunisation and Well Child tamariki ora checks (EOA) • Develop and test • Implement	 Q1 Q2
Māori influenza immunisation programme Continue to support Māori-led vaccination services that employ a holistic model to reach, educate and engage whānau/communities in their own care. Support includes NIR access and immunisation training to help sustain this service (EOA)	Ongoing
Focus on: increased immunisation at 2 years (CW05) Develop a nurse-led phone follow-up programme with whānau who decline immunisation to support informed choice. Increasing the opportunity for a conversation with an immunisation nurse to provide access to quality information may result in some whānau reconsidering vaccinations • Co-design concept with whānau • Trial and evaluate service	 Q2 Q4
Boost immunisation-positive messages on Māori/Pacific-targeted social media to reduce the impact of negative messages (EOA) • Identify or develop collateral • Release information to social media	 Q2 Q4
Prioritise referral of children overdue immunisations and not enrolled in a PHO to Noho Āhuru – Healthy Homes, including Māori and Pacific, for a social work assessment and facilitated engagement with primary care (EOA) (focus on ASH in children). We are seeking to ensure that the comprehensive supports provided by Noho Āhuru – Healthy Homes include offering immunisation along with other health interventions and engagement. Noho Āhuru can offer material supports to families (with a focus on young children) and is designed to work collaboratively, and in a way that is flexible and acceptable to families (e.g. with a home visit) • Co-design plan with Noho Ahuru and Immunisation Missed Event Services • Implement and review concept	 Q2 Q4
Improving immunisation coverage from infancy to five years of age Establish a joint Metro-Auckland Immunisation Operations Group, including PHOs, DHBs, Māori, Pacific, WCTO and LMC representatives, that will monitor coverage from birth to five years of age, streamline action plans and share learnings from the respective top performing GP clinics (EOA)	Q2
Contributory measures to support measurement of progress Timeliness of Māori immunisation measured at 6 and 18 months	 85%
Declined immunisation (by ethnicity)	<3.5%

Youth health and wellbeing

Actions to improve the health of our youth population

Action	Milestone
Improve the health and wellbeing of priority youth populations Establish routine catch-up vaccination programme for Year 9 students alongside HEADDSSS. This additional vaccination opportunity will identify and vaccinate under-immunised, particularly Māori and Pacific, students who have missed out or are new to New Zealand (EOA)	
• All SBHS have NIR results for Year 9 students	Q1
• ≥50% of students identified as unimmunised are fully vaccinated	Q4
SBHS quality improvement Research demonstrated that YouthCHAT was more effective at eliciting some information from students and its use should be optimised, and barriers to its use be removed to improve AOD screening quality	
• Obtain baseline data	Q2
• All schools to review the use of YouthCHAT as a routine part of HEADDSSS and use YouthCHAT alongside ≥80% of HEADDSSS assessments	Q4
Telehealth Build capacity for virtual appointments during school holidays for ESBHS students who otherwise may miss out on healthcare	
• Agree the approach with nursing teams	Q1
• Virtual appointments over the holidays are in place	Q3

Family violence and sexual violence

Actions to reduce family violence and sexual violence in our communities

Action	Milestone
Support COVID-19 recovery/embed learnings With school attendance disrupted, and some households experiencing the challenges with maintaining privacy of virtual sessions, discussions and education regarding sensitive issues was reduced, resulting in variable application of both screening and education within the ESBHS. This was a particular risk for Māori and Pacific households (EOA)	
• Review the delivery of Sexual Violence/Consent and Relationship Education by School Based secondary school nursing team	Q2
• Results (and training, if required) disseminated to all SBHS nurses, GPs and guidance counsellors	Q4
Evidence-based equity actions Core elements of achieving equity for Māori include training for health professionals to screen for family violence, and better linked services to ensure appropriate referrals are made once detected (EOA)	
• Ensure family violence training is available for staff of Māori health providers	Q1
• Establish a working group, or connect with existing groups, of stakeholders to focus on improving links between Māori health providers, iwi and providers the offer family violence programmes	Q2
• Review all relevant existing programmes to determine if family violence and sexual violence education, screening, and workforce development is required, and roll out recommendations of this review	Q4
Family violence literature suggests that immersive cultural and clinical services that deal with the perpetrator, victims and wider whānau are critically important for stopping violence within the home. Across Waitematā and Auckland DHBs, there is currently no kaupapa Māori family violence service for whānau (EOA)	
• Review existing family violence services across the two districts	Q1
• Recommend an agreed service model to the Waitematā and Auckland DHBs Boards, and Kōtui Hauora for support and implementation	Q3
• Implement a kaupapa Māori family violence services for Waitematā and Auckland DHBs	Q4
Work with Pacific providers to identify any family violence and sexual violence training needs to support them to deliver services (EOA)	Ongoing

Improving mental wellbeing

Waitematā DHB will embed a focus on wellbeing and equity at all points of the system, with increased focus on mental health promotion, prevention, identification and early intervention, especially in response to the impacts of COVID-19 and its impacts on people's wellbeing. We will strengthen existing services to ensure that mental health services are cost effective, results focused and have regard to the service impacts on people who experience mental illness. Our range of services will be of high quality, safe, evidence-based and provided in the least restrictive environment.

Improving mental wellbeing Working in collaboration with all stakeholders to transform mental health and addiction services, grounded in wellbeing and recovery and with a deliberate focus on equity of outcomes and responding to the impacts of COVID-19	
Action	**Milestone**
Psychosocial response to and recovery from COVID-19 Expand the evidence-based DBT in schools programme to intermediate schools. This programme supports teachers via an apprenticing model to manage a 30-week evidence-based group for students struggling with emotion regulation leading to self-harm and risk-taking behaviours. Expected benefits include more students with access to self-regulation skills in schools to improve resilience and skill development, partnered schools able to run the programme without needing specialist staff	
• Two new schools, one each in North and West areas	Q2
Agree and implement telehealth guidelines across the SMHAS service to support robust and consistent service delivery during pandemic lockdowns. Guidelines to reflect youth and cultural perspectives and be associated with data collection (EOA)	Q1
Integration of primary with secondary services Support capacity development in GP practices by continuing to deliver youth- and child-focused education sessions to GPs and expand recipients to include Health Improvement Professionals (HIPs), Health Coaches and practice nurses to improve their understanding of common psychiatric disorders in children and youth and confidence to manage such disorders	
• Deliver two sessions per annum, average of 35 participants per session	Q4
Partner with police to develop community suicide prevention skills for the Asian population to increase awareness of mental health and suicide prevention knowledge (EOA)	
• Deliver four integrated meetings/workshops	Q4
Evidence-based equity actions To improve addictions outcomes for Māori, we plan to increase the number of Māori in culturally matched addictions counselling at Te Ātea Marino, which provides evidence-based harm reduction interventions enhanced by Mataruanga Māori to support Māori in their recovery journey. Improving access to services designed to meet the needs of Māori is a key approach in reducing inequity and aligns with the recommendations of He Ara Oranga, the NRA AoD Model of Care Review and the intent of Pae Ora and Whakamaua: Māori Health Action Plan 2020-2025. Increase the referral rate to Te Ātea Marino (Māori addictions service) by 20% (baseline = 897 in the year to Dec 2020) (EOA)	
• Contribute to a review of the 1818 phone-line referral system and implement recommendations to increase the number of appropriate Māori accessing Te Ātea Marino services	Q2
• As part of the refurbishment of CADS West offices, ensure co-location of Te Ātea Marino amokaiora (addictions counsellors)	Oct 2021
• Implement systems across CADS sites to increase appropriate Māori referral rates to Te Ātea Marino services	Q4
• Achieve 500 referrals	Q2
• Achieve 1,076 referrals	Q4
We plan to improve access to Pacific mental health and addiction services to improve wellbeing, by increasing the volume of available cultural support (including navigation and welcome across) the primary care and secondary care continuum, including inpatient (baseline referrals to Malaga = 172 in the year to Dec 2020) (EOA)	
• Draft plan with partners	Q1
• Submit RFP to Wellbeing Budget	Q2
• Increase FTE	Q3
• Achieve >200 referrals	Q4
Follow-up within 7 days post-discharge from an inpatient mental health unit (MH07)	
We plan to improve the quality of follow-up within 7 days of discharge from our inpatient mental health units by engaging family/whānau in collaborative recovery planning, which is expected to support the recovery	Q1: 50% Q2: 55%

Improving mental wellbeing Working in collaboration with all stakeholders to transform mental health and addiction services, grounded in wellbeing and recovery and with a deliberate focus on equity of outcomes and responding to the impacts of COVID-19	
Action	**Milestone**
from an acute episode and enhance resilience of the tangata whai i te ora and their family/whānau, by increasing the number of adult mental health service users who received at least one family/whānau contact per quarter (baseline = average 44.75% in the year to Dec 2020)	Q3: 60% Q4: >60%
We plan to improve the awareness of the rights and needs of families/whānau to enhance staff engagement and support recovery planning from an acute episode of care, by increasing the number of adult mental health staff trained in Family Inclusive Practice, including senior clinical leaders (baseline 21% staff at 31 Dec 2020)	Q1: 30% Q2: 35% Q3: 45% Q4: 50%
Contributory measures from the KPI programme 7-day post discharge follow-up (face-to-face) (baseline = average 89.9% in the year to Sep 2020)	95%
% of episodes with family/whānau engagement (baseline = average 47.5% in the year to Dec 2020)	60%

Improving wellbeing through prevention

Our foremost priority is responding to COVID-19 as a public health emergency and global pandemic. We will focus on working with the Ministry to ensure our DHB/Auckland Regional Public Health Service to design and implement a national public health response where we will more effectively share limited resources, avoid duplication and increase the agility with which we mount a surge response anywhere in the country and/or address future challenges.

Preventing ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As our population grows and ages, it is important to orient the health and disability system towards prevention. This preventive focus includes supporting people to live active and healthy lives, working with other agencies to address key determinants of health, and identifying and treating health concerns early in life and in the disease progression.

Communicable diseases Actions to advance communicable diseases control work, particularly implementation of the COVID-19 elimination strategy	
Action	**Milestone**
Support COVID-19 recovery/embed learnings Maintain outbreak response capability for COVID-19 in the areas of prevention, preparedness and response, which is fundamental to New Zealand's public health response to the global COVID-19 pandemic	Ongoing
Transition Pae Ora Māori and Pacific response models, including makaaki services, from the COVID-19 Response Unit to the wider Auckland Regional Public Health Service (ARPHS), which transfers learnings into ARPHS service delivery and deepens the cultural appropriateness of responses to communicable disease events (EOA)	Q4
Core functions ARPHS maintains an appropriate and efficient system for receiving, considering and responding to: • notifications of suspected and confirmed cases of communicable disease • public health management of cases of communicable disease and their contacts • enquiries from medical practitioners, the public and others about suspected communicable disease of public health concern These actions help to ensure that the population of Tāmaki Makaurau is protected from notifiable infectious diseases	As required

Environmental sustainability

Actions to positively mitigate or adapt to the effects of climate change and their impacts on health

Action	Milestone
Support COVID-19 recovery/embed learnings Our COVID-19 response required a revision of work arrangements and travel, providing opportunities for alternative working arrangements and improved public transport connections to reduce travel-related carbon	
• Develop a draft of our 3-year travel plan for staff and visitors	Q3
Both our COVID-19 response and the Carbon Neutral Government Programme highlight a need to review the organisational boundary and emissions inclusions of our carbon inventory and reduction plan to progress the carbon neutral 2025 goal	
• Develop a draft of our carbon management programme for review	Q2
• Finalise and obtain approval for programme	Q4
• Continue to measure, verify and report greenhouse gas emissions through Toitu Carbon Reduce and have an established reduction plan	Ongoing
Evidence-based equity actions Connect with our iwi partners and Pacific community to develop an overarching Sustainability Vision for the DHB that is culturally appropriate (EOA)	
• Engage with iwi and Pacific community	Q3
• Finalise and endorse the Sustainability Vision	Q4
Transitioning fleet to electric vehicles Fleet use represents approximately 5% of our CO_2 emissions; we are making substantial investment in fleet transition to electric vehicles alongside development of charging infrastructure to reduce emissions	
• Develop a plan to transition our existing fleet to electric vehicles	Q4

Antimicrobial Resistance (AMR)

Actions to improve equity in outcomes and patient experience

Action	Milestone
Support COVID-19 recovery/embed learnings Support ARC facilities to maintain preparedness to effectively respond to COVID-19 (and other infectious disease) outbreaks through the work plan set by the Northern Region COVID-19 ARC Outbreak Steering Group and the associated Operations Working Group and Clinical and Public Health Working Group	Ongoing
Establish a permanent PPE coordinator role to provide leadership and linkage across the various elements of PPE (OHSS, Education and Training, IP&C, Procurement and supply). This enables the DHB to deliver high quality care to all patients admitted with infections that require PPE use	Q2
Managing the threat of AMR Regularly audit wards for compliance against the revised MDRO admission pathway from ED/ADU wards to ensure appropriate isolation and precautions to help prevent the acquisition of MDROs within the hospital environment	Ongoing
Advancing AMR management *Primary care* Implement an education plan to support improved antimicrobial prescribing, with focus on Māori and other high need populations (EOA)	Ongoing
Age-related residential care services Continue to use the ARC forum and cluster groups to ensure facilities are informed of front-line infection prevention and control practices and the CPE Guidelines; monitor corrective actions from ARC audits for the Infection Prevention and Control Standard	Ongoing
Hospital services Penicillin allergy labels are associated with harm and result in the use of alternative antibiotics that are needlessly broader spectrum. De-labelling incorrect penicillin allergies may help to reduce unnecessary use of broad spectrum antimicrobials and prevent harms associated with incorrect labels, e.g. increased risk of surgical site infections, more *C. difficile* colitis, and increased risk of MDRO colonisation and death	
• Implement a penicillin allergy assessment programme to de-label incorrect penicillin allergy labels in high-risk populations to reduce unnecessary use of alternative, broader spectrum antibiotics	Q4

Drinking water
Actions to support our Public Health Unit to deliver drinking water activities

Action	Milestone
Compliance and enforcement activities • Undertake interim compliance and enforcement activities relating to the Health Act 1956, while drinking water functions are transferred to Taumata Arowai, the new national drinking water regulator. This will ensure there are no gaps in enforcement during the transition to the new authority • Transfer drinking water supplies data and regulatory function to Taumata Arowai • Report against the performance measures contained in the Drinking Water planning and reporting template 2021/22 (Vital Few Report)	As required Ongoing until the transfer Q2, Q4
Highlight non-compliant supplies, or water supplies that predominantly serve Māori or Pacific, or those which potentially pose public a health risk, to Taumata Arowai (EOA)	Ongoing

Environmental and Border Health
Actions to ensure compliance with environmental and border health legislation

Action	Milestone
Support COVID-19 recovery/embed learnings In the event of a suspected, probable or confirmed COVID-19 case on board of a ship in New Zealand waters, liaise with maritime stakeholders, NZ Customs, Ministry for Primary Industries, ship agents, Ports of Auckland/Harbour Control for the prevention of secondary spread of the infection into the community	Ongoing
Continue to focus on the border worker and household contacts of border worker cohorts of the COVID-19 vaccination roll-out, including priority populations (Māori and Pacific) within those cohorts with input from external partners (e.g. employers, iwi) in the most appropriate ways (including communication, venues) to maximise cohort engagement and vaccine uptake (EOA)	Ongoing
Manage extension of the Northern Region's vaccination programme to include priority groups (as indicated by the Ministry) within the general population through co-developed strategies with Māori and Pacific community partners, venue selection and communication activities (EOA)	Ongoing
Evidence-based equity actions Partner with Ngāti Whātua to identify common priority areas of environmental health activity and develop an equitable action plan to address concerns. This will include an agreed communications pathway, sharing of information and timely response to emerging issues (EOA)	Q2, Q4
To ensure culturally appropriate community engagement with Pacific communities (EOA): • Develop and implement a Pacific model for enteric disease investigation (DI) • Deliver training to all DI staff on the new Pacific engagement model	 Q2 Q4
Compliance and enforcement activities Within the funding provided, undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation, by delivering on the activities and reporting on the performance measures contained in the Environmental Health planning and reporting 2021/22 template, across the three Metro Auckland DHBs. This is important to minimise the risks of adverse health to enable communities living in Tāmaki Makaurau to be free from environmental health hazards. Activities include: • Work with Auckland Council to provide public health advice on strategic long-term planning regarding urban development while ensuring ARPHS focus is aligned with mana whenua priorities within the ARPHS region • Provide Vital Few reports	Ongoing Ongoing Q2, Q4

Healthy food and drink environments
Actions to create supportive environments for healthy eating and healthy weight

Action	Milestone
Create support environments for healthy eating Continue to implement the National Healthy Food and Drink Policy for staff and visitors, targeting priority groups, including Māori and Pacific (EOA) • Engage and consult with unions and relevant stakeholders to move to water and unflavoured milk only policy	 Q2

Healthy food and drink environments

Actions to create supportive environments for healthy eating and healthy weight

Action	Milestone
• Remove the cold drinks currently under the 'orange' category of the policy and allow the sale of only bottled water, unflavoured mild and compliant smoothies ('green' category)	Q4
Healthy Active Learning Support early childcare education centres to establish food and drink policies to encourage healthy nutrition behaviours in the early years of life: • initial engagement with Auckland kindergarten association • engage all kindergartens in the Auckland kindergarten Association (approximately 100 centres) in establishing a food and drink policy	 Q2 Q4

Smokefree 2025

Actions to advance progress towards the Smokefree 2025 goal

Action	Milestone
Support COVID-19 recovery/embed learnings Embed a new model in the provider arm to offer smoking cessation support via virtual, as well as face-to-face, meetings as a new way of working, to increase flexibility for clients to improve engagement in quit attempts • Embed model as BAU	 Q2
Improve stop smoking outcomes for Pacific Review the findings of the evaluation of the Pacific community smokefree pilot project and use the findings to procure future services to reach more Pacific smokers and support them to quit (EOA) • Agreement with evaluation provider in place • Evaluation received • Ongoing services revised and procured	 Q1 Q3 Q4
Reducing equity gap for Māori Review the findings of the evaluation of the Wāhine Māori community smokefree pilot project (in including young Māori women) and use the findings to procure future services to reach more Wāhine Māori smokers and support them to quit (EOA) • Agreement with evaluation provider in place • Evaluation received • Ongoing services revised and procured	 Q1 Q3 Q4
Compliance and enforcement activities Undertake compliance and enforcement activities relating to the Smokefree Environments and Regulated Products Act 1990 by delivering the activities and reporting on the performance measures contained in the Smokefree 2025 planning and reporting 2020/21 template (Vital Few Report). This work supports the 2025 Smokefree initiative in Tāmaki Makaurau and aims to reduce access and exposure to tobacco • Provide Vital Few reports	Ongoing Q2, Q4

Breast screening

Improve access to screening to detect cancer earlier to reduce mortality and morbidity, particularly for Māori and Pacific

Action	Milestone
Support COVID-19 response and recovery Work with provider to test whether prioritised appointment times for Māori and Pacific wāhine result in improved access (EOA). The measure is PV01, 70% breast screening coverage for women aged 45-69 years for Māori, Pacific, Asian and total population	Q4
Participation Share recommendations from the Find 500 Māori Women campaign and review the results (EOA) • Work with the project team, including providers, to identify the limitations and strengths of the approach • Work with Pacific stakeholders to consider whether learnings can be applied to the Pacific community • Embed identified strengths of the approach into engagement, recruitment and retention strategies for Māori and Pacific women	 Q1 Q1 Q4
Work with breast screening providers to develop a proposal to pilot and evaluate an incentive programme	Q4

Breast screening Improve access to screening to detect cancer earlier to reduce mortality and morbidity, particularly for Māori and Pacific	
Action	**Milestone**
to engage low income Māori and Pacific women to attend their first breast screen (EOA). The measure is PV01, 70% breast screening coverage for women aged 45-69 years for Māori, Pacific, Asian and total population	

Cervical screening Provide equitable access to screening to reduce mortality and morbidity, particularly in Māori, Pacific and Asian women	
Action	**Milestone**
Improve coverage in Māori and Pacific Pilot and evaluate an incentive scheme for low income unscreened and overdue Māori and Pacific women to engage in cervical screening (EOA)	Q4
Reduce equity gap in screening Explore opportunities to promote screening uptake in collaboration with Māori and Pacific providers (EOA) • Complete plan with input from stakeholders • Collate learnings	 Q1 Q4
Improve equitable access to diagnostic and treatment colposcopies Work with colposcopy clinics, the register and SSS to understand any system improvement opportunities for any person with HG cytology who has no recorded histology at 6 months	Q1
Support COVID-19 recovery/embed learnings Share COVID-19 recovery learnings from NCSP with stakeholders to manage screening catch-up and prioritisation in case of future COVID-19 outbreaks	Q2

Reducing alcohol related harm Actions to support our Public Health Unit to advance activities relating to reducing alcohol related harm, undertake enforcement of the Sale and Supply of Alcohol Act 2012, and achieve equitable outcomes for Māori; ensuring programme delivery is underpinned by the Treaty of Waitangi and its principles for Pae Ora – healthy futures for Māori	
Action	**Milestone**
Evidence-based actions to reduce inequities in alcohol-related harm Re-design ARPHS's compliance processes to consult with Ngāti Whātua and Tainui on new bottle shop licence applications to give greater consideration and a stronger voice to Māori needs when assessing applications (EOA)	Q4
Establish regional advocacy group on alcohol harm minimisation	Q4
Following Board endorsement, ensure ongoing implementation of the DHB's Position Statement on Reducing Harms from Hazardous Alcohol Use in our communities • Work with people, whānau, families, communities, health agencies and other partners to influence the social and environmental determinants of hazardous alcohol use and improve access to healthcare services for people experiencing alcohol-related harm • Ensure equitable access to alcohol harm reduction services, especially in Māori communities who experience a significantly higher burden of alcohol-related health conditions (EOA)	Ongoing
Compliance and enforcement Undertake compliance and enforcement activities relating to the Sale and Supply of Alcohol Act 2012 to help reduce alcohol-related harm. This includes delivering on the activities and reporting on the performance measures contained in the Reducing Alcohol Related Harm planning and reporting 2021/22 template (Vital Few Report) • Assess all alcohol off licence applications received • Provide Vital Few reports	Ongoing Ongoing Q2, Q4

Sexual and reproductive health

Actions to advance sexual health services and sexual health promotion work

Action	Milestone
Support COVID-19 recovery/embed learnings Strengthen service capability to provide patients options. This enable careful triage management during changing COVID-19 alert levels to ensure continuity of care through telehealth and virtual channels	
• Clinko system (a patient self-booking system) in place	Q2
• Streamline patient follow-up by offering virtual 15-minute follow-up consults for HIV PrEP	Q4
Reducing inequities Review clinic locations in conjunction with community/local iwi representatives to ensure appropriate services are offered locally for Māori and Pacific (EOA)	
• Complete West Auckland review	Q2
• Complete South and North Auckland reviews	Q4
Refine metrics that provide outcome data for patient populations to improve our understanding of health outcome gaps, particularly for our Māori and Pacific patients (EOA)	
• Embed metrics as part of service operating model	Q2
• Review metrics and complete clinical outcomes audit	Q4
Implement point-of-care syphilis testing aimed at Māori and Pacific in high needs areas to increase case detection (EOA)	
• Define model	Q2
• Implement model	Q4

Cross-sectoral collaboration including Health in All Policies

Actions to continue the integration between health and social services, with a focus on influencing healthy public policy towards achieving equity

Action	Milestone
Support COVID-19 recovery/embed learnings ARPHS shares COVID-19 learnings with cross-sectoral organisations as appropriate	
• Report on information shared	Q2, Q4
Wider determinants of health ARPHS works in partnership with other cross- sectoral organisations across the Auckland region to support Health in All Policies to achieve equitable health outcomes (EOA), where resources and capacity allows	
• ARPHS leads the Healthy Auckland Together (HAT)[2] coalition.	Q4
• ARPHS leads the Auckland Intersectoral Public Health Group (AIPHG)[3]	Quarterly
Working with key stakeholders (the AIPHG group), ARPHS aims to improve whole-of-government responsiveness to public health issues in Tāmaki Makaurau. The Healthy Auckland Together coalition aims to improve nutrition, increase physical activity and address obesity in Tāmaki Makaurau. ARPHS ensures that HAT and AIPHG membership includes Māori and Pacific representation	
To share ARPHS knowledge and expertise on public health topics and to promote Health in All Policies, ARPHS contributes to relevant regional and national policy development process on wider social and economic determinants of health. An equity lens will be applied to all submissions through the use of the Heath Equity Assessment Tool (HEAT) to consider impacts on Māori and Pacific populations (EOA)	As required
ARPHS engages with the Metro Auckland DHBs on its newly developed Pacific Strategy. This in turn, will inform the development of the strategy's implementation plan. ARPHS' Pacific Strategy focus areas are community engagement, outbreak surveillance, Smokefree 2025, reducing alcohol harm and nutrition	
• Engagement with Auckland DHB	Q1
• Engagement with Counties Manukau and Waitematā DHBs	Q2, Q3

[2] Stakeholders: 32 organisations representing local government, mana whenua, health agencies, NGOs, university and consumer interest groups.
[3] Stakeholders: DHBs planning and funding representatives, Northern Regional Alliance, and Ministry of Health.

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System

New Zealanders are living longer but are spending more time in poor health. Therefore, we expect strong demand for health services in the community, our hospitals, and other healthcare settings. Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development, and joined-up service planning to maximise system resources and to improve health and increase equity.

Delivery of Whānau Ora
Actions that demonstrate system-level changes by delivering whānau-centred approaches to Māori health and equity

Action (all are EOA)	Milestone
Support COVID-19 recovery/embed learnings The unregulated/community support/navigator workforce was critical to the agile models that Māori health providers and whānau ora employed in response to COVID-19. We will continue to work with the NRHCC to fund these roles and provide support to develop and train this workforce to take on more responsibility for their communities. We plan to: • Continue support for Kaimanaaki/Whānau navigator roles • Offer professional development opportunities to this workforce	 Q4 Q4
Work with Pacific providers, communities and stakeholders to identify joint approaches to support Pacific recovery in Pacific communities (including vaccination roll-out), informed by learnings and insights from joint work on the Pacific COVID-19 response	Ongoing
Evidence-based equity actions Continue to provide a whānau ora response network of providers to support COVID-19 outbreaks, welfare support cases and networking among providers/teams	Ongoing
Continue to work with the Fono to support Enua Ola stakeholders to deliver services to address their communities' identified needs	Ongoing

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025
Actions that demonstrate delivery of the most important aspects of Ola Manuia

Action (all are EOA)	Milestone
Support COVID-19 recovery/embed learnings *Real-time data and contact tracing* Continue to influence data collected, and analyse and share Pacific data to inform and enable actions, initiatives and policies (including COVID-19 vaccination roll-out) to reduce Pacific health inequities	 Ongoing
Communications for Pacific communities – health literacy In partnership with Health Literacy NZ, develop professional development opportunities for key staff and teams throughout the DHB • Create professional development for specific services and tailor to their identified needs	 Q3
Communications for Pacific communities – dissemination of public health messages Work with Cause Collective, Pacific providers and local Pacific community networks to identify ways to support and strengthen effective dissemination of culturally appropriate public messages for Pacific communities	Ongoing
Ongoing access to wrap-around services Continue to support Integrated Services to access wraparound health and social services for Pacific families with complex needs and experiencing hardship, including due to the impact of COVID-19	Ongoing
Relationships with the Pacific health sector Refer to the Pacific COVID-19 action in the Delivery of Whānau Ora section, and the communication actions above	
Ola Manuia health and disability system indicators *Support and grow our Pacific workforce* Increase Pacific participation in the workforce through Pacific Science Academy programme, our scholarship programme, regular fonos with Pacific staff and support in tertiary study (refer to the Health Workforce section) • Increase Pacific health workforce by 5% (baseline 464)	 Ongoing Q4
Develop cultural responsiveness of our services Expand the delivery of Pacific Best Practise to all clinical orientations sessions • Commence	 Q1

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025 Actions that demonstrate delivery of the most important aspects of Ola Manuia	
Action (all are EOA)	**Milestone**
• All clinical orientation sessions receive Pacific Best Practise education	Q4
Capture and review Pacific patient and family experience of accessing Cancer care services, and assess how the findings can be used to support the cultural responsiveness of Cancer services • Develop questionnaire and start to use and compile responses • Review findings • Complete report and present recommendations to Cancer Services	 Q1, Q2 Q3 Q4

Care Capacity and Demand Management (CCDM) Actions for full implementation of CCDM for nursing and midwifery	
Action	**Milestone**
Complete and/or maintain implementation of CCDM for nursing and midwifery in all qualifying inpatients units/wards Undertake annual CCDM FTE calculations into nursing and midwifery as per annual plan • Ensure that annual FTE calculations are on track and reported • Provide quarterly updates as required by the Ministry	 Quarterly Quarterly
Maintain permanent governance for CCDM for the organisation and embed Local Data Councils at the Service level with participation from wards/units • Meet, monitor and report to plan	 Quarterly
Use the Core Data Set to evaluate the effectiveness of CCDM in Waitemata DHB, report and make improvements, as led by the CCDM Council • Meet, monitor and report to plan	 Quarterly
Continue quality improvement activities in Variance Response Management led by a working group • Meet, monitor and report to plan	 Quarterly

Health outcomes for disabled people Actions that demonstrate commitment to embed key learnings from the COVID-19 response and to improving outcomes for Māori and Pacific disabled people	
Action (all are EOA)	**Milestone**
Support COVID-19 recovery/embed learnings Ensure the inclusion of closed captions on all Waitematā DHB-generated social media videos to improve accessibility for the deaf and hearing-impaired community	Ongoing
Refer to the Health Workforce section for a further priority action	
Evidence-based equity actions Maintain our Accessibility Tick programme accreditation by completing actions in the 2021/22 Accessibility Tick Action Plan	Q4
Co-design with an external agency and facilitate e-learning and face-to-face workshops for staff on working with Tangata Whaikaha /Māori disabled people and Māori disability cultural perspective	Q4
Work with supported employment agencies to actively employ Māori and Pacific disabled people and support candidates to be job ready	Q4
Develop health needs assessment information for disabled people	Q4

Planned Care Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes	
Action	**Milestone**
Support COVID-19 recovery/embed learnings Ensure Planned Care is managed in a 'business as usual' approach that is separate from COVID-19 pathways to maintain uninterrupted service provision and reduce acute pre-operative wait times and cancellation rates • Review operating theatre structures to redefine	 Q1

Planned Care Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes	
Action	**Milestone**
• Build capacity in acute and elective theatre pods, casual theatre staff and establish a dedicated surgeon of the day role/resource to lead theatres each day	Q2
No reduction in productivity from the loss of Elective Surgical Centre capacity due to stand down for COVID-19. This leads to improved clinical outcomes for patients in acute and elective care through improved reliability and patient experience	
• Review the COVID-19 Readiness Plan to ensure affected patients are managed in medical wards	Q1
• Scenario testing in COVID-19 designated units; remove ESC from capacity escalation plans	Q2
Strategic priorities of the Three-Year Plan for Planned Care	
Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed	
Develop the integrated stroke unit, combining acute and rehabilitation pathways to reduce hospitalisation	
• Develop detailed project and implementation plans, including performance monitoring metrics	Q1
• Test the new model of care on 30 patients to ensure safety and good patient experience	Q3
• Implement in full with ongoing monitoring of agreed metrics, including access times	Q4
Balance national consistency and the local context	
Develop a standardised governance and improvement framework to lift performance	
• Develop a performance and accountability framework	Q1
• Educate and socialise team to accountabilities	Q2
• Match scorecards to accountabilities within the framework	Q3
• Re-design governance committees to better align to framework	Q4
Support consumers to navigate their health journeys	
Expand the use of the patient portal to improve the patient experience for navigating the health journey	
• Complete RFP process and approve vendor; identify trial services	Q1
• Develop change management and communication strategy	Q1
• Implement changes, including an equity lens, and roll-out communication to staff and patients (EOA)	Q2
• Test changes with identified services and review	Q3
• Phased roll-out to all identified services; analyse update data, including an equity lens (EOA)	Q4
Optimise sector capacity and capability	
Implement agreed model of care changes to optimise capacity (incremental). Implement pilot – community models e.g. non-surgical osteoarthritis pathway (MSK)	
• Establish steering committee	Q1
• Develop referrals pathways	Q3
• Initiate project	Q3
• Monitor and assess outcomes against agreed metrics	Q4
Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future	
Develop the ORL and Head and Neck service to RDM level 5 to reduce vulnerability and increase reliability of service delivery	
• Identify gaps in service resources, skills and infrastructure	Q1
• Develop a business plan and negotiate with Auckland DHB	Q2
• On-board additional staff and upgrade supports	Q3
• Identify service volumes and growth for 2022/23	Q4
SS07 Planned Care Interventions (SS07)	
Develop and implement a process in Radiology for systematic tracking of wait times by ethnicity and clinical priority (EOA)	
• Review available data and investigate methods to include ethnicity data	Q1
• Refine and implement reporting measures to allow patient tracking by ethnicity and clinical priority	Q2
• Further develop methods of ethnicity identification in data to meet booking and scheduling needs	Q3
• Implement, review and refine (if needed)	Q4
Outpatient Improvement Programme (OIP)	
• Review performance to the agreed DHB service trajectories with contingency planning where required	Ongoing
• Assign programme manager to educate and complete rollout of telehealth to clinicians across all service groups	Q2
• Support equity programme with the establishment of telehealth community pods to maximise	Q2

Planned Care

Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes

Action	Milestone
telehealth utilisation • Work with the MoH National Intentions programme to select a vendor for electronic OPD room scheduling system for roll out by the end of 2021/22	Ongoing
Contributory measures (2021/22 targets) Achieve 80% of positive responses to the National Adult Hospital Survey question: '*Did those involved in your care ask you how to say your name if they were uncertain?*'	≥80%
Reduce DNA rates in total, Māori and Pacific populations to <10% in radiology and endoscopy services	<10%

Acute demand

Actions to improve the management of patient flow and data in Emergency Departments

Action	Milestone
Acute data capture SNOMED data can help identify patients with long-term conditions who would potentially benefit from being on a specific pathway	
• Develop a community model for congestive heart failure	Q1
• Provide training on SNOMED for in-house and community users	Q4
• Develop a working group to establish community referral pathways with an equity focus to be linked to current ED bundle of care	Q1
• Establish baseline for reporting against agreed measures	Quarterly
• Initiate pilot	Q3
Improve acute care flow and support COVID-19 recovery/embed learnings We developed a clear process for managing acute COVID-19 patients, both suspected and confirmed cases. We will continue to respond and learn from future COVID-19 outbreaks, including any changes arising from new strains, to provide the highest infection prevention and control protection possible	Ongoing
Equity in acute care To improve wait times for patients requiring mental health and addiction services who present to ED:	
• ED/Mental Health working group to develop pathway through ED to expand acute bed capacity once available	Q2
• Confirm decision support tool to facilitate disposition from ED into high care or general acute ward care; evaluate outcomes of disposition decisions	Q4
• Expand current high care capacity to reduce delays in transfer from ED from unavailability of these beds; implementation is dependent on staff availability	Q2
• Refine the model of care for mental health service at Waitakere Hospital, based upon work to define the model of care at North Shore ED	Q3
The Karearea Service was initially set up to address the needs of Māori pipi, tamariki and rangatahi aged ≤24 years (and their whānau) who attended ED more than twice in 12 months. Patients/whānau are referred to a kairahi (navigator) to identify and overcome barriers to community-based health services to reduce the need for ED visits (EOA)	
• Re-institute Karearea Service at Waitakere Hospital	Q2
• Establish Karearea Service at North Shore Hospital	Q4
Refer to the Primary Options for Acute Care (POAC) priority areas in Section 7 of the 2021/22 Metro Auckland System Level Measures Improvement Plan for further actions to manage acute patients in primary care; the organisations we will work with are GP clinics and PHOs. The target for acute bed days is the same as the 2021/22 Metro Auckland System Level Measures Improvement Plan, i.e. a 3% reduction for Māori and Pacific populations	
Equity Governance Committee to implement equity-focused access initiatives by implementing initiatives from the DNA strategy to address service-specific DNA rates. Implement coordinated equity-based care to address equity of access for Māori and Pacific in terms of navigation support and appointment attendance that is culturally sensitive and flexible, with a focus on diagnostic imaging and endoscopy services (EOA)	Ongoing
• Improve communication with Māori patients, including at booking; test initially in a small number	Q1
• Establish baseline reporting to monitor effectiveness of DNA strategies for equity	Q2
• Establish Māori and Pacific Health Navigator positions	Q4

Rural health

Actions to plan and provide for the health needs of our rural population

Action	Milestone
Support COVID-19 recovery/embed learnings Continue to support COVID-19 response and recovery, including roll-out of the COVID-19 vaccination programme in rural areas	Ongoing
Evidence-based equity actions Continue to implement the Rural Ferinject and Rural Point of Care Testing Programmes, with a focus on Māori and Pacific populations (EOA)	Ongoing

Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022

Actions to care for our older population, as identified in the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022

Action	Milestone
Support COVID-19 recovery/embed learnings Support and facilitate the COVID-19 vaccine roll out to Aged Residential Care (ARC) and Home and Community Support Service (HCSS) providers	Ongoing
Support ARC and HCSS providers to maintain preparedness to effectively respond to COVID-19 (and other infectious disease) outbreaks	Ongoing
Emerging frailty in community and primary care settings, with a focus on Māori and Pacific Continue to enhance the KARE project (coordinated care, assessment, rehabilitation and education) in general practice, which includes a focus on Māori and Pacific (EOA) • Support the KARE practices to implement and refine the recently developed cognitive impairment comprehensive assessment and care planning tool	Q4
Dementia services Implement the new model of dementia care (to be developed in 2020/21) or components as relevant; this is dependent on funding and system capacity	Q4
Early supported discharge services and community-based support and restorative services, with an equity focus Identify patients that can be discharged from ED or the acute medical or surgical wards without requiring admission to AT&R and wards, and develop a preferred model of service delivery taking into consideration the cost and benefit implications of changes to community models of care and the likely impact on inpatient capacity	Q2

Health quality and safety (quality improvement)

Actions to improve equity in outcomes and patient experience

Action	Milestone
Improving quality As part of the Patient Deterioration Programme, recognition and response systems work stream, ensure the recognition of maternity inpatients who are deteriorating and escalate to ensure appropriate care • Achieve 100% of eligible Maternity wards using the NZ Maternity Early Warning System (NZMEWS)	Q4
Spreading hand hygiene practice Provide additional number of Gold Auditor training days to increase the number of staff on each ward who is able to deliver local education to other staff • Increase the number of Gold Auditors trained by 10% (2020 baseline = 18 for 12 months)	Q2
Improve the accuracy of hand hygiene compliance results by increasing the number of hand hygiene moments recorded for RMOs working in ED/ADU • Increase by 10% (2020 baseline = 1,500 moments per quarter)	Q4
Improving equity – diabetes *Retinal screening data match* Undertake quarterly diabetic retinal screening data matches (PHO and DHB data) to identify those at highest risk of developing diabetic eye disease (based on ethnicity and diabetes control) and proactively working with the PHOs/primary care to refer people in, starting with those at highest risk (EOA) • 40% of the highest risk patients (identified as at June 2021) are referred, accepted and screened	Q4
Improving consumer engagement Continue to support staff and consumer council with implementation of the consumer engagement	Ongoing

Health quality and safety (quality improvement) Actions to improve equity in outcomes and patient experience	
Action	**Milestone**
marker. Quality Executive Committee and Consumer Council continue to have oversight of implementation • Report against this online twice-yearly • Create a database for electronic recording and reporting of consumer engagement activity	 Q1, Q3 Q4

Te Aho o Te Kahu – Cancer Control Agency Actions that demonstrate collaboration with all stakeholders to prevent cancer and improve detection, diagnosis, treatment and care after treatment	
Action	**Milestone**
Impact of COVID-19 resurgence Continue to monitor framework for FCT data	 Ongoing
Monthly review of diagnostic and ESPI data	Ongoing
Equity First - New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi Work regionally to develop and implement electronic prescribing to enable full reporting of SACT data into national systems	 Ongoing
Work regionally to implement the MDM Care Pathway developed for lung and the MDM Care Pathway being developed for gynaecology	Apr 2022
Work regionally to implement the agreed Radiation Therapy Regional Plan 2020-2030	Ongoing
Refer to the 2021/22 Auckland DHB Annual Plan for LINAC actions	
Equity First - New Zealanders experience equitable cancer outcomes – He taurite ngā huanga Participate with Te Aho o Te Kahu Transport and Accommodation project, once agreed	MoH to advise
Work in partnership with Te Aho o Te Kahu, once the national programme details for delivery of local community-based Māori Hui are released	MoH to advise
Equity First - New Zealanders have fewer cancers – He iti iho te mate pukupuku Refer to the Smokefree 2025, Reducing Alcohol Related Harm, Healthy Food and Environments, Long-Term Conditions, Cross-Sectoral Collaboration, Breast Screening and Cervical Screening sections	
New Zealanders have better cancer survival, supportive care and end-of-life care, He hiki ake i te o ranga Revise and update the Bowel Cancer Service Improvement Plan following publication of the QPI report	 Q3
Implement recommendations from the Lung QPI reports (once released) via a service improvement plan	Q3
Develop a Prostate Cancer Service Improvement Plan, following the publication of the QPI report	Q3
Continue to meet FCT targets and engage with regional FCT group to manage cross-DHB issues	Ongoing
Ensure the Consumer Council is a key stakeholder in the development of the cancer improvement plan, including engagement of Māori and Pacific representatives	Ongoing
FCT data quality Continue to monitor FCT data accuracy and work collaboratively with the annual audit process	 Ongoing

Bowel screening and colonoscopy wait times Actions to meet colonoscopy wait times by actively managing demand, capacity and capability	
Action	**Milestone**
Support COVID-19 recovery/embed learnings Overall participation decreased to ≤60% over the past year. The objective is to ensure that participation overall returns to ≥60%. Deliver three comprehensive communications campaigns focused on priority and non-priority population groups, utilising print media/radio/social media /outdoor advertising and print collateral • First campaign • Second campaign • Third campaign	 Q1 Q2 May 2022
Maintain a programme of health promotion and community engagement in a wide range of community settings and across all ethnic groups (EOA)	Ongoing
Reduce colonoscopy demand via retrospective application of the new polyp surveillance guidelines for the estimated 2,500 people due to have their colonoscopy in 2021/22 • All eligible people deferred or removed from the wait list due to surveillance no longer being required;	 Q3

Bowel screening and colonoscopy wait times Actions to meet colonoscopy wait times by actively managing demand, capacity and capability	
Action	**Milestone**
estimated to reduce demand by 1,000 procedures • To better understand the impact of prolonged colonoscopy wait times for symptomatic patients, conduct a case review for any sentinel events • To increase internal capacity, explore options to open additional sessions (8 per week) at Waitakere Hospital and allocate a daily acute list at North Shore Hospital • An established multi-disciplinary review team to identify opportunities to further utilise CT colonoscopy using more liberal inclusion criteria	Q1 Q1 Q1
Participation rates (focus on equity) Maintain or increase Māori participation and increase participation to ≥60% for Pacific and Dep 9 and 10 groups (EOA) • Implement an outreach programme designed to reach priority population non-participants by phone/text/email	Ongoing Jul 2021
Participation rates (overall population) Primary care is a key stakeholder in bowel screening, although stretched resources mean that the programme needs to provide support to implement actions designed to improve participation in their enrolled populations • Appoint to a primary care liaison role • Design and implement at least one additional strategy that supports practices to increase participation within their enrolled population	 Q1 Q2
Achievement of bowel screening indicator 306 Achieving this target is dependent upon the availability of the screening colonoscopy lists and timely and accurate data entry. The maximum number of screening colonoscopy lists is based on modelled demand, which may vary • Work in partnership with the symptomatic endoscopy service to ensure that the required number of lists are available to bowel screening and that any lists surplus to screening requirements are released for symptomatic patients, while meeting the indicator #306 target • Support bowel screening nurses to ensure timely and accurate data entry	 Ongoing Ongoing

Health workforce Actions to support and improve the skills, flexibility, mobility and diversity of our staff members, and improve our organisational health and wellbeing	
Action	**Milestone**
COVID-19 learnings Work jointly with staff and unions on flexible and remote working options to enable staff to undertake their work at any location: • Establish steering group • Complete project	 Q1 Q4
Using a skills-based approach, develop multi-professional teams to support contact tracing, testing and vaccination teams	Q3
Identify fundamental skillsets required for key roles within an IMT structure, and provide/support wide advanced uptake of CIMS training for Waitematā DHB staff to increase our level of preparedness and ensure a sustainable IMT	Q4
Continue to work in partnership with our aged residential care (ARC) and public health colleagues to progress learnings from the COVID-19 response in ARC facilities, working towards an agreed escalation plan and integrated multiagency response utilising shared resources in the event of any future outbreak	Q4
Refer to the Data and Digital Enablement section for telehealth actions	
Engagement with unions Introduce 'high performance and high engagement', an operational strategic partnership programme and structure to deliver change and solve issues collaboratively with affected workers and unions, including Māori problem solving processes, leadership development and diversity of representation (EOA) • Complete first service	 Q2
Diversity of representation in leadership Support the development of diverse staff networks e.g. Rainbow and access network, enabling their leadership and input into DHB environmental matters and the staff and patient experience programmes.	

Health workforce

Actions to support and improve the skills, flexibility, mobility and diversity of our staff members, and improve our organisational health and wellbeing

Action	Milestone
This is a different way of looking at increasing a diverse contribution to leadership within the DHB. The key aspect of this action is to develop existing networks we have in place, i.e. rainbow staff, Māori staff, Pacific staff and those to be developed, i.e. access network and embed their voice in DHB processes, helping provide diverse input into the decisions and direction of DHB strategic and operational programmes such as wayfinding, facilities builds, staff experience, improvement and change (EOA) • Network development embedded into DHB processes	Q4
Develop culturally reflective leadership programmes to grow Māori, Pacific and Asian leadership skills across all leadership levels in the health sector to embed the DHB's equity framework (EOA)	Q4
Cultural competence and safety While we embark on a multi-year programme to update all professional development programmes to include training around the three Articles of Te Titiri o Waitangi: Kawanatanga (shared governance), Rangatiratanga (Māori self-determination) and Oritenga (Māori equitable outcomes), we will specifically focus on the following goal (EOA): • Specific staff training will be developed around the unconscious bias of health staff, which may negatively impact Māori outcomes	Q4
Sustainability, health, safety and wellbeing Work towards achieving ISO 45001:2018(E) level competence by June 2023, representing world best practise in Health and Safety Management to provide a safe workplace for our workers and contractors • Achieve 80% of priority actions	Q4
In line with the Worksafe Mentally Healthy Work programme (Supporting Mentally Healthy Work) and based on the WHO Healthy Workplaces Model, we will develop, deliver and evaluate initiatives that support the wellbeing of staff	Q4
Sustainably grow the number of disabled staff through pathways to work, ensuring the DHB continues to be a proactive employer of people with impairments or disabilities (EOA) • Identify and implement priority actions	Q4
Refer to Section 4, Organisational health, safety and wellbeing for further health and safety information	

Data and digital enablement

Actions to improve our information technology systems to better support healthcare delivery to our population, including supporting COVID-19 recovery

Action	Milestone
Support COVID-19 recovery/embed learnings Re-platform regional data store and dashboards onto cloud services to strengthen regional analytics (this re-uses the MoH national COVID-19 surveillance platform design and data) • Re-platformed • In place	 Q1 Q2
Address and resolve significant initiatives delayed by COVID-19 Publish interactive visualisations of regionally aligned, current waitlist data by ethnicity. COVID-19 preparation delayed a wide range of procedures for patients. This work will reveal the patient groups affected and allow DHB comparisons, leading to greater equity of access to procedures (EOA) • Available to all DHBs	 Q1
Improve digital inclusion in health services Establish four Telehealth Pods in community sites to enable access to telehealth for people in rural areas or without digital connectivity in their home (EOA) • Commence pilot • Complete pilot	 Q1 Q3
Improve equity of access to health services via digitally enabled means Establish patient online booking and scheduling to give greater patient choice, which is especially important to priority population groups with less flexibility in attending clinics. The online booking system will enable a telehealth choice as well as booking time choice (EOA) • Developed • Established	 Q2 Q3

Implementing the New Zealand Health Research Strategy Actions that demonstrate a commitment to support the implementation of the New Zealand Health Research Strategy	
Action	**Milestone**
Support COVID-19 recovery/embed learnings Within the funding available, ARPHS will: • increase research and evaluation capacity and capability across the organisation • strengthen its research and evaluation policies and procedures; these reflect Māori mātauranga and guidance and Pacific knowledge and guidance (EOA)	 Q4 Q4
Mobilising the knowledge gained from the outcomes of COVID-19 research and innovation will enable new and/or adapted models of care to reach the appropriate audience and support the translation of equitable and evidence-based practice of COVID-19 research and innovation (EOA) • Report progress updates/outcomes for Waitematā DHB-approved COVID-19 research and innovation projects • DHB research symposium/forum and journal publication	 Q1 Q1
COVID-19 saw an unprecedented and rapid research response to evaluate new and/or adapted equitable models of care. Evaluation of the facilitators and barriers in the locality approval process for COVID-19 research in 2020 will enable the DHB to appropriately prioritise research and innovation protocols in response to future events • Review locality approval response for COVID-19 related research and innovation projects to ensure robust, safe, equitable and ethical research practice	 Q3
Working with regional research networks to support research and innovation staff The Auckland Academic Health Research Alliance, a collaborative initiative between the University of Auckland and Waitematā DHB will benefit cross-sectoral programmes of research and innovation, enable the sharing of resources, ideas, expertise and education, support successful seeking of funding, and increase joint appointments between alliance partners • Establish Alliance • Implementation	 Q1 Q4
Building DHB capacity and capability to enhance research and innovation Engage in strategic-level hui with Te Runanga o Ngāti Whātua and Te Whānau o Waipererira Trust partners to support the development of meaningful Māori engagement (as researchers and participants) in the research domain (EOA) • Begin engagement	 Q2
Building a supportive environment for clinical staff to engage in research and innovation Annual Waitematā DHB competitive research funding round to support programmes of research integrated into clinical practice and/or to provide seed funding for preliminary research that contributes to staff applying for national research funding • Funding round in place	 Q2
Providing staff with professional development opportunities Tino Rangahau, Māori Health Centre of Research Excellence is resourced to sustainably support the ongoing development of kaupapa Māori and whānau-centred research design to help meet Māori aspirations for wellbeing and address unmet needs (EOA)	Q1

Better population health outcomes supported by primary health care

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase the use of illness-preventing behaviours and treatments, thereby increase people's ability to participate in work and education. Primary health care is earlier, safer, cheaper, and better connected to people's daily routines. We aim to improve the primary care model to better suit people's lives and integrate across health disciplines and facilities, thereby improving health outcomes and serving all people equitably.

Primary care
Actions to strengthen our district alliances, address equity gaps and improve access to primary care services

Action	Milestone
Support COVID-19 recovery/embed learnings Support continued implementation and use of telehealth in primary care • The Alliance to review use • The Alliance to develop an improvement plan	 Q2 Q4
Evidence-based equity actions – Māori and Pacific Support the roll-out of the COVID-19 vaccination programme, with a focus on Māori and Pacific coverage	Ongoing

Pharmacy
Actions to support the optimisation of pharmacy services

Action	Milestone
Support COVID-19 recovery/embed learnings Continue to support the COVID-19 response and recovery, including the roll-out of the COVID-19 vaccination programme • Commission up to approximately 100 pharmacy providers to support the delivery of the COVID-19 vaccination programme across Metro Auckland DHBs	Ongoing Q2
Improving influenza vaccination rates in priority populations Support pharmacies to increase coverage rates of Māori, Pacific and target populations who are eligible for influenza vaccination (EOA) • Identify key vaccinating pharmacy providers with the highest number of Māori, Pacific and target populations • Collect baseline data (including ethnicity) to monitor coverage over time. Use the data to support pharmacies to promote targeted approach to immunise eligible Māori and Pacific populations in their communities	 Q3 Q4
Integrated community pharmacy services Sustain the Safety in Practice Programme to support local pharmacists working as part of an integrated system with the key aim of working with primary care to reduce preventable patient harm and adverse drug events through quality improvement (note this programme is currently postponed while we divert resources to support the COVID-19 vaccination programme; tentative re-start date is Jan 2022)	Ongoing

Reconfiguration of the National Air Ambulance Service Project – Phase Two
Actions that demonstrate active participation in the national two-phased 10-year reconfiguration of the national air ambulance service

Action	Milestone
The DHB is committed to the 10-year plan to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative to implement Phase II. The DHB: • will support the implementation of changed governance arrangements to include DHBs to effect improved partnership with MoH and ACC in all elements of leadership of the NASO work programme, including identifying appropriate nominees, participating in meetings and workshops, provision of information in a timely manner • supports the development of a robust national process to develop a national tasking service	Ongoing

Long-term conditions Actions to strengthen public health promotion on preventing and managing long term conditions, including equitable service access	
Action	**Milestone**
Improving prevention through evidence-based nutritional and physical activity advice provided to at-risk population groups In addition to existing indoor green prescription (GRx) programmes, connect people from high deprivation areas to free outdoor, nature-based, physical activity opportunities (e.g. maunga, parks, beaches), including sites of cultural significance to Māori (EOA). Our GRx providers routinely survey participants for feedback to help develop the most effective services and activities • Deliver ≥10 nature-based sessions each quarter	Q2, Q3
Strengthening identification, intervention and recall of people with high and moderate risk Improving coding of ethnicities at level 4 for screening newly eligible population in line with the 2018 MoH CVD Risk Assessment and Management Primary Care guidelines. • 70% of all newly eligible population (Māori, Pacific and South Asian men 30-34 years old and women 40-44 years old) requiring a CVD risk assessment will be able to be identified	Q4
Management of people with long-term conditions The redesign of diabetes retinal screening services is driven by a strong service user voice, including Māori and Pacific people living with diabetes. The new service will support improved retinal screening coverage and equity of coverage through multiple access points in the community and an outreach service (EOA) • Complete the procurement process for a new model of care for diabetic retinal screening	Q4
Hepatitis C • Work with MoH to undertake a datamatch to identify people with known hepatitis C and re-offer treatment (follow-up action from previous datamatch in 2018) • Under the Māori Health Pipeline, establish a hepatitis C team to re-offer treatment to those identified, on behalf of the Northern region, with a focus on elimination for Māori first	Q1 Q2
Adult ASH (SS05) Refer to actions in the Complex Conditions and Frail Elderly and Primary Options for Acute Care (POAC) priority areas in Section 7 of the 2021/22 Metro Auckland System Level Measures Improvement Plan	

Financial Performance Summary

Statement of Comprehensive Income	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Government and Crown Agency Revenue	1,815,097	1,907,238	2,092,738	2,135,405	2,178,030	2,209,870
Patient Sourced and Other Income	28,530	47,480	32,437	25,798	26,266	26,746
IDFs and Inter DHB Provider Income	93,878	106,167	101,883	103,899	105,962	108,062
Total Funding	**1,937,505**	**2,060,885**	**2,227,058**	**2,265,102**	**2,310,258**	**2,344,678**
Personnel Costs	789,356	822,767	846,806	837,749	854,738	872,067
Outsourced Costs	92,460	100,124	104,902	106,954	109,054	113,934
Clinical Supplies Costs	134,297	140,670	150,830	151,787	154,787	157,835
Infrastructure and Non-Clinical supplies Costs	109,061	103,350	74,539	82,042	83,425	70,448
Payments to Other Providers	880,529	947,982	1,089,481	1,086,570	1,108,254	1,130,394
Total Expenditure	**2,005,703**	**2,114,893**	**2,266,558**	**2,265,102**	**2,310,258**	**2,344,678**
Net Surplus/(Deficit)	**(68,198)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**
TOTAL COMPREHENSIVE INCOME	**(68,198)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**
Extraordinary Items						
Holiday Pay	41,800	24,000	20.000	0	0	0
COVID-19	28,800	204	0	0	0	0
Total Extraordinary Items	**70,600**	**24,204**	**20,000**	**0**	**0**	**0**
Operating Surplus/(Deficit)	**2,402**	**(29,804)**	**(19,500)**	**0**	**0**	**0**
Budget	0	(36,000)	(19,500)			
BAU Variance to Budget Surplus/(Deficit)	**2,402**	**6,196**	**0**	**0**	**0**	**0**

In brief:

- 2019/20 Result favourable to budget $2.402m
- 2020/21 Result favourable to budget $6.196m
- 2021/22 Plan result $16.5m improvement on 2020/21.

Notes

- 2019/20 result contains $41.8m for Holiday Pay Remediation Provision and $28.8m for COVID-19-related costs.
- 2020/21 forecast result contains $24m for Holiday Pay Remediation Provision and $0.2m for COVID-19-related costs.
- 2021/22 forecast result contains $20m for Holiday Pay Remediation Provision assumes funding of $98m will be provided to fully offset $98m of anticipated COVID-19-related costs.

Four-year plan

Prospective summary of revenues and expenses by output class	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Early detection				
Total revenue	494,355	497,128	507,044	516,019
Total expenditure	497,935	497,128	507,044	516,019
Net surplus/(deficit)	**(3,580)**	**0**	**0**	**0**
Rehabilitation and support				
Total revenue	393,659	394,585	402,456	409,903
Total expenditure	395,337	394,585	402,456	410,908
Net surplus/(deficit)	**(1,678)**	**0**	**0**	**0**
Prevention				
Total revenue	49,739	50,492	51,498	52,290
Total expenditure	50,532	50,492	51,498	52,290
Net surplus/(deficit)	**(793)**	**0**	**0**	**0**
Intensive assessment and treatment				
Total revenue	1,289,305	1,322,897	1,349,261	1,366,466
Total expenditure	1,322,754	1,322,897	1,349,261	1,366,466
Net surplus/(deficit)	**(33,449)**	**0**	**0**	**0**
Consolidated surplus/(deficit)	**(39,500)**	**0**	**0**	**0**

SECTION 3: Service Configuration

Service coverage exceptions and service changes are formally approved by the Ministry of Health prior to being undertaken. In this section, we signal emerging issues. Waitematā DHB will manage its functions in a way that supports the intended direction and anticipated system change programme.

Service coverage

The Service Coverage Schedule is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability (NZPHD) Act 2000, which is subject to endorsement by the Minister of Health. The Schedule allows the Minister to explicitly agree to the level of service coverage for which the Ministry of Health and DHBs are held accountable. Waitematā DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2021/22.

Ability to enter into service agreements

In accordance with section 25 of the New Zealand Public Health and Disability Act, Waitematā DHB is permitted by this Annual Plan to:

- negotiate and enter into service agreements containing any terms and conditions that may be agreed;
- negotiate and enter into agreements to amend service agreements.

Service change

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Regional sustainable services post-COVID-19	NRHCC vulnerable services identified for further action plans to be completed for implementation in 2021/22: • Oral health specialist services streamlining patient pathway, reducing wait times and review of service locations • Continuing review of complete oral health pathway for children, including Auckland Regional Dental Service • Sarcoma services. Continue streamlining patient pathway, review and consider implementation of alternative service locations • Vascular services. Streamlining patient pathway and implementation reconfiguration of regional services as per regional agreement	• Children and adolescents receive timely secondary level dental care closer to home • Sarcoma patients receive timely tertiary level services in the most appropriate setting • Patients receive timely secondary and tertiary level vascular services in the most appropriate setting and closer to home, where appropriate	Oral health - Regional and Local Sarcoma - Regional and National Vascular - Regional and Local
Re-establishment of services post-COVID-19	• General Surgery will temporarily increase the access score for acceptance of bariatric FSA referrals from 20 to 35 • Haematology to temporarily restrict access for referrals graded P4 due to staff shortage • Orthopaedics will temporarily decline referrals for joints graded P3 to focus efforts on reducing the large backlog of existing planned surgery (ESPI5); recovery plan agreed with MoH	COVID-19 response	Local (Waitematā DHB only)
Expansion of Service	The Northern Region Chief Executive forum endorsed in Dec 2020 the recommendations from the High Users of Inpatient Services in the Northern Region report to invest from late 2020/21 across the region in: 1. a regional 10-bed intensive residential service (or equivalent packages of care) for older high users (age 55+ years); estimated cost is $1,656,690 per annum	Improved access to and delivery of services to increase responsiveness and flexibility, and better respond to client needs and reduce long-stays in inpatient units, which are not clinically indicated	Regional

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	2. an annual budget to finance 21 intensive packages of care for high users of inpatient services; estimated total cost is $3,780,000		
Change in location and expansion of services	CADS Regional Medical Detox and Regional Social Detox service to co-locate at a new build in central Auckland (Mission Homeground), now expanded by an additional 5 beds	Service will be delivered within a purpose-built building; service will be located with other complementary services	Regional
Change in location of services	*High And Complex Residential Services* Due to ongoing delays with the building of a purpose-built facility, costs have escalated; the provider is exploring funding options and seeking advice. In the interim, the service is provided from two temporary locations	Continued delivery of service while alternative is considered	Local (Waitematā DHB)
Potential change in model of service delivery	*Supra Regional Eating Disorder Service (EDS)* Midland DHBs originally withdrew from all elements of Supra Regional EDS except residential service, and the service adjusted capacity accordingly. Midlands DHBs previously signalled an intention to withdraw from the residential service over time; however, engagement with them confirmed we are the only provider of this service in New Zealand that can accommodate them. One Midland DHB is exploring the option of delivering this service closer to home as part of their new capital build, which will likely be completed in 3-5 years. Hence there is an on-going need to consider a regional response to service delivery to be prepared for any potential future withdrawal by Midland DHBs	Auckland DHB service resized for the Northern Region population for all EDS, including residential services. Uncertainties regarding ongoing Midland DHBs population demand and potential to accommodate a residential service closer to home is expected to be clarified over time, enabling Auckland DHB to progress medium to longer term planning residential services	Supra Regional DHBs - Northern Region and Midland DHBs
Expansion of service	*Acute mental health* Create four 'step-down' high care beds within the North Shore adult acute mental health inpatient unit (He Puna Waiora). New service will be embedded in 2021/22 and require 12.4 additional FTE to operationalise	• Improved patient flow to reduce waiting time for service users awaiting an inpatient bed in ED • Ability to provide the most appropriate and least restrictive environment for service users, according to their clinical need • Reduce the use of one-to-one care in the acute unit and ED	Local (Waitematā DHB) – service is not currently provided
Embedding of service	Enhance the current mental liaison team to enable the service to provide on-site mental health staff 24/7 in the North Shore Hospital ED. New service will be embedded in 2021/22 and require additional 4.5 FTE to operationalise	• Improved equity in service provision; currently available in the Waitakere Hospital ED • Improved patient flow to reduced waiting times for mental health assessments and decision for disposition • Improved continuity of care	Local (Waitematā DHB) – service is not currently provided
Service enhancement	Two new senior nursing positions were developed to support service provision to people experiencing mental health disorders: 1.0 FTE Clinical Nurse Specialist (to provide support to primary care) and 0.70 FTE Clinical Nurse Educator (to provide support to ED staff)	• Staff working outside of Mental Health Services are supported to develop required skills and expertise • Improved outcomes for service users • Improved staff experience • Improved relationships across services and continuity of care	Local (Waitematā DHB) – service enhancement
Review and change in service	*Termination Services* Return responsibility for first trimester abortion services from Auckland DHB to home DHBs and establish or purchase new services	Services that are safe, convenient and more accessible and acceptable to women in the legislative framework. Improve the sustainability of second trimester surgical abortion services to be delivered by Auckland DHB for	Metro-regional

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
		Metro Auckland and other DHBs, as agreed	
Change in service delivery model	*Maternity Services* Engage with maternity stakeholders to identify opportunities to improve equity of services	• Improve birthing options for local population • Promote normal delivery in community settings	Metro-regional (delivered by Auckland DHB)
Level of service provision	Improve clarity on the range of conditions for which pre-implantation genetic diagnosis (PGD) is provided and, subject to funding approvals, remove any waiting lists for PGD	• Improve access to services • Improve waiting times for services	Metro-regional (delivered by Auckland DHB)
Review and change in service	Review, enhance and undertake tender for improved youth health services	Improve range and access to services	Metro-regional
Change in service delivery model and potential change of provider(s)	*Home and Community Support Services (HCSS)* Transition to the new national HCSS Restorative Model	Improved delivery of services to increase responsiveness and flexibility and better respond to client needs	Local (Waitematā DHB) (aligned to the national HCSS service specification)
Implementation of new service	Implementation of the left atrial appendage closure procedure. New evidence supports the introduction of new technology in the management of this complex cardiac condition. This is supported by the Northern Regional Clinical Practice Committee and is currently awaiting Ministry approval. The indications for use and implementation will be driven by the Northern Cardiac Network under the guidance of the regional service development workstream	Improved patient outcomes through provision of alternative evidence-based treatment for those patients contraindicated for oral anticoagulation but who are at risk of stroke	Regional
Potential change in model of service delivery	*Vascular Services* The model of service delivery to Waitematā DHB was reviewed, including which services could be delivered on site, which at other hospitals, and how regional on-call rosters should work that better support current surgical provision at Waitematā DHB. As a result, some clinics and surgical/procedural sessions will commence locally in 2021/22	• Improved sustainability of local and regional services • Improved patient experience and outcomes	Local, regional
Shift in service	*Head and Neck Services* A regional review was completed and the region is working together to improve oversight, coordination and management. There may be a change in location of some elements of service delivery arising from the regional planning process in 2021/22	• Improved sustainability of local and regional services • Improved patient outcomes	Regional and local
Potential change in model of service delivery	*Sleep Service* Progress planning towards developing a new service model based on ambulatory models currently in place in New Zealand that makes the best use of available capacity and resources (including funding) to increase the number of patients assessed and treated	• Improved access • Improved clinical and financial sustainability of regional model	Regional and local
Change in model of service delivery	*Outpatient Services* Services are expected to review traditional face-to-face models and develop new models that incorporate alternative methods of delivery. Projects underway include satellite and nurse-led clinics, telehealth (telephone and video consultations, specifically for follow-ups), community-based IV infusions and patient-generated follow-ups. This work continues to be implemented throughout Auckland and Waitematā DHBs and further changes were accelerated due to the COVID-	• Provision of more flexible, accessible patient-centred services • Better use of new technology to deliver cost effective and efficient services	Sub-regional (Auckland and Waitematā DHBs)

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	19 response. Continuing in 2021/22		
Integration of services	Redesign and integration of diabetes retinal screening services across Auckland and Waitematā DHBs. The redesigned service will take screening services out into the community at a significantly expanded range of locations and make appointment booking flexible and fitted to patient needs. Note: this work was deferred due to COVID-19 response activities, but is now being progressed	• Improved screening coverage • Improved equity of screening coverage • Consequent reductions in the burden of diabetic retinopathy and diabetic maculopathy	Sub-regional (Auckland and Waitematā DHBs)
Change in location	*Northern Region Interventional Radiology (NRIR) Service* The NRIR Service is up and running well at Waitematā DHB and as a result, repatriation of procedures performed at Auckland DHB will commenced in 2021/22	• Local access for patients requiring more complex interventional procedures • Alternative to inpatient stay for some procedures, which will improve waiting times	Sub-regional (Auckland and Waitematā DHBs)
Improved local access	*Local delivery of Oncology Services* Auckland region will continue to work together to increase delivery of non-surgical cancer services locally at Waitematā and Counties Manukau DHBs, with the timing and scope of services to be determined by the need for additional capacity in the regional service. Further modelling to be undertaken regarding local delivery arrangements for cytotoxic chemotherapy for breast cancer patients, due to an indicated demand increase. Development of a five-year plan commenced in 2020/21 to further expand local delivery, including other tumour streams, for ongoing implementation from Q4 2021/22	• Improved local access • Additional regional service capacity developed in a planned and cost effective manner	Metro-regional
Improved local access	*National Peptide Receptor Radio-nuclide Therapy (PRRT) Service* To be developed and established by Auckland DHB through an alliance with the Auckland DHB Radiology Service, the Regional Cancer and Blood Service, the University of Auckland, and Clinical Support Services (Laboratory), following the funding decision by Pharmac. Auckland DHB business case for New Zealand National PRRT Service was approved in principle by Ministry of Health; planned for implementation in Q1 2021/22	• Improved access to New Zealand-based service for patients that meet the Pharmac funding criteria for PRRT • Improved equity of access • Additional regional and national service capacity developed in a planned and cost effective manner • Reduce requirement for patients to travel overseas to access this treatment at their own cost	National (based in Auckland DHB)
Implementation of an enhanced and regionally consistent model of care – stroke	*Stroke care/rehabilitation* • Revised model of care, agreed regionally, local delivery for all ages • Proposed integrated Stroke Unit for North Shore Hospital: business case being finalised, including impact on those aged <65 years stroke rehabilitation (i.e. move to the stroke unit rather than Rehab Plus) • Continue to full implementation of streamlined care pathways for patients as part of the integrated stroke unit at Auckland City Hospital, opened Dec 2020	• Streamlined pathway • Equitable access to rehabilitation services • Consistent quality of care delivery	Regional (some local delivery)
Improved local access	*Adolescent and Young Adult (AYA) acute lymphoblastic lymphoma* The MoH National AYA Cancer Network is developing a national clinical trial pathway for AYA patients, which may lead to further service change in 2021/22	Additional regional and national service capacity developed in a planned and cost effective manner	Regional and national
Additional FTEs	Embedding the full-year effect of Care Capacity Demand Management, which was	Required to comply with current nursing MECAs and safe staffing levels	Waitematā DHB (national programme)

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	commenced in 2020/21: 122 FTEs		
	Regional COVID-19 Response: 56.5 FTEs	• Improved efficiency in data collection • Improved staff experience	NRHCC Regional response team transferred to Waitematā DHB Payroll
	RM O allocation: 11 FTE	Required to comply with RMO roster and safe staffing level	Regional allocation
	Planned Care initiatives: 38.24 FTE	Required to provide Planned Care volumes and meet Planned Care targets	Local (Waitematā DHB) – service delivery
	Other Mental Health initiatives: 13 FTE	• Improved outcomes for service users • Improved staff experience	Regional
	Breast screening service New service will be embedded in 2021/22. This requires 36 FTE for baseline delivery	Improved access to service for patients	Sub-regional (service provided by Waitematā DHB for Auckland DHB population)

SECTION 4: Stewardship

Managing our business

To manage our business effectively and deliver on the priorities described in Section 2 and our Statement of Intent (Appendix A), we must translate strategic planning into action, with supportive infrastructure in place. We must be fiscally responsible and accountable for our assets, and spend every public dollar wisely to improve, promote and protect the health of our population.

Organisational performance management

We developed an organisational performance framework that links our high-level performance framework with daily activity. The organisational performance monitoring processes in place include our Annual Report, monthly Board and Committee reporting of key Ministry of Health performance measures, monthly reporting against Annual Plan deliverables, ongoing analysis of inter-district flow performance, and monitoring of responsibility centre performance and services analysis. Performance monitoring is built into our human resource processes; all staff have key performance indicators linked to organisational performance that are reviewed annually.

Risk management

Waitematā DHB has a formal risk management and risk escalation framework. Our Risk Management Strategy clearly documents risk management principles and provides a framework that enables an organisation-wide consistent approach to risk management.

We continue to monitor our risk management practices to ensure we meet our obligations as a Crown Entity, including compliance with the risk management guidelines ISO 31000:2018 and SA/SNZ HB 436:2013.

The Corporate Risk Register is the repository for the most significant risks we face, underpinned by a structure of Committee, Division and Service risk registers. The Corporate Risk Register is reviewed by the Board's Audit and Finance Committee quarterly, providing assurance on the management of these significant risks. It is operationally managed by the Executive Leadership team and reviewed monthly by the Senior Management team.

Quality assurance and improvement

Our Promise Statement to our community is **Best Care for Everyone**. We aim to provide care that is safe, clinically effective, focused on the individual needs of every patient and their whānau and targets equity in health outcomes.

To achieve our quality vision, the DHB set four aims that reflect the key elements of quality.

Safe care. No avoidable harm to patients will come from the care they receive, which will be provided in an appropriate, clean and safe environment at all times.

Effective care. The most appropriate treatments, support and services will be provided at the right time to those who would benefit, to achieve the best possible health outcomes and eliminate wasteful or harmful variation.

Person-centred care. Each patient and their whānau will experience compassionate care, feel informed, supported and listened to, and be engaged and involved in their care. They will be provided with information to enable them to make informed choices about the care they receive. There will be mutually beneficial partnerships between patients, their whānau and those providing healthcare services.

Equity of health outcomes. Continuous improvement in equity of health outcomes, quality and value.

We focus on quality improvement in all areas and use our quality assurance framework to identify improvement areas. Achieving excellent results in the Health Quality and Safety Commission (HQSC) markers is a priority.

Assurance with regard to quality assurance and improvement activities is provided to every meeting of the Waitematā DHB's Hospital Advisory Committee.

The Institute for Innovation and Improvement (i3) helps us to realise our Board's priorities of improving health outcomes and patient and whānau experience. i3 brings together people with a range of expertise and experience to support clinicians, patients and whānau to lead care redesign and best practice innovation and improvement. i3 promotes and supports person-centred design to ensure what matters to our patients, their whānau and our community is at the heart of service design, delivery and improvement, and facilitates the rapid development, testing and implementation of ideas and innovations. We share our quality improvement activities with our community through the i3's website http://i3.Waitematādhb.govt.nz/.

We have responsibility under the New Zealand Public Health and Disability Act (2000) to monitor the delivery and quality of contracted services. We carry out this responsibility through a number of auditing agencies and ongoing relationship management with providers.

Asset management

The Treasury assigned Waitematā DHB an Investor Confidence Rating (ICR) of B in the 2019 assessment. Our asset management maturity score improved, with the gap from the long-term target maturity reducing from 14 to six points. Waitematā DHB was identified as one of the highest maturity DHBs and our Asset Management Plan (AMP) was identified as an exemplar for the sector. We lead the Northern Region DHBs asset management committee.

During the year, these improvements were achieved:

- We developed a regional asset management policy
- Working with Ministry of Health and Treasury, we further developed asset levels of service statements and related performance measures and targets
- We implemented a comprehensive rolling programme of building condition assessments based on priority and risk.

Future focus areas include:

- Redevelopment of the AMP
- Development of a regional asset management strategy
- Completion of levels of service and asset performance measures for all DHB services.

Northern Region Planning

2021/22 is the third year of implementation of our Northern Region Long Term Investment Plan (LTIP), published in 2018 for the period 2018-2037. Our investment plan sets out agreed changes in our models of care, the planning and commissioning of services in our region, and the capital, workforce, and information technology to deliver our future vision for the health system. Our strategy addresses the three key strategic challenges faced by the Northern Region:

1. Health status is variable; there are significant inequities for some population groups and geographic areas, as well as a large burden of ill health, which need a rebalancing of investment into prevention and early intervention.
2. Health services are not sufficiently centred around the patient and whānau; in certain areas, the quality, safety and outcomes of care are not optimal, which require proactive networked care, centralising where beneficial for quality, and localising where beneficial for access, in co-designed services that enable choice and control for whānau.
3. The needs of our rapidly growing, ageing and changing population are not clinically or financially sustainable with our current capacity and models of care; new approaches are needed to moderate the demand for hospital care and enhance productivity and efficiency of services.

Our DHB annual plan, together with the agreed regional work programme, aims to deliver on the commitments set out in our DHB and Northern Region strategies, including our fundamental Te Tiriti commitments.

In line with national guidance and no mandatory Ministry requirements for a Regional Services Plan in 2021/22, our strategy remains as an extension of our 2020/21 Regional Service Plan. Our regional work programme for 2021/22 builds on the key themes that we delivered or initiated in 2020/21, including:

- Delivering and implementing transformational changes to our models of care for vulnerable services to achieve resilience, quality and equity
- Transforming diagnostics through regional pathology and imaging programmes
- Continuing an equity-led recovery from COVID-19 in our Planned Care wait times and improving our collaboration in managing capacity
- Continuing to strengthen our regional emergency preparedness and response
- Further progressing our extensive workforce modernisation programme
- Rapid developments in IT systems to support COVID-19 and to leverage broader change
- Continue to improve care through regional clinical networks to support cancer, cardiac care, stroke, trauma, hepatitis C elimination, mental health and addiction, child health and child development services.

In the coming year, we aim to strengthen this by:

- Expanding Māori and Pacific health gain programmes, contributing to equity
- Developing the next level of detail in our longer-term clinical service, capital and technology plans.

Our Planning commitments in 2021/22 include:

- Developing a longer-term capital road map (2025-2037) in partnership with the Ministry of Health
- Combining our LTIP with our sector-specific deep dives in primary and community services, public and population health, and with spatial clinical service planning to form a refreshed LTIP
- Horizon two for our Information Systems Strategic Plan, moving from foundations to the underpinning technology to deliver transformational clinical service change
- Incorporating changes to ways of working within the region and in DHBs in line with the year one plans of

the government's response to the Health and Disability Review.

All of our 2021/22 programmes of regional collaborative work align with national, and our regional, strategic directions. This regional work will continue to be delivered through well-established mechanisms functioning under regional oversight and regional governance groups with the continuing leadership and engagement of the Chairs, Chief Executives and Chief Medical Officers of all four DHBs.

Shared service arrangements and ownership interests

Waitematā DHB is involved in two joint venture agreements. One is a jointly controlled operation, Awhina Waitakere Health Campus. healthAlliance N.Z. Limited is a joint venture company that provides a shared services agency to the four Northern Region DHBs (each with a 25% share), delivering information technology, procurement and financial processing support.

Waitematā DHB has a 33% shareholding in Northern Regional Alliance Limited (NRA). The NRA is an associate with Waitematā, Auckland and Counties Manukau DHBs. It supports and facilitates employment and training for Resident Medical Officers across the three DHBs and provides a shared services agency to the Northern Region DHBs in their health and disability service funder roles.

Building capability

Capital and investment development

We are progressing the delivery of several major Crown-funded capital projects. These include Tōtara Haumaru, a new elective capacity and inpatient facility on the North Shore ($260M), the first tranche of critical infrastructure at North Shore Hospital ($30M) and an upgraded Central Sterile Services Department (~$12M). We continue to progress business cases to seek Crown funding for a standalone ward unit to provide interim capacity prior to redeveloping Waitakere Hospital (~$30-40M); the next stage of the Mason Clinic Development (~$60m).

Other major programmes and capital investment will be required over the next 10 years with planned investment of more than $2 billion in the NRLTHP.

Business cases requiring Crown funding and/or >$10M are subject to approval by joint Ministers.

Information technology and communications systems

Digital systems are fundamental to our ability to meet the organisation's purpose and priorities. Our goal is for information to be easily accessible to those who need it, including patients, to support the best decisions, improve the quality and safety of care provided, and patient experience. Our three to five year plans demonstrate our commitment to increasing digital maturity.

Our programme of work is derived directly from the Regional Information Systems Strategic Plan (ISSP), or aligns with the ISSP in principle. All new projects are overseen by the new regional governance structure, established in 2019.

Our strategic direction is a shift to Cloud services, aligning with NZ Digital Health Strategic Framework principle of 'Cloud First'. The shift of the regional data store and dashboard, established to support the COVID-19 response, aligns with the Ministry of Health cloud-based toolset, enabling easy data exchange between Northern Region DHBs and the Ministry.

The Clinical Digital Academy, established at Waitematā in 2019, focuses on increasing informatics capability in our clinical workforce. The week-long hands-on course includes modules on consumer engagement, Māori data sovereignty and data governance, agile clinical change management and data analytics.

Implementation of the regional collaborative community care system (RCCC) is planned to commence in 2021/22. While Waitematā DHB plans to join in later years, our contribution to design and implementation will be critical. This project is a major enabler of better collaboration and information exchange between community, primary and secondary care.

Our outpatient online booking system will give patients greater control over the timing of their outpatient care. This is a significant step toward easier access to their health services.

Telehealth (telephone and video) appointments enabled us to deliver approximately 17,000 appointments during COVID-19 lockdown that would otherwise have been cancelled. Patient feedback was positive and tells us we should continue to offer telehealth appointments. Work to sustain and implement telehealth includes building patient choice into our booking processes (as outlined above), integration of the video platform with our booking system, establishing community pods for telehealth, and development of electronic tools, such as

Patient Emailer (an in-house built tool), patient questionnaires, eLabs, ePrescribing and eOutcomes.

We plan to implement a secure communications solution to replace the pager system in 2021/22. This system will provide communication for critical 777 emergency responses, and clinical and non-clinical task management.

A replacement electronic Whiteboard for ED is planned for roll-out in 2021/22. It allows single-click launching of nearly all clinical systems and performance is significantly faster than the current product.

Our Māori and Pacific Health Gain teams require intuitive data explorers to support their goal of reducing inequity of access. We will work with these teams to design specific Qlik Sense dashboards with that purpose in mind.

Cyber security and the impact of a compromise was made very clear to the New Zealand Health System. There are two key aspects to cyber security:

1. The security or our systems including our ability to prevent and minimise a given threat.

   Our IT security matured greatly in the last two years through a significant investment in cyber security. It is important to maintain and strengthen our digital security in our increasingly interconnected world. Subject to funding, the region aims to build on investment to date, such as foundational security incident event management (SIEM) tools and resources, to further embed a cyber security controls framework that complies with HISF/NZISM and Ministry of Health digital service requirements.

2. Our business continuity plans enable us to provide safe and effective healthcare if we suffer a major event.

   A recent cyber attack clearly illustrates that we can do more to help the organisation provide ongoing service to the community. Work was completed to ensure our most critical clinical documents are replicated into the cloud to ensure their ongoing availability following a complete shutdown. These business continuity plans will be further strengthened from planned cyber scenario readiness testing and lessons learned from the recent incident.

Refer to Section 2, Data and digital enablement for further information.

Workforce

Culture, leadership and development

Waitematā DHB recently established a Staff Experience programme, recognising that staff expectation of their experiences at work are evolving, with staff increasingly wanting an overall experience that fits more seamlessly into their lives. There is clear evidence that improving staff experience directly improves attraction, engagement, performance and retention, as well patient experience and health outcomes. Prioritised initiatives include: leadership development, embedding values and behaviours, improving communications, growing a performance culture, and wellbeing. The programme will use a design thinking approach to engage staff and unions in the process of designing best-fit solutions for a positive employee experience, and seeks to empower staff networks to bring their ideas and passion to develop and implement solutions for their communities, and to shape the culture of the organisation.

We will instil a refreshed approach to implementing the Te Tiriti o Waitangi, in line with the Government's stronger approach to persistent Māori inequalities. To achieve more equitable outcomes for Māori, we will continue to work with Māori health providers/partners to improve their workforce stability, increase their collective attractiveness to Māori whānau and continue to build capacity and capability. A strategic focus on how capacity and capability development is implemented needs to be refreshed to help achieve this outcome.

Responsiveness to Pacific health inequities, Asian cultural values and our rainbow and disabled staff are important to our staff experience and leadership programmes.

Cooperative developments

Integrated regional, national and international cooperative partnerships enable our organisational performance.

- We collaborate with our educational partners on NZQA support and profession-based workforce planning and curricula, student placements, and joint education and employment ventures and research.
- We collaborate nationally and regionally on a comprehensive range of system-wide improvements, encompassing capability development, technology to meet our changing educational needs, graduate pipelines and leadership development.
- Our residential aged care integration programme (RACIP) provides education, consultation and advice to community aged carers, registered nurses and health care assistants in community settings.

We work with our public health physicians in the Planning and Health Outcomes department and i3 to ensure health needs assessments and measures respond to population-level health issues and outcomes.

Organisational health, safety and wellbeing

At Waitematā DHB, our health, safety and wellbeing aspiration is expressed in a promise to our staff:

> *To have a safe environment for our people, patients, visitors and contractors, where our health and safety obligations, risk and harm is understood, regularly discussed, assessed, and addressed.*

Our promise reflects our organisational culture, where innovation, excellence and learnings combine to support our staff to achieve the best care for everyone. Over the next three years, our key strategic focus is to implement the ISO standards, which will help our workplace health and safety systems to mature to world-class standards.

Through our Safe Way of Working policies, we have a systematic approach to monitoring our health and safety performance. Our annual self-audit measures 12 elements of health, safety and wellbeing, allowing us to take a whole-of-system and a ward/unit quality improvement approach that defines, guides, measures and embeds our practices.

Waitematā DHB has undergone an independent assessment of our health and safety maturity, utilising Safe365. The resulting score of 80% is by far the highest of any DHB in New Zealand and represents best practice in health and safety management. This assessment also identifies opportunities for further improvement, ultimately leading to our goal of meeting the requirements of the ISO 45001:2018 standard, as well as informing our annual planning. As identified through our last independent assessment, our focus for the next 12 months is on increasing governance and leadership expertise in health and safety matters, continuing to build worker engagement, and developing a strong and embedded health and safety culture.

Refer to Section 2, Health workforce for further information.

SECTION 5: Performance Measures

2021/22 Performance measures

The following table presents the full suite of Ministry of Health 2021/22 non-financial reporting indicators. This section is a Ministry requirement, but many of these measures appear elsewhere in the Annual Plan, as much of our work is centred on government priorities and these measures are useful in monitoring progress and achievement.

Performance measure			Expectation
Improving child wellbeing (CW)			
CW01 Children caries free at 5 years of age	Year 1		65%
	Year 2		65%
CW02 Oral health: mean DMFT score at school year 8	Year 1		<0.56
	Year 2		<0.56
CW03 Improving the number of children enrolled and accessing the Community Oral Health Service (COHS)			
Children (aged 0-4 years) enrolled in COHS	Year 1		≥95%
	Year 2		≥95%
Children (aged 0-12 years) overdue for their scheduled examinations with COHS	Year 1		≤10%
	Year 2		≤10%
CW04 Utilisation of DHB-funded dental services by adolescents (school Year 9 up to and including age 17 years)	Year 1		≥85%
	Year 2		≥85%
CW05 Immunisation coverage	% of eight-month-olds fully immunised		95%
	% of five-year-olds fully immunised		95%
	% of girls and boys fully immunised – human papilloma virus (HPV) vaccine		75%
	% of 65+ years olds immunised – influenza vaccine		75%
CW06 Child health (breastfeeding)	% of infants exclusively or fully breastfed at three months		70%
CW07 Newborn enrolment with General Practice	The DHB has reached the 'total population' target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets		55% by 6 weeks 85% by 3 months
CW08 Increased immunisation at two years	% of two-year-olds fully immunised		95%
CW09 Better help for smokers to quit (maternity)	% 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		90%
CW10 Raising healthy kids	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions		95%
CW12 Youth health initiatives			
Focus area 1: Youth SLAT	Provide reports as required		
Focus area 2: School Based Health Services	Provide reports as required		
Focus area 3: Youth Primary Mental Health services	Refer to MH04		
Improving mental wellbeing (MH)			
MH01 Improving the health status of people with severe mental illness through improved access (CY2019 baseline)	Age 0-19 years	Māori Other Total	≥5.43% ≥3.45% ≥3.76%
	Age 20-64 years	Māori Other Total	≥8.86% ≥3.23% ≥3.72%
	Age 65+ years	Māori Other Total	≥2.25% ≥2.16% ≥2.16%
MH02 Improving mental health services using wellness and transition (discharge) planning	% of clients discharged will have a transition or wellness plan		95%

Performance measure		Expectation
	% of audited files meet accepted good practice	95%
MH03 Shorter waits for non-urgent mental health and addiction services (0-24 year olds)	Provide reports as specified	
MH04 The Mental Health and Addiction 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 the end of the reporting year	↓ by ≥10% (baseline is Q3 2020/21)
MH06 Mental health output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within: a. 5% variance (+/−) of planned volumes for services measured by FTE b. 5% variance (+/−) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day c. actual expenditure on the delivery of programmes or places is within 5% (+/−) of the year-to-date plan	
MH07 Improving mental health services by improving inpatient post discharge follow-up rates	Provide reports as specified	
Improving wellbeing through prevention (PV)		
PV01 Improving breast screening coverage and rescreening	% coverage for women aged 45-69 years for Māori, Pacific and total population	70%
PV02 Improving cervical screening coverage	% coverage for all ethnic groups and overall	80%
Better population health outcomes supported by strong and equitable health and disability system (SS)		
SS01 Faster cancer treatment (31-day indicator)	% of patients receive their first cancer treatment (or other management) within 31 days from date of decision to treat	85%
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	Age 0-4 years	Refer to our 2021/22 SLM Improvement Plan
	Age 45-64 years	≤3,971 per 100,000
SS07 Planned Care measures		
1. Planned care interventions	Number of interventions	TBC
2. Elective service patient flow indicators	ESPI 1: 100% (all services) report Yes (that >90% of referrals within the service are processed in ≤15 calendar days)	100%
	ESPI 2: patients waiting over four months for FSA	0%
	ESPI 3: patients in active review with a priority score above the actual treatment threshold	0%
	ESPI 5: patients waiting over 120 days for treatment	0%
	ESPI 8: patients prioritised using an approved national or nationally recognised prioritisation tool	100%
3. Diagnostic waiting times	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
	95 % of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days)	95%
	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days)	90%
4. Ophthalmology follow-up waiting times	No patient will wait ≥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	0%
6. Acute readmissions (0-28 days)	The proportion of patients who were acutely re-admitted post discharge improves from base levels	<12.4%
7. Did not attend rates (DNA) for first specialist assessment (FSA) by ethnicity	Developmental measure – no target	
SS09 Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		

Performance measure		Expectation
Focus area 1: Improving the quality of identity data within the NHI	New NHI registration in error (causing duplication)	Group A >2% to ≤4%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% to ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% to ≤2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% to ≤85%
	Invalid NHI data updates	MoH to advise
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	≥90% to <95%
	National Collections completeness	≥94.5% to <97.5%
	Assessment of data reported to NMDS	≥85% and <95%
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 (EDs)	% of patients will be admitted, discharged or transferred from an ED within six hours	95%
SS11 Faster cancer treatment (62-day indicator)	% 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 2 weeks	90%
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 (LTCs)	Report on actions, milestones and measures to support people with LTC to self-manage and build health literacy	
Focus area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*	
	Ascertainment	95-105% and no inequity
	HbA1c <64 mmol/mol	>60% and no inequity
	No HbA1c result	<7-8% and no inequity
Focus area 3: Cardiovascular health	Provide reports as specified	
Focus area 4: Acute heart service	Door to cath within 3 days for >70% of acute coronary syndrome (ACS) patients undergoing coronary angiogram	>70%
	≥95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within 30 days, and ≥99% within 3 months of discharge	≥95% within 30 days ≥99% within 3 months
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF	≥85%
	In the absence of a documented contraindication/ intolerance, ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge: aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes) - ACEI/ARB if any of the following: LVEF, 50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes) - beta-blocker if LVEF <40% (5classes) * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents	≥85%
	≥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	≥99%
	≥99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure	≥99%
Focus area 5: Stroke Services	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke	80%

Performance measure		Expectation
	pathway within 24 hours of their presentation to hospital	
	12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7)	12%
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
	60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge	60%
SS15 Improving waiting times for colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure within 14 calendar days, 100% within 30 days	90% within 14 days 100% within 30 days
	70% of people accepted for a non-urgent diagnostic colonoscopy receive (or are waiting for) their procedure within 42 calendar days, 100% within 90 days	70% within 42 days 100% within 90 days
	70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure within 84 calendar days of the planned date, 100% within 120 days	70% within 84 days 100% within 120 days
	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	95%
SS17 Delivery of whānau ora	Appropriate progress identified in all areas of the measure deliverable	
Better population health outcomes supported by primary care and prevention (PH)		
PH01 Delivery of actions to improve SLMs	Provide reports as specified	
PH02 Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of >90%	100%
PH03 Access to care (Māori PHO enrolments)	The DHB has an enrolled Māori population of ≥95%	95%
PH04 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	90%
Annual plan actions		
Annual plan actions – status update reports	Provide reports as specified	

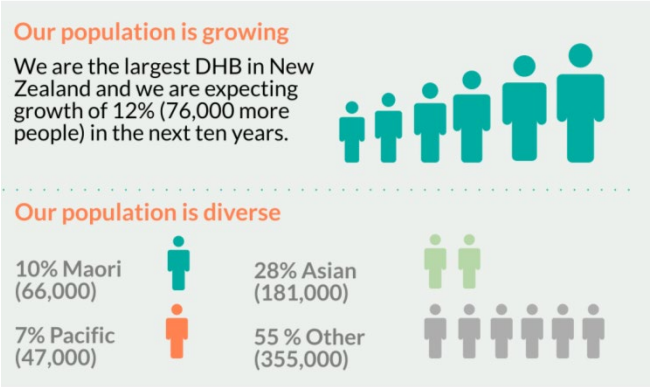
Appendices

APPENDIX A: STATEMENT OF INTENT – 2019/20 TO 2022/23

About Waitematā DHB

Who we are

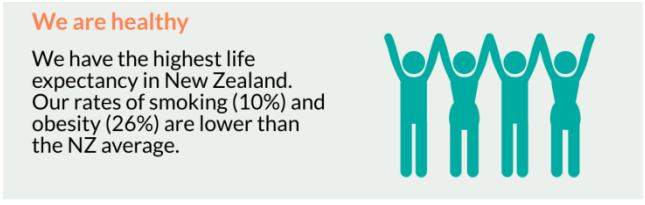
Waitematā DHB is the Government's funder, and provider of health services to the estimated 650,000[4] residents living in the areas of North Shore, Waitakere and Rodney. We are the largest DHB in the country and are experiencing rapid population growth.



The age composition of Waitematā residents is similar to the national picture, with 19% aged less than 15 years and 14% aged over 65[1] years.

Our population is diverse. 10% of Waitematā residents are Māori, 7% Pacific, and 28% are Asian[1]. Our Asian population is proportionally our fastest growing population and is projected to increase to 30% of the total in the next ten years.

Waitematā's population is generally healthier than that of New Zealand as a whole. We have the highest life expectancy in New Zealand, at 83.9 years (2017-19), with an increase of 3.3 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (61%) and over a quarter of our adults are classified as obese (26%) (New Zealand Health Survey 2016/17). Ten percent are current smokers (2018 Census Usually Resident Population).



Cancer is the most common cause of death (29%), and there are over 2,900 new cancer registrations in Waitematā every year (excludes in-situ). Cardiovascular disease (CVD; 28%) and respiratory disease (10%) also account for a large proportion of deaths. Our 5-year survival rate for cancer is among the highest in New Zealand (68%) and our CVD and cancer mortality rates are very low. However, there is room for improvement, as a significant proportion of all deaths in those aged under 75 years are amenable through healthcare interventions (45% or 484 deaths in 2017).

The boundaries of Waitematā DHB extend to Wellsford in the north and as far south as the Auckland Harbour Bridge, incorporating Whangaparaoa in the east and the west coast beaches of Muriwai, Piha and Karekare. The North Shore and Henderson-Massey are densely populated suburban areas, while the large rural areas to the north and west have a much sparser population.

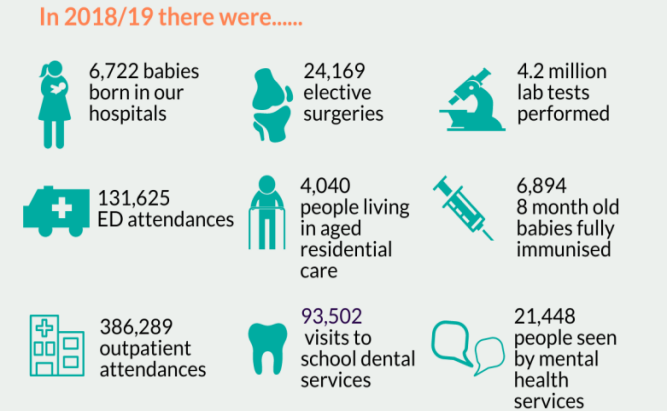
We are a relatively affluent population, with a large proportion living in areas of low deprivation. One in ten of our total population and 21% of Māori and Pacific people live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals generally experience poorer health outcomes than those residing in more affluent areas.

What we do

DHBs act as planners, funders and providers of health services, as well as owners of Crown assets. Waitematā DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. Waitematā DHB employs more than 8,600 people. We have an estimated budget of $2.23 billion revenue in 2021/22.

We provide child disability, forensic psychiatric services, school dental services, and alcohol and drug services to the residents of the overall Auckland region on behalf of the other DHBs. Since 2013, we have been the national provider of hyperbaric oxygen therapy services.

We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, and have contracts with approximately 600 other community providers.



[4] Projected 2021/22 population – 2020 update.

The key challenges we are facing

Although the majority of our population enjoy very good health, a number of challenges exist as a provider and funder of health services.

Growing and ageing population. The population will increase by 12% to approximately 726,000 over the next ten years, and the 65+ year-old population will increase by more nearly 70% over the next 20 years; combined with growth in demand, this will place considerable pressure on heavily utilised services and facilities, including primary and community health services (older people currently occupy around half of beds).

Prevention and management of long-term conditions. The most common causes of death are cancer (29%) and CVD (28%). Many deaths are potentially amenable through healthcare interventions (45% or 484 deaths of those aged less than 75 years in 2017).

Health inequities. Particular populations in our catchment continue to experience differences in health outcomes. This is most starkly illustrated by the gap in life expectancy of 3.8 years for Māori and 6.8 years for Pacific compared with other ethnicities.

Patient-centred care. Patients, whānau and our community are at the centre of our health system. We want people to take greater control of their own health, be active partners in their own care and access relevant information when they need it.

One system. We need to ensure healthcare is seamless across the continuum and reduce disconnected and replicated services, as well as fragmentation of data and information between and across hospital, community and other services.

Financial sustainability. The financial challenge facing the broader health sector and Waitematā DHB is substantial; the current trajectory of cost growth is estimated to outweigh revenue growth by 2025. We need to make deliberate and focused strategic investment relevant to the specific needs of our population. This may require hard decisions about where we commit resource, including reallocation of investment into services where we know we can achieve better outcomes.

Given the challenges we are facing, we identified three key areas of risk, and the focus needed to address these.

1. **Ensuring long-term sustainability through fiscal responsibility**
   To ensure we continue to live within our means, we need to focus on:
   - effective governance and strong clinical leadership
   - connecting the health system and working as one system
   - delivering the best evidence-based care to avoid wastage
   - tight cost control to limit cost growth pressure.
2. **Changing population demographics**
   To cope with our growing and ageing population, we need to:
   - engage patients, consumers and their families and the community in the development and design of health services and ensuring that our services are responsive to their needs
   - assist people and their families to better manage their own health, supported by specialist services delivered in community settings and hospitals
   - increase our focus on proven preventative measures and earlier intervention.
3. **Meeting future health needs and the growing demand for health services**
   To deliver better outcomes and experience for our growing population, we must maintain momentum in key areas, by:
   - focusing on upstream interventions to improve the social and economic determinants of health, within and outside of the health system
   - providing evidence-based management of long-term conditions
   - working as a whole system to better meet people's needs, including regionally and across Government and other services
   - addressing quality improvement in all areas
   - ongoing development of services, staff and infrastructure
   - involving patients and families in their care.

Our strategic direction

Best care for everyone

Our promise, purpose, priorities and values are the foundation for all we do as an organisation.

- Our **promise** is that we will deliver the **'best care for everyone'**. This means we strive to provide the best care possible to every single person and their family engaged with our services. We put patients first and are relentless in the pursuit of fundamental standards of care and ongoing improvements enhanced by clinical leadership.
- Our **purpose** defines what we strive to achieve, which is to:
  - Promote wellness
  - Prevent, cure and ameliorate ill health
  - Relieve suffering of those entrusted to our care.
- We have two priorities:
  - Better outcomes
  - Patient experience.

The way we plan and make decisions and deliver services on a daily basis is based on our **values** – **everyone matters; with compassion; better, best, brilliant** and **connected**. Our values shape our behaviour, how we measure and continue to improve.

Delivering on our strategic direction

Our strategic objectives are to achieve better and more equitable health outcomes for everyone in our community and enhance patient, family and whānau experience. We will do this by working with our communities and partners to deliver high quality, effective, patient-focused and compassionate services.

We are taking a population health perspective to improve the health of the entire population and achieve health equity for all groups, in particular for Māori. We will work with our Iwi Partnership Board in the planning and provision of healthcare services to further Māori health gain. Our Waitematā DHB Consumer Council provides a strong voice for consumers on quality improvement and service delivery that meet the needs of our population.

We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, to ensure patients receive more effective and co-ordinated care.

Our Institute for Innovation and Improvement (i3) supports the design and implementation of new models of care and best practice processes. Examples include redesigning our outpatient and surgical services to improve patient experience, scaling telehealth and electronic tools in outpatients, building our e-data environment to support care redesign, and redesigning hospital services in the community.

Our clinical leadership programme, Transforming Care, is helping to build capability for care redesign and enhanced care management.

We expect our population to reach 726,000 by 2032; this significant growth in our population and increased demand for clinical and community services provide both challenges and opportunities in the coming year. We have several major facilities developments planned and work with the Northern Region DHBs on the NRLTHP to guide medium- to long-term planning decisions.

Environmental sustainability continues to be a priority. We have plans in place to reduce our carbon emissions and address the impact of climate change on health.

The financial challenge facing the broader health sector and Waitematā DHB is substantial. To ensure long-term sustainability, we need effective governance and strong clinical leadership to deliver the best evidence-based care in a connected health system.

National, regional and sub-regional strategic direction

National

Waitematā DHB operates as part of the New Zealand health system. Our overall direction is set by the Minister's expectations and the Government's priority outcomes.

The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

- improve, promote, and protect the health of communities
- reduce inequalities in health status
- integrate health services, especially primary and hospital services
- promote effective care or support of people needing personal health services or disability support.

Waitematā DHB is committed to working in partnership with the Auckland Regional Public Health Service in their work on responding to COVID-19, health promotion/ improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and undertaking regulatory functions.

We actively work with other agencies to support at-risk families and progress outcomes for children and young people, including the Ministry for Children, Oranga Tamariki. We will continue to work with New Zealand Health Partnerships Limited to progress initiatives.

Regional

The NRLTIP was developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. It identifies the key challenges for the four Northern Region DHBs and sets priorities for regional planning work, ISSP (and implementation) and capital investment. The regional work plan will continue to be developed updated to form the Northern Region Long Term Health Plan (NRLTHP).

Sub-regional

Waitematā and Auckland DHBs have a bilateral agreement that joins governance and some activities. Furthermore, collaboration across the Northern Region is increasingly critical as we strive to deliver services for our whole population, invest across the health system, and increase co-ordination of care to improve access, equity and healthcare outcomes, and reduce duplication.

Short-term focus

Waitematā DHB is committed to achieving healthy equity for everyone in our community, in particular for Māori. We will work with our Iwi Partnership Board to plan and provide healthcare services to further Māori health gain.

We want a culturally aware workforce that reflects our communities to care for our patients. The Māori Advisory Leadership Team (MALT) oversees the implementation of the joint Waitematā and Auckland DHBs' Māori Health Workforce Development Strategy. This helped our total Māori workforce increase by around 15% since 2016, to a total of 568 current Māori employees. By 2025, we aim to reach parity with the proportion of Māori and Pacific people in our working age population.

The significant growth expected in our population and increased demand for clinical and community services provide both challenges and opportunities in the coming years.

The DHB will continue to progress the following major developments:

- Design and begin construction of Tōtara Haumaru, our new $240 million, four-storey surgical hospital at the North Shore Hospital campus, due for completion in 2023.
- Complete and open E Tū Tanekaha, the $22.46 million, 15-bed medium secure unit at the Mason Clinic. Design and begin construction on two additional inpatient units at the Mason Clinic campus.
- Refurbishment and expansion of the Waitakere Special Care Baby Unit.
- Engage with the other Northern Region DHBs in the planning process. The regional work plan will continue to be developed around the NRLTHP.

Staff and patient feedback informed our new organisational development plan to improve staff and patient experience. We will focus on compassion with organisation-wide activity, such as wellbeing initiatives, compassion-based leadership and education programmes, collecting and sharing stories of compassion, and trialing compassion grand rounds.

Key programmes and initiatives

Māori health partnerships

We established a Māori health committee representing Northland, Waitematā and Auckland DHBs, jointly with our iwi partners, with the intention of working together to achieve Māori health equity. A similar committee was established between Counties Manukau and Waikato DHBs and their iwi partners. The two Māori governance groups will regularly meet to share regional opportunities to advance Māori health gain.

Māori pipeline projects

A Māori health pipeline of projects was established that focuses on identified areas to accelerate Māori health gain and reduce the life expectancy gap. The pipeline has matured and was reviewed in December 2020, with some projects being completed and other extension projects being developed. The refreshed pipeline currently includes lung cancer screening pilot, a kapa haka pulmonary rehabilitation prototype, targeted HPV self-testing cervical cancer projects, hepatitis C acceleration of

elimination for Māori re-offer of treatment, and support to extend AAA screening for Māori to Northland DHB.

The Waitematā Experience programme
This programme encompasses all activity that seeks, collects and analyses patient and whānau feedback to inform quality improvement activity. Co-design methodology is used to redesign services and to ensure we deliver an excellent experience for patients, whānau and staff. The programme aligns all of the patient experience work occurring in the DHB with the staff values programme to ensure the patient's voice is heard and patient/whānau-centred care practices are embedded throughout the organisation.

Waitematā DHB Consumer Council
The Waitematā DHB Consumer Council provides a strong voice for consumers on quality improvement and delivery of services that meet the needs of our population. Aligning strategically with DHB priorities, the Consumer Council enhances consumer engagement and patient experience across all services. The Consumer Council will further focus our organisation to become more patient- and whānau-centred, and transform our culture to one where working in partnership with our community is business as usual.

Waitematā 2025
We have a 10-year plan to redesign and improve our physical environment so it is more comfortable for patients and their whānau, and will accommodate our increasing population. Developments planned and underway include Tōtara Haumaru, our new surgical hospital at the North Shore Hospital campus, extensive upgrades of the Mason Clinic site and improvements to the Waitakere Special Care Baby Unit.

Transforming Care
Transforming Care is a clinical leadership programme designed to build capability for care redesign and enhanced care management at Waitematā DHB. The programme was developed from the work led by Professor Richard Bohmer.

The Institute of Innovation and Improvement (i3)
Our i3 Institute provides expertise to support clinical teams to design and implement new models of care and best practice processes. The Institute brings together expertise in costing analysis, data analysis, digital platforms, evaluation, innovation, leadership, patient and whānau experience, population health and quality improvement.

LeapFrog programme
The Leapfrog programme is focused on accelerating the DHB's strategic innovation projects. The programme advances the support of patient care through electronic systems, the use of data and improved workflows. A series of new Phase Four projects will lead our transformation to an integrated digital environment. Underpinned by the LeapFrog programme, Waitematā DHB is recognised as a leader in the movement toward a more mobile, electronic health record.

Managing Our Business

Section 4 details how we will manage our functions and operations to deliver on our strategic intentions and maintain our organisational health and capability.

Improving health outcomes for our population

Waitematā DHB's performance framework demonstrates how the services we fund or provide contribute to the health of our population and result in the achievement of our longer-term outcomes and the expectations of the Government.

Our performance framework reflects the key national and local priorities that inform this Annual Plan. There is considerable alignment between our performance framework, the System Level Measures framework set by the Ministry of Health, the Minister of Health's planning priorities, and the over-arching Government Priorities.

We have two overall long-term population health outcome objectives. These are:

- life expectancy at birth continues to increase
- inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced.

The outcome measures are long-term indicators; therefore, the aim is for a measurable change in health status over time, rather than a fixed target.

We identified medium-term outcome goals and short-term priorities that will support the achievement of these overall objectives. Equity underpins our performance framework and our goals are focused on three key areas: child wellbeing, prevention and early intervention, and mental health.

Our medium-term outcomes define our priorities for the next 3-5 years and allow us to measure the difference we are making for our population. Our short-term priorities are essential to the achievement of our outcome goals and are front-line measurements of the success of specific health processes or activities. To help identify equity gaps and measure progress, we will monitor all of our medium term outcomes by ethnicity and track local progress.

Child wellbeing

We want to ensure that all children in our district have the best start to life. Pregnancy and early childhood are the most effective times to intervene to reduce inequalities and improve long term health and wellbeing.

Smoking is a leading risk factor for many diseases, and exposure to smoke during pregnancy and early childhood strongly influences health outcomes. Smoking rates among Māori and Pacific are double that of other ethnicities; less than half of all Māori and around half of all Pacific babies currently live in smokefree households. By supporting whānau to quit, we aim to increase the number of babies living in smokefree homes.

Pacific children, in particular, have very high hospital admission rates for conditions that can be potentially prevented or managed by primary and community care. We will improve immunisation rates and access to oral health services to help keep these children out of hospital.

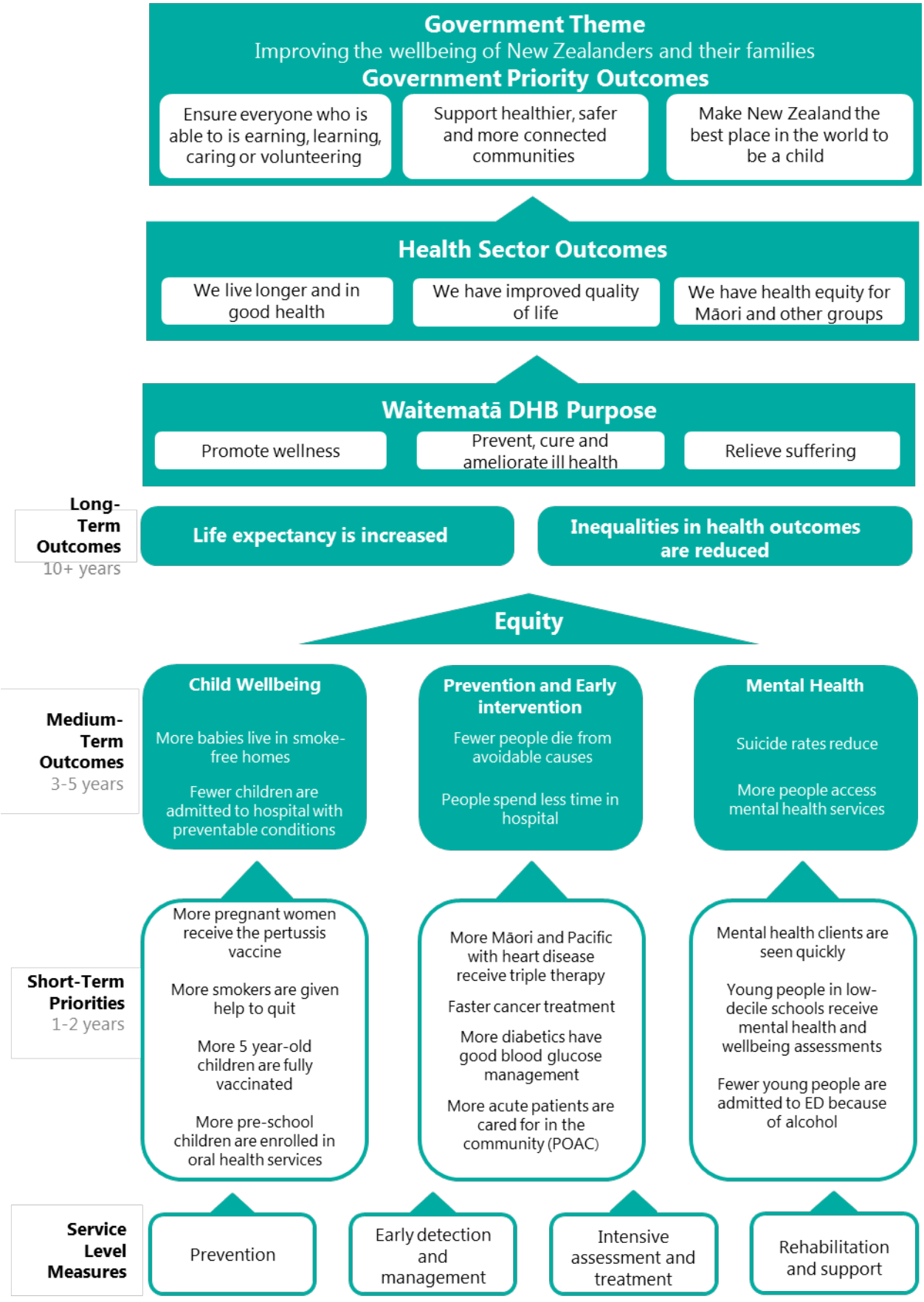
Prevention and early intervention

Preventative care is centred around individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Māori and Pacific have a higher incidence of chronic conditions and experience poorer outcomes; we want to address this inequity. Our aim is for fewer people to die from potentially avoidable conditions. We also want to make sure that, where possible, treatment and management happens in community settings and for people to spend less time in hospital when they are acutely unwell. Cardiovascular disease and diabetes rates are higher for our Māori and Pacific populations. We need to focus on good management of these conditions through support, education and prescribing of appropriate medications to improve the health outcomes of those most affected. Likewise, we need to continue to ensure that our cancer pathways remain timely and that there are no barriers to accessing cancer treatment.

Mental health

Mental health and addiction problems affect the lives of many people in our district, with around 20% experiencing mental illness or distress. New Zealand has high suicide rates, with rates for Māori twice that of other ethnicities. We will ensure that practical help and support is available in the community to all people who need it, with good access to acute mental health support when required. Young people in lower decile schools will be supported to receive help for mental health, alcohol and drug, sexual health, social and physical health issues.

Performance and intervention framework



Long-term outcomes

The long-term outcomes that we aim to achieve are to increase life expectancy (measured by life expectancy at birth) and reduce ethnic inequalities (measured by the ethnic gap in life expectancy).

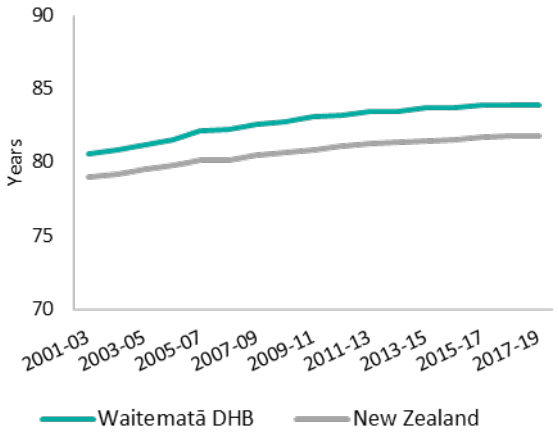
Increasing life expectancy

Life expectancy at birth is recognised as a general measure of population health status.

We have the highest life expectancy in the country at 83.9 years (2017-19), which is 2.1 years higher than New Zealand as a whole. Half of this difference in life expectancy between New Zealand and Waitematā DHB is attributed to our lower mortality rates from cardiovascular disease and cancer. Our life expectancy increased by 3.3 years since 2001, which is 6 months more than that of New Zealand.

Over the longer term, we aim to maintain the highest life expectancy in the country and expect our life expectancy to reach 85 years by the end of the next decade.

Outcome measure – life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

Reduce inequalities for all populations

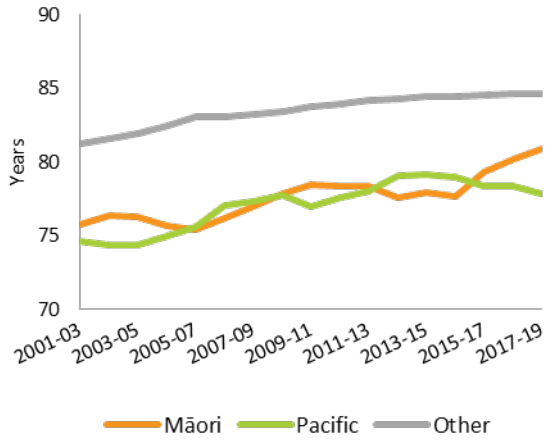
Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 3.8 years for Māori and 6.8 years for Pacific (2017-19).

Life expectancy has increased in both our Māori (5.1 years) and Pacific (3.2 years) populations since 2001. While the gap in life expectancy is closing for Māori, it appears to be increasing slightly for Pacific.

Mortality at a younger age from cardiovascular disease and cancers accounts for over half of the life expectancy gap in our Māori and Pacific populations.

We expect a reduction in the gap in life expectancy over the next decade, declining at the same or a greater rate than that observed in the last ten years.

Outcome measure – ethnic gap in life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used. 'Other' ethnicity includes non-Māori/non-Pacific ethnicities.

Medium-Term Outcomes

Child Wellbeing

The foundations of a healthy adult life are laid in early childhood. Promoting healthy behaviours and environments, along with ensuring access to well integrated primary and community services, can prevent health problems and improve health outcomes. We aim to increase the proportion of babies living in smoke-free homes and reduce the number of children admitted to hospital with preventable health conditions.

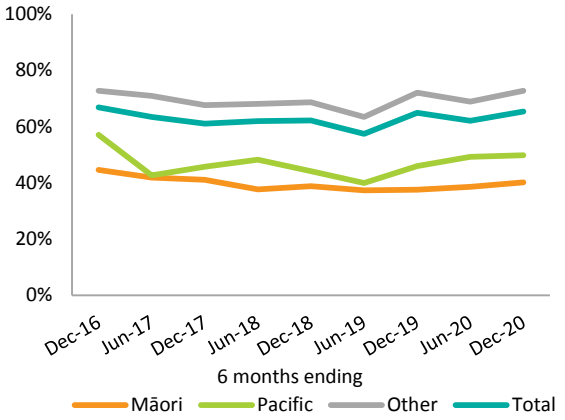
Medium-Term Outcomes

More babies live in smoke-free homes

Infants and young children are exposed to second-hand smoke more often in homes than in other places. Second-hand smoke exposure is associated with preventable and harmful effects in children, and the effects of exposure are lifelong. Exposure is a significant contributor to health inequalities in children.

As at December 2020, less than half (40%) of all Māori and half of Pacific babies were living in a smokefree household in contrast to more than 70% of other ethnicities. The proportion of all babies who live in smokefree households showed a small increase for all ethnic groups between this and last reporting periods.

Proportion of babies living in smokefree households at 6 weeks postnatal



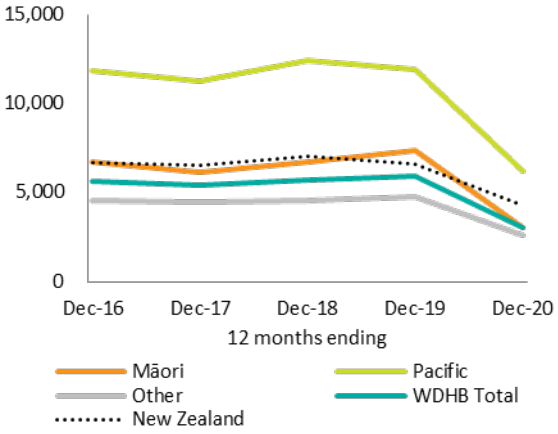
Fewer children are admitted to hospital with preventable conditions

We seek to reduce admission rates to hospital for a set of conditions that are potentially avoidable through prevention or management in primary care, known as ambulatory sensitive hospitalisations (ASH). In children, these conditions are mainly respiratory illnesses, gastroenteritis, dental conditions, and cellulitis.

A significant reduction in ASH admissions was observed in the 12-month period ending December 2020. This is because many people avoided seeking treatment at healthcare facilities, including hospitals, during the COVID-19 Alert Level 4 lockdown in March-April 2020. The incidence of some ASH conditions also improved through the efforts to reduce the spread of COVID-19; seasonal influenza and other respiratory infection rates dropped due to social distancing and good hygiene practices, as well as improved vaccination rates. Performance will need to be monitored over time to determine if this improvement is sustained.

ASH rates remain higher in Māori (3,074 per 100,000) than other ethnicities (2,607 per 100,000), and nearly three times as high in the Pacific population (6,220 per 100,000).

Ambulatory sensitive hospital admissions per 100,000 in those aged 0–4 years



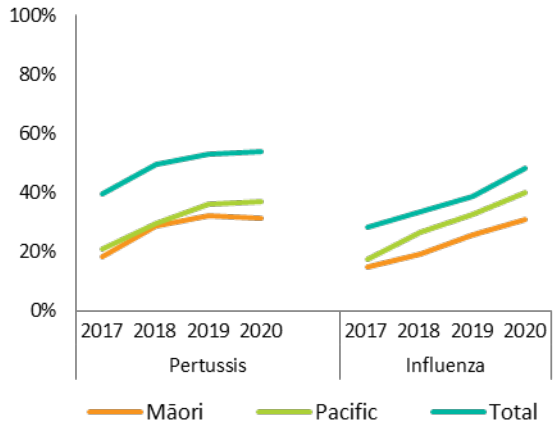
Short-Term Priorities

More pregnant women receive antenatal immunisations

Respiratory conditions are the largest contributor to ASH rates in Waitematā. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants that can lead to further respiratory complications. Both are vaccine preventable and vaccination during pregnancy protects both mother and baby against these diseases for the first few months of life.

Vaccination rates are increasing. For babies born in 2020, 54% of mother received a pertussis vaccination during pregnancy and 48% received an influenza vaccination; however, the rates are considerably lower for Māori and Pacific.

Proportion of pregnant women receiving pertussis and/or influenza vaccinations during pregnancy



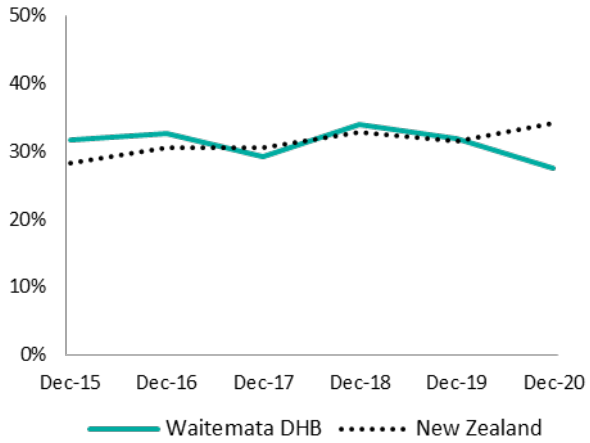
More smokers receive help to quit

Life-long smoking is associated with a decade of life lost for an individual. Quitting smoking before the age of 40 years, and preferably much earlier, will reduce about 90% of the years of life lost from continued smoking.

Providing smokers with brief advice to quit increases their chances of making a quit attempt. The likelihood of that quit attempt being successful increases if behavioural support, such as a referral to quit smoking services and/or pharmacological smoking cessation aids, is provided.

As at December 2020, 28% of smokers were provided with smoking cessation support in the past 15 months. There are known issues with data coding behind this measure. This indicator has been replaced in the SPE with more robust smoking cessation measures.

Proportion of smokers receiving cessation support in primary care



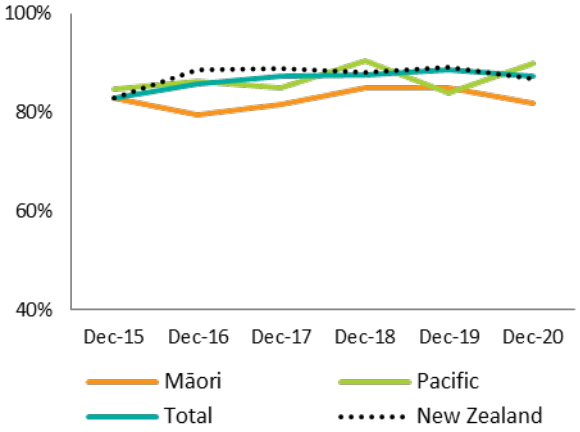
More five year-old children are fully vaccinated

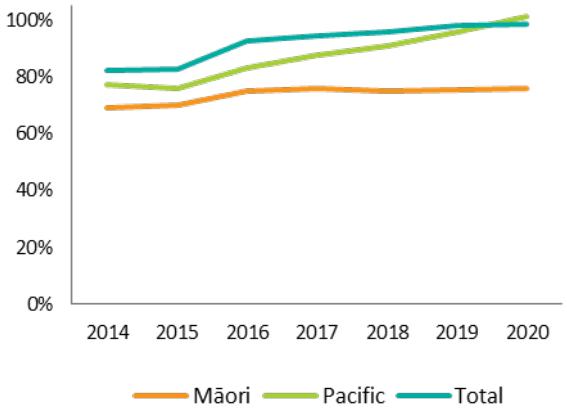
Immunisation is one of the most effective and cost-effective medical interventions to prevent disease. Vaccine-preventable diseases (such as measles, mumps, and rubella) can cause serious health problems, disabilities, and even death. Immunisation not only protects the child, but others that are unable to be vaccinated, via herd immunity.

Receiving scheduled vaccinations on time provides a good opportunity for children and families to engage with health services on a relatively regular basis.

In the quarter ending December 2020, 87% of all five-year old children were fully vaccinated, similar to the national rate; however, the rate is significantly lower for Māori children (82%).

Proportion of children fully vaccinated by five years of age

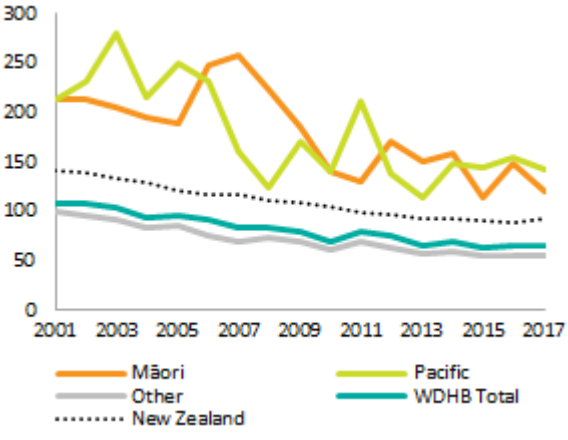


More pre-school children are enrolled in oral health services	
Dental care comprises a leading cause of preventable admission to hospital among pre-school children. The consequences of poor dental health in childhood can carry into adulthood. Prevention and early intervention are key to reducing the number of children hospitalised for dental conditions. Dental care for preschool children is free; however, not all children are enrolled in oral health services, with Māori children in particular missing out on dental care. Note: the denominator for this measure is the estimated population, as published by Statistics NZ, as it is not possible to have an exact count of all the children in our district at any point in time. As at December 2020, the estimated Pacific population was lower than the actual number of children enrolled with oral health services, and therefore the calculated result is over 100%. While we know not all Pacific children are enrolled with oral health services, the number of enrolled children is increasing and we are confident we are close to achieving our aim of all children enrolled in oral health services and receiving dental care.	**Proportion of pre-school children enrolled in oral health services** 

Prevention and Early Intervention

Chronic diseases are the leading cause of death and disability, with increasing prevalence linked to increasing health costs. Preventative care is centred around individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Identifying and preventing potential problems downstream, such as addressing the socio-economic determinants of health, is one strategy to improve health outcomes. When people do become unwell, prompt diagnosis and early intervention in the initial stages of illness can significantly affect the outcome. Our aim is for fewer people to die from potentially avoidable conditions and for people to spend less time in hospital when they are acutely unwell.

Medium-Term Outcomes

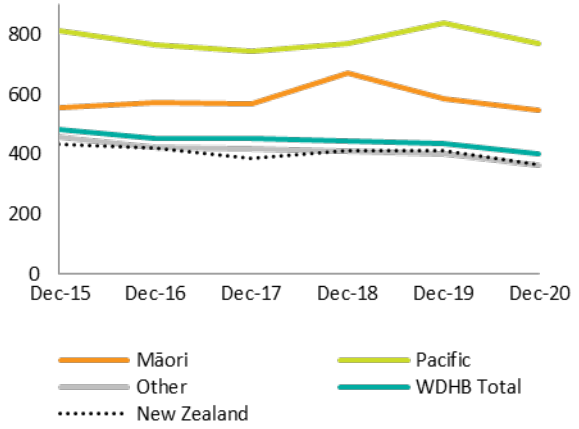
Fewer people die from avoidable causes	
Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care where such health interventions exist. In 2017, we estimate that 484 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were potentially amenable. The rate of amenable mortality has steadily decreased over the past decade and is currently at 65.0 per 100,000 population. We aim to continue this rate of reduction in amenable mortality.	**Mortality rate from conditions considered amenable, per 100,000 population** 

People spend less time in hospital

Acute admissions account for approximately half of all hospital admissions in New Zealand. Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressures on DHB staff and facilities. Reductions may result from effective management in primary care, optimising hospital patient flow, discharge planning, community support services and good communication between healthcare providers.

A reduction in acute bed days was observed in the 12-month period ending December 2020, as some people avoided seeking treatment at healthcare facilities, including hospitals, during the Alert Level 4 lockdown in March-April 2020.

Acute hospital bed days rate per 1,000 population



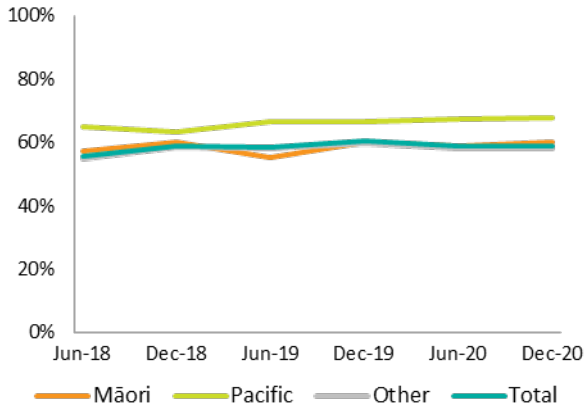
Short-Term Priorities

More Māori and Pacific with heart disease receive triple therapy

New Zealand guidelines recommend that, where appropriate, people who previously had a heart attack or stroke are treated with a combination of medications known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta-blocker to treat hypertension and a statin to reduce cholesterol), to reduce the risk of another cardiovascular disease (CVD) event.

As at December 2020, 60% of Māori and 68% Pacific who had a previous CVD event were prescribed triple therapy medication.

Proportion of Māori and Pacific with a prior CVD event are prescribed triple therapy



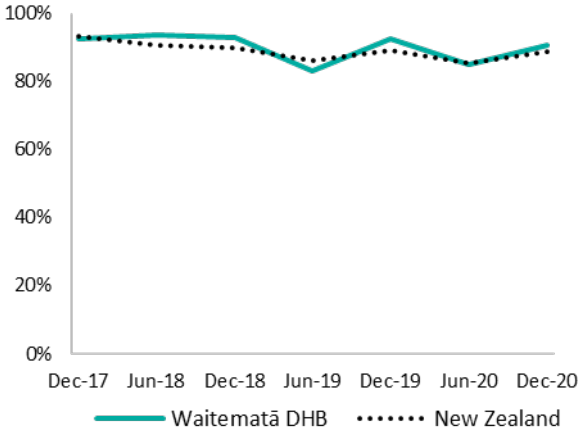
Faster cancer treatment

Cancer is a leading cause of morbidity and mortality in Waitematā DHB, accounting for over one quarter of all deaths. Prompt investigation, diagnosis and treatment increases the likelihood of better outcomes for cancer patients, and assurance regarding waiting time can reduce the stress on patients and families at a difficult time.

Our aim is for all patients diagnosed with cancer to receive their first treatment or other management within 62 days of referral.

In the six months to December 2020, 91% of cancer patients received their first treatment within the target time.

Proportion of cancer patients receiving treatment within 62 days of referral



More people with diabetes have good blood glucose management

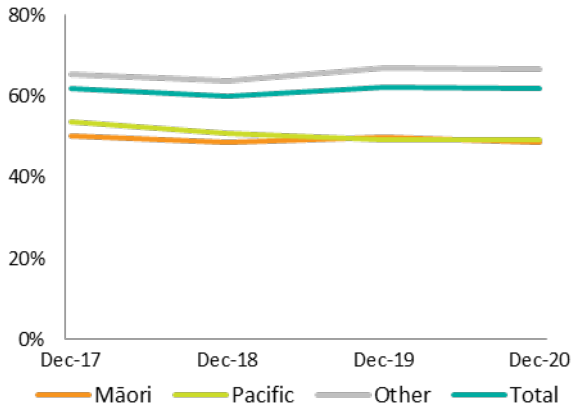
The management of type 2 diabetes is multi-faceted. Following diagnosis, patients require education to help manage their condition and make lifestyle changes.

HbA1c is a measure of a patient's average blood glucose level over the past few months and can be used as an indicator of how well their diabetes is being controlled.

Well managed diabetes decreases the likelihood of onset and progression of microvascular complications, such as retinopathy, nephropathy and neuropathy.

As at December 2020, 62% of all diabetics had an HbA1c of ≤64mmol/mol, indicating their diabetes is well managed.

Proportion of people with diabetes with good blood glucose management



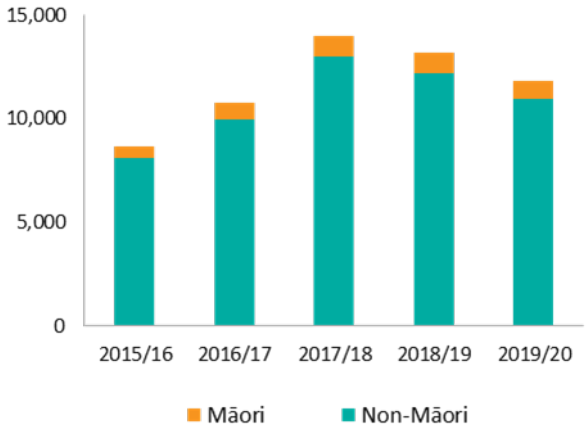
More acute patients are cared for in the community (POAC)

Primary Options for Acute Care (POAC) provides access to investigations, care or treatment in the community so that patients can be safely managed by primary care at home, thus avoiding acute hospital admissions or shortening hospital stays.

We aim to have more people treated through the POAC pathway, thus preventing unnecessary and costly acute hospital admissions.

In 2019/20, 11,798 patients were referred to POAC services. The decrease in referrals observed in 2019/20 is largely due to the impact of the Alert Level 4 restrictions in place during March-April 2020.

Number of POAC referrals



Mental Health

Mental health and addiction problems affect the lives of many people in our district. Each year, around one in five of our population experience mental illness or significant mental distress. Increasing numbers of children and young people show signs of mental distress and intentional self-harm. In addition, New Zealand has persistently high suicide rates. The responsibility for improving mental health outcomes for our population does not lie solely with the health system; there are clear links between poverty and poor mental health. We aim to ensure that practical help and support is available in the community to people who need it. Our people need safe and affordable houses, good education, jobs and income for mental wellbeing.

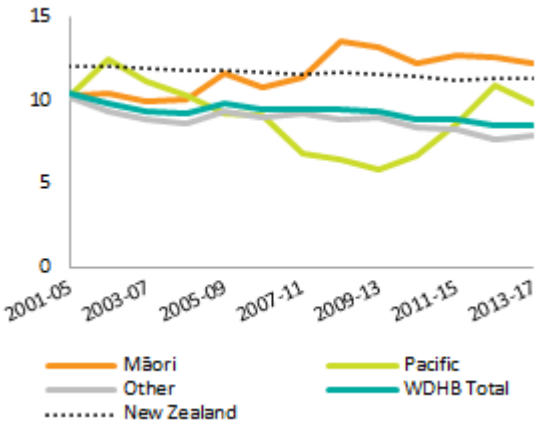
Medium-Term Outcomes

Suicide rates reduce

Suicide is a serious health and social issue. Suicide rates are a sign of the mental health and social wellbeing of the population. Suicide prevention initiatives aim to promote protective factors, reduce risk factors for suicide and improve the services available for people in distress.

Although our suicide rates are lower than the national rate, there is a clear equity issue and a concerning trend, particularly among our Pacific population. Our long-term aim is for zero suicides. Reducing suicide rates requires a whole-of-government approach to support wellbeing and address multiple social determinants.

Rate of suicide per 100,000 population

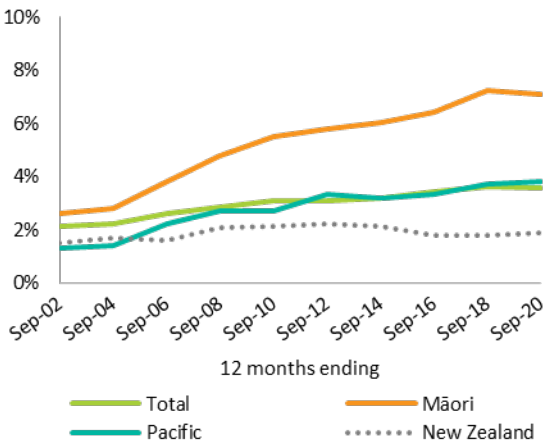


More people access mental health services

Each year, around one in five individuals experience mental illness or significant mental distress. Increasing numbers of children and young people show signs of mental distress and intentional self-harm. While not all individuals with mental health and addiction challenges need or will seek access to a specific service intervention, over time, more people should be able to access support.

In the 12 months to September 2020, 3.6% of the total Waitematā DHB population was seen by specialist mental health services. The prevalence of mental distress is much higher in Māori than other ethnicities, 7.1% of Māori accessed mental health services in the same period.

Proportion of population accessing mental health services – all ages



Short-Term Priorities

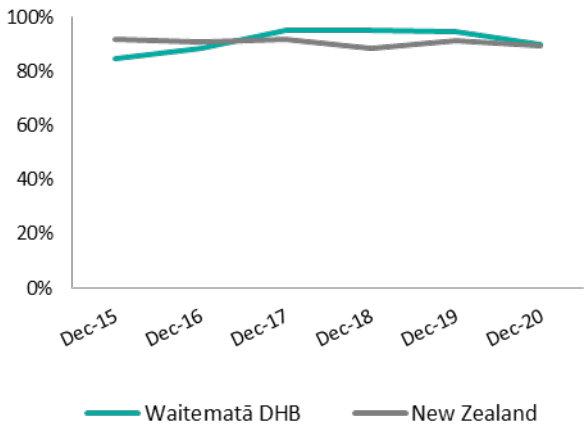
Mental health clients are seen quickly

Individuals experiencing mental distress or with mental health needs do not always require a referral or access to specialist mental health services. However, where a need does arise and people reach a point of crisis, it is critical to intervene quickly with a variety of well-supported and culturally safe treatment options, which may include a referral to specialist mental health services.

We aim to ensure that when individuals are referred to specialist mental health services, they are seen quickly.

In the 2020 calendar year, 90% of people referred non-urgently to mental health services were seen within 8 weeks.

Proportion of non-urgent referrals to mental health services that are seen within eight weeks

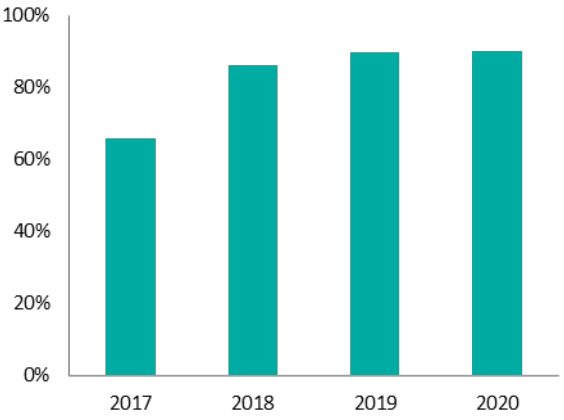


Young people in low-decile schools receive mental health and wellbeing assessments

Adolescence is a challenging time when many emotional and physical changes take place, and can be a potentially dangerous time of experimentation. HEEADSSS is a validated assessment tool used to help assess youth wellbeing through a series of questions relating to Home life, Education/employment, Eating, Activities, Drugs, Sexuality, Suicide/depressions and Safety. The tool is administered to Year 9 students in a number of schools and provides a mechanism for health professionals to evaluate young people's developmental stage, risk-taking behaviour, their risk and protective factors, and the environment around them.

In the 2020 school year, 90% of eligible students received a HEEADSSS assessment, a similar rate to the previous year.

Proportion of eligible Year 9 students receiving HEEADSSS assessment

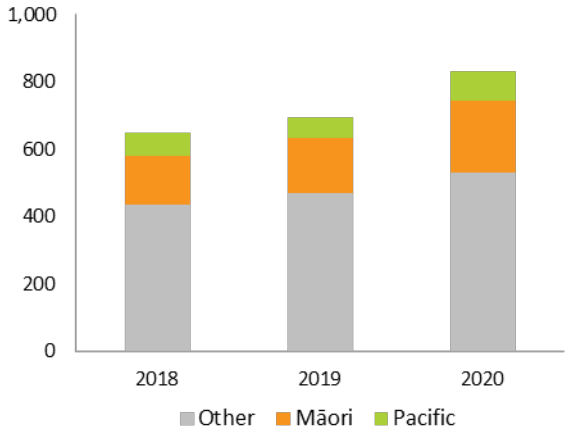


Alcohol is the most commonly used recreational drug in New Zealand, and young people are at a higher risk of harm from alcohol use than older adults.

Identifying and monitoring alcohol-related emergency department (ED) presentations enables DHBs to better understand the impact of excessive alcohol consumption on young people. It is a starting point to encourage DHBs to move toward more extensive screening, brief intervention and referrals, including to primary care and community care.

There were more alcohol-related ED admissions recorded in 2020 than previous years, but this is likely due to vast improvements in alcohol data recording in our EDs rather than an actual increase in numbers, especially given the lower numbers of overall ED attendances during the COVID-19 outbreak in early 2020.

Alcohol related ED admissions for youth aged 10-24 years



APPENDIX B: STATEMENT OF PERFORMANCE EXPECTATIONS WAITEMATĀ DHB 2021/22

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for 2021/22.

Measures in our SPE represent those outputs/activities we deliver to meet our goals and objectives in Section 2 and our Statement of Intent (Appendix A), and provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators. Performance measures are concerned with the volume (V), quality (Q), timeliness (T) and population coverage (C) of service delivery. Actual performance against these measures will be reported in our audited Annual Report at year end.

The Crown Entities Act 2004 requires the SPE to include forecast financial statements for the financial year, prepared in accordance with generally accepted accounting practice. Our forecast financial statements for the year ended 30 June 2022 (Appendix C) and the Financial Performance Summary table (Section 2) form part of our 2021/22 SPE.

Four Output Classes (Prevention, Early Detection and Management, Intensive Assessment, and Treatment and Rehabilitation and Support) are to be used by all DHBs to reflect the nature of services provided. These classes include outputs we propose to supply in the financial year and are directly funded (in whole or in part) by the Crown in accordance with: an appropriation for the purpose; by grants distributed under any Act, or by levies, fees, or charges prescribed by or under any Act.

Statistics New Zealand and the Ministry of Health released updated population estimates and projections in late 2020 based on the 2018 Census. Many of our measures and targets rely on this data, so there may be changes in both performance and target data when comparing this Plan to previous plans and reports.

The COVID-19 outbreak in early 2020 saw a significant reduction in clinical activity because of restrictions under the lockdown period, the re-purposing of staff and facilities for COVID-19 functions, and members of the public choosing not to access health services. Data collection was also affected. This has affected the performance of many 2019/20 results, therefore the 2019/20 baseline result may not be an accurate indicator of expected 2021/22 performance. Measures significantly affected by COVID-19 have been identified in the footnotes.

In August 2021, the Government announced the introduction of the Health System Indicators framework to replace the previous national Health Targets as the new monitoring and reporting framework for the health and disability system. This is an initial set of 12 high level, national indicators focused on the Government's priority areas, listed in the table below. The first update will be published in December 2021 and will report by DHBs for the July-September quarter of 2021/22. The Ministry and the Health, Safety and Quality Commission will work with the Transition Unit and sector stakeholders during 2021/22 to further develop the framework and ensure it complements overarching monitoring and accountability arrangements for the health and disability system.

Government priority	High-level indicator	Description
Improving child wellbeing	Immunisation rates for children at 24 months	Percentage of children who have all their age-appropriate schedule vaccinations by the time they are two years old
	Ambulatory sensitive hospitalisations for children (age range 0-4)	Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community
Improving mental wellbeing	Under 25s able to access specialist mental health services within three weeks of referral	Percentage of child and youth accessing mental health services within three weeks of referral
	Access to primary mental health and addiction services	In development
Improving wellbeing through prevention	Ambulatory sensitive hospitalisations for adults (age range 45-64)	Rate of hospital admissions for people aged 45-64 for an illness that might have been prevented or better managed in the community
	Participation in the bowel screening	In development

Government priority	High-level indicator	Description
	programme	
Strong and equitable public health system	Acute hospital bed day rate	Number of days spent in hospital for unplanned care including emergencies
	Access to planned care	People who had surgery or care that was planned in advance, as a percentage of the agreed number of events in the delivery plan
Better primary health care	People report they can get primary care when they need it	Percentage of people who say they can get primary care from a GP or nurse when they need it
	People report being involved in the decisions about their care and treatment	Percentage of people who say they felt involved in their own care and treatment with their GP or nurse
Financially sustainable health system	Annual surplus/deficit at financial year end	Net surplus/deficit as a percentage of total revenue
	Variance between planned budget and year end actuals	Budget versus actuals variance as a percentage of budget

Performance measurement framework

Our focus for 2021/22 is on delivering the key targets identified in our performance framework, which will ultimately result in better health for our population, measured by our two long term outcomes:

- an increase in life expectancy
- a reduction in the ethnic gap in life expectancy.

Targets and achievements

Targets and comparative baseline data for each of the output measures are included in the following sections. Measures with a target of Ω are demand driven, where it is not appropriate to set a target.

We use a grading system to rate performance against each measure. This helps to identify measures where performance was very close to target versus those where under-performance was more significant. The criteria to allocate grades are as follows.

Criteria		Rating	
On target or better		Achieved	
95–99.9%	0.1–5% away from target	Substantially achieved	
90–94.9%	5.1–10% away from target*	Not achieved but progress made	
<90%	>10% away from target**	Not achieved and no progress made	

*and improvement on previous year

** or 5.1–10% away from target and no improvement on previous year

Output class 1: Prevention Services

Preventative services protect and promote health by targeting changes to physical and social environments that engage and support individuals to make healthier choices. Prevention services include: health promotion to prevent illness and reduce unequal outcomes; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services, e.g. immunisation and screening services. By supporting people to make healthy choices and maintain good health, effective prevention can significantly improve health outcomes. The DHB works with the Auckland Regional Public Health Service to promote and protect wellness and prevent disease.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Health promotion			
% of PHO-enrolled patients who smoke are offered brief advice to stop smoking in the last 15 months	C	79%	90%
% of PHO-enrolled patients who smoke and are referred to smoking cessation providers	Q	5%	6%
% of PHO-enrolled patients who smoke and are prescribed smoking cessation medications	Q	7%	12%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	193	231
Number of clients engaged with Green Prescriptions	V	4,900[5]	4,618
% of clients engaged with Green Prescriptions	C		
- *Māori*		*13%*	*13%*
- *Pacific*		*15%*	*12%*
- *South Asian*		*6%*	*8%*
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy	C	54%	50%
- *Māori*		*32%*	
- *Pacific*		*39%*	
- *Asian*		*66%*	
% of pregnant women receiving influenza vaccination in pregnancy	C	44%	50%
- *Māori*		*26%*	
- *Pacific*		*39%*	
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness	C	18%	30%
- *Māori*		*10%*	
- *Pacific*		*9%*	
% of eight months olds will have their primary course of immunisation on time	C	93%	95%
- *Māori*		*87%*	
- *Pacific*		*92%*	
% of five year olds will have their primary course of immunisation on time	C	89%	95%
- *Māori*		*86%*	
- *Pacific*		*88%*	
- *Asian*		*93%*	
Rate of HPV immunisation coverage	C	68%[6]	75%
Population-based screening			
% of women aged 45-69 years having a breast cancer screen in the last 2 years	C	66%[5]	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	69%[5]	80%
HEEADSSS assessment coverage in DHB-funded school health services	C	90%[6]	95%
% of 4 year olds receiving a B4 School Check	C	68%[5]	90%
Bowel cancer screening			
% of people aged 60-74 years invited to participate who returned a correctly completed kit[7]	Q	61%	60%
- *Māori*		*63%*	
- *Pacific*		*49%*	
- *Asian*		*55%*	
- *Other*		*64%*	
% 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	T	95%	95%

[5] The performance of this measure was significantly affected by COVID-19 in 2019/20.
[6] 2019 school year.
[7] Proportion of people invited to take part in the programme who were screened in the two years prior to the reporting period.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Auckland Regional Public Health Service[8]			
Number of alcohol licence applications and renewals (on, off club and special) that were processed	V	3,625	Ω
Number of tobacco/vaping retailer compliance checks conducted	V	184	300
% of smear-positive pulmonary tuberculosis cases contacted by a public health nurse within 3 days of clinical notification	T	95%	90%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	96%	90%
% of COVID-19 confirmed cases that started isolation/quarantine within 48 hours after notification (time case notification to isolation/quarantine of contact P002)	T	New indicator	80%

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various settings, including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. Access to these services ensures that those at risk, or with disease onset, are recognised early and their condition is appropriately managed. Early detection and management services also enable patients to maintain their functional independence with less invasive intervention.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Primary health care			
Rate of primary care enrolment in Māori	C	83%	95%
% of newborn babies enrolled with a general practice or primary health organisation (PHO) at 3 months of age	C	93%	85%
- *Māori*		79%	
- *Pacific*		82%	
Primary Options for Acute Care (POAC) utilisation rate	V	1.60%	3%
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices who does not have an HbA1c recorded in the last 15 months	C	12%	<8%
- *Māori*		*19%*	
- *Pacific*		*14%*	
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol	Q	63%	60%
- *Māori*		*49%*	
- *Pacific*		*49%*	
% of the highest priority (priority 1) patients who are not known to retinal screening, in Waitematā DHB clinics	C	300[9]	≤151
- *Māori*		77[9]	≤39
- *Pacific*		110[9]	≤55
- *Asian*		46[9]	≤23
- *Other*		67[9]	≤34
% of Māori and Pacific patients with prior CVD who are prescribed triple therapy	Q		70%
- *Māori*		59%	
- *Pacific*		67%	
Pharmacy			
Number of prescription items subsidised	V	8,165,354	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	34,003	Ω
Number of community laboratory tests	V	4,013,632	Ω
Oral health[10]			
% of preschool children enrolled in DHB-funded oral health services	C	98%	95%
- *Māori*		*75%*	
- *Pacific*		*96%*	
- *Asian*		*93%*	

[8] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.
[9] Baseline is data as at March 2021.
[10] To align with the school year, all baseline results are for the calendar year prior to the end of each financial year, i.e. CY2019.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 - *Māori* - *Pacific* - *Asian*	Q	0.61 *0.85* *0.79* *0.63*	<0.56
% of children caries free at five years of age - *Māori* - *Pacific* - *Asian*	Q	58% *49%* *38%* *47%*	65%
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years	C	68%	85%

Output class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by specialist providers in facilities that co-locate clinical expertise and specialised equipment, such as a hospital or surgery centre. These services include ambulatory, ED and inpatient services (acute and elective streams), such as diagnostic, therapeutic and rehabilitative services. Effective and prompt resolution of medical and surgical emergencies and treatment of significant conditions reduces mortality, restores functional independence and improves health-related quality of life, thereby improving population health.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Acute services			
Number of ED attendances	V	122,215[5]	Ω
% of ED patients discharged, admitted or transferred within six hours of arrival	T	96%	95%
% of patients who 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	T	89%	90%
% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7)	Q	12.9%	12%
% of ACS inpatients receiving coronary angiography within 3 days	T	76%	70%
Maternity			
Number of births in Waitematā DHB hospitals	V	6,627	Ω
% of babies exclusively breastfed on discharge	Q	75%	>75%
Elective (inpatient/outpatient)			
Number of planned care interventions (V) - *Inpatient surgical discharges* - *Minor procedures* - *Non-surgical interventions*	V	32,032 *19,413* *12,619* *0*	TBC
% of accepted referrals receiving their CT scan within 6 weeks	T	63%[5]	95%
% of accepted referrals receiving their MRI scan within 6 weeks	T	83%[5]	90%
% of people receiving urgent diagnostic colonoscopy in 14 days	T	99%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days	T	42%[5]	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	15.4%[5]	0%
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	n/a[11]	80%
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision	Q	n/a[11]	100%
% of hip and knee procedures given right antibiotic in right dose	Q	n/a[11]	95%
% of positive responses to the National Adult Hospital Survey question: '*Did those involved in your care ask you how to say your name if they were uncertain?*'	Q	79%[12]	80%
Palliative care, in-hospital			
Total number of referrals	V	1,387	Ω
Referral to response (mean time from referral to first contact with referrer)	T	7.6 h	≤6 h
Referral to assessment (mean time from referral to first face-to-face patient assessment)	T	9.25 h	≤24 h

[11] In response to the COVID-19 pandemic, the Health Quality & Safety Commission temporarily suspended the requirement for DHBs to report on manually collected quality and safety marker measures from 23 March to 30 June 2020, therefore 2019/20 results are unavailable.
[12] Result for the three months to Feb-2021.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Mental health			
% of population who access Mental Health services	C		
- Age 0–19 years		3.69%[5]	≥3.76%
- *Māori*		*5.09%*	≥5.43%
- Age 20–64 years		3.83%	≥3.72%
- *Māori*		*9.03%*	≥8.86%
- Age 65+ years		2.19%	≥2.16%
- *Māori*		*2.40%*	≥2.26%

Output class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination provided by the Needs Assessment and Service Coordination (NASC) Service for a range of services, including palliative care, home-based support, and residential care services. Rehabilitation and support services are provided by the DHB and non-DHB sector, e.g. residential care providers, hospice and community groups. Effective support services restore function and help people to live at home for longer, therefore improving quality of life and reducing the burden of institutional care costs.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Home-based support			
% of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI)	Q	n/a[13]	95%
Palliative care, hospice			
Total number of contacts in the community	V	19.940	Ω
% of patients acutely referred who waited >48 hours for a hospice bed	T	0.5%	<5%
Residential care			
ARC bed days	V	982,979	Ω

[13] Due to COVID-19, service provision in Q4 2019/20 was reduced to minimise transmission risk, and providers were switched to fixed funding rather than fee for service, which means accurate data for this measure is not available for 2019/20.

FINANCIAL PERFORMANCE

In the 2020/21 financial year, Waitematā DHB's operating result, before one-off adjustments for Holiday Pay and COVID-19 impacts, is forecast to be $6m favourable to the planned deficit of $36m.

This operating result, however, will be impaired by unfunded costs of COVID-19, estimated to be $0.2m at 30 June 2021, and further provisions required in relation to the Holidays Act of $24m for the 2020/21 year.

Within each arm of the DHB (principally Funder and Provider), different financial results are expected to be achieved, with the Provider forecasting a deficit of $50.3m, excluding extraordinary costs of $24.0m for the Holidays Act and $5.0m for COVID-19 costs.

This is offset by surpluses in the Funder and Governance Divisions totalling $20.5m, resulting in a DHB deficit of $29.8m, being $6.2m better than the budgeted result before extraordinary costs. This situation of deficits in Provider divisions offset by Funder surpluses is not uncommon in the DHB sector.

The Board recognises that these offsetting results are unacceptable and are not sustainable. Continued adverse variances in the Provider Arm of the DHB necessarily limit the options available to the Board to invest in new services and initiatives, both in the hospital sector and in primary care.

Historically, we have performed well financially, with surpluses generated in the prior years. Continued focus on financial sustainability has contributed significantly to the achievement of prior year surpluses in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

However, the rate of recent population growth, the ageing of the population the DHB serves, the state of our ageing infrastructure and facilities, and requirements for the development of services, facilities and information systems to provide high quality, safe and effective care has increased the financial pressures on the DHB, and the financial challenges are the greatest they have been for several years. Remediation of the Holiday Pay situation will potentially increase the DHB's operating costs by $20m per annum going forward, excluding any other similar increase incurred by our NGO providers.

Construction works are progressing on a number of major facility programmes to redevelop the two hospital sites, the Mason Clinic campus and associated infrastructure. The first of these programmes is the Tōtara Haumaru facility that will see additional theatre, inpatient wards and endoscopy capacity on the North Shore campus.

For the 2021/22 financial year, the DHB is forecasting a $20.7m deficit in the Provider and surplus in the Funder of 1.2m prior to impacts of the Holidays Act and COVID-19.

The 2021/22 deficit of $19.5m prior to extraordinary impacts of COVID-19 and the Holidays Act provisions is an improvement of $16.5m against the 2020/21 budgeted deficit of $36m, and represents a $32.5m improvement in operating terms, because the 2020/21 budget included a one-off $16m gain on sale of property.

Accordingly, the 2021/22 deficit of $19.5m is an improvement of more than half of the 2020/21 operating deficit.

The 2021/22 operating deficit of $19.5m is forecast to be impacted by further extraordinary costs relating to the Holidays Act of $20m and assumes that COVID-19 costs of $98m will be funded.

The Provider result assumes that a $18m savings plan will be achieved. The budgeted result in the Funder also contains risk with regards to IDF payments, NGO demand-driven expenditure, Pay Equity and In Between Travel.

The Board approves any significant savings projects and plans, especially those that are high risk. The CEO and CMO have the Board's delegation to halt any project they believe might affect quality or patient outcome.

At an operational level, the savings plan is monitored by the Financial Sustainability Governance Group, which is chaired by the Director of Hospital Services. The Executive Leadership Team receives a regular report on progress against the plan.

Improving the financial performance of the Provider Arm is being delivered via a series of tactical, operational and strategic initiatives. The strategic initiatives are developed with senior management and clinicians, with a high degree of focus on improving patient care as well as improving financial performance. The Board will not compromise patient care and safety in its endeavours to improve financial performance.

The financial challenges facing the DHB are considerable, and as noted above, the current performance of the Provider Arm is not sustainable.

The challenges we face include:

- A reduction in Waitematā DHB's estimated population led to a reduction in the share of population-based funding received in 2020/21, which in has an ongoing impact in revenue for 2021/22. Therefore, despite the Vote Health uplift being significantly greater for the sector, Waitematā DHB received the same dollar uplift in 2020/21 as it did for 2019/20.
- Increased personnel costs for Care Capacity Demand Management (CCDM).
- Continuing clinical wage settlement and contractual increases.
- High population growth, particularly in the 65+ age group, is driving service demand with a lagging funding stream.
- Critical restraint in regional IT infrastructure.
- Investment in facilities to replace those not fit for purpose and to accommodate growth.
- Increases in National Price from the NCCP review increased IDF net outflows by $24m in the 2020/21 financial year and is anticipated to repeat in 2021/22.

Key assumptions for financial projections

Revenue Growth

Key assumptions on the DHB revenue from the MoH are as following:

- DHB revenue increase for CCP and demographic growth as per the funding envelope for 2021/22 and not be less in absolute value than that indicated.
- Revenue in out years will not be less in absolute value than that indicated for 2021/22 and increase by 2% year on year
- That $98m of funding will be provided to cover $98m of anticipated COVID-19 related costs.
- That funding for DHB sustainability indicated in 2020/21 will be provided in 2021/22.

Expenditure Growth

Expenditure growth excluding Holiday Pay and additional costs of COVID-19 $53.6m (2.5%) above 2020/21 forecast expenditure is planned for the DHB. This is driven by: demographic growth-related cost pressure on the services we provide; demographic growth impact on demand-driven third party contracts; clinical staff volume growth to meet service growth requirements; costs for staff employment contract agreements and step increases and inflationary pressure on clinical and non-clinical supplies and service contracts. Key expenditure assumptions also include the below.

- The impact of Care Capacity Demand Management (CCDM), which is expected to add 122 FTEs in the latter part of 2020/21, with full-year effect in 2021/22.
- Impact on personnel costs of all settled employment agreements, automatic step increases and new FTEs, estimated provisions for expired employment contracts and of employment agreements expiring during the planning period.
- Clinical supplies cost growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. Costs also reflect the impact of volume growth in services provided by us and are mitigated by the impact of procurement cost savings initiatives.
- That staff cost (MECA) increases will be aligned with planned settlements of current employment negotiations.
- The 2021/22 plan includes extraordinary costs relating to the Holidays Act of $20m and additional COVID-19 related costs of $98m.

Forecast Financial Statements

The Board of Waitematā DHB is responsible for the issue of the forecast financial statements, including the appropriateness of the assumptions underlying the forecast financial statements.

These forecasts include a further provision of $20m of extraordinary cost in relation to Holiday Pay in 2021/22.

Financial statements were prepared to comply with the requirements of Section 139 of the Crown Entities Act. The forecast financial statements may not be appropriate for use for any other purpose.

In line with requirements of Section 149G of the Crown Entities Act 2004, we provide both the financial statements of Waitematā DHB and its subsidiaries (together referred to as 'Group') and Waitematā DHB's interest in associates and jointly controlled entities.

The Waitematā DHB group consists of the parent, Waitematā District Health Board and Three Harbours Health Foundation (controlled by Waitematā District Health Board). Joint ventures are with healthAlliance N.Z. Limited and HealthSource New

Zealand Limited; Awhina Waitakere Health Campus is a jointly controlled operation. The associate companies are Northern Regional Alliance Limited formerly called Northern DHB Support Agency Limited (NDSA).

The tables below provide a summary of the financial statements for the audited result for 2019/20, year-end forecast for 2020/21, planned results for 2021/22 and out years 2022/23 to 2024/25. The financial statements have been prepared on the basis of the Key Assumptions for Financial Forecasts and the significant accounting policies summarised in the Statement of Accounting Policies. The actual financial results achieved for the period covered are likely to vary from the forecast/plan financial results presented. Such variations may be material.

Summary Forecast Statement of comprehensive income – group

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Funding	1,937,505	2,060,885	2,227,058	2,265,102	2,310,258	2,344,678
Total Expenditure before extraordinary items	1,935,103	2,090,689	2,246,558	2,265,102	2,310,258	2,344,678
Net Surplus/(Deficit) before extraordinary items	**402**	**(29,804)**	**(19,500)**	**0**	**0**	**0**
Approved Operating Budget	**Breakeven**	**(36,000)**	**(25,000)***	0	0	0
Performance against Plan Favourable/ (Unfavourable)	**402**	**6,196**	**5,500**	**0**	**0**	**0**
COVID-19 and Holiday Pay Expense	68,600	**24,204**	**20,000**	**0**	**0**	**0**
TOTAL RESULT	**(68,198)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**

* Per year two of 2021/22 approved plan.

Forecast Statement of comprehensive income – group

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Government and Crown Agency Revenue	1,815,097	1,907,238	2,092,738	2,135,405	2,178,030	2,209,870
Patient Sourced and Other Income	28,530	47,480	32,437	25,798	26,266	26,746
IDFs & Inter DHB Provider Income	93,878	106,167	101,883	103,899	105,962	108,062
Total Funding	**1,937,505**	**2,060,885**	**2,227,058**	**2,265,102**	**2,310,258**	**2,344,678**
Personnel Costs	789,356	822,767	846,806	837,749	854,738	872,067
Outsourced Costs	92,460	100,124	104,902	106,954	109,054	113,934
Clinical Supplies Costs	134,297	140,670	150,830	151,787	154,787	157,835
Infrastructure & Non-Clinical supplies Costs	109,061	103,350	74,539	82,042	83,425	70,448
Payments to Other Providers	880,529	947,982	1,089,481	1,086,570	1,108,254	1,130,394
Total Expenditure	**2,005,703**	**2,114,893**	**2,266,558**	**2,265,102**	**2,310,258**	**2,344,678**
Net Surplus / (Deficit)	**(68,198)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**
Other Comprehensive Income	0					
Gains/(Losses) on Property Revaluations	0	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**(68,198)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**

Notes:

- 2019/20 result contains $41.8m for Holiday Pay Remediation Provision and $28.8m for COVID-19-related costs.
- 2020/21 forecast result contains $24m for Holiday Pay Remediation Provision and $0.2m for COVID-19-related costs.
- 2021/22 forecast result contains $20m for Holiday Pay Remediation Provision and $98m will be provided to fully offset $98m anticipated COVID-19-related costs.

Forecast Statement of comprehensive income – parent

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Government and Crown Agency Revenue	1,815,097	1,907,238	2,092,738	2,135,405	2,178,030	2,209,870
Patient Sourced and Other Income	28,031	47,480	32,437	25,798	26,266	26,746
IDFs & Inter DHB Provider Income	93,878	106,167	101,883	103,899	105,962	108,062
Total Funding	**1,937,006**	**2,060,885**	**2,227,058**	**2,265,102**	**2,310,258**	**2,344,678**
Personnel Costs	789,356	822,767	846,806	837,749	854,738	872,067
Outsourced Costs	92,959	100,124	104,902	106,954	109,054	113,934
Clinical Supplies Costs	134,297	140,670	150,830	151,787	154,787	157,835
Infrastructure & Non-Clinical supplies Costs	109,061	103,350	74,539	82,042	83,425	70,448
Payments to Other Providers	880,529	947,982	1,089,481	1,086,570	1,108,254	1,130,394
Total Expenditure	**2,006,202**	**2,114,893**	**2,266,558**	**2,265,102**	**2,310,258**	**2,344,678**
Net Surplus / (Deficit)	**(69,196)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**
Other Comprehensive Income	0					
Gains/(Losses) on Property Revaluations	0	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**(69,196)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**

Forecast Statement of comprehensive income – governance & funding administration

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Revenue	16,561	16,746	13,231	13,483	13,747	14,011
Expenditure						
Personnel	12,226	11,197	13,873	14,125	14,384	14,662
Outsourced services	8,178	8,802	6,616	6,736	6,856	6,976
Clinical supplies	7	10	14	14	14	14
Infrastructure & non clinical supplies	(6,237)	(5,943)	(7,272)	(7,392)	(7,507)	(7,641)
Total Expenditure	**14,174**	**14,066**	**13,231**	**13,483**	**13,747**	**14,011**
Surplus/(Deficit)	**2,387**	**2,680**	**0**	**0**	**0**	**0**

Forecast Statement of comprehensive income – provider

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Income						
MoH via Funder	930,030	970,170	998,159	1,044,022	1,064,902	1,086,190
MoH Direct	42,766	31,923	71,230	72,623	74,040	63,832
Other	48,339	76,245	53,757	48,404	49,315	50,251
Total Income	**1,021,135**	**1,078,338**	**1,123,146**	**1,165,049**	**1,188,257**	**1,200,273**
Expenditure						
Personnel	777,130	811,570	832,933	823,624	840,354	857,405
Outsourced services	84,282	91,322	98,286	100,218	102,198	106,958
Clinical supplies	134,290	140,660	150,816	151,773	154,773	157,821
Infrastructure & non clinical supplies	115,298	109,293	81,811	89,434	90,932	78,089
Total expenditure	**1,111,000**	**1,152,845**	**1,163,846**	**1,165,049**	**1,188,257**	**1,200,273**
Surplus / (Deficit)	**(89,865)**	**(74,507)**	**(40,700)**	**0**	**0**	**0**

Notes:

- 2019/20 result contains $41.8m for Holiday Pay Remediation Provision and $28.8m for COVID-19-related costs.
- 2020/21 forecast result contains $24m for Holiday Pay Remediation Provision and $0.2m for COVID-19-related costs.
- 2021/22 forecast result contains $20m for Holiday Pay Remediation Provision and assumes $16m will be provided to fully offset $16m of anticipated COVID-19-related costs.

Forecast Statement of comprehensive income – funder

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Income						
Revenue	1,846,061	1,952,645	2,102,011	2,144,015	2,186,843	2,230,535
Expenditure						
Personal Health	1,315,705	1,375,466	1,460,057	1,490,713	1,520,782	1,551,464
Mental Health	241,848	260,414	273,122	278,450	283,864	289,387
DSS	226,069	233,420	261,403	266,550	271,796	277,148
Public Health	23,301	45,076	89,208	90,940	92,703	94,502
Māori Health	3,636	3,776	3,850	3,939	4,011	4,083
Governance	16,222	16,674	13,171	13,423	13,687	13,951
Total Expenditure	**1,826,781**	**1,934,826**	**2,100,811**	**2,144,015**	**2,186,843**	**2,230,535**
Surplus/(Deficit)	**19,280**	**17,819**	**1,200**	**0**	**0**	**0**

Notes:

- 2021/22 forecast assumes funding of $82m will be provided to fully offset $82m of anticipated COVID-19 related costs.

Forecast capital costs

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Depreciation	28,927	30,000	31,853	33,252	33,252	33,924
Capital Charge	29,315	21,634	20,004	23,220	29,580	31,872
Capital Costs	**58,242**	**51,634**	**51,857**	**56,472**	**62,832**	**65,796**

Capital costs are expected to increase with additional capital investments. The increase in depreciation charge is mainly due to our accelerated facilities programme and continued investment in facilities and equipment.

Waitematā DHB is required to revalue its land and building assets in accordance with the New Zealand Equivalent to International Accounting Standard 16 Land and Buildings, Plant and Equipment (NZIAS 16) every three to five years. The three-year cycle for detailed revaluation exercises for Waitematā DHB was last prepared on 30 June 2018 and will be due on 30 June 2021. The effects of the asset revaluation due at 30 June 2021 were not incorporated into the plan for 2021/22.

Forecast statement of cashflows – parent

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,912,292	2,006,895	2,194,621	2,239,304	2,283,992	2,317,932
Other Income	17,451	46,552	26,735	20,000	20,360	20,732
Interest received	1,596	672	352	352	352	352
Payments for Personnel	(722,580)	(775,042)	(806,472)	(837,749)	(854,738)	(872,067)
Payments for Supplies	(1,136,724)	(1,224,427)	(1,365,495)	(1,370,881)	(1,392,688)	(1,406,815)
Capital Charge Paid	(28,834)	(21,398)	(20,004)	(23,220)	(29,580)	(31,288)
GST Input Tax	417	(15)	0	0	0	0
Net cashflow from operating activities	**43,618**	**33,237**	**29,737**	**27,806**	**27,698**	**28,846**
Cashflow from investing activities						
Sale of Fixed Assets	0	38,832	0	0	0	0
Capital Expenditure (-ve)	(46,837)	(76,599)	(163,486)	(199,436)	(81,806)	(30,000)
Acquisition of investments	(7,144)	0	0	0	0	0
Net cashflow from investing activities	**(53,981)**	**(37,767)**	**(163,486)**	**(199,436)**	**(81,806)**	**(30,000)**
Cashflow from financing activities						
Capital contributions from the Crown	26,050	**24,400**	**57,660**	**167,500**	**88,600**	**0**
Proceeds from borrowings	0	0	0	0	0	0
Repayment of borrowings	0	0	0	0	0	0
Net cashflow from financing activities	**26,050**	**24,400**	**57,660**	**167,500**	**88,600**	**0**
Net cash movements	**15,687**	**19,870**	**(76,089)**	**(4,130)**	**34,492**	**(1,154)**
Cash and cash equivalents at the start of the year	36,685	52,372	72,242	(3,847)	(7,977)	26,515
Cash and cash equivalents at the end of the year	**52,372**	**72,242**	**(3,847)**	**(7,977)**	**26,515**	**25,361**

Forecast statement of cashflows – group

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,912,292	2,006,895	2,194,621	2,239,304	2,283,992	2,317,932
Other Income	17,275	46,552	26,735	20,000	20,360	20,732
Interest received	1,596	672	352	352	352	352
Payments for Personnel	(722,580)	(775,042)	(806,472)	(837,749)	(854,738)	(872,067)
Payments for Supplies	(1,136,724)	(1,224,427)	(1,365,495)	(1,370,881)	(1,392,688)	(1,406,815)
Capital Charge Paid	(28,834)	(21,398)	(20,004)	(23,220)	(29,580)	(31,288)
GST Input Tax	417	(15)	0	0	0	0
Interest payments	0	0	0	0	0	0
Net cashflow from operating activities	**43,442**	**33,237**	**29,737**	**27,806**	**27,698**	**28,846**
Cashflow from investing activities						
Sale of Fixed Assets	0	38,832	0	0	0	0
Capital Expenditure (-ve)	(46,837)	(76,599)	(163,486)	(199,436)	(81,806)	(30,000)
Acquisition of investments	(7,144)	0	0	0	0	0
Net cashflow from investing activities	**(53,981)**	**(37,767)**	**(163,486)**	**(199,436)**	**(81,806)**	**(30,000)**
Cashflow from financing activities						
Capital contributions from the Crown	26,050	24,400	57,660	167,500	88,600	0
Proceeds from borrowings	0	0	0	0	0	0
Repayment of borrowings	0	0	0	0	0	0
Net cashflow from financing activities	**26,050**	**24,400**	**57,660**	**167,500**	**88,600**	**0**
Net cash movements	**15,511**	**19,870**	**(76,089)**	**(4,130)**	**34,492**	**(1,154)**
Cash and cash equivalents at the start of the year	41,053	56,564	76,434	345	(3,785)	30,707
Cash and cash equivalents at the end of the year	**56,564**	**76,434**	**345**	**(3,785)**	**30,707**	**29,553**

Forecast statement of financial position – parent

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Current Assets	139,035	147,567	74,264	104,540	174,230	208,814
Non-current assets	801,141	846,900	954,175	1,119,091	1,165,705	1,158,825
Total assets	**940,176**	**994,467**	**1,028,439**	**1,223,631**	**1,339,935**	**1,367,639**
Current Liabilities	285,331	531,070	543,982	568,774	593,578	618,382
Non-current liabilities	211,723	47,600	50,500	53,400	56,300	59,200
Total liabilities	**497,054**	**578,670**	**594,482**	**622,174**	**649,878**	**677,582**
Net assets	**443,122**	**415,797**	**433,957**	**601,457**	**690,057**	**690,057**
Total equity	**443,122**	**415,797**	**433,957**	**601,457**	**690,057**	**690,057**

Forecast statement of financial position – group

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Current Assets	146,939	155,471	82,168	112,444	182,134	216,718
Non-current assets	812,164	857,923	965,198	1,130,114	1,176,728	1,169,848
Total assets	**959,103**	**1,013,394**	**1,047,366**	**1,242,558**	**1,358,862**	**1,386,566**
Current Liabilities	287,231	532,970	545,882	570,674	595,478	620,282
Non-current liabilities	211,723	47,600	50,500	53,400	56,300	59,200
Total liabilities	**498,954**	**580,570**	**596,382**	**624,074**	**651,778**	**679,482**
Net assets	**460,149**	**432,824**	**450,984**	**618,484**	**707,084**	**707,084**
Total equity	**460,149**	**432,824**	**450,984**	**618,484**	**707,084**	**707,084**

Disposal of land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, Waitematā DHB will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. Waitematā DHB will comply with the relevant protection mechanism that addresses the Crown's obligations under Te Tiriti o Waitangi and any processes related to the Crown's good governance obligations in relation to Māori sites of significance.

Statement of movement in equity – parent

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Balance at 1 July	**486,268**	**443,122**	**415,797**	**433,957**	**601,457**	**690,057**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	(69,196)	(54,008)	(39,500)	0	0	0
Other Comprehensive income	0	0	0	0	0	0
Total Comprehensive Income	**(69,196)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown	26,050	24,400	57,660	167,500	88,600	0
Repayments of capital to the Crown	0	0	0	0	0	0
Movement in Trust and Special Funds	**0**	**2,283**	**0**	**0**	**0**	**0**
Balance at 30 June	**443,122**	**415,797**	**433,957**	**601,457**	**690,057**	**690,057**

Statement of movement in equity – group

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Balance at 1 July	**502,297**	**460,149**	**432,824**	**450,984**	**618,484**	**707,084**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	(68,198)	(54,008)	(39,500)	0	0	0
Other Comprehensive income	0	0	0	0	0	0
Total Comprehensive Income	**(68,198)**	**(54,008)**	**(39,500)**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown	26,050	24,400	57,660	167,500	88,600	0
Repayments of capital to the Crown	0	0	0	0	0	0
Movement in Trust and Special Funds	**0**	2,283	**0**	**0**	**0**	**0**
Balance at 30 June	**460,149**	**432,824**	**450,984**	**618,484**	**707,084**	**707,084**

Additional information

Capital expenditure

	2019/20 Audited $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Funding Sources						
Free cashflow from depreciation	28,927	30,000	31,853	33,252	33,252	33,924
External Funding	26,050	24,400	57,660	167,500	88,600	0
Inflow from sale of fixed asset	0	38,832	0	0	0	0
Cash reserves	43,618	33,237	29,737	40,062	40,746	42,434
Total Funding	**98,595**	**126,469**	**119,250**	**240,814**	**162,598**	**76,358**
Baseline Capital Expenditure						
Land	0	0	0	0	0	0
Buildings and Plant	(14,987)	(16,674)	(41,089)	(17,865)	(17,865)	(17,865)
Clinical Equipment	(6,561)	(9,098)	(10,127)	(9,747)	(9,747)	(9,747)
Other Equipment	(1,181)	(675)	(1,751)	(723)	(723)	(723)
Information Technology	5,627	(1,341)	(5,660)	(1,437)	(1,437)	(1,437)
Intangible Assets (Software)	0	0	0	0	0	0
Motor Vehicles	(923)	(213)	0	(228)	(228)	(228)
Total Baseline Capital Expenditure	**(18,025)**	**(28,001)**	**(58,627)**	**(30,000)**	**(30,000)**	**(30,000)**
Strategic Investments						
Land	(16,373)	0	0	0	0	0
Buildings and Plant	(12,439)	(48,598)	(104,859)	(169,436)	(51,806)	0
Clinical Equipment	0	0	0	0	0	0
Other Equipment	0	0	0	0	0	0
Information Technology	0	0	0	0	0	0
Intangible Assets (Software)	0	0	0	0	0	0
Motor Vehicles	0	0	0	0	0	0
Total Strategic Capital Expenditure	**(28,812)**	**(48,598)**	**(104,859)**	**(169,436)**	**(51,806)**	**0**
Total Capital Payments	**(46,837)**	**(76,599)**	**(163,486)**	**(199,436)**	**(81,806)**	**(30,000)**

Banking facilities

Shared commercial banking services

Waitematā DHB is in the shared commercial banking arrangements with various other DHBs, the Bank of New Zealand ('BNZ') and New Zealand Health Partnerships Limited. The BNZ provide banking services to the sector, managed by New Zealand Health Partnerships Limited. DHBs are no longer required to maintain separate standby facilities for working capital.

Statement of accounting policies

Statement of accounting policies for the year ended 30 June 2020

Reporting entity

The Waitematā District Health Board (the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate controlling entity is the New Zealand Crown. The consolidated financial statements of Waitematā DHB for the year ended 30 June 2020 comprise Waitematā DHB and its subsidiaries (together referred to as the 'Group'). The Group consists of the controlling entity, Waitematā District Health Board and Three Harbours Health Foundation.

The Waitematā District Health Board's primary objective is to deliver health, disability, and mental health services to the community within its district. The group does not operate to make a financial return. Accordingly, the DHB and Group are public benefit entities (PBE) for financial reporting purposes. The DHB's subsidiary, associates and joint arrangements are incorporated and domiciled in New Zealand.

Measurement base

The financial statements were prepared on a historical cost basis, except for items identified below which were measured at fair value.

Presentation currency and rounding

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

Changes in accounting policies and disclosures – New and amended standards and interpretations

The Group has not early adopted any standards, interpretations or amendments that have been issued but are not yet effective.

Standards issued and not yet effective, and not early adopted

Amendment to PBE IPSAS 2 Statement of Cash Flows

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

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. Waitematā DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2020. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Waitematā DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

Subsidiaries

Subsidiaries are entities controlled by Waitematā DHB that are exposed, or have rights to variable benefits from its involvement with the other entity and has the ability to affect the nature or amount of those benefits through its power over the other entity. These financial statements include Waitematā DHB and its subsidiaries, the acquisition of which are accounted for using the acquisition method. The effects of all significant intercompany transactions between entities are eliminated on consolidation. In Waitematā DHB's financial statements, investments in subsidiaries are recognised at cost less any impairment losses.

Joint arrangements

Investments in joint arrangements are classified as either joint ventures or joint operations. The classification depends on the contractual rights and obligations of each investor.

Joint Venture

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint control is the agreed sharing of control of an arrangement by way of a binding arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control. Where the joint venture's results are material, the DHB includes the interest in the joint venture in the consolidated financial statements, using the equity method, from the date that joint control commences until the date that joint control ceases. The investments in joint ventures are accounted for in the parent entity financial statements at cost.

Joint Operation

A joint operation is a joint arrangement whereby the parties that have joint control of the arrangement recognise their direct right to the assets, liabilities, revenues and expenses of joint operations and their share of any jointly held or incurred assets, liabilities, revenues and expenses. These have been incorporated in the financial statements under the appropriate headings.

Associates

An associate is an entity over which the DHB has significant influence and that is neither a controlled entity nor an interest in a joint arrangement. The investment in an associate is recognised at cost of the investment plus the DHB's share of the change in the net assets of associates on an equity accounted basis, from the date that the power to exert significant influence commences until the date that the power to exert significant influence ceases. When The DHB's share of losses exceeds its interest in an associate, The DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that The DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Revenue

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

Revenue from exchange transactions

MoH population-based revenue

The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within the Waitematā region. MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

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. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks. 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. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC contracted revenue

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

Revenue from other DHBs

Inter district patient inflow revenue is recognised when a patient treated within the Waitematā DHB region is domiciled outside of Waitematā district. The Ministry credits Waitematā DHB with a monthly amount based on estimated patient treatment for non-domiciled Waitematā residents within the Waitematā district. An annual wash up occurs at year end to reflect the actual revenue for non Waitematā-domiciled patients treated within the Waitematā district.

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 when the transaction outcome can be estimated reliably. Revenue from these services is recognised in proportion to the completion stage in the Statement of Comprehensive Revenue and Expense.

Non exchange transactions

Donated services

Certain operations of the DHB are reliant on services provided by volunteers. Volunteers' services received are not recognised as revenue or expenditure by the DHB.

Capital charge

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

Borrowing costs

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

Leases

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 where the DHB is the lessee 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 on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether the 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.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. 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 as a reduction of rental expense over the lease term.

Foreign currency transactions

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

Financial Instruments – Initial recognition and subsequent measurement

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Financial Assets

Initial recognition

Financial assets are classified, at initial recognition, as 'measured at amortised cost', 'fair value through other comprehensive revenue and expense' and 'fair value through surplus or deficit'. See discussion below for determination of classification. A financial asset is initially measured at its fair value plus, in the case of a financial asset not at fair value through surplus or deficit, transaction costs that are directly attributable to the acquisition or issue of the financial asset or financial liability.

Subsequent measurement

Financial assets at amortised cost

This category is the most relevant to the DHB and Group. The classification of financial assets at amortised cost at initial recognition depends on the financial asset's contractual cash flow characteristics and the business model for managing them. For a financial asset to be classified and measured at amortised cost, it needs to give rise to cash flows that are 'solely payments of principal and interest' on the principal amount outstanding (SPPI). This assessment is referred to as the SPPI test and is performed at an instrument level. The business model for managing financial assets refers to how it manages its financial assets in order to generate cash flows. The business model determines whether cash flows will result from collecting contractual cash flows, selling the financial assets, or both.

Financial assets at amortised cost are subsequently measured using the effective interest rate (EIR) method and are subject to impairment. Gains and losses are recognised in surplus or deficit when the asset is derecognised, modified or impaired. The DHB and Group measure the following financial assets at amortised cost, Cash and cash equivalents, Short Term Deposits, Trade and Other Receivables, Prepayments and Trusts and Special Purpose Funds not recognised at a market value. Cash and cash equivalents includes cash on hand, deposits held at call with banks and with NZ Health Partnerships Limited, other short-term highly liquid investments with original maturities of 3 months or less.

Financial assets at fair value through surplus or deficit

Financial assets at fair value through surplus or deficit include financial assets held for trading, financial assets designated upon initial recognition at fair value through surplus or deficit, or financial assets mandatorily required to be measured at fair value. Financial assets are classified as held for trading if they are acquired for the purpose of selling or repurchasing in the near term. Financial assets with cash flows that are not solely payments of principal and interest are classified and measured at fair value through surplus or deficit, irrespective of the business model. Notwithstanding the criteria for debt instruments to be classified at amortised cost or at fair value through other comprehensive revenue and expense, as described above, debt instruments may be designated at fair value through surplus or deficit on initial recognition if doing so eliminates, or significantly reduces, an accounting mismatch.

Financial assets at fair value through surplus or deficit are carried in the statement of financial position at fair value with net changes in fair value recognised in the statement of surplus or deficit. The DHB and Group has the following financial assets classified at fair value though surplus or deficit, Investments in associates and portfolio investments.

Financial assets at fair value through other comprehensive revenue and expense

Financial assets at fair value through other comprehensive revenue and expenses comprise of those equity instruments that the DHB and Group has elected to classify as fair value through other comprehensive income on initial recognition when they meet the definition of equity instruments. Gains and losses on these financial assets are never recycled to surplus or deficit. Dividends are recognised in surplus or deficit when the right to receive payment has been established. The Group does not hold any financial assets classified at fair value through other comprehensive revenue and expense.

Derecognition

A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is primarily derecognised (i.e., removed from the Group's consolidated statement of financial position) when the rights to receive cash flows from the asset have expired.

Impairment of financial assets

The DHB recognises an allowance for expected credit losses (ECLs) for all debt instruments not held at fair value through surplus or deficit. ECLs are based on the difference between the contractual cash flows due in accordance with the contract and all the cash flows that the DHB and Group expects to receive, discounted at an approximation of the original effective interest rate. ECLs are recognised in two stages. For credit exposures for which there has not been a significant increase in credit risk since initial recognition, ECLs are provided for credit losses that result from default events that are possible within the next 12-months (a 12-month ECL). For those credit exposures for which there has been a significant increase in credit risk since initial recognition, a loss allowance is required for credit losses expected over the remaining life of the exposure, irrespective of the timing of the default (a lifetime ECL).

For trade and other receivables, the DHB and Group applies a simplified approach in calculating ECLs. Therefore, credit risk is not tracked; instead, the DHB and Group recognises a loss allowance based on lifetime ECLs at each reporting date. The DHB and Group has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. The DHB and Group considers a financial asset in default when contractual payments are 90 days past due. However, in certain cases, the DHB and Group may also consider a financial asset to be in default when internal or external information indicates that the DHB and Group is unlikely to receive the outstanding contractual amounts in full before taking into account any credit enhancements held. A financial asset is written off when there is no reasonable expectation of recovering the contractual cash flows.

Financial liabilities at amortised cost

Initial recognition and measurement

Financial liabilities are classified, at initial recognition, as financial liabilities at fair value through surplus or deficit, or at amortised costs, as appropriate. All financial liabilities are recognised initially at fair value and, in the case financial liabilities at amortised cost, net of directly attributable transaction costs. The DHB's and Group's financial liabilities include trade creditors and other payables, borrowings including an overdraft facility which are classified at amortised cost. The DHB has not classified any financial liabilities as financial liabilities through surplus or deficit. Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Subsequent measurement

The measurement of financial liabilities depends on their classification, as described below. This is the category most relevant to the DHB. After initial recognition, financial liabilities at amortised cost are subsequently measured at amortised cost using the effective interest rate (EIR) method. Gains and losses are recognised in surplus or deficit when the liabilities are derecognised as well as through the EIR amortisation process. Amortised cost is calculated by taking into account any discount or premium on acquisition and fees or costs that are an integral part of the EIR. The EIR amortisation is included as finance costs in the statement of surplus or deficit. Short-term payables are recorded at their face value due to the short-term nature of them they are not discounted. A financial liability is derecognised when the obligation under the liability is discharged or cancelled or expires.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Inventories

Inventories held for distribution at no charge or for a nominal charge or consumption in the provision of services to be rendered at no charge or for a nominal charge are measured at cost (using the FIFO method), adjusted, when 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 costs (using the FIFO method) 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 in surplus or deficit in the period of the write-down.

Property, plant, and equipment

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

- Land
- Buildings (including fit outs and underground infrastructure)
- Clinical Equipment
- IT Equipment
- Other Equipment and Motor Vehicles.

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

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value at the reporting date. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued. Land and building revaluation movements are accounted for 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 in other comprehensive revenue and expense but is recognised in the surplus or deficit. 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, and then recognised in other 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 the 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 fair value as at the date of acquisition.

Disposals

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.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the 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.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant and equipment have been estimated as:

- Buildings (including components) 2 to 80 years (1.25%-50%)
- Clinical equipment 3 to 20 years (5%-33%)
- Other equipment and motor vehicles 3 to 15 years (6.67%-33%)
- IT Equipment 5 to 15 years (6.67%-20%).

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter. The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end. Work in progress is recognised at cost, less impairment, and is not amortised.

Intangible assets

Software acquisition and development

Acquired computer software licenses 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 associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

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 useful lives and associated amortisation rates of major classes of intangible assets have been estimated as:

- Acquired software 3 to 5 years (20% - 33%)
- Internally developed software 3 to 5 years (20% - 33%).

Indefinite life intangible assets are not amortised but are reviewed annually for impairment.

Finance, Procurement and Information Management System (formerly National Oracle Solution)

The Finance, Procurement and Information Management System (FPIM), (previously part of the National Oracle Solution programme), is a national initiative, funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Waitematā DHB holds an asset at cost of capital invested by the DHB in FPIM. This investment represents the right to access the FPIM assets and is considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets' standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Impairment of property, plant, and equipment and intangible assets

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

Non-cash generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use. Value in use is determined using an approach based on either a depreciated replacement 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 the information. If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

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 to but not yet taken at balance date, continuing medical education, 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 an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that has created a contractual obligation and a reliable estimate of the obligation can be made.

Long-term 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 long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on the:

- likely future entitlements accruing to staff based on years of service; years to entitlement; and
- 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, continuing medical education, annual leave and vested long service and, sabbatical leave, are classified as a current liability. Non-vested long service leave, sabbatical leave, retirement gratuities, sick leave and continuing medical education 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

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

Defined benefit schemes

The DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the Scheme), which is managed by the Board of Trustees of the National Provident Fund. 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/deficit will affect future contributions by individual employers, as there is no prescribed basis of allocation. The Scheme is therefore accounted for as a defined contribution scheme. If the other participating employers ceased to participate in the Scheme, the employer could be responsible for any deficit of the Scheme. Similarly, if a number of employers cease to have employees participating in the Scheme, the DHB could be responsible for an increased share of the deficit.

Provisions

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

Make Good Lease Provision

A make good lease provision is made where operating leases contain clauses which specify that the Group should incur periodic charges for maintenance, make good dilapidations or other damage occurring during the rental period or requires the Group to return the asset to the configuration that existed at inception of the lease. The provision reflects the estimate of only the conditions as at the reporting date. The outflow of the provision would be expected at cessation of each lease. Assumptions were made around the term of the period of the lease based on the contractual term and expectations around exercising rights of renewal, which is subject to uncertainty. Further assumptions

are made around the expected cost of meeting these lease obligations and estimating the present value of the provision, which also come with inherent uncertainty.

ACC Accredited Employers Programme

The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan) whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC. The liability for the ACC Accredited 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 wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match future cash flows.

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 surplus/(deficit)
- property revaluation reserves
- trust funds.

Contributions from/(repayment to) the Crown

The DHB Crown approved projects funding.

Property Revaluation reserve

The revaluation reserve movement relates to the independent valuation of land and buildings carried out by Telfer Young (Auckland) Ltd.

Trust /special funds

Trust/special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds. All trust funds are held in bank accounts that are separate from the DHB's normal banking facilities. Refer to Note 29 for details.

Goods and services tax

All items in the financial statements are presented exclusive of goods and service tax (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. 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 paid to, or received from the IRD, 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.

Income tax

The DHB is a public authority and is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Budget figures

The budget figures are derived from the Statement of Performance Expectations (SPE) as approved by the Board at the beginning of the financial year to ensure we report against original approved budget. The budget figures were prepared in accordance with NZ GAAP, using accounting policies consistent with those adopted by the Board in preparing these financial statements. The format of the budget is different to that shown in the Financial Statements. The amounts that are disclosed are the same, however what has been presented has been reformatted to the purpose of these Financial Statements.

Cost allocation

The DHB has determined the cost of outputs using the cost allocation system outlined below. Direct costs are those costs directly attributed 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 outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output. There were no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

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

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

Land and building revaluations

Note 13 provides information on the estimates and assumptions applied in the measurement of revalued land, buildings, underground infrastructure and fixed dental clinics and pads. The significant assumptions applied in determining the fair value and buildings are disclosed in note 13.

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 of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by the DHB, and expected disposal proceeds from the future sale of the asset. An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the statement of financial position. The DHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programmes;
- review of second-hand market prices for similar assets; and
- analysis of prior asset sales.

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

Retirement and long service leave

Note 17 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Holiday Pay Provision

Refer to Note 17 for details on the exposure in relation to the estimates and uncertainties surrounding holiday provisions.

Provision for expected credit losses

The Group uses a provision matrix to calculate ECLs for trade and other receivables and contract assets. The provision rates are based on days past due. The ECL calculation is initially based on the Group's historical observed default rates. The Group will adjust the historical credit loss experience with forward-looking information. For instance, if forecast economic conditions are expected to deteriorate over the next year, the historical default rates are adjusted. At every reporting date, the historical observed default rates are updated and changes in the forward-looking estimates are analysed. The assessment of the correlation between historical observed default rates, forecast economic conditions and ECLs is a significant estimate. The amount of ECLs is sensitive to changes in circumstances and of forecast economic conditions. The Group's historical credit loss experience and forecast of economic conditions may also not be representative of customer's actual default in the future. The information about the ECLs on the Group's trade receivables and contract assets is disclosed in Note 8.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised. The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

Agency relationship

Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sales of goods or the rendering of services. The judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship. The DHB entered into a contract for services with providers for laboratory services. Services are provided across several DHB districts. The contracting DHB makes payment to the provider on behalf of all the DHBs receiving the services, and the recipient DHB will then reimburse the contracting DHB for the cost of the services provided in its district. There is a Memorandum of Understanding that sets out the relationships and obligations between each of the DHBs. Based on the nature of the relationship between the contracting DHB and the recipient DHBs, the contracting DHB has assumed it has acted as agent on behalf of the recipient DHBs. Therefore, the payments and receipts in relation to the other DHBs are not recognised in the contracting DHB's financial statements.

APPENDIX C: DHB BOARD AND MANAGEMENT

Governance for our DHB is provided by a Board of eleven people, seven of whom are elected and four of whom are appointed by the Minister of Health; two of these positions are currently vacant. Members provide strategic oversight for the DHB, taking into account the Government's vision for the health sector and its current priorities.

Board members	Dr Judy McGregor, Chair	(appointed)
	Kylie Clegg, Deputy Chair	(appointed)
	Chris Carter	(elected)
	Sandra Coney	(elected)
	Warren Flaunty	(elected)
	Dr John Bottomley	(elected)
	Renata Watene	(appointed)
	Edward Benson-Cooper	(elected)
	Allison Roe	(elected)
	Eru Lyndon	(appointed)
	David Lui	(appointed)
Senior Leadership Team for Waitematā DHB	Dr Dale Bramley	Chief Executive
	Dr Andrew Brant	Deputy Chief Executive
	Robert Paine	Executive Director Finance, People and Planning
	Tim Wood	Executive Director, Tier 1 Community Services
	Vacancy	Executive Director, Māori Equity
	Dr Debbie Holdsworth	Director of Funding (Waitematā, Auckland DHBs)
	Dr Karen Bartholomew	Director of Health Outcomes (Waitematā, Auckland DHBs)
	Dr Jonathan Christiansen	Chief Medical Officer
	Dr Jocelyn Peach	Chief of Nursing Officer, Professional Leadership
	Melody-Rose Mitchell	Associate Director of Nursing Medicine
	Kate Gilmour	Associate Director of Nursing Surgical and Ambulatory Services
	Mark Shepherd	Executive Director Hospital Services
	Stuart Bloomfield	Chief Information Officer
	Tamzin Brott	Chief Allied Health, Scientific and Technical Officer
	Dr William Landman	Head of Division (HOD) Specialty Medicine and Health of Older People
	Mr Richard Harman	Chief of Surgery
	Brendan Docherty	GM Surgical and Ambulatory Services
	Dr Meia Schmidt-Uili	HOD Child, Women and Family Services
	Michele Kooiman	Acting GM Child, Women and Family Services
	Dr Murray Patton	Clinical Director of Specialist Mental Health and Addiction Services
	Stephanie Doe	GM Specialist Mental Health and Addiction Services
	Fiona McCarthy	Director of People and Culture
	Dame Rangimarie Naida Glavish	Chief Advisor Tikanga (Waitematā, Auckland DHBs)
	Dr Penny Andrew	Executive Director, Innovation and Improvement
	Dr Andrew Old	Clinical Director of Health Gain
	Dr Gerard de Jong	HOD Acute and Emergency Medicine
	Alex Boersma	GM Acute and Emergency Medicine
	Brian Millen	GM Specialty Medicine and Health of Older People
	Nigel Ellis	GM Facilities and Development
	Josephine Aumea Herman	Director of Pacific Health (Waitematā DHB)
	Vacancy	GM Māori Health (Waitematā, Auckland DHBs)
	David Price	Director of Patient Experience
	Matthew Rogers	Director of Communications

APPENDIX D: MINISTER OF HEALTH'S LETTER OF EXPECTATIONS

The Minister of Health's Letter of Expectations to DHBs is available online:

https://nsfl.health.govt.nz/202122-planning-package-0

APPENDIX E: 2021/22 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

Once available, the Metro Auckland DHBs' 2021/22 System Level Measures Improvement Plan will be published online:

https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/slm-improvement-plans