DISTRIBUTION

Board Members (1 copy each)

- Mr B Simcock (Chair)
- Ms S Webb (Deputy Chair)
- Ms S Christie
- Ms C Beavis
- Mr M Gallagher
- Mrs MA Gill
- Ms T Hodges
- Mr D Macpherson
- Mrs P Mahood
- Ms S Mariu
- Dr C Wade

Executive Management Team

- Dr N Murray, Chief Executive
- Mr B Paradine, Executive Director, Waikato Hospital Services
- Ms M Chrystall, Executive Director, Corporate Services
- Mr N Hablous, Chief of Staff
- Mr D Hackett, Executive Director, Virtual Care and Innovation
- Mrs S Hayward, Director of Nursing & Midwifery
- Ms L Elliott, Executive Director, Maori Health
- Dr T Watson, Chief Medical Advisor
- Mr I Wolstencroft, Executive Director, Strategic Projects
- Ms J Wilson, Executive Director, Strategy and Funding
- Dr D Tomic, Clinical Director, Primary and Integrated Care
- Mr D Wright, Executive Director, Mental Health & Addictions Service
- Mr M Spittal, Executive Director, Community & Clinical Support
- Ms M Neville, Director, Quality & Patient Safety
- Ms L Aydon, Executive Director, Public and Organisational Affairs
- Ms T Maloney, Commissioner, Women's Health Transformation Taskforce
- Prof R Lawrenson, Clinical Director, Strategy and Funding
- Mr C Cardwell, Executive Director, Facilities and Business
- Mr M ter Beek, Executive Director, Operations and Performance
- Mr P Mayes, Ministry of Health
- Minute Secretary
- Board Records

Contact Details:
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www.waikatodhb.health.nz

Next Meeting Date: 26 July 2017

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

Agenda

Board

Date: **28 June 2017**

Time: **2pm**

Place: **Level 1**
Hockin Building
Waikato Hospital
Pembroke Street
HAMILTON

Waikato District Health Board

Meeting of the Waikato District Health Board

to be held on Wednesday 28 June 2017
commencing at 2pm at Waikato Hospital

AGENDA

Note: Board members only session will be held at 1pm
Board members/Chief Executive session will be held at 1.30pm

Item

1. Apologies

2. **INTERESTS**
- 2.1 Schedule of Interests
- 2.2 Conflicts Related to Items on the Agenda

3. **MINUTES AND BOARD MATTERS**
- 3.1 Board Minutes: 24 May 2017
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 1 June 2017
  - 3.2.2 Performance Monitoring Committee: 14 June 2017
  - 3.2.3 Health Strategy Committee: 14 June 2017
  - 3.2.4 Maori Strategic Committee: 21 June 2017

4. **CHIEF EXECUTIVE REPORT**

5. **QUALITY AND SAFETY**

No reports this month

6. **DECISION REPORTS**
- 6.1 2017/20 Midland Regional Services Plan
- 6.2 Waikato DHB Annual Plan 2017/18 Submission
- 6.3 Waikato DHB Annual Plan Update
- 6.4 Memorandum of Understanding and Terms of Reference between the Waikato DHB and Iwi Maori Council

7. **FINANCE MONITORING**
- 7.1 Finance Report

8. **PRESENTATION**

No presentations this month

9. **PAPERS FOR INFORMATION**
- 9.1 Health Targets
- 9.2 Provider Arm Key Performance Dashboard
- 9.3 Strategy and Funding Key Performance Dashboard

10. **NEXT MEETING: 26 JULY 2017**

RESOLUTION TO EXCLUDE THE PUBLIC
NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

THAT:

(1) The public be excluded from the following part of the proceedings of this meeting, namely:

Item 12: Minutes – Various
- **(i) Waikato District Health Board for confirmation: Wednesday 24 May 2017 (Items taken with the public excluded)**
- **(ii) Sustainability Advisory Committee – to be adopted: Wednesday 24 May 2017 (All items)**
- **(iii) Sustainability Advisory Committee – verbal update to be received: Wednesday 28 June 2017 (All items)**
- **(iv) Audit and Corporate Risk Management Committee – to be adopted: Wednesday 24 May 2017 (All items)**
- **(v) Performance Monitoring Committee – to be adopted: Wednesday 14 June 2017 (Items 7-8)**
- **(vi) Midland Regional Governance Group – to be received: Friday 2 June 2017**

Item 13: Risk Register – Public Excluded
Item 14: Chief Executive's Report – Public Excluded
Item 15: Audit Reports – Public Excluded
Item 16: FY17/18 Operating Budget and Capital Plan – Public Excluded
Item 17: Gallagher Drive Warehouse and Community and Southern Rural Health Facility Capital Investment – Public Excluded
Item 18: Waikato DHB System Level Measures Plan 2017/18 – Public Excluded
Item 19: Care and Support Workers Settlement Agreement Update – Public Excluded
Item 20: Funding Advice – Public Excluded

(2) The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 12(i-vi): Minutes		Items to be adopted / confirmed / received were taken with the public excluded
Item 13:	Risk Register	Avoid inhibiting staff advice about organisational risks
Item 14:	Chief Executive's report – verbal update	Negotiation will be required
Item 15:	Financial audit reports update	Negotiation will be required
Item 16:	Operating budget and capital plan 2017/18	Negotiation will be required
Item 17:	Gallagher Drive Warehouse and Southern Rural Health Facility capital investment request	Negotiation will be required
Item 18:	System Level Measures plan	Negotiation will be required
Item 19:	Pay equity settlement update	Negotiation will be required
Item 20:	Funding advice	Negotiation will be required

(3) This resolution is made in reliance on Clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public are as follows:

Item 12:	**As shown on resolution to exclude the public in minutes.**
Item 13:	**Section 9(2)(c) of the Official Information Act 1982 – To avoid prejudice to measures protecting the health or safety of members of the public.**
Item 14-20:	**Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

Item

12. MINUTES – PUBLIC EXCLUDED

12.1 Waikato District Health Board: 24 May 2017
To be confirmed: Items taken with the public excluded

12.2 Sustainability Advisory Committee: 24 May 2017
To be adopted: All items

12.3 Sustainability Advisory Committee: 28 June 2017
Verbal update: All items

12.4 Audit and Corporate Risk Management Committee: 24 May 2017
To be adopted: All items

12.5 Performance Monitoring Committee: 14 June 2017
To be adopted: Items 7-8

12.6 Midland Regional Governance Group: 2 June 2017
To be received: All items

13. RISK REGISTER – PUBLIC EXCLUDED

14. CHIEF EXECUTIVE REPORT –– PUBLIC EXCLUDED

15. AUDIT REPORTS –– PUBLIC EXCLUDED

16. FY17/18 OPERATING BUDGET AND CAPITAL PLAN –– PUBLIC EXCLUDED

17. GALLAGHER DRIVE WAREHOUSE AND COMMUNITY AND SOUTHERN RURAL HEALTH FACILITY CAPITAL INVESTMENT –– PUBLIC EXCLUDED

18. WAIKATO DHB SYSTEM LEVEL MEASURES PLAN 2017/18 –– PUBLIC EXCLUDED

19. CARE AND SUPPORT WORKERS (PAY EQUITY) SETTLEMENT AGREEMENT UPDATE –– PUBLIC EXCLUDED

20. FUNDING ADVICE –– PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

THAT:

(1) The Public Be Re-Admitted.

(2) The Executive be delegated authority after the meeting to determine which items should be made publicly available for the purposes of publicity or implementation.

Waikato District Health Board

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO JUNE 2017

Bob Simcock

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Chair, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Chairman, Orchestras	TBA	TBA	
Member, Waikato Regional Council	Pecuniary	Perceived	
Director, Rotoroa LLC	TBA	TBA	
Trustee, RM & AI Simcock Family Trust	TBA	TBA	
Wife is Trustee of Child Matters, Trustee Life Unlimited which holds contracts with the DHB, Member of Governance Group for National Child Health Information Programme, Member of Waikato Child and Youth Mortality Review Group	Pecuniary	Potential	

Sally Webb

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Deputy Chair and Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Deputy Chair, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Bay of Plenty DHB	TBA	TBA	
Member, Capital Investment Committee	TBA	TBA	
Director, SallyW Ltd	TBA	TBA	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Crystal Beavis

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Deputy Chair, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Director, Bridger Beavis & Associates Ltd, management consultancy	Non-Pecuniary	None	
Director, Strategic Lighting Partnership Ltd, management consultancy	Non-Pecuniary	None	
Life member, Diabetes Youth NZ Inc	Non-Pecuniary	Perceived	
Trustee, several Family Trusts	Non-Pecuniary	None	
Employee, Waikato District Council	Pecuniary	None	

Sally Christie

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Partner, employee of Workwise	Pecuniary	Potential	

Martin Gallagher

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hamilton City Council	Pecuniary	Perceived	
Board member Parent to Parent NZ (Inc), also provider of the Altogether Autism service	Pecuniary	Potential	
Trustee, Waikato Community Broadcasters Charitable Trust	Non-Pecuniary	Perceived	
Alternate Member, Waikato Spatial Plan Joint Committee	Non-Pecuniary	Perceived	
Wife employed by Selwyn Foundation and Wintec (contracts with Waikato DHB)	Pecuniary	Potential	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Mary Anne Gill

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Life Unlimited Charitable Trust	Pecuniary	Perceived	
Son is an employee of Hongkong and Shanghai Banking Corp Ltd (NZ)	Non-Pecuniary		

Tania Hodges

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Deputy Chair, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Iwi: Ngati Pahauwera, Ngati Ranginui, Ngati Haua, Tuwharetoa, Maniapoto	Non-Pecuniary	Perceived	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	
Trustee/Shareholder, Whanau.com Trust	Pecuniary	None	
Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None	
Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None	
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None	
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None	
Justice of the Peace	Non-Pecuniary	None	

Dave Macpherson

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Councillor, Hamilton City Council	Pecuniary	Perceived	
Deputy Chair, Western Community Centre, Inc	Non-pecuniary	Potential	
Partner is Chair of Ngaruawahia Community House, Inc	Non-pecuniary	Potential	
Member, Waikato Regional Transport Committee	Non-pecuniary	Potential	
Member, Waikato Water Study Governance Group	Non-pecuniary	None	
Member, Future Proof Joint Council Committee	Non-pecuniary	None	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Pippa Mahood

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Chair, Waikato Health Trust	Non-Pecuniary	None	
Life Member, Hospice Waikato	TBA	Perceived	
Member, Institute of Healthy Aging Governance Group	TBA	Perceived	
Board member, WaiBOP Football Association	TBA	Perceived	
Husband retired respiratory consultant at Waikato Hospital	Non-Pecuniary	None	

Sharon Mariu

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived	
Director/Shareholder, Asher Group Ltd	Pecuniary	Perceived	
Director, Hautu-Rangipo Whenua Ltd	Pecuniary	Perceived	
Owner, Chartered Accountant in Public Practice	Pecuniary	Perceived	
Daughter is an employee of Puna Chambers Law Firm, Hamilton	Non-Pecuniary	Potential	
Daughters are employees of Deloitte, Hamilton	Non-Pecuniary	Potential	

Clyde Wade

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Shareholder, Midland Cardiovascular Services	Pecuniary	Potential	
Trustee, Waikato Health Memorabilia Trust	Non-Pecuniary	Potential	
Trustee, Waikato Heart Trust	Non-Pecuniary	Potential	
Trustee, Waikato Cardiology Charitable Trust	Non-Pecuniary	Potential	

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Patron, Zipper Club of New Zealand	Non-Pecuniary	Potential	
Emeritus Consultant Cardiologist, Waikato DHB	Non-Pecuniary	Perceived	
Cardiology Advisor, Health & Disability Commission	Pecuniary	Potential	Will not be taking any cases involving Waikato DHB
Fellow Royal Australasian College of Physicians	Non-Pecuniary	Perceived	
Occasional Cardiology consulting	Pecuniary	Potential	

Note 1: Interests listed in every agenda.
Note 2: Members required to detail any conflicts applicable to each meeting.

Waikato District Health Board

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 24 May 2017 commencing at 1.30 pm in the Board Room, Hockin Building, Waikato Hospital Campus

Present:
Mr B Simcock (Chair)
Mrs S Webb
Ms T Hodges
Mrs S Christie
Ms C Beavis
Ms S Mariu
Dr C Wade
Mr M Gallagher
Mrs P Mahood
Ms M A Gill
Mr D Macpherson

In Attendance:
Dr N Murray (Chief Executive)
Mr N Hablous (Chief of Staff) – part of the meeting
Mr A McCurdie (Chief Financial Officer)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Mr M Spittal (Executive Director, Community and Clinical Support)
Mrs J Wilson (Executive Director, Strategy and Funding)
Mr D Wright (Executive Director, Mental Health and Addictions Service)
Ms L Elliott (Executive Director, Maori Health)
Mr M ter Beek (Executive Director, Performance and Operations)
Mr A Gordon (Director of Medicine and Oncology)
Mr M Neville (Director, Quality and Patient Safety)

ITEM 1: APOLOGIES FOR ABSENCE

There were no apologies for absence.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

No conflicts of interest were foreshadowed in respect of items on the current agenda. There would be an opportunity at the beginning of each item for members to declare their conflicts of interest.

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 26 April 2017

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 26 April 2017 taken with the public present were confirmed as a true and accurate record.

3.2 Committees

No committee meeting had been held during this period.

3.3 Establishment of Maori Health Strategic Committee

A paper was tabled for the Board's consideration and approval. The Board accepted the recommendations of the report.

Resolved
THAT

1. The Board approved the establishment of a committee to undertake the tasks set out in point 2 below.
2. The terms of reference of the committee:
    a. To oversee the development of the Priority Programme Plan to radically improve Maori health outcomes by eliminating health inequities for Maori noting that the Plan would be developed by staff in conjunction with a working group including representation from outside Waikato DHB;
    b. To oversee the implementation of the Priority Programme Plan to radically improve Maori health outcomes by eliminating health inequities for Maori;
    c. To identity and consider other areas of the Waikato DHB that could contribute towards radical improvements in Maori health outcomes by eliminating health inequities for Maori;
    d. To consider the version of the Memorandum of Understanding proposed by the Iwi Maori Council and recommend to the Iwi Maori Council and Board any changes considered necessary; and
    e. To recommend the name of the new committee.
3. The Board did not delegate authority to the committee but adopted the principles outlined above in the section headed "Delegation".
4. The committee to meet every month, and otherwise as needed.
5. The Board approved the proposed membership of the committee comprising of eight members, four of whom are from the Board and four of whom are appointed on recommendation from the Iwi Maori Council.
6. The Board would appoint the chair of the committee.
7. The Board would seek approval to pay the member of the committee on the same basis as payment is made to other Board committees.

3.4 Appointment to Midland DHB Statutory Committees

The Chair presented a paper explaining that it had been agreed that Waikato, Lakes and Bay of Plenty DHBs would appoint to each other's statutory committees. This paper recommended the appointment of five Waikato DHB board members to the three statutory committees at Lakes DHB and two statutory committees at Bay of Plenty DHB.

Resolved
THAT

The following Board member appointments were approved**:**

1) Lakes District Health Board

- Community and Public Health Advisory Committee: Mrs Pippa Mahood
- Disability Support Advisory Committee: Mrs Pippa Mahood
- Hospital Advisory Committee: Mr Martin Gallagher

2) Bay of Plenty District Health Board

- Hospital Advisory Committee: Dr Clyde Wade
- Community and Public Health Advisory Committee/Disability Support Advisory Committee: Mrs Mary Anne Gill

ITEM 4: CHIEF EXECUTIVE REPORT

The Chief Executive provided the Board with an update on:

4.1 Waikato Medical School

There had been a significant amount of media on the proposed Waikato Medical School. Weekly reports were forwarded to Board members through Fuseworks.

Board members were briefed on the progress of the business case and process of evaluation being carried out by the Government.

4.2 Ransomware Virus: WannaCry

The IS team had deployed various precautionary contingency measures to ensure the DHB was not impacted by the ransomware virus and had implemented additional protective toolsets as part of the security programme of work. Waikato DHB would remain extremely vigilant.

4.2 2017/18 Budget

The draft budget for 2017/18 would be presented to the Board in June.

4.3 HDC Complaints

The Chief Executive is to meet with the Health and Disability Commissioner in July to discuss trends in complaints against Waikato DHB and its performance in a variety of areas including orthopaedics,

women's health, first specialist assessments and follow up and staffing levels.

The Chief Executive would also update the Director General of Health on these matters.

4.4 Primary Health Care Strategy

A workshop would be held on 28 June before the Board Meeting to discuss the Primary Health Care Strategy.

Resolved
THAT
The Board received the report.

Following the Chief Executive's report Mr Dave Macpherson was given an opportunity to suggest some changes to the DHB's Smoking Policy.

Mr Macpherson's request would be passed on to the DHB's management for them to consider. A response would be provided at a future meeting possibly in 2 to 3 months' time. Mr Macpherson requested that if a full report was not available within that timeframe, an interim report be provided.

ITEM 5: FINANCE REPORT

5.1 The Chief Financial Officer asked that his report for the month of April 2017 be taken as read highlighting the following:

- The DHB continued on track and expected to break even at year end.
- The provider was unfavourable to budget to 30 April 2017:

1. Revenue favourable to budget $0.1m.
2. Employed personnel costs were unfavourable to budget $5.4m the dominant negative variances being within nursing and a smaller unfavourable variance in allied health personnel. Medical personnel were favourable to budget $0.9m and administrative and support personnel have small favourable variances.
3. Outsourced personnel were unfavourable to budget $11.5m – this related to medical locums ($4.0m), nursing ($1.1) and admin/management contractors for the National Oracle Solution (NOS) project ($5.18m) which had an offset in other revenue (3.5m).
4. Outsourced services were unfavourable at $4.0m.
5. Clinical supplies were unfavourable at $0.1m.
6. Infrastructure and non-clinical supplies were unfavourable to budget at $0.8m.
7. Interest depreciation and capital charges were favourable to budget $7.6m.

It was noted that:

- Acute cases excluding ED: episodes 2.6% above plan; case-weights 6.3% above plan

- Elective cases: episodes 9.7% below plan; case-weights 17.3% below plan
- Overall 0.7% below plan for cases and 1.0% below plan for case weights
- ED attends: YTD ED attends are 3.2% higher than the same period last year
- The result for the Funder was favourable due to favourable Provider payment costs
- The result for Governance was close to budget.

Resolved
THAT
The financial statements of the Waikato DHB for the month to 30 April 2017 were received.

5.2 Banking Services Supplier Change

The current banking arrangement with Westpac expired on 2 April 2017. The NZHP "Banking and Treasury Services Supplier Recommendation Report" recommended a change for the sector in its banking services provider to BNZ.

Waikato DHB supported the recommendation to change banks noting the reliance on system changes to the National Oracle System would impact Waikato DHB's timeframe to be able to implement a change in banking service provider. The risks and benefits associated with this change were discussed at the Audit and Risk Management Committee Meeting on 22 March 2017.

Resolved
THAT

1) The Board approved the Supplier Recommendation Report.
2) The Board approved Waikato DHB changing its banking services provider from Westpac to BNZ, in conjunction with the Sector noting its reliance on the implementation of the National Oracle System.

ITEM 6: PERFORMANCE REPORTING

6.1 Health Targets

Alex Gordon attended for this item. The Health Targets report was submitted for information.

Management noted:

- **Shorter stays in the Emergency Department** – Medical recruitment was ongoing. Appointments had been made to two substantive positions. Offers had been made to a Medical Officer and two Fellows as part of the strategy to increase out of hours medical cover in the Emergency Department. A service manager and a clinical nurse director had been appointed. The priority would now be to recruit to the nursing vacancies.

- **Improved Access to Elective Surgery** – most recent result was 109.3%.

- **Faster Cancer Treatment** – preliminary results for quarter 3 showed a result of 89%.

- **Increased immunisation for 8 month olds** –the result was still concerning at 90%.

- **Better help for smokers to quit** – maternity – quarter three information was incomplete. Quarter two result was 95.9%.

Resolved
THAT
The Board received the report.

6.2 Provider Arm Key Performance Dashboard

The high level Provider Arm Key Performance Dashboard for April 2017 was submitted for the Board's information.

Clinical and Community Support

The report was taken as read.

Breast Screening Maori volumes – it was noted that this target would not be met for the year. Waikato DHB was holding discussions with Bay of Plenty DHB and 3 PHOs in an attempt to reduce Maori woman breast screening inequalities.

Mental Health and Addictions Service

The report was taken as read. Management noted:

Occupancy – HRBC had been at full capacity all year due to a few high and complex needs clients who had not been able to be moved out to supported accommodation. Discussions had been taking place with Strategy and Funding to determine a way forward.

Seclusion – Total hours spent in seclusion for Adults was 714.55 ours.

Waikato Hospital Services

Management noted:

Long wait patients on outpatient waiting lists – ESPI2 was compliant in April.

Number of long wait patients on outpatient waiting lists **–** ESPI5 was compliant in April.

Resolved:
THAT
The Board received the report.

6.3 Strategy and Funding Key Performance Dashboard

The Strategy and Funding key performance dashboard was submitted for the Board's information.

Management noted:

- **Proportion of older people waiting greater than 20 days for assessment or reassessment** – the result showed significant reductions in the number of patients waiting more than 20 days for initial assessment and reassessment. The clients waiting more than 20 days have mitigating reasons such as START or Acute care still in place and not ready for assessment.
- **AOD and mental health waiting times (% of new clients seen within 3 and 8 weeks of referral)** – concerns remained in relation to this target and the accuracy of information reported.

Resolved
THAT
The Board received the report.

ITEM 7: PLANNING

Southern Rural Primary Maternity Services

The Southern Rural Maternity Services Consultation Process Report was presented for the Board's approval.

Following on from discussions at the December 2016 Board Meeting when a report setting out a future service model for the primary maternity services that are delivered in the southern part of the DHB's catchment area was considered, the consultation process had taken place between 6 March 2017 and 14 April 2017. This paper set out the final recommendations to the Board following the consultation process.

Resolved
THAT
1) The Board received the report.
2) Agreed that Waikato DHB:
    a. Implement the primary maternity hub service model as proposed.
    b. Close the Te Kuiti Birthing Unit.
    c. Move to a Lead Maternity Carer model for Te Kuiti and Tokoroa.
    d. Offer an enhanced facility contract for the two birthing units in Tokoroa and Taumarunui.
    e. Develop a physical primary maternity hub location in Te Kuiti Tokoroa and Taumarunui.
    f. Commence a co-design process to include working with Strategy and Funding, Te Puna Oranga, key stakeholders and local service providers to develop enhanced access to services and well-coordinated antenatal and post-natal service i.e. the operational underpinning of the primary maternity hub service model.

ITEM 8: WAIKATO DHB POSITION STATEMENT AND POLICIES

There were no items this month.

ITEM 9: PRESENTATION

A Consumer Council for Waikato DHB.

Wendy Entwistle attended for this item.

The Board were updated on the progress made to establish a Consumer Council for Waikato DHB.

The draft terms of reference and expression of interest process were considered.

Resolved
THAT
The Board received the report.

ITEM 10: PAPERS FOR INFORMATION

10.1 Mental Health and Additions Service s99 (Mental Health (CAT) Act 1992 Inspection Report Action Plan

An update on progress on the recommendations in the s99 (Mental Health (CAT) Act 1992 Inspection Report Action Plan was tabled. The report was taken as read.

Resolved
THAT
The Board received the report

10.2 A Strategy to Prevent Suicide in New Zealand

Mo Neville and Julie Wilson presented this item.

A consultation document released by the Ministry of Health had been circulated to Board members for their information and feedback.

Resolved
THAT
The Board received the report

ITEM 11: NEXT MEETING

Date of Next Meeting

The next meeting to be held on Wednesday 28 June 2017, commencing at 1.30 pm in the Board Room, Hockin Building, Waikato Hospital Campus.

ACTION LIST

(Relates to Items to be reported to the Board and not implementation of substantive decisions)

	ACTION	**BY**	**WHEN**
1	Agenda Item 4 – Suggested changes to the Smoking Policy	Nigel Murray	August/ September Meeting
2	Agenda Item 6.2 Mental Health and Additions Services KPI Report – Seclusion – Future reports to include the number people in seclusion not just percentage number of hours spent in seclusion	Derek Wright	July Meeting
3	Agenda Item 13 – Add Waikato population growth to the Risk Register	Mo Neville	July Meeting

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Māori Council
Held on Thursday 1st June 2017 at 9.30am

Present:

Mr H Mikaere (Chair)	Hauraki Māori Trust Board
Ms J Eketone	Maniapoto Māori Trust Board
Dr K McClintock	Waikato Tainui Te Whakakitenga o Waikato Inc.
Ms F Chase	Whanganui
Ms T Moxon	Te Rūnanga o Kirikiriroa
Mr B Bryan	Raukawa Charitable Trust

In Attendance:

Matua H Curtis	(Pou Herenga Te Puna Oranga)
Ms P Mahood	(WDHB Board member)
Ms T Hodge	(WDHB Board member)
Ms N Barrett	(Minute taker)
Ms D Harema	(Support)

Apologies:

Ms G Roberts	Kaunihera Kaumātua Chair
Mr T Sewell	Te Rūnanga o Kirikiriroa
Ms T Thompson-Evans	Waikato Tainui Te Whakakitenga o Waikato Inc.
Ms T Bell	Maniapoto Māori Trust Board
Mr M Gallagher	WDHB Board Member
Ms L Elliott	Executive Director Māori Health

Item 1 Karakia:

Matua Hemi Curtis

Item 2 Mihimihi:

Mr H Mikaere

Item 3 Apologies:

Apologies received by P. Mahood

Item 4A: Minutes of last meeting

1. Action 12- Ms Mahood brought the report on Waikato Health Trust to IMC
2. Action 7- Ms Eketone to present in general business

Actions:

1	Update from WDHB Board to confirm that IMC representatives are approved for following: o Health and Safety Committee- Ms Moxon and Ms Thompson o PMC- Mr Tupuhi and Dr McClintock	Mr Mikaere to speak/write a letter to Board re: outcome of request.

2	Fix sentence on page 7 of minutes "Is this correct? May need to be reformatted."	Ms Barrett to delete

Received: Ms Moxon
Seconded: Ms Mahood

Item 4B: Matters Arising

Passed by Mr Mikaere.

Item 4C: Correspondence received

Acknowledged by IMC

Item 4D: List of appendices/attachments

i. MOU and TOR process from here:
   a. amendments made from joint hui
   b. MOU and TOR to go to Māori Strategic Committee for proofing and duplication with a return date of 1st August 2017.
   c. Māori Strategy Committee to return MOU and TOR to IMC by 1st August 2017.
   d. IMC to send to Waikato DHB Board for scheduled August meeting

Actions:

3	Send up to date ToR and MoU to Ms Hodge, Ms Eketone, Mr Tupuhi, Ms Te Pora, Ms Moxon	Ms Barrett to email to Ms Hodge, Ms Eketone, Mr Tupuhi, Ms Te Pora, Ms Moxon

Item 5A: MOU discussed earlier in meeting.

Item 5C: Governance Training

- Ms Moxon for
- Ms Chase against
- Mr Tupuhi against maybe behaviour training
- Dr McClintock similar training to Board members and maybe IMC members join their orientation
- Mr training with purpose, designed for skill set, experience, should be provided for those that need it. Specific process to IMC of orientation
- Ms Eketone more emphasis on joint training with WDHB board, strengthen the relationship. Be orientated to the organisation.
- Majority support training but what that is and the area of focus needs to be determined. Individuals have different needs.

Actions:

3	Link with Donna Stratton new induction of IMC members alongside WDHB Board. Any WDHB Board training IMC should be invited, early.	Te Puna Oranga (Māori Health Service) to connect with Ms Stratton to include IMC on Board trainings/inductions.

Item 6B: Ms E McKenzie-Norton update on Priority Programme Plans.

1.1, 1.2, 1.3- Big priorities
The other 20 priorities are being divided into 3 phases.
Phase one: 70 working days to be developed (not implemented).

Waikato DHB strategy is for the Waikato DHB with a focus on "us getting our house in order to improve our relationship with other stakeholders".

1.4 Culture is about Māori culture as well as working culture.
Some of the objectives in the plan reflect 'hiring a workforce reflective of our population.
Those involved in developing this plan-

- People and performance staff (can give us breakdown of workforce ethnicity, HR statistics)
- Ms M Berryman co-lead
- Matua Hemi Curtis
- Finance
- Corporate

Response from IMC members and follow on response from Ms. McKenzie-Norton:

- Need KPI's set by the board to make the work that is happening real.
- What is the process with the plan?
  - The plan is taken to Ex. Group
  - The Board has given authority to Statutory group to make comments
  - Then the Statutory group will allow the plan to go forward for investigation of activities associated with the plan
- Possibility for IMC to feed in earlier? The beginning of preparing plan.
- How many Māori are represented on these groups?
  - There are many people involved in planning however the number of Māori participating not happened.
- Need for Māori representation on PPP to go wider than Te Puna Oranga (Māori Health Service) staff.
- The two plans coming to IMC are coming too late and we have missed the boat.
- Any updates that relate to the PPP should go to Te Puna Oranga (Māori Health Service) to be distributed to IMC before IMC Hui.
- IMC are here to support, going forward how can we work together.

Actions:

4	Need a breakdown of number of Māori represented on the PPP groups.	Ms. McKenzie-Norton to provide scope before each hui on each plan and the number of Māori on each PPP

Item 6B: Mr D. Hackett Priority Programme Plan 4.4- Enable a culture of innovation to achieve excellence in health and care services

"Culture is embedded around profession, place and people."
Focus in the plan on understanding and growing from the staff themselves. Innovation not just on the service we delivery or technology, but on the way people think. Challenge- understanding how people think today and change that because that is going to give us the ability to survive.

Plan (attached in agenda handout)
Page 5- Activities that are taking place/ going to take place.-
E.g.

- WDHB staff initiatives money given to month long projects to increase cultural engagement within the hospital.
- DHB values workshops

Response from IMC members and follow on response from Mr Hackett:

- The project initiative "Dragon's Den". Each month 4x projects (1x selected by staff, 3x by the dragon's den) will go through to a judging panel and be selected. No exclusion (as long as they do not interfere with policy or HR processes, ideas will be put up on the intranet.
- Page 10. Governance paragraph 3, how many of these people who are named have whakaaro Māori?
    - Dr Nina Scott, however we have identified a need for more Māori voice
    - Waiting for Ms Elliott to be in place as Executive Director of Māori Health

Māori lens oversees the entire process, where as a cultural advisor plays a small role and this is an 'old way' of thinking- a cultural advisor for the cultural stuff and not at the population we are trying to change outcomes for, and get good outcomes.

Actions:

5	Confirmation on whether the 'dragon's den' project has been promoted externally.	Mr Hackett to inform IMC if and how this has been promoted to external DHB stakeholders.

Item 6E: Ms C. Simcock and Mr R. Tapsell Suicide Prevention Programme (SPP) update

Rates of Waikato Suicide- publicly available every year from MoH
Role:

- Action from Waikato DHB Suicide Prevention and Postvention plan 2014-2017
- Based in Quality and Patient Safety
- Two district but overlapping areas of work
- Guide by health advisory group

Current Priority
Māori: >25yrs- South Waikato/Waipa 25-65yrs- South Waikato
10yrs to 25yrs predominately Male
Rangatahi

- Iwi classification is not yet determined however through the SPP review group will be able to determine that.
- Unemployment is a risk factor for suicide.
- The Health Advisory Group has not made a target yet.
- Community involvement in prevention is key.
- Majority of suicides have not engaged with secondary services
- 0% goal should be all of this
- The only way a suicide is classified as a suicide is if the corner has named that as cause of death

Postvention:

- Offer support
- Bereavement support:
    - WAVES training
    - Funded counselling
- Tikanga Māori grief hui
- Ngā Kūaha Tūmanako Conference at Turangawaewae 26th and 27th June
- Ngaruawahia High School Careers Day expo in June
- Wellness resources available area specific

Key messages (World Health Organisation)

- Suicide is preventable
- Intersectoral approach
- Restrict access to means
- Core component of health care
- Community can play a key role.

2 key issues highlighted:

1. Research shows suicide is not predictable. The attempts to suicide and/or self-infliction are visible but the issue is how we differentiate between those who do not harm themselves and those that follow through to commit suicide. A focus on the risk factors is needed, and a number of those are not necessarily health specific, much wider, family, connectedness, employment, money.
2. Need to focus on how we better engage with Māori communities. We would really appreciate input. Currently Te Puna Oranga (Māori Health

Service) sit on the advisory group but happy to take on board feedback and guidance from IMC.

IMC- Māori are experts in Tangihana and grieving process. It is in the genes we know what to do.

Item 6F: Ms. J. Wilson update on WDHB Annual Health Plan

System level measures Ministry of Health requirements:

1. ASH 0-6 years
2. Avoidable deaths
3. Acute bed days
4. Youth Health
5. 6week old babies smoke-free households

Māori inequities are the focus.

Item 7A: Ms. J. Wilson update on Strategy and Funding

Smoking contracts provided to Midlands are they performing?

Actions:

6	Provide IMC with statistics of smoking, % of staff who ask and the number of those that quit?	Ms Wilson to provide smoking statistics to IMC

Item 8: General Business

I. Treaty of Waitangi claim-
   - There is opportunity to feed to the government new ideas/initiatives to see what can health for our people look like going forward.
   - Also promote to our whānau what this claim is and that it is happening now
   - Coordination of remedies would be useful
   - The way health services are delivered and funding distributed

II. Concerns on suicide prevention project and lack of Māori engagement

III. Dr McClintock will remain on the statutory group.

IV. Ms Eketone will draft a letter to CE Dr N Murray regarding concerns about internal contracts vs provider funding

V. Ms T Hodges will no longer sit on IMC

Karakia whakamutunga: 1.30pm Mr Tupuhi
Next Hui: Thursday 6th July 2017

Full Action list from minutes

1	Update from WDHB Board to confirm that IMC representatives are approved for following: o Health and Safety Committee- Ms Moxon and Ms Thompson o PMC- Mr Tupuhi and Dr McClintock	Mr Mikaere to speak/write a letter to Board re: outcome of request.
2	Fix sentence on page 7 of minutes "Is this correct? May need to be reformatted."	Ms Barrett to delete
3	Link with Donna Stratton new induction of IMC members alongside WDHB Board. Any WDHB Board training IMC should be invited, early.	Te Puna Oranga (Māori Health Service) to connect with Ms Stratton to include IMC on Board trainings/inductions.
4	Need a breakdown of number of Māori represented on the PPP groups.	Ms. McKenzie-Norton to provide scope before each hui on each plan and the number of Māori on each PPP
5	Confirmation on whether the 'dragon's den' project has been promoted externally.	Mr Hackett to inform IMC if and how this has been promoted to external DHB stakeholders.
6	Provide IMC with statistics of smoking, % of staff who ask and the number of those that quit?	Ms Wilson to provide smoking statistics to IMC

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Performance Monitoring Committee Meeting held on Wednesday 14 June 2017 commencing at 8:30am

Present:
Ms S Christie (Chair)
Ms C Beavis (Deputy Chair)
Mr M Gallagher
Mrs MA Gill
Dr K McClintock
Mr D Macpherson
Dr P Malpass
Dr A Rolleston
Ms S Webb

In Attendance:
Mr B Paradine (Executive Director Waikato Hospital Services)
Mr M Spittal (Executive Director Community & Clinical Services)
Mr D Wright (Executive Director Mental Health & Addictions Service
Ms M Chrystall (Executive Director of Corporate Services)
Mr L Wilson (Acting Director Older Persons Rehabilitation and Allied)
Mr A Gordon (Director Medicine, Oncology, Emergency and Ambulatory Services)
Ms J Farley (Acting Director, Surgery, CCTVS, Care & Theatre)
Ms W Sutherland (Director Women's and Children)
Ms M Neville (Director Quality and Patient Safety)
Ms L Aydon (Executive Director Public and Organisational Affairs)
Mr G King (Director, Information Services)
Mr G Peploe (Director, People and Performance)
Ms J Wilson (Executive Director Strategy and Funding)
Mr A McCurdie (Chief Financial Officer)
Mr N Hablous (Chief of Staff)
Mr C Wade (Chair Health Strategy Committee)
Mrs C Atherfold (Acting Chief Nursing & Midwifery Officer)

IN THE ABSENCE OF DELEGATED AUTHORITY ALL ITEMS WERE FOR RECOMMENDATION TO THE BOARD

ITEM 1: APOLOGIES

Apologies were received for Mr B Simcock, Ms A Morrison and Mr K Price. Mr K Price has tendered his resignation from the Committee which was formally accepted. His contribution to the Committee will be formally acknowledged. External members will be reviewed once the consumer council is established.

ITEM 2: INTERESTS

2.1 Changes to Register

Ms S Webb is no longer a member of Health Workforce New Zealand.
Mr M Gallagher is an employee of WINTEC and the Selwyn Foundation (both of whom are contracted by Waikato DHB).

2.2 Conflicts Related to Any Item on the Agenda

No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 3: MINUTES AND MATTERS ARISING

3.1 Performance Monitoring Committee Meeting: 12 April 2017

Resolved
THAT
The minutes of a meeting of the Performance Monitoring Committee held on 12 April 2017 are confirmed as a true and correct record.

3.2 Lakes DHB – Hospital Advisory Committee: 1 May 2017

Minutes were noted.

ITEM 4: SYSTEM LEVEL MEASURES

4.1 System Level Measures Report

Mrs J Wilson presented this agenda item.

Significant work on system level measures is ongoing with engagement across the primary, secondary and NGO sectors with the focus being on local priorities.

The draft plan will be reviewed by the Health Strategy committee.

The smoking cessation data provided by Pinnacle is not a straightforward analysis and there is a lack of information about primary care smoking cessation targets such as the percentage of patients referred for smoking cessation.

Committee members highlighted that it would be useful to see targets applied for both smoking cessation, particularly for young, pregnant Maori women and immunisation to allow for reporting at future meetings, as well as DNA rate for paediatric outpatients (primary care indicator).

Resolved
THAT
The Committee received the report.

ITEM 5: OPERATIONS AND PERFORMANCE

5.1 Operations and Performance Report

Mr M ter Beek presented this agenda item.

Areas highlighted included:

- A coordinated incident management response was put in place due to high bed occupancy on the 23rd May. The CIMS response ensured that there was a focus on effective discharge planning for patients without high acuity needs with increased transfers to rural hospitals.
  Learnings included improving understanding of how best to anticipate similar situations in the future, given that winter is traditionally a time of increased presentations to the Emergency Department.
- High rates of nursing sick leave were apparent at the time of the CIMS response and were a contributing factor to difficulties with high bed occupancy experienced on the 23rd May. This is closely monitored with plans put in place to source external nursing cover as required. A nursing acuity tool has also been employed particularly to review resourcing in Wards 2 and 12. Additional nursing resources may be required in these wards in the future to alleviate demand pressures.

  Committee members highlighted that it would be beneficial for the acuity tool to be demonstrated and also for the Chief Nursing & Midwifery Officer to attend committee meetings on a regular basis in the future.

  The Theatre Improvement Governance Group has discussed the issue of acute theatre time improvements and planning for the right capacity to ensure more timely acute theatre access, and less impact on elective surgery to reduce the flow-on effects of not meeting Ministry targets and thereby lessening financial penalties.

Resolved
THAT
The Committee received the report.

5.2 Acute Flow: Analysis and insights

Since the inception of the Ministry's Shorter Stays in ED target, this has been an ongoing area of concern as Waikato has not met the target.

There are many initiatives underway to improve patient flow. A governance group is focusing on impactful changes to improve patient flow across the continuum.

Committee members highlighted that it would be beneficial to have graphical analysis of staff availability (hours) against ED presentations to assess where the staffing mix has a negative impact on patient flow and compare the pressure points on the patient journey. Ethnicity data is also a key component.

Resolved
THAT
The Committee received the report.

ITEM 6: SERVICES

6.1 Community and Clinical Support

Presented by Mr M Spittal.

Highlights included:

- The Ka Pai Kai community development project in the South Waikato, now run as a community NGO entity, has been a very successful part of long term strategy in the improvement food and nutrition education in the South Waikato
- Thames Hospital is experiencing a significant increase in demand for their services from the local population and one of the initiatives introduced is the Productive Operating Theatre to ensure front line continuous improvement, with safer and reliable care, improved team performance and adding value and improving efficiencies
- Financial targets for savings are forecasted to be met by the service
- The clinical leader for Quality & Patient Safety is working with the Radiology service to audit current practices and report on the outcome of this audit will be forthcoming

Resolved
THAT
The report be received.

6.2 Mental Health & Addictions

Presented by Mr D Wright.

Highlights included:

- The effects of methamphetamine and synthetic cannabis use in the community has seen an increased demand for services
- Work does need to be done on improving wellbeing in the community to build resilience and developing coping mechanisms, this is particularly evident amongst young people who report feeling suicidal
- The number of ED presentations has increased and there is a flow-on effect in the number of Mental Health presentations as a result. The service is working hard with NZ Police to ensure that mental health assessments are not completed in police cells, but rather at the Waikato Hospital Emergency department
- The service is aiming for all patient records to be provided electronically by the end of this year

Resolved
THAT
The report be received.

6.3 Waikato Hospital Services overview report

Mr B Paradine introduced Ms J Farley (Acting Director Surgical and Critical Care), Mr A Gordon (Director of Medicine, Oncology, Emergency and Ambulatory Care), Ms M Sutherland (Director of Women's and Children's Health) and Mr L Wilson (Acting Director Older Persons & Rehabilitation Service and Allied Health).

Older Persons, Rehabilitation and Allied Health
Mr L Wilson presented this agenda item.

- As a result of changes in bed mix in the service, it has been noted that ACC patient volumes are reducing. This is monitored and work is underway with ACC to determine if this is a local or national reduction trend
- The Committee highlighted that regular reporting on the Childhood Development Centre as part of the service overview report would be beneficial

Internal Medicine Oncology, Emergency and Ambulatory Care
Mr A Gordon presented this agenda item.

- The service is a strong national performer against the Faster Cancer Network pathway
- The Regional bowel screening programme is recruiting a nurse endoscopist to assist with predicted volumes that flow from the introduction of the national bowel screening programme. The Committee signalled their desire to ensure that the programme consider the negative impact of bowel cancer on the Maori population

Surgical and Critical Care
This item was presented by Mrs J Farley.

Womens and Children Health
Ms M Sutherland presented on this agenda item.

- The sad and sudden passing of Dr Stewart Hastie, obstetrician, was noted
- Accreditation has been regained for the colposcopy service
- Midwifery training participation will be provided to the Committee in future reporting

Resolved
THAT
The report be received.

ITEM 7: QUALITY

7.1 Quality Report

Ms M Neville presented this agenda item.

- Committee members were updated on the report with the change of reporting lines from the Audit & Risk Committee to the Performance Monitoring Committee
- Committee members signalled that these agenda items be reviewed earlier in the meeting and the agenda will be reworked to accommodate this

Resolved
THAT
The Committee received the report.

ITEM 8: FINANCE REPORT

8.1 Finance report
Noted.

Resolved
THAT
The Committee received the report.

ITEM 9: PEOPLE

9.1 People and Performance Report
Mr G Peploe attended for this item.

Resolved
THAT
The Committee received the report.

ITEM 10: INFRASTRUCTURE

10.1 Next report due 9 August 2017

ITEM 11: INFORMATION SERVICES

11.1 Information Services Plan Report
Mr G King attended for this item.

Resolved
THAT
The report be received.

ITEM 12: PERFORMANCE OF FUNDED ORGANISATIONS

12.1 Performance of Funded Organisations
Mrs J Wilson provided background to the reporting of the performance of funded organisations which will be presented at a future Committee meeting.

ITEM 13: DATE OF NEXT MEETING: 9 AUGUST 2017

Chairperson: _____

Date: _____

Meeting Closed: 12.29 pm.

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Health Strategy Committee held on 14 June 2017 commencing at 12.46pm

Present:
Mr C Wade (Chair)
Ms T Hodges (Deputy Chair)
Ms S Webb
Ms S Mariu
Mrs P Mahood
Mr J McIntosh
Mr C Beavis
Ms TP Thompson-Evans
Mr M Arundel

In Attendance:
Ms S Christie, Waikato DHB Board member
Mrs MA Gill, Waikato DHB Board member
Ms J Wilson, Executive Director, Strategy & Funding
Mr N Hablous, Chief of Staff
Mr M ter Beek, Executive Director, Operations and Performance
Ms T Maloney, Commissioner, Women's Health Transformation Taskforce
Mr D Hackett, Executive Director, Virtual Care and Innovation
Mr D Tomic, Clinical Director, Primary and Integrated Care
Mr B Paradine, Executive Director, Waikato Hospital Services
Ms M Chrystall, Executive Director, Corporate Services
Mr A McCurdie, Chief Financial Officer
Mr D Wright, Executive Director, Mental Health and Addictions Service
Ms E McKenzie Norton, Strategy and Funding
Ms N Parker, Change Team
Mr W Skipage, Strategy and Funding

IN THE ABSENCE OF DELEGATED AUTHORITY ALL ITEMS WERE FOR RECOMMENDATION TO THE BOARD

The Chair welcomed new committee members Ms T Thompson-Evans (an Iwi Maori Council member) and Mr M Arundel (a board member from Bay of Plenty DHB) to the meeting.

ITEM 1: APOLOGIES

Apologies from Mr B Simcock, Mr D Slone, Mr F Mhlanga and Mr R Vigor Brown were received.

Resolved
THAT
The apologies were received.

ITEM 2: LATE ITEMS

There were no late items raised at the meeting.

ITEM 3: INTERESTS

3.1 Register of Interests

There were no changes made to the Interests register.

3.2 Conflicts Relating to Items on the Agenda

No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 4: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved
THAT

1) The minutes of a meeting of the Waikato DHB Health Strategy Committee held on 12 April 2017 be confirmed as a true and correct record.
2) The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 18 April 2017 be noted.

ITEM 5: WORKPLAN

The work plan was reviewed by the Committee who confirmed they would like to receive a strategic view of the Pharmacy, Translation Services and Tobacco plans. The proposed "understanding our population" has been covered by the LTIP so that session can be replaced by understanding how the population profile data impacts on the development of service specific plans.

Ms Beavis referenced a document due to be released for consultation shortly that would be relevant in terms of future population growth. The document is the draft Future Proof Strategy and has been published by the Hamilton City Council, Waikato District Council, Waipa District Council, Waikato Regional Council, NZTA and tangata whenua.

With regard to prevention programme assessments the Committee requested a paper on how effective current prevention programmes are, what can be done to make them more effective and were there other prevention programmes that the DHB should doing.

Management noted the programme to improve access to primary care for the intellectual disability community had not progressed.

Resolved
THAT
The Committee received the report.

ITEM 6: STRATEGY AND FUNDING OVERVIEW REPORT

The Strategy and Funding overview report was submitted for the Committee's information.

Key areas included:

Staff
The appointment of Mr W Skipage as Senior Planning Manager at Waikato DHB.

Annual Plan and Budget Submission
The deadline for submitting the 2017/18 budget had been extended to 30 June 2017.

There were issues with the initial funding envelope released by the Ministry of Health and Waikato DHB is waiting the finalised envelope. This has made the budget process challenging.

Community Health Forum
A new community health forum has been included in Raglan. This forum will be trialled for 12 months to ascertain good engagement with this community.

Management will ensure the timetable and agenda for each forum is circulated to board and committee members. A section will be included in the agenda seeking community views and feedback.

Mental Health and Addictions Programme
This is a large work programme which will run alongside the Mental Health and Addictions service Creating Our Futures programme.

Membership includes DHB services, NGOs and primary care.

Strategic Service Plans
Work has commenced on the structure for developing strategic service plans. These plans will have a system wide focus, will be essential for the long term investment plan and integrate with the DHB's strategy.

The strategic service plans will be built from robust population needs analysis.

Pay Equity Settlement
This is a national settlement which will be rolled out at the beginning of July. It is a very large investment with a nationally determined approach that DHBs will implement. There will be flow on impacts that will cause challenges across the health sector.

System Level Measures Plan
The Systems Level Measures plan focuses on key local health priorities with engagement on the development of the plan for 2017/18 occurring across primary, secondary and other service groups. Working groups have also been established with cross sector representation. The plan will be finalised over the next week and submitted to the June board meeting.

The Committee stressed the importance of ensuring the contributory measures and related activities have a significant impact on the high needs and vulnerable populations.

It was noted that the work to be undertaken does not have a specific budget however the primary care quality fund would support some of this work.

Resolved
THAT
The Committee received the report.

ITEM 7: PAPERS FOR ACTION

No papers for action.

ITEM 8: PAPERS FOR INFORMATION

No papers for information.

ITEM 9: STRATEGIC PROGRAMME PLANS

9.1 eSPACE

Ms S Baker and Mr M Hamid from the eSPACE Programme team gave a demonstration of the Midland Clinical Portal Foundation test system.

Of note:

- The eSPACE programme business case has been approved by the five Midland DHBs for $74m.
- Within the eSPACE programme there are a number of projects to be delivered over the next five years.
- The first project is the Midland Clinical Portal Foundation project which will go live in July 2017.
- Planning is also underway for future releases.

Resolved
THAT
The Committee received the presentation.

9.2 Mental Health and Addictions Model of Care

No paper this month.

9.3 SmartHealth

No paper this month.

9.4 Rural Project

No paper this month.

9.5 Women's Health Transformation

Ms T Maloney attended for this agenda item.

Of note:

- Recent focus has been on the appointment of substantive leadership roles for Women's Health service and midwifery workforce including trialling a shift pattern for midwives.
- A proposal for change to the management and leadership structure (excluding medical leadership) is out for consultation. The closing date is 16 June.
- Training of midwives in a hospital setting is an area that needs to be focused on.
- An overview of progress of all the transformation workstreams will be presented to the Committee.

Resolved
THAT
The Committee received the report.

9.6 Elective Services Improvement

Mr B Paradine attended for this agenda item.

An update report on the work undertaken in the area of elective services improvement was submitted for the Committee's information.

Of note:

- Results for ESPI 2 (outpatients waiting more than four months for assessment) show the DHB will be compliant for May.
- Results for ESPI 5 (inpatients waiting more than four months for treatment) show the DHB will be at amber status for June and July.

Resolved
THAT
The Committee received the report.

9.7 Patient Flow

Mr M ter Beek attended for this item.

A report on the DHB's patient flow programme to improve performance was submitted for the Committee's information.

Management noted that the Governance Group of the patient flow programme will refocus effort to where the greatest impact is expected as well as integrating with other improvement work that is underway.

Resolved
THAT
The Committee received the report and noted the next steps for the patient flow programme.

9.8 Quality Account

Ms M Neville attended for this item.

A paper on the preparation of the Quality Account was submitted for the Committee's consideration.

All DHBs have a Quality Account and the Committee will be involved in setting the priorities that will sit alongside Waikato DHB's strategic imperatives. Progression with most programme plans in the Quality Account has been slower than expected but are now beginning to get traction.

An update report will be provided to the Committee every six months.

Resolved
THAT
The Committee received the report.

9.9 Medical School

A progress report on the proposed third Medical School, being led by Waikato DHB and the University of Waikato, was submitted for the Committee's information. The business case was completed and submitted on 31 May 2017. A formal presentation on this matter would be given at the next Committee meeting.

Committee members agreed that information is required on the costs and benefits of the medical school and that this should be submitted to the next Board meeting under public excluded.

Resolved
THAT
The Committee received the report.

9.10 CBD Accommodation Project

No paper this month.

9.11 Primary Care Integration

A presentation was given by Dr D Tomic on the portfolio and activities occurring across Primary and Integrated Care.

Resolved
THAT
The Committee received the presentation.

ITEM 10: PRIORITY PROGRAMME PLANS

10.1 PPP 1.4: Enable a Workforce to Delivery Culturally Appropriate Services

Mr D Hackett, Executive Director Executive Director of Virtual Care and Innovation and Ms M Berryman, Kaitakawaenga, attended for this item.

The second priority programme plan to operationalise the Waikato DHB's strategy was submitted for the Committee's consideration and approval to progress to implementation phase.

This priority programme plan is concerned with enabling a workforce to deliver culturally appropriate services within Waikato DHB. Management advised that this paper was lengthy due to the attachments (including literature and research) and the templated

process followed to produce a priority programme plan. The attachments could be dispensed for the purposes of providing them to the Committee.

Key points raised by the Committee included:

- Workforce development is more than learning how to pronounce names correctly.
- Cultural competency comes from having a programme or service well equipped to identify where a culture change needs to be made for Maori and all ethnicities.
- With the DHB limited in terms of time and resources a clearer picture is needed of the activities that will make an impact, improve performance and that achievable.
- There are gaps in the activities and objectives gathered for this plan and this needs to be relooked at. For example, a focus on anti racism.
- It is not apparent from the activities listed which will contribute to the organisation's top priority to make radical improvements in Maori Health.
- The plan lacks a sense of urgency.
- The organisation needs to show more courage and strong leadership in terms of the activities that will drive change and improvements.
- The number of priority programme plans for implementation is of concern, especially given the timeframes attached to these.
- The staff orientation programme should include a cultural training session for all new staff members, and this should be implemented immediately.
- The importance of delivering appropriate services and care to other cultures such as disability (approximately 15% of Waikato's population).
- Reviewing the work undertaken by the Waikato University for the Education sector around culturally appropriate teaching methods and relationships to ascertain whether a strand/s of this work could be applied to health education.

Resolved
THAT

1) The report be received.
2) Management to submit a simplified list of targeted activities and actions that will make a direct impact on improving the delivery of culturally appropriate services and associated timelines for the Committee's consideration at their August meeting.
3) Future submissions to the Committee to include the priority programme plan document and specific bibliography only.

Ms S Webb left the meeting at 3.30pm.

10.2 Priority Programme Plan Project Update

Ms E McKenzie-Norton and Ms N Parker attended for this agenda item to provide a recap and update on the priority programme plan project.

Resolved
THAT
The update be received.

ITEM 11: GENERAL BUSINESS

There were no general business items raised.

ITEM 12: DATE OF NEXT MEETING

9 August 2017

RESOLUTION TO EXCLUDE THE PUBLIC
NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

THAT:

(1) The public be excluded from the following part of the proceedings of this meeting, namely:

Item 13: Minutes of the Health Strategy Committee dated 12 April 2017
Item 14: CBD Accommodation Projects

(2) The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 13: Minutes	Items were taken with the public excluded
Item 14: CBD Accommodation	Contract negotiations will be required

(3) This resolution is made in reliance on Clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public are as follows:

Item 13: As shown on resolution to exclude the public from the minutes.

Item 14: Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.

ITEM 14: PUBLIC EXCLUDED MINUTES OF THE HEALTH STRATEGY COMMITTEED DATED12 APRIL2017

Resolved
THAT
The minutes of the public excluded part of a meeting of the Waikato DHB Health Strategy Committee held on 12 April 2017 be confirmed as a true and correct record.

ITEM 15: CBD ACCOMMODATION PROJECTS

This agenda item was referred to the June board meeting.

RE-ADMITTANCE OF THE PUBLIC

THAT:

(1) The Public Be Re-Admitted.

(2) The Executive be delegated authority after the meeting to determine which items should be made publicly available for the purposes of publicity or implementation

Chairperson: _____

Date: _____

Meeting Closed: 4:30pm

Waikato District Health Board

Chief Executive Report

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 4

CHIEF EXECUTIVE'S REPORT

Purpose	For consideration and information.

Format of Agenda

At the last meeting and subsequent to it there were discussions around the format of the Board agenda and, more broadly, the format for the day of the Board meeting. It was agreed that we would run a programme which every second month allowed for a discussion of strategic items outside of the formal Board meeting. Thus the day would be as follows:

Month A

1.00 – 1.30pm Board only.
1.30 – 2.00pm Board and Chief Executive only.
2.00 – 3.00pm Strategic workshop.
3.00pm Board meeting.

Month B

1.00 – 1.30pm Board only.
1.30 – 2.00pm Board and Chief Executive only.
2.00pm Board meeting.

In month A the monitoring reports would be reduced to allow the extra time prior to the meeting.

For June we are in Month A except that the previously scheduled primary care workshop is the strategic workshop for the day and has not been rescheduled to align with the proposed programme.

Please note that for this month we have not truncated the monitoring reports in keeping with this approach. That will occur for the first time in August.

It was agreed that the agenda flow would be from more important to less important, and we have reflected that in the format.

It was proposed that irrespective of reporting elsewhere each Board report from the Chief Executive contains a paragraph or two on the key issues confronting the organisation.

I am proposing the following list for now and invite comments on it:

- Budget for 2017/18
- ED performance and acute flow
- Theatre performance and ESPIs
- Cardiac waiting list
- Current financial status for 2016/17
- SmartHealth
- Waikato Medical School.

Finally it was suggested that Quality and Safety would become a regular feature of Board reporting, as per the current agenda format. Given the extensive reporting on quality and safety elsewhere can I confirm that this is indeed the intention?

Budget for 2017/18

A budget paper is included in this agenda. Key aspect is that it reflects a deficit of $38m, subject to finalisation of the funding envelope. It should be noted that that this number is after many hours of discussion as to how costs might be reduced and is therefore already challenging.

ED Performance and Acute Flow

For May 2017, Waikato Hospital continued to struggle with performance on the 6 hour target, ending the month on 82.8% within 6 hours. Thames hospital experienced a busy month and did not meet the 6 hr target either, however improved its performance from 90.1% to 93.8% within six hours. Combined for the DHB, performance was 86.4% for May.

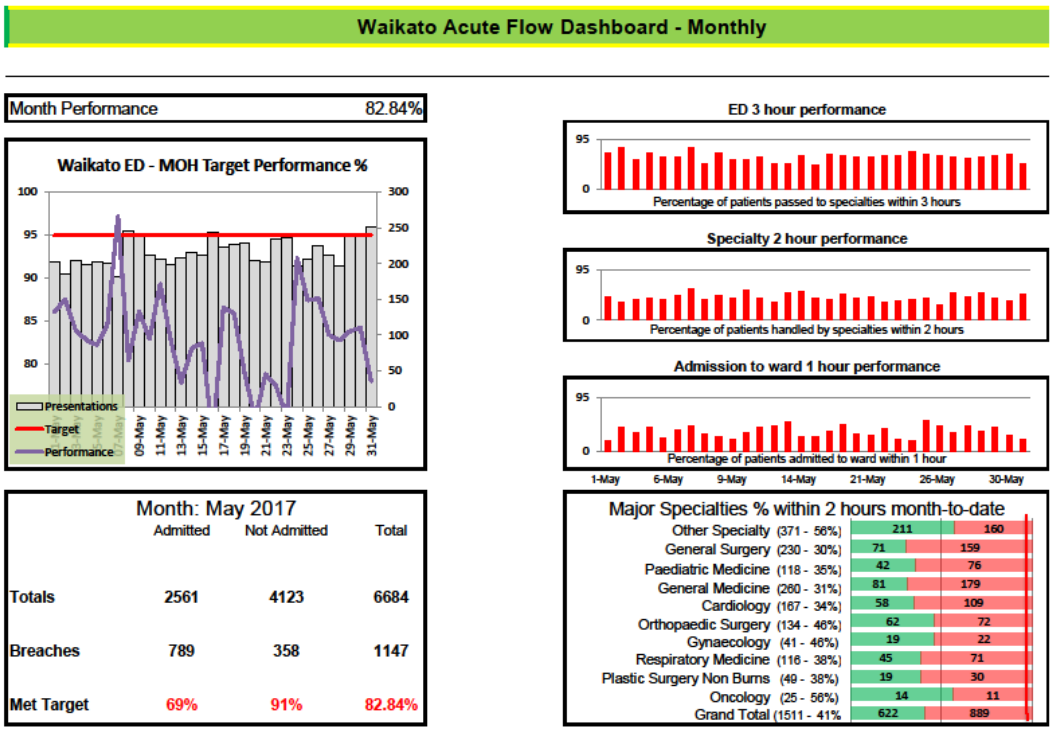
Presentations to ED in Waikato Hospital for the month of May were 8% higher than previous year, and YTD May presentations were 3.8% higher than last year.

For Waikato Hospital, 'main delay' phases for patient breaches in May were most commonly specialist assessment (39%), ED assessment (37%), and bed allocation (24%).

Pressure on beds in Waikato Hospital remains a concern particularly after weekends, with the hospital having to invoke an incident management response to address the hospital being overloaded on Tuesday 23 May. The intervention of expedited discharging, demand management with primary care and the region, and cancelling of some electives clearly had good effect to reduce occupancy, however this level of escalation can only be used sparingly.

The response to the identified pressure points in the acute flow patient journey includes the implementation of a number of interventions in the short, medium and longer term. In the short term, focus has been on strengthening the escalations to expedite discharges and patient transfers to local care facilities, improved response to surges in ED presentations and increasing discharges over the weekends. Further, there has been renewed focus on embedding care pathways for semi-acute patients and establishing hot clinics, in particular in Cardiac, ENT and Ophthalmology, and on ensuring sufficient availability of Telemetry units as these have been holding back patient admissions. The short term initiatives are progressed through the weekly DHB wide demand and capacity meeting.

This work is in preparation for the planned launch of SAFER bundle project on 2 August as part of the patient flow programme. Also in the medium term, bed capacity will increase with the opening of OPR5 ward expected in September/October, planning for which is underway with urgency. With regard to longer term initiatives, I am pleased to advise that we received news that the business case for iMPACT patient flow manager tool has now been approved by the Ministry of Health.



While performance has not improved (in fact deteriorated) my present view is that the multiple initiatives outlined above should be allowed to mature in their implementation.

Theatre performance and ESPIs

ESPI compliance has been an area of intense focus with initiatives continuing in relation to managing inflows, advancing recruitment and implementing an action plan for the orthopaedic service. While there is more work to do before I can be comfortable with our management of ESPIs there has been very pleasing progress in this area.

We achieved ESPI 2 compliance (amber level) in April in official Ministry reporting and our internal assessment is that we also achieved amber compliance in May. That is the first time in the last year that we have achieved two consecutive months of amber compliance. While the result for June is a little tighter and remains uncertain, at the time of reporting we are realistically planning to comply in June too, barring a higher than planned level of cancellations due to acute demand. Achieving three months of compliance in succession will be a milestone to celebrate.

ESPI 5 was compliant in March but continued reduced elective operating theatre capacity due to anaesthetic RMO vacancies and high acute demand (made worse by the number of public holidays that occur in April) had a knock on impact which meant

that we were not compliant in April or May. We do however expect to be compliant for June and July.

A significant piece of work that has been undertaken to develop an outsourcing and facility list plan for 2017/18 should support reliable ESPI 5 performance as production becomes more assured and flows can be better managed against known capacity. Although we are not in a steady state yet regarding ESPI results we are moving in the right direction.

As far as theatre performance goes, elective theatre utilisation remains an area of particular attention. The deficit in anaesthetic resource will continue to adversely affect this marker in the short term however recruitment to four additional anaesthetist positions is looking promising, due to start by end of Q2. There is robust weekly management of utilisation against this resource through our Theatre Operational Group (TOG). The high number of public holidays days in April impacted on our elective utilisation however it is encouraging that utilisation is trending upwards YTD.

The waiting time for acute theatre access is consistently below our internally set 24hr and 48 hr targets. Our Theatre and Interventional Governance Group (TIGG) has initiated a piece of work supported by clear outcomes and deliverables to right size acute theatre capacity across both the week and weekends. The first phase has been to run two regular additional acute theatre sessions at weekends; this is now in place. The second phase is to establish the demand Monday to Friday in hours and develop an implementation plan to address this within existing capacity based on conversion of some elective sessions to acute. Modelled against actual elective displacement on acute patients this will not result in reduced elective cases but should improve patient experience by reducing short notice cancellations, while at the same time improving performance in relation to timeliness of acute surgery. The third phase is to assess what is required to right size evening acute theatre sessions.

Despite these initiatives, I am concerned at the overall performance of our surgical division. We are working through next steps to improve overall productivity.

Cardiac waiting list

This waitlist has been concerning us as the number waiting exceeds target. A recovery plan over a 10 week period was initiated in April comprising short term support from Auckland DHB and local outsourcing. We have commenced regular teleconferences with the Ministry to provide updates on this recovery plan. The number of people waiting in April was 91 compared to the guideline of 65 (maximum) patients waiting. At the time of this report there are 82 patients waiting. The recovery plan projects that by July end the number waiting will be 65; the need for further remedial action will be evaluated at that point.

The situation in respect of cardiac intervention has been complicated by a high number of transcatheter aortic valve implantation (TAVI) referrals. We are working with our Central region partners and the Ministry of Health to develop a plan to address the current backlog and develop a sustainable inflow path moving forward. The Clinical Unit Leader is working with the service to develop a single point of entry for all patients requiring intervention for aortic valve disease.

Current financial status for 2016/17

We continue to expect to deliver a break-even FY16/17 result, recognising that it is expected to be achieved through "grey areas" boundary pushing in terms of capitalisations of around $3.6m which will come back into future years as depreciation and other one-off adjustments.

SmartHealth

The rollout of SmartHealth has moved ahead with the integration with HealthLine completed on 6 June. We have had several referrals to the virtual after hour's doctor service from that date which have resulted with account being created in SmartHealth after the referrals.

The rollout to Hauraki PHO is now well underway with the first patient going live on the 16 of June. Over the next few weeks several practices will come onto SmartHealth with their patients and General Practitioners. At the Field Days event we had 178 patients sign up with brand recognition now happening with patients understanding the service offer via SmartHealth.

There is ongoing engagement with other DHB's with Southern DHB visiting last week to understand the service change being enabled by SmartHealth. There are further discussion planned next week with lance O'Sullivan and the iMOKO initiative.

There is ongoing work with Waikato Hospital to bring the clinical services onto the SmartHealth platform as quickly as possible. The plan is still to have all areas onto the system by the end of this calendar year. One of the keys to enabling this has been the establishment of the Virtual eHealth Clinical Design Authority which gives clinical staff direct oversight and prioritisation of work undertaken to evolve the SmartHealth platform.

District-wide Retrieval Service project

The DHB does not have a formal district wide retrieval service. Urgent retrievals currently occur on a best endeavours basis if ICU staff are available to undertake them. This is regularly not the case and as a consequence there can be delays in transferring high risk patients from a rural ED to Waikato. While the numbers of affected patients are low the potential clinical consequences are high. This is obviously a clinical risk and is of considerable concern both to front-line practitioners and the Executive. The actual number of urgent ED transfers is c. 15-20 a week, not all of which are retrieved by air nor involve ICU staff. Just over 2,000 triage category 1 and 2 patients attend the rural EDs each year, mostly at Thames, and most do not require urgent retrieval.

Site	Thames	Tokoroa	Taumar	Te Kuiti	all sites
all presentations, all triage categories	16,767	11,354	6,051	2,279	36,451
Triage 1 and 2	1,225	733	164	97	2,219
Percent of all presentations	7%	6%	3%	4%	6%

Significant funds have been allocated in the 2017/18 budget to establish a stand-alone virtual ED and retrieval service. This will involve unbundling existing resources from various services as well as creating additional capacity and systems. The final service will focus on facilitating high risk transfers, providing virtual support for high

risk local cases, and providing a virtual service for low risk low acuity Ed presentations in the rural setting. Whilst it may seem paradoxical to consider highest and lowest risk patients as part of the same service, this is the logical way to manage the downtime between high risk cases. This combination of Virtualised low-risk emergency medicine consults and centralised high risk retrieval coordination has proven to work well in rural Australia.

The service is expected to be operational from January 2018 onwards. Considerable service design and operational planning needs to be completed over the next six months. Progress will be reported to the Board through the Rural Strategy updates to the Health Strategy Committee.

Waikato Medical School

Waikato DHB and the University of Waikato have finalised the business case for a third medical school in the Waikato region business case, after responding to a number of questions raised by Ministers. The business case was completed and submitted on 31 May 2017. Government agencies including the Tertiary Education Commission, Treasury, Ministry of Health and Ministry of Primary Industries are presently review the business case.

Fieldays

During Fieldays there was a strong interest in the proposed Waikato Medical School and we had a stand which had a large “sign up” board where people could please their signatures or comments demonstrating support for the Waikato Medical School. Attached is the “sign up” board for your information.

A number of dignitaries also signed this board.

Waikato Mayoral Forum

On behalf of our Chairman, I recently attended the Waikato Mayor Forum and presented on the Waikato Medical School to Mayors and MPs. This presentation was well received and the Mayors were thanked for their letters of support to Government over the benefits of the Waikato Medical School.

MPs who were in attendance were:

- Hon Anne Tolley, Minister for Local Government
- Hon Scott Simpson, MP for Coromandel and Minister of Statistics
- Nanaia Mahuta, MP for Hauraki-Waikato
- Sue Moroney, List Member – Labour Party.

Research Grants

The Waikato DHB and University of Waikato alliance has scored a coup in attracting three project grants from the HRC worth in total just over $3.3 million. Professor Ross Lawrenson has been awarded two project grants from the Health Research Council worth nearly $2.4 million dollars. The funding will be used to investigate how we can improve outcomes in patients with cancer by focussing on reducing delays in diagnosis. The first grant, will examine ways to improve early diagnosis of lung cancer among Maori and rural communities. Lung cancer survival in New Zealand is poor especially for Maori. This is because lung cancer is generally diagnosed at a

late stage. Early stage cancer can be cured with surgery in 75% of patients. The reasons for late diagnosis can be due to both patient and system factors. This study will be through a multi-site intervention within targeted populations to increase awareness of lung cancer, the benefits of early diagnosis and to reduce fear of presenting. In the three-year, $1,199,000 project, Professor Lawrenson will work on a community designed intervention to increase early presentation for Māori with symptoms of lung cancer. He plans a multi-site intervention within targeted populations that will help people to increase awareness of the disease, the benefits of early diagnosis and which will also reduce the fear of presenting. There is a strong change orientation within the project which involves stakeholders such as the Māori community, GPs and lung cancer specialists. By initially targeting Māori we ensure we do not increase inequity in the system whilst aiming to improve the diagnostic pathway for all. Co-investigators on this project include the Waikato Hospital Clinical Director of the Respiratory Department Dr Janice Wong and a, respiratory physician from Lakes DHB Dr Denise Aitken.

A second project will focus on finding ways to avoid delays in diagnosis for colorectal cancer. This project will also span three years and is worth $1,195,378. Again early cancer diagnosis is the focus. We know from our earlier HRC study led by Professor Chris Jackson from the Cancer Society the benefits from early diagnosis of colorectal cancer in improved chances of survival. Part of the research will be interviewing patients about their experiences, and analysing referral pathways and GP practice to find ways to quicken the diagnostic process, including follow-up pathways despite negative tests, and smoother transitions between primary and secondary care. This project includes as investigators Dr Ralph Van Dalen, Consultant colorectal and general surgeon at Waikato hospital and regional chair for National cancer working group on colorectal cancer and Ms Judith Warren, the Waikato colorectal cancer specialist nurse. Professor Lawrenson is also working closely with the Midland Cancer Network and Regional Director Jan Smith.

In a third project grant awarded to a collaboration between the Waikato DHB and the University of Waikato led by Dr Nina Scott, from Te Puna Oranga (Māori Health Service), a study will examine whether a holistic approach improves health outcomes for Maori children admitted to hospital. The Waikato Hospital-based study will be conducted over three years and has received $933,933 from the Health Research Council. Dr Scott says half of hospitalised tamariki Māori aged zero to four are re-admitted to hospital within months of going home. That led Dr Scott and her colleagues to develop Harti Hauora Tamariki, a health-screening tool based on whānau ora, piloted in 2015 and still used at Waikato Hospital. This new research, will use Māori health research processes to show the effect of follow up actions from Harti Hauora Tamariki screening and effects on child health outcomes, including readmission rates and whānau satisfaction with care. Two other Waikato academics will be involved. Public health physician Associate Professor Polly Atatoa-Carr and community psychologist Dr Bridgette Masters-Awatere are working with Dr Nina Scott.

These successes build on another local HRC success when Waikato University lecturer Dr. Jamie Veale was awarded $238,000 in May for a transgender health survey. All of these projects add resource into the DHB and local community to help better understand the health needs of our patients.

Payment of Members of Maori Health Committee

The Board has been advised previously of the likely obstacles to paying the members of the Maori Health Committee. Further inquiry of the Ministry has revealed that for payment purposes there is a distinction between the Board members appointed to the Committee and external members appointed to it.

For the Board members it is necessary to demonstrate that the overall work-load of the Board members is in excess of the 30 days assumed annual workload (excluding any time spent sitting on other committees). Informal advice remains that we are highly unlikely to be successful in doing that. However, we will endeavour to do so once the committee has met a couple of times and it is clearer what it demands of its members.

For the external members the Cabinet's Fees Framework for Members Appointed to Bodies in Which the Crown has an Interest allows payment up to a maximum of the daily equivalent of the full member fee. Ministry advice is that to pay the external members at the same rate as the members of the statutory committees (i.e. $250 per meeting) seems reasonable.

It is therefore recommended that the members of the Maori Health Committee who are not members of the Board are paid at the rate of $250 per meeting with mileage reimbursement for attendance as necessary.

Ideally this decision should be retrospective to take account of the meeting already held.

Influenza Vaccination Update

I believe it is only a matter of time before the influenza season will be declared in the Waikato. Data is indicating that influenza is on the rise in the Waikato as well as nationally.

When influenza season is officially declared by our Chief Medical Officer of Health, section 2.2 of the Vaccination for Health Care Workers policy will become effective. This requires all health care workers who come in contact with patients to get the influenza vaccine or wear a mask during the official declared influenza season. Staff will also need to remember to follow normal infection control protocols when using masks.

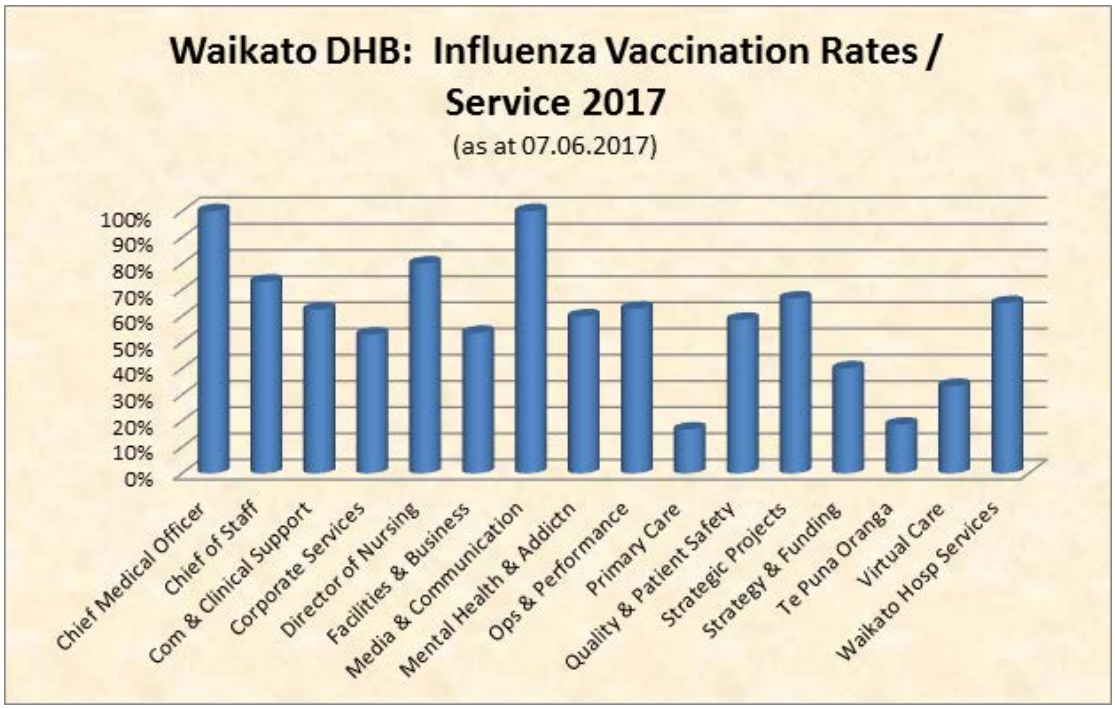
We will also be asking our visitors to wear a mask if they have not been vaccinated. Masks are to be readily available to both staff and public as they walk into the patient care location. There will be appropriate notices and available masks at main entrances to our facilities as well as at entrances to patient care locations.

I want to stress that getting vaccinated still remains the most effective way for staff to prevent the transmission of flu and keep them, their loved ones and patients safe this winter.

Below are the staff influenza vaccination details to date by Executive Director areas as well as staff group (19 June)

STAFF GROUP

Allied Vaccinated	655 (66%)
Doctor Vaccinated	582 (64%)
Midwives Vaccinated	57 (44.5%)
Non-Clinical Vaccinated	1015 (61%)
Nurses Vaccinated	1743 (69%)
Other Health Vaccinated	451 (60%)
Total Vaccinated	4520 (64.91%)



Executives Directors have been asked to share this year to date staff influenza data with their management teams, to encourage staff who have not had their free vaccinations to do so and to highlight the vaccination healthcare workers policy.

Waikato Hospital is experiencing increased pressure with high occupancy of sick and vulnerable patients. Along with staff sickness this puts us at risk of being in overload and above capacity. Therefore, it is very important that our community get prepared for the flu season. We are sending out the messages to public to be prepared for Winter by getting their flu vaccination, check their prescriptions are up-to-date and working for them, and to visit their GP before they get too sick rather than turning up at ED. No one really wants to get sick if they can help it so having a flu jab is a good start for those still to get vaccinated.

Recommendation
THAT
The Board receives the report.

DR NIGEL MURRAY
CHIEF EXECUTIVE


Waikato District Health Board
THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato
SIGN UP TO SUPPORT OUR
WAIKATO MEDICAL SCHOOL
MANA-MOTUHAKE!
Write your messages of support here
#WaikatoMedicalSchool

Waikato District Health Board

Quality and Safety

Waikato District Health Board

Decision Reports

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 6.1

2017/20 MIDLAND REGIONAL SERVICES PLAN

Purpose	For consideration and approval.

The 2017/20 Midland Regional Services Plan, Strategic Directions, Initiatives and Activities is attached for the Board's approval.

Mr Andrew Campbell-Stokes, Chief Executive of HealthShare, will attend the Board meeting to present on this item.

Recommendation
THAT
The report be received.

BOB SIMCOCK
CHAIRMAN

2017-20 Midland Regional Services Plan

SUBMITTED TO: Midland DHB Boards

Date: 6 June 2017

Prepared by: Suzanne Andrew, Manager, Regional Services Plan & Executive Projects, HealthShare

Submitted by: Andrew Campbell-Stokes, Chief Executive Officer, HealthShare

Attachments:

1. 2017-20 Midland Regional Services Plan (second draft) [Strategic Directions]
2. 2017-20 Midland Regional Services Plan (second draft) [Initiatives & Activities]
3. MoH introduction to the Regional Services Plan – see page 3
4. Overview of HealthShare Ltd (Appendix 4 from Midland Region Governance Collaboration Manual) – see pages 4-5

Recommendations:

1. **NOTE** the updated regional Maori health content in the 2017-20 Midland Regional Services Plan - Initiatives & Activities document (second draft)
2. **NOTE** the request to update Regional Objective No.1 from '*Improving Māori Health Outcomes*' to '*Health Equity for Māori*' – as proposed by the Midland Iwi Relationship Board and Nga Toka Hauora (Midland GMs Māori Health) to the Midland Region Governance Group and Midland DHB CEs Group for consideration, 1-2 June 2017 (outcome awaited)
3. **APPROVE** the 2017-20 Midland Regional Services Plan – Strategic Directions document (second draft), subject to further MoH feedback, and
4. **APPROVE** the 2017-20 Midland Regional Services Plan – Initiatives & Activities document (second draft), *subject to further drafting required by the MoH via informal and final feedback.*

Background

The Ministry of Health requires DHBs to collaborate regionally and for each region to develop a Regional Services Plan (RSP) – see page 3 for an overview of the Ministry's guidance for RSP development.

HealthShare Ltd, the Midland DHBs shared services agency, is tasked with developing the Midland RSP, on behalf of the Midland region. This work is done in consultation with the Midland DHBs Annual Plan Writers Group and DHB Executive Groups to ensure collaboration and a line of sight between the region and DHB planning. An overview of HealthShare is included as background information for Boards (see pages 4-5).

Further reading on HealthShare – HealthShare Ltd Annual Report for the Year Ended 30 June 2016

Feedback

Feedback on the 2017-20 Midland RSP Strategic Directions and Initiatives and Activities documents can be made to:
Suzanne Andrew suzanne.andrew@healthshare.co.nz

Timeline:

Midland Regional Services Plan writing, submission and MoH review process:

<table>
<tr><th>Activity</th><th>Date</th><th>Progress</th></tr>
<tr><td>Ministry of Health (MoH) Regional Services Plan (RSP) guidance updates received</td><td>February 2017</td><td>Complete</td></tr>
<tr><td>Midland Clinical Networks and Clinical Action Groups developed 2017-18 proposed key outputs/focus areas for GMs Planning & Funding and Chief Operating Officers' joint meeting on 7 February 2017</td><td>7 February 2017</td><td>Complete</td></tr>
<tr><td>Midland Clinical Networks and Clinical Action Groups, Workforce, IS, Quality, Maori Health, Audit & Assurance, Internal Audit, Map of Medicine submit draft content and 2017-18 full work plans (where applicable) to Manager, RSP</td><td>23 February 2017</td><td>Complete</td></tr>
<tr><td>2017-20 Midland RSP (first draft) and proposed key outputs/focus areas submitted for the MRGG and Midland CE Group meetings</td><td>3 March 2017</td><td>Complete</td></tr>
<tr><td>Midland DHBs submit 2017-20 Midland RSP (first draft) to the MoH (includes any updated content and work plans)</td><td>31 March 2017</td><td>Complete</td></tr>
<tr><td>MoH facilitates feedback on draft RSPs.
Final draft 2017-20 Midland RSP is supplied to MRGG for approval</td><td>10 May 2017</td><td>Complete</td></tr>
<tr><td>Review of feedback, amendment to work plans and RSP content
(note: guidance received re SUDI 23 May 2017 – awaiting advice re content required)</td><td>10-30 May 2017</td><td>Complete</td></tr>
<tr><td>Midland DHBs submit 2017-20 Midland RSP (final version) to the MoH</td><td>30 May 2017</td><td>Complete</td></tr>
<tr><td>2017-20 Midland RSP (second draft) and proposed key outputs/focus areas submitted for the MRGG and Midland CE Group meetings</td><td>2 June 2017</td><td>Complete</td></tr>
<tr><td>Submit 2017-20 Midland RSP (final version) to the Midland DHB Boards for feedback and approval
<table>
<tr><th>Midland DHBs</th><th>Midland Boards - papers due date</th></tr>
<tr><td>Bay of Plenty DHB</td><td>9 June 2017</td></tr>
<tr><td>Lakes DHB</td><td>6 June 2017</td></tr>
<tr><td>Hauora Tairawhiti</td><td>TBC</td></tr>
<tr><td>Taranaki DHB</td><td>19 June 2017</td></tr>
<tr><td>Waikato DHB</td><td>19 June 2017
Note 'First Version' RSP has gone through previous board papers</td></tr>
</table></td><td>June 2017</td><td></td></tr>
<tr><td>MoH facilitates feedback on 2017-20 Midland RSP (final version)</td><td>12 June 2017</td><td></td></tr>
<tr><td>MoH ongoing resolution of issues with RSPs</td><td>From 12 June 2017</td><td></td></tr>
<tr><td>Material changes to the second draft of the Midland RSP will be detailed for MRGG and the Midland CE Group prior to submission of the final version.</td><td>19 June 2017</td><td></td></tr>
<tr><td>Midland DHBs submit final signed 2017-20 Midland Regional Services Plan to Minister of Health for approval (if not already done so)</td><td>23 June 2017</td><td></td></tr>
</table>

'**Regional collaboration**

District Health Boards (DHBs) are expected to work together at a regional level to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services. Improving regional collaboration between DHBs has been an evolving process over time. In the last few years, significant progress has been made in establishing the key foundations to assist regional collaboration and DHBs are in a good position to continue implementing their regional and sub-regional priorities.

Regional Service Plan

The purpose of a Regional Service Plan (RSP) is to provide a mechanism for DHBs to document their regional collaboration efforts and align service and capacity planning in a deliberate way. The RSPs include national priorities for regional delivery and locally agreed regional priorities, and outline how DHBs intend to plan, fund and implement these services at a regional or sub-regional level. The plans have a specific focus on reducing service vulnerability, reducing costs and improving the quality of care to patients.

High-quality health care results from the simultaneous implementation of three quality dimensions: improved quality, safety and experience of care, improved health and equity for all populations, and best value for public health system resources. High-quality health and disability services respond to the needs and aspirations of diverse population groups, and the health system must work to eliminate barriers to accessing high-quality health care. Therefore, the 2017/18 RSP guidance again includes a focus on health equity, which is a cross-cutting dimension of quality.

In 2017/18 the regions are expected to strengthen their focus on the regional enablers, and the guidance has been updated to reflect this. The 2017/18 RSPs must reflect the New Zealand Health Strategy's and in particular the RSPs should clearly align to the Strategy themes of people powered, closer to home, value and high performance, one team, and smart system.'

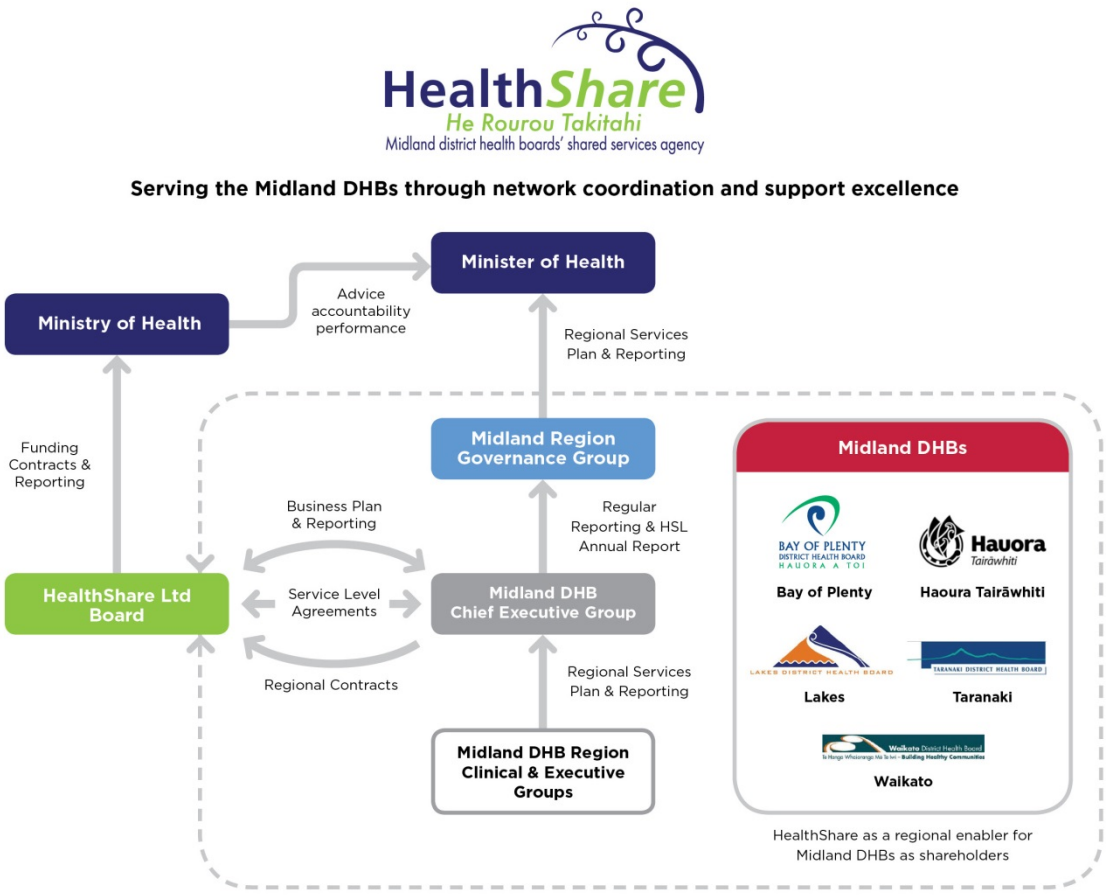
Overview of HealthShare Ltd

HealthShare Ltd, established in 2001, is the Midland Region's Shared Services Agency. It is jointly owned by Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato District Health Boards, each with a 20% shareholding.

Until mid-2011 HealthShare op'erated as a single function shared service agency with the primary purpose of assisting the Shareholding DHBs in meeting their statutory and contractual obligations to monitor the delivery and performance of services through the provision of routine third party audit programmes.

From August 2011 HealthShare took on an expanded role and now provides operational support to the Midland DHBs in a number of areas identified as benefiting from a regional solution. Where HealthShare provides services to non-shareholding DHBs, (eg. third party audit and assurance) this support is provided under contract.

HealthShare has a five member Board of Directors comprising the CE of each of the shareholding DHBs. The CE is accountable to the Board, through the Chairman, for the management of HealthShare and day to day operations. The Board meets monthly to monitor performance.



The Midland DHBs determine the services that HSL provide and the level of these services on an annual basis. These determinations are made through the RSP and regional business case processes.

HSL has key roles to play in the following areas:

Regional clinical service development initiatives through the following groups:

- Regional networks
    - Midland Cancer Network
    - Midland Cardiac Network
    - Midland Stroke Network
    - Midland Elective Services Network
    - Midland Mental Health and Addictions Network

- Regional clinical groups
    - Child Health Action Group
    - Midland Radiology Action Group
    - Health of Older People Action Group
- Regional e-health IT systems implementation
- Workforce development and intelligence support
- Regional shared service delivery including:
    - Third party provider audit and assurance service
    - Regional internal audit service (Waikato, Lakes, Taranaki, Tairāwhiti)
    - Map of Medicine regional pathway of care development and implementation
    - Taleo IS Admin support (for HR / Recruitment)

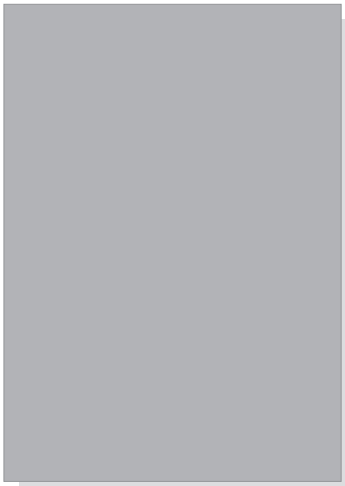
The nature of the services provided by HealthShare to the Midland region requires a close working relationship with DHB staff and key stakeholders. A key stakeholder relationship is with the Midland DHB CE Group, with the HealthShare Chief Executive in attendance.

2017 - 2020

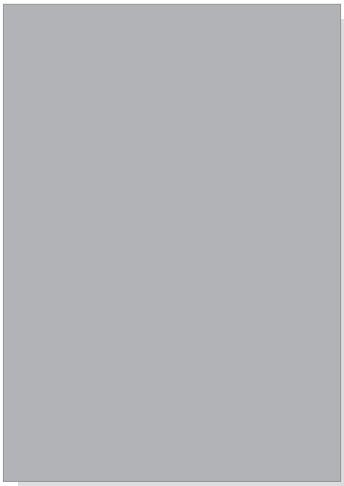
Regional Services Plan
Strategic Direction

Midland
District Health Boards
www.midlanddhbs.health.nz

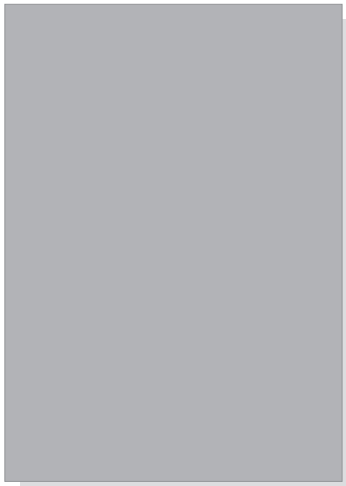
Midland DHBs Annual Plans



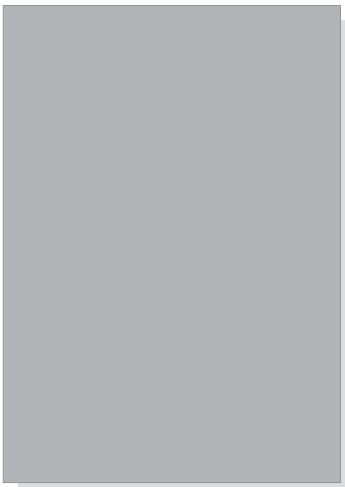
BAY OF PLENTY



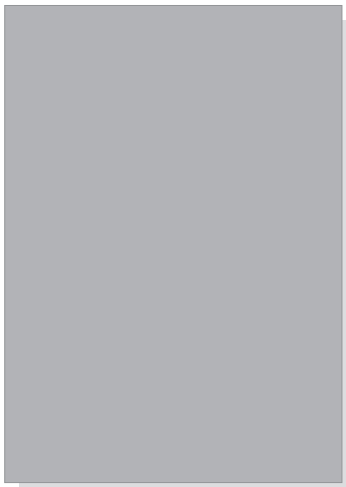
HAUORA TAIRĀWHITI



LAKES



TARANAKI



WAIKATO

The thought and creative design of this document has been intentionally aligned to the Bay of Plenty DHB 2015-16 Annual Plan Summary. Midland DHBs acknowledge the creativity of Bay of Plenty DHB and thanks them for their permission to apply this approach more widely.

Endorsement by Minister

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Endorsement by Board Chairs and Chief Executive Officers of Midland District Health Boards

Sally Webb
Chair

Helen Mason
Chief Executive

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

David Scott
Chair

Jim Green
Chief Executive

Hauora Tairāwhiti

Deryck Shaw
Chair

Ron Dunham
Chief Executive

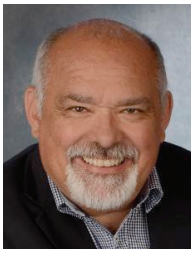
LAKES DISTRICT HEALTH BOARD

Pauline Lockett
Chair

Rosemary Clements
Chief Executive

TARANAKI DISTRICT HEALTH BOARD

Bob Simcock
Chair



Dr Nigel Murray
Chief Executive

Waikato District Health Board
Te Hanga Whaioranga Mō Te Iwi – Building Healthy Communities

Introduction

The 2017-20 Regional Services Plan (RSP) continues to focus on the greater achievement of health and wellbeing for the populations served by the Midland DHBs.

Bob Simcock
Chair, Midland Region Governance Group (DHB Board Chairs)

Collaboration between DHBs will always be a challenge as we struggle to find space to think outside of the district boundaries that demand so much of our attention. But our recent highly successful Midland DHB Boards development days provided a wonderful reminder of how much progress we are making as a region. Presentations on trauma, cancer, auditing, IT and quality all demonstrated how we are increasingly operating as a single region when we plan services. Our challenge now is to integrate this way of operating into everything we do.

The Midland region has the largest Māori population of any region in New Zealand. We cannot significantly improve the health of our population without dramatically improving the health of our Māori population. To do that Māori must be involved at every level of our planning. On top of the work being done within each board, over the last year the region has ensured that the regional Iwi Relationship Board is involved in each of our fora and as a result the challenge of improving Māori health is becoming increasingly central to everything we do.

Nationally, the Ministry of Health's focus on the New Zealand Health Strategy continues with its five strategic themes of: people-powered; closer to home; value and high performance; one team; and smart-system. These themes have been incorporated into the regional initiatives and activities of Midland's clinical networks and action groups work plans in 2017-18. The New Zealand Health Strategy is further enhanced by the Ministry's introduction of system-wide measures in 2016; supporting further quality improvements to deliver better health services and improved patient outcomes.

The Minister of Health, Dr Jonathan Coleman, has recently highlighted the improvement plans being developed by DHBs and PHOs to help keep patients out of hospital, improve patients' experience, and utilise prevention and early detection to avoid unnecessary or early deaths. These improvement plans are centred on the following nationally developed System Level Measures (SLMs); promoting better understanding and use of health information, engagement with

people in the design and delivery of health services, and better health investment in models of care based on local population needs:

- Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds (ie keeping children out of hospital) acute hospital bed days per capita (ie using health resources effectively)
- patient experience of care (ie person-centred care)
- amenable mortality rates (ie prevention and early detection)
- proportion of babies who live in a smoke-free household at six weeks postnatal (ie a healthy start)
- youth SLM (ie youth are healthy, safe and supported).

Each of our Midland DHB annual planning processes incorporates these SLMs, the associated contributory measures, and locally agreed actions. SLMs provide an opportunity for the region's DHBs to work with their communities, and primary and secondary care providers to improve health outcomes of their local populations. Specific activities, baseline and milestone measures (by ethnicity) are contained in individual Midland DHB Annual Plans. The work plans of the Midland region's clinical networks/action groups and regional enablers describe the initiatives and activities to be undertaken in 2017-18; supporting Midland DHBs' chosen contributory measures.

At a regional level the Midland DHBs Board Chairs and Chief Executives are continuing a journey of co-design with the region's communities; acknowledging that the wider determinants of health (environment, economy, education, housing, social support, workplaces, transport and recreation) are centrally important to improving the health outcomes of our populations.

Working regionally is challenging and complex, but the Midland region is making considerable progress, and our various boards are now seeing the real benefits of planning our services collaboratively.

""...the challenge of improving Māori health is becoming increasingly central to everything we do".

Our Vision
Tā Mātou Moemoea

All New Zealanders live well, stay well, get well.

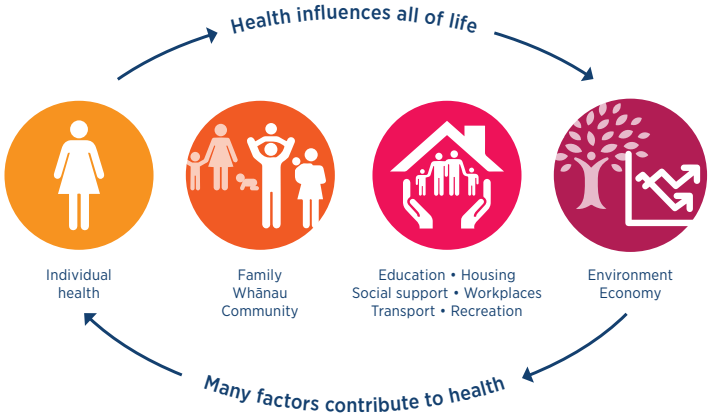
NZ Health Strategy 2016
Strategic Themes

This Strategy places particular emphasis on integration, which is critically dependent on a team approach.

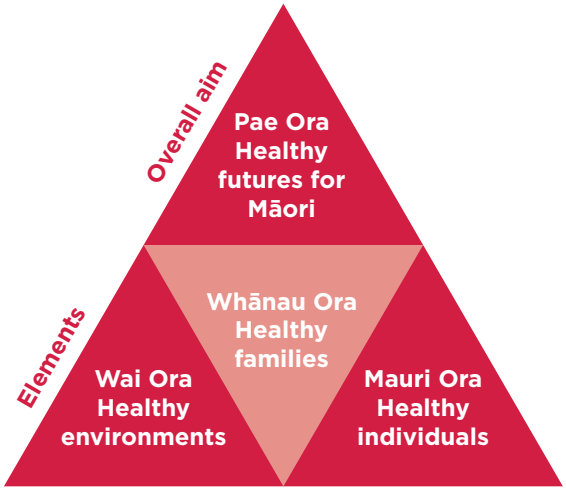
Particular examples of integration in the health system include:

- Integrated care for a disease condition or population that improves an individual person's journey (for example, a diabetes pathway)
- Integrated health services that combine different services under one roof (for example, provision of Well Child / Tamariki Ora checks at the same location as ultrasound scans)
- Coordination with initiatives in other sectors (for example, the Healthy Homes Initiatives)
- Vertical integration and service planning that make the right facilities available in the right coverage areas (for example, access to specialists from remote locations, or sharing equipment across hospitals)

Health links with the wider environment



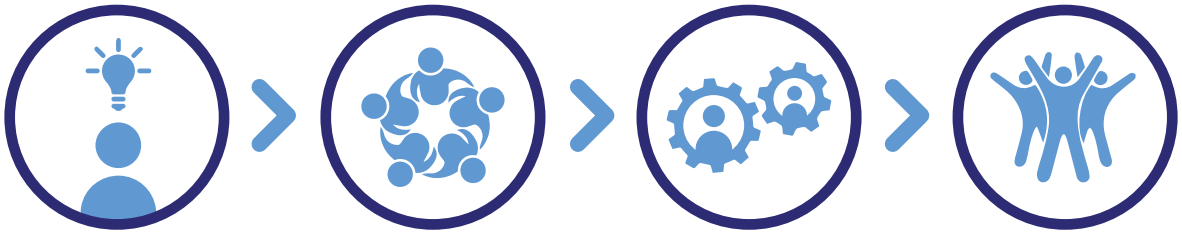
Pae Ora (Healthy Futures)



REFRESHED GUIDING PRINCIPLES FOR THE SYSTEM

1. The best **health and wellbeing** possible for all New Zealanders **throughout their lives**
2. An **improvement in health status** of those currently disadvantaged
3. Collaborative **health promotion** and disease and **injury prevention** by all sectors
4. Acknowledging the **special relationship** between Māori and the Crown under the **Treaty of Waitangi**
5. **Timely and equitable access** for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
6. A **high-performing system** in which people have **confidence**
7. Active **partnership** with **people and communities** at all levels
8. Thinking beyond narrow definitions of health and **collaborating with others** to achieve wellbeing

Investment approach



Information and knowledge → **Planning and collaborative working** → **Action and a high performing system** → **Long term gain and evaluation**

Our Strategic Outcomes

1 Improve the health of the Midland populations

Health and wellbeing is everyone's responsibility. Individuals and family and whānau are to actively manage their health and wellbeing; employers and local and central body regulators and policymakers are expected to provide a safe and healthy environment that communities can live within.

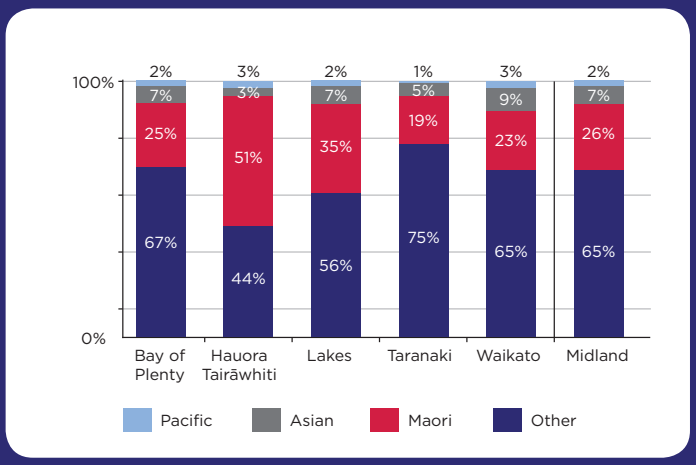
2 Eliminate health inequalities

The New Zealand health service has made good progress over the past 75 years. However, an ongoing challenge is to reduce ethnic inequalities in health outcomes for populations, particularly Māori and Pacific peoples. As a key focus Midland DHBs will work to eliminate health inequalities in its populations.

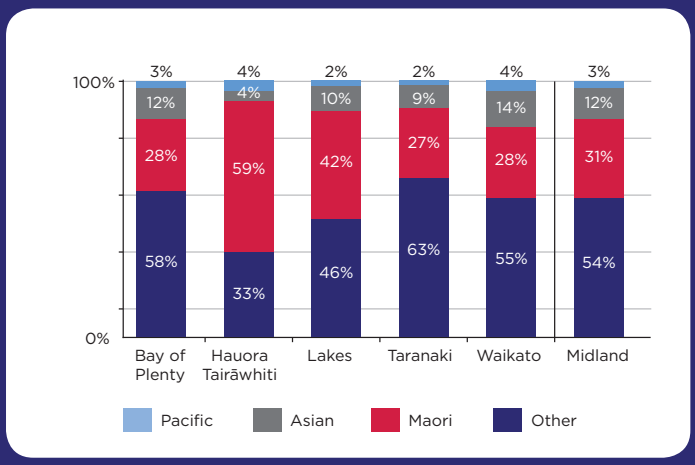
A core function of DHBs is to plan the strategic direction for health and disability services. This occurs in partnership with key stakeholders and our community (i.e. clinical leaders, iwi, Primary Health Organisations and non-Government organisations) and in collaboration with other DHBs and the Ministry of Health. Eliminating health inequalities is the goal.

Projected change in population distribution from 2017/18 to 2037/38

2017/18 Midland Total Projected Population by four main ethnicities



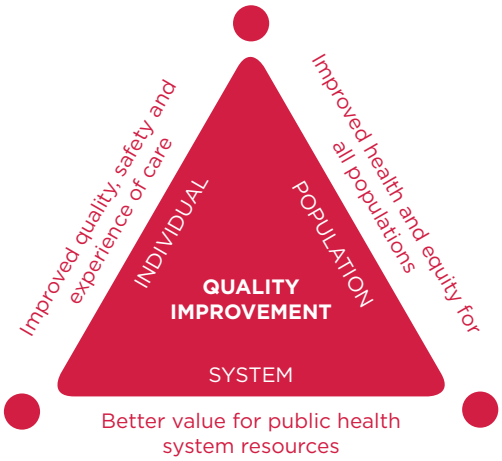
2037/38 Midland Total Projected Population by four main ethnicities



Source: Statistics NZ: Projected Population Tables (released Nov 2016)

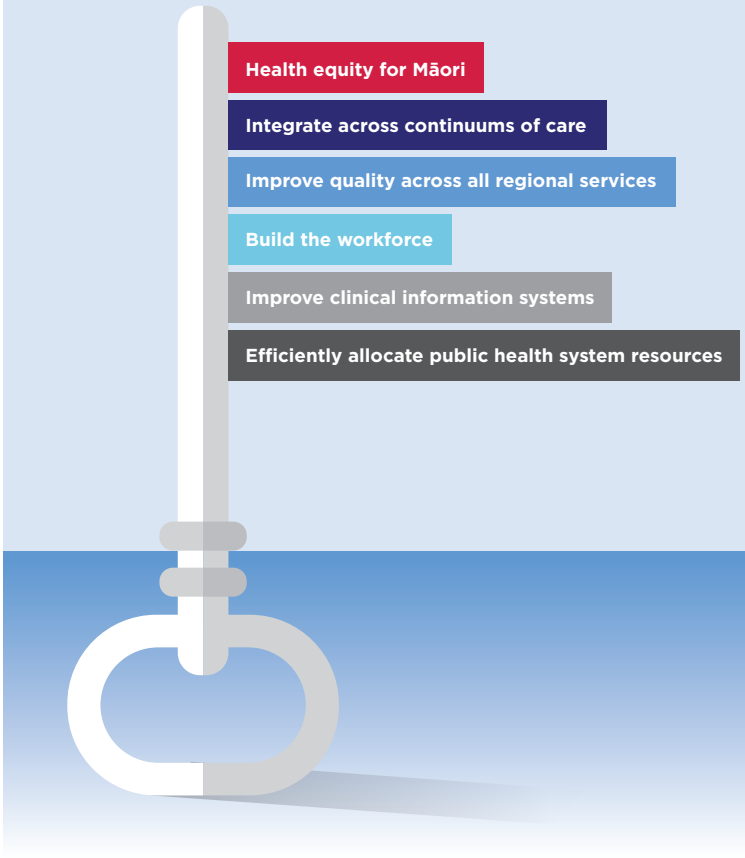
The NZ Triple Aim

The New Zealand Triple Aim Framework underpins the region's activities. The Triple Aim means:



The three objectives, applied in a consistent manner to quality improvement initiatives, challenge us to ensure all New Zealanders receive the best health and disability care within available resources.

Our six regional objectives



Our Health Targets

95% of patients will be admitted, discharged or transferred from an Emergency Department within six hours

The volume of elective surgery will be increased by at least 4,000 discharges per year

90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks.

95% of infants will be fully immunised by eight months of age

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% 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.

By December 2017, 95 percent 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.

About us

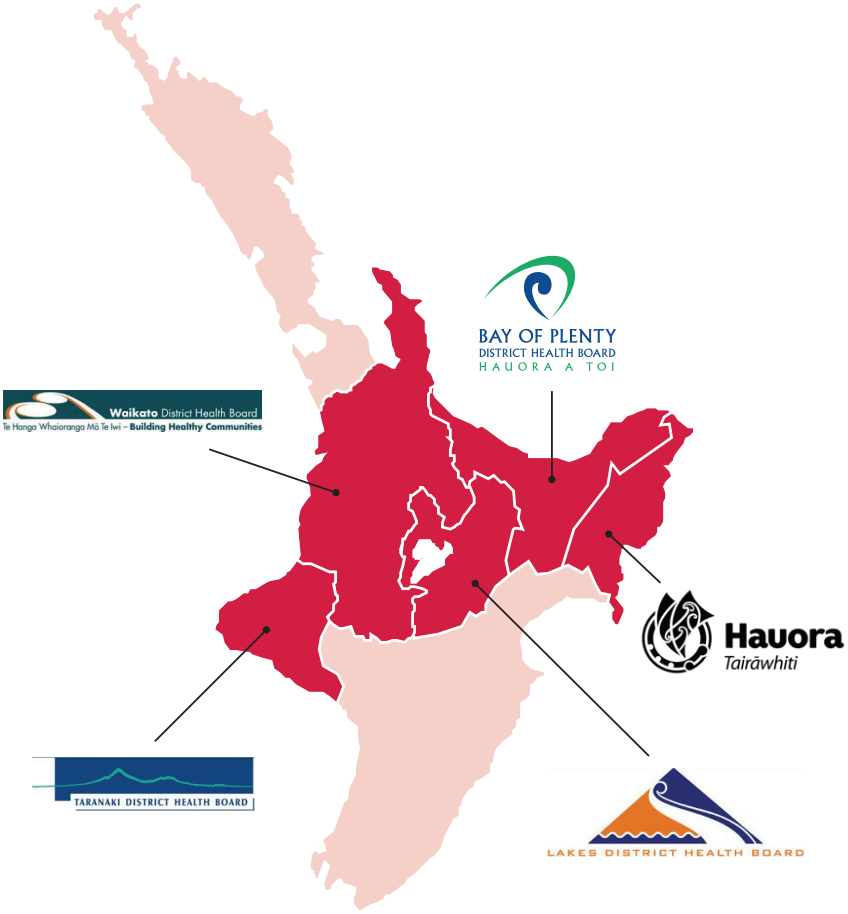
21% The Midland region covers an area of 56,728 km², or 21% of New Zealand's land mass.

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

5 DHBs Five District Health Boards: Bay of Plenty, Lakes, Tairāwhiti, Taranaki, and Waikato.

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

920,825 people (2017/18 population projections), including 236,830 Māori (26%) and 43 local iwi groups.



Midland region Iwi

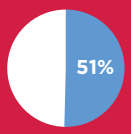
Māori population of DHB region

Bay of Plenty DHB

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

Hauora Tairāwhiti

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



Lakes DHB

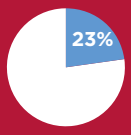
Te Arawa, Ngāti Tuwharetoa, Ngati Kahungunu ki Wairarapa

Taranaki DHB

Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngaruahinerangi, Ngāti Ruanui, Ngā Rauru

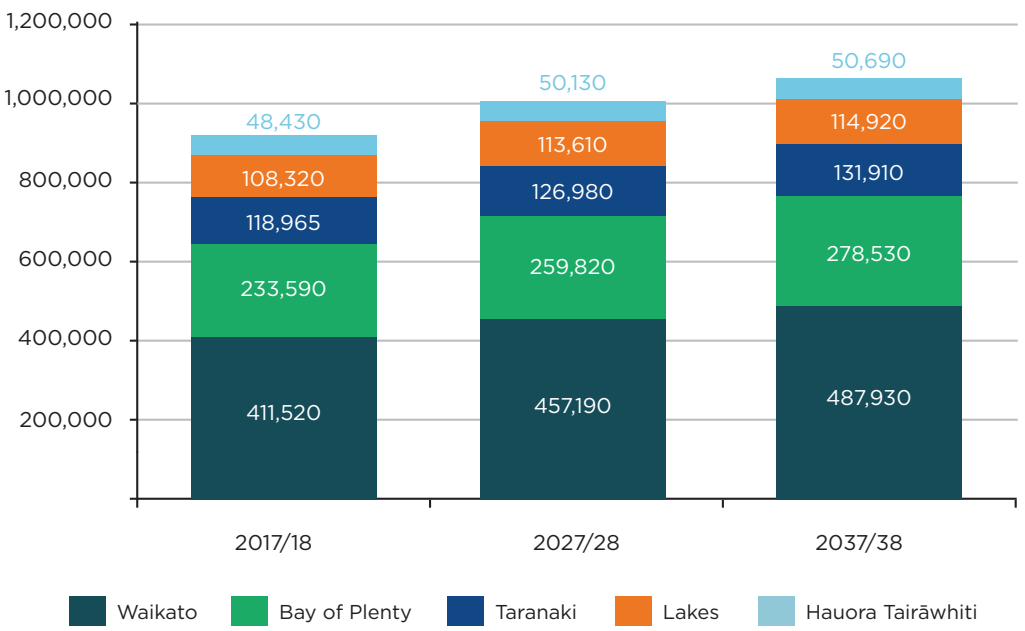
Waikato DHB

Hauraki, Ngāti Maniapoto, Ngāti Raukawa, Waikato, Tuwharetoa,Whanganui, Maata Waka

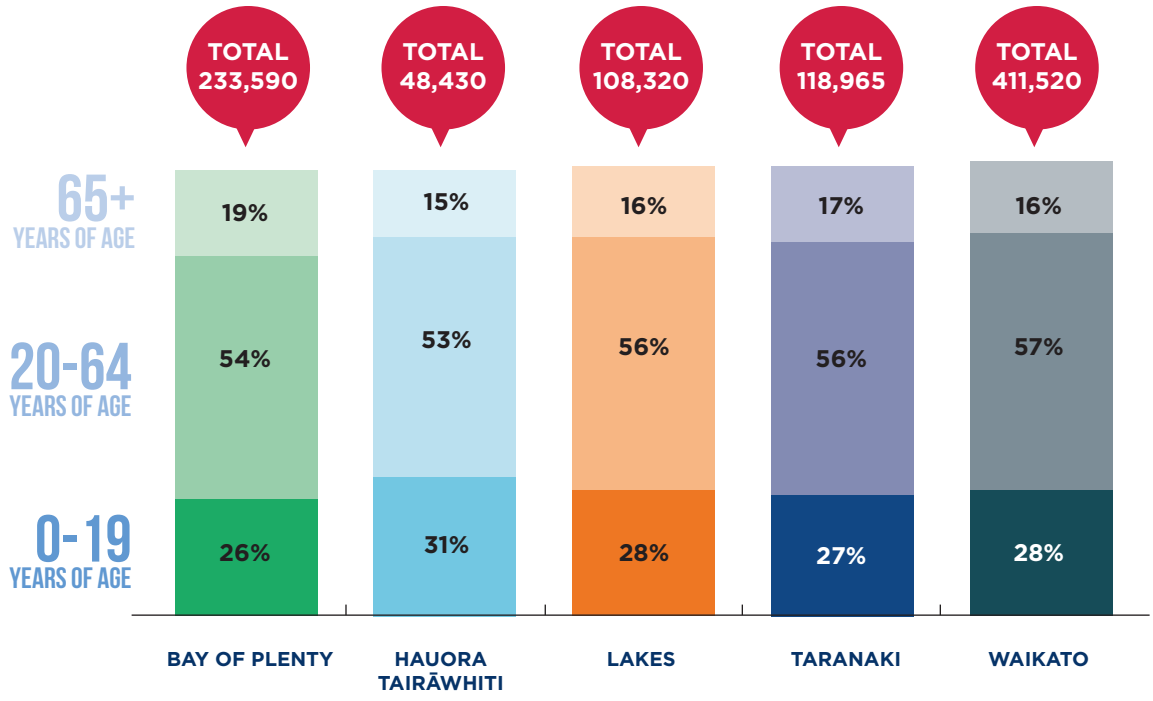


Midland DHB populations

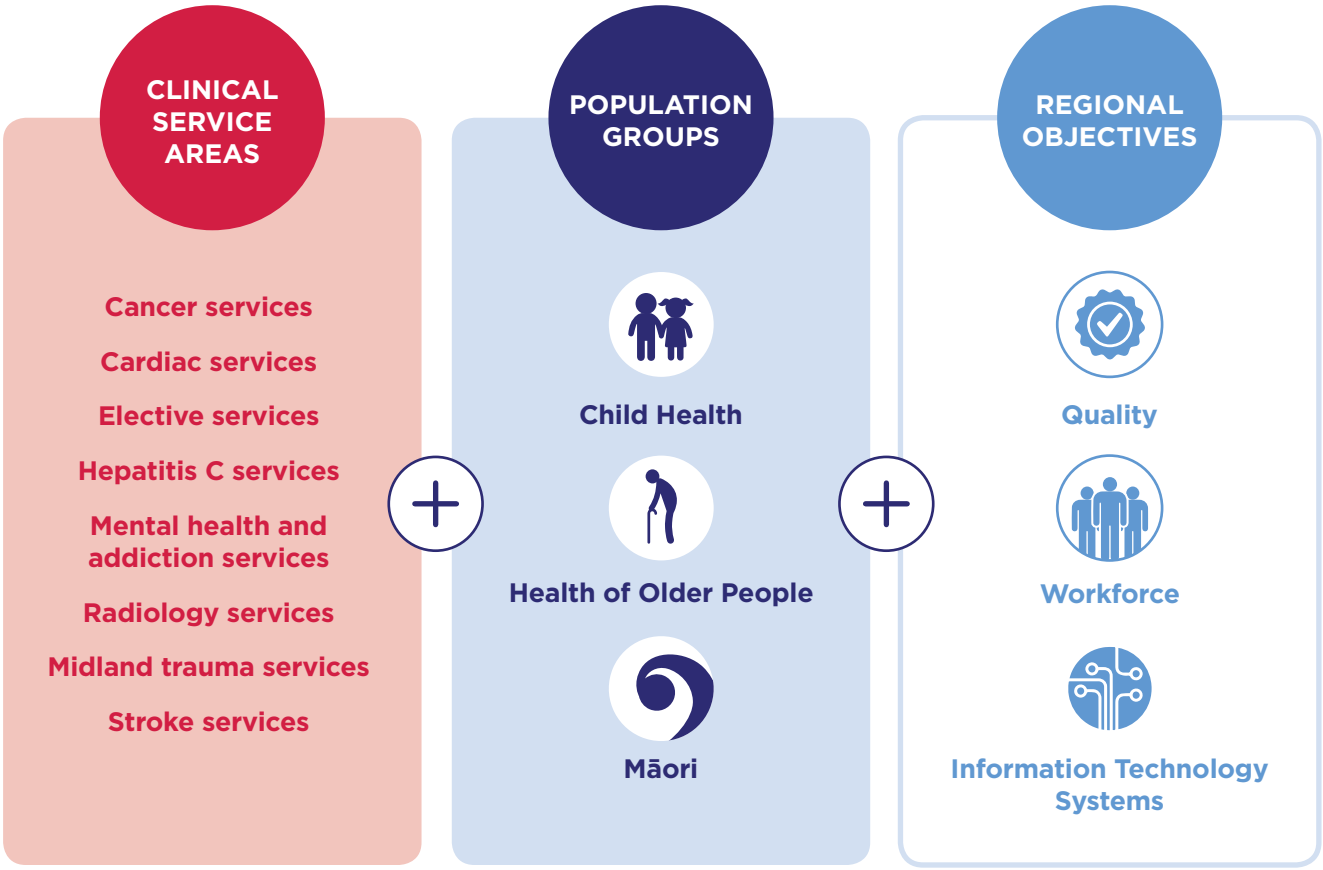
Projected change to Midland total population from 2017/18 to 2037/38



Source: Statistics NZ: Projected Population Tables (released Nov 2016)

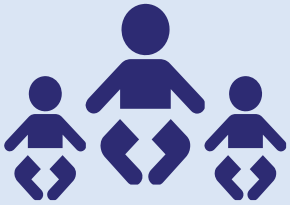


Regional Initiatives to Achieve Our Regional Objectives



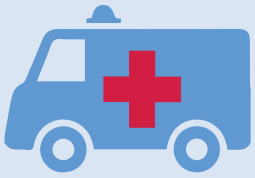
EVERY DAY
— IN THE REGION —

2015/16



33
BABIES WERE BORN [1]
(LAST YEAR: 33)

WE ENSURED
103 PATIENTS
RECEIVED THEIR ELECTIVE SURGERY DISCHARGES [2]
(LAST YEAR: 106)

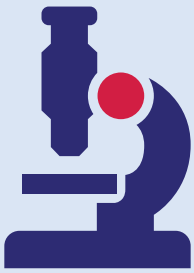


WE COMPLETED
824
EMERGENCY DEPARTMENT PRESENTATIONS [3]
(LAST YEAR: 788)

19
PEOPLE DIED [1]
(LAST YEAR: 18)

WE ADDRESSED
379 PATIENTS
ACUTE INPATIENT NEEDS [3]
(LAST YEAR: 441)

OUR COMMUNITY PHARMACISTS DISPENSED
37,074
ITEMS [3]
(LAST YEAR: 36,447)



OUR COMMUNITY LABS UNDERTOOK
16,682
TESTS [3]
(LAST YEAR: 15,040)

Notes

[1] Births and deaths: 2015/16 result is 2014/15 average and last year result is 2013/14 average from Statistics NZ. 2015/16 data available in March 2017. Births and deaths data recorded by regional council groups, not by DHB.

[2] Data sourced from DHBs' 2015/16 Electives Initiatives Report - surgical discharges are defined as discharges from a surgical purchase unit (PUC) including Intraocular Injections and Skin Lesions reported to NMDS, or discharges with a surgical DRG.

[3] Data sourced from DHB Annual Reports or directly from DHBs

The full document is available on the HealthShare website:

www.healthshare.co.nz

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Midland
District Health Boards
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2017 – 2020

Regional Services Plan
Initiatives and Activities
Second Draft

Midland
District Health Boards
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Note: This Regional Services Plan should be read in conjunction with the companion document '*The 2017-20 Regional Services Plan – Strategic Direction*', the Annual Plans, and the Regional Public Health Units Plans of the Midland District Health Boards.

Section 1: Regional initiatives and activities to achieve our regional objectives

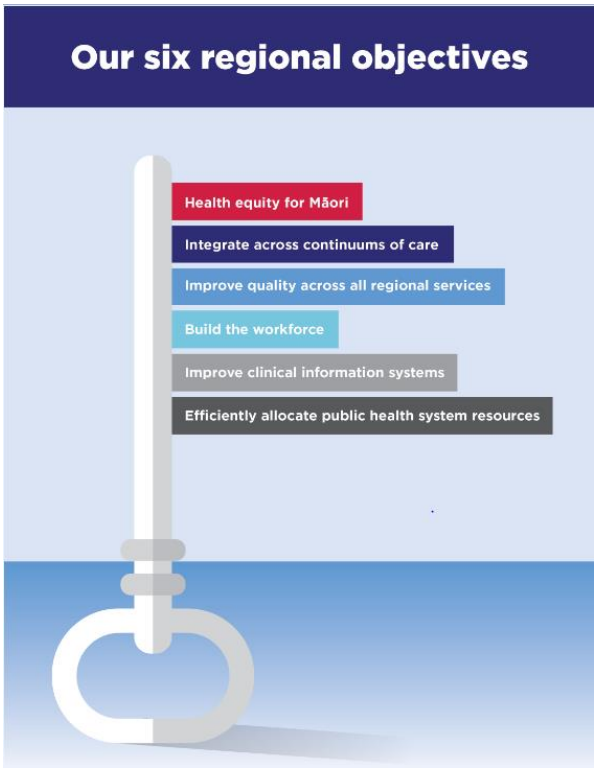
This document is a companion to the document *2017-20 Regional Services Plan – Strategic Direction*, which sets out at a high level the vision, strategy themes, priorities and objectives of the Midland District Health Boards (DHBs).

2017-20 Regional Services Plan – Initiatives and Activities provides detail about how DHB management groups, regional networks and clinical action groups (clinical and management representatives arranged in activity groups) are working to achieve our shared strategic direction. This is accompanied by more detail in Appendix 1.

As an overview, the structure of this document begins in Section 1 by clarifying what each regional strategic objective means, and our approach to achieving this. The regional strategic objectives were reviewed by the Midland Region Governance Group (MRGG) in December 2013 and endorsed with a sixth objective agreed. The Midland Iwi Relationship Board (MIRB) and Nga Toka Hauora (the Midland DHB GMs Māori Health) have requested that the first regional objective's wording be changed to: 'Health equity for Māori'. The Midland DHB CEs and Midland DHB Boards will look to formally confirm this change prior to the Minister's approval of this regional services plan. This enabled the strategic objectives to align well with the NZ Triple Aim Framework.

Section 2 then describes the activities of the Midland regional clinical networks and clinical action groups. Appendix 1 describes the activities of the regional enablers, ie Māori health, workforce, hepatitis C service, quality, workforce, Information Systems (IS), audit and assurance service, and regional internal audit service. Appendix 2 provides information about regional governance; Appendix 3 outlines the System Level Measures and contributory measures, and Appendix 4 provides a glossary of definitions of terms found in this document.

Figure 1: Midland DHBs six regional objectives



Objective 1: Health equity for Māori

Health inequalities affect a range of population groups including Māori, Pacifica, low socio-economic, low income workers, rural, elderly, disabled, migrants, refugees, those with poor English language skills, and those living in specified localities.

Midland region DHBs acknowledge that Māori are the main population group that are affected by health inequity across the Midland region and that DHBs have obligations under the Treaty of Waitangi to ensure Māori achieve the same health status as non-Māori.

> **"Totally support the Equity of Health Care for Māori Framework: *Championing the provision of high quality health care that delivers equity of outcomes for Māori*"**
>
> **Midland Iwi Relationship Board January 2017**

The Midland region's approach in 2017-18 is to focus efforts on supporting the Midland region DHBs, including its agencies, to build a culture which is enabling of attaining health equity for Māori. To achieve this there is a commitment to:

1. Health equity assessment using the Health Equity Assessment Tool, or an appropriate tool, being scheduled and/or carried out to assess the effectiveness for Māori, of existing regional services and/or new regional service models, programmes, policies and projects identified in the Regional Services Plan;
2. Applying whānau-centred health information management to regional services that supports whānau to better self-manage their own health and wellbeing;
3. Setting, monitoring and reporting 'no differential' targets for Māori and non-Māori for all monitored regional activity;
4. Increasing the Māori health and disability workforce across Midland DHBs, including its agencies; and providing support to increase the responsiveness of the health workforce to Māori.

Nga Toka Hauora, the Midland DHB GMs Māori Health, will work with HealthShare, with regional and local networks to guide the application of commitments 1 to 4 above across 2017-18 regional network activity in accordance with the 'Health Equity Template' on the following page, and also included in Appendix 1 with further detail.

Table 1: Health equity template

Priority area	Outcome reported	Responsibility	Milestones reported against
Building the evidence base	**Establish and embed ethnicity data reporting by:** Carrying out detailed analysis of relevant data and information relevant to each clinical regional priority to establish whether, and where, inequalities exist and to: • Establish baseline performance data • monitor and report on progress towards targets and inequality • Inform health equity assessment of current or future services as appropriate.	Regional groups supported by Nga Toka Hauora (Chair GM)	• 100% of regional priorities have baselines established that measure inequality between Māori and non-Māori[1] • 100% of regional priorities are reported quarterly by ethnicity[2]
Building a culture of equity	**Health equity assessment either scheduled or undertaken** • Health equity assessment using HEAT, or an appropriate tool, will be carried out on existing services to assess the effectiveness of current delivery models for meeting the needs of Māori or • Health equity assessment using HEAT, or an appropriate tool, will be carried out on proposed services to assess the likely impact of proposed delivery models on meeting the needs of Māori.	Regional groups supported by Nga Toka Hauora (Chair GM), HealthShare	• all regional groups will have carried out a health equity assessment of their work plan initiatives and activities, or will have scheduled a health equity assessment
Health Literacy	**Improve health literacy by:** • Assessing the need to review existing information resources within the department or service using *Rauemi Atawhai: A guide to developing health education resources in New Zealand*[3] with a view to improving information available to patients and whānau. • Undertaking a health literacy review with a view to improving information available to patients and whānau so that they can obtain, process and understand.	Regional groups supported by Nga Toka Hauora (Chair GM)	• all regional services have carried out a health literacy review • scope the opportunities for development of a health literacy app, working together collaboratively
Workforce	**Build Māori health workforce** • Each Midland DHB provides a workforce profile report that identifies the number and percentage of Māori employed by professional group within each of the DHBs. This workforce profile is utilised to track building Māori health workforce capacity development. • Establish a strategy to increase the Māori health and disability workforce, by DHB.	RDOW GMs HR supported by Nga Toka Hauora (Chair GM)	• a regional workforce profile will be established for all Midland DHBs that identifies the Māori and non-Māori workforces • strategy in place across Midland DHBs for Māori workforce increase in priority areas (refer workforce section of RSP) • Quarterly reporting of regional workforce by DHB are routinely produced and distributed

[1] In year one we will determine whether this can be achieved.

[2] In year one we will determine whether this can be achieved.

[3] Ministry of Health 2012. *Rauemi Atawhai: A guide to developing health education resources in New Zealand.* Wellington: Ministry of Health

Table 2: Summary of national Māori health indicators

National Priorities	Māori Health Indicators		Why this issue is important
Data Quality	1. Ethnicity data accuracy		Collecting accurate ethnicity data in accordance with the national Ethnicity Data Collection Protocols will improve the quality of ethnicity health data enabling us to effectively measure working towards health equity for Māori.
Access to care	2. 100 % of Māori enrolled in PHOs		PHO enrolment is the first step in ensuring all population groups have equitable access to primary health care services and is therefore a critical enabler for first point of contact health care. Differential access to and rganizatio of healthcare services plays an important role in health inequities, and for this reason it is important to focus on enrolment rates for Māori.
	3. Ambulatory sensitive hospitalisation (ASH)	0-4 yrs 45-64 yrs	ASH is a proxy measure for avoidable hospitalisations, and unmet healthcare need in a community based setting. There are significant differences in ASH rates for different population groups and a key focus on activities to reduce ASH must address the current inequities.
Child health[4]	4. Exclusive or fully breastfed at LMC discharge 5. Exclusive or fully breastfed at 3 months 6. Receiving breast milk at 6 months	6 weeks 75% 3 months 60% 6 months 65%	Breastfeeding provides infants with nutritional needs and builds infant immunity against a range of infectious diseases within the first 6 months of life.
Diabetes/ Cardiovascular Disease	7. 90% of 'eligible Māori men in the PHO aged 35-44 years' who have had a CVD risk recorded within the past five years		The burden of cardiovascular disease (heart and stroke) is greatest among the Māori population, and mortality is more than twice as high compared to non-Māori. CVD risk assessments are an important tool to enable early identification and management of people at risk of heart disease and diabetes. Fast access to treatment for heart related attacks is essential to achieve health equity and improve health outcomes for Māori.
Cancer	8. Breast screening rate 70% of eligible woman		Historically, Māori women have significantly higher incidence and mortality from breast cancer compared to non-Māori. Inequities in access to screening services need to be addressed to ensure Māori women experience the benefits of early detection of breast cancer.
	9. Cervical screening rate 80% of eligible woman		In 2012, Māori women were twice as likely as non-Māori to develop cervical cancer, and 2.3 more likely to die from it. Regular cervical screening detects early cell changes that would, over time, lead to cancer if not treated. Nationally, cervical screening coverage for Māori is 62.2%, compared to coverage in European/Other populations with coverage at 82.2%. Improving screening coverage in Māori women is therefore an important activity to improve this equity gap.

[4] Ministry of Health. 2016. Indicators for the Well Child / Tamariki Ora Quality Improvement Framework: September 2015. Wellington: Ministry of Health

National Priorities	Māori Health Indicators	Why this issue is important
Smoking	10. 95% of pregnant Māori women who are smoke free at two weeks postnatal	Hapu Māori wahine have very high smoking prevalence (three times higher than the national prevalence). Smoking during pregnancy increases the risk for pregnancy complications and tobacco smoke harms babies before and after they are born.
Immunisation	11. 95% of infants fully immunised by 8 months of age	Immunisation is the most effective way to actively protect your child from preventable diseases, ranging from whooping cough to meningitis and measles (Immunisation Advisory Centre, 2013). Although immunisation rates are high there is still a large health equity gap between Māori and non-Māori. Initiatives need to target Māori pēpi in order to achieve health equity.
	12. 75% of the eligible population (>65 years) are immunised against influenza annually	In 2014 Māori had the second highest rate of influenza confirmed hospitalisation, 49.2 per 100,000. The 65 years and over age group also have the highest rates of influenza admissions to ICU. A 75 percent influenza vaccination rate is required to provide the best protection for this age group and in particular for Māori. If we are able to increase immunisation rates for Māori, we will see a significant reduction in overall influenza cases.
Rheumatic Fever	13. 55% reduction in the number and rate of hospitalisations for acute rheumatic fever rate 1.2 per 100,000	Rheumatic fever is a serious but preventable illness that mainly affects Māori and Pacific children and young people aged 4 to 19 years. Reducing rheumatic fever will contribute to achieving equity of health for Māori.
Sudden Unexplained Death in Infancy	14. National SUDI target – 0.4 SUDI deaths per 1,000 live births	The target for SUDI will be lowered from 0.5 to 0.4 SUDI per 1,000 live births. The target has been lowered to match the reduced rate of SUDI among non-Māori infants (0.38 SUDI per 1,000 live births during 2010-2014). Yet there is still a significant difference in SUDI rates between Māori and non-Māori families living in Midland.
	15. All caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1 (minimum of 70% of all caregivers)	
Mental Health	16. Mental Health Act: section 29 community treatment order comparing Māori rates with other (per 100,000)	New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity.
Oral Health	17. 95% of Māori preschool tamariki are enrolled in the community oral health service	The inequity between Māori and non-Māori enrolments is significant therefore the need for more Māori targeted initiatives and programmes is crucial.

Objective 2: Integrate across continuums of care

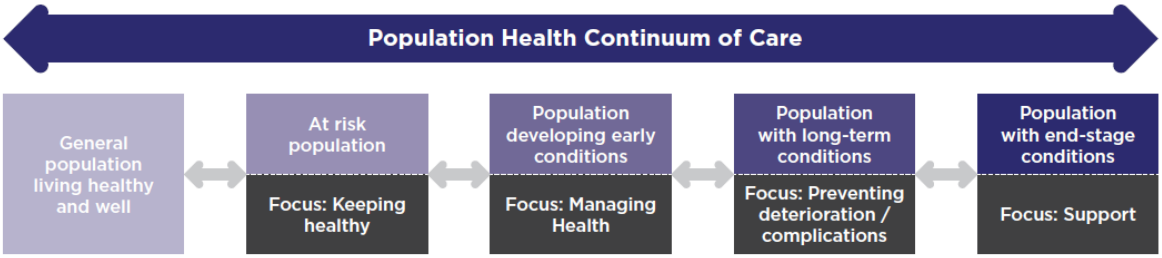
Midland DHBs are committed to developing integrated services across continuums of care. This provides improved quality, safety and the patient's experience of care. It also leads to more timely treatment and care, which in turn can result in better patient outcomes. Improved system integration can also support clinical and financial sustainability of services.

Figure 2 below describes a population health continuum of care. It describes various stages in decline in health and wellbeing, from (reading left to right) being healthy and well to having end-stage (end-of-life) conditions. Keeping healthy and people proactively managing their health to prevent deterioration and complications is vital. It is important to note that everyone will not experience all stages equally. For example, the length of time spent living healthy and well may differ for individuals, as may the length of time with end-stage conditions.

The vision statement of the New Zealand Health Strategy 2016 puts it well that

'All New Zealanders live well, stay well, and get well'

Figure 2: Population health continuum of care



There is no single accepted definition of integrated healthcare[5]. However, most definitions include references to seamlessness, co-ordination, patient centeredness, and whole of system working together.

Health and disability services are delivered by a complex network of organisations and people. Integrated healthcare is seen as essential to transforming the way that care is provided for people with long-term chronic health conditions and to enable people with complex medical and social needs to live healthy, fulfilling, independent lives[6]. People living with multiple health and

[5] The King's Fund: Lessons from experience - Making integrated care happen and scale and pace
[6] A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together http://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together

social care needs often experience highly fragmented services which are complex to navigate, leading to less than optimal experiences of care and outcomes.

Our response to the challenge requires a strong re-orientation away from the current emphasis on episodic and acute care towards prevention, self-care, better co-ordination, and care that addresses social determinants of health.

Midland DHBs are supporting integration across the continuum of care by implementing agreed care pathways using Map of Medicine and Bay Navigator. DHBs and PHOs are actively working to integrate services between primary and community care, and hospital care. Regional clinical groups are reviewing systems and processes across hospitals in the region to improve the flow of information, patients and clinicians. An example of integration across continuums of care in the Midland region is the regional pathways of care.

(i) Regional pathways of care

Regionally developed pathways of care are a key step in transforming patient care in the Midland region. They enable a collaborative regional approach to more integrated care, allowing the patient journey to be considered along the continuum of care across the region; between community and hospital care and across organisational boundaries. The pathways of care draw together groups of clinicians and management from primary, secondary and other stakeholders to critically evaluate current pathways of care which may include inefficiencies, variation in practice, inequity and gaps in service across our region.

The voice of the patient is of central importance in the design of pathways of care, and wherever possible this occurs to ensure that the needs of patients and their carers and whānau can be included. This includes referrals to NGO providers for respite care, education and support. It also includes self-help information and information to promote independence and goal setting.

The development process is a process of co-creation and highlights opportunities for service redesign, operational process improvement, and possibilities to shift services closer to home, leading to better patient satisfaction and outcomes. Some of the questions that may be asked as a pathway is developed include, "how will this improve the timeliness of care for the patient?", "who is best to treat the patient?", "how can we prevent this condition occurring in the population?", and "how do we improve the health outcomes for Māori?"

Many common issues are being dealt with simultaneously across our region and this can lead to duplication of effort. Regional pathways enable shared knowledge, learnings and current innovations that are occurring locally to improve patients' health outcomes for the entire region. The use of eReferral and decision support tools can assist primary care and community clinicians to streamline their processes and handling of information.

These dedicated pieces of work enhance the communication between clinicians as they work together across organisations and care settings to support a smooth transition for their patient between health providers and a mutual understanding of the pathway of care in a shared care environment. The interface between general practices and hospital

services was recognised as a major area requiring redesign and key to the development of an integrated health system.[7]

Regional pathways of care are published on the international evidence based software tool 'Map of Medicine' containing up-to-date international best practice guidance. Building on this best practice guidance, the pathway development process incorporates national, regional and local guidance. The publishing of a pathway of care allows all health providers in the Midland region to have visibility of the regionally agreed pathway of care. A feedback mechanism is used by clinicians to continually improve the pathways.

Overseeing the development of regional pathways of care in Midland region is the Regional Pathways of Care Governance Group (RPoCGG). The role of this group is to provide operational governance across the five Midland DHBs and eight PHOs in the Midland region. This group also has responsibility for coordinating and aligning the work plans of the regional eReferral development as well as the regional Map of Medicine pathways of care work plan.

A further example of regional integration across the Midland region is the implementation of the integrated hepatitis C service.

(viii) Midland integrated hepatitis C service

In 2016-17 a regional project working group was established to develop a regional clinical pathway of care for people with hepatitis C. The care pathway has now been published in the Map of Medicine tool, including a treatment pathway for community prescribers also published within Bay Navigator. Waikato DHB, in partnership with Hepatitis Foundation of New Zealand, has been contracted to provide a regional service that is, liver elastography scans and patient education closer to the patient's home. A regional centrally based eReferral system has been implemented.

Actions in 2017-18 to support the implementation of integrated hepatitis C assessment and treatment services in Midland include:

- continuing to raise community and GP awareness, and education of the hepatitis C virus (HCV)
- providing community based access to HCV testing, plus targeted testing, and care that will include Liver Elastography Scans[8] services to all regions
- establishing systems to report on the delivery of Liver Elastography Scans in primary and secondary care settings
- providing community based ongoing education and support

[7] NZMJ, January 2015, vol, 128, Number 1408, Consensus pathways: evidence into practice,
[8] Liver Elastography Scans include mobile and fixed Fibroscan machines and Shear Wave machines being used in radiology departments and in the community.

- providing long term monitoring (life-long in people with cirrhosis and until cured in people without cirrhosis)
- providing good information sharing with relevant health professionals
- working collaboratively with primary and secondary care to improve access to treatment.

In addition to the development of an integrated hepatitis C service across the region, a high level summary of actions to integrate across the continuum of care is provided in Appendix 1.

(viii) Midland United Regional Integrated Alliance Leadership team (MURIAL)

The Midland United Regional Integrated Alliance Leadership team (or MURIAL Team) is a regional Alliance Leadership Team (ALT) and is made up of the five DHB CEOs, GMs Planning & Funding (GMs P+F), clinical leaders (as determined), a Population Health and Māori Health Representative, the eight PHO CEOs and PHO clinical leaders (as determined) and the HealthShare CEO. The MURIAL Team's primary objective is "to develop and lead a regional strategic 'whole of system' approach that will contribute to the delivery of better health outcomes through more integrated health and social services".

Specific work streams will be defined through an agreed annual work programme.

Objective 3: Improve quality across all regional services

Quality in health is a fundamental expectation. Within healthcare there is no universally accepted definition of 'quality'. However, the US Institute of Medicine (IoM) definition states that quality is *'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*.'

Midland DHBs are committed to working collaboratively, and with the Health Quality & Safety Commission (HQSC) in the ongoing development of a quality framework for the New Zealand health system; including further development of DHB Quality Accounts, Quality Safety Markers, and patient safety programmes.

Going forward the focus will be on agreeing the regional strategy for quality and patient safety that enables quality to be embedded across all our systems and puts patient safety at the core of what we do. In addition, there is an opportunity to maximise collective power through a regional approach to core systems such as ICNet (infection control) to minimise the costs wherever possible, better sharing of best practice, and the rollout of initiatives across the region.

The region has an increasing number of Improvement Advisors (IA) within DHBs and primary care, some of whom were supported by the HQSC to undertake in depth training on improvement science.

- Consult and agree on the Midland Quality & Patient Safety Collaborative Strategy
- Develop road maps for the key areas of focus specifically measurement (of strategy achievement and improvement measures), and building capability
- Set up the new Midland Quality Network (membership and terms of reference) to support the delivery of the Quality & Patient Safety Strategy
- Maintain regional collaboration with improvement work streams – deteriorating patient, Advance Care Plan (ACP), consumer engagement and patient safety programmes such as Falls
- Continue to develop a regional approach to core systems such as Datix (risk management) and ICNet.

In addition to the Midland DHBs Quality 2017/18 Work Plan in Appendix 1 – objective 3; Section 2 describes regional initiatives being progressed in 2017/18 by the regional clinical networks and clinical action groups.

Objective 4: Build the workforce

The Regional Services Plan (RSP) provides the opportunity for the Midland District Health Boards to take a collective approach to identifying workforce priorities and activities that will support a move forward.

Workforce development initiatives spanning the Midland region are those where taking a regional approach adds value – either through leveraging regional expertise or identifying how workforce issues could be addressed. Individual DHBs will make their own decisions about how to proceed.

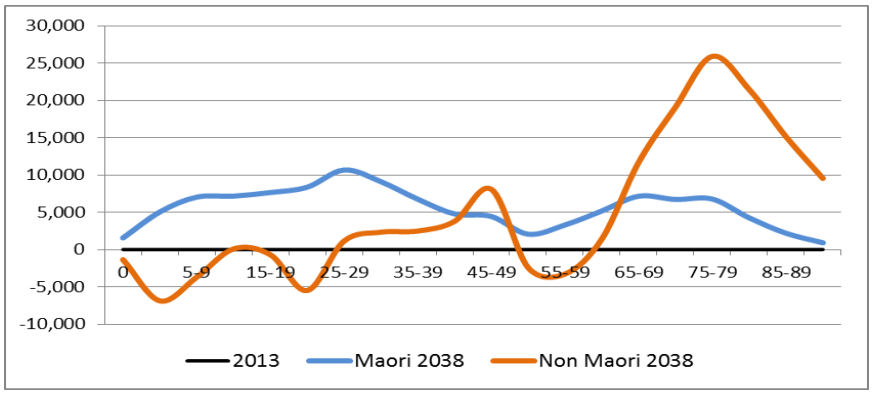
The previous 2016-19 RSP workforce development activities were over a three year horizon, including the key activities to:

- grow the health workforce through strengthening recruitment and repatriation
- strengthen health workforce intelligence
- strengthen health workforce planning – determine need and expectations of clinical networks/action groups, whilst developing workforce intelligence across the whole of service to support robust planning guidance
- support national schedules of work determined by Health Workforce New Zealand (HWNZ).

Midland's population is ageing with the non-Māori population over 60 years expected to increase markedly from 2013 levels in the next 25 years, while people of working age increase only slightly or decline.

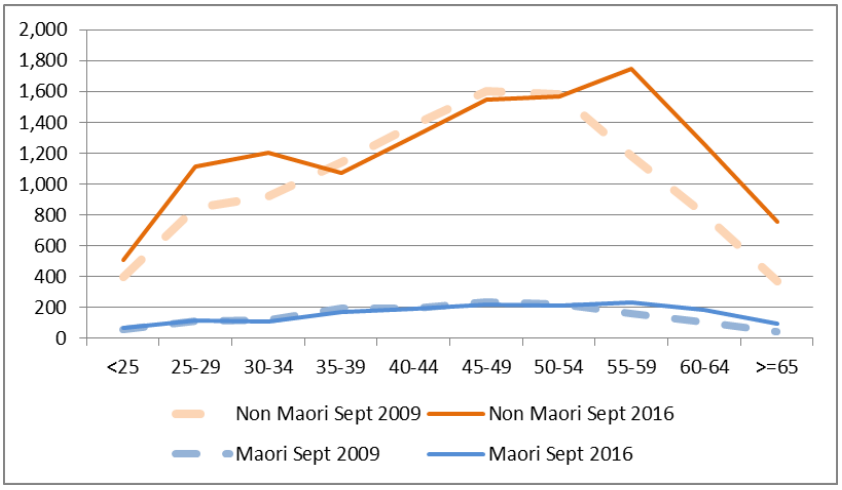
Māori on the other hand are projected to increase across the board but without the peaks in the older age groups. Increasing the attractiveness of a health career to Māori is a practical response to the population projections.

Figure 3: Midland DHBs medium population projections 2038 indexed to 2013



The health workforce age profile has changed from 2009 with increasing numbers of older employees. Increasing the ability of older and retired health care workers to remain engaged with health care delivery is another practical response to forecasted growth in demand for experienced people, and takes advantage of the trend of the workforce ageing.

Figure 4: Midland DHB workforce 2009 and 2016



The 2017-18 regional workforce initiatives builds on the previous RSP and aligns with the NZ Health Strategy 2016 *(Action 23 build leadership and manage talent, and Action 24 support a sustainable and adaptive workforce)*, and the MoH regional services plan guidance.

Each regional clinical network and clinical action group has its own workforce development initiatives which are included in their 2017-18 work plans. The Regional Director of Workforce Development (RdoWD) function provides support with implementation as required.

A number of activities require collaboration with other stakeholders: including DHB Shared Services; the National Workforce Strategy Group; and the Ministry of Health, prior to implementation.

The Midland 2017-18 workforce initiatives focus on supporting a sustainable and adaptive workforce through:

enhancing capacity through increasing the use and span of workforce data to inform workforce planning and modeling; supporting older or retired employees to continue to use their workplace skills; reviewing the medical pipeline and deciding what can be done regionally if improvements are needed; supporting a DHB led initiative to share low fidelity simulation scenarios and establish competency assessment simulation packages, and establishing a sector wide workforce planning and development interest group

enhancing diversity through identifying ways to increase representation of Māori in the health workforce; and supporting ways to increase the cultural competence of the healthcare workforce

enhancing succession planning through supporting DHBs to implement the State Services Commission leadership and talent management initiatives

building workforce flexibility by identifying how to increase competency based workplace training for care and support workforce.

Objective 5: Improve clinical information systems

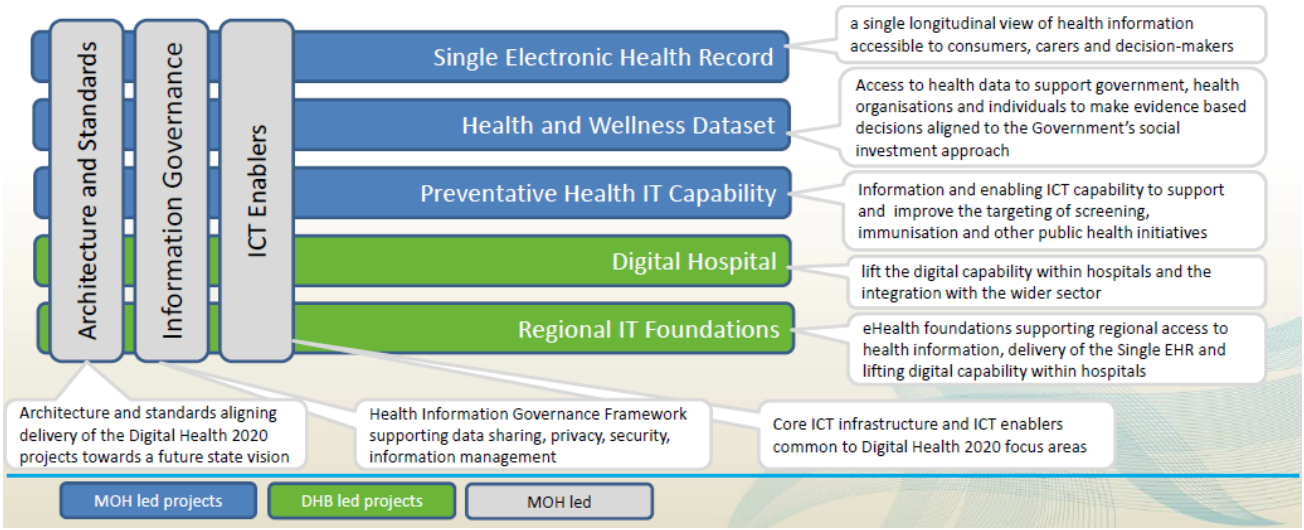
The 2017-20 Regional IS Plan reflects the New Zealand Health Strategy's direction, which has set a goal of a people-powered, smart health system by 2025.

Delivery of ICT enabled change and innovation is critical in supporting the delivery of the New Zealand Health Strategy and the Government ICT Strategy.

Figure 5: NZ Health Strategy 2016 – five strategic themes

Digital Health 2020 has been developed in response to the New Zealand Health Strategy, to progress the core digital technology opportunities present in the strategy. It delivers on the focus that together will drive towards a uniform information platform and a consistent data approach across the health sector.

Figure 6: Digital Health 2020 Strategy (MoH)



Midland region projects are required to align with national architecture standards and guidelines and the Ministry of Health's Digital Health 2020 Strategy. The region further supports this through sector architect membership and participation in national activities.

An Annual Plan for the 2017/18 financial year has been developed with a 'line of sight' to regional[9] and national strategic plans and directives.

Line of Sight
• DHB Annual Plans: BOP DHB (Sections 5.2.1, 5.2.2), Lakes DHB (Sections 2B.1.5.5, 5.2.1, 5.2.2),Hauora Tairāwhiti (Sections 5.2.1, 5.2.2), Taranaki DHB (Sections 2 and 4), Waikato DHB (Section 4)

The key priorities and programmes that are expected to be implemented regionally by Midland DHBs are below, and are described in more detail in Appendix 2:

- eSPACE as an enabler for achieving the region's priorities in regards to integrating across continuums of care and improving clinical information systems; supports the Ministry of Health's 'smart system' strategic theme; backed-up by sound business case propositions to drive improved clinical practice, both within and between health providers in Midland.
- Regional clinical data repositories (CDRs) will be established. The Sysmex CDR, for example, is being established under the umbrella of the eSPACE Results Foundation Project.
- Progressing the rollout of Telehealth across the Midland region, with involvement in the Stroke Thrombolysis Telehealth trial with the aim of helping achieve our strategic outcomes of 'eliminate health inequalities' and 'improve the health of the Midland populations'.

The successful delivery of these initiatives requires ongoing review and prioritisation of current activities at both a local and regional level to enable appropriate resources to be made available.

Alongside the clinical IS delivery are interrelated initiatives that will be planned and delivered in parallel:

- Transition to IaaS (Infrastructure as a Service). Midland DHBs and HealthShare are in the planning phase for transitioning IaaS.
- Extension of the Midland Regional Platform services to include reporting services capabilities as required.
- Continuation of integration between primary and secondary data through to authorised DHB, primary and community agencies to enable information sharing, electronic collection of health data and enhanced ability to identify trends.

[9] Midland Regional Information Services Strategy & Plan (MRISS and MRISP)

As regional IS structures and capability mature, opportunities to leverage the foundation infrastructure building blocks such as the regional network (Midland Connected Health) and the regional hosting platform (Midland Regional Platform) are being identified. The major risks to the ICT enablement of the RSP are:

- The near and long-term affordability of the ICT programme (as described in the IS Regional Work Plan) with several Midland DHBs under considerable and increasing financial pressure.
- The volume of competing demand for local, regional and national IS delivery far exceeds capacity and requires ongoing, rigorous efforts directed at visibility and prioritisation to manage conflicts.
- Some business work plans are not yet defined to a level of detail where there is an ability to sufficiently assess and understand the prerequisites, funding and resource implications, which may introduce a higher level of change to the work plan than anticipated.

Each of the governance groups that have direct responsibility for the areas covered will provide the ICT programme with detailed guidance on requirements and aspects of design, and help to ensure that decisions are properly considered with outcomes that are realistic and deliverable. Overall, the IS Regional Work Plan will inform recommendations to DHBs on the IS funding decisions required to support local, regional and national priorities.

Objective 6: Efficiently allocate public health system resources

Efficiently allocating public health system resources can occur in a variety of ways. Measuring efficiency savings may be difficult and can take time. The role of Midland DHBs is to fund the provision of the majority of the public health and disability services in the region through the contracts that the five DHBs have with providers. Midland DHBs are working together to deliver a health system that is clinically and financially sustainable, where safe and effective services are provided as close to people's homes as possible.

For highly specialised clinical services, Midland DHBs work together to ensure that patients are transported in a timely manner to the hospital that performs complex services; providing safe and effective services.

The Midland region is acutely aware of the fiscal constraints impacting health services and the need to focus on innovation, service integration, improved efficiency and reduced waste to support provision of high quality care. Proposals for regional activity must clearly identify the value proposition for patients and/or the system.

As the work plans are developed and endorsed, any resource requirements are identified through a business case process with the Midland DHBs GMs P+F and Chief Operating Officers (COOs). Any regional resourcing requests will be prioritised against national, regional and local priorities. Regional activity that needs project or capital funding for Information Service and other capital investments involves discussions with Midland DHB Chief Executives (CEs) and Chief Financial Officers (CFOs).

(iv) Outcomes framework (intervention logic)

The outcomes framework (figure 7 over page) demonstrates how the region's vision, strategic outcomes, long term impacts and regional strategic objectives are aligned with national outcomes and impacts and the New Zealand Health Strategy's strategic themes. The framework provides regional and national alignment with the vision, mission, values, goals, aspirations, strategic focus and priority areas and overarching outcomes of each Midland DHB.

Figure 7: Outcomes framework

Ministry of Health purpose and role	**Improve and protect the health of New Zealanders**			
Long-term success measures	Health expectancy improves over time	Life expectancy increases over time	Life expectancy by health spending per capita compares well within the OECD	Health spending growth slows over time
Health system outcomes	New Zealanders live longer, healthier, more independent lives		The health system is cost effective and supports a productive economy	
Ministry's high-level outcomes	New Zealanders are healthier and more independent	High-quality health and disability services are delivered in a timely and accessible manner	The future sustainability of the health and disability system is assured	
Ministry's impacts	1. The public is supported to make informed decisions about their own health and independence	3. The public can access quality services that meet their needs in a timely manner where they need them	6. The health and disability system is supported by suitable infrastructure, workforce and regulatory settings	
	2. Health and disability services are closely integrated with other social services and health hazards are minimised	4. Personalised and integrated support services are provided for people who need them		
		5. Health services are clinically integrated and better coordinated	7. Quality, efficiency and value for money improvements are enhanced	
New Zealand Health Strategy – strategic themes	**People-powered**	**Closer to home**	**Value and high performance**	**One team**	**Smart system**

Midland vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives					
Regional strategic outcomes	To improve the health of the Midland populations		To eliminate health inequalities			
Regional long term impacts	People take greater responsibility for their health		People stay well in their homes and communities		People receive timely and appropriate care	
Regional strategic objectives	Health equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Build the workforce	Improve clinical information systems	Efficiently allocate public health system resources

Midland DHBs Performance Story			
Midland DHBs vision, mission and values	**Bay of Plenty** Vision : Kia momoho te hāpori rgani – Healthy, thriving communities	Mission : Enabling communities to achieve good health, independence and access to quality services	Values: CARE (Compassion, Attitude, Responsiveness and Excellence)
	Lakes Vision: Healthy Communities – *Mauriora!*	Mission: Improve health for all; maximise independence for people with disabilities; with tangata whenua support a focus on health	Values: Manaakitanga; Integrity; Accountability
	Tairāwhiti Vision: WAKA (Whakarangātira, Awhi, Kotahitanga, Aroha)	Mission: Whaia te Hauora I Roto I te Kotahitanga A healthier Tairāwhiti by working together	Values: Hauora pai rawa/ wellbeing, partnership, quality – striving for excellence, integration, choice, He Tangata/responsiveness, financial responsibility

		Taranaki Vision: Taranaki Together, a healthy community – Taranaki Whanui He Rohe Oranga	Mission: Improving promoting, protecting and caring for the health and wellbeing of the people of Taranaki	Values: We value how we work together with others – Ngā Tikanga • Treating people with trust, respect and compassion • Communicating openly, honestly and acting with integrity • Enabling professional and organisational standards to be met • Supporting achievement and acknowledging successes • Creating healthy and safe environments • Welcoming new ideas
		Waikato Vision: Healthy people. Excellent care	Mission: Enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative delivery	Values: People at heart Te iwi Ngakaunui Give and earn respect – Whakamana Listen to me; talk to me – Whakarongo Fair play – Mauri Pai Growing the good – Whakapakari Stronger together – Kotahitanga
Midland DHBs goals and aspirations	Bay of Plenty	No significant increase in hospital bed capacity	Strong focus on improving health equity	Shifting care closer to home
	Lakes	5 year plan: • Babies are born well, grow well, live well as adolescents, stay well as adults, age well and eventually die well. When needed services will help people get well	• No health disparity	• People live longer, healthier lives
	Tairāwhiti	**Join** patient, family/ centred care	**Know** excellent Iwi/ community, family/ whānau knowledge and engagement	**Shape** working with community relationships	**Vision** building a "will do" culture	**Connect** enabling good health and wellbeing through technology
	Taranaki	To improve the health of the Taranaki DHB population	To reduce or eliminate health inequalities	
Midland DHBs strategic focus and priority areas	Bay of Plenty	1. Live well – empower our population to live healthy lives	2. Stay well – develop a smart, fully integrated system to provide care close to where people live, learn, work and play	3. Get well – evolve models of excellence across all of our hospital services.
	Lakes	• First 2,000 days • All vulnerable children • Child, youth and maternal care	• Mental health and addictions • The frail elderly • Managing long term conditions	• Oral health
	Tairāwhiti	• Care Closer to Home • Increased patient Quality and Safety	• Health of Older People • Regional and National Cooperation	• Living within our means
	Taranaki	• Meeting Health Targets • Addressing Māori Health/Disparities	• Supporting Older people to live well within their community • Addressing a system wide approach to integrated services	• Supporting wellness and managing Chronic Conditions
	Waikato	• Health equity for high needs populations • Safe, quality health services for all • People centred services	• Effective and efficient care and services • A centre of excellence in learning, training, research, and innovation	• Productive partnerships
Midland DHBs overarching outcomes		**To improve the health of our population**	**To reduce or eliminate health inequalities**	
Midland DHBs outcomes	Bay of Plenty	**Priority 1 above:** • First 1,000 days of life • At-risk youth • Māori • Older people	**Priority 2 above:** • Extended general practice • Risk stratification and stepped care • Multidisciplinary community health and support service clusters • System-wide care coordination	**Priority 3 above:** • Management of frail elderly and people with complex conditions • Mental health and addiction services • Scope and mix of services • Step-down care

	Lakes	• Lower acute demand • Better mental health and addictions support • Fewer teenage pregnancies • More people age well in own homes	• Better oral health for children and adolescents • Less obesity • Fewer people smoke • Less diabetes • Less CVD	• Fewer rheumatic fever cases • Fewer sudden unexpected death in infancy (SUDI) cases • Healthy birth-weight • Better health for Māori	
	Tairāwhiti	Prevent ill health	Reduce health inequalities between population groups	Support people to stay well in the community	Ensure people receive timely and appropriate complex care
	Taranaki	**People are supported to take greater responsibility for their health** • Fewer people smoke • Reduction in vaccine preventable diseases • Improving health behaviours		**People stay well in their homes and communities** • An improvement in childhood oral health • Long-term conditions are detected early and managed well	
	Waikato	**Health equity for high needs populations**	• Radical improvement in Māori health outcomes by eliminating health inequities for Māori • Eliminate health inequities for people in rural communities • Remove barriers for people experiencing disabilities • Enable a workforce to deliver culturally appropriate services		
		Safe, quality health services for all	• Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement, and innovation • Prioritise fit-for-purpose care environments • Early intervention for services in need • Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives		
		People centred services	• Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services • Provide care and services that are respectful and responsive to individual and whanau needs and values • Enable a culture of professional cooperation to deliver services • Promote health services and information to our diverse population to increase health literacy		
		Effective and efficient care and services	• Live within our means • Achieve and maintain a sustainable workforce • Redesign services to be effective and efficient without compromising the care delivered • Enable a culture of innovation to achieve excellence in health and care services		
		A centre of excellence in learning, training, research, and innovation	• Build close and enduring relationships with local, national, and international education providers • Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research • Cultivate a centre of innovation, research, learning, and training across the organisation • Foster a research environment that is responsive to the needs of our population		
		Productive partnerships	• Incorporate te Tiriti o Waitangi in everything we do • Authentic collaboration with partner agencies and communities • Focus on effective community interventions using community development and prevention strategies • Work towards integration between health and social care services		

(v) Health Partnership Limited

Midland DHBs are working with Health Partnership Ltd (HPL), a national agency that is standardising non-clinical services. HPL's initiatives include a national Oracle Solution (formerly Finance, Procurement and Supply Chain), Food Services, Linen and Laundry Services, and a National Infrastructure Platform.

(vi) HealthShare Limited

HealthShare Limited (HSL), established in 2001, is the Midland region's shared services agency. It is jointly owned by Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato DHBs. HSL employs staff to perform tasks on behalf of the Midland DHBs, each with a 20% shareholding.

Until mid-2011 HSL operated as a single function shared service agency with the primary purpose of assisting the shareholding DHBs in meeting their statutory and contractual obligations to monitor the delivery and performance of services through the provision of routine third party audit programmes.

From August 2011 HSL has taken on an expanded role and now provides operational support to the Midland DHBs in a number of areas identified as benefitting from a regional solution. Where HSL provides services to non-shareholding DHBs, eg third party audit and assurance, this support is provided under contract.

HSL has a five member Board of Directors comprising the CE of each of the shareholding DHBs. The CE is accountable to the Board, through the Chairman, for the management of HSL and day to day operations. The Board meets monthly to monitor HSL performance.

The Midland DHBs determine the services that HSL provide and the level of these services on an annual basis. These determinations are made through the RSP and regional business case processes.

Categories of possible regional service delivery include:

- Activities that support future regional direction and change through the development of regional plans
- Facilitating the development of clinical service initiatives undertaken by regional clinical networks and regional clinical action groups that support clinical service change
- Key functions that support and enable change through the ongoing development of the region's workforce and information systems
- Back office service provision that can drive efficiencies at a regional level, alongside new national back office shared services.

The annually agreed regional services form the basis for HSL's Business Plan which specifies the company's performance framework, the services to be provided, and the associated performance measures. HSL's Business Plan also details at a service level the activities that have been purchased by the shareholding DHBs. Midland DHB CFOs

recommend to HSL Directors the funding to be provided by Midland DHBs for the coming financial year.

HSL has multiple planning and reporting relationships within the Midland region and to national agencies as depicted in Figure 8.

Regional clinical service development initiatives are expected to be provided from HSL in 2017-18 through the following groups:

- Regional clinical networks and clinical action groups:

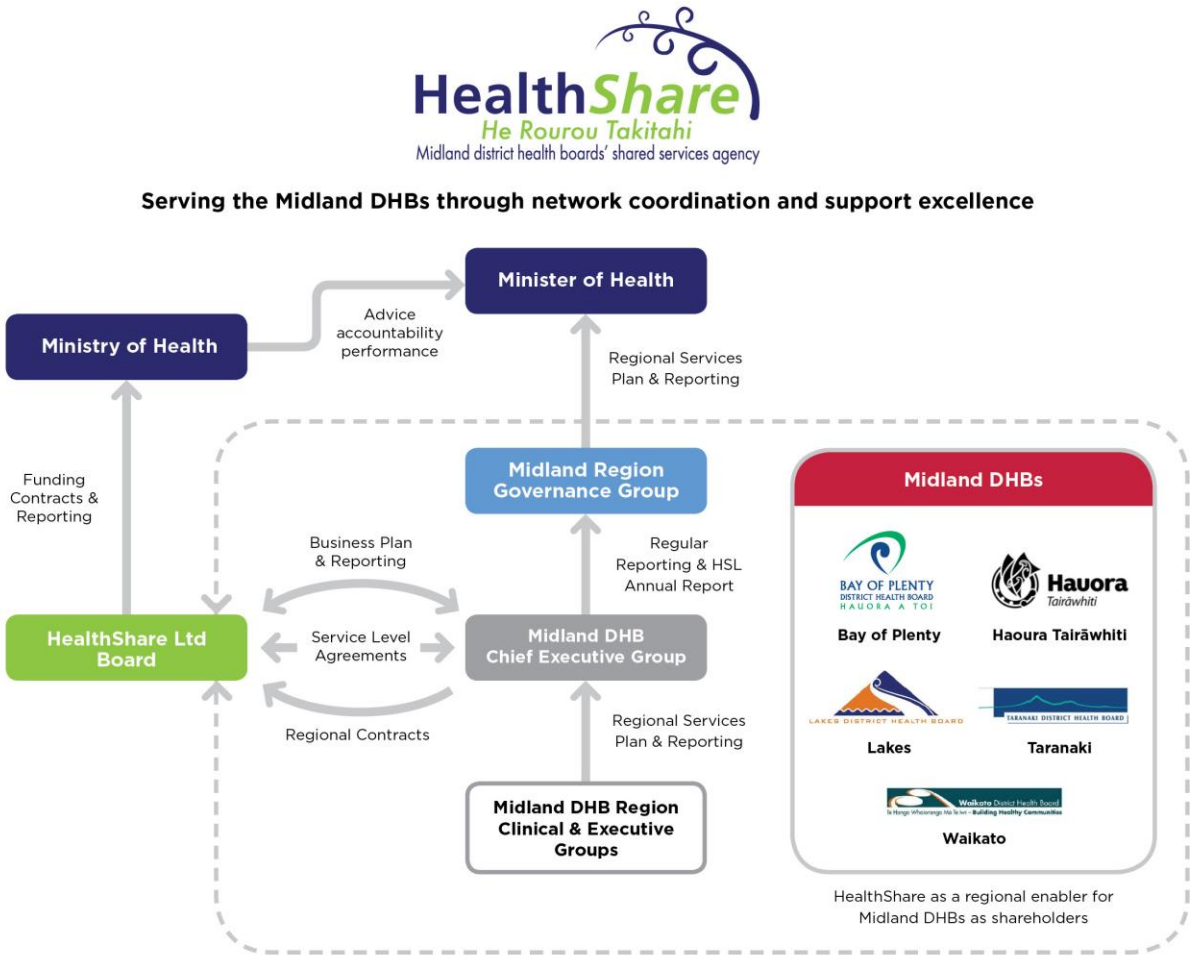
  Midland Cancer Network
  Midland Cardiac Network
  Child Health Action Group
  Regional Elective Services Network
  Health of Older People Action Group
  Midland Mental Health & Addictions Network
  Midland Radiology Action Group
  Midland Stroke Network
  Midland Trauma System*

- Regional e-health IT systems implementation
- Workforce development and intelligence support
- Regional shared service delivery, including:
  - Third party provider audit and assurance service
  - Regional internal audit service (Lakes, Tairāwhiti, Taranaki, Waikato)
  - Map of Medicine regional pathways of care development and implementation
  - Taleo IS administration support (for HR/Recruitment).

The nature of the services provided by HSL to the Midland region requires a close working relationship with DHB staff and key stakeholders.

*HSL provides a link between the Midland Trauma System (MTS) and the 2017-20 Midland RSP for reporting purposes.

Figure 8: Overview of Healthshare Ltd (Midland DHBs shared services agency)



(vii) Audit and Assurance Service

HSL Audit and Assurance (A&A) provides routine audit and assurance to the five Midland DHBs on their Non-Government Organisation (NGO) contracted provision of services. An annual audit plan is agreed collectively by the five DHBs Planning & Funding and targets NGOs using risk history and based on a one in three to four year audit cycle. A&A have experienced and qualified auditors with a range of clinical competence and expertise and specialist knowledge in health and disability services. A&A auditors are careful to always exercise impartiality, manage conflict(s) of interest and to ensure objectivity in carrying out all audit assessment and reporting.

The audit and assurance activity encompasses contracted funding and service agreements for:

- Personal health
- Mental health services
- Health of older people
- Disability support services

- Māori and Pacific health services.

A&A is also a Designated Auditing Agency (DAA) approved by the Director General of Health to audit health services pursuant to the Health & Disability Services (Safety) Act 2001. As a DAA, A&A provides certification services across the country to a range of providers including aged residential care, mental health providers, and home and community support services.

In line with emerging issues and DHB changing environments, the audit work schedule remains flexible with a continual process of audit additions and cancellations or postponements.

(viii) Regional Internal Audit Service (Lakes, Tairāwhiti, Taranaki, Waikato)

The general purpose of the HSL regional Internal Audit Service is to provide independent assurance and consulting services to support and monitor the Midland DHBs risk management, internal control and governance processes that have been implemented by management to run these organisations. The role and responsibilities of the service are outlined in the Regional Internal Audit Team Charter.

The internal audit function assists DHB management and staff by developing recommendations for improvement or enhancement in a number of areas, for example:

- the efficiency and effectiveness of a department's business operations and administrative activities, including service delivery procedures
- protection and overall management of medical equipment and other assets
- supplier contract management and monitoring
- the provision, accuracy and usefulness of financial, revenue, contract and other information
- health and safety management systems
- maximising/optimising the use made of computer systems available within the organisation
- security and access to the organisation's information systems.

The diversity of Internal Audit's work is demonstrated by the types of risk and audit activity the service aims to cover within each DHB's annual internal audit plan (mainly developed using a risk-based approach), as follows:

- compliance and assurance
- corporate and social responsibility
- ethics and business conduct
- fraud
- information technology effectiveness
- operational /clinical effectiveness

- project risk
- quality and performance improvement
- security and technology.

The Midland DHBs internal audit plans are flexible and agile in order to cater for urgent issues or significant emerging risks.

Section 2: Activities of regional groups, clinical networks and clinical action groups

(ix) Midland DHBs regional groups

There are a variety of Midland DHB groups that meet to collaborate as a region on a regular basis including Nga Toka Hauora, the Midland GMs Māori (objective 1), the Regional Quality Managers (objective 3), General Managers – Human Resources (objective 4), and the Chief Information Officers (objective 5). Appendix 2 provides information about the regional governance arrangements for Midland DHBs.

Other important regional DHB leadership groups include:

- Midland Region Governance Group (MRGG)
- Midland Chief Executives Group (MCEG)
- Regional GMs Planning and Funding
- Chief Operating Officers forum
- Chief Financial Officers forum
- Chief Information Officers (Midland IS Leadership Team)
- Midland Annual Plan Writers Group
- Chief Medical Advisors
- Directors of Nursing
- Directors of Allied Health
- eSPACE Programme Board
- Regional Quality Managers

(x) Midland DHBs regional clinical networks and clinical action groups

Regional clinical groups enable clinical leaders and managers to shape the development of services so that services are of a high quality, sustainable and there is equal access to these services for people across the region. The goal is to ensure people have the same health outcomes irrespective of geographical location, ethnicity, and gender. Another benefit of working together is that there can be some coordination of the public health system resources and support to match demand and capacity.

Regional clinical initiatives are reviewed by Midland DHB executives and agreed by CEs. Much of what occurs is supported with national guidance as part of the annual DHB planning process and aligns with activity each DHB is also undertaking. Each regional initiative is assessed against the region's six strategic objectives to show how these contribute to the region's strategic outcomes and vision. A shading key is used to demonstrate whether activities will have a direct or indirect impact on a regional strategic objective. For milestones, where these are ongoing, then more than one box may be shaded.

Table 3 provides a summary of the highest priority initiative that each regional clinical group is working on in 2017-18 (full 2017-18 work plans are detailed in Appendix 1). This is to enable the reader to appreciate a key focus of the clinical group.

Table 3: Top initiative for delivery by July 2018 for each regional clinical group

Regional Clinical Network and Clinical Action Group	Top priority	Quantitative measure of success
Cancer	Midland Cancer Network initiatives that support the Midland DHBs to: • achieve the Faster Cancer Treatment Health Target; and • prepare for roll out of the national bowel screening programme.	90% of patients referred with a high suspicion of cancer and a need to be seen within 2 weeks have their first treatment (or other management) within 62 days by June 2017
Cardiac	Achieve equality for Māori in key rates of diagnostic and interventional cardiac services per DHB for KPIS that can be measured.	SIR rates for Angiography, Angioplasty, Cardiac Surgery
Child Health	Childhood obesity and oral health • Work with DHBs to promote that oral health databases are linked with NCHIP • Support and encourage further action to address childhood obesity in DHBs including facilitating sharing and implementation of evidence based life style programmes in the region for children and families • Oversee and provide support for the implementation of the childhood obesity care pathway (Map of Medicine) • Support a regional Sugar Sweetened Beverages policy/position statement/plan of action in conjunction with the region's Public Health units and actions to implement.	• NCHIP linked to oral health databases (where implemented) • All DHBs will have access to an evidence based life style programme for at risk children/families identified in the obesity pathway • Childhood obesity care pathway (Map of Medicine) will be in use across the region • Broader implementation of the SSB policy/position statement/plan of action.
Electives	A specialty based, regional electives initiative will be developed and implemented to support the delivery of health target discharges, waiting time requirements, improved equity of access, resource utilisation and pathway of care.	Regional delivery of a specialty based electives service
Health of Older People	Consolidate work on dementia through the strengthening of components of the dementia pathway and ensuring family and whanau carers of people with dementia have access to support and education programmes.	Increased referrals from GP practices to Alzheimer's and Dementia organisations Standardised training is available on a consistent basis for family and whanau carers
Mental Health & Addictions	Implementation of the Substance Abuse Legislation (SAL) across the Midland region • Develop funding proposal for the MoH • Identify workforce development priorities • Develop an Implementation plan • Involve key stakeholders in the consultation process • Implement MoH communication strategy	• The public is well informed of the SAL process and criteria • Midland has systems and process put in place to meet the demand • Standardised processes are regionalised • The workforce is well prepared for the SAL 1 February 2018 start date
Radiology	Ultrasound model demonstrating the Midland region volumes, case mix and resource used (US) across the Midland DHBs	Ratios of US caseload outputs at Midland DHBs
Stroke	• Support and facilitate the implementation of a pathway of care for accessing thrombectomy services through ADHB • Support and facilitate the development of a pathway of care for accessing thrombectomy services through WDHB (five-year timeframe)	Pathway(s) of care available for Midland DHB use to access thrombectomy services for their patient population.
Trauma (MTS)	Provide adequate regional resources to achieve agreed objectives defined in the MTS Strategic Plan	Approval of MTS Business Case 2017-2020

Through the work programmes on the following pages there are references which show alignment with the five themes of the New Zealand Health Strategy 2016.

(xi) Midland Regional Public Health Network

Another regional group is the Midland Regional Public Health Network (the Network). The Network provides an opportunity for Public Health Units (PHUs) to work together on public health issues affecting the Midland region. As part of the DHB function PHUs provide public health advice and expertise with a general goal of protecting and improving the health of the population with a focus on reducing inequalities.

Midland DHBs and their PHUs work closely together to deliver on the five public health core functions:

1. Health promotion
2. Health protection
3. Preventative interventions
4. Health assessment and surveillance
5. Public health capacity development

In addition to providing advice and expertise to individual DHBs, the Network provides leadership for and strengthens the performance and sustainability of the Midland PHUs. Leadership of the Network comprises the Manager and Clinical Director from each of the four PHUs in the Midland region: Toi Te Ora - Public Health Service (Bay of Plenty and Lakes DHBs); Population Health (Waikato DHB); Population Health - Hauora Tairāwhiti (Hauora Tairāwhiti) and Public Health Unit (Taranaki DHB).

The Network aims to further strengthen relationships with the Midland Regional Clinical Networks and Clinical Action Groups to ensure a public health perspective is considered within their planning.

At a national level the Network is a member of the National Public Health Clinical Network (NPHCN), whose membership comprises Clinical Leader and Manager from each PHU and representatives from the Ministry of Health.

The goals of the Midland Regional Public Health Network are to:

- Enhance the consistency, coordination and quality of public health service delivery across the region;
- Support other Midland health networks by promoting the 'population health approach' and providing public health advice on issues that can have a population health outcome.

The Network's work to date has included collaborative annual planning, business continuity planning, supporting the development of Midland position statements on key health issues, setting up a mechanism for a regional approach to health intelligence

work, standardising communicable disease control processes, peer review, staff orientation programmes, and support of sole practitioners.

Work streams are in place to support a consistent approach to common areas of work:

- Public health capacity
- Health Promotion Leadership Group
- HealthScape – Public Health Information Management system
- Public Health Intelligence

Future work streams will be determined based on the need to increase the focus on a particular public health issue and/or what might come from the New Zealand Health Strategy.

In determining its direction for 2017/18, the Network will continue to align with the Ministry of Health's five core functions of public health (Health Assessment and Surveillance, Public Health Capacity Development, Health Promotion, Health Protection, and Preventive Interventions).

The Network will also continue to focus on:

- Better integration of services within health and across the sector
- Lifting of quality and performance
- Supportive leadership and capability for change.

In line with the wider health sector goal of better, sooner, more convenient health services for all New Zealanders, emphasis for the Network will continue to be on effective and efficient working and service delivery.

Midland Regional Clinical Networks and Clinical Action Groups

2.1 Cancer services (Midland Cancer Network)

Midland Cancer Network Executive Group Chairs: Dr Humphrey Pullon and Brett Paradine
Programme Manager: Jan Smith
Lead Chief Executive: Dr Nigel Murray

Context: ***"working together to achieve better faster cancer care"***

The Midland Cancer Network is guided by the Midland Cancer Strategy Plan 2015-2020 with a vision of by working together as one, we will lift the performance of our health systems. The Midland Cancer Strategy Plan aligns with:

- the New Zealand Cancer Plan better, faster cancer care 2015-2018 to improve: equity of access to cancer services; timeliness of services across the whole cancer pathway; and the quality of cancer services delivered
- National Bowel Screening Programme
- National Adult Palliative Care Service Review.

The Midland Cancer Strategy Plan 2015-2020 strategic objectives are to:

1. reduce the cancer incidence through effective prevention, screening and early detection initiatives
2. reduce the impact of cancer through equitable access to best practice care
3. reduce inequalities with respect to cancer
4. improve the experience and outcomes for people with cancer.

The strategic objectives are supported by five enablers: infrastructure, information systems, workforce, supportive care, knowledge and research.

The Midland strategic framework for action takes a total continuum of care approach for the Midland population from prevention and early detection – screening – diagnosis and treatment – follow-up and surveillance – survivorship – palliative care and last days of life. 2017/18 plan aims to build and strengthen the alignment and linkages of the various Midland health services related to the cancer continuum. This is demonstrated in the Line of Sight Section (refer over page).

Planned outcomes for 2017/18:

1. Faster Cancer Treatment (FCT) initiative key outcomes are:
   - two regional tumour standard reviews against national standards are completed with improvement plans
   - the four Midland round 2 FCT projects are completed with final reports
   - continue to implement the Midland Psychological and Social Support Services Plan 2015-2018
   - that each DHB facilitates one Kia Ora E Te Iwi (KOETI) community based health literacy programme.
2. Improve Midland palliative care services initiatives are:
   - update *the Midland Specialist Palliative Care Service Development Plan* following the National Adult Palliative Care Service Review recommendations (yet to be completed)
   - continue to support implementation of *Waikato Palliative Care Strategy Plan 2016-2021*
   - support the development of local Palliative Care Strategy Plans for Lakes and BOP
   - support the Midland Health of the Older Person (HOP) Group with HOP workforce development related to palliative care and last days of life.
3. Midland bowel screening regional centre (BSRC) initiative key outcomes are:
   - Midland BSRC service specification agreement signed with Ministry by 1 July 2017 to ensure set up phase for go live is completed to enable the Midland BSRC to go live in 2018/19
   - Midland DHBs bowel screening business cases approved and roll out commenced as per the national bowel screening work programme tranche order.
4. Improved access to colonoscopy/endoscopy services initiative key outcomes are:
   - evaluation of the regional direct access to colonoscopy e-referral is completed.
5. National lead for the lung cancer work programme initiatives:
   - Midland Cancer Network is working in partnership with the Ministry of Health Cancer team to finalise the national lung cancer work programme for 2017/18 – 2018/19.

Measures: (by ethnicity, locality and deprivation where possible)

90% of Midland DHB patients referred with a high suspicion of cancer and a need to be seen within two weeks have their first treatment (or other management) within 62 days (Cancer Health Target).

85% of Midland DHB patients with a confirmed diagnosis of cancer receive their first treatment (or other management) within 31 days of decision-to-treat (policy priority 30).

Colonoscopy (policy priority 29):

- 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days
- 70% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days
- Surveillance colonoscopy – 70% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days.

Line of Sight
• DHB Annual Plans: Please see BOP, Lakes, Waikato, Tairāwhiti sections for faster cancer treatment, all five DHBs for bowel screening • RSP: Please see section improving 2.7 radiology services wait times for diagnostic CT & MRI and Radiology Oncology Stream Pathways, Map of Medicine pathways of care, and objective 2 regional hepatitis C service • Māori Health: see Appendix 1 Objective 1: Health equity for Māori – Māori health gain cancer, breast/cervical screening • Workforce: Please see Appendix 1 Objective 4 : Build the Workforce and RSP 2.5 Healthy ageing section (palliative care) • Regional IS: Please see Appendix 1 Objective 5 : Improve Clinical Information Systems – Bowel screening, Cancer Information Strategy

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Faster Cancer Treatment	Milestone/Date	Responsibility
1.1. In partnership with DHBs coordinate a regional review of national melanoma standards (tbc) of service provision and identify key activities to address issues identified as a result of the regional review • Undertake a stocktake of melanoma services and gap analysis against the national melanoma standards of service provision in New Zealand • Midland DHB self-assessments and data analysis completed by October 2017 • Establish a regional melanoma work group to review findings and develop regional report by December 2017	Quarter 1 and 2 Midland DHB review against national melanoma standards of service provision report completed by 31 December 2017	MCN and Midland DHBs
1.2. In partnership with DHBs coordinate a regional review of national upper GI standards (tbc) of service provision and identify key activities to address issues identified as a result of the regional review • Undertake a stocktake of upper GI services and gap analysis against the national colorectal standards of service provision in New Zealand • Midland DHB self-assessments and data analysis completed by April 2018 • Establish a regional add work group to review findings and develop regional report by June 2018	Quarter 3 and 4 Midland DHB review against national upper GI standards of service provision report completed by June 2018	MCN and Midland DHBs
1.3. Continue to support DHBs to implement service improvements from previous regional reviews i.e. gynae-oncology, colorectal, lung, breast lymphoma, sarcoma, myeloma		
1.4. Continue the MCN-Waikato Faster Access to Cancer Services through a Staged Tumour Approach to Treatment Project 2015-2018	Quarter 1 – 4 30 June 2018	MCN and Waikato DHB
1.5. Continue the MCN-Lakes FCT Service Improvement Project 2015-2020	Quarter 1 – 4 30 June 2018	MCN and Lakes DHB
1.6. Continue the Midland Routes to Cancer Diagnosis and Treatment Project 2015-2018	Quarter 1 – 4 30 June 2018	MCN and Midland DHBs

1.7. Continue the Midland Patient Information Resource Project 2016/17 – 2017/18				Quarter 1 – 4 30 June 2018	MCN, Midland Cancer CNS/CNC and Consumer Work Groups
1.8. Continue to implement the *Midland Psychological and Social Support Services Plan* 2015-2018				Quarter 1 – 4 30 June 2018	MCN Supportive Care Work Group and Midland DHBs
1.9. Support the delivery of one Kia Ora E Te Iwi community health literacy programme per DHB				Quarter 1 – 4 30 June 2018	MCN, Cancer Society, Midland DHBs, MHPs
1.10. Continue Lakes-Waikato medical oncology, radiation oncology and haematology model of service improvement project. • Support implementation of Lakes resident medical oncology service with Waikato				Quarter 1 – 4 30 June 2018	Lakes, Waikato DHBs and MCN
1.11. Support national cancer work programme i.e. phase 2 tumour work programme, national radiation oncology plan, CNCI (within available resources)				Quarter 1 – 4 30 June 2018	MCN, Midland DHBs, Ministry of Health
1.12. Regional work to support national Cancer Health Information Strategy Plan initiatives • Continue the Midland MDM systems gap analysis project against business processes, systems requirements and data requirements (tbc) • Midland radiation oncology plan and data extracts and reasons for possible variations • National tumour standards core data and measurability work (tbc)				Quarter 1 – 3 31 March 2018	MCN, Midland DHBs, Regional IS, CHIS team
1.13. Scope and review implications of implementing the national Adolescent and Young Adult Cancer Patient in New Zealand including Standards of Care (note resource dependent)				Quarter 1 – 4 30 June 2018	MCN & Midland DHBs
1.14. Identify components of the national Early Detection of Lung Cancer Guidance that can begin to be implemented (note resource dependent)				Quarter 1 – 4 30 June 2018	MCN & Midland DHBs & NLCWG
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
Initiative 2: Improve Midland palliative care services				**Milestone/Date**	**Responsibility**
2.1. Update *the Midland Specialist Palliative Care Service Development Plan* following the National Adult Palliative Care Service Review recommendations • Support Midland Health of Older People work programme related to workforce development on palliative care and last days of life • Support national palliative care work programme i.e. outcomes framework				Quarter 1 - 4 30 June 2018	Midland Palliative Care Work Group
2.2. Continue to support Midland to implement the *Midland Medical Advanced Palliative Care Trainee Model of Service* 2015-2018				Quarter 1 - 4 30 June 2018	Midland Palliative Care Work Group
2.3. Continue to support implementation of *Waikato Palliative Care Strategy Plan 2016-2021*				Quarter 1 - 4 30 June 2018	Waikato Palliative Care Group and MCN
2.4. Support Lakes and BOP to develop a local Palliative Care Strategy Plans				Quarter 1 - 4 30 June 2018	MCN, BOP & Lakes Palliative Care Work Groups
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 3: Midland bowel screening regional centre				Milestone/Date	Responsibility
3.1. Implement Midland bowel screening regional centre set up phase activities as directed by Ministry of Health Agreement service specifications (to be signed by 30 June 2018)				Quarter 1 - 4 30 June 2018	Midland BSRC Governance Group, Waikato DHB, MCN
3.2. Support Midland DHBs to plan and get ready for bowel screening roll out				Quarter 1 - 4 30 June 2018	Midland BSRC Governance Group, Midland DHBs, MCN
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 4: Improved access to colonoscopy/endoscopy services				Milestone/Date	Responsibility
4.1. Evaluation of the regional direct access to colonoscopy e-referral is completed tbc 4.2. Implement any enhancements to the colonoscopy e-referral as required.				Quarter 4 – tbc 30 June 2018	MCN, Midland DHBs, HSL MOM project manager
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 5: National lead for the lung cancer work programme				Milestone/Date	Responsibility
Midland Cancer Network is working in partnership with the Ministry of Health Cancer team to finalise the national lung cancer work programme for 2017/18 – 2018/19 on initiatives such as: • implement and evaluate the national Early Detection of Lung Cancer Guidance • develop national standardised lung cancer key performance indicators • develop nationally consistent information to be collated at lung cancer multidisciplinary meetings (MDM) aligning with National CHIS • review and update the 2015 Standards of Service Provision for Lung Cancer Patients in New Zealand to the revised national tumour standards template • develop nationally consistent Lung Cancer Standards Review methodology and template • undertake a high level national benchmarking exercise to identify areas of variation to inform further enhancements to service delivery. Note: 2017/18 – 2018/19 NZ lung cancer work programme to be determined and confirmed by Ministry of Health. Draft work plan sent to Ministry 12/12/16.				to be confirmed	Ministry of Health Cancer Team Midland Cancer Network
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

2.2 Cardiac services (Midland Cardiac Clinical Network)

Chair: Dr Jonathan Tisch **Project Manager:** Philippa Edwards
Lead Chief Executive: Dr Nigel Murray

Context:
Cardiovascular diseases (CVD) are a leading cause of death in New Zealand. The MCCN vision is a population with increasingly well managed risk factors and timely access to appropriate prevention and intervention leading to reduced presentation, readmission rates and mortality due to heart diseases and abnormalities. In particular there must be no inequality across ethnicity or residential location. (People powered; Closer to home; High value and performance; Smart system; One team)

The Heart Foundation and Public Health messaging is increasing cardio-vascular health literacy, and improvements in prevention and intervention have been significant however inequality exists by ethnicity. Additionally, the impact of the aging population and the increasing prevalence of the cardiovascular risk factors diabetes and obesity are predicted to adversely impact future cardiovascular demand.

Data from ANZACSQI from 2006 to 2013 indicates the annual total number of Acute Coronary Syndrome (ACS) admissions in NZ has fallen by 26% to 15,202. The improvement was greatest for Māori and lowest for Pacific people, however rates remain higher overall for Māori and Pacific compared with European and Other peoples.

The NZ angiography standardised intervention rates (SIRs) have increased from 33.5 to 48.3. The increase is across all ethnic groups; however the rates in European/Others at 50 remain higher than for Māori and Pacific people at 37.4 per 100 and 39 per 100 respectively. Revascularisation rates mirror the angiography rates with 35.5 in European/Other, 21.4 in Māori and 24.1 in Pacific in 2013.

Service performance has steadily improved across the Midland DHBs. The five Midland DHB Cardiac Specialist Services recognise the value in planning and working together. A clear and unified direction is being used to form the virtual Midland Regionally Integrated Cardiac Service to enable integrated strategic planning, annual planning and daily operations management.

Planned Outcomes for 17/18:
The Midland Cardiac Clinical Network (MCCN) provides for a regionally collective approach that is both clinically informed and service improvement focused.

In 2017/18 tangible outcomes will be:

1. Achieve or exceed equality for Māori at each DHB in key rates of diagnostic and interventional cardiac services per DHB for KPIS that can be measured. These are SIR rates for Angiography, Angioplasty, and Cardiac Surgery.
2. Recommendations against the NZ National Expected Clinical Standards on ways to address gaps identified in 16/17.
3. A region wide embedded production planning process for acute and elective cath lab facilities for angiograms and percutaneous interventions (PCI) such as angioplasty and the insertion of arterial stents.
4. Compliance with the MOH acute coronary syndrome (ACS) and elective services ESPI KPIs - timeliness of angiogram and the data entry into the ANZACS-QI data registry monitored by each of the five Midland DHBs and by ethnicity; electives within 4 months
5. Development of Systems of Care to support the National STEMI pathway
6. Input to NZ Cardiac Network work including workforce and national cardiac working group topics
7. Inform and support regional IS e-space initiatives

Key objectives:
The Midland Cardiac Clinical Network's focus will be on reducing the burden of cardiovascular disease through improving the management of risk factors and improved access across the continuum though:

- Delivery of services in alignment with the NZ Health Strategy 5 strategic themes
- Meeting Ministry of Health targets and performance objectives
- Achieving equality by domicile and by ethnicity of populations

- Supporting the five Midland DHBs and Public Health entities to empower the population in knowledge and skills to increasingly understand and manage their own health conditions
- Living well with long term conditions - ensure health interventions increase quality of life
- Health quality and safety - take a governance role to ensure patients with a similar level of need receive comparable access
- Ensure high quality assessment, treatment and risk management.

Measures: (by ethnicity, locality and deprivation where possible)

The regional measures for cardiac services are the same as the national indicators for DHBs. Measures would be monitored for the Māori population comparative to the non-Māori population.

Primary Service KPIs (PHOs report these measures to the MoH)

- Monitor the % of patients identified as having CVDRA risk >15% who are on recall/ follow up by GP and have management as per clinical guidelines
- % of eligible population having CVDRA
  Indicator 1: 90% of the eligible population will have had their cardiovascular risk assessed in the last five years.
  Indicator 2: 90% of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the last five years.

Cardiology Services

1. Acute- 70% of high risk patients will receive an angiogram within 3 days of admission for Māori and non Māori
2. Acute – over 95% of patients presenting with ACS who undergo coronary angiography to have completion of ANZACSQI ACS and Cath/PCI Registry data collection within 30 days
3. Elective - Patients to wait no longer than 4 months for a Cardiology FSA for Māori and non Māori
4. Elective – 95% of accepted referrals for elective coronary angiography with receive their procedure within 3 months (90 days) Coronary Angiogram for Māori and non Māori
5. Elective + Acute -SIR coronary angiography of at least 34.7 per 10,000 population for Māori and non Māori
6. Elective + Acute - SIR percutaneous revascularization of at least 12.5 per 10,000 population for Māori and non Māori
7. Elective - Echocardiography, holter, device implantation and exercise tests to be completed within 4 months of request being submitted

Cardiac-Thoracic Services (Waikato Hospital reports these measures)

1. Over 95% of patients undergoing cardiac surgery will have completion of Cardiac Surgery registry data collection within 30 days of discharge
2. Elective - Patients to wait no longer than 4 months for a Cardio-thoracic FSA
3. Report the proportion of patients scored using the national cardiac surgery Clinical Priority Access tool (CPAC)
4. Report the proportion of cardio-thoracic patients treated within assigned CPAC urgency timeframes
5. The cardio-thoracic waitlist must remain between 5 and 7.5% of planned annual throughput, and must not exceed 10% of annual throughput
6. SIR of 6.5 per 10,000 population

Line of Sight
• DHB Annual Plans: Section 2 -Delivering on Priorities and Targets: • **Waikato**- Shorter Stays in ED No.6 STEMI Pathway; Delivery of Regional Services- Cathlab Planning Tool, HF and AF projects • **BOP** – section 2.2 Government planning priorities; section 5 performance measures; appendix A 1.4.3 appropriate access to services • **Taranaki-** Participate regionally in Heart Failure service redesign improvement project ; Establish and embed ethnicity data reporting and health equity assessment to inform future services; Atrial fibrillation stock take to inform service design regionally • **Lakes-** Electives funding will be allocated to support increased levels of diagnostics; SIRs and/or other mechanisms (such as demand analysis) will be used to assess areas of need for improved equity of access • **Tairāwhiti** Section 3 – Service Configuration: Rural Services Urgent Care • **Waikato** –access earlier intervention with better coordinated and integrated services • **BOP** • **Tairāwhiti** Section 5: Performance measures: • All DHBs – PP20 Improved management for long term conditions (CVD, Acute Hart Health); PP29 Improved wait times for elective Dx services; SI4 SIR rates for Angiogram, PCI and Cardiac Surgery; ESPI compliance • Māori Health: Please see Appendix 1 Objective 1: Health equity for Māori • Workforce: Please see Appendix 1 Objective 4 : Build the Workforce Section WF10, WF11 • Regional IS: Please see Appendix 1 Objective 5 : Improve Clinical Information Systems – Preventative Health IT Capability • Linkages : NZCN, Heart Foundation, NZCS, MOH, Pharmac

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Ischaemic heart disease	Milestone/Date	Responsibility
• **National Expected Standards –** recommendations based on the gap analysis of the five Midland DHBs against the National Expected Standards • **ACS -** Embed the virtual regionally integrated Midland Cardiac Service as business as usual across the five Midland DHB Cardiac Services to deliver value and high performance working as one virtual service. During this process opportunities for service improvements will be identified and addressed • **STEMI -** Develop Systems of Care across the continuum to support national STEMI guideline • **Primary Prevention** - understand the barriers to Cardiology FSA and develop a mechanism to count and track outcomes for cardiac attendances to general medicine OP clinics in DHBs where this occurs • **Secondary Prevention and Rehabilitation** - Sub- group will make recommendations from the gap analysis undertaken in the 17/18 yr. **Output / Deliverables** • Recommendations against National Expected Standards per Midland DHB • Continuously improved ACS forecasting • Standard Operating Procedures and Variance Response Management Plans (SOPs, VRMs) for Cardiac Services • Documented understanding of how secondary prevention and rehabilitation will be delivered across the five Midland DHBs • Achieve no inequality across ethnicity or residential location in KPIs	Q4 2017/18 Q2 2017/18 Q3 2017/18 Q4 2017/18 Q4 2017/18	Midland DHBs – embed the use of the Cathlab forecasting and planning tool into business as usual. HealthShare – monitor and refine the Cathlab tool with DHB feedback and variance tracking. Develop a 10yr Cathlab demand -capacity predictive model Clinical Network – publish agreed ACS Standard Operating Procedures and Variance Management Responses

NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 2: Heart failure	Milestone/Date	Responsibility
Patients with heart failure are optimally managed across the continuum, reducing the occurrence of acute admissions and disability. This care is to be delivered closer to home where practicable with a focus on: • Efficacy of management of heart failure		Midland DHBs HF clinical specialists will need to be released to meet

• Timely access to investigations (as per expected standards) • Inequality across ethnicity or residential location must be addressed **Output / Deliverables** • 16/17 stocktake of services and analysis of data will inform recommendations to meet the National Expected Standards per Midland DHB • Document how heart failure services will ideally be delivered across the five Midland DHBs to improve outcomes for the worst affected groups now identified as Māori, low deprivation, male, ages 40 – 65				Q2 2017/18 Q4 2017/18	and inform the service design
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
Initiative 3: Atrial fibrillation				**Milestone/Date**	**Responsibility**
Patients with atrial fibrillation are optimally managed across the continuum, reducing the occurrence of acute admissions and disability. This care is to be delivered closer to home where practicable with a focus on: • Risk assessment and prevention of stroke • Timely access to Echo (as per expected standards) **Output / Deliverables** • Do a stocktake of services • Request analysis of data by population health to inform recommendations to meet the National Expected Standards per Midland DHB • Document how atrial fibrillation services will ideally be delivered across the five Midland DHBs to improve outcomes for the worst affected groups once identified				Q2 2017/18 Q3 2017/18 Q4 2017/18	DHBs will need to provide service stocktake information from their DHBs Waikato Population Health would do the data analysis using admissions data from Costpro in a similar methodology to the 16/17 Heart Failure analysis
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
Initiative 4: IS and IT projects				**Milestone/Date**	**Responsibility**

Regional IS/IT Projects
• Explore development of an outpatient coding system across the five DHBs aligning to coding standards and similar to the Bay of Plenty DHB paediatric system that is in place. This is required to understand what conditions patients are being referred to FSA for. In the context of Cardiology – Chest Pain, Heart Failure, Arrhythmias.
 	
• eSPACE Service Transformation: Cardiology;
  • eReferrals and shared service data sets
  • Electronic transfer of data between NEXUS, ANZACSQI and DHB CWS fields
 	
• Design a Regional ACS Whiteboard Live Management Tool
 	
• Engage with NPF OP aspects to ensure coding of OP appointments will differentiate IHD, HF and Arrhythmias. This information with inform future service needs analyses
				Q2 2017/18
				
				Q4 2019/20
				Q4 2019/20
				
				Q4 2019/20
				
				ongoing
					Midland DHB IS departments
					
					eSPACE
					eSPACE
					
					eSPACE
					
					Clinical Networks

NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

2.3 Child health (Child Health Action Group)

Chair: Dr David Graham
Lead Chief Executive: Ron Dunham
Project Manager: Kerry-Ann Adlam / Jane Hawkins-Jones

Context:
Over the next year the Child Health Action Group will plan and work to develop Child Health Services across the Midland region to improve health outcomes and achieve equity in child health.

Child Health in the Midland region has been chosen as a focus area because it has different challenges to the rest of New Zealand in terms of the constitution of the population and the highest levels of poverty and rurality in the country. The Child Health Action Group work plan provides an opportunity to invest in the long term health of our children and future adult population by working together regionally to maximise health gains in a cost effective way.

Further aims include supporting vulnerable children and contributing to the Government's overall priorities by improving services and reducing avoidable expenditure in the justice, health and welfare systems – helping to deliver better public services within financial constraints and helping build a more competitive and productive economy. So that all New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system (NZ Health Strategy 2016).

Planned Outcomes for 17/18:
- The wider implementation of the Harti Hauora tool into Midland DHBs
- CH obesity strategic plan
- CH obesity pathway of care
- Regional SSB strategy agreed
- Regional review of asthma and bronchiolitis maps of medicine

Key objectives:
- Recommend regional solutions to meet child health care needs in the primary, community and secondary sectors and implement solutions within current capacity
- Promote organised systems of care
- Support continuing work on Information Systems to support Child Health
- Consider and implement 'choosing wisely' approach
- Facilitate/promote regional Well Child/Tamariki Ora Quality Improvement initiatives
- Raise the profile of regionally-led child health improvement initiatives

Measures: (by ethnicity, locality and deprivation where possible)
- Increased immunisation rates
- Reduced rates of rheumatic fever
- Lower rates of SUDI
- Reduced 'did not attend' (DNA) rates
- Reduced ambulatory sensitive hospitalisation (ASH) rates – constipation, asthma, bronchiolitis
- Improved regional performance against the WCTO Quality Indicators

Line of Sight
• Midland DHB Annual Plans: Please see section 2 – delivering on priorities and targets • Māori Health: Please see Appendix 1 Objective 1: Health equity for Māori • Workforce: Please see Appendix 1 Objective 4 : Build the Workforce • Regional IS: Please see Appendix 1 Objective 5 : Improve Clinical Information Systems

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Childhood obesity and oral health				Milestone/Date	Responsibility
CHAG will focus on activities that have a wellness and disease prevention focus for children in the Midland region. This focus will also include decreasing the acute and chronic burden of disease for tamariki Māori, children living in poverty and other populations suffering a disproportionate burden of disease. For 2017/2018 this will again include **childhood obesity and oral health**. We will: • Work with DHBs to promote that oral health databases are linked with NCHIP • Supporting and encourage further action to address childhood obesity in DHBs including facilitating sharing and implementation of evidence based lifestyle programmes in the • region for children and families • Oversee and provide support for the implementation of the childhood obesity care pathway (Map of Medicine) • Support a regional Sugar Sweetened Beverages policy/position statement/plan of action in conjunction with the region's Public Health units and actions to implement **Rationale (why does this matter?):** NZ has one of the highest rates of childhood obesity in the OECD – it is well known that obesity is a contributor to a range of chronic conditions including, diabetes, metabolic syndrome, cardiovascular diseases etc and a major contributor to obesity and tooth decay is the high consumption of sugar sweetened beverages. **Outputs (what you will see at June 2018):** • NCHIP linked to oral health databases (where implemented) • All DHBs will have access to an evidence based life style programme for at risk children/families identified in the obesity pathway • Childhood obesity care pathway (Map of Medicine) will be in use across the region • Broader implementation of the SSB policy/position statement/plan of action.				Q4 2017/2018 Q4 2017/2018 Q4 2017/2018 Q2 2017/2018	CHAG/PM Midland DHBs Midland DHBs CHAG/PM
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 2: Implementation of the Harti Hauora tool				Milestone/Date	Responsibility
CHAG will continue to support the wider implementation of the Harti Hauora tool into other Midland DHBs. We will also support the formal evaluation of the secondary units Harti Hauora tool (contingent on Health Research Council Funding). The Harti Hauora tool was developed because of the inequities that exist in access, timeliness, and quality of health care between ethnic and socioeconomic groups. The Harti Hauora programme came into being in 2015 in WDHB, to help improve the health and wellness of Māori and other at risk children and meet standards set by the Ministry of Health. The tool assesses the child's risks in the following areas: • Enrolments and Entitlements – General Practitioner, Well Child/Tamariki Ora (WCTO), Oral health, B4 School check, early childhood education (ECE) • Health Protection – Immunisation status, household smoking exposure, breastfeeding, housing, safe sleep, Car Safety, Shaken Baby, Family Violence Screening • General Health – frequent hospital admissions, BMI/healthy weight, sore throat **Outputs (what you will see at June 2018):** • Formal evaluation of the secondary unit Harti Hauora tool is underway (subject to funding – likely to be a three year process) • Implementation of the Harti Hauora tool into other Midland DHBs				Q4 2017/2018 and ongoing (3 year) Q4 2017/2018	CHAG PM and HH governance group
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 3: Regional pathways of care	Milestone/Date	Responsibility
The Child Health Action Group will continue to lead and support work on agreed pathways through Map of Medicine. **2017/2018 will focus on reviewing the asthma and bronchiolitis maps.** **Rationale (why does this matter?):** These maps are regularly used by clinicians and both asthma and bronchiolitis remain two of the top admissions into secondary services. Both maps are due for review. **Outputs (what you will see at June 2018):** • Completed reviews of asthma and bronchiolitis Maps of Medicine	Q4 2017/2018	CHAG/PM

NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 4: Sharing of information and resources	Milestone/Date	Responsibility
Paediatric outpatient coding We will support the implementation of paediatric outpatient coding IT systems and electronic growth chart across remaining three DHBs, aligning to standards such as SNOMED. Paediatric outpatient coding and electronic growth charts have been implemented and validated in both WDHB and BOPDHB – CHAG will support the broader implementation of an outpatient coding platform as part of the national patient flow project being run through the Ministry of Health. **Rationale (why does this matter?):** There is a need to be able to identify priority conditions and develop pathways of care to ensure consistent practice occurs both locally and regionally. We need to be able to identify changing patterns of referral locally and regionally, identify priorities and health need for youth transitioning into adult services locally and regionally identify capacity against need across the health sector workforce for primary care, nursing, paediatricians and allied workforces. We want to be able to provide visibility of referral trends and resources used in outpatient setting for primary/community organisations locally and regionally, to be able to quantify what paediatricians do individually and as a department, and then make data and evidence-based decisions as a service. Without this we were essentially 'flying blind' and relying on anecdote to explain what each of the services provide across the Midland region Finally, to identify and eliminate "post-coding" across the region and find where there is unmet need. **Outputs (what you will see at June 2018):** • Investigate and support work on a national platform for outpatient coding through the Ministry of Health • Consider broader implementation of web based paediatric outpatient coding and electronic growth chart in the remaining three Midland DHBs.	Q4 2017/2018 Q4 2017/2018	CHAG/PM CHAG/PM
Child/parent attachment project (Lakes DHB) Consider sharing the education and work undertaken by Lakes DHB to date on early, preventative models of intervention and practice that target and promote child/parent attachment. **Rationale (why does this matter?):** Attachment is a basic human function; it has enabled our species to develop into highly organised intelligent beings. Attachment ensures survival, development, safety and reproduction. It is as central to the wellbeing and successful development of an infant as water and nourishment. This first relationship with another human forms the blueprint from which the child will make all future relationships. The safer and more predictable the caregiver, the greater the capacity the child has to learn, explore the world around, and build adaptive		

relationships. Less than optimal relationships in the period 0-3 years can result in significant impairment to cognitive functioning, and social and emotional regulation[10]. **Outputs (what you will see at June 2018):** • Review Lakes DHB evaluation and learnings as they implement the child/parent attachment project • Consider and develop plan of action for implementation across remaining four DHBs.				Q2 2017/2018 Q4 2017/2018	Lakes DHB and CHAG/PM CHAG/PM
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

[10] Evaluation Report "Falling in Love with You, Baby" An attachment informed project – Liz Carrington (Project Manager)

2.4 Elective services (Regional Elective Services Network)

Lead Chief Executive: Rosemary Clements
Clinical Lead: (to be based on specialty)
COO Lead: Gillian Campbell
Project Manager: Jocelyn Carr

Context:
The regional electives project has been reviewed to ensure both the structure supporting the project and the process to agree regional initiatives deliver maximum value to the region. The outcome of the review is that governance of the project has been devolved to the Chief Operating Officers and a more robust process has been implemented to ensure the agreed initiative(s) better reflect the objectives below. Based on the success of the regional clinical networks, agreement has been reached to use a similar approach for regional elective initiatives focusing on single specialty or service that is informed by business intelligence tools. The driver for this change is the understanding that elective service delivery is a component of a specialty which if viewed in isolation misses the opportunity to consider the inter-relationship between acute demand and electives capacity.
The regional COOs will review a short list of specialties and consider the benefits and critical success factors of each. A decision will be made to progress one specialty with an agreed initiative directly contributing to the improved delivery of an elective service.

Further development and enhancement of business intelligence tools will impact on the ability to effectively report electives at a regional level. This includes ethnicity, age and gender reporting at specialty and procedure level.

Key Objectives:
- Reduce inequalities
- Improve quality using evidence-based best practice models of care
- Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.
- Develop clinical leadership
- Support continuing work on technological developments which support services

Measures to show success annually: (by ethnicity, locality and deprivation where possible)
- Agreed number of procedures and 'first specialist assessments' (FSA) are delivered without compromising quality of care
- Reduced waiting times and maintenance of elective service performance indicator (ESPI) compliance
- Variation in Clinical Priority Access Criteria (CPAC) scoring thresholds are reducing once nationally approved tools are implemented
- Increased number of consistent clinical pathways across work streams and increased use of those pathways
- Improved management of elective volumes within regional capacity.

Line of Sight

DHB Annual Plans: Section 2 -Delivering on Priorities and Targets:

- **Waikato:**
  - Implementation of solutions enabling integration between patient care partners
- **BOP:**
  - The BOPDHB will monitor the timeliness of patient's access to services and treatment and address barriers that impact on meeting the four month time frames for assessment and treatment. The BOPDHB will work at a regional level to identify elective services that could benefit from regional management and service delivery.
- **Taranaki:**
  - Work collaboratively with the Midland Regional Electives team to explore the level and type of services provided across the region (utilising the role delineation model)
  - Patient flow indicators are met with all patients waiting 4 months or less for specialist assessment or treatment. National Patient Flow requirements are met
  - Patients will be prioritised for treatment using national, or nationally recognised tools and treatment will be in accordance with assigned priority and waiting times.
- **Lakes :**
  - With our tertiary and external providers of Clinical Services will deliver against agreed volume schedule (included in PBF, funding advice), including elective surgical discharges, to deliver the Electives Health Target
  - Standardised intervention rates and/or other mechanisms (such as demand analysis) will be areas of need for improved equity of access.
- **Tairāwhiti:** the Hauora Tairāwhiti plan has yet to be accepted

- **Māori Health:** aligned
- **Workforce:** aligned
- **Regional IS:** aligned

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Service improvement initiative				**Milestone/Date**	**Responsibility**
A specialty based, regional electives initiative will be developed and implemented to support the delivery of health target discharges, waiting time requirements, improved equity of access, resource utilisation and pathway of care.				Q1 Specialty and electives initiative agreed and work programme developed Q2 Clinical lead agreed Q4 Electives initiative is implemented within agreed timeframes	Regional Electives Governance Group
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
Initiative 2: Ongoing development of regional information tools				**Milestone/Date**	**Responsibility**
Accurate and timely Information enabling a regional view of elective services delivery by specialty and procedure supports decision making and reporting across the region. Information includes: • Volumes • Waiting times • Demographics (age, gender and ethnicity) • Geographical location				Q1 work plan for tool is developed and agreed Q4 Tool is delivering agreed enhancements as per work plan	Regional Electives Governance Group
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

2.5 Healthy ageing (Health of Older People Action Group)

Chair: Dr Phil Wood **Project Manager:** Kirstin Pereira
Lead Chief Executive: Helen Mason

Context:
The recent release of the Healthy Ageing Strategy[11] provides a clear direction for New Zealand and the health of its older people. In the next decade a substantial increase is expected in the number of older people. The strategy urges the health sector to plan and ensure it is prepared at national, regional and local levels.

People with long term conditions, including dementia, need support and information to help manage their conditions and to help stay well. Family and whanau carers play a crucial role in caring for older people with long term conditions. In order to be able to continue in this role without impacting on their own health they will need training and information. The health workforce, including home and community support services, also needs to be better equipped to support older people either at home or in residential care. Expanding the capabilities of the workforce and ensuring they have the training they need to help keep older people healthy is vital.

The strategy also includes a focus on the systems and technologies available in health. The health system is 'data-rich' and holds a vast amount of information. In order to benefit from this, planning needs to include how that information can be used to help improve quality and service delivery.

Planned Outcomes for 17/18:
The outcomes planned for 2017/18 are;
- Dementia assessment and management pathways are informed by current evidence and best practice
- Referrals to Alzheimer's and Dementia organisations are easier to make using e-Referrals
- Whanau and family carers of people with dementia have access to standardised support and education programmes
- InterRAI data is accessed and used, by the sector, on a regular basis
- The requirements for a minimum workforce data set are identified by the Ministry of Health.

Key objectives:
- Improve the ease of use of the dementia pathways
- Validate the evidence and best practice underpinning the dementia pathways
- Measure GP and Practice Nurse access of the dementia pathways and if there has been an increase in confidence levels using the pathways
- DHBs work in conjunction with the dementia sector to ensure education and support programmes are provided for family and whanau carers of people with dementia
- Improve the use of InterRAI data across the continuum
- An agreed minimum workforce data set for the aged care workforce and a mechanism for collecting the data - *Currently seeking clarification from the Ministry of Health regarding objective of collecting a minimum workforce data set and what that minimum workforce data set will be*
    - Identify the workforces working with older people, (including those requiring palliative care) their families, whanau and informal carers
    - Ensure these workforces have the training and support required to deliver high-quality, person-centred care.

Measures: (by ethnicity, locality and deprivation where possible)
- Increased referrals from GP Practices to Alzheimer's and Dementia organisations
- Increased confidence levels in GPs and Practice Nurses in the use of the dementia pathways
- Standardised training is available on a consistent basis for family and whanau carers of people with dementia across the Midland region
- Increase in the number of reports based on InterRAI data agreed to by the sector and produced on a regular basis
- *Workforce measure – mechanism for minimum workforce data set - waiting for clarification from the Ministry of Health*

[11] Associate Minister of Health. 2016. *Healthy Ageing Strategy*. Wellington: Ministry of Health

- Workforce plan in place to deliver required training and education to workforces working with older people, (including those requiring palliative care) their families, whanau and informal carers

- Reporting for the Health of Older People Action Group to include Maori and non-Maori normalised against standardised population data (where this level of data is available).

Line of Sight
• DHB Annual Plans: Please see section 2 pg 16 Waikato DHB, section 2 pg 15 Taranaki DHB, section 2 pg 11 & 14 Lakes DHB, section 2 pgs 10, 17,18 and 29 Bay of Plenty DHB and section 2 pgs 17 & 21 and section 3 pg 25 Tairāwhiti, Section 5 PP23 Improving wrap around services for Older People, all DHBs • Māori Health: Please see Appendix 1 Objective 1: Health equity for Māori • Workforce: Please see Appendix 1 Objective 4 : Build the Workforce • Regional IS: Please see Appendix 1 Objective 5 : Improve Clinical Information Systems • Healthy Ageing Strategy, 2016. • New Zealand Framework for Dementia Care, 2013

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Strengthen the implementation of the NZ Dementia Framework and the actions specified in *Improving the Lives of People with Dementia* (Ministry of Health 2014). Action 11a Healthy Ageing Strategy	Milestone/Date	Responsibility
Through the continued coordination and support of the Dementia Pathway Working Group strengthen areas of the dementia pathways being used in primary care.		- HOP Project Manager - Project Manager - Regional Pathways of Care - Midland Dementia Pathway Working Group - HSL Analyst
• Develop e-Referrals to Alzheimer's and Dementia organisations in conjunction with the Regional Pathways of Care team	Q1 – Q2 2017/18	
• Coordinate review of the evidence base and best practice underpinning the dementia assessment and management pathways	Q1 – Q2 2017/18	
• Determine if Maori are being recognised as having problems with cognition at the same rate as non-Maori using InterRAI data, including the trigger rate of Dementia and Cognitive CAPs	Q1 – Q2 2017/18	
• Develop and deliver a survey of GP Practices to determine use of the dementia assessment and management pathways and their impact on GP and Practice Nurse confidence levels	Q1 2017/18	
• Analyse and distribute the survey results	Q2 2017/18	
• Determine any changes to the pathways to be made as an outcome of the survey	Q3 2017/18	
• Implement changes identified in the review of the dementia pathways	Q3 2017/18	
• Based on the outcomes of reviewing InterRAI data on cognition, identify ways to support primary care to recognise cognitive decline in older Maori in the same was as in non-Maori and support NASCs to provide for those needs equitably.	Q3 – Q4 2017	
Ensure education and support programmes for family and whanau carers of people with dementia are standardised and accessible. • Support the development of a framework for the delivery of education and support programmes for family and whanau carers • Review and endorse quality and equity indicators identified by DHBs for delivery across the region • Support the sector to identify ways to ensure access for family and whanau carers to the education and support programmes.	Q2 – Q3 2017/18 Q3 2017/18 Q4 2017/18 – 2018/19	HOP Project Manager HOP Action Group DHBs Service Providers

NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 2: Identification and use of InterRAI data to support quality initiatives and service improvement in the sector. Action 8b NZ Healthy Ageing Strategy				Milestone/Date	Responsibility
The goal of InterRAI is to promote evidence based practice and policy decisions through the collection of high-quality data about the characteristics and outcomes of people served across the continuum. The data collected can then be used to improve outcomes for older people. • Continue to provide and monitor InterRAI reporting created in 2016/17 • Determine if there is equity of assessment and access to Home and Community based support for Maori across the Midland region • Identify the means of addressing any identified equity gaps and begin implementation • Identify the data required by the sector for service improvement through workshops • Provide the identified requirements in a user friendly format • Support the sector to identify quality indicators to be reported against on an agreed frequency.				Q1 – Q2 2017/18 Q1 – Q2 2017/18 Q3 – Q4 2017/18 Q2 – Q3 2017/18 Q3 2017/18 Q4 2017/18	- HOP Project Manager - HSL Analyst - HOP Action Group - DHBs - Service Providers
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 3: Health of older people workforce				Milestone/Date	Responsibility
The workforce working with older people, including those requiring palliative care, need to be able to deliver high-quality and person centred care. • Work in collaboration with the Ministry of Health, DHB Shared Services and the sector working with older people to establish the mechanism to collect whole of sector workforce data • Identify the allied health, kaiawhina and carer and support services workforces working with older people (including those requiring palliative care) and their family / whanau / informal carers – Palliative Care has been included here as this will involve exactly the same workforce as described in the Health of Older People Workforce • Develop a workforce plan to ensure that those working with older people, including older people requiring palliative care, have the training and support they require to deliver high-quality, person-centred care - Palliative Care has been included here as this will involve exactly the same workforce as described in the Health of Older People Workforce.				Q1 – Q2 2017/18 Q1- Q2 2017/18 Q1 – Q2 2017/18	- Regional Director of Workforce Development - MoH - DHB Shared Services - in partnership with Midland Specialist Palliative Care providers (MCN)
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 4: NZ Healthy Ageing Strategy - Placeholder				Milestone/Date	Responsibility
Awaiting the Implementation plan from Ministry of Health. Possibly available by Q4 2016/17. • Review the Healthy Ageing Strategy implementation plan • Identify regional initiatives from the Ministry of Health Implementation Plan. Frailty is a potential area of focus for the Midland region • Agree initiative to be started in the 2017/18 year • Utilise the Healthy Ageing Strategy to inform the 2018/19 plan.				Q1 2017/18 Q2 2017/18 Q3 2017/18 Q4 2017/18	- HOP Project Manager - HOP Action Group
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 5: Advance Care Planning - Placeholder	Milestone/Date	Responsibility
To be determined – in conjunction with Regional Quality		

2.6 Mental Health & Addictions (Regional Mental Health & Addictions Network)

Chair: Professor Graham Mellsop **Regional Director:** Eseta Nonu-Reid
Lead Chief Executive: Ron Dunham

Context:
Since the 1990s the mental health and addiction sector has been through significant growth and rapid change, not only in relation to the range of services available, the way they are provided and the strong emphasis on a culture of recovery, but also in terms of the expectations of people who use services, their families and whānau, and communities. The service changes have only been possible through the efforts of an innovative and energetic sector that is willing to make continual improvements and never stand still. Despite all the improvements over recent years, service quality and the level of access to services remain variable for people with mental health and addiction issues. It is essential we continue to make changes, with a renewed focus on earlier and more effective responses, improved outcomes, better system integration and performance, increased access to services, effective use of resources and stronger whole-of-government partnerships.

Māori continue to more frequently experience mental health and addiction issues (Oakley Browne et al 2006), inpatient admission, seclusion and compulsory treatment (Ministry of Health 2012a*)* than other groups. We also continue to have:

- one of the highest rates of youth suicide in the developed world
- high rates of the use of seclusion, with variation between district health boards (DHBs)
- high rates of the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992, with variation between DHBs
- variation in access to services especially for children and youth
- variable waiting times for access to mental health and addiction services
- variable alignment and integration between services provided by DHBs and those provided by NGOs
- variable integration between specialist services and primary care
- limited and variable primary mental health responses for people experiencing common but debilitating mental health and addiction issues and no ability to measure access to these primary mental health responses
- gaps in responses for people with co-existing mental health and addiction problems, and those with co-existing mental health issues and disabilities
- variability in the quality of specialist inpatient facilities.

To tackle these challenges, significant changes are needed to better meet the needs of those in our communities who use our services. We must take the time to consider cutting-edge practice and this plan allows the region to take incremental steps towards achieving these goals.

Planned Outcomes for 17/18:

Vision: ***"Improving Mental Health and Addiction with Integrated and Supported Systems"*** underpinned by:

1. Quality services
2. Sector infrastructure
3. Integration and social inclusion
4. Workforce capacity and capability
5. Health system relationships and integration
6. Early detection and intervention focusing on recovery
7. Information management

Key objectives:

a) Leading regional mental health and addiction planning
b) Leading regional service improvement
c) Supporting the achievement of health targets and policy priorities
d) Linking to national and regional governance structures and processes
e) Leading and/or supporting the development of nationally consistent approaches to mental health and addiction

f) Reducing inequalities in mental health and addiction outcomes
g) Efficiency and effectiveness to determine and inform funding prioritisation decisions

This plan is inclusive of primary, secondary, and the tertiary mental health and addiction sectors and should be read in conjunction with the local District Annual Plan.

Measures: (by ethnicity, locality and deprivation where possible)

- A reduction in waiting lists and times for people entering for service as per the national benchmarks.
- Increased access to services for the primary health sector
- Reduction in Māori place on a compulsory treatment order
- Reduction in people being secluded as per the national benchmarks

Line of Sight
○ DHB Annual Plans: BOP DHB, Lakes DHB, Hauora Tairāwhiti, Taranaki DHB and Waikato DHB – section 2 – delivering on priorities and targets; section 3 – service configuration; section 5 – performance measures • Māori Health: Please see Appendix 1 Objective 1: Health equity for Māori • Workforce: Please see Appendix 1 Objective 4 : Build the Workforce • Regional IS: Please see Appendix 1 Objective 5: Improve Clinical Information Systems

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Midland eating disorders model of care				Milestone/Date	Responsibility
Continued regional provision of eating disorder inpatient services • Implement the Midland Eating Disorders Model of Care as outlined in the MoH Change Management proposal • Implement the workforce recommendations.				Q2 2017/18	Regional Director and Clinical Governance
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
Initiative 2: Substance abuse legislation				**Milestone/Date**	**Responsibility**
Improved addiction service capacity and capability for implementation of substance abuse legislation • Submit a Midland proposal to the MoH • Implement the objectives as identified in the proposal • Implement the workforce development requirements				Q1 2017/18 Q2 2017/18 Q1 2017/18	Midland Regional Director Midland SAL Project Manager
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
Initiative 3: Physical health care for low prevalence mental health disorders				**Milestone/Date**	**Responsibility**
Develop a plan to improve physical health outcomes of people with low prevalence disorders • Develop a regional agreement across the Midland that identifies an agreed strategy for ensure physical health needs for low prevalence disorders are identified and addressed consistently • Develop an integration paper in collaboration with Primary Mental Health to determine an agreed model of care focusing on whole-of-health needs.				Q2 2017/18 Q3 2017/18	Midland Clinical Governance Midland Clinical Governance
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 4: MH&A clinical workstation				Milestone/Date	Responsibility
The successful implementation of modern clinical workstations across the Midland region. • Ensure all approvals for PID and Business Case are obtained and there is regional agreement going forward • Undertake a Training Needs Analysis across the region and design a workforce plan • Work with local Champions Groups to ensure local processes are implemented.				Q1 2017/18 Q1 2017/18 Q1 - Q4 2017/18	Midland Clinical Governance and CWS Coordinator
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 5: Midland Infant Perinatal Clinical Network				Milestone/Date	Responsibility
The Midland Infant Perinatal Clinical Network will: • Complete the review of the primary care pathway (Map of Medicine) and consult with primary, maternity and mental health and addictions services • Develop regionally agreed policies, procedures and clinical best practice guidelines to ensure regional consistency • Participate in the evaluation of the e-Learning tool in partnership with the Central region.				Q1 2017/18 Q1 - Q4 2017/18 Q1 - Q4 2017/18	Midland Infant Perinatal Clinical Network
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

2.7 Radiology services (Midland Radiology Action Group)

Chair and Clinical Lead: Dr Alina Leigh – Taranaki DHB **Project Manager:** Philippa Edwards
Lead Chief Executive: Dr Nigel Murray

Context:
Midland Radiology Departments work together regionally on quality standards, information sharing and service improvement initiatives.
MRAG is a resource for the other regional networks and for MOM in the design of service delivery models. The MRAG clinical lead and a DHB management representative attend the National Radiology Advisory Group (NRAG) quarterly meetings.

DHBs face challenges due to increasing demand, inequitable access, and the sustainability and affordability of services within a financially constrained landscape. Radiology departments are a support service and want to be responsive to DHBs meeting national priorities, targets and the implementation of new service delivery models and pathways. Responding nimbly is a challenge within a costly equipment based environment and where there are challenges due to technologies emerging faster than the workforce and skill base required.

To be responsive MRAG would ideally be included at the earliest stages of development of clinical pathways and service delivery models.

Improving access to diagnostics will improve patient outcomes in a range of areas:

- Cancer Pathways – CT Colonography access is a fast, cost effective less invasive modality suitable for some patients that would reduce the demand on Colonoscopy services
- Cardiac Cath labs – CT Coronary Angiography is a fast, cost effective less invasive modality suitable for some patients that would reduce the demand on Cath labs
- Emergency department – wait times can be improved if radiology is not a bottleneck
- Electives Services – decision making enables certainty which affects patient outcomes and the use of hospital beds and resources

Planned Outcomes for 17/18:
The MRAG work program for 2017/18 provides tangible value while also providing a leadership and monitoring role.

In 2016/17 tangible outcomes from the 4 initiatives will be:

1. US modeling of demand capacity - a regional model for the US modality will provide DHBs a regional and local understanding of volumes, sources of demand, case mix and capacity currently utilised.
2. US workforce – a bi-annual follow up survey across the public and private providers to include echo sonographers
3. Cancer Streams/Pathways – involvement to improve the value proposition and performance delivered by working closely with the Cancer Network and other services, on their referral criteria, timeliness required, pathway development and the Choosing Wisely methodology
4. Work closely with regional and national groups on their initiatives – NRAG, eSPACE, MOM

Additionally leadership, monitoring and benchmarking will be provided for:

- Midland DHB performance against MOH timeline KPIs for CT and MRI
- Quarterly updates of service improvement initiatives within the five Midland DHB Radiology departments
- Providing collaborative advice to clinical services

Key objectives:
Guided by the Health Strategy Framework and Midland Quality Framework the focus is on wellness of the population, reduced service vulnerability, and improved value to the population through:

People powered

- Particular focus on Cancer Pathways and Timelines
- Work closely with the National Radiology Advisory Group to advise impacts and enable change – Pharmac, Cancer Stream, HWFNZ

Closer to Home

- Equitable access criteria that is clinically and financially sustainable and delivered close to home
- Meet MoH targets and performance objectives in alignment with the NZHS's 5 strategic themes

Value and high performance

- US modeling to give visibility to the demand and capacity flows per modality across the Midland region. This information will provide a regional view of potential capacity and bottlenecks, enabling a data informed regional approach to capital investment
- Cancer Streams/Pathways –improve the value proposition and performance by working closely with the Cancer Network and other services on their referral criteria, required timeframes and pathway development
- Evaluation of nuchal translucency scans vs emerging technology blood tests with regard to best use of regional resource

One Team

- Clinical best practice will be enabled with the implementation of national access criteria based on clinical need. Capability stocktakes across the region will identify where current and potential capacity and bottlenecks exist, enabling a regional approach to capital investment
- Work with Regional Workforce identifying intelligence on current and future workforce requirements for the region
- Work with MOM on local pathways as requested

Smart System

- Working with the regional IS e-space team to inform development of eReferrals and i-referrals, data repositories and links to other radiology provider studies

Measures: (by ethnicity, locality and deprivation where possible)
Ministry of Health CT, CTC, MRI primary care timeliness measures and indicators

1. CT– 95% of accepted referrals from primary care or outpatients for CT scans will receive their scan within six weeks (42 days)
2. CT Colonoscopy (Subset of CT) – 95% of accepted referrals from primary care or outpatients for CT Colonoscopy will receive their scan within six weeks (42 days)
3. MRI - 90% of accepted referrals from primary care or outpatients for MRI scans will receive their scan within six weeks (42 days)
4. Agreed National Patient Flow system changes are implemented

Line of Sight
Midland DHB Annual Plans: Section 2 -Delivering on Priorities and Targets: • **Waikato**- Implementation of solutions enabling integration between patient care partners - focus includes Radiology providers • **BOP-** Implementation of 2nd CT Scanner at Tga Hospital and Internal e-Referrals System, participation in BOPDHB "Acute Flow Improvement Project" and further development and expansion of Radiology Interventional • **Taranaki-** Replace Picture Archiving Communication System and Radiology Information System • **Lakes** – Improved access to elective services through action on direct access to diagnostic/treatment; Local and regional enabler –(IS) Radiology reports for Lakes added to the regional repository • **Tairāwhiti** **Section 5: Performance measures:** • All DHBs – PP29 Improved wait times for elective diagnostic services – CT and MRI KPIs • Māori Health: Please see Appendix 1 Objective 1: Health equity for Māori • Workforce: Please see Appendix 1 Objective 4 : Build the Workforce • Regional IS: Please see Appendix 1 Objective 5 : Improve Clinical Information Systems – Digital Hospital • Linkages : NRAG, MOH, Pharmac, HWFNZ, Primary Care providers, Midland Cancer Services

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Demand – capacity modeling	Milestone/Date	Responsibility
Ultrasound - the volumes, case mix and machine time for Ultrasound (US) will be modeled across the Midland DHBs to inform resource preparation required to respond to national and local demands and priorities		MRAG, Midland DHBs for US data
• Collect US data counting per scan	Q1 2017/18	
• US modeling to provide regional clarity on demand trends per referrer type and per US examination along with the resources used to achieve current delivery. This data will be	Q3 2017/18	

useful to inform DHB and regional decisions on how to most effectively support achievement of volumes required to meet national priorities and/or changes in service delivery models • Ratios of US caseload outputs at Midland DHBs.				Q4 2017/18	
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 2: Ultrasonography workforce sustainability				**Milestone/Date**	**Responsibility**
Conduct the second bi-annual survey of sonographers across the Midland regions public and private providers as a part of on-going work to predict and track the Sonographer workforce trends and requirements for training within the Midland region. In collaboration with the Ministry of Health and DHB shared services MRAG will: • This round of survey will include Echo technicians • Analyse the gap between forecast workforce status and actual workforce status across Midland region. • Evaluate the number of trainee positions required across the region to home grow the future Sonographer workforce • Evaluate the turnover of Midland Sonographers against the national trends to see if the home-grown approach via the 50:50 public private training model is effective.				Q2 2017/18 Q3 2017/18 Q4 2017/18 Q4 2017/18	MRAG, Midland Workforce
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 3: Involvement in cancer streams/pathways at a regional level to reduce delays in patient flows				**Milestone/Date**	**Responsibility**
Improve the value proposition and performance delivered by working closely with the Midland Cancer Network and other services criteria, timeliness required • Access cancer pathway data where possible to inform where radiology needs to improve its timeliness of service delivery • Be actively involved in the local implementation of the cancer stream work and related national radiology cancer pathways and guidance and MoM pathways				Q2 2017/18 ongoing	
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 4: National and local initiatives				**Milestone/Date**	**Responsibility**
Improve the value proposition and performance delivered by working with: • National Radiology Advisory Group (NRAG) and key national groups such as Pharmac, Cancer Stream Pathways, HWFNZ to offer formal advice on the impacts of new treatments and ensure the implication of national guidelines on imaging services and clinical efficacy are well understood. • Obstetricians and Path lab to create a position document on the use of Nuchal translucency vs genetic blood testing (NPPT) in providing best outcomes for mothers and babies, first choice of parents and improved use of regional resource. • Midland Regional Regional IS and eSPACE teams to ensure effective functionality of the regional CWS, eReferral and regional PACS systems with regional integration for information access and patient flow are patients centric. • MOM on local pathways within and across DHBs, with cognisance of the Choosing Wisely methodology where appropriate.				ongoing Q2 2017/18 ongoing ongoing	MRAG, eSPACE, MOM
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

2.8 Stroke services (Midland Stroke Network)

Chair: Peter Wright, Neurologist, Waikato DHB **Project Manager:** Kerry-Ann Adlam

Lead Chief Executive: Rosemary Clements

Context:
Stroke is the second most common cause of death worldwide and a common cause of disability in adults in developed countries (Johnston et al, 2009; Rothwell, 2001). Stroke is a major public health challenge in New Zealand (MOH, 2000). It is the third greatest cause of death in New Zealand, after all cancers combined and heart disease (MOH, 2009), and has an enormous physical, psychological and financial impact on patients, families, the health care system and society (Strong et al, 2007; Caro et al, 2000).

Planned Outcomes for 17/18:
Health Literacy - Stroke /TIA (as per the FAST campaign) education for the community as well as the primary and secondary workforce.

Rehabilitation - Ensure rehabilitation services for stroke patients across the region aligns to the "*NZ Organised Stroke Rehabilitation Service Specifications (in-patient and community)"*.

Service provision - Ensure thrombolysis services across the region aligns to the "*NZ Organised Acute Stroke Service Specifications"* (prepared by the National Stroke Network)

Key objectives:
- To improve primary and secondary stroke prevention and reduce stroke related disability and mortality.
- To improve access to quality assured organised acute, rehabilitation, and community stroke services.
- To ensure all stroke patients have access to high-quality stroke services regardless of age, gender, ethnicity or geographic domicile.

Measures: (by ethnicity, locality and deprivation where possible)
- 8 percent or more of potentially eligible stroke patients thrombolysed 24/7 (see PP20 for definition of 'eligible')
- 80 percent of stroke patients admitted to a stroke unit or organised stroke service (see PP20 for definitions).
- 80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission (also report percent of acute stroke patients transferred to inpatient rehab).

Line of Sight
• Midland DHB Annual Plans: Please see section 2 – delivering on priorities and targets • Māori Health: Please see Appendix 1 Objective 1: Health equity for Māori • Workforce: Please see Appendix 1 Objective 4 : Build the Workforce • Regional IS: Please see Appendix 1 Objective 5: Improve Clinical Information Systems – Regional IT Foundation

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Organisation of stroke services including thrombolysis and rehabilitation	Milestone/Date	Responsibility
Thrombolysis		
• Support and facilitate the implementation of a pathway of care for accessing thrombectomy services through ADHB	Q4 2017/2018	MSN/PM
• Support and facilitate the development of a pathway of care for accessing thrombectomy services through WDHB (five-year timeframe)	Q4 2017/2018	MSN/PM
• Support the implementation and evaluation of the Telestroke pilot in Hamilton/Thames/Rotorua hospitals. If demonstrated positive patient outcomes consider providing this service regionally as part of long term planning.	Q2 2017/2018	WDHB

Rehabilitation • Review quarterly measure of percentage of patients who receive rehabilitation within seven days of discharge from stroke unit (from relevant allied health clinician) to ensure equity of access – develop plan of action if equity issues are identified.				Q1 2017/2018 and ongoing	MSN/PM/Analyst
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 2: Education, training and audit				**Milestone/Date**	**Responsibility**
• Undertake a prospective audit to identify disparities between Māori and Non- Māori accessing acute and rehabilitation stroke services. This will include: ○ the number of Māori vs Non-Māori accessing inpatient rehabilitation ○ the number of Māori vs Non-Māori accessing thrombolysis treatment ○ the number of Māori vs Non-Māori accessing the acute stroke unit ○ the number of Māori vs Non-Māori accessing community rehabilitation services then develop plan of action to improve these disparities.				Q4 2017/2018	MSN/PM
• BOPDHB will also undertake a three-month audit to ascertain reasons why Māori stroke patients delay accessing stroke services				Q3 2017/2018	MSN/PM
• The Midland Stroke Network will support the delivery of all local, regional and national acute stroke and rehabilitation study sessions/days; have representation at all study days and provide feedback to the wider group				Q1 2017/2018 and ongoing	BOPDHB reps/PM
• Ensure all stroke and rehabilitation study days are available to the primary/community sector				Q1 2017/2018 and ongoing	MSN
• Set up and support regular email/online sharing of relevant research and information amongst the group				Q1 2017/2018 and ongoing	MSN/PM
• Consider setting up a Facebook group for Midland Stroke Network to better enable sharing of key stroke information				Q1 2017/2018 and ongoing	PM
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 3: Workforce				**Milestone/Date**	**Responsibility**
• Provide collegial support for new incumbent lead stroke clinicians through the meeting structure and peer support groups e.g. regional CNS group				Q1 2017/2018 and ongoing	MSN/PM
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 4: Information technology				**Milestone/Date**	**Responsibility**
• Establish virtual regional analyst group to streamline and troubleshoot data collection and identified issues for quarterly and ad hoc reporting				Q1 2017/2018	PM/analyst
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

2.9 Trauma services (Midland Trauma System - MTS)

Chair: Dr Grant Christey, Clinical Director **MTS Programme Manager:** Alaina Campbell

Lead Chief Executive: Dr Nigel Murray

Context:
Trauma is the leading cause of death for New Zealanders under 45[12,13] and continues to have a major impact on our Midland communities and health services. It is estimated that for every death following injury there are a further 9 people who survive with major injuries requiring complex, multidisciplinary care[14]. For those who survive traumatic injury, recovery periods and long term disabilities result in a reduced economic contribution and/or long-term economic liability imposed on health and social systems[2]. Trauma volumes continue to rise in Midland with 5679 incidents resulting in 6720 admissions in 2015/16 and 26622 hospital bed days[15]. The total cost of this to the hospitals alone is approximately $50 million a year.

Trauma is preventable and we are committed to reducing this burden on our community and health services.

The Midland Trauma System (MTS) has four main aims:

1. Improve the delivery of high quality clinical care to trauma patients
2. Develop implement and maintain regional trauma system infrastructure
3. Support injury prevention and awareness
4. Establish a Trauma Quality Improvement Program (TQIP) to enable evidence-based change.

Planned Outcomes for 17/18:
- Clinical and Hub services FTE requirements adjusted to service requirements
- Completion and implementation of Trauma relational data platform (TQual) to allow merging of information from various sources and real time reporting for Midlands staff
- Development of structural plan for TQIP and delivery of primary actions and outcomes.
- Update of regional trauma guidelines
- Implementation of prehospital and inter-hospital destination matrices
- Implementation of formal recommendations from regional trauma verification program
- NZMTR hosting contract adjusted and renewed (July 2017-2020).

Key objectives:
- Development of a comprehensive Trauma Quality Improvement Programme
- MTS clinical staff receive and utilise regular volume and quality indicator information
- Implement pre hospital and inter-hospital destination matrices
- Develop model of post injury rehabilitation with locally based resources and networks
- Optimise multimedia pathways for distribution of information to the public and health professionals
- Midland Trauma Research Centre fully staffed including roles of Epidemiologist and Research Assistant to provide optimal utilisation of information.

Measures: (by ethnicity, locality and deprivation where possible)
- Reduce regional mortality in severely injured from 8.0% (2016) to 7.0% in 2018
- Revised regional trauma guidelines published.
- TQual build complete and functional
- TQIP plan identified and initial reporting commenced.
- Verification recommendations communicated widely and included in DHB and Midland action plans.

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[12] Gulliver PJ Simpson JC (editors) (2007) Injury as a leading cause of death and hospitalisation. Fact Sheet 38. Injury Prevention Research Unit. (Updated April 2007). http://www.otago.ac.nz/ipru/FactSheets/FactSheet38.pdf
[13] Leonard E, Curtis K. Are Australians and New Zealand trauma service resources reflective of the Australasian Trauma Verification Model Resource Criteria? ANZ J Surg. 2014 Jul-Aug; 84(7-8):523-7. doi: 10.1111/ans.12381. Epub 2014 Feb 12.
[14] Gosselin RA, Spiegal DA, Coughlin R, Zirkle LG. Injuries: the neglected burden in developing countries. Bull World Health Organ. 2009;87(4):246
[15] Midland Trauma System Annual Report 2015-16. ISBN#1-877296-29-5 www.midlandtrauma.nz

- Deficits in regional trauma staff FTE addressed
- Reduce LOS in severely injured from 14 (2016) to 12 days (2019)
- 100% of severely injured patients (Injury Severity Score >13) clinically reviewed by MTS staff.
- All baseline incidence and equity studies completed 2018.
- Regional prehospital and inter-hospital referral matrices implemented and monitored(2019)

Line of Sight
• Midland DHB Annual Plans, section 2 – delivering on priorities and targets • Māori Health: Please see Appendix 1 Objective 1: Health equity for Māori • Workforce: Please see Appendix 1 Objective 4 : Build the Workforce • Regional IS: Please see Appendix 1 Objective 5: Improve Clinical Information Systems

Work Plan Key	Actions are specifically aimed at achieving the NZHS five strategic themes/ Midland DHBs regional objectives

Initiative 1: Improve the delivery of high quality care to trauma patients	Milestone/Date	Responsibility
• Complete review of CNS, TOC and data management roles: define appropriate FTE for Hub and clinical services	Q1 2017/2018	MTS
• Gain endorsement and support from regional service management and professional bodies, and work through governance levels to ensure implementation of resourcing.	Q1 2017/2018	
• Ensure membership and engagement to appropriate professional bodies by MTS personnel	Q1 2017/2018	
• Identify and implement action plan based on the findings and recommendations from regional trauma verification	Q1 2017/2018	
• Develop "push" reporting system on key information to assist clinicians to highlight priorities in clinical care.	Q1 2017/2018	
• Develop breach reporting process within clinical feedback loop	Q2 2017/2018	
• Define model of post injury rehabilitation care with locally based services and networks	Q2 2017/2018	
• Implement and monitor trial of prehospital and inter-hospital destination policy matrices	Q1 2017/2018 and ongoing	
• Develop tools within TQual to guide clinical strategies	Q3-4 2017/2018	
• Update guidelines and review current challenges to use. Develop implementation plan that encourages compliance	Q3-4 2017/2018	
• Complete qualitative research study in collaboration with WINTEC and Monash university to assess patient experience with trauma services	Q3 2017/2018	
• Implement sustainable long term patient/family feedback process	Q4 2017/2018	
• Coordinate and report preliminary PATCH trial findings https://www.patchtrauma.org/ .	Q3-4 2017/2018	

NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Initiative 2: Develop and maintain regional trauma system infrastructure	Milestone/Date	Responsibility
• Gain approval and secure funding for business case 2017-2020.	Q1 2017/2018	MTS
• Implement all elements of business case including epidemiologist to maximize information	Q2 2017/2018	
• Implement recommendations from trauma verification to improve MTS infrastructure and function	Q1 2017/2018	
• Identify and secure external sources of funding to support MTS activities with indicative target of $500k over 3 years	Q3-Q4 2017/2018	
• Complete build of TQual relational database	Q1 2017/2018	
• Define and implement information for automation from internal DHB hospital systems into TQual.	Q1 2017/2018	
• Review and analyse all parts of data collection process e.g. St John EPRF, data collect, audit process to ensure alignment throughout Midland/nationally.	Q2-3 2017/2018	
• Maintain training and education programs to ensure a consistent flow of complete, accurate and representative trauma data into the registry	Q1 2017/2018 and ongoing	
• Submission of data to the NZ Major Trauma Registry no more than 30 days after patient discharge.	Q1-Q4	
• Complete mobile data collection trial (handheld)	Q2 2017/2018	
• Establish and optimise sever based Qlik Sense for data visualisation in district hospitals	Q2 2017/2018	

• Develop strategic plan for Midland Trauma Research Centre (MTRC) including marketing strategy that supports research to address the needs of the Midland community. • Develop web based common node on Midland trauma website linked to TQual • Deliver annual trauma symposium and research training workshop.				Q1 2017/2018 Q3 2017/2018 Q4 2017/2018	
NZ Health Strategy: **5 Strategic Themes**	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
Initiative 3: Support injury prevention and awareness				**Milestone/Date**	**Responsibility**
• Complete regional injury incidence study program for baseline data on injury patterns and equity. • Develop functional information pathways with key partners to translate trauma data into reduction of injury rates • Utilise trauma calendar dates of interest to promote MTS registry information to extend the uses and impact of trauma data e.g. Falls month • Extend community education and awareness programs to schools, councils, community groups • Complete prevention pilots with WINTEC and University of Waikato assess collaboration outputs for ongoing and relationships. Assess feasibility of extension of program regionally. • Develop and implement a program of infographics and communication tools that can be used in DHB's and communities to support trauma prevention in target groups and creation of action plans • Capture individual patient and family/whanau stories to reveal the reality of the impact of trauma. To be used in various communication and education program • Optimise website to address the needs of clinicians and members of the public www.midlandtrauma.nz				Q4 2017/2018 Q2 2017/2018 Q1 2017/2018 Q1 2017/2018 Q3 2017/2018 Q3-4 2017/2018 Q3-4 2017/2018 Q2 2017/2018	MTS
NZ Health Strategy: **5 Strategic Themes**	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
Initiative 4: Establish a Trauma Quality Improvement Program to enable evidence- based change				**Milestone/Date**	**Responsibility**
• Develop detailed TQIP structural plan with definable actions and outcomes • Identify external data sources that may extend the influence of TQIP to pre-hospital and post-hospital realms e.g. Met Service, LTSA, St John • Complete construction of the "TQual" relational data platform to provide high quality information for TQIP and local reporting capability • Review and define service and process indicators and implement regular regional reporting regime • Develop detailed TQIP structural plan with definable actions and outcomes • Identify external data sources that may extend the influence of TQIP to pre-hospital and post-hospital realms e.g. Met Service, LTSA, St John • Complete construction of the "TQual" relational data platform to provide high quality information for TQIP and local reporting capability • Review and define service and process indicators and implement regular regional reporting regime • Review information pathways for trauma services in each DHB with emphasis on reporting, escalation, feedback and loop closure processes • Develop regional clinical case discussion program with defined templates and reporting mechanisms • Develop professional development pathways that expose MTS staff to new opportunities and to enable MTS personal to lead new trauma programs regionally and nationally e.g. verification, AIS instructing, Trauma Team Training (TTT), research				Q2 2017/18 Q2 2017/201 and ongoing Q1 2017/2018 Q2 2017/2018 Q2 2017/18 Q2 2017/201 and ongoing Q1 2017/2018 Q2 2017/2018 Q2 2017/2018 Q2 2017/2018 Q2 2017/2018	

• Provide funding avenues to support staff to in trauma training and professional development. • Promote MTS staff involvement in research centre production • Continue to develop program for National Major Trauma Registry hosting and introduction of Qlik Sense tool for data visualisation in New Zealand DHBs.				Q1 and ongoing Q1 and ongoing Q1 and ongoing	
NZ Health Strategy: 5 Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system
1: Health equity for Māori	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Appendix 1: Work programmes of: objective 1 – health equity for Māori; objective 2 - integrate across continuums of care; objective 3 - improve quality; objective 4 - build the workforce; and objective 5 - improve clinical information systems

Objective 1: Health equity for Māori

Lead: Nga Toka Hauora (Midland DHBs GMs Māori Health)

Lead Chief Executive: Jim Green

Priority area	Outcome reported	Timeframe	Responsibility	Milestones reported against
Building the evidence base	**Establish and embed ethnicity data reporting by:** Carrying out detailed analysis of relevant data and information relevant to each clinical regional priority to establish whether, and where, inequalities exist and to: • establish baseline performance data • monitor and report on progress towards targets and inequality • inform health equity assessment of current or future services as appropriate.	Q2 2017-18	Regional groups supported by Nga Toka Hauora (Chair GM)	• 100% of regional priorities have baselines established that measure inequality between Māori and non- Māori[16] • 100% of regional priorities are reported quarterly by ethnicity[17]
Building a culture of equity	**Health equity assessment either scheduled or undertaken** • Health equity assessment using HEAT, or an appropriate tool, will be carried out on existing services to assess the effectiveness of current delivery models for meeting the needs of Māori or • Health equity assessment using HEAT, or an appropriate tool, will be carried out on proposed services to assess the likely impact of proposed delivery models on meeting the needs of Māori.	Q4 2017-18	Nga Toka Hauora (Chair GM), HealthShare	• all regional groups will have carried out a health equity assessment of their work plan initiatives and activities, or will have scheduled a health equity assessment
Health Literacy	**Improve health literacy by:** • assessing the need to review existing information resources within the department or service using *Rauemi Atawhai: A guide to developing health education resources in New Zealand*[18] with a view to improving information available to patients and whānau.	Q4 2017-18	Regional groups supported by Nga Toka Hauora (Chair GM)	• all regional services have carried out a health literacy review • scope the opportunities for development of a health literacy app, working together collaboratively

[16] In year one we will determine whether this can be achieved.

[17] In year one we will determine whether this can be achieved.

[18] Ministry of Health 2012. *Rauemi Atawhai: A guide to developing health education resources in New Zealand.* Wellington: Ministry of Health

Health Literacy	• undertaking a health literacy review with a view to improving information available to patients and whānau so that they can obtain, process and understand.			
Workforce	**Build Māori health workforce** • Each Midland DHB provides a workforce profile report that identifies the number and percentage of Māori employed by professional group within each of the DHBs. This workforce profile is utilised to track building Māori health workforce capacity development. • Establish a strategy to increase the Māori health and disability workforce, by DHB.	Q1 Q2-Q3 Q1-Q4 2017-18	RDOWD GMs HR supported by Nga Toka Hauora (Chair GM)	• a regional workforce profile will be established for all Midland DHBs that identifies the Māori and non-Māori workforces • strategy in place across Midland DHBs for Māori workforce increase in priority areas (refer workforce section of RSP) • quarterly reporting of regional workforce by DHB are routinely produced and distributed

(1-2) REGIONAL GOVERNANCE AND DECISION MAKING/ REGIONAL MĀORI HEALTH TOOLS

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against
Regional Governance & Decision Making	*Ensure Iwi Governance actively participates in planning and decision-making*	Q2- Q4 2017-18	Regional Governance and decision-making	• The Midland Iwi Relationship Board (MIRB) is actively engaged in the development of the Māori Health component to the Regional Services Plan (RSP). • The Midland Iwi Relationship Board (MIRB) receives quarterly updates on the implementation of the current plan. Work on the development and implementation for the Regional Service Plan will remain part of the MIRB's formal work agenda. • The MIRB will maintain an established meeting schedule with the regional All Boards of Governance Chairs forum regional lead whereby joint issues of concern on how to improve Māori Health can be discussed. • Nga Toka Hauora the Midland GMs Māori Health will provide secretarial support to the Midland Iwi Relationship Board.
Regional Tools	*Continue to develop and use regional tools to support Māori Health Gain* • Trendly report against Midland DHBs performance against Māori Health Plan national indicators completed every six months (Midland Māori Health Indicator Report) • Webinar Health Excellence Seminars will be completed in a minimum of two health priority areas • Review He Ritenga Cultural Audit tool for greater alignment to Māori health Indicators and apply audit in one regional service • Integrate He Ritenga into HealthShare audit schedule	Q2- Q4 2017-18	Nga Toka Hauora, HealthShare	• At a national level an online Trendly reporting tool has been developed and will be enhanced further to a gold standard, to more effectively allow Midland DHBs to compare performance and identify high performers who could provide insights to other DHBs on how to lift performance. • Webinar Health Excellence Seminars will be completed in a minimum of two health priority areas per annum which identify best performers against Māori Health priority areas in DHBs across the country, and endeavours to promote best practice. • He Ritenga cultural audit tool will be integrated into day to day auditing function of HealthShare. Six monthly reports provide overview of implementation of He Ritenga into HealthShare audits.

(3) REDUCING THE IMPACT AND INCIDENCE OF CANCER ON MĀORI

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against
Māori Health Gain- Cancer (Breast and Cervical)	*Reduce Māori Cancer rates, specifically in the area of Breast and Cervical cancer* • Establish Regional Work Plan around Breast and Cervical screening • Convene Health Excellence wānanga around best practice to improve Māori regional breast screening rates • Convene Health excellence Wānanga around best practice to improve Māori regional Cervical Screening rates • Deliver Kia Ora E te Iwi cancer health literacy initiative with Māori communities/ NGO's and the Cancer Society • Report finalised for BOP review of cancer enablers and barriers initiative 2016 • Report on Hei Pa Harakeke Māori Cancer Advisory Groups annual work plan, specifically complete	Q2- Q4 2017-18	Nga Toka Hauora, Midland Cancer Network, Hei Pa Harakeke	• The annual work plan for Hei Pa Harakeke the Midland Māori Cancer Advisory Group has been integrated into the Midland Cancer Network's work plan.
Māori Health Gain- Cancer (Lung, early detection, Prostate (survival)	*Reduce Māori Cancer rates, specifically in the area of Lung, Prostate, Liver, Bowel* • Priorities and focus areas are Lung (early detection), Prostrate (Survival, Breast/Cervical (increase screening), Liver (prevention of hepatitis), Bowel (preparation for screening programme, increase survival and improve access to chemotherapy). • Review Cancer pathway (early detection/prevention, investigation/diagnostics, treatment, palliative care, follow up), • Supportive Care (E Te Iwi Programme), • Workforce (increase Māori Workforce in oncology), focus on prevention (healthy eating/healthy lifestyle) and partnerships encourage networking of a Midland primary care incentive programme aimed at all pregnant female smokers and Māori/Pacific female smokers giving up smoking over a four week period. • Outcome – a Hei Pa Harakeke cancer information booklet has been completed and distributed to all Midland Cancer Society branches and twenty Midland Māori Health Providers • Māori bowel screening pilot implemented and evaluation report completed showing improvement in Māori screening rates • A Māori Cancer WOF has been developed and promoted to five Midland Māori Health providers for use. • Four Midland KOETI Māori community training Wananga held and evaluation evidences an understanding of cancer signs, symptoms and what services are available to assist Whanau. • Midland training Wananga for Midland Māori health providers Kaiatawhai/Kaiawhina held and evaluation showed over twenty Midland Māori Health Provider Kaiatawhai/Kaiawhina have acquired greater knowledge of Cancer prevention, treatment, management and tools available to assist Whanau.	Q2- Q4 2017-18	Nga Toka Hauora, Midland Cancer Network, Hei Pa Harakeke	• To assist implementation of a Bowel Screening pilot for Māori to commence with recommendation age be lowered to 50 years of age to enable equity gap improvement. • To encourage networking of a Midland primary care incentive programme aimed at all pregnant female smokers and Māori /Pacific female smokers giving up smoking over a four week period. • To support a Māori Health NGO to develop an indigenous intervention programme for prostate cancer. • To encourage and assist the NZ Cancer Society to develop a Māori Cancer Warrant of Fitness for CVD, Breast, Diabetes Cervical and Adenoma (polyp) screening. • To develop a Hei Pa Harakeke cancer information booklet for Midland Māori. • To network with the NZ Cancer Society to deliver "E Te Iwi" Cancer training Wananga in five Midland Māori Communities. • To facilitate a Midland Cancer training Wananga for Kaiatawhai/Kaiawhina of Midland Māori Health Providers to increase their understanding of cancer prevention, cancer management and the cancer treatment pathway consequently upskilling them to help address Whanau equity of access issues.

REGIONAL NETWORK ACTIVITY THAT WILL IMPACT ON NATIONAL MĀORI HEALTH INDICATORS

Regional Network and Clinical Action Group	Activity that links directly to lifting performance against National Māori Health Indicators
Cancer	A wide range of activity occurs within this workstream that supports reducing the impact and incidence of cancer. The top priority for the coming period includes implementing Faster Cancer Treatment for people with suspected cancer. Activity within this workstream that aligns to the work of Hei Pa Harakeke the Midland Māori Cancer Advisory Group, seeks to lift performance around Māori cervical screening rates, Māori breast screening rates and Māori quit smoking support rates all of which are Māori health indicator priority areas within DHB Māori Health Plans. Midland aims to hold one Kia Ora e Te Iwi community based health literacy programme per BOP, Lakes, Waikato and Hauora Tairāwhiti DHBs.
Child Health	The Child Health Action Group has a comprehensive range of activities that will directly impact on Māori child health priority areas. In particular work in regards to oral health, obesity, immunisation and the implementation of the Harti Hauora, a tool which covers a range of health priority areas for tamariki including GP enrolment, rheumatic fever, quit smoking support, oral health, SUDI and ASH will seek to lift performance against Māori health indicator priority areas. HARTI Hauora was developed by Waikato DHB Māori Health in 2015 in conjunction with Waikato DHB Child Health services.
Mental Health & Addictions	Mental Health and Addictions is undertaking a number of initiatives that will improve the way in which regional Mental Health & Addictions Services are delivered to the general population including Māori. A specific link to a national Māori health priority indictor relates to work around monitoring section 29 community treatment orders, this indicator is a Māori Health Plan indicator for all DHBs.
Workforce Development	The Workforce Development Network and the Midland GMs HR have agreed to support the implementation of Kia ora Hauora, Nga Toka Hauora the Midland GMs Māori workforce development programme.
Other Regional Networks and Clinical Action Groups	Regional Clinical Networks and Clinical Action Groups such as Cardiac, Electives, Health of Older People, Radiology, Stroke and Trauma (MTS) all will undertake activities that seek to improve Māori health inequity. As required, Nga Toka Hauora the Midland DHB GMs Māori Health can be approached for advice and guidance on how to effectively meet the needs of Māori.

Objective 2: Integrate across continuums of care

Regional hepatitis C service

Clinical Chair: Dr Frank Weilert, Waikato DHB

Project Manager: TBA (Waikato DHB)

Measures

The Midland region will report in Q2 and Q4 on the service delivery process and outcome measures, broken down by ethnicity and age bands (by decade) as outlined below on the following measures.

Measures	Data Collection Process	Milestone/Date
1. Number of people diagnosed with hepatitis C per annum by genotype.	DHB regions to obtain data (by age bands) from 5 reference labs on the total number of people with a positive HCV PCR test and report to the Ministry of Health via six monthly RSP reports.	Q2 and Q4
2. Number of HCV patients who have had a Liver Elastography Scan in the last year: (a) new patients (b) follow up	DHB regions to establish a data collection process to obtain regular data (by age and ethnicity) from the delivery of Liver Elastography Scans in primary and secondary care and report to the Ministry of Health via six monthly RSP reports. Note all Liver Elastography Scans are to be counted irrespective of the device used.	Q2 and Q4
3. Number of people receiving PHARMAC funded antiviral treatment per annum by medication type	Ministry of Health to obtain data (by age, ethnicity and medication type) from PHARMAC and provide this to the Midland region via annual reporting in the Regional Services Plan.	Q2 and Q4
4. Incidence of HCV related HCC	Ministry of Health to obtain data (by age and ethnicity) from the Liver Transplant Unit HCC national data collection and provide this to the Midland region via annual reporting in the Regional Services Plan.	Q2 and Q4
5. Number of liver transplants for people with hepatitis C performed each year		Q2 and Q4
6. Percentage of patients with HCV caused HCC who have new HCV diagnosis at time of HCC cancer diagnosis		Q2 and Q4

Line of Sight

- DHB Annual Plans: Waikato DHB - section 2.2 Delivering on Priorities and Targets; Lakes DHB – section 2B; Bay of Plenty DHB – section 2, Taranaki DHB – section 2.

Initiatives: to support the implementation of integrated hepatitis C assessment and treatment in services in Midland	**Milestone/Date**	**Responsibility**
1. Continue to raise community and GP awareness, and education of the hepatitis C virus (HCV) and the risk factors for infection.	Q1-Q4	Waikato DHB as contract holder
2. Providing targeted testing of individuals at risk for HCV exposure.	Q1-Q4	
3. Continue to raise patient and GP awareness of long term consequences of HCV and the benefits of treatment, including lifestyle management and antiviral therapy.	Q1-Q4	
4. Providing community based access to HCV testing and care that will include Liver Elastography Scans[19] services to the Midland region as a means for assessment of disease severity and as a triage tool for referral to secondary care and prioritisation for antiviral therapy.	Q1-Q4	
5. Establishing systems to report on the delivery of Liver Elastography Scans in primary and secondary care settings.	Q1-Q4	
6. Providing community based ongoing education and support (including referral to needle exchange services, community alcohol and drug services, GP primary care services or social service agencies).	Q1-Q4	
7. Providing long term monitoring(life-long in people with cirrhosis and until cured in people without cirrhosis)	Q1-Q4	
8. Providing good information sharing with relevant health professionals.	Q1-Q4	
9. Working collaboratively with primary and secondary care to improve access to treatment.	Q1-Q4	

[19] Liver Elastography Scans include mobile and fixed Fibroscan machines and Shear Wave machines being used in radiology departments.

Objective 3: Improve quality across all regional services

Lead: Midland DHB Quality Managers

Lead Chief Executive: Rosemary Clements

Objective	Actions to deliver improved performance	Measure	Reporting
Governance	• A proposed structure for a wider membership for the regional quality network to be agreed by the Midland CEOs including refreshed terms of reference and reporting to support the draft strategy • Regional groups exist for deteriorating patients, infection control and falls that report to the current Q&R group	• Expanded quality network agreed and in place by end of September • Sub groups reporting templates and frequency of reports to be agreed by end of October	Q1 Q2
To reduce the number of falls	• Complete an update on falls reduction activity across the Midland DHBs	• Falls: 90 percent of older patients are given a falls risk assessment	Q2 and Q4
		• Falls: 98 percent of older patients assessed as at risk of falling receive an individualised care plan addressing the risks identified	
To improve hand hygiene	• Increase publicity and awareness campaign across all DHBs	• Hand hygiene: 80 percent compliance with good hand hygiene practice	Q1-Q4
Safe surgery	• Ensure that data is being collected prior to the 'go live' of the new QSM in July	• Safe surgery: QSM continues to improve and exceeds target set by HQSC	Q2-Q4
Surgical site infection	• Present quarterly SSI report to Midland quality meetings • Action to be taken where results are below target	• SSI: 95 percent of hip and knee replacement patients receive cefazolin ≥ 2g or cefuroxime ≥ 1.5g as surgical prophylaxis • SSI: 100 percent of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision	Q1-Q4
	• Develop business case for ICNet as a regional approach in liaison with HQSC and ACC	• ICNet business case approved and implemented by year end	Q4
Medication safety	• Continue discussions on feasibility of achievement of medicines reconciliation by proposed HQSC date of 2016/17	• Medication Safety: implementation of the electronic medicine reconciliation platform	Q2 and Q4
To promote consumer	• Develop / refine the consumer engagement framework for the region	• Performance updates published by HQSC and included in DHB local quality accounts	Q2 and Q4

engagement		• Quarterly Reporting on patient experience as set out in performance measure DV3 'Improving patient experience'	
Patient Safety	• Support and implement the deteriorating patient work stream in line with the objectives and timescales of the national program • Regional working group to be in place by end of June 2017 • An agreed regional plan to be in place by end of December 2-17 • Shared learning from pilot in Tairāwhiti for EWS to be discussed and regional adoption planned	• As per HQSC measures once agreed	Q2 and Q4
Advance Care Planning	Placeholder – to be determined in conjunction with the Health of Older People Action Group		

Objective 4: Build the workforce

Lead: Regional Director of Workforce Development function

Lead Chief Executive: Helen Mason

Key area of focus	Actions to deliver	Measure 17/18 (until Dec 2017)	Milestone (Q1-Q2)	Responsibility
Enhance capacity	• Review current workforce data available and access • Identify gaps (clinical networks, DHBs, DHB Shared Services, Ministry of Health) • Develop sustainable plan to access data required plus enhance modelling capability • Utilise work of national occupational task forces to inform regional workforce development planning	• Review completed • Gap analysis completed • Plan developed	Q1 Q1 Q1-Q2	RDOW / GMs HR
	• Build a regional analyst network to share knowledge and skills and increase utilisation and access to workforce information • Produce regular workforce intelligence reports for DHBs and sector groups with analysis of workforce trends including workforces with lower numbers	• Network established	Q1 Q1-Q2	HSL analyst team / GMs HR / DHB HR analyst team RDOW
	• Identify potential for a sector interest group to increase understanding of workforce needs across the sector, current workforce development, and to share information, ideas, and so that a broader perspective of the needs of those utilising health care workers can be taken during planning. • Develop communication approach including regular information sources, mechanism	• Identify potential stakeholders • Identify how to market concept • Complete communications plan • Identify resource requirements for implementation	Q1 Q1 Q2 Q2	RDOW / GMs HR / GM P&F RDOW / GMs HR RDOW RDOW
	• Review the medical pipeline in the Midland region, identify issues and propose process to correct if required.	• Review Ministry of Health pipeline, establish regional implications	Q1-Q2	RDOW
	• Support DHB led initiative to share low fidelity simulation scenarios and establish competency assessment simulation packages	• Identify support requirements and implement	Q1-Q2	BOP DHB / RDOW
	• Support older or retired employees to continue to use their workplace skills (if necessary)	• Support medical taskforce ageing workforce initiative • Identify outcomes that could be applied within DHBs	Q1-Q2 Q1-Q2	RDOW / GMs HR
	• Explore areas of need to improve utilisation, capability, or capacity of the nursing and midwifery workforces. Identify opportunities to work regionally. Identify if the pipeline needs to be improved.	• Identify stakeholder group and engage • Identify measures and access workforce data • Determine planning methodology and engage with stakeholders • Scope drafted for approval"	Q1-Q2	RDOW DON/M

Key area of focus	Actions to deliver	Measure 17/18 (until Dec 2017)	Milestone (Q1-Q2)	Responsibility
	Mental Health & Addictions (Midland Mental Health & Addictions Network) – workforce capacity and capability: • Work regionally to implement the actions sett in the Mental Health and Addictions Workforce Action Plan 2017-2021	• Review alignment with Midland Region Workforce Strategic Plan 2013-2016 and update Midland plan • Priorities agreed • Scoping documents for top priorities drafted and approved	Q2 Q2 Q3-Q4	Workforce planning lead Workforce planning lead /Midland MH&A Network
Enhancing diversity	• Identify opportunities for DHBs to enhance numbers of Māori health workforce via policy, systems or processes (see Māori Health equity template) • Identify opportunities to support Kia Ora Hauroa graduates to transition to work	• Analysis of legislation and policy; identify potential to amend systems and processes • Develop a strategy across Midland DHBs for Māori workforce increase in priority areas	Q1-Q2 Q2-Q3	RDOW / GMs Māori / GMs HR RDOW / GMs Māori / GMs HR
	• Identify opportunities to enhance access to cultural competence training	• Complete stocktake and provide DHBs with results	Q2	RDOW
Enhancing succession planning	• Support DHBs to implement the State Service Commission leadership and talent management framework, and the NGO and Volunteer sector (if required)	• Identify where shared service can add value.	Q1-Q2	RDOW/GMs HR
Building workforce flexibility	• Collaborate with the Industry Training Organisation, and community health care providers to increase the numbers of workforce with L3 qualifications • Identify opportunities to increase numbers of the assistant workforce with the L3 qualification	• Scoping document completed.	Q2 Q2	RDOW DAH / RDOW

Objective 5: Improve Clinical Information Systems

Lead Chief Executive: Rosemary Clements

Regional Priorities

The published[20] Ministry of Health regional priorities for 2017/18 have a focus on reducing service vulnerability, reducing costs and improving the quality of care to patients, and are as follows:

Digital Health 2020					
Investment focus	Approach	Description of Activity	DHBs involved	Measures	Milestones
Single Electronic Health Record	Align with national programme led by Ministry of Health	Single National eHR – involvement in Sector Advisory Committee	Taranaki	• Business case approved	• National business case preparation and approval
		Primary Care Dataset – complete delivery of integrated primary / secondary data to authorised DHB & primary/community users to increase clinical visibility of patient data	BoP / Lakes / Tairāwhiti / Taranaki	• Successful bi lateral clinical access to primary/secondary CIS	• Business case approval
Digital Hospital	Identify gaps using EMRAM assessment and work towards closing these gaps by the timelines set by the Ministry of Health, using regionally aligned solutions where possible	Lakes MedCheck – BoP DHB to work with Lakes DHB to bring Lakes community pharmacy data into shared sub-regional Éclair CDR.	BoP / Lakes	• Capability across the Midland Region has increased against assessment criteria	• Information Live
		eLabs Orders – Continue local orders project based on regional results application. Initiative to utilise and align to regional	BoP / Lakes	• Successful clinical access to primary maternity information and results management	• Business case approval • Information live
		Local Integration of Independent Midwives information system	Tairāwhiti / Waikato	• Successful clinical access to primary maternity information and results management	• LMC web portal access to patient data & results management Live
		Upgrade of Sub Regional PACS/RIS and implementation of view anywhere solution	Waikato/BoP/ Tairāwhiti Taranaki/Lakes	• Solution is current & enhanced functionality delivered	• Business case approval • System Live

[20] 2017/18 Planning Priorities for Annual Plans and Regional Service Plans (December 2016)

Digital Health 2020					
Investment focus	Approach	Description of Activity	DHBs involved	Measures	Milestones
		Lifecycle refresh of PACs and RIS and review of regional solutions as an option		• 3rd party partner care provider access to radiology images enabled for patients in shared care. • Solution implemented/upgraded	
Health and Wellness Dataset	In line with Ministry of Health led initiatives establish information governance based on the draft health information governance framework	Define and agree governance structure. Align information standards across the Midland Region for key datasets	All	• Information Governance is established across the Midland Region • Key datasets can be accessed across the Midland Region enabling better information analysis	• Quarterly reporting
Preventative Health IT Capability	Await further details from Ministry of Health before rolling out	Prepare for 2018 Bowel screening rollout	Waikato and Midland BSRC	• Rollout as per Ministry of Health Plan	• Quarterly reporting
Regional IT Foundations	Phased implementation of regional clinical portal functionality to replace legacy systems	Midland Clinical Portal (eSPACE Programme) • Midland Clinical Portal Foundation Project (MCPFP)	All	• MCPFP live • Clinician acceptance	• Q2
		• Phased implementation of regional clinical portal functionality to replace legacy systems		• PID approved	• Quarterly reporting
		Midland Éclair Project (Regional Results) • Transitioning BOP Éclair environment onto Midland Regional Platform • Lab results (community and/or hospital) added to create regional repository • Radiology reports for Lakes to added to repository • Adoption of common results acknowledgement Electronic ordering	BoP All Lakes BoP / Lakes / Taranaki / Waikato	• Visibility of all regional Laboratory results within the regional repository from CWS within patient context. • Clinician acceptance	• Quarterly reporting
	Medications Management	eMeds – including electronic prescribing & reconciliation • ePrescribing - Transition and upgrade MedChart onto Midland Regional Platform • To be scoped for ePrescribe, eDispense, eRconciliation and eManagement.	Taranaki All	• Business Case approved	• Quarterly reporting • Scope defined • Quarterly reporting

Digital Health 2020					
Investment focus	Approach	Description of Activity	DHBs involved	Measures	Milestones
	TeleHealth	Lakes Tele-Health foundation project	Lakes	• Telehealth services can be utilised in clinical practice	• System Live Aug 2017
		Actively progressing the rollout of Telehealth solution, inclusive of fixed Telehealth VC units & soft clients (Jabber). Participation in the Stroke Thrombolysis telehealth trial.	Waikato	• Migration from Lync to Jabber aligned with regional direction	• Lync to Jabber Migration - 2017
	IaaS	Transition to AoG IaaS solution	Waikato	• IaaS Live	• Quarterly reporting

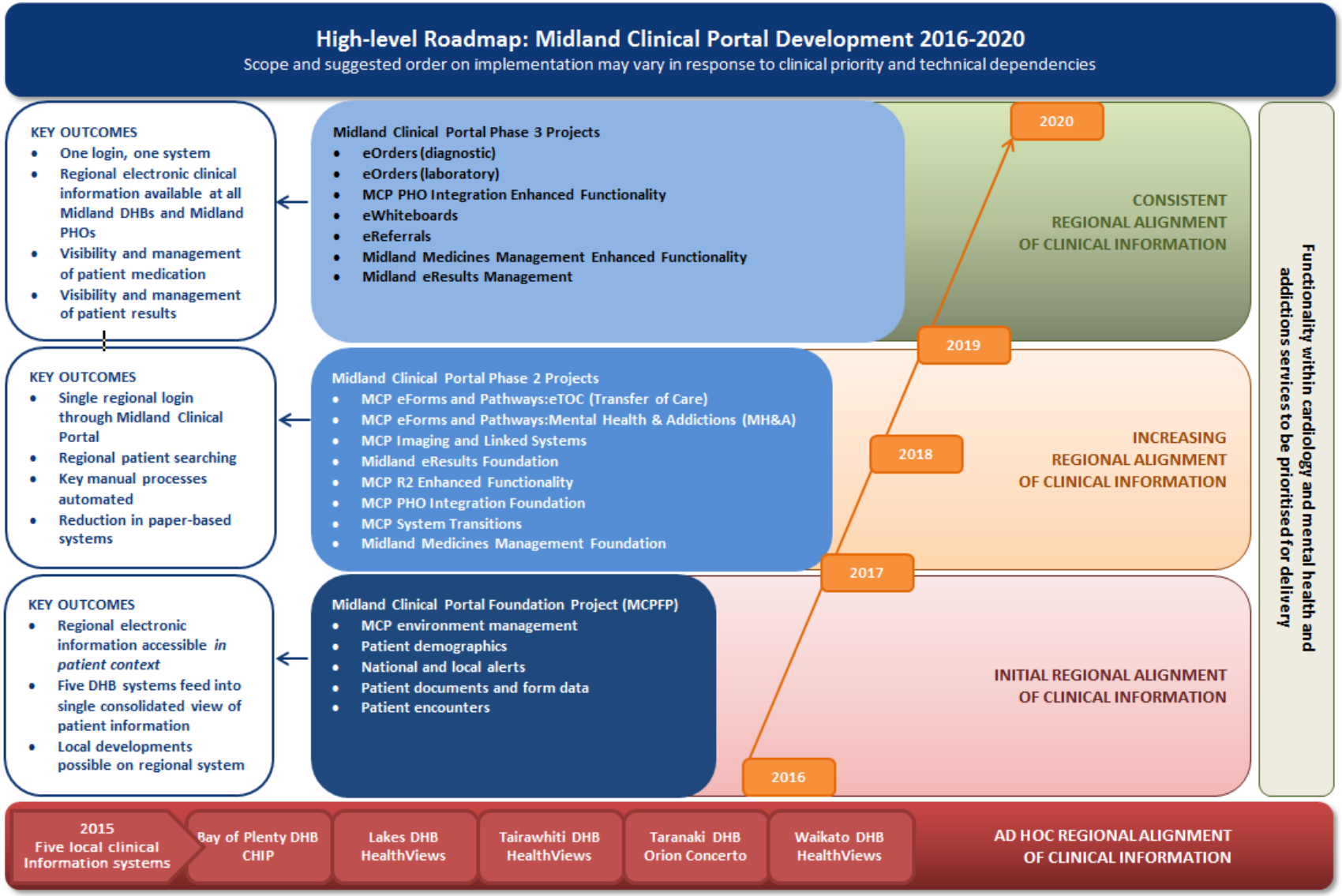
Other eHealth Business Priorities					
Investment focus	Approach	Description of Activity	DHBs involved	Measures	Milestones
Maternity	National Maternity Information System to commence once second adopter options released by national programme	Implementation to commence following review and approval of business case. Plan for implementation (subject to other priority projects).	BoP / Lakes / Taranaki / Waikato	• Business case approved • Quarterly reporting • System Live	• Business case approval • Project commencement
Nationally consistent Electronic Oral Health Record (EOHR)	National Oral Health Record	Participation in MoH led programme	BoP / Lakes / Taranaki /	• Business case approved • Quarterly reporting	• National business case preparation and approval
		Implement Titanium across Hospital Dental Service (implemented for community oral health). CIO representation on EOHR Programme	Waikato	• Titanium utilised by hospital dental service	• Quarterly reporting NA
Cancer Information Strategy	Support national initiatives	Work with Midland Cancer Network to develop required business case(s)	Waikato	• Business case developed	• Business case approved

Other eHealth Business Priorities					
Investment focus	Approach	Description of Activity	DHBs involved	Measures	Milestones
National Immunisation Register (NIR) replacement	Support national initiatives	Involvement in national initiatives and working groups where required	BoP / Lakes / Taranaki / Waikato	• Business case developed	• Business case approved

eSPACE roadmap

The eSPACE roadmap is subject to change and eSPACE governance approval.

Figure 10: Midland eSPACE roadmap



Midland DHBs four year forecast IS investments (17/18 – 20/21)

Please note that these are forecast investments only and will not be approved until the relevant formal approval processes have been undertaken. Additionally, due to the current financial situation of the Midland DHBs it is expected that ongoing change to this forecast will be required.

Table 4: Midland DHBs four year forecast IS investments (17/18 – 20/21)

Local - New and Lifecycle Mgt									
	2017/18	2018/19	2019/20	2020/21			2017/18	2018/19	2019/20	2020/21
	'000						'000			
Lakes	**7,052**	**785**	**930**	**3,520**		**Waikato**	**16,288**	**13,030**	**9,530**	**8,580**
Lifecycle - Corporate	1,303	250	645	650		Lifecycle - Clinical	3,420	2,350	1,500	1,300
Lifecycle - Clinical	1,829	240	155	2,595		Lifecycle - Corporate	6,818	5,430	5,780	5,030
New - Corporate	308	140	80	150		Regulatory - Clinical	2,100	350	700	700
New - Clinical	3,612	155	50	125		Regulatory - Corporate	4,500	3,000		
						Strategic - Clinical	3,580	400	400	400
Taranaki	**0**	**0**	**0**	**0**		Strategic - Corporate	2,920	500	150	150
Lifecycle - Corporate	970	1,000				Sustainability - Clinical	4,970	400	400	400
Lifecycle - Clinical	2,500	800	800	800		Sustainability - Corporate	380			
New - Corporate	300	1,800				TrueUp/Contractrual - Licencing	600	600	600	600
New - Clinical		1,500				Savings target	-13,000			
Bay of Plenty	**3,600**	**4,810**	**4,350**	**4,350**		**Tairawhiti**				
Baseline	1,500	2,710	2,250	2,250		No estimates can be provided until funding information and agreed capex is known				
Strategic	2,100	2,100	2,100	2,100						

Regional & National Aligned									
	2017/18	2018/19	2019/20	2020/21		2017/18	2018/19	2019/20	2020/21
	'000					'000			
Lakes	**599**	**2,805**	**2,100**	**890**	**Waikato**	**3,554**	**8,051**	**9,184**	**3,863**
eSPACE	599	1,857	2,100	890	eSPACE	2,558	7,931	8,970	3,803
National Oracle Solution		948			Regulatory	120			
Lifecycle	75	75	25	25	Lifecycle	326	120	214	60
					Clinical	350			
Bay of Plenty	**1,335**	**4,140**	**4,682**	**1,985**	National - Clinical	200			
eSPACE	1,335	4,140	4,682	1,985					
					Taranaki	**660**	**2,048**	**2,316**	**982**
Tairawhiti	**302**	**935**	**1,058**	**448**	eSPACE	660	2,048	2,316	982
eSPACE	302	935	1,058	448					

Objective 6: Efficiently allocate public health system resources

HealthShare Limited – Third Party Provider Audit & Assurance Service

Lead: Ajit Arulambalam

Third party provider audit and assurance service	Milestone/Date	Responsibility
The third party provider audit and assurance service covers the five Midland DHBs and supports the performance evaluation of contracted Non Government Organisations.		
• Support Midland DHBs Planning & Funding by completing agreed audit work plan	% of work plan completed at Q2 & Q4	HSL Audit & Assurance
• Provide audit related risk assurance to funding DHBs P&F as requested	% of requests completed Q2 & Q4	HSL Audit & Assurance

HealthShare Limited – Regional Internal Audit Service

Lead: Ian Cowley, Regional Internal Audit Manager

Activities against DHB internal audit plans	Milestone/Date	Responsibility
Progress against the approved Internal Audit Plans for the client DHBs, expressed as a percentage of each internal audit plan achieved to date for the income year, is as follows: • Lakes DHB • Hauora Tairāwhiti • Taranaki DHB • Waikato DHB	Q1-Q4	Regional Internal Audit Manager, HSL

Appendix 2: Regional governance

(i) Regional collaboration framework

The Midland region is defined by the boundaries of five District Health Boards (DHBs) - Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato. The DHBs have a history of co-operating on issues of regional importance and on new programmes of change. The formalising of regional collaboration structures, and their respective accountabilities, provides the strategic framework for aligning work as a region (or part thereof).

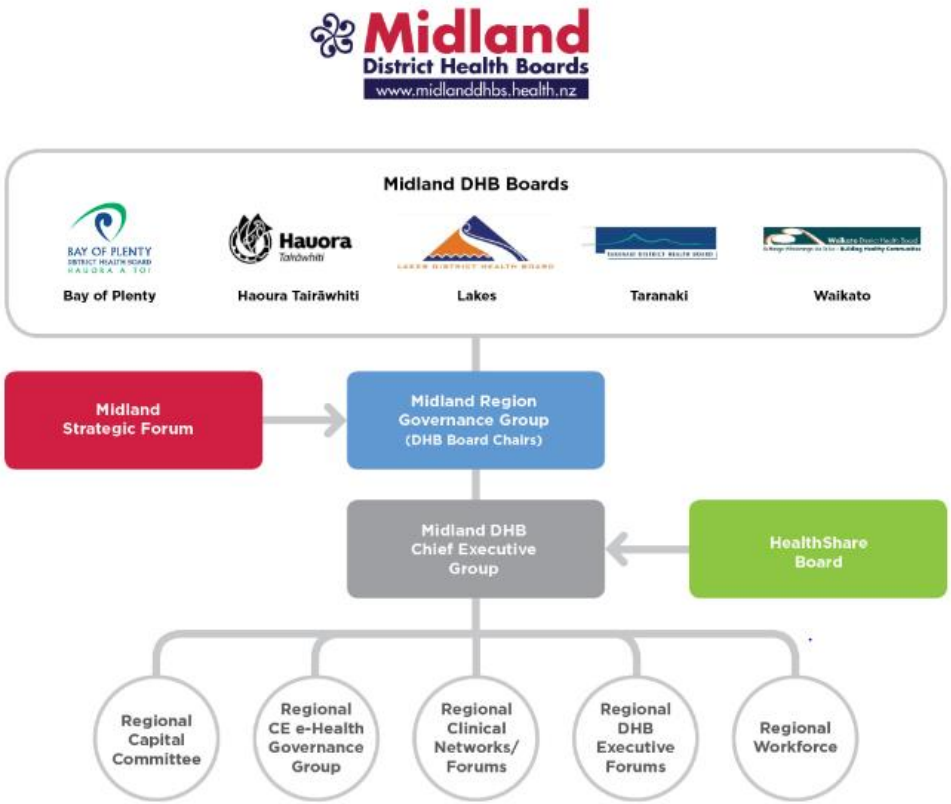
It is acknowledged that regional work is complex and occurs as part of DHBs responsibilities to meet the current health needs of their populations. However, as the Midland region continues to plan for service improvement within the current and mid-term environments, via the Midland Regional Services Plan (RSP), the region's governors have signaled their desire to take a longer-term, more integrated, approach to improving health and community wellbeing. They see the development of a more formal regional collaboration framework as supporting the improving health and community wellbeing of their populations.

Regional structure

While responsibility for the overall performance of regional activity collectively rests with the five Midland DHB Boards, operational and management matters concerning the RSP and its implementation have been delegated to the Midland Chief Executives Group.

The diagram below illustrates the overarching regional reporting and accountability arrangements for Midland DHBs. This includes those for HealthShare Ltd and for various regional projects and work streams.

Figure 10: Midland region's governance structure



- The Midland Regional Governance group (MRGG) is the key DHB governance group for the region, overseeing and taking accountability and responsibility for regional direction, strategy and key programmes of change. Each member is accountable to their DHB Board and is responsible for informing their DHB of matters of significance, including risk and mitigation strategies, for matters arising from the group's deliberations.
- The Midland DHB Chief Executive Group (MCEG) provides active leadership and operational decision making for regional initiatives and activities. The group is responsible for the resourcing, and the ongoing support and monitoring of progress, for agreed regional initiatives and activities. The Group manages any associated issues and risks for the Midland region and/or its DHBs.
- The Midland Strategic Forum (MSF) enables a broader dialogue on regional matters that are to be presented to all DHB Boards. Prior to being received by DHB Boards the MSF is a forum to socialise and further inform the proposal. Membership is based on the topic under discussion. As a minimum its membership includes DHB Board Chairs and a selection of Board members; Midland Iwi Relationship Board; DHB CEs and a selection of DHB Executives and staff; PHO Executives; and appropriate clinicians from across the health sector; consumers; HealthShare CE; and in-sector and out-of-sector experts.

HealthShare is the Midland DHBs shared services agency and is a limited liability company with the five Midland DHBs holding equal shares. An outline of HealthShare's services can be found on pages 23-27, which includes support for the regional clinical networks/action groups and regional enablers to complete annual work plans. Healthshare submits an annual budget, which includes costs related to the support for regional clinical networks/action groups and Midland's regional enablers. The formal budget approval process requires the agreement of the Midland DHB Chief Financial Officers, and the Midland DHB CEs. Midland DHBs also support the agreed work plans by releasing staff from their organisations, ie medical, nursing, allied health, public health, management, to attend regional meetings - either face-to-face, or by using teleconferencing and videoconferencing technology. In addition to this 'in kind' resourcing, where there are significant individual DHB contributions and/or lead DHB roles then these are identified in the specific work plans. Where substantial additional financial investment is required, a formal business case process is developed.

The Regional Capital Committee comprises the five DHB CEs and this committee is responsible for taking a regional overview for the capital investment by each Midland DHB, documented in the Long Term Capital Investment Plans (LTCIP) of each DHB. The DHB LTCIP is developed / updated during the annual DHB planning process. Strategic discussions on possible new regional capital investment are held at the MRGG and subject to individual DHB Board approval through the normal approval processes.

The Regional CE e-health governance group comprises the five Midland DHB CEs and this committee is responsible for taking a regional overview for the implementation of regional IT systems (including the associated regional standardisation of clinical processes and investment).

The regional clinical networks and forums, regional executive forums, and regional workforce are linked to the Midland CE Group through a Midland DHB CE lead (as sponsor) and through regular reporting to the Midland CE Group.

Decision making principles for MRGG, MCEG and MSF

The purpose of these principles is to facilitate greater levels of regional co-operation and integration across the Midland DHBs and regional health system. The principles apply to any significant and substantive decision of a Midland DHB that impacts another Midland DHB. The

principles apply to the Midland Region Governance Group; Midland DHB CE Group; and Midland Strategic Forum.

Any significant decision taken shall:

- Require the agreement of all Midland DHBs, but it is not necessary that all Midland DHBs will be involved in the implementation of the decision
- Be approved through appropriate approval processes in each DHB
- Provide that no DHB shall opt out of their commitments around decisions that they have agreed to

Definition: Midland collaboration can mean a number of DHBs working together virtually across Midland on a particular function, service or programme of work. Midland collaboration may also mean either clinical or non-clinical service provision between two or more DHBs.

Decision making criteria

The following criteria shall be applied to any decision:

- It makes the service more sustainable by improving any or all of -
    - Effectiveness (providing the right services at the right time)
    - Efficiency (providing services the right way, to spend the health dollar once)
    - Economy (input costs lower now or in the future)
- It reduces service risk, particularly around vulnerable services
- It improves health outcomes, including equity of access and equity of outcomes across the region
- It is aligned to national expectations
- There is an opportunity for local say on clinical services (ie. localisation)
- It builds clinical capability
- It reduces duplication in clinical and non-clinical services
- It aligns with regional services (clinical and non-clinical) plans
- It acknowledges that all other things being equal that the provision of clinical and non-clinical services be located as close to the patient (virtual or otherwise) as may be reasonable given the application of the criteria above. This supports patients and their family and whanau to have an optimal experience with the NZ public health system.

Decision making processes

The following principles provide guidance to the processes that support regional decision making:

- Decision making processes should support timely decision making. Decisions should be agreed, documented, visible and enacted
- Key initiatives will have a lead appointed who will be accountable for progressing the agreed milestones
- Common briefings to DHB Boards will be used wherever possible

In relation to decisions made, members of each regional collaboration group have a responsibility to:

- Communicate with colleagues locally and consult if necessary
- Ensure that decisions are communicated to and acted on within their own DHB.

Code of ethics

Good collaboration/governance requires members to exhibit behaviour of the highest ethical and professional standards. Members of regional collaboration groups and any committees or working parties formed as a result of regional initiatives and activities shall exhibit the following behaviours:

- **Good faith:** Act honestly and in good faith at all times in the best interest of the Midland region and it's communities
- **Care:** Exercise diligence and care in fulfilling the functions of membership
- **Regional knowledge:** Maintain sufficient knowledge of the Midland region's business and performance to make informed decisions
- **Participation:** Attend regional meetings and devote sufficient time to preparation for the meetings to allow for full and appropriate participation in the regional group's discussions and decision making
- **Decisions:** Abide by the regional group's decisions once reached, notwithstanding a member's right to pursue a review or reversal of a regional group decision
- **Relationships:** Foster an atmosphere conducive to good working relations
- **Behaviour:** Treat all others fairly and with dignity, courtesy and respect
- **Due diligence:** Not agree to Midland DHBs incurring obligations unless he or she believes that such an obligation can be met when required
- **Confidentiality:** Not disclose to any other person confidential information other than as agreed by the regional group or as required under law
- **Collective responsibility:** Not to make, comment, issue, authorise, offer or endorse any public criticism or statement having or designed to have an effect prejudicial to the best interests of the Midland DHBs
- **Conflicts of interest:** Declare all interests that could result in a conflict between personal and regional priorities and comply with the Conflicts of Interest Policy.

Formation of a regional group

The need for a formal regional group may arise from:

- A Ministry of Health initiative that requires a regional approach
- The development of a new regional strategy or work programme which requires a formal mechanism to ensure successful delivery
- A regional service or function that can be enhanced with support from a cross functional group
- An informal regional group that has identified that a more formal regional structure would support their work programme.

As appropriate the MRGG or the MCEG will endorse the formation of all new formal regional groups to ensure that the group's mandate is aligned to the Midland strategic direction and other change programmes that are underway.

Where appropriate, depending on the nature of the work programme, a new regional group may be required to develop a Terms of Reference (TOR) which includes the regionally agreed principles relating to Decision Making and the Code of Ethics, and the policies relating to a Conflict of Interest and Disclosure of Information. A new regional group's TOR may detail a regional group's membership and appropriate member representation detailed.

(ii) Regional IS governance

Integrated, multi-disciplinary, executive level governance and leadership is critical to support the delivery of the Midland Regional Information Services Plan (MRISP) and other regional IS initiatives.

Additionally, there is a need for strong clinical leadership and governance across the multiple activities in the clinical programme of work, however, given the work demands and time pressure that clinical leaders find themselves under, this leadership needs to be applied judicially to ensure maximum return on the time invested.

With this in mind, a delineation of the governance applied to MRISP work programmes has been used to ensure strong executive leadership is in place across all activities, and that the outcomes from the time available from the clinical leaders is maximised.

The regional IS governance arrangements are tailored in relation to the needs of the various programmes of work in the Midland region, and are aligned to the Midland coordinated services model. One such individual governance structure is eSPACE.

- **eSPACE governance arrangements**

  In October 2016 the Midland DHB CEs approved a review of the existing governance structure of the programme, designed to bring a stronger clinical focus to governance and provide each project within the programme with appropriately specialised governance support. The revised governance structure for the eSPACE Programme is summarised below.

  The **eSPACE CEO Governance Group (CEOGG)** monitors the performance of the Programme and is an escalation point for executive intervention where the Programme Board is unable to reach a decision or considers that risks require CEO action.

  The **Senior Responsible Owner (SRO)** is accountable for delivery of the programme as delegated by the Midland DHB CEs on the basis of approved business cases. It is the SRO's responsibility to ensure the delivery of all activities within the Programme and realise the projected benefits.

  The **Programme Board** reviews Programme progress and interim results on a frequent, scheduled cycle, taking responsibility for delivery and ensuring alignment with the overall strategic vision and delivery timeframes.

  The Programme Board is supported by a **Clinical Authority**, a **Design Authority** and an **Operational Advisory Group**. These authorities own and oversee the implementation of the Programme's business and service transformation activities and ensure alignment with national and regional strategies. Most Programme artefacts need to pass through at least one of these three authorities.

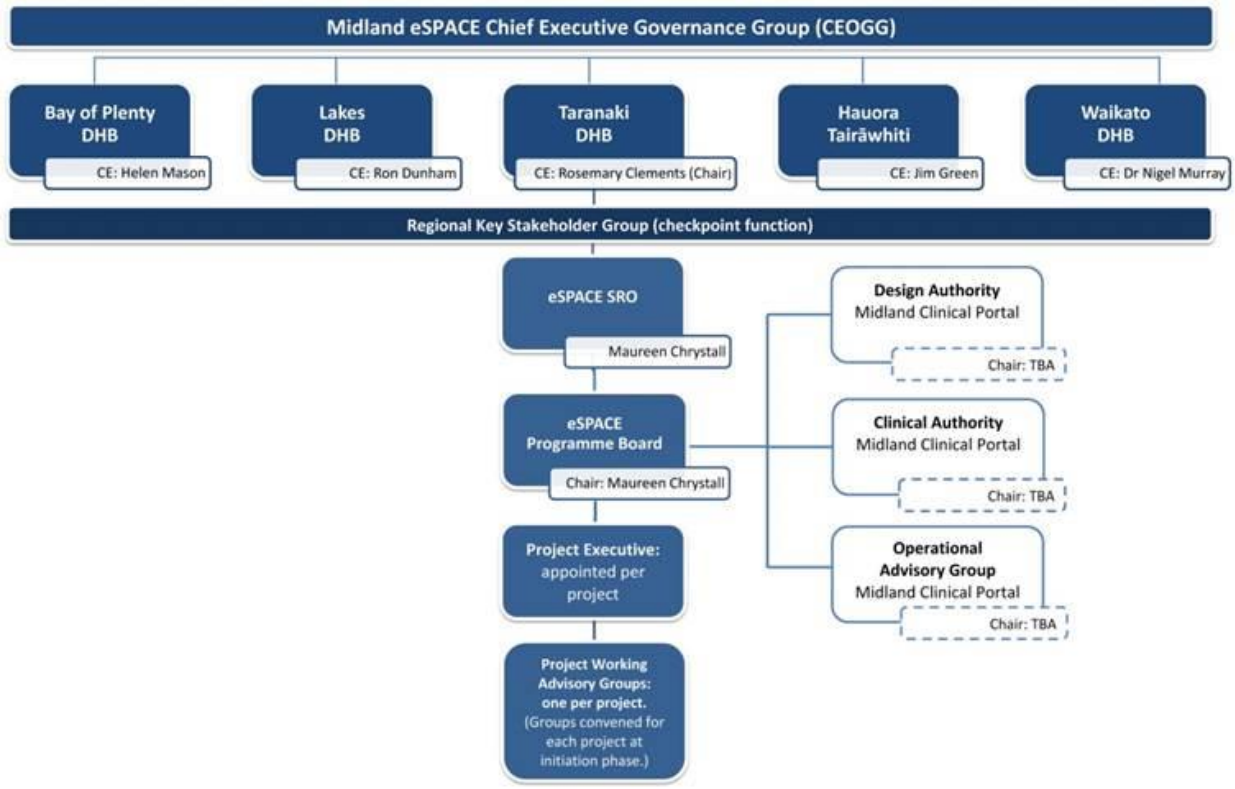
  Additionally, the Programme is supported by a **Regional Key Stakeholder Group** which holds a collaborative 'checkpoint' role only, with no formalised governance responsibilities. This group offers an opportunity for key senior stakeholders from within Midland DHBs to come together periodically with the Chief Executives to:

  - receive an update on CEs current thinking on eSPACE and any decisions made or Programme guidance they have provided

- have open-forum discussion on eSPACE progress
- raise any key concerns or issues in an environment where they can be worked through transparently.

Following each meeting attendees may be asked to provide further feedback on matters discussed. The **Programme management hierarchy** is led by the Programme SRO, supported by the Programme Director, the Programme Manager, the Technology Director, and the Programme Board.

Figure 11: Midland eSPACE CEO Governance Group (CEOGG)



(iii) Regional IS portfolio

Capital IS investment in the Midland region is informed by and informs the annual capital planning and budgeting processes at each DHB, and for the region. With a move towards IaaS and SaaS type solutions, and a range of capitalisation policies across the region, the portfolio is now updated to include potential non-capital investment which is still required to align to approved governance structures.

Requests for IS investment are evaluated based on business priority, affordability and achievability via agreed processes and governance structures.

Approved business cases are delivered through regional programmes and projects. Where possible, programme and project teams are formed in HealthShare through permanent appointments or DHB staff secondments. A programme approach is used to ensure a focus on benefits and business case delivery for the eSPACE components; while projects deliver the discrete service components that programmes require.

Appendix 3: System Level Measures (SLMs)

SLMs are high-level aspirational goals for the health system that align with the five strategic themes of the New Zealand Health Strategy and other national strategic priorities, such as Better Public Service Targets. The national SLMs have a focus on children, youth and vulnerable populations.

The SLM framework:

- is set nationally
- reflects integration of health services
- highlights equity gaps
- connects to contributory measures.

Contributory measures:

- contribute to achievement of SLMs
- are front line service level measurements of health processes or activity – tangible and clinically meaningful
- align with local quality improvement.

How Midland DHBs use SLMs

The SLMs are part of each Midland DHB's annual planning process and provides an opportunity for DHBs to work with their community, primary and secondary care providers to improve the health outcomes of their local population. The measures promote better understanding and use of health information, engagement with people in the design and delivery of health services, and better health investment in models of care based on local population needs.

The national SLMs include:

- Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds (ie keeping children out of hospital)acute hospital bed days per capita (ie using health resources effectively)
- patient experience of care (ie person-centred care)
- amenable mortality rates (ie prevention and early detection)
- proportion of babies who live in a smoke-free household at six weeks postnatal (ie a healthy start)
- youth SLM (ie youth are healthy, safe and supported).

(*view Midland DHBs' SLM Improvement Plans in each DHB's 2017-18 Annual Plan*)

Midland region's contribution to achieving the national SLMs

The initiatives and activities of the regional clinical networks/action groups and regional enablers support the achievement of the SLMs.

The table over page outlines the national SLMs and contributory measures, and each Midland DHB's chosen contributory measures to achieve the SLMs. The work plans of the regional clinical networks/action groups and regional enablers describe the initiatives and activities to be undertaken in 2017-18; supporting Midland DHBs' chosen contributory measures. The table provides a line of sight across the national, regional and local DHB region within the SLM national framework which measures the performance of the whole system.

Specific improvement activities, baseline and milestone measures (by ethnicity) are contained in individual Midland DHB Annual Plans.

Ambulatory Sensitive Hospitalisation (ASH) rates 100,000 for 0-4 year olds	Acute hospital bed days per capita	Patient experience of care	Amenable Mortality	Number of babies who live in a smoke-free household at 6 weeks postnatal	Youth access to and utilisation of youth appropriate health services
"Keeping children out of the hospital" ASH highlights the burden of disease in childhood with a strong emphasis on health equity. There is a high variance among priority populations and according to social gradient. Reducing ASH rates requires well integrated, preventative, diagnostic management systems and a well-skilled and resourced workforce.	"Using health resources effectively" A measure of acute demand on secondary care that is amenable to good upstream primary care, discharge planning and transition requiring good communication between primary and secondary care.	"Person centred care" How people experience health care is a key element of system performance that can be influenced by all parts of the system people who provide the care. Integration has not happened until people experience it.	"Prevention and early detection" Deaths under age 75 years ('premature' deaths) from causes classified as amenable to health care (currently a list of 35 causes)	"Healthy start" A reduction in prevalence of smoking in pregnancy is a priority. This measure will focus attention beyond just maternal smoking to the home and family/whanau environment and will encourage an integrated approach between maternity and primary care.	"Young people make good choices" Early detection and proactive management is vital to youth health, especially to youth mental health. Provision of youth appropriate services and access by youth is variable.
Contributory measures include:					
• LMC registration rate • Newborn enrolment rate • Referral rate from LMC to WCTO • Breastfeeding rates • Core WCTO visits achieved • Respiratory initiatives • Housing sensitive hospitalisations • Immunisations • Enrolment with oral health services	• Length of stay • Acute readmissions • Frequent representations • Polypharmacy • Flu vaccinations in the elderly • CVD risk assessment • Smoking rates • Admission rates – ASH • ED health target	• E portal uptake and use • DHB inpatient care • Uptake of primary care patient experience survey • Sentinel events in hospital and primary care • Access to diagnostics • Admissions for drug reactions • Quality and safety markers	• Cancer screening and treatment timeliness • Cardiovascular risk management • Other chronic disorder management (COPD, diabetes) • Injuries (unintentional, self-harm) prevention • Smoking rates	• Smokers at first registration with LMC • Mothers given cessation support • Smoking rates in women 15-40 years • Early registration with LMC • Early enrolment with PHO • WCTO checks rate • Mothers smoke-free at two weeks postnatal • Breastfeeding rates	• Waiting times for youth access to mental health and AOD services • Access to and utilisation of Youth One Stop Shop and school bass • Utilisation and access rates

• Caries free at 5 years				• B4SC checks rate • LMC referral to PHO • Newborn enrolment rate • Smoking rates	
Midland DHBs chosen contributory measures:					
Ambulatory Sensitive Hospitalisation (ASH) rates 100,000 for 0-4 year olds	Acute hospital bed days per capita	Patient experience of care	Amenable Mortality	Number of babies who live in a smoke-free household at 6 weeks postnatal	Youth access to and utilisation of youth appropriate health services
Bay of Plenty DHB: • Collective understanding of ASH activity for 0-4 year olds • Early enrolment for newborns • Vaccination of eligible children for Seasonal Influenza • Improving outcomes for children living in environments that may be adversely impacting their health	**Bay of Plenty DHB:** • Improved management of patients with significant (>10%) CVD risk factors • Reduced mortality through improved outcomes from smoking cessation support • Weight Management and Lifestyles Self-management Group • Improved Breast and Cervical Screening rates for all eligible women	**Bay of Plenty DHB:** • Improved management of patients with COPD within the community • General Practice responsiveness to acute bed day utilisation • Acute Demand Management Plans • Maintained and improved Cardio-Vascular Disease Risk Assessment of eligible population	**Bay of Plenty DHB:** • Access to Patient Portals • Improved management of DNA rates for Specialist Appointments • Effective transition to the National Enrolment Service (NES) • Specialist response to General Practice referrals	**Bay of Plenty DHB:** • *Awaiting MoH guidance on this measure*	**Bay of Plenty DHB:** • *Awaiting MoH guidance on this measure*
Lakes DHB: (TBC) • Hospital admissions for 0-4 year olds with primary diagnosis of a respiratory condition • Full enrolment with a PHO by 3 months of age • Immunisation 2 years	**Lakes DHB:** (TBC) • ED presentation rates • Reduction in low acuity ED presentation rates at Rotorua and Taupo Hospitals • The number of influenza vaccinations for people over the age of 65 years	**Lakes DHB:** (TBC) • An increase in the percentage of GP practices offering patient e-portal • An increase in the percentage of patients using patient e-portal	**Lakes DHB:** (TBC) • Percentage of enrolled people in the PHO within the eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64mmol/mol or less • Percentage of PHO enrolled people within the eligible population who have had a CVD risk recorded within the last 5 years and/or measure showing good management of CVD	**Lakes DHB:** (TBC) • Healthy Mums and Babies: 'By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups' • Percentage of women identified as smokers at first registration with a Lead Maternity Carer • Percentage of Māori women identifying post natal period (two weeks after birth)	**Lakes DHB:** (TBC) • Utilisation of primary health GP services by youth • Utilisation of youth one-stop shops Rotovegas (Rotorua) and Anamata (Café for Youth Health Taupo) • Pathways for transgender youth are developed and implemented

			risk • Percentage of PHO enrolled Māori and Asian women aged 25 to 69 years who have had a cervical sample taken in the past three years • Percentage of registered smokers who have been referred to a smoking cessation service		
Hauora Tairāwhiti: • Hospital admissions for 0-4 year olds with primary diagnosis of a respiratory condition • Full enrolment with a PHO by 3 months of age • Immunisation 2 years	**Hauora Tairāwhiti:** • ED presentation rates • The number of influenza vaccinations for people over the age of 65 years • People aged 65 years and older dispensed 8 or more unique long term medications	**Hauora Tairāwhiti:** • GP practices offering an e-portal • Proportion of total enrolled patients registered for e-portal • GP practices using the primary care patient experience survey to inform quality improvement	**Hauora Tairāwhiti:** • Percentage of enrolled people in the PHO within the eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64mmol/mol or less • Percentage of PHO enrolled people within the eligible population who have had a CVD risk recorded within the last 5 years and/or measure showing good management of CVD risk • Percentage of PHO enrolled women aged 25 to 69 years who have had a cervical sample taken in the past three years • Percentage of registered smokers who have been referred to a smoking cessation service	**Hauora Tairāwhiti:** • *Awaiting MoH guidance on this measure*	**Hauora Tairāwhiti:** • *Awaiting MoH guidance on this measure*
Taranaki DHB: • *Unavailable at time of submission*	**Taranaki DHB:** • *Unavailable at time of submission*	**Taranaki DHB:** • *Unavailable at time of submission*	**Taranaki DHB:** • *Unavailable at time of submission*	**Taranaki DHB:** • *Awaiting MoH guidance on this measure*	**Taranaki DHB:** • *Awaiting MoH guidance on this measure*
Waikato DHB: • *Unavailable at time of*	**Waikato DHB:** • *Unavailable at time of*	**Waikato DHB:** • *Unavailable at time of*	**Waikato DHB:** • *Unavailable at time of*	**Waikato DHB:** • *Awaiting MoH guidance*	**Waikato DHB:** • *Awaiting MoH guidance*

submission	*submission*	*submission*	*submission*	*on this measure*	*on this measure*
Regional line of sight – regional clinical networks/action groups and regional enablers					
Ambulatory Sensitive Hospitalisation (ASH) rates 100,000 for 0-4 year olds	Acute hospital bed days per capita	Patient experience of care	Amenable Mortality	Number of babies who live in a smoke-free household at 6 weeks postnatal	Youth access to and utilisation of youth appropriate health services
• Regional pathways of care (Map of Medicine) • Midland Child Health Action Group	• Regional pathways of care (Map of Medicine) • Midland Child Health Action Group • Midland Trauma System • Health of Older People • Midland Stroke Network	• Regional pathways of care (Map of Medicine) • Regional IS • Regional Quality • Midland Trauma System • Health of Older People	• Regional pathways of care (Map of Medicine) • Midland Cancer Network • Midland Clinical Cardiac Network • Midland Child Health Action Group • Health of Older People • Midland Stroke Network • Midland Trauma System	• Child Health Action Group	• Regional pathways of care (Map of Medicine) • Midland Mental Health & Addictions Network

Appendix 4: Glossary of terms

Activity	What an agency does to convert inputs to outputs.
Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships) to efficiently deliver the outputs required to achieve the Government's goals.
Contributory measures	Contribute towards the achievement of System Level Measures (SLMs) and are front line service level measurements of health processes or activity – tangible and clinically meaningful; and align with local quality improvement.
Efficiency	Reducing the cost of inputs relative to the value of outputs.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Management systems	The supporting systems and policies used by the DHB in conducting its business.
Objectives	Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve 'outputs'. For example, increasing the take-up of programmes; improving the retention of key staff; improving performance; improving governance etc. are internal to the organisation and enable the achievement of 'outputs'.
Outcomes	Outcomes are the impacts on or the consequences for the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome but in itself is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome (refer http://www.ssc.govt.nz/glossary/). A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).
Outputs	Final goods and services that are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).
Performance measures	Selected measures must align with the DHBs Regional Services Plan and Annual Plan. Four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2012/13) and show intended results for the two subsequent financial years. (Refer to www.ssc.govt.nz/performance-info-measures)
Results	Sometimes used as a synonym for 'outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once. (http://www.ssc.govt.nz/glossary/)
System Level Measures (SLMs)	SLMs are high-level aspirational goals for the health system that align with the five strategic themes of the New Zealand Health Strategy and other national strategic priorities such as Better Public Service Targets. The SLMs have a focus on children, youth and vulnerable populations

Targets	Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.
Values	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which in turn tend to be drawn from social norms, democratic principles and professional ethos. (http://www.ssc.govt.nz/glossary/)
Value for money	The assessment of benefits relative to cost in determining whether specific current or future investments/expenditures are the best use of available resources.

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 6.2

WAIKATO DHB ANNUAL PLAN 2017/18 SUBMISSION

Purpose	To seek delegation to submit the annual plan to Ministry of Health for final review on the 14 July.

The process of developing the annual plan for 2017/18 has progressed well with initial feedback from the Ministry of Health being positive and the majority of areas requiring amendment being relatively minor changes rather than significant changes in approach. As previously noted the required template for the plan has been streamlined from previous years with the document having an increased focus on activities and measures.

As can be seen in the summary attached there are still a number of areas awaiting finalisation and in some instances awaiting final advice from the Ministry of Health. Whilst our alliance partners have been involved in the development of the system level measures plan, the document is currently with them for confirmation prior to this section being finalised.

At this stage it is expected the narrative sections of the annual plan will be able to be completed and submitted by the due date of 14 July 2017. This is subject to the feedback from the Ministry of Health being received within the next two weeks and no material matters presenting.

As there is no Board meeting prior to 14 July 2017, approval is sought to finalise and submit the plan to the Ministry of Health. The plan submitted can then be brought to the July or August Board meeting for final approval once Ministry confirmation has been received that there are no outstanding issues.

RECOMMENDATION
THAT
The draft Annual Plan is submitted to the Ministry of Health noting that that there feedback may result in changes which will be brought to the July or August Board meeting.

JULIE WILSON
EXECUTIVE DIRECTOR STRATEGY AND FUNDING

Waikato District Health Board 2017/18 Annual Plan

INCORPORATING THE 2017/18 STATEMENT OF PERFORMANCE EXPECTATIONS

Important note: This is a draft plan written prior to funding confirmation and will require review following confirmation.

Annual Plan dated March 2017
(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

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

This document is available on the Waikato District health Board website
http://www.waikatodhb.health.nz/

Mihi

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

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Minister's 2017/18 Letter of Expectations to Waikato DHB

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

16 DEC 2016

Mr Bob Simcock
Chairperson
Waikato District Health Board
Private Bag 3200
Hamilton 3240

chairman@waikatodhb.health.nz

Dear Mr Simcock

Letter of Expectations for DHBs and Subsidiary Entities 2017/18
The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2016 Vote Health received an additional $568 million, the largest increase in seven years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy
The refreshed New Zealand Health Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to ensure that all New Zealanders live well, stay well and get well.

The DHB annual plans are the primary document for demonstrating DHB delivery of the Strategy, and your 2017/18 annual plan is expected to clearly demonstrate the linkages between the five themes of the Strategy and your DHB's performance story, activities and outcomes, while also maintaining a focus on Māori health outcomes and health equity.

In particular I want to see a strong focus on providing care in the community and for services to be provided closer to home, especially for the management of long-term conditions.

Finally, I want your Board to very carefully consider how any new local initiatives fit within the context of the Strategy.

Living Within our Means
While the global economic environment continues to be challenging, DHB funding has continued to be increased year on year. DHBs need to budget and operate within allocated funding and must have clear plans to improve year-on-year financial performance. Your DHB's financial performance is currently unfavourable to your agreed budget for 2016/17. I expect that you will improve this position throughout the year and will continue to make efficiency gains to ensure better performance in 2017/18. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. In particular your Board must work closely with NZ Health Partnerships Ltd on ensuring the delivery of their current work programmes and services.

Working Across Government
I expect DHBs to continue supporting cross-agency work to support vulnerable families and progress outcomes for children and young people, including working with the new Ministry for Vulnerable Children, Oranga Tamariki once this has been established.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

All DHBs must continue to work closely with other social sector organisations to achieve cross-sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as the Prime Minister's Youth Mental Health Project, the Childhood Obesity Plan and the *Living Well with Diabetes* Plan.

Locally, I expect Waikato DHB will continue working with other agencies to sustain its reduction in rheumatic fever through the delivery of its rheumatic fever prevention plan, increase immunisation coverage rates to target levels and improve outcomes for children not enrolled with a PHO, and reduce the use of seclusion in inpatient mental health services.

National Health Targets

All of the national health targets are very important for driving overall performance, and have resulted in major improvements in the health outcomes of New Zealanders. I expect DHBs to remain focussed on achieving and improving performance against all six health targets. The *faster cancer treatment* target remains a top priority for service delivery for DHBs and further progress is expected during 2017/18.

The first national result for the *raising healthy kids* health target is 49 percent. I expect results for all DHBs to improve considerably each quarter as referral processes and clinical pathways are fully implemented.

Locally, Waikato DHB has shown good performance in relation to the *improved access to elective surgery* health target. However, performance in relation to the other health targets needs to be improved, particularly for the *shorter stays in emergency departments* and *increased immunisation* health targets. Please ensure delivery of these health targets is a priority for your DHB.

Streamlining of DHB Annual Planning

In order to ensure that the Health Strategy is informing DHB planning, DHB annual plans will be streamlined in 2017/18 so that they are focussed on my key expectations for your DHB. Your DHB should also be considering longer-term strategic planning (ten-year horizon) as a way to deliver on the vision of the Health Strategy, and I expect that in the future you will be able to demonstrate this planning.

Working regionally also continues to be important, and I expect that when you are considering your long-term strategic planning you are also considering this in a regional context.

There are a number of key planning priorities for 2017/18 that DHBs will need to clearly respond to in their annual plans. These planning priorities have been selected in order to progress the key Government expectations outlined above, and also to progress other key health initiatives, such as Bowel Screening, implementation of the Healthy Ageing Strategy and continued integration of health care in order to better prevent and manage long term conditions, and provide services and care in the best ways to meet local needs. This will require ongoing engagement with your primary and community partners, including implementation of the System Level Measures.

The full list of my planning priorities for 2017/18 is attached for your information. I have asked the Ministry to provide separate advice about how each of these should be reflected in your plan.

Concluding comments

In implementing your annual plan it is important that clinicians are engaged and involved throughout; clinical leadership is fundamental in delivering high-quality health services.

Please note that I am not requiring DHBs to refresh their statements of intent (SOIs) for tabling in 2017/18. However, please ensure you review your SOI produced in 2016/17 to confirm that there are no significant changes. The statements of performance expectations will still need to be produced and tabled.

Keep in mind that the Budget 2017 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available, including information on planning priorities.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2017/18.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

2017/18 DHB Annual Planning Priorities

Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target
Supporting Vulnerable Children Better Public Service Target
Reducing Rheumatic Fever Better Public Service Target
Increased Immunisation Better Public Service and Health Target
Shorter Stays in Emergency Departments Health Target
Improved Access to Elective Surgery Health Target
Faster Cancer Treatment Health Target
Better Help for Smokers to Quit Health Target
Raising Healthy Kids Health Target
Bowel Screening
Mental Health
Healthy Ageing
Living Well with Diabetes
Childhood Obesity Plan
Child Health
Disability Support Services
Primary Care Integration
Pharmacy Action Plan
Improving Quality
Living Within our Means
Information Technology
Workforce.

Minister's 2017/18 Letter of Approval to Waikato DHB

(Placeholder for Annual Plan approval letter.)

SECTION 1: Overview of Strategic Priorities

This Annual Plan articulates Waikato District Health Board's (DHB)'s commitment to meeting the Ministers expectations, and our continued commitment to our Board's vision – Healthy People. Excellent Care.

National Strategic Intentions

The Treaty of Waitangi

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

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

New Zealand Health Strategy

The New Zealand Health Strategy is the key source of direction for the health sector. The refreshed New Zealand Health Strategy provides the sector with clear strategic direction and a road map for delivery of more integrated health services for New Zealanders. The strategy has a ten-year horizon, so impacts on not just immediate planning and service provision but enables and requires DHBs and the sector to have a clear roadmap for future planning as well.

The Healthy Aging Strategy

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

The UN Convention on the Rights of Persons with Disabilities

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

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

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

Regional Strategic Intentions

See the Midland Regional Service Plan for details.

Local Strategic Intentions

Waikato DHB Strategy

During 2015/16 Waikato DHB undertook a Strategic Refresh Project. This project was driven by our Board and concentrated on ensuring the organisation was heading in the right direction, focusing its resources and making the most of future opportunities. It is recognised that there are some fundamental challenges we must face along the way if we want to continue improving the health status of our population and our work to eliminate health inequities.

Our Vision - Healthy people. Excellent Care.

Our Mission - Enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative delivery

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

Implementing Our Strategy

To connect strategy with day-to-day activity, we are developing priority programme plans during 2017. These plans will describe how we will implement each of the priorities identified in the Waikato DHB Strategy. The plans will also detail the transformative innovation needed to create the health system that works best for the Waikato. A priority programme plan is designed to:

Coordinate, direct and oversee implementation of a set of related projects and activities in order to deliver outcomes and benefits related to Waikato DHB's strategic imperatives.

A member or members of the Waikato DHB Executive Group are leading each of the priority programme plans. Development of the plans may also include both DHB, primary care and other sector representation. The plans will identify specific activity and actions that will contribute to the achievement of our strategic imperatives and vision. The priority programme plans will not be individual stand-alone developments; they will link with other priority programmes.

Monitoring the strategy

We will monitor delivery of the strategy by assigning performance and progress measures to each priority programme plan. Progress measures will be assigned to each of the strategic imperatives, which will be reported on publicly in our Annual Report.

Message from the Chair – Bob Simcock

As we look forward to the year ahead at the Waikato DHB it's important to recognise that while we have made good progress in a range of areas there is still much that needs to be improved.

Our new vision Healthy People, Excellent Care and the strategic imperatives which flow from it will ensure that we stay focused on what's important for our population.

We want to radically improve the health outcomes of our Maori population; work productively with our health partners; deliver safe, quality health services for everyone and work towards becoming a centre of excellence for learning, research and innovation.

People are at the heart of everything we do and we have a number of key priorities for the year which we will be discussing with our community.

These include a review of mental health and addiction services in our district – not just what we provide at our facilities but also the model of care for the services in our community.

We are also reviewing our delivery of rural health services. We have the largest rural population in the country and people living in our rural communities have poorer access to services and poorer health status. We need to ensure our rural services and facilities are meeting the needs of our population now and into the future.

We are committed to working with our communities, health providers and other agencies to improve the health outcomes of our vulnerable populations. This requires transformational change which I know we can deliver.

Message from the Chief Executive – Dr Nigel Murray

This Annual Plan sets out the direction and priorities for the coming 2017/18 year for the Waikato DHB.

We know that in order to meet the coming challenges of an aging population with increasing chronic disease, and to improve the health outcomes of our population, incremental changes are not enough. We need to do things in a radically different way and provide innovative solutions.

One way we are innovating is through virtual health. We will continue to roll out our SmartHealth initiative across our services this year. More and more of our patients are enjoying the convenience of having an out-patient appointment over their smartphone from home, or being able to talk to a doctor out of hours for free.

A Centre for Virtual Health and Innovation is the first initiative for the Waikato Institute of Health and Medicine to be set up as part of our deepening relationship with the University of Waikato.

The institute will also provide a framework for the establishment of a third New Zealand Medical School based in the Waikato. Our proposal for the Waikato Medical School is currently with the government.

We will also be focusing on our health targets for the year, in particular our immunisation rates and treating people in our Emergency Department promptly. To this end we have an exciting new patient flow project which will help to improve the flow of patients through Waikato Hospital and get them admitted to wards quickly for treatment.

Meeting our elective services targets has been a challenge and will continue to be so, but we have been working hard to increase staff, improve our theatres and work with other providers to improve performance against this target.

The year ahead will be challenging but I am confident that we will continue to empower our citizens to live healthy lives and make sure everyone has access to our services no matter who they are or where they live.

Signatories

Agreement for the Waikato DHB 2017/18 Annual Plan

between

Hon Jonathan Coleman Minister of Health Date:	Bob Simcock Chair Waikato DHB Date:	Dr Nigel Murray Chief Executive Waikato DHB Date:

SECTION 2: Delivering on Priorities and Targets

Government Planning Priorities

Government Planning Priority	Link to NZ Health Strategy	Link to WDHB – Strategic Imperative	Waikato DHB Key Response Actions to Deliver Improved Performance		
			Activity	Milestones	Measures
Prime Minister's Youth Mental Health Project	Value and high performance	Safe, quality health services for all - Haumaru	*Waikato DHB is committed to continue activity to deliver on the Prime Ministers Youth Mental Health Project by:* 1. Implementing the 1-2 year ACC suicide prevention pilot in Waikato Hospital Emergency Department focusing on youth 10 to 25 years (if business case approved by ACC)	Progress report quarterly	PP25: Prime Minister's Youth Mental Health Project
		Health equity for high need populations - Oranga	2.Evaluation of the new Waikato Youth INtact AOD services for 12-19 year olds	Final evaluation report by 30 May 2018	
			3.Developing a new model of care and outcome framework for Child &Youth Mental Health Services which spans the continuum from promotion/prevention to secondary care	30 June 2018	
			4.Ensuring youth voice and participation in model of care and outcomes framework development	30 June 2018	
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	People powered	People centred services - manaaki	*Waikato DHB will continue to build on the substantive activities identified in our 2016/17 annual plan to reduce unintended teenage pregnancy by:*		PP38: Delivery of response actions agreed in annual plan
			1.Development of a Youth SLAT to oversee and monitor this priority	1. Group set up and meeting regularly by Q1	
		Health equity for high need populations - Oranga	2. Carry out an assessment of access and uptake of free contraceptive services across the district particularly for rural communities	2. Assessment completed by Q4	
			3. Work with key stakeholders and consummers to co-design and implement a multi-facetted programme of work to address the high rates of teen pregnancy for Maori. This project will link with System Level Measure for youth. (Equitable Outcomes Action)	3. Co design and implement by Q4	
Supporting Vulnerable Children BPS Target	One team	Productive partnerships - Whaneketanga	*Waikato DHB will commit to continue activity to contribute to the reduction in assaults on children by:* 1. a) Engaging with national directorate and participating in the Clinical Governance Group on the Hamilton Children's Team by providing FTE allocation for the panel, including Emergency Department representation b) Development and implementation of a vulnerability assessment tool - Harti Hauora, for use in the Hamilton Children's Team (Equity Outcomes Action)	1a) Ongoing b) Tool available to be rolled out and in use for all children by Q4	PP27: Supporting vulnerable children
		for high need popula tions -	2. Ensure that all staff across mental health, Emergency Department, maternal and child health, sexual health and addiction services have undertaken the Family Violence training	2. All staff trained by Q4	

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
			3. Revise and refresh the Waikato DHB Child Health Protection Policy and submit onto the DHB website.	3. Refreshed policy released by Q2	
			4. Contribute to the intersectorial Integrated Safety Response pilot. Involvement in the daily panel and extensive case management.	4. On-going participation in ISR	
Healthy Mums and Babies BPS Target	**One team**	**Health equity for high need populations - Oranga**	*Waikato DHB is committed to supporting delivery of Healthy Mums and Babies interim target of 80% of pregnant women are registered with a Lead Maternity Carer in the first trimester by 2019, with equitable rates for all population groups by:* Maternal child health has a growing focus for Waikato DHB. Our population profile shows inequity for our Maori population for the early registration with LMC. 1. In order encourage early registration with LMC we require sufficient LMC coverage for our population. We have recently identified an issue with coverage not only over the Christmas break but also with a number of very busy LMC's retiring in Hamilton. A plan will be put in place for this (see service coverage). 2. Roll out the early pregnancy Map of Medicine to ensure primary care are encouraging and assisting women with early registration with LMC. Targeting of GP practices in areas where early registration is low will be carried out and education provided. 3. Targeting of areas where early registration is low. Investigate rolling out a similar campaign to Thames/Hauraki area – "Never too Late Campaign", where free pregnancy tests, lists of LMCs etc were provided. 4. Work with school based health services to ensure pregnant young women enrol with a midwife as early as possible. 5. Investigate how best to work with Māori and Pacific health providers to encourage early registration.	1. Plan in place by Q2 2. Roll out Map of Medicine by Q1 3. Areas identified and investigation carried out as to feasibility of campaign by Q2 4. Completed by Q2 5. Meet and work through a plan by Q2	PP38: Delivery of response actions agreed in annual plan (section 1)

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
Keeping Kids Healthy		Health equity for high need populations - Oranga	*Waikato DHB is committed to supporting delivery of the keeping kids healthy interim target of 15% reduction in hospital admission rates for children aged 0 - 12 years by 2019, by targeting the following areas, intervening early and preventing the need for hospitalisation:* **1. Flu vaccination** Respiratory conditions appears in the top 10 0-4 ASH conditions. Rates for the flu immunization remain low. We will develop a program to identify and vaccinate all children 0-5 who qualify for the free influenza vaccine. **2. Skin infections** Skin infections appear in top 10 0-4 ASH conditions also and there is a high and growing rate of hospitalizations for serious skin infections. We will develop a new primary care system of care around childhood skin infections in order to manage in primary care **3. Dental** Hospitalizations due to dental conditions in the 0-4 age group are significant and increasing We will focus on: • Ensuring the 'lift the lip' assessment is carried out earlier than B4SC by primary care, well child and secondary providers to identify and treat earlier • Increasing the number of Early Childhood Education (ECE) Centres with water and milk only policies **4. Gastroenteritis** We will focus on ensuring gastro conditions are supported in primary care by: • Expansion of paediatric business rules for primary options • Ensure Map of Medicine for primary and secondary are aligned and clinical pathways are accessable to pharmacy	1. Systems in place by Q3 2.a. Data analysis completed by Q1 b. Review Map of Medicine by Q2 c. Investigate the use of standing order in pharmacy by Q3 3. a. Deliver training and revised referral process by Q4 b. Capture baseline data in number of ECE's by Q2. Promote water/milk only policys to target ECE's by Q4 4. Map of medicine by Q4 Primary option business rules expanded by Q4	PP38: Delivery of response actions agreed in annual plan (section 1)
Reducing Rheumatic Fever	People powered	People centred services - manaaki	*Waikato DHB will commit to reduce rheumatic fever rates in all ethnicity groups in the Waikato District by:* 1. Implementing the Rheumatic Fever Prevention plan	1.On-going implementation of plan to ensure meeting target: 1.2/100,000 acute rheumatic fever hospitalisation rates	PP28: Reducing Rheumatic Fever
			2. Continue delivery of the Healthy Homes service through the Kaupapa Maori providers in Huntly/Ngaruawahia and Tokoroa to the 3 eligible groups Group A: 0 to 5 year olds hospitalised with specified housing-related indicator conditions; Group B: Priority population of 0 to 5 year olds – all families/whānau with children aged 0-5 years old for whom at least two of the following risk factors apply:	2. Ensure referrals are received from all 3 eligible groups, assessments and interventions are completed	

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
		Health equity for high need populations - Oranga	Child Youth and Family finding of abuse or neglect; caregiver with a corrections history; mother with no formal qualifications; long term benefit recipient; and Group C: Pregnant women and new-born babies	by Q4	
			3. Population Health will continue engaging with our Pacific communities via our key stakeholders including Aere Tai Collective and their representation on the Rheumatic Fever Steering Group and working group and contracts regarding sore throat services. This also includes the provision and distribution of RF information printed in a number of different Pacific languages. (Equity Outcomes Action)	3. Ensure provision of resources, continued representation on RF steering group and annual updates to Pacific provider	
			4. Maintain timely access to free sore throat management service for the eligible population	4. Ensure access to eligible 4 – 19 year olds for timely sore throat management, monitor by ethnicity	
			5. Consider a Smart Health trial with patients who have had Rheumatic Fever by way of ensuring they continue to be compliant with their medication – thus reducing their likelihood of developing ongoing and long term complications	5. Outcome of trial	
Increased Immunisation BPS and Health Target 	One team	Productive partnerships - Whaneketanga	*Waikato DHB will provide robust governance to ensure that the DHB, PHOs and practices work as one team to increase immunisation coverage rates, to target levels and improve outcomes for children not enrolled with a PHO:* 1. Implementing the Immunisation Plan under the governance of the Immunisation Steering Group	1. Plan implemented by Q1	Immunisation Health Target PP21: Immunisation Services 95% of 8 month olds are fully immunised 95 % of two year olds are fully immunised 95% of 4 years are fully immunised
			2. Weekly teleconferences identifying NHI level data to ensure that the DHB, PHO's, practice teams and outreach immunisation work collaboratively to reduce missed events	2.Missed events are reduced by Q2	
		Health equity for high need populations - Oranga	3. Waikato DHB will support and work with PHOs to establish improved efficiencies and the effectiveness of outreach immunisation delivery for their enrolled population, while also managing non-enrolled children	3. On-going	
			4. Support primary care around full electronic GP enrolment at birth.	4. Full enrolment launched by Q2	
			5. Launch of the Harti Hauora Hubs within the hospital and central city to conduct opportunistic immunisations, PHO enrolment, opportunistic screening of Māori, Pacific and high – deprivation populations (Equity Outcomes Action)	5. Both hubs launched by Q4	
Shorter Stays in Emergency Departments Health Target 	Value and high performance	Effective and efficient care and services – Ratonga a iwi	*Waikato DHB is committed to achieving and maintaining the Shorter Stays in Emergency Departments Health Target and improvement of acute patient flow within our hospitals by:* 1. Addressing acute demand with primary care and St John, to include redirection pathways when clinically appropriate i.e. chronic conditions and falls via the Demand Management Advisory Group	1.On-going	95% of patients will be admitted, discharged or transferred from an Emergency Department

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			2. Roll-out of the Emergency Department workforce business case - Improving workforce resource to better manage increasing demand	2. October, 2017	within 6 hours of presentation
			3. The LEAN project rollout in Emergency Department focusing on streamlining processes within the department. This will include reviewing the bed booking process, patient hand over within Emergency Department, patient hand over to inpatient services, reduce written duplication, agree pathways of care between Emergency Department and inpatient specialities	3.Plan agreed by September 2017 with full implementation by July 2018	
			4.Pilot to establish a Smart Health kiosk in Tokoroa Emergency Department which will enable people who are triaged as level 4 or 5 to access the Smart Health doctor via a laptop in that booth. A successful trial is expected to result in a roll out across all Waikato DHB Emergency Departments.	4. Tokoroa 1 July 2017. Evaluation of trial at 3 months post implementation and assessment of applicability to other ED contexts	
			5. Launch of Accident Compensation Corporation project which focuses on suicide prevention, Waikato Emergency Department is a national pilot site	5. October, 2017	
			6. Rollout of iMPACT patient flow manager IT project. It will have the effect of shortening length of stay, provide better visibility of patient status in the hospital, and workflow management associated with inpatient care	6. To commence in Q4 dependant on business case approval	
			7. The Acute Medical Unit at Waikato DHB remit and function will be reviewed to improve access for patients on the acute pathway.	7. May, 2018	
			8. The Patient Flow programme will provide a focused project on improved discharges from the DHB	8. June, 2018	
			9. Work with operation and support team and Te Puna Oranga to review the Maori/Pacific patient journey in emergency departments. Analysis of journey to identify key action areas. (EOA)	9. September, 2017	
Improved access to Elective Surgery Health Target	**Value and High performance**	**Effective and efficient care and services – Ratonga a iwi**	*Waikato DHB will deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services by:* 1. Progressing the '*Patient Flow Programme'*, including projects for production planning, ward management and improving bed availability, design and implementation of DHB wide patient flow manager IT toolset.		Electives Health Target SI4 Standardised Intervention Rates
			2. Roll out and embed SmartHealth for vascular services outpatients.	TBC	OS3: Inpatient Length of Stay (Electives)
			3. Reduce surgery cancellations – continue to roll out the 'Pre hospital Preparedness Programme' to ensure patients are ready for surgery	By 30 June	Electives and Ambulatory

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
			4. Clinical pathway audit for equity to be completed by Te Puna Oranga (Equity Outcomes Action)	To be completed by Q4	Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
			5. Plan delivery in a more structured, consistent and balanced manner to maximise volume delivery subject to budget. Examples of possible changes to resourcing, subject to more careful capacity planning and investment decisions: a) increase anaesthetists and Medical Radiation Technicians to improve utilisation and/or b) contract with external facilities to ensure delivery of target volumes and/or c) increase Senior Medical Officers in cardiac and thoracic surgery and/or d) Long term planning will look at increasing orthopaedic resource	TBC	
			6. Continue the implementation of the bariatric pathway for local and regional patients.	TBC	
Faster Cancer Treatment Health Target	**One team**	**Safe, quality health services for all - Haumaru**	*Waikato DHB is committed to improving access, timeliness and quality of cancer service* by: 1. Monitoring Faster Cancer Treatment (FCT) achievement of health target for patients on lung cancer pathway ensuring gains of the one stop shop model are embedded and maintained	1. On-going monitoring	Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving wait times for diagnostic services – CT & MRI SI10:Cancer Screening (Cervical) SI11: Cancer Screening (Breast)
			2. Transitioning urology service to fully utilise DHB patient management system and embed FTC business rules into urology business as usual. Carry out a review of the transitional impact of the business rules.	2. Transition will be complete by Q3	
			3. Management and clinical leadership to continue to work together to implement service improvement initiatives to ensure women meet the FTC health target and indicator wait times. A dedicated gynae oncologist was appointed in January 17 to ensure all patients are discussed in a timely manner at the joint weekly multi-disciplinary meetings with Auckland. A review of the effectiveness of joint multi-disciplinary meetings will be carried out. Depending on the outcome of the review, local DHBs will have to agree, in conjunction with the Midlands Cancer Network, what patients will be seen and treated in Waikato and those discussed at the specialist MDM in Auckland	3. Review commenced Q1 and any changes arising from the MDM review are implemented by Q4	
			4. Implement and monitor fast tracking process to identify all FCT referrals for diagnostics with a high suspicion of cancer with red stamp on referral form. · Review effectiveness of new high suspicion of cancer stamp · Monitor appropriate use of high suspicion of cancer stamp	4. Initiative commenced Q2	
			5. Service to engage with Te Puna Oranga to minimise inequity in cancer service by addressing 'Did Not Attends' DNA's and identifying barriers. This will be addressed by the promotion of the Clinical Nurse Specilist Equity and Access to identify did not attends (DNA's), reasons for DNAing, breaking down barriers and re-engaging with the services to ensure patients are seen and treated in a timely manner	5. Engagement will occur in Q1	

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Better Help for Smokers to Quit Health Target	**Smart system**	**Health equity for high need populations - Oranga**	*Waikato DHB is committed to maintain the smoke free public hospital, and to meet the primary and maternity targets – better help for smokers to quit by:*		Tobacco Health Target PP31: Better help for smokers to quit in public hospitals PP34: Improving percentage of households smoke free at 6 weeks postnatal Pregnant Maori women smoke free at 2 weeks postnatal
			1. Developing of a 3 year tobacco plan along with an approach to increase and support referral and cessation for high needs groups	1. Development of plan and approach by Q1	
			2. Work with Midland Health Network PHO (Lead smoking cessation service providers) to achieve the target of: • 5500 referrals with a particular focus on Maori, Pacific, pregnant women • 2700 enrolments into the smoking cessation programme • 50% of enrolments quit This will include supporting the use of eReferral, patient prompt and best practice intelligence reporting tools. (Equity Outcomes Action)	2. Numbers of referrals and 4 weeks successful quits for Maori, other and total population met by Q4	
			3. Progress towards System Level Measure - babies who live in a smoke-free household at six weeks post-natal	4. Working group identifies quality improvement initiatives by Q3	
			4. Review of the current DHB smoke free policy with the goal of strengthening and invigorating a supported smoke free DHB. Emphasising our commitment to the 2025 New Zealand smoke free goal.	5. Review carried out by Q2	
Raising Healthy Kids Health Target	**Closer to home**	**People centred services - Manaaki**	*Waikato DHB will identify actions to take to ensure that the clinical referral pathway and processes to be established in 2016/17 achieves the Raising Healthy Kids target by December 2017 by:*		Healthy Kids Health Target
			1. Roll out strategies to increase the Before School Check uptake for Maori and high needs populations (Equity Outcomes Action) • Utilising the Child and Youth Coordination Service to identify up to date contact details on children through the Ministry of Social Development – (Work and Income) for all children late or missing a before school check, majority are Maori • Utilising the outreach teams at both Pinnacle and Hauraki PHO's to locate children missing the check and carry out the B4SC at home within the child's own environment. There will be a particular focus on Maori children • Weekend clinics being held	1. An increase in Before School Check seen for the Maori population by Q2	
			2. District wide implementation of internal and clinical pathways for obese children identified in the Before School Check. Waikato Child Health Network to monitor for equity and quality improvement	2.Implementation of pathways carried out by Q1	
		Health equity for high need populations - Oranga	3. Roll out education and clinical tools for management of childhood obesity once diagnosed to enable primary care and families/whanau to better manage in the community and at home (Be Smarter tool, Map of Medicine, eReferral)	3. Clinical tools rolled out by Q2	

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
			4. Provide an educational update for Well Child/Tamariki Ora providers to assist with support in this area	4. Education update provided by Q4	
Bowel Screening	Value and high performance	Safe, quality health services for all - Haumaru	*Waikato DHB will contribute development activities for the national bowel screening programme to ensure the National Bowel Screening Programme will roll out in 2018/19 by:* 1. Ensuring dedicated resource is allocated to prepare for Bowel Screening	1. Resource allocated by Q1	PP29: Improving waiting times for diagnostic services – colonoscopy National Bowel Screening quality, equity and performance indicators
			2. Preparation work on waiting lists prior to roll out. The work still to be undertaken is triaging of non referral co-ordination centre referrals and surveillance patients. Also preparation within our IS system of the way we will handle the direct referral for GP for the colonoscopy procedure.	2. Q4	
			3. Active integration and linkages with the Bowel Screening Regional Committee. Equity and access will be linked though this forum with proactive Maori and Pacifica representation	3. Integration, linkages and representation established by Q1	
			4. Waikato DHB is committed to implementing the necessary changes and integration to support the National Bowel Screening Programme (NBSP). This has been included on our DHB's IT work plan. (See the IT section of this plan)	4. IT changes completed in Q1	
			5. Submit DHB financial business case to the Ministry for formal approval for Bowel Screening	5. Business case submitted Q4	
			6. In addition to the regional work underway, a local action for Waikato DHB to prepare to prepare to join NBSP will be to employ a Project Manager to liase with the National Bowel Screening Programme the regional work and ensure that there is open communication and dialogue.	6. To commence in Q1	
			7. As part of our pre-preparation programme to ensure Waikato DHB will sustainably meet colonoscopy wait time indicators, we will be employing a Clinical Nurse Specialist to ensure that the colonoscopy wait times are met and reported on.	7. To commence in Q1	

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Mental Health		**Safe, quality health services for all - Haumaru**	*Waikato DHB is committed to improving population mental health, especially for priority populations including vulnerable children, youth, Maori and Pacifica, by increasing the uptake of treatment and support earlier, further integrating mental and physical health care and co-ordinating mental and physical health care with wider social services. We also commit to improving the quality of mental health services & reducing the use of seclusion:* Mental Health has a large focus for Waikato DHB for 17/18. Our population profile shows a high Maori and rural mental health population as identified from the Mental Health and Addictions Needs Assessment recently completed. This has helped us identify that our priority focus needs to be in these areas when looking at the development of new models of care. 1. The programme of work entitled "Te Pae Tawhiti" is commencing in 2017/18 - there are four major work-streams - • Child & Youth Mental Health • Adult Mental Health • Adult Addictions • Mental Health and Addictions for Older People. Te Pae Tawhiti encompasses new and re-vitalised models of care that will take a fresh look at service delivery for communities and their families across the full social spectrum of their lives and consequent decisions on re-configuration and possible new investment in services will then occur.	1. Models of care will be finalised by Q4	PP38: Delivery of response actions agreed in annual plan
			2. Working groups will be formed to include those with lived experience, primary care and population health with the work spaning the spectrum from prevention/promotion through to secondary care. This will ensure a population approach, early intervention and service integration are addressed. The working groups will be required to use the Health Needs Assessment to guide their work.	2. Working groups formed by Q1 and work commeneced with the first workstream Adult Addictions by Q1	
			3. The Mental Health Integrated Transition Project will be launched via the Mental Health Integrated Coordination Care Team. This will transition mental health patients from secondary to primary mental health services with free and extended general practice visits and a keyworker for 12 months to help move the patient closer to home and reduce the incidence of readmission.	3. To commence Q1	

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			5. Reduction in the use of seclusion through continued implementation of the seclusion elimination strategy which applies the six core strategies for seclusion reduction as promoted by Te Pou. In addition we have a seventh strategy Hei Oranga ake which ensures a culturally responsive approach. Seclusion reduction is also the indicator we are focused on for national benchmarking. As a result we are ensuring in depth reviews of all patients who have high use of seclusion. Community teams are part of the reviews to ensure we are preventing seclusion prior to admission, particularly with the use of Advanced Directives	5. Reduction in the use of seclusion	
			6. Identify and analyse ethnicity data around wait times. Analyse ethnicity data around access. Work with the district to set up a data dashboard for monitoring. (Equity Outcomes Action)	6. Equity data identified and analysed by Q2	
			7. Contribute to the development of a regional Model of Care for eating disorders with implementation of relevant components	7. Model developed by Q4	
Healthy Ageing	Closer to home	People centred services – Manaaki	*Waikato DHB is committed to the delivery of priority actions identified in the Healthy Aging Strategy 2016, where we are in lead and supporting roles including :* 1. Development of a Waikato Healthy Aging Strategy and implementation plan to support the implementation of the NZ Healthy aging Strategy into Waikato DHB.	1. Strategy and Implementation plan completed and commenced by Q4	PP23: Improving Wrap Around Services – Health of Older People
			2. Continue to work with ACC, HQSC, and the Ministry of Health to further develop and measure the progress of our integrated falls and fracture prevention services	1. On-going	
			3. Implement agreed activity from the IBT settlement Part 2	2. Q2	
			4. InteRAI Data- • Work with Midlands DHBs to ensure InterRAI assessment data is used to identify quality indicators and service development opportunities. Agree integrated pathways where data identifies need.Prioritise implementation of access to InterRAI data at NHI level across primary and secondaryIdentify a specific equity issue via use of InteRai data and work to address that issue.	3. a) Quality indicators are developed and utilised for service development initiatives by Q3. b) Access is implemented by Q4 c) Equity issue will be identified by Q1 and work will commence to address it by Q2	
			4. Contribute to the work of TAS shared services for Health of the Older People for a funding model review and options across aged residential care to support person centred care service delivery and future models of care	4. Q4	

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
			5. Support the Regional Services Plan work of: • Consolidation of components of the dementia pathway • Ensuring family and whanau carers of people with dementia have access to support and education programmes.	5. Increased referrals from GP practices to Alzheimer's and Dementia organisations Standardised training is available on a consistent basis for family and whanau carers by Q4	
Living Well with Diabetes	Closer to home	Safe, quality health services for all - Haumaru	*Waikato DHB will continue to implement the actions in the Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020 by:* **High Risk of Diabetes** 1. The area with the most significant equity gap between Maori and other in the Waikato is diabetes. Diabetes is also the highest cause of amenable mortality for Maori within the Waikato. Therefore we have a focus on diabetes with our Maori population to improve outcomes with the following projects: • Collaborative development work has occurred with the University of Waikato to develop the He Pikinga Waiora Implementation Framework – with the aim of making health interventions work in Māori communities • Utilising the He Pikinga Waiora framework, co design work to begin with Te Kohao Health to develop a programme around preventing progression from pre-diabetes to diabetes for Maori.	1. Work commenced and programme developed by Q4	PP20: Improved management for long term conditions, focus area - Diabetes services
			2. A study to validate the new diabetes prevention programme - Betame will commence led by Pinnacle PHO and the University of Otago. The App is designed to equip people with pre- diabetes with tools, support, education and confidence to take control of their own health and prevent diabetes. The study will commence in 17/18 and take approximately 3 years. It is hoped this will provide a robust evidence base for its use in both Maori, Pacific and other patients.	2. Evaluation will commence in Q1	
		Health equity for high need populations - Oranga	**Living with Diabetes – Complex cases** 3. Development and implementation of a district wide strategically aligned education plan for General Practice, practice nurses, pharmacists and non-clinical workforce ie. Kaiawhina. The education plan will help improve knowledge and familiarity with managing complex cases of diabetes	3. Execution of the education plan by Q4	
			4. Development and implementation of IT resources to standardise and improve management of complex cases of diabetes in the community	4. Development of required tools/clinical pathways and implementation by Q4	

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
			5. Acquiring enhanced diabetes specialist dietetic support in the community to enable safe and effective progression of insulin therapy, necessary to manage complex cases of diabetes along with patient resources and education material	4. Staff support available and development of patient education material by Q4	
Childhood Obesity Plan	Closer to home	Productive partnerships - Whaneketang	*Waikato DHB will commit to progress DHB-led initiatives from the Childhood Obesity Plan by:* 1. **Childhood Healthy Weight Plan:** Completion and implementation of the Waikato Childhood Healthy Weight Plan which as an overarching goal of improving healthy eating and active lives for Waikato children.	1. Implementation commenced by Q3	PP38: Delivery of response actions agreed in annual plan
			2**. Population level** Population Health to roll-out their programme of work to increase healthy eating environments within the Waikato community, ensuring they have a first 1000 day approach	2. Plan completed and implementation commenced Q3	
			3**. Healthy eating and nutrition programmes**: • Expansion of healthy eating and physical activity programmes for decile 1 – 3 and Kura Kaupapa Maori schools. • Sustainability and monitoring of existing preschool, primary and middle school 'Under 5 Energize' and 'Project Energize' programmes into the schools via Sport Waikato and Population Health. • Increase the number of Kohanga Reo with water/milk only polices. (EOA)	3.Expansion of programme by Q2 Increase the number of water and milk only policies by Q4	
		Health equity for high need populations - Oranga	4. **Preschool BMI Screening:** • Ensure on-going monitoring and screening of BMI is occurring at Well Child/Tamariki Ora checks and General Practice visits. • Implement clear pathway including referrals for those children requiring more intensive support for a healthy weight.	4. Monitor uptake of BMI screening in general practice including referrals from Q1	
			5. Pregnancy: • Increase promotion of healthy weight during pregnancy via the Healthy Start and Healthy Conversations Skills training for midwives • Include measuring BMI, healthy weight gain conversation and resources in Early Pregnancy Map of Medicine. • Roll out healthy weight gain in Hapu Wananga pregnancy and parenting classes. (EOA)	5. Roll out further training for LMC's by Q3 Ensure added to Map of Medicine by Q1. Roll out of healthy eating in Hapu Wananga by Q2	
Child Health	Value and high		*Waikato DHB commits supporting the national work underway to improve the health outcomes for children, young people and their family's service by*	1. Gateways Service Level	PP38:Delivery of response

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		Productive partnerships - Whaneketanga	*Oranga Tamariki, particularly young people in care by:* 1. Waikato DHB representation by a senior paediatrician, a Strategy and Funding portfolio manager and an NGO Child and Youth mental health clinician at the interagency Waikato interagency Gateways Governance Group	Agreement with Waikato Hospital Child Health Services reviewed quarterly against contracted volumes. Service is responsive to social workers referrals	actions agreed in annual plan
		Health equity for high need populations - Oranga	2. Our priority population is Maori. To reduce barriers for vulnerable Maori children we will roll out our vulnerable children's Harti Hauora Assessment Tool for use in the Hamilton Children's Team. The benefits of using this tool are increased opportunistic screening, increased interventions for Māori and vulnerable children, increased number of referrals made to appropriate services when indicated, enhanced clinician skills and expertise when working with vulnerable children, particularly Maori	2.Tool will be rolled out into the children's team by Q1	
			3. Undertake diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki within the Waikato DHB through the Harti Hauora assessment work	3. Complete diagnostic work by Q4	
			4. Children unenrolled with GP contract to roll out for PHO's to enable referral from ED to GP of choice at no cost to patient	4. Contract in place by Q1	
Disability Support Services	One team	Health equity for high need populations - Oranga	*Waikato DHB will enhance the following mechanisms and processes to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances):* 1)Improved Campus entry lobby signage	. 1. Q4	PP38: Delivery of response actions agreed in annual plan
			2) Improved way finding signage and guidance within Meade Clinical Centre/ Waiora	2. Q4	
			3) An enhanced Enquiries focal point in Meade Clinical Centre	3. Q4	
			4) Expanded visitor greeting services at key navigation points with the core campus	4. Q4	
Primary Care Integration	Closer to home	Productive partnerships - Whaneketanga	*Waikato DHB will continue to work with its alliances and other providers in the Waikato district to move care closer to home for people through improved integration with the broad health and disability sector by*: 1. Providing robust governance through the Inter-Alliance to ensure that the DHB and PHOs work collaboratively to: • Identify 10 key areas of focus for primary and secondary integration and clinical pathway work • Provide action plan agreed by Inter-Alliance • Oversee the SLM work	1. Key areas identified by Q1 Action plan completed by Q3 SLM Improvement Plan signed off by July 2017	PP38: Delivery of response actions agreed in annual plan

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
			2. IT integration for community pharmacy and St John access to clinical workstations and primary care access to InterRai assessment data	2. Integration enabled by Q1	
			3. Evaluation of the Primary Options Programme under oversight of the Demand Management Group, commitment to actions identified through evaluation and reporting on actions each quarter	3. Evaluation by Q1, actions to commence in Q2	
			4. With a focus on as our priority group – Maori, carry out full implementation of the GP enrolment project in Waikato Hospital ED and the Hauora Hubs. This will enable referrals to a GP of choice for after hours care at no cost to the patient, and all patients will then be enrolled with a PHO if not already enrolled If successful, full rollout into other hospitals	4. Rolled out Waikato Hospital by Q2. If successful other hospitals rolled out Q4.	
			5. COPD new care model initiative in the community launched	5. Launched by Q3	
			6. Rural accelerated chest pain pathway trail rolled out	6. Rolled out by October 2017	
	Value and high performance	Safe, quality health services for all - Haumaru	The bulk of Waikato primary care integration activity is related to improving performance and health outcomes as reflected in meeting our SLM Improvement Milestones. See the System Level Measure Improvement Plan attached in appendix. All improvement initiatives within the system level measures support the focus within the pharmacy action plan and have been jointly developed, and agreed with Inter-alliance, and working groups		PP22:Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	One team	Productive partnerships - Whaneketanga	*Waikato DHB supports the focus within the pharmacy action plan and enhanced pharmacist services by:*		PP38: Delivery of response actions agreed in annual plan
			1. Development of an Access Sustainability Plan to ensure appropriate minimum coverage across the district	1. The Access Sustainability Plan is developed by Q1	
			2. Develop local pharmacy service enhancements which align with the Pharmacy Action Plan and the "Integrated Pharmacist Services in the Community" vision, to better meet local need, enhance healthcare and medicines management expertise delivered by pharmacists and support pharmacists to work as one team with primary care.	2. Progress update Q3	
			3. Identify opportunities for information enhanced integration across primary, secondary and pharmacy.	3. Use the findings to affect change by Q4	
			4. Analyse pharmaceutical access across locations and ethnicities (Ethnicity Outcomes Actions)	4. Analysis completed Q4	
Improving Quality	Value and high perfo	healt h servi ces for all	*Waikato DHB is committed to improving patient experience by:*	1. By Dec 2017 Board approval gained, initial	PP38: Delivery of response

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
			1. Developing and implementing a Waikato DHB consumer council to advise the DHB Board	hui and rural roadshows completed, chair and council recruited, TOR agreed	actions agreed in annual plan
			2. The communication and coordination categories has been selected to focus on from the inpatient survey, specifically around reducing harm from medicines. • Develop and implement quality improvement project targeting timely, informed discharge planning' to ensure patients aware of medications on discharge, and who to contact if any problems • Establish a medicines safety programme • Patient safety week (Oct) to support medicines safety • Improve discharge planning to include safe medication transfer	2. By September 2017 the medicine safety programme will be in place	
			3. Develop an end of life care framework for Waikato DHB • Roll out the advance care planning (ACP) process across district • Appropriate staff in PHO and acute sector trained at level 1, 1A and 2	3. By June 2018 30% of all patients admitted, have an ACP in place	
			4. Active participation in the development of a Midland Region Quality Network (MRQN) and supporting strategy with 2 focused work streams in place • Recognition and early action for deteriorating patient • Infection, prevention and control	4. June 2018 MRQN in place	
Living Within our Means	**Value and high performance**	**Effective and efficient care and services – Ratonga a iwi**	*Waikato DHB commits to manage our finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results by:* • Operating within agreed financial plans • Continue to participate in implementation of National Entity initiatives as appropriate for Waikato DHB • Proactively manage cost growth and improve use of workforce. • Provide information on the production plans and explain major variations in the yearly variations in the production schedule		Agreed financial templates.

Government Planning	Link to NZ	Link to WDHB – Strategic	Waikato DHB Key Response Actions to Deliver Improved Performance		
Delivery of Regional Service Plan	**NA.**		*Waikato DHB is undertaking to deliver on the Regional Service Plan priorities for the following areas:* **1. Cardiac Services** • Embed the use of the Cathlab forecasting and planning tool into business as usual. • Release Heart Failure clinical specialists to meet and inform the service design • Contribute to the atrial fibrillation stocktake to inform service design regionally • Provide data analysis using admissions data from Costpro in a similar methodology to the 16/17 Heart Failure analysis		NA.
			2. Stroke • Contribute, support and localise the implementation of a pathway of care for accessing thrombectomy services through Auckland District Health Board		
			3. Hepatitis C • Implement, support and utilise new regional Hepatitis C service		
			4. Major Trauma • Support timely trauma data entry, post verification activities and the development of a data platform • Support and carry out professional development of Trauma Service staff		

FINANCIAL PERFORMANCE SUMMARY

Unfortunately there was confusion around the funding that Waikato DHB received for 2017/18. In view of the need to work through these issues we will not be able to submit our budget by the due date.
We can assure you this is being given the appropriate attention and will contact you to provide updates around when the submission may be possible.

Local and Regional Enablers

Local and Regional Enabler	Link to NZ Health Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
IT	Smart system	*Waikato DHB is regionally aligned and leveraging digital hospital investment by:* 1. Virtual health care/telehealth/telemedicine: • Actively progressing the rollout of Telehealth solution, participation in Stroke Thrombolysis telehealth trial. • Virtual Health: Progressive rollout in accordance with multi-year programme of work	1.On-going	Quarterly reports from regional leads.
		2. eSpace: • Regional Midland Clinical Portal (MCP): Standardisation across region, EMRAM delivery. • eSPACE Programme is a 4 year Roadmap which is yet to have definitive milestones established and is dependent on processes to evaluate and set the priorities and affordability aspects. The Roadmap has been committed to by the 5 DHBs (at Board & CE level) and is as defined within the business case submitted to the ministry. Progression of the programme, inclusive of establishment of definitive milestones, is dependent on Ministry & Cabinet approval of the business case.	2. To be determined following approval of business case	
		3. Integration: • Implementation of solutions enabling integration between patient care partners. Focus includes; Indici, St John, Radiology providers, Community Pharmacy, LMC's, Lakes DHB. *Note: The DHB has a dependency on MoH to deliver access to NZePS data to enable realisation of our integration & medication management initiatives*	3. Integration completed for Primary Care (Indici), Community Pharmacy, LMCs, Lakes DHB, St John, Radiology by Q4	
		4. Patient Flow (iMPACT): • Significant investment to transition services from manual to automated toolsets to realise significant improvement in Patient flow (from presentation to discharge), integrated with Clinical Work Stations & Midland Clinical Portal	4. Commencing in Q4	
		5. Medication management: • ePA (eMeds): ePrescribing and Administration is within the scope of the regional eSpace strategy. The regional plan is that the regional requirements & competitive procurement process will be completed over the next 12 months (see regional ISSP). • eOrders: As requested DHB initiatives on hold to enable regional solutions to progress (see Regional ISSP) • *Note: The DHB has a dependency on MoH to deliver access to NZePS data to enable realisation of our integration & medication management initiatives*	5. see Regional ISSP (eSpace)	
		6. NCHIP (National Child Health Information Programme) • Roll out of enhancements	6. 2017/18: Enhancements out	
		7. Titanium: • Implemented solution for community oral health. Phase 2 to implement across Hospital Dental service.	7. 2017/18: In Hospital. Paper to electronic migration	

		8. Maternity: • Business Case approved, local team stood down due to national issues. Awaiting guidance from Ministry on likely timetable.	8. Investigate implementation viability	
		9. Bowel screening integration with Ministry of Health • The Midland region and each of the 5 DHBs continue to work towards the establishment of the bowel screening service in accordance with the evolving programme and plans being developed by the Ministry. Accordingly the Midland regional Business Case for the establishment of the Regional Centres (BSRC) has been submitted and reviewed by the Ministry. The Ministry have indicated that Waikato DHB is within tranche 2 (2018). We have provided a high-level indicative estimate of the likely budgetary costs for integration with the national solution. We await further information from the Ministry to commence planning & scoping to enable the development of the Waikato DHB Business Case.	9. Awaiting further information from the Ministry before milestones can be confirmed.	
Workforce	**One Team**	*Waikato DHB is committed to addressing capability and capacity with the following key actions and milestones*: 1. Support the regional review of current workforce data available and enhancement of modelling capacity	1. Review carried out Q3-4	
		2. Progress considerations with related government agencies and other DHBs in relation to a new medical school to support availability of a workforce with particular strengths in primary care and rural services	2. Q4	
		3. Work in conjunction with the broader primary care sector to identify options for addressing workforce gaps/improving access in rural communities.	3Q4	
		4. Expanded registered Health Practitioner roles being rolled out:- Increasing prescribers (pharmacists/ nurses) as well as nurse practitioners. - The launch of a rural nurse practitioner in Tokoroa in Gerontology spanning hospital, aged care and community settings.	4.Q4	
		5. Expanding unregulated but trained health workers ie navigators and dental assistants. Devolving dental therapist work to dental assistants with our training packages, protocols and standards. (Being picked up nationally as part of the reform of the oral health workforce).	5. Q4	
		6. The Smart Health pilot continues providing out of hours online doctor services to address the many communities that can't access appropriate out of hours medical care. Evaluate pilot.	6. Pilot evaluated by Q4	
		7. Identification of actions to regularise and improve the training of the Kaiawhina workforce in home and community support services particulaily around Health of Older People (EOA)	7. Actions identified by Q2	
		8. Continued roll out of Kia Ora Hauora to encourage and support Waikato Maori to pursue health professional careers within the health and disability sector (EOA)	8. Roll out complete December 2017	

		9. Te Puna Oranga, Wintec and Pinnacle PHO rolling out the first primary Maori health workforce care assistant pilot programme Kaimahi Maori. This programme aims to further upskill Maori community health workers in their support of general practice by helping apply positive change that is sustainable and achievable; not just in the short term but for lifelong behavioural commitment	9. Programme complete October 2017.	

SECTION 3: Service Configuration

Service Coverage

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

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

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

Waikato DHB is not seeking any changes to the formal exemptions to the Service Coverage Schedule in 2017/18.

Waikato DHB have highlighted concerns around service coverage and access to DSS inpatient and outpatient services for under 65 disability support services. These services are funded by the Ministry of Health at a significantly lower level than are being provided, which is not sustainable. In order to maintain equity of access with other districts increased funding will be required.

Midwifery coverage

Service Change

The table below describes all service reviews and service changes that have been approved or proposed for implementation in 2017/18.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Women's Health	Redevelopment of the Delivery Suite with respect to • Theatre capacity, • High Dependancy Unit • Induction of labour rooms. • Reconfiguration of women's health wards	Increased access to theatre for planned / elective caesarean section, resulting in an increase of quality and safety of care for women. Separation of gynaecology and antenatal care will improve the quality of care for patients, and will enable a more appropriate skill mix in both gynaecology and maternity care	Primarily local, although the increase capacity benefits the wider region
Rural Services	Ongoing implementation of the Rural Health Services review which includes potential service changes in any aspect of rural service delivery, including, but not limited to, the early priority areas of: • Rural primary maternity • Surgical termination of pregnancy • Child oral health (dentistry under GA) • Urgent care services (primary and secondary) • Virtual service delivery • Inpatient services • Community based (non-hospital) services • Rural laboratory services	Improved access, earlier intervention, better co-ordinated and integrated services	Local with some inter-DHB (sub-regional) aspects at the DHB boundaries; eg surgical Termination of Pregnancies.

	• Service changes associated with service redesign to support the development of integrated rural health and social services in Ruapehu, South Waikato, King Country, Thames& Coromandel, and North Waikato • Service changes to support enhanced workforce development in rural settings		
Mental Health and Addictions	**Mental Health and Addictions** Programme of work to develop new models of care and outcomes frameworks with significant engagement with the community in four areas: • Adult Mental Health • Adult Addictions • Child & Youth Mental Health • Mental health & Addiction Services for Older People Development work/consultation to be completed with implementation in 18/19.	Improved access, earlier intervention, better co-ordinated and integrated services	Local
Primary care integration	Detail to be formalised prior to final document Considerations are occurring in relation to strategies and mechanisms to increase clinical leadership, and integration across primary care and with secondary services. These considerations may lead to service change later in 2017/18 or outyears.	Increased integration between primary and secondary services Increased clinical leadership Enhanced sustainability of rural services	Local
Termination of pregnancy services	Regional considerations are occurring in relation to the location of services across the Waikato, Bay of Plenty and Lakes DHB districts	Improving accessibility and reducing travel requirements	Regional
SmartHealth	There will be no significant change of approach in relation to SmartHealth and the enhancement of virtual health services across the district. During 2017 there is however expected to continual growth and expansion across services areas to ensure that patients are supported virtually when appropriate for their care		

SECTION 4: Stewardship
(refer to Waikato DHB's 2016/17 Statement of Intent for more information)

This section provides an outline of the arrangements and systems that Waikato DHB has in place to manage our core functions and to deliver planned services. Greater detail is included in Waikato DHB's three-yearly Statement of Intent, which was last produced for the 2016/17 year and is available on our website at *www.waikatodhb.health.nz*

Managing our Business

Organisational performance management
Waikato DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at various level(s) of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

Table: External Reporting Framework

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

Funding and financial management
Waikato DHB's key financial indicators are Revenue, Net Surplus/Deficit, Fixed Assets, Net Assets and Liabilities. These are assessed against and reported through Waikato DHB's performance management process to stakeholders on a monthly basis. Further information about Waikato DHB's planned financial position for 2017/18 and out years is contained in the Financial Performance Summary section of this document on page 16, and in Appendix A: Statement of Performance Expectations on page 33.

Investment and asset management
Waikato DHBs has completed a stand-alone Long Term Investment Plan (LTIP) covering 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system.

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

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

Quality assurance and improvement
Waikato DHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. The DHB Board approved and published a quality governance strategy 'listen, learn, improve' in December 2016, with progress monitored by the Board of Clinical Governance.

Building Capability

Capital and infrastructure development
Business case expecting approval in 2017/18 includes the Tokoroa project.
Business cases due for completition in 2017/18 include the Adult Mental Health, Taumaranui and Education Centre projects.
Business cases that will be started in 17/18 include the Ward Block A project, multi level carpark and oncology/haematology project.
The Waikato University/Waikato DHB medical school is currently awaiting approval in concept, if approved design work and implementation will commence in 17/18.

Information technology and communications systems
Waikato DHB's information technology and communication systems goals align with the national and regional strategic direction for IT. Further detail about Waikato DHB's current IT initiatives is contained in the 2017/18 Midland Regional Service Plan, and in the section on local and regional enablers within this document, on page 17.

Workforce
Future workforce development - our people strategies – will see evolving alignment and integration with the Ministry of Health's New Zealand Health Strategy: Future Direction, and the Waikato DHB Strategy. Futher detail can be found in the section on local and regional enablers within this document, on page 18.
However in summary the key areas are:

- A strategic alliance of Waikato DHB with the University of Waikato has resulted in a proposed third Medical School for New Zealand to develop a new kind of rurally focused workforce. (business case currently with the Government)
- In addition to the plan to train doctors, our alliance with the University of Waikato has resulted in a Post Graduate Certificate in Management (Health Management and Leadership) programme. Management and leadership capability is a priority for the Waikato DHB, with the key requirement for first line managers to learn and assume the individual accountabilities of a front line position.
- Use of smart technologies has and will result in innovation and changes to the way we deliver care, and achieve sustainability, given aging population demands and fiscal constraints. SmartHealth – virtual patient care – includes all of the normal aspects of patient care without having in-person contact with the patient. Other technologies and innovation will require our workforce to adapt and change to new ways of working.
- Supporting the development of a culture of innovation is an intentional focus on the culture of our workplace; the environment our people work in. Investment is and will occur in making the workplace safer for staff, finding creative ways to address equity, living and embedding the values staff developed, and enabling ways that staff can speak up about matters that concern them. A culture that encourages ideas that can result in transformational innovation is required.

Co-operative developments
Waikato DHB works and collaborates with a number of external organisation and entities, including:

- Education,
- Corrections,
- Police,
- Child, Youth and Family,
- Local Government

SECTION 5: Performance Measures

The DHB non-financial monitoring framework aims to provide a rounded view of performance in key areas using a range of performance markers. The measures are intended to cover a specific set of markers of DHB performance in key areas, rather than all health services or DHB activity. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- achieving Government's priority goals/objectives and targets or 'Policy priorities'
- meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- providing quality services efficiently or 'Ownership'
- purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

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

Code Dimension
HS Health Strategy
PP Policy Priorities
SI System Integration
OP Outputs
OS Ownership
DV Developmental – Establishment of baseline (no target/performance expectation is set)
Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.

Performance measure	Performance expectation		
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes.		
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19		**17/18**
		Maori	4.41%
		Other	4.13%
		Total	4.23%
	Age 20-64	Maori	7.85%
		Other	3.86%
		Total	4.68%
	Age 65+	Maori	2.35%
		Other	2.00%
		Total	2.03%
PP7: Improving mental health services using wellness and transition (discharge) planning	95% of people have a transition plan at discharge		
	95% of those who have been in the service for a year or more will have a wellness plan		
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	80% of people seen within 3 weeks.		
	95% of people seen within 8 weeks.		
PP10: Oral Health- Mean DMFT score at Year 8	Year 1	Maori	0.92
		Other	0.92
		Total	0.92
	Year 2	Maori	0.92
		Other	0.92
		Total	0.92
PP11: Children caries-free at five years of age	Year 1	Maori	64%

		Other	64%
		Total	64%
	Year 2	Maori	64%
		Other	64%
		Total	64%
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	Year 1	Maori	85%
		Other	85%
		Total	85%
	Year 2	Maori	85%
		Other	85%
		Total	85%
PP13: Improving the number of children enrolled in DHB funded dental services (0-4 years)	Year 1	Maori	90%
		Other	90%
		Total	90%
	Year 2	Maori	95%
		Other	95%
		Total	95%
PP13: Improving the number of children enrolled in DHB funded dental services, (children not examined 0 – 12)	Year 1	Maori	≤10%
		Other	≤10%
		Total	≤10%
	Year 2	Maori	≤10%
		Other	≤10%
		Total	≤10%

PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)		
Focus Area 1: Long term conditions	Report on activities in the Annual Plan.	
Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.	
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).	
Focus Area 3: Cardiovascular health	90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.	
	Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years.	82% (providing a 50% impact on equity gap reduction)
Focus Area 4: Acute heart service	70% of high-risk patients receive an angiogram within 3 days of admission.	
	Over 95% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	
	Over 95% of patients undergoing cardiac surgery at the regional cardiac centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge.	
Focus Area 5: Stroke services	8% or more of potentially eligible stroke patients thrombolysed 24/7.	
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	
PP21: Immunisation coverage	At least 95% of two year olds fully immunised and coverage maintained	
	At least 95% of four year olds fully immunised by five years and coverage is maintained	
	75% of girls fully immunised – HPV vaccine	
	75% of 65+ year olds immunised – flu vaccine	
PP22: Delivery of actions to improve system integration including SLMs		Report on activities in the Annual

		Plan.
PP23: Implementing the Healthy Ageing Strategy		Report on activities in the Annual Plan.
Percentage of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.		95%
PP25: Prime Minister's youth mental health project	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.	
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).	
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.	
PP27: Supporting Vulnerable Children		Report on activities in the Annual Plan.
PP28: Reducing Rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever	
PP29: Improving waiting times for diagnostic services	90% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	
	90% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	
	85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.	
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.	
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.	
PP30: Faster cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	
PP32:Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).	
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.	
PP34: Improving the percentage of households who are smoke free at six weeks postnatal	TBC	
PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
PP37: Improving breastfeeding rates	60% of infants are exclusively or fully breastfed at three months	
PP38:Delivery of response actions agreed in annual plan	Report on activities in the Annual Plan.	
SI1: Ambulatory sensitive hospitalisations	0-4 years	See System Level Measure Improvement Plan included as Appendix B.
	46 – 64 years	
SI2: Delivery of Regional Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population.	
	Cataract procedures - a target intervention rate of 27 per 10,000 of population.	

	Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population.	
	Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population.	
	Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.	
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.	
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI10: Improving cervical screening coverage	80% coverage for all ethnic groups and overall.	
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall.	
OS3: Inpatient Average Length of Stay (LOS)	Elective LOS suggested target is 1.47 days, which represents the 75th centile of national performance.	TBC
	Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.	TBC
OS8: Reducing Acute Readmissions to Hospital	TBA – indicator definition currently under review.	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	Group A >2% and <= 4% Group B >1% and <=3% Group C >1.5% and <= 6%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% and <= 2%
	Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and <= 2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and <= 85%
	Invalid NHI data updates	TBA
Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	>= 97% and <99.5%
	National Collections File load Success	>= 98% and <99.5%
	Assessment of data reported to NMDS	>= 75%
	Timeliness of NNPAC data	>= 95% and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified about data quality audits.	
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	
DV4: Improving patient experience		No performance expectation/target set, remains under development
DV6: SLM youth access to and utilisation of youth appropriate health services		No performance expectation/target set, remains under development.
DV7: SLM number of babies who live in a smoke-free household at six weeks post natal		No performance expectation/target set, remains under development.

APPENDIX A: 2017/18 Statement of Performance Expectations including Financial Performance

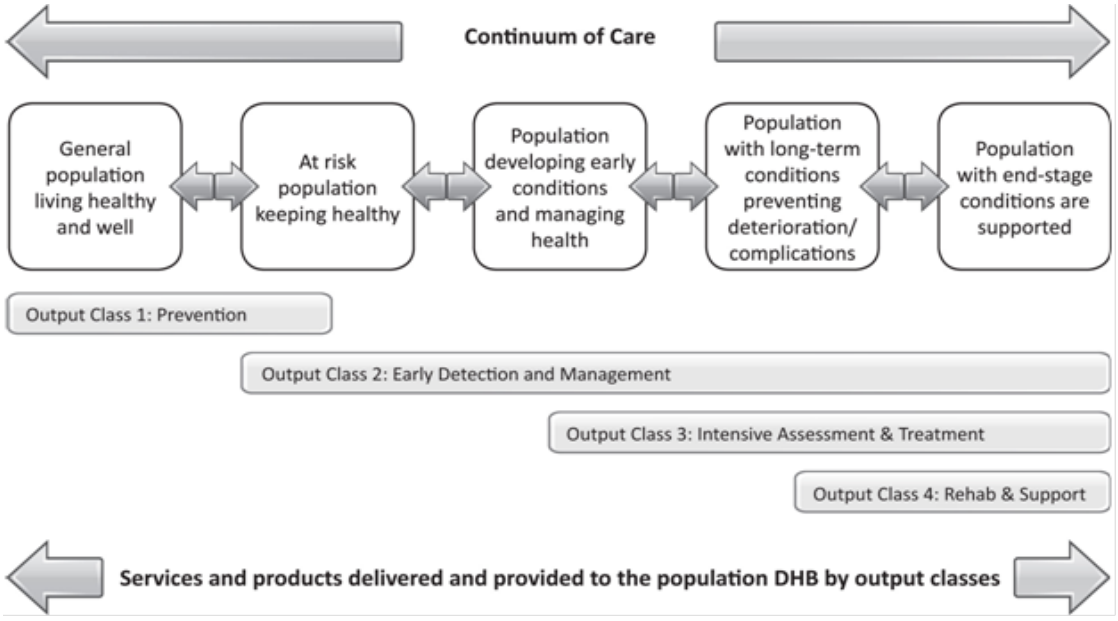
Statement of Performance Expectations

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2017/18. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the full range of outputs that we fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes (see modules 1 and 2). Where possible, we have included with each measure past performance as baseline data.

Activity not mentioned in this module will continue to be planned, funded and/or provided to a high standard. We do report quarterly to the Ministry of Health and / or our Board on our performance related to this activity.

Output classes

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of forecast service performance are also reflected in our financial measures. The four output classes that have been agreed nationally are described below. They represent a continuum of care, as follows:



Guide to reading the statement of service performance

The following points provided should be kept in mind when reading the rest of this module:

- Further detail of the performance story logic and rationale is contained in section
- In the performance measures table and where available the average column presents the national or regional average for the output performance measure
- Most measures have been adopted regionally
- Some measures fall across more than one impact. Where this is the case they have only been included once.
- Measurement type key: qn = Quantity, t = Timeliness, ql = Quality
- There are some services we provide that support the rest of the health system so we have included these in a "Support Services" section of our performance story
- Detailed information about the rationale for each output measure is provided in appendix
- Baseline data is taken from Quarter 4 results for 2015/16 unless otherwise stated
- Although targets are the same for all ethnicities, achievement is not. Areas where there is disparity are marked with a ??.

People are supported to take greater responsibility for their health

Long Term Impact	**People are supported to take greater responsibility for their health**		
Intermediate Impacts	**Fewer people smoke**	**Reduction in vaccine preventable diseases**	**Improving health behaviours**

Fewer People Smoke

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	1	qn		
Māori				95%
Non-Māori				95%
Total			94%	95%
Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care pratitioner in the last 15 months	1	qn		
Maori				TBC
Non Maori				TBC
Total			90%	90%
Percentage of pregnant women who identify as smokers upon registration with a DHB- employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	1	qn		
Māori				90%
Non-Māori				90%
Total			95%	90%

Reduction in Vaccine Preventable Diseases

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of eight month olds will have their primary course of immunisations (six weeks, three months and 5 months immunisation events) on time Māori Non-Māori Total	1	qn	 91%[1]	 95% 95% 95%
Percentage of two year olds are fully immunised and coverage is maintained Māori Non-Māori Total	1	qn	 90%	 95% 95% 95%
Percentage of eligible children fully immunised at 5 years of age Māori Non-Māori Total	1	qn	 90%	 95% 95% 95%
Percentage of girls: fully immunised HPV vaccine			 - -	 75% 75%

Improving Health Behaviours

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Exclusive or fully breastfed at lead maternity carer discharge (4 – 6 weeks) [i] Māori Non-Māori Total	1	Qn/T	 68%	 75% 75% 75%
Exclusive or fully breastfed at 3 months Māori Non-Māori Total	1	Qn/T	 54%	 60% 60% 60%
Receiving breastmilk at 6 months Māori Non-Māori Total	1	Qn/T	 61%	 65% 65% 65%
The number of people participating in Green Prescription programs Maori Non Maori Total	1	Qn	 5802	 TBC TBC TBC
Percentage of primary schools participating in Project Energize Kura Kaupapa Maori Total	1	Qn	 93.8% 98.8%	 93.8% 98.8%

[1] Baseline is the quarter to June 30, 2016.

People Stay Well in Their Homes and Communities

Long Term Impact	People stay well in their homes and communities			
Intermediate Impacts	An improvement in childhood oral health	Long-term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	More people maintain their functional independence

An Improvement in Childhood Oral Health [ii]

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of children (0-4) enrolled in DHB funded dental services Māori Non-Māori Total	2	Qn	 70%	 90% 90% 90%
Percentage of enrolled pre-school and primary school children (0-12) overdue their scheduled dental examination Māori Non-Māori Total	2	Qn/T	 14%	 Less than 7%
Percentage of adolescent utilisation of DHB funded dental services Māori Non-Māori Total	2	Qn	 70%	 85% 85% 85%

Long-Term Conditions are Detected Early and Managed Well

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of eligible population who have had their cardiovascular risk assessed in the last five years Māori Non-Māori Total	2	Qn	 90%	 90% 90% 90%
Percentage of women aged 25 – 69 years who have had a cervical screening event in the past 36 months Māori Non-Māori Total	2	Qn/T	 74%	 80% 80% 80%

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of eligible women aged 50 – 69 who have a Breast Screen Aotearoa mammogram every 2 years Māori Non-Māori Total	2	Qn/T	 68%	 70% 70% 70%

Fewer People are admitted to Hospital for Avoidable Conditions

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of eligible population who have had their before school check completed Māori Non-Māori Total	1	Qn/T	 90%	 90% 90% 90%
Acute rheumatic fever initial hospitalisation	2	Qn/T	74%	80% 80% 80%
Percentage of eligible women aged 50 – 69 who have a Breast Screen Aotearoa mammogram every 2 years Māori Non-Māori Total	2	Qn/T	 68%	 70% 70% 70%

More People Maintain their Functional Independence

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan Māori Non-Māori Total	4	Qn/T	 100%	 TBC
Percentage of people enrolled with a primary health organisation Māori Non-Māori Total	2	Qn/T	 95%	 TBC
Percentage of needs assessment and service coordination waiting times for new assessments within 20 working days Māori Non-Māori Total	4	Qn/T	 62%	 TBC

People Receive Timely and Appropriate Specialist Care

People Have Prompt and Appropriate Acute and Arranged Care

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Acute admission rate [iii] Māori Non-Māori Total	3	Q1	 10%	TBC
90% of patients to receive their first cncer treatment (or other management) within 62days of being referred with a high suspicion of cmncer and a need to be seen ithin 2 weeks Māori Non-Māori Total	3	Qn/T	 56%	TBC
Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries Māori Non-Māori Total	3	Qn	 10%	TBC

People Have Appropriate Access to Elective Services

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of patients waiting longer than four months for their first specialist assessment Māori Non-Māori Total	3	Qn/T	 0%	TBC
Improved access to elective surgery, health target, agreed discharge volumes Māori Non-Māori Total	3	Qn	 15,693	TBC
Did not attend percentage for outpatient services Māori Non-Māori Total	3	Qn/T	 10%	TBC
Elective surgical inpatient average legth of stay Acute inpatient average length of stay	3 3	Qn/T	 TBC	TBC

Improved Health Status for those with Severe Mental Illness and/or Addiction

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three or eight weeks Māori Non-Māori Total	3	Qn/T	75% 91%	3 weeks – 80% 8 weeks – 95%
Percentage of child and youth with a transitional (discharge) plan Māori Non-Māori Total	3	Qn	 98%	 95% 95% 95%
Average length of acute inpatient stay Māori Non-Māori Total	3	Qn/T/Ql	 14.41 days	TBC
Rates of post-discharge community care Māori Non-Māori Total	3	Qn/T/Ql	 87%	 TBC
Improving the health status of people with severe mental illness through improved access Māori Non-Māori Total	3	Qn	 TBC	 TBC

More People with End Stage Conditions are Supported Appropriately

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of aged residential care facilities utilising advance directives	3	Qn	100%	100%
Number of new patients seen by the Waikato Hospirtal palliative care services	3	Qn	652	TBC

Support services

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	3	Qn/T	94%	TBC

Outputs	Output Class	Measure Type	Baseline	Target 2017/18
Percentage of accepted referrals for CT scans, and percentage of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	2	T	CT – 90% MRI – 48%	TBC
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), and percentage within 30 days	2	T	Within 14 days – 78% Within 30 days – 94%	TBC
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 42 days, and percentage within 90 days	2	T	Within 42 days – 49% Within 90 days – 86%	TBC
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date, and percentage within 120 days	2	T	Within 84 days – tbc% Within 120 days – tbc%	TBC
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	2	Qn/T	100%	TBC
Pharmaceutical measure to be developed during 2017/18	2	TBC	TBC	TBC

Financial Performance

Unfortunately there was confusion around the funding that Waikato DHB received for 2017/18. In view of the need to work through these issues we will not be able to submit our budget by the due date.
We can assure you this is being given the appropriate attention and will contact you to provide updates around when the submission may be possible

APPENDIX B: System Level Measures Improvement Plan

(Placeholder for SLM Improvement Plan).

Extension in place until 14th July, work underway.

[i] Baseline for these measures is 1 January 2014 – 30 June 2014
[ii] Childhood oral health measures are for a calendar year
[iii] indicator definition currently under review

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 6.3

WAIKATO DHB DRAFT ANNUAL PLAN 2017/18 UPDATE

Purpose	To provide members with an update on the development of the annual plan.

Introduction
This paper follows on from the paper in the March 2017 agenda. It provides an update on the responses to the first round of Ministry of Health feedback received in May 2017.

Background
- The working draft Waikato DHB Annual Plan 2017/18 was included with the March 2017 Board agenda for review and feedback;
- The draft Waikato DHB Annual Plan 2017/18 was submitted to the Ministry of Health at the end of March 2017 incorporating the feedback in relation to showing the alignment with the areas within the Waikato DHB strategy;
- Provisional feedback (i.e. not complete and not all areas) from the Ministry of Health was received on the 10th of May;
- Updated planning guidance and the new Better Public Service (BPS) targets were received on the 12h of June and the due date for submission of Annual Plans was extended until the 30th of June 2017.
- The final funding envelope was received on the 16th of June. Because of the delays the Ministry advised the revised date for submission of annual plans was extended until the 14th of July.
- For the sections of the Annual Plan not approved/partially approved, feedback was sought as required and a rework carried out. Preapproval was then sought from the Ministry of Health and all have been preapproved excepting:
    - Improved Access to Elective Surgery health target
    - Living within our Means
    - Some performance measures
    - System Level Measure Improvement Plan (which is still awaiting sign-off from our alliance partners)
- The two new Better Public Service targets are also to be approved.

Discussion
The areas still requiring preapproval/feedback from the Ministry of Health are as follows at the time of writing.

Item	Rating in Ministry of Health feedback	Current update
Improved Access to Elective Surgery health target	Partially agreed - Thank you for your plan. All activities identified support the delivery of agreed service volumes, in a way that meets timeliness and prioritisation of electives services. We look forward to confirmation of your planned 2017/18 electives volumes once the Electives advice is provided.	Awaiting confirmation of our planned 2017/18 electives volumes at the time of writing
Living within our Means	Pending: This section of your plan will be reviewed once you have resubmitted your plan and financial templates following the announcement of the funding envelope as part of Budget 2017.	Presenting at June Board
Performance measures: PP6: Improving the health status of people with severe mental illness through improved access	Pending: TBC, awaiting assessment by the Ministry of Health	
PP34: Improving the percentage of households who are smoke free at six weeks postnatal	Pending: TBC by the Ministry of Health	
- SI4: Standardised Intervention Rates (SIRs)	Not agreed: A confirmed target needs to be included	Awaiting confirmation of target for 2017/18
OS3: Inpatient Average Length of Stay (LOS)	Not agreed: A confirmed target needs to be included	Awaiting confirmation of target for 2017/18
OS8: Reducing Acute Readmissions to Hospital	Pending: TBA – indicator definition currently under review.	

System Level Measure (SLM) Improvement Plan	Draft Improvement Plan sent for informal feedback. - Your Plan is clear, concise and well written. The background and contextual information provided is helpful. The system approach to the development of the Plan and focus on equity gaps is very good. We are also impressed with the level of clinical input. Of particular note are pages 12 - 14 describing your approach to Acute bed days which is excellent. We do have a few comments to be addressed in your next iteration: - Only require one improvement milestone per SLM - All signatures required ie DHB, PHO and any relevant stakeholders outside of DHB/PHO - Ambulatory Sensitive Hospitalization SLM : it is not clear how your activities are targeted to Maori and Pacific in order to reach the Maori/Pacific Improvement Milestone - Patient experience SLM - We recommend that you choose one as a Milestones, specifically the % of patients completing the PC Survey,	Requires feedback to all working groups Awaiting feedback from Inter-Alliance (due Friday 23rd) and Board.
(New BPS target) Healthy Mums and Babies	Please ensure commitment to supporting delivery of the interim target of 80% of pregnant women are registered with an LMC in the first trimester by 2019	Actions identified, requires preapproval
(New BPS target) Keeping Kids Healthy	Please ensure commitment to supporting delivery of the interim target of 15% reduction in hospital admission rates for children aged 0 – 12 years by 2019	Actions identified, requires preapproval

Recommendation
THAT
The report be received.

KATHRYN FROMONT
PLANNING MANAGER
STRATEGY AND FUNDING

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 6.4

MEMORANDUM OF UNDERSTANDING AND TERMS OF REFERENCE BETWEEN THE WAIKATO DHB AND IWI MAORI COUNCIL

Purpose	For consideration and approval.

The Memorandum of Understanding and Terms of Reference between the Waikato District Health Board and Iwi Maori Council (Iwi within its District) is attached for Board approval.

Recommendation
THAT
The Board approves the Memorandum of Understanding and Terms of Reference and that this document is submitted to the Iwi Maori Council to be signed off by the Signatories.

LORAINE ELLIOTT
EXECUTIVE DIRECTOR TE PUNA ORANGA

MEMORANDUM OF UNDERSTANDING BETWEEN THE WAIKATO DISTRICT HEALTH BOARD AND IWI WITHIN ITS DISTRICT

INTRODUCTION

1.0 The Parties

1.1 The Waikato District Health Board is a statutory corporation established under the New Zealand Public Health and Disability Act 2000.

1.2 **The Iwi** (Ngāti Maniapoto, Hauraki, Waikato-Tainui, Raukawa, Ngāti Tuwharetoa, Whanganui), **Te Rūnanga O Kirikiriroa** (organisation) and **Kaunihera** Kaumātua represent the interests of Māori within the area of the Waikato DHB.

2.0 Definitions

2.1 Board means the Waikato District Health Board.

2.2 The Iwi and Te Rūnanga O Kirikiriroa means Ngāti Maniapoto, Hauraki, Waikato-Tainui, Raukawa, Ngāti Tuwharetoa, Whanganui, and Te Rūnanga O Kirikiriroa, Kaunihera Kaumātua (Council of Māori Elders from within the area of the Waikato DHB).

2.3 Statutory committees mean committees as required under the Act and any other newly formed statutory committees.

2.4 Council means the Iwi Māori Council.

2.5 The Act means the New Zealand Public Health & Disability Act 2000.

2.6 The Provider-arm means services that are directly delivered by the DHB, these are not contracted services.

2.7 The Kaunihera Kaumātua representatives are the appointed Chair of the Waikato DHB Kaunihera Kaumātua and one other member of the Kaunihera

3.0 The Act

3.1 The Act provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

3.2 These mechanisms include:

- A prescribed function of establishing and maintaining processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement.

- A prescribed function of fostering the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori.
- Providing for Māori representation on the advisory committees required by the Act.

THE BOARD AND IWI MĀORI COUNCIL AGREE AS FOLLOWS:

4.0 The Values

4.1 People at heart – Te Iwi Ngākaunui
4.2 Give and earn respect – Whakamana
4.3 Listen to me – talk to me – Whakarongo
4.4 Fair play – Mauri Pai
4.5 Growing the good – Whakapakari
4.6 Stronger together - Kotahitanga

5.0 Relationship

5.1 Te Tiriti o Waitangi (The Treaty of Waitangi) shall guide the relationship between the Iwi Māori Council and the Waikato DHB Board. This relationship is founded on the principles of:

Partnership - working together with iwi, hapū, whānau and Māori communities to radically improve Māori health outcomes and reduce Māori health inequities, and to develop appropriate health and disability services.
Participation that requires Māori to be involved at all levels of the health and disability sector, including in decision-making and planning and development roles and the delivery of health and disability services.
Protection which requires the Government to safeguard Māori cultural concepts, values and practices, and to ensure that Māori have at least the same level of health as non-Māori.

5.2 That their relationship shall be built on good faith, honesty and integrity, shall be maintained in a spirit of commitment and cooperation and shall be recognised as developing over time on the basis of mutual trust.

5.3 That the cultural norms and values of the Waikato DHB on the one hand and the Iwi on the other shall be acknowledged, preserved and promoted in their relationship.

5.4 That Iwi, Te Rūnanga O Kirikiriroa are legitimate representatives of Mana whenua and maata waka and that Kaunihera Kaumātua are recognised as contributors to the maintenance and upkeep of tikanga and kawa within the district of the Waikato DHB and that the Waikato DHB is the body appointed to ensure the provision of health and disability services within its district.

5.5 That no party to this agreement shall take any action or participate in any activity that may adversely affect this Statement and associated documents, or any party to them.

5.6 To endeavour in good faith to meet the Board's obligations with respect to Māori under the New Zealand Public Health and Disability Act 2000.

5.7 To be committed to work collaboratively at a strategic level to achieve the goals pertaining to the impact of health and disability services on Māori.

5.8 To consider the appointment of representatives nominated by the Council to the statutory committees.

5.9 To acknowledge that consultation by the Board with the Iwi shall occur through the Council but without restricting the Council's right to suggest more extensive consultation with third parties.

6.0 Goals

6.1 The overarching goal of this collaborative relationship is to radically improve Māori health outcomes, and to reduce health inequities.

6.2 The Council and the Board will give effect to this overarching goal by jointly supporting the following Māori health strategic priorities:

- Radical improvement in Māori health outcomes by eliminating health inequities for Māori.
- Promoting the implementation of the philosophy of Whānau Ora.
- Radical improvement of mainstream responsiveness to Māori health needs.
- Ensure the growth of sustainable Kaupapa Māori health services.
- Remove barriers for Māori experiencing disabilities.
- To increase and build a sustainable Māori workforce to contribute to the delivery of excellent culturally appropriate services.
- To grow future Māori leadership in the Health and Disability Sector at governance, and service delivery levels.

7.0 Roles and Responsibilities

7.1 The Board and Council will work together on activities associated with planning of health services in the Waikato DHB district.

7.2 The Board and Council will take responsibility for the activities listed below.

7.2.1 The Board will:

(a) Involve the Council in matters relating to the development and planning of significant health initiatives in the Waikato DHB district.

(b) Involve the Council in decision making processes that may have a significant impact on Iwi Māori within the Waikato DHB district.

(c) Feedback information to the Council on significant matters that may impact on the health of Māori within the Waikato DHB district.

(d) Move towards ensuring every provider and employee who receives DHB funding will actively contribute to and be accountable for achieving radical improvements in Māori health outcomes, and eliminating Māori health inequities. These requirements will be stipulated in provider contracts and employee key performance indicators.

7.2.2 The Council will:

(a) Recognise the Board as the body appointed to ensure the provision of health and disability services and Māori representation under the Act.

(b) Acknowledge that consultation aligned to the Treaty of Waitangi, by the Board with the Iwi shall occur through the Council and that the Board shall be deemed to have discharged any obligation to bring matters to the attention of Iwi in requesting that such matters be placed on the agenda of the Council.

(c) Maintain a Council to undertake those responsibilities set out in the terms of reference.

(d) Operate the Council in accordance with the requirements set out in the terms of reference.

(e) Involve the Board in matters relating to the development and planning of Māori health.

(f) Ensure that the Board is informed of decisions that are made by the Council that may have an impact on the Board.

(g) Feedback information to hapū / iwi o Tainui, Tuwharetoa, Whanganui and maata waka on matters which may impact on the health of Māori living within the Waikato DHB district.

(h) Assist the Board, in conjunction with the Kaunihera Kaumatua, in any matters relating to Māori customs and Tikanga (rules of conduct).

(i) Nominate representatives for appointment to the statutory advisory committees be rotated every three years.

8.0 Ngā Hui / Joint Meetings

8.1 The parties will give effect to the Memorandum of Understanding through the following:

(a) At least 2 meetings per annum between the Board and IMC.

(b) The relationship between the Board and the Council will be reviewed by June of each year as an agenda item to either of the agreed meeting per annum.

(c) A relationship between the Council Chair, Deputy Chair and the Board Chair and Chief Executive Officer based on quarterly meetings between them.

(d) The Board Chair is expected to attend Iwi Māori Council meetings (where possible).

(e) The Chair of the Iwi Māori Council is able to attend Waikato DHB Board meetings as an ex-officio member.

8.2 All meetings shall observe the appropriate Tikanga and Kawa and be conducted according to the protocols and procedures of the host party.

8.3 When required, the parties may nominate and engage independent meeting facilitators selected by mutual agreement.

8.4 Written record of the resolutions of these meetings shall be kept and when required, circulated as an action list to each party's principal representative. Resolutions will be mutually agreed by both parties.

8.5 Subject to the provisions of the Official Information Act 1982, no record of these meetings shall be circulated beyond the representatives of the parties without prior approval of the respective principal representatives.

8.6 The parties shall provide secretarial services for meetings from their own resources as required.

8.7 Each party shall be entitled to adjourn meetings by simple verbal notification for the purpose of holding a "caucus" meeting, but no such adjournment shall exceed one hour.

AMENDMENT OF AND WITHDRAWAL FROM MEMORANDUM

9.0 Review of Memorandum

9.1 This Memorandum shall be amenable to amendment by agreement of all parties to it at the time amendment is proposed. Review should occur every three years from the date it is given effect.

9.2 The parties to this memorandum shall be free to withdraw from it upon giving three months' notice to the other parties.

10.0 Signatories

Waikato District Health Board

Maniapoto Māori Trust Board

Hauraki Māori Trust Board

Te Rūnanga O Kirikiriroa

Tuwharetoa Māori Trust Board

Waikato Tainui Te Whakakitenga o Waikato Inc

Raukawa Charitable Trust

Whanganui River Trust

Kaumātua Kaunihera Representative

Date:

TERMS OF REFERENCE OF THE IWI MĀORI COUNCIL

Purpose

The purpose of Iwi Māori Council in conjunction with Waikato DHB Board will provide strategic leadership and oversight on all matters pertaining to the impact of health and disability services on Māori. The Memorandum of Understanding between the Board and Iwi Māori Council articulates the intent and contribution of both parties.

Specific Responsibilities

- The Iwi Māori council membership: Iwi means Ngāti Maniapoto, Hauraki, Waikato-Tainui, Raukawa, Ngāti Tuwharetoa, Whanganui, and Te Rūnanga O Kirikiriroa (Maata Waaka) and the Kaunihera Kaumātua (Council of elders)

- So far as this is practicable, to affirm the Iwi Māori Council's position as a primary advocate for Māori at the strategic level in relation to the Board, and to do this by maintaining a strategic overview of the Board's activities and advising where these activities are not considered to reflect the interests of Māori

- To respond to the Board, either directly or following the completion of consultation undertaken by the Council itself, on all matters in respect of which the Board seeks advice collectively from Iwi, Te Rūnanga O Kirikiriroa and the Kaunihera Kaumātua.

- To rise with the Board at its own initiative any matters relating to the other specific responsibilities of the Council including the need to obtain further information as a prerequisite to effective decision making.

- To advise on an appropriate process of consultation where such consultation is proposed to extend beyond consultation with the Council itself.

- To maintain a strategic overview of the Board's programme in respect of identifying and addressing particular areas of concern in relation to Māori health.

- In relation to the responsibilities mentioned above, to maintain a strategic overview of, and provide comment on and input to the Board on its Strategic Plan, Annual Plan and Statement of Intent.

- To nominate persons to represent Māori on the statutory committees of the Waikato DHB.

- To actively participate in the induction and orientation of newly appointed Board and Iwi Māori Council members and the priority given to Māori health gain within the Waikato DHB district.

- To review from time to time in conjunction with the Board these Terms of Reference.

Operational requirements of the Iwi Māori Council

1) The Iwi Māori Council shall comprise two members from each of the Iwi, two representatives from the Kaunihera Kaumātua and two representatives from Te Rūnanga O Kirikiriroa.

2) The Iwi, Te Rūnanga O Kirikiriroa and the Kaunihera Kaumātua shall be free to appoint their respective members to the Iwi Māori Council as they see fit.

3) The Iwi, Te Rūnanga O Kirikiriroa and the Kaunihera Kaumātua shall advise the Board of their members appointed to the Iwi Māori Council and of any subsequent change to their members.

4) The Iwi, Te Rūnanga O Kirikiriroa and the Kaunihera Kaumātua may send a replacement(s) should their members on the Iwi Māori Council be unable to attend a meeting of the Council so long as the total number of attendees does not exceed two.

5) The Iwi Māori Council shall appoint a Chair from within its membership, by any manner deemed appropriate and utilise a rotational option of three years with a maximum of 6 years total or two terms maximum.

6) The Iwi Māori Council shall appoint a Deputy Chair from within its membership, by any manner deemed appropriate and utilise a rotational option of three years with a maximum of 6 years total or two terms maximum

7) The Iwi Māori Council shall not meet less frequently than once every three months and shall have a maximum of 10 paid meetings per annum except with the consent of the Board. This shall not, however, preclude the Council holding informal (that is unpaid and not reimbursed) meetings as often as it requires.

8) The members or replacements shall receive a fee for the attendance of their members at meetings of the Iwi Māori Council of $250 per meeting per person. This fee will be paid to the individual unless specified by their representing entity (in which case the fee will be paid directly to the representing entity).

9) The Chair shall receive an annual payment of $12,500.00 and the Deputy Chair shall receive an annual payment of $6,240, paid on a monthly basis.

10) Members of the Iwi Māori Council shall upon submission of a claim form be reimbursed for expenses incurred in attending meetings of the Iwi Māori Council at the same rate as Board members. Payment of any additional actual and reasonable expenses incurred by the Iwi Māori Council or its members e.g. training expenses shall be approved by the Chief Executive of the Waikato DHB.

11) The point of origin for determining the reimbursement of expenses shall be the member's normal residential address.

12) The Iwi Māori Council shall meet at a location determined by the Council within the district of the Board.

13) The Iwi Māori Council shall be serviced by Te Puna Oranga.

14) The Board will receive the minutes of the Iwi Māori Council.

15) The Iwi Māori Council shall set its own agendas. However, the Board through the Te Puna Oranga secretariat, request that specific items be considered by the Council.

16) For each of the statutory committees the Iwi Māori Council shall recommend one person (who may or may not be a member of the Council) to be a member. The term should not exceed three years.

17) The persons recommended by the Iwi Māori Council to the membership of the statutory committees shall be chosen having regard to the skills and expertise required by the committees as advised to the Iwi Māori Council by the Board at any time that a vacancy arises.

18) In making recommendations for the appointment of persons to the statutory committees, the Iwi Māori Council shall recognise that the Board has authority, in law, to determine who shall be appointed and cannot restrict its responsibility to do so in favour of another party.

19) Where a recommendation of the Iwi Māori Council is not appointed by the Board, the Council shall have the opportunity to make a further recommendation.

Constraints

The Council shall not concern itself with the following:

(1) Decisions of Waikato DHB, Māori providers and other private providers to the extent that such decisions concern business planning, the welfare of individual patients or groups of patients or operational management.

(2) Employment matters arising in relation to Waikato DHB, Māori providers and other private providers to the extent that such matters concern individual employees or positions. Except where a key management position for Te Puna Oranga is being considered.

Waikato District Health Board

Finance Monitoring

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 7.1

FINANCE REPORT

Purpose	For information.

The financial result summary is attached for the Board's review.

Recommendation
THAT
The report be received.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Result for May 2017	Year to Date			Budget
	Actual $m	Budget $m	Variance $m	Jun-17 $m
Funder	41.2	40.6	0.6 F	42.9
Governance	(0.3)	(0.3)	0.0 F	(0.3)
Provider	(39.4)	(31.9)	(7.5) U	(38.1)
DHB Surplus/(Deficit)	**1.5**	**8.4**	**(6.9) U**	**4.5**

Note: $ F = favourable variance; ($) U = unfavourable variance

FINANCIAL PERFORMANCE MONTHLY COMMENT:

This report includes commentary on current year to date performance compared to the year to date budget.

For May 2017 YTD we are unfavourable to budget by $6.9m. Unfavourable variance arises mainly from higher outsourced elective costs, nursing personnel annual leave costs and outsourced personnel costs.

Forecast:

The DHB has a budget for a surplus of $4.5m for the year.

We are forecasting a break-even for the year through June results and a range of year end adjustments.

There are a range of year end adjustments to be made - these may not land us on break-even, but we expect it to be close.	Neutral

Provider:

The Provider is unfavourable to budget for May 2017, variances include:

1. Revenue favourable to budget $7.3m mainly as a result of favourable IDF In and Sector Services revenue and unbudgeted NOS reimbursement. This offset by lower revenue as a result of under delivery of mainly orthopaedic volumes.
2. Employed personnel costs unfavourable to budget $5.7m, the dominant negative variance being within nursing.
3. Outsourced Personnel costs unfavourable to budget $13.3m, the dominant variances relate to medical locums ($4.8m), Nursing ($1.3m) and admin/management contractors for the National Oracle Solution (NOS) project ($6.7m) which has an offset in Other Revenue of ($3.6m).
4. Outsourced Services unfavourable to budget $5.1m mainly due to higher outsourcing of electives.
5. Clinical supplies unfavourable to budget $0.2m.
6. Infrastructure & Non Clinical supplies are favourable to budget $0.5m.
7. Interest, depreciation and capital charge favourable to budget $9.0m mainly due to decrease in capital charge rate, reduction in interest charge after debt/equity swap and favourable depreciation cost.

It should be noted that this is in the context of:

- Acute cases, excluding ED: episodes 3.2% above plan; case-weights 7.2% above plan
- Elective cases: episodes 11.3% below plan; case-weights 18.9% below plan
- Overall 0.8% below plan for cases and 1.0% below plan for case-weights
- ED attends: YTD ED attends are 3.6% higher than the same period last year.

Funder and Governance:

The result for the Funder is close to budget mainly due to favourable External Provider payment costs. Governance is on budget.

RECOMMENDATION(S):

That this report on May 2017 year to date result be received.

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$1.0 F**	Neutral
CFA Revenue		
Unfavourable to budget mainly due to: ● Reduction in revenue received relating to the change in rate for the capital charge $3.0m. This reduction is offset by a reduction in capital charge paid. ● In between travel wash up relating to 2016/17 $1.0m (offset by reduced cost in External Provider payments) and to 2015/16 $0.4m. ● Reduction in revenue as a result of debt to equity conversion $2.3m (offset in reduction of interest payable). Offset by favourable variances relating to: ● 15/16 elective surgery wash-up $1.5m received, ● additional funding received which is offset by cost in External Provider Payments: Palliative Care $0.8m Rheumatic fever $0.2m ● PHO Care Plus wash-up & VLCA $1.0m, ● other favourable variances $0.7m.	($2.5) U	Neutral
Crown Side-Arm Revenue		
Side-arm contracts revenue favourable due mainly to: ● Funds received for the 2015/16 Colonoscopy project $0.3m ● A contract variation on the main Public health contract $0.1m (offset by costs) ● Breast screening running ahead of contract volumes $0.2m ● Gynae colps catch up on contract volumes $0.2m (offset by costs)	$0.8 F	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is $1.7m favourable mainly due to: ● Reimbursement of costs associated with the implementation of NOS $3.6m favourable (offset in Outsourced Personnel), ● Catch up invoicing for outreach clinics at Bay of Plenty and Lakes DHBs $0.5m, ● Catch up invoicing to HWNZ $0.4m. ● Other favourable variances including haemophilia $0.5m. Offset by: ● ACC unfavourable $1.0m due to non acute rehab contract running lower than planned due to less discharges and the focus on Elective Service Performance Indicators meaning the elective surgical treatments contract patients are being delayed. ● Inter District Flows (IDF) in which is $2.3m unfavourable due to reduced IDF inflow when compared with Ministry of Health budget file.	$1.7 F	Neutral
Other Revenue		
Other revenue is favourable primarily due to higher sales in the Café than expected $0.8m and the favourable revenue washup from Urology Services Limited relating to 2015/16 of $0.2m.	$1.0 F	Favourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($7.9) U**	Unfavourable
Personnel (employees and outsourced personnel total)	**($19.0) U**	
Employed personnel are unfavourable to budget mainly due to:	($5.6) U	Unfavourable
• Medical costs are favourable by $1.3m. Senior Medical Officers (SMO's): SMO costs are $1.9m favourable mainly due to: - paid FTE costs favourable $2.3m arising from vacancies, - favourable course and conference costs which is as a result of reduced accrual for CME costs following SMO resignations $0.6m, - annual leave movement $0.8m unfavourable due to less leave earned offset by less leave taken, - professional membership fees $0.2m unfavourable. Resident Medical Officers (RMO's) RMO costs are $0.6m unfavourable due to vacancies offset by annual leave taken running lower than budgeted. The net direct financial YTD impact of the RMO strikes on personnel costs is currently: October 2016 / January 2017 SMO claims cover RMO shifts: $0.3m / $0.5m Savings on payments to RMO's: $0.1m / $0.2m Net impact: $0.2m / $0.3m The far greater cost of the strikes is the impact on volume delivery. • Nursing costs are unfavourable to budget by $6.3m. Paid FTE cost is $1.2m unfavourable due to budgeted vacancy savings not being achieved. In addition to this the annual leave movement is running $5.8m unfavourable. Course conference fees and payment on return from maternity leave are running favourable by $0.7m. • Allied Health costs are unfavourable to budget by $1.2m. Base costs are $0.5m favourable offset by unfavourable overtime $0.5m and penals $0.2m due to vacancies. In addition annual leave taken unfavourable to budget $1.0m. • Other favourable variances, largely in Management, Administration and Support $0.4m.		
Outsourced personnel are unfavourable mainly due to:		
• Higher than planned use of locums within medical personnel to cover vacancies $5.3m, • Nursing is $1.4m unfavourable due to external agency costs to fill roster gaps and watches.	($6.7) U	Unfavourable
• Higher than planned use of contractors in management/admin $6.7m primarily due to contractors working on the NOS implementation. Costs recovered in Other Government Revenue - $3.6m.	($6.7) U	Unfavourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**($5.1) U**	
Outsourced services are unfavourable primarily due to: ● Outsourced clinical service costs are unfavourable to budget $6.5m due to higher than planned outsourcing of electives and unmet savings. ● Off set by outsourced corporate services $1.4m favourable primarily due to reduced spend on Clinical Work Station - budget set on business case but expected spend has been revised and is lower due to reduced costs over the first months of the year. In addition the actual calculation of Health Share Limited (HSL) operating costs has come in lower than budget for the first half of the financial year.	($5.1) U	Unfavourable
Clinical Supplies	**($0.2) U**	
Instruments & equipment are $0.2m favourable primarily due to favourable service contract costs.	$0.2 F	Favourable
Implants & prosthesis are $2.9m favourable due to underspends on spinal plates and screws and implants and prosthesis due to a combination of outsourcing to private providers and lower than planned orthopaedic volumes.	$2.9 F	Neutral
Treatment disposables unfavourable due to savings allocation of $4.5m offset by favourable variances across a range of areas such as dressings, staples, tubes/drainage/suction, IV fluids and rebates.	($2.1) U	Unfavourable
Pharmaceuticals $1.0m unfavourable primarily due to cytotoxic drug costs running higher than budgeted. This in part due to the newly approved melanoma treatment. Movement in month due to partial payment of Hospital Pharmacy rebate $0.9m	($1.0) U	Unfavourable
Diagnostic Supplies & Other Clinical Supplies - close to budget.	($0.2) U	Unfavourable
Infrastructure and non-clinical supplies	**$0.5 F**	
Infrastructure and non-clinical supplies are $0.5m favourable primarily due to: ● IT costs $1.0m favourable due to favourable variances for mobile phones and software maintenance charges. The movement from an unfavourable April YTD variance to favourable in May is as a result of capitalisation of pooled assets largely in the virtual health area. ● Facilities favourable variance of $2.9m due to delayed start of maintenance programme and Hilda Ross House demolition ● hotel services costs are $0.8m favourable due to cleaning and laundry costs running lower than budgeted. Offset by: ● Savings allocation unfavourable by $2.3m, ● Cost of Goods Sold (COGS) is $1.9m unfavourable as a result of higher sales by Pharmacy on Meade resulting in higher cost of goods sold. Offset in Non Government Organisations (NGO) provider payments ($1.9m),	$0.5 F	Neutral

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$6.9 F**	
IDF out unfavourable by $2.2m due to increased outflow to Counties Manukau DHB due to timing of a GP practice PHO change not aligning with budget assumption. In addition, two high cost patients who have gone to Counties Manukau for treatment.	($2.2) U	Unfavourable
External Provider payments are favourable largely due to: ● a revised PHARMAC forecast $4.5m favourable. However this is offset in clinical supplies (Pharmaceutical costs - oncology drugs $0.8m) and Infrastructure costs (Retail Pharmacy COGS $1.9m). ● PHO Quality Indicator pool - prior year over accrual $0.6m, ● Dental FSS volumes favourable to budget $0.7m, ● Reduction in costs for in between travel (offset by reduced revenue) $0.7m, ● Post acute convalescent care $0.6m favourable as the cost is being reflected in Outsourced Services ($0.2m), ● Other favourable variances across MH, DSS FFS, Urology and residential care offset by unfavourable variances arising mainly from additional costs relating to additional funding (Healthy Homes Initiative, Palliative Care, Rheumatic Fever) $2.0m.	$9.1 F	Neutral
Interest, depreciation and capital charge	**$9.0 F**	
Interest charge favourable mainly due to interest costs on the Ministry of Health loan ceasing after the debt equity swap in March. Largely offset in CFA Revenue.	$2.7 F	Neutral
Capital charge is favourable to budget as a result of the reduction in the rate from 8% to 6%. Offset in CFA revenue.	$2.9 F	Neutral
Non Cash Depreciation favourable mainly due to: ● Timing of capitalisation of IS projects and slower than expected spend on Clinical Equipment.	$3.4 F	Favourable

TREASURY

Opinion on Result:	
Cash flows are favourable to budget	Favourable

YTD Actuals May-16 $'000	Waikato DHB Cash flows for year to May 2017	Year to Date Actual $'000	Year to Date Budget $'000	Year to Date Variance $'000	Budget Jun-17 $'000
	Cash flow from operating activities				
1,192,995	Operating inflows	1,229,839	1,241,907	(12,068)	1,355,379
(1,142,995)	Operating outflows	(1,184,158)	(1,174,372)	(9,786)	(1,296,243)
50,000	**Net cash from operating activities**	**45,681**	**67,535**	**(21,854)**	**59,136**
	Cash flow from investing activities				
1,559	Interest income and proceeds on disposal of assets	1,455	1,155	300	1,260
(16,770)	Purchase of assets	(25,874)	(62,337)	36,463	(68,003)
(15,211)	**Net cash from investing activities**	**(24,419)**	**(61,182)**	**36,763**	**(66,743)**
	Cash flow from financing activities				
1	Equity repayment	0	0	0	(2,194)
(8,713)	Interest Paid	(6,763)	(7,931)	1,168	(8,645)
(292)	Net change in loans	345	(194)	539	(198)
(9,003)	**Net cash from financing activities**	**(6,418)**	**(8,125)**	**1,707**	**(11,037)**
25,785	**Net increase/**(decrease) in cash	**14,844**	**(1,772)**	**16,616**	**(18,644)**
(8,948)	Opening cash balance	856	856	(0)	856
16,838	**Closing cash balance**	**15,700**	**(916)**	**16,616**	**(17,788)**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($21.8) U**	
• **Operating inflows**	**($12.1) U**	
Revenue received unfavourable primarily as a result of: - revenue reduction relating to the change in rate for the capital charge $3.0m, - reduction in CFA revenue relating to the debt equity swap $2.3m, - Interdistrict flows unfavourable by $2.3, - ACC revenue unfavourable $1.0m, - reduction in revenue relating to the unfavourable washup of In Between Travel $1.4m, - Increase in accrued debtors $11.1m arising mainly from a higher than budgeted balance owing by MoH $8m and accrual of DSS<65 contract which will be invoiced in June - $3m. Unfavourable inflow offset by: - Prior year elective funding washup received $1.5m, - Additional care and other initiatives funding $2.7m, - Reimbursement of costs associated with the implementation of NOS $3.6m, - Crown side arm revenue favourable $0.8m, - Other favourable variances $0.4m	($12.1) U	

Cash flow variances resulted from:	Variance $m	Impact on forecast
• **Operating outflows**	**($9.7) U**	
○ Personnel cost variances are unfavourable against budget due to the timing of fortnightly pay runs.	($0.1) U	
○ Operating cash outflows for non-payroll costs are unfavourable as a result of: - Higher prepayments than budgeted $1.4m primarily as a result of timing of payments for IS related costs, - the remaining unfavourable variance includes unfavourable P&L expenditure variances together with differences between timing of budgeted and actual payments.	($11.4) U	
○ GST cash movement is favourable due to timing variances on GST transacted.	$1.8 F	
Net cash flow from Investing Activities	**$36.8 F**	
○ Interest received is favourable due to slightly higher than expected funds with NZHPL.	$0.3 F	
○ Capital spend is slower than planned for the year to May - refer to capital expenditure report for further details.	$36.5 F	
Net cash flow from Financing Activities	**$1.7 F**	
○ Cash flow from financing activities is favourable mainly due to interest no longer being payable on the long term loan as a result of the debt equity swap.	$1.7 F	

The cash flow statement budget has been calculated on the same basis as the income statement budget. The main difference to actual cash transactions is that the cash flow budget nets off GST payments to the IRD against GST inputs and outputs.

The statement of cash flow (above) is based on the cash book values derived from the general ledger. The following forecast statement of cash flows is based on bank account balances.

WAIKATO DISTRICT HEALTH BOARD
CASHFLOW FORECAST (GST INCLUSIVE)

As at 31-May-17	May-17 Actual	Jun-17 Forecast	Jul-17 Forecast	Aug-17 Forecast	Sep-17 Forecast	Oct-17 Forecast	Nov-17 Forecast	Dec-17 Forecast	Jan-18 Forecast	Feb-18 Forecast	Mar-18 Forecast	Apr-18 Forecast	May-18 Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	7,396	4,300	5,240	4,564	4,228	4,448	4,452	4,116	4,340	4,116	4,340	4,116	4,564
Funder inflow (MoH, IDF, etc)	122,244	123,065	124,542	124,523	126,378	121,680	124,523	129,203	124,523	124,523	128,638	123,958	123,958
Donations and Bequests	0	0	0	0	0	0	0	0	0	115	0	0	0
Other Income (excluding interest)	2,333	2,415	2,415	2,645	2,415	2,530	2,530	2,400	2,415	2,070	2,415	2,185	2,645
Rents, ACC, & Sector Services	2,805	2,935	2,971	3,112	2,375	2,608	2,695	2,584	2,592	2,504	2,681	2,514	2,761
	134,777	132,716	135,168	134,844	135,396	131,266	134,200	138,304	133,870	133,328	138,074	132,773	133,928
Cash was applied to:													
Personnel Costs (incl PAYE)	(47,123)	(43,215)	(42,034)	(51,461)	(45,868)	(41,974)	(49,832)	(42,064)	(51,243)	(45,808)	(42,094)	(41,974)	(47,452)
Other Operating Costs	(25,151)	(29,900)	(34,760)	(34,200)	(34,900)	(33,900)	(34,100)	(27,160)	(28,300)	(28,100)	(35,700)	(30,700)	(30,000)
Funder outflow	(45,588)	(43,995)	(45,749)	(46,419)	(49,470)	(45,981)	(46,084)	(45,079)	(45,749)	(45,079)	(49,470)	(45,311)	(46,353)
Interest and Finance Costs	(5)	(6)	(6)	(6)	(6)	(6)	(6)	(21)	(6)	(6)	(6)	(31)	(6)
Capital Charge	0	(7,073)	0	0	0	0	0	(7,073)	0	0	0	0	0
GST Payments	(14,114)	(7,000)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(14,420)	(9,000)	(7,210)	0	(13,710)
	(131,982)	(131,189)	(129,759)	(139,296)	(137,454)	(129,071)	(137,232)	(121,397)	(139,718)	(127,993)	(134,480)	(118,016)	(137,521)
OPERATING ACTIVITES	**2,796**	**1,527**	**5,409**	**(4,451)**	**(2,058)**	**2,195**	**(3,032)**	**16,906**	**(5,848)**	**5,335**	**3,594**	**14,757**	**(3,593)**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	42	75	75	75	75	75	75	75	75	75	75	75	75
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
	42	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(6,180)	(4,600)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)
Investment in NZHPL (Finance project)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(6,180)	(4,600)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)
INVESTING ACTIVITIES	**(6,137)**	**(4,525)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from NZHPL	110,652	5,192	0	7,903	5,482	1,230	6,483	0	9,273	0	0	0	7,044
MoH loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	110,652	5,192	0	7,903	5,482	1,230	6,483	0	9,273	0	0	0	7,044
Cash was applied to:													
Capital Repayment	0	(2,194)	0	0	0	0	0	0	0	0	0	0	0
Transfer to NZHPL	(107,284)	0	(1,984)	0	0	0	0	(13,481)	0	(1,884)	(169)	(11,332)	0
MoH loan repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)
	0	0	0	0	0	0	0	0	0	0	0	0	0
	(107,310)	(2,194)	(1,984)	(26)	0	0	(26)	(13,481)	0	(1,910)	(169)	(11,332)	(26)
FINANCING ACTIVITIES	3,342	2,998	(1,984)	7,877	5,482	1,230	6,457	(13,481)	9,273	(1,910)	(169)	(11,332)	7,018
Opening cash balance	0	0	0	0	0	(0)	(0)	(0)	0	0	0	0	0
Overall increase/(decrease) in cash	0	(0)	(0)	0	(0)	(0)	0	0	(0)	(0)	0	0	(0)
CLOSING CASH BALANCE	0	0	0	0	(0)	(0)	(0)	0	0	0	0	0	0
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	0	(0)	(0)	(0)	0	0	0	0	0	0
Funder Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Investment funds/(loan)													
NZ Health Partnerships Ltd (NZHPL)	15,649	10,456	12,440	4,537	(945)	(2,176)	(8,659)	4,822	(4,450)	(2,566)	(2,398)	8,935	1,891
Long-term Loans													
Ministry of Health	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA Loan	(273)	(273)	(273)	(247)	(247)	(247)	(221)	(221)	(221)	(195)	(195)	(195)	(169)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	15,376	10,184	12,167	4,291	(1,192)	(2,422)	(8,880)	4,602	(4,671)	(2,761)	(2,592)	8,740	1,722
LOANS AVAILABLE													
MoH loans	0	0	0	0	0	0	0	0	0	0	0	0	0
Working capital facility (NZHPL)	(64,367)	(64,367)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(64,367)	(64,367)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)

BALANCE SHEET

Opinion on Result:	
There are no material concerns on the balance sheet and all performance indicators are within acceptable tolerances.	On Target

Prior Year May-16 $'000	Waikato DHB Financial Position	As at May 2017 Actual $'000	Budget $'000	Variance $'000	Budget Jun-17 $'000
49,321	Total current assets	81,009	49,313	31,696 F	50,193
(154,967)	Total current liabilities	(176,005)	(169,728)	(6,277) U	(198,229)
(105,647)	**Net working capital**	**(94,996)**	**(120,415)**	**25,419 F**	**(148,036)**
568,417	Term assets	558,429	591,511	(33,082) U	611,664
(227,011)	Term liabilities	(14,569)	(226,912)	212,343 F	(226,771)
341,406	**Net term assets**	**543,860**	**364,599**	**179,261 F**	**384,893**
235,759	**Net assets employed**	**448,864**	**244,184**	**204,680 F**	**236,857**
235,759	**Total Equity**	**448,864**	**244,184**	**204,680 F**	**236,857**

Prior Year May-16 $'000	Waikato DHB Ratios	As at May 2017 Actual $'000	Budget $'000	Achieved	Trend	Budget Jun-17 $'000
54,575	Borrowing facilities available at month end	64,198	63,266	✓	⇔	46,394
0.9	Debt to Equity ratio	0.0	0.9	✓	⇩	1.0
0.5	Debt to Debt + Equity	0.3	0.6	✓	⇩	0.6
0.3	Current ratio	0.5	0.3	✓	⇔	0.3
38.2%	Equity to total assets	70.2%	38.1%	✓	⇧	35.8%
-6.5%	Return on equity	0.3%	3.4%	✓	⇩	1.9%
3.43	Interest covered ratio	8.93	7.45	✓	⇧	6.96

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital		
Net working capital is favourable against budget mainly due to: Current Assets: - Cash held with New Zealand Health Partnerships Limited is higher than planned by $15.7m, mainly due to lower than budgeted capital spend, - Prepayments are higher than planned by $1.4m due to the timing of annual IS spend, - Total accounts receivable and accrued debtors is higher than planned by $14.2m largely due to the accrual timing of cash received compared to budget assumptions. - Other favourable variances $0.4m	**$31.7 F**	

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital (continued)		
Current Liabilities: - Payroll liabilities are $7m unfavourable to budget mainly due to the timing of pay runs and IRD payments resulting in higher month end accruals, - Bank overdraft liability $0.9m favourable to budget as bank was not overdrawn. Budgeted overdraft based on high capital spend which has not eventuated. - Other unfavourable variances $0.2m	**($6.3) U**	
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $36.5m and favourable YTD depreciation $3.4m. Please see attached for latest forecast of capital spend for the year for further detail.	**($33.1) U**	
Non Current Liabilities:		
Favourable variance mainly due to the unbudgeted Debt to Equity swap for MOH loans which was transacted in February 2017.	**$212.3 F**	
Equity		
Variance mainly due to : - Debt to Equity swap for MOH loans transacted February 2017 - $211.6m - Unfavourable variance in overall result against budget $6.9m	**$204.7 F**	
The MoH debt to equity swap also resulted in the movement in financial ratios relating to return on equity and equity to total assets: Equity to Total Assets: Budgeted 38.1%, Actual 70.2% Return on Equity: Budgeted 3.4%, Actual 0.3%		

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

	CAPITAL PLANS				CASHFLOW FORECAST					FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 31 May-17 (M)	Planned Expenditure from 1st Jun 17 to 30 Jun-17 (N)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
Total Under $50K Projects:	2,300		-	2,300	-	2,300	2,192	108	-	2,300	0
CLINICAL EQUIPMENT				-							
SUB TOTAL CLINICAL	12,455	27,393	1,136	40,984	2,031	7,724	7,540	184	30,774	40,529	455
INFORMATION SYSTEMS											
SUB TOTAL INFORMATION SYSTEMS	28,788	38,198	3,316	70,302	6,880	10,648	8,192	2,456	51,161	68,688	1,614
PROPERTY & INFRASTRUCTURE - PLANT											
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	1,493	4,601	-	6,094	1,180	1,325	893	433	3,580	6,085	9
PROPERTY PROJECT SERVICES											0
SUB TOTAL PROPERTY PROJECT SERVICES	21,188	8,370	-175	29,383	10,173	5,424	4,765	658	13,769	29,366	18
VEHICLES											0
SUB TOTAL VEHICLES	950	700	47	1,697	235	3	3	-	1,450	1,688	9
STRATEGIC PROJECT OFFICE											0
SUB TOTAL STRATEGIC PROJECTS	25,077	60,992	0	86,069	0	85	25	60	85,833	85,918	151
CORPORATE											0
SUB TOTAL CORPORATE PROJECTS	8,000	800	-791	8,009	1	1,667	367	1,300	6,467	8,135	-126
MOH Projects (funded externally)						-					
SUB TOTAL MOH PROJECTS	426	-	-	426	197	216	213	3	55	469	43
Trust Funded Projects (funded externally)						-					0
SUB TOTAL TRUST FUNDED PROJECTS	-		577	577	333	332	332	-	-	666	(89)
TOTAL CAPITAL EXPENDITURE						29,724	24,522	5,202	193,088	243,843	1,998
				-				-		0	0
CAPITALISED COMPLETED PROJECTS	4,981		275	5,256	4,297	1,538	1,538			5,835	(580)
REPORT TOTALS	105,658	141,054	4,385	251,097	25,328	31,262	26,060	5,202	193,088	249,678	1,418

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

CAPITAL PLANS					CASHFLOW FORECAST					FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 31 May-17 (M)	Planned Expenditure from 1st Jun 17 to 30 Jun-17 (N)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
Total Under $50K Projects:	**2,300**		-	**2,300**	-	**2,300**	**2,192**	**108**	-	**2,300**	**0**
CLINICAL EQUIPMENT				-							
Urology - Equipment	-	300	-	300	-	-	-	-	200	200	100
Heart Lung machines - Cardiac surgery	-	680	-	680	-	-	-	-	680	680	0
Heater Cooler units	-	156	-	156	-	159	159	-		159	(3)
Echo vivid - Cardiology - portable	-	400	-	400	-	-	-	-	400	400	0
Trans-Oesophageal Echo (Toe)		329		329	-	-	-	-	250	250	79
Cardiac output machines (critical care) EV1000	90	-		90		-	-	-	90	90	0
Radiation Dispenser manual - Oncology	-	90	-	90	-	-	-	-	90	90	0
Supra laser - Opthalmology	-	170	-58	112	-	-	-	-	112	112	0
Retinal Camera Head	-	-	58	58		58	58	-	-	58	(0)
Ultrasound Replacement (Endoscope, Operating Table & EMG System)	-	100	-	100	-	83	83	-	17	100	0
Cytogenics Incubators NICU	25	-	-	25	-	-	-	-		0	25
Endoscopy scope cleaning equipment	-	174		174	-	193	193	-	-	193	(19)
Endoscopes 16/17		1,040	-604	436	-	-	-	-	436	436	0
Endoscopy scope replacement			604	604	-	604	604	-		604	0
Ultrasound scanner replacement		175		175	-	10	10	-	165	175	0
Theatre Instruments	300	-	-	300	-	-	-	-	150	150	150
Transeosophageal Echo machine (Philips IE33)	-	226		226	-	-	-	-	226	226	0
Equipment and Supply Washer	50	-	-	50	-	-	-	-	50	50	0
Washer/Disinfector (Thames)	125	-	-92	33	-	-	-	-		0	33
Washer Decontaminator for Thames Sterile Services	-	-	92	92	-	85	85	-	7	92	0
Il Machine (Thames)	120	-	-	120	-	-	-	-	120	120	0
Transport Monitors (Critical Care)	75	-	-	75	-	-	-	-	75	75	0
Endoscope Camera (Thames)	103	-	-	103	-	42	42	-	61	103	(0)
ENT Zeiss S21 (Theatres)	50	50	-	100	-	-	-	-	50	50	50
X-ray Specimen (Theatres) Faxitron	85	-	-	85	-	89	89	-	-	89	(4)
Gynae Urodynamics	55	-	-	55	-	-	-	-	55	55	0
GP Pumps (Biomed)	450	-	-	450		-	-	-	450	450	0
Bed Replacement Programme	800	-	-330	470		-	-	-	470	470	0
Bed Replacement	-	-	330	330		354	354	-		354	(24)
Gamma Camera (Nuclear Med Imaging Scanner)	1,200	-	-	1,200	-	880	880	-	320	1,200	(0)
Home Haemo Dialysis Replacement 16/17	-	62	-	62		-	-	-	62	62	0
Haematology Main Analyser (to be approved for hA negotiationing for all hospital	715	-	-	715	-	519	519		-	519	196
Bio Chemistry Lab - Mass Spectrometer	500	-	-	500	-	-	-	-	500	500	0
Linear Accelerator (approved by BRRG Nov-15)	4,000	-	-	4,000	2,031	2,191	2,191	-	-	4,222	(222)
-Rapid ARC Licences (Oncology)	123	-	-	123	-	-	-	-	123	123	0
PCA Pumps (Biomed)	500	-	-	500	-	-	-	-	500	500	0
Treon Plus Stealth station OE9823	-	450		450		-	-	-	450	450	0
Haemodialysis (Incentre)	650	-	-	650	-	-	-	-	527	527	123
Eyese Heidelberg - Theatres	200			200		-	-	-	200	200	0
CT Replacement - Thames (to be approved)	1,500	-	-	1,500	-	-	-	-	1,500	1,500	0
Non-Invasive Ventilator	-	-	-	-	-	-	-	-	-	0	0
Oversize Operating theatre table RX500	-	83	-	83	-	-	-	-	83	83	0
Bipap Respironics (CCD x 4) - Respiratory	-	120	-	120	-	-	-	-	120	120	0
Bronchosopes (CCD x $) - Respiratory	-	70	-	70	-	61	61	-	9	70	(0)
Scopes - eBus - Respiratory	-	120	-	120	-	-	-	-	120	120	0
Trolley Washer - SSU	-	276	-	276	-	-	-	-	276	276	0
Telemetry	-	800	-	800	-	-	-	-	800	800	0
Cordless Driver (incl wore collect) - Theatres	-	69	-	69	-	-	-	-	69	69	0
IMM4 Anaesthethic Monitoring system	-	114	-	114	-	-	-	-	114	114	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No1	-	93		93	-	-	-	-	93	93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No2	-	93		93	-	-	-	-	93	93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No3	-	93		93	-	-	-	-	93	93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No4	-	93		93	-	-	-	-	93	93	0

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

CAPITAL PLANS					CASHFLOW FORECAST					FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 31 May-17 (M)	Planned Expenditure from 1st Jun 17 to 30 Jun-17 (N)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No5	-	93		93	-	-	-	-	93	93	0
MONITOR IMM4 FM FLEXIBLE MONITOR & LIC E13191	-	60	-	60	-	-	-	-	60	60	0
Replacement of Task Operating Theatre Lighting in OT7 & OT8	-	-	70	70	-	71	71	-	-	71	(1)
Replacement of Task Operating Theatre Lighting in OT 9 - 12	-	-	140	140	-	140	140	-	-	140	(0)
Orthopeadic Cordless Driver 4300 sets x 7	-	141	-	141	-	-	-	-	141	141	0
Orthopeadic system - 6 rotary sets x 2	-	63	-	63	-	-	-	-	63	63	0
System 6 dual Trigger Rotary Hand Piece	-	65	-	65	-	-	-	-	65	65	0
System 6 Sag Saw	-	65	-	65	-	-	-	-	65	65	0
Ultrasound - diagnostic E14773	-	224	-	224	-	-	-	-	224	224	0
Cardotokograph	-	510	-	510	-	-	-	-	510	510	0
Colposcope	-	66	-	66	-	-	-	-	22	22	44
Dinamap	-	150	-	150	-	-	-	-	60	60	90
Echocadiograph (Wakids)	-	272	-	272	-	-	-	-	272	272	0
Foetal heart detector	-	100	-	100	-	-	-	-	100	100	0
Foetal monitor, CTG	170	-	-	170	-	-	-	-	170	170	0
Humidifier	-	150	-	150	-	-	-	-	150	150	0
Infusion pumps (Thames)	-	408	-	408	-	-	-	-	408	408	0
Intellivue physiologic monitor	-	352	-	352	-	-	-	-	352	352	0
Immunology - Molecular Micro Array	50	-	-	50		-	-	-	-	0	50
Monitor cardiac , multi parameter	-	320	-	320	-	-	-	-	320	320	0
Scanner, ultrasonic	-	300	-	300	-	-	-	-	300	300	0
Scanner, ultrasonic ob/gyn	-	320	-	320	-	-	-	-	320	320	0
Warmer, radiant, infant IW930	-	72	-	72	-	-	-	-	72	72	0
Cathlabs	-	2,500	-	2,500	-	-	-	-	2,500	2,500	0
Incubator	400	1,440	-	1,840	-	-	-	-	1,840	1,840	0
Haematology Flow Cytometry Robotics system	-	200	-	200	-	-	-	-	200	200	0
Histology Pathvision Radiographic system	-	400	-	400	-	-	-	-	400	400	0
Building Refurnishment - free up space	-	77		77		-	-	-	77	77	0
Biochemistry LC Tandom Mass Spectrometer	-	500	-	500	-	-	-	-	500	500	0
Cytogenetics Digital Imaging system	-	800		800		16	16		784	800	0
Scanner 3D Cone Beam (maxFac)	-	150	-	150	-	-	-	-	150	150	0
Med - Dispense Units	-	900	-	900	-	-	-	-	900	900	0
Licensing (breast screening)	-	52	-	52	-	-	-	-	52	52	0
CT Scanner	-	5,200	-	5,200	-	-	-	-	5,200	5,200	0
Digital Mobile X - ray	-	1,500	-470	1,030	-	-	-	-	1,030	1,030	0
Fluro Room units	-	750	-619	131	-	-	-	-	131	131	0
Combi Diagnost Fluoroscopy Unit			619	619	-	184	-	184	435	619	0
Mobile Image Intensifier - Waikato	-	1,500	-550	950	-	-	-	-	950	950	0
X-ray machines and Image Intensifiers	-	-	1,020	1,020	-	1,020	1,020	-	-	1,020	0
Ultrasound (medical Photography / imaging)	-	200	-	200	-	-	-	-	200	200	0
Infusion pumps (Thames)	-	67	-	67	-	-	-	-	67	67	0
Steriliser Autoclave (Thames)	-	200	-	200	-	-	-	-	200	200	0
Blood gas analysers	-	800	-50	750	-	-	-	-	750	750	0
Blood Gas Analyser - Critical Care			50	50		-	-		50	50	0
Echo Ultrasound Machine Replacement				-		-	-			0	0
Kay Pentax Stroboscopy System			100	100		-	-		100	100	0
Stryker Lease Agreement			600	600		600	600			600	(0)
GE Logiq - 9 Vascular Ultrasound	-	-	-	-	-	138	138	-	-	138	(138)
CEP - Pool - 2016/17	119			119	-	-	-		192	192	(73)
Clinical - Pooled Items			226	226		226	226			226	0

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

Activity	CAPITAL PLANS: Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	CASHFLOW FORECAST: Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 31 May-17 (M)	Planned Expenditure from 1st Jun 17 to 30 Jun-17 (N)	Forecast Subsequent Years (P)	FULL PROJECT FORECAST: Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
SUB TOTAL CLINICAL	**12,455**	**27,393**	**1,136**	**40,984**	**2,031**	**7,724**	**7,540**	**184**	**30,774**	**40,529**	**455**
INFORMATION SYSTEMS											
PLATFORM						-	-	-			
ISSP - Decommission Galen 15/16	300	-	15	315	53	68	59	9	-	121	194
ISSP - Decommission Galen 16/17	-	251	-	251		-	-	-	159	159	92
ISSP - File Server -(profile , home drive, appv)rearchitecture	-	150	-	150	-	-	-	-	150	150	0
NIPS - Local Capacity Augments	-	700	-	700	-	-	-	-	700	700	0
ISSP - Lifecycle - Infrastructure Application Workplan 16/17	-	1,000	-	1,000	-	75	64	11	924	999	1
ISSP - Lifecycle - Infrastrucure 15/16	300		-	300	232	67	67	0	-	299	1
ISSP - Clinical and Corporate Platform		500		500		-	-	-	500	500	0
ISSP - Clinical and corporate Platform SQL Server consolidation	475		-	475	99	94	84	10	170	363	112
ISSP - Disaster Recovery Solution 15_16	1,150		-	1,150	2	59	47	12	1,062	1,124	26
ISSP - Backup Capacity Augment	200		-	200	0	50	46	4	150	200	(0)
ISSP - Contingency (IS)	100		-64	36	-	-	-	-	-	0	36
ISSP - Windows Server Migration 2003-2008 (DIA)	491		-221	270	-	-	-	-	270	270	0
STORAGE & REPORTING						-	-	-			0
ISSP - Clinical PhotographyImage Management	-	300	-	300	-	-	-	-	300	300	0
ISSP - DataWarehouse Phase 2 - after 16/17	-	400	-200	200	-	-	-	-	200	200	0
ISSP - Enterprise Reporting Content remediation -after 16/17	-	250	-250	-	-	-	-	-	-	0	0
ISSP - Enterprise Reporting 16-17			250	250	-	1	1		200	201	49
ISSP - Data Analyst Toolset Implementation (16/17)	-	700	-350	350	-	-	-	-	350	350	0
ISSP - Enterprise Business Intelligence Tool			350	350	-	88	88	-	262	350	0
ISSP - Lifecycle - Sharepoint Workplan (e.g. replace fileshares, online sharepoint)		1,100	-200	900	-	-	-	-	900	900	0
ISSP - San Controller		322		322	-	-	-	-	322	322	0
ISSP - SharePoint (Doc Management Pilot)	700		-	700	230	2	2	-	453	685	15
ISSP - Data Warehouse Upgrade	400		-	400	175	82	75	7	142	399	1
ISSP - Data Warehouse Phase 2 15_16			200	200	-	9	9	-	191	200	0
ISSP - Business Intelligence Data and Reporting 16_17						-	-		-	0	0
ISSP- Phlebotomy Bedside Labelling Discovery						-	-		-	0	0
NETWORK & COMMUNICATIONS				-		-	-	-			
ISSP - Paging System Replacement	-	350	-	350	-	57	35	22	294	351	(1)
ISSP - Unified Comms Phase 4 (16/17)	-	174	-112	62	-	-	-	-	62	62	0
ISSP - Jabber Instant Messaging and Guest			201	201	-	57	51	6	151	208	(7)
ISSP - Lifecycle - 1-2 Communication Tools Workplan	-	400	-	400	-	29	23	7	370	400	0
ISSP - WiFi Rollout	-	1,000	-	1,000	-	381	375	6	619	1,000	(0)
ISSP - Network Remediation Work Package 2015/2016	400			400	262	0	0	-	138	400	(0)
ISSP - Network Remediation Lifecycle Work Plan 16/17	300			300	-	237	237	-	80	317	(17)
ISSP - Comms Rooms remediation 2015/2016	230		-	230	44	36	36	-	150	230	(0)
ISSP - Unified Comms Phase 4	147		-	147	35	61	61	-	-	96	51
ISSP - Hylafax replacement	96			96	-	17	12	5	79	95	0
ISSP - IaaS Implementation						-	-			0	0
DEVICES				-		-	-	-		0	0
ISSP - Telehealth- replacement schedule	-	1,800	-	1,800	-	-	-	-	1,800	1,800	0
ISSP - Telehealth- Expansion		200	-27	173	-	-	-	-	173	173	0
ISSP - Southern Rural Outpatient Video Units			27	27		27	25	2	-	27	0
ISSP - Tablets to enable mobile workforce	-	500	-	500	-	-	-	-	500	500	0
ISSP - Touch screens	-	300	-	300	-	-	-	-	300	300	0
ISSP - Desktop - increase coverage		200		200		-	-	-	200	200	0
ISSP - Desktop upgrade from windows 7 to windows 10		2,000		2,000		-	-	-	2,000	2,000	0
ISSP - Desktop environment replacement >$2k	100		-	100	-	-	-	-	100	100	0
ISSP - Mobile device management	90		-54	36	-	-	-	-	36	36	0
ISSP - iPads / Phones for Smart Health	745		293	1,038		1,038	1,038		-	1,038	(0)
ISSP - iPads / Phones / Desktops - Pooled items			1,176	1,176		1,176	1,176		-	1,176	0
ISSP - Hardware Solution - Medication Room	20		-	20	-	9	9	-	-	9	11
ENTERPRISE SERVICE BUSINESS / RULES ENGINE				-		-	-	-			
ISSP - Clinical Business Rules	-	250	-	250	-	-	-	-	250	250	0

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

CAPITAL PLANS					CASHFLOW FORECAST					FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 31 May-17 (M)	Planned Expenditure from 1st Jun 17 to 30 Jun-17 (N)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
ISSP - Web Applications -S_Web_Services Infra_Mess Standards	-	500	-	500	-	-	-	-	500	500	0
ISSP - Web Applications -S_Web_Services Infra_Solution Select_Impl	-	500	-	500	-	-	-	-	500	500	0
TOOLS				-		-	-	-			
ISSP - PVS Citrix	39	-	-	39	-	15	15	-	-	15	24
ISSP - Citrix Sharefile	150	150	-150	150	98	51	51	-	-	149	1
ISSP - Archiving Tool	-	380	-	380	4	9	9	-	348	361	19
ISSP - TQUAL Reporting	50	50	-	100	1	34	27	7	20	55	45
ISSP - Toolsets (after 16/17 refer to Lifecycle plan line items)		452		452		-	-	-	452	452	0
ISSP - Toolsets (IS Toolsets 15/16)	563		-	563	178	273	269	4	111	562	1
ISSP - Toolsets (14/15)	130		-	130	72	40	40	-	15	128	2
ISSP - Citrix Netscaler10.5 upgrade	-	150	-	150	-	-	-	-	-	0	150
ISSP - Rapid Logon	-	700	-	700	-	5	5	-	700	705	(5)
ISSP - e2e Clinical Docs		499		499		-	-	-	499	499	0
ISSP - EMRAM compliance to lvl 6 - upgrade / implementation	-	700	-	700	-	-	-	-	700	700	0
ISSP - Lifecycle integration Tools workplan - Rhapsody etc	-	1,000	-	1,000	-	-	-	-	1,000	1,000	0
ISSP - Anivirus / Malware - Toolset upgrade / replacement	-	150	-	150	-	-	-	-	150	150	0
ISSP - Lifecycle - Desktop Workplan (Outlook, Flexplus, etc)	-	1,200	-292	908	-	-	-	-	908	908	0
ISSP - Desktop Work Plan 16/17	-	-	292	292	-	0	0		292	292	(0)
ISSP - Lifecycle - Development tools (Visual studio, Kendo etc)	-	200	-	200	-	-	-	-	200	200	0
ISSP - Team foundation Server - Source Code management	-	250	-250	-	-	-	-		-	0	0
ISSP - SahrePoint Work Pan 16-17	-	-	450	450	-	2	2	-	450	452	(2)
ISSP - LIS Reporting Development	200		-	200	83	50	44	6	67	199	1
SECURITY				-		-	-	-		0	0
ISSP - Perimeter Redesign		598	-262	336		-	-	-	336	336	0
ISSP - Perimeter Remediation Work Plan 16/17			173	173	-	2	2	-	171	173	0
ISSP - Lifecycle - 1-2 Security tools Workplan (cardex, etc)		600	-	600	-	-	-	-	600	600	0
ISSP - Perimeter Redesign	150		-	150	33	49	49	-	-	81	69
ISSP - Security Defence in depth	500		-122	378	29	49	39	10	299	377	1
LICENSING				-		-	-	-		0	0
ISSP - MS Licensing True-Up (16/17)	300		-	300	-	-	-	-	300	300	0
ISSP - Other Licensing True-Up (16/17)	300		-29	271	-	-	-	-	271	271	0
ISSP - Other True-Up Winscribe	-	-	29	29	-	23	23	-	6	29	0
ISSP - Other Licensing True-Up	300		-251	49	49	16	16	-	-	65	(16)
ISSP - MS Licensing True-Up	300		-124	176	129	-	-	-	35	164	12
CLINICAL SYSTEMS						-	-	-		0	0
ISSP - Lifecycle: LIS Workplan	150		-79	71		-	-	-	71	71	0
ISSP - Healthviews DC Uploader replacement		150	-150	-		-	-	-		0	0
ISSP - Clinical Workstation Core Component Workplan	-	-	480	480		209	208	1	270	479	1
ISSP - NCAMP. 3M, MKR	250	250	-250	250	78	102	94	8	70	249	1
ISSP - NCAMP 2017			250	250	-	26	13	13	224	250	0
ISSP - Workflow eData	250	-	-	250	3	126	126	-	121	250	(0)
ISSP - Workflow eData		2,100		2,100	-	-	-	-	2,100	2,100	0
ISSP - Database Replacements		300	-	300	2	43	25	18	254	299	1
ISSP - Oral Health system		1,000	-	1,000	165	601	601		234	999	1
ISSP - eTasks	-	230	-	230	-	27	2	25	204	230	(0)
ISSP - Cardiac Dendrite Phase 3	200	200	-116	284	-	-	-	-	284	284	0
ISSP - Surgical Services Audit Systems			116	116	-	60	42	19	56	116	0
ISSP - eProgesa replacement impacts - NZ Blood Service	-	150	-	150	-	-	-	-	-	0	150
ISSP - Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense		250	-150	100		-	-	-	80	80	20
ISSP - LIS Drop 8			150	150	-	1	1	-	150	151	(1)
ISSP - Life cycle - cat 1-2 Medical Records Workplan (eg Kofax)	-	600	-	600	-	-	-	-	600	600	0
ISSP - Life cycle - cat 1-5 In house Apps Workplan(eg Whitboards)	-	1,400	-350	1,050	-	-	-	-	1,050	1,050	0
ISSP - Cat1-5 In-House Developed Applications Work Plan	-	-	350	350	-	116	111	5	234	350	(0)
ISSP - Life cycle - cat 2 Clinical Apps Workplan(eg NHI Gateway)	-	600	-150	450	-	-	-	-	450	450	0
ISSP - Cat 2 Off-the-shelf Applications Work Plan	-	-	150	150	-	23	15	8	127	150	0
ISSP - Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	-	1,400	-	1,400	-	78	78	-	1,320	1,398	2
ISSP - Life cycle - CWS / Healthviews Workplan	-	1,000	-654	346	-	-	-	-	346	346	(0)

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

CAPITAL PLANS					CASHFLOW FORECAST					FULL PROJECT FORECAST	
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ISSP - Software Upgrades (Apps Lifecycle 15/16)	250		-	250	149	83	77	6	17	250	0
ISSP - Master Data Implementation- after 16/17	-	100	-	100	-	-	-	-	100	100	0
ISSP - Laboratory Information Systems June 2016 GA upgrade	-	400	-	400	-	-	-	-	400	400	0
ISSP - Lab Analysers	-	600	-	600	-	-	-	-	600	600	0
ISSP - HealthViews - External eReferrals	-	300	-	300	-	8	8	-	216	224	76
ISSP - Clinical workstations - Document Tree search	-	100	79	179	-	4	4	-	196	200	(21)
ISSP - Access to community pharmacy	-	100	-100	-	-	-	-	-	-	0	0
ISSP - Data collection	-	100	-	100	-	-	-	-	50	50	50
ISSP - Procedure based Booking / Scheduling	-	1,250	-	1,250	-	-	-	-	1,250	1,250	0
ISSP - Structured programme - scanned history	-	200	-	200	-	-	-	-	200	200	0
ISSP - Cardiology - Xcelera to ISCV	-	100	-	100	-	-	-	-	-	0	100
ISSP - ipm upgrade to V10 - after 16/17	-	450	-	450	-	203	198	6	246	450	0
ISSP - SSU re-engineering	-	666	-	666	-	-	-	-	666	666	0
ISSP - eCWB Infrastructure	-	739	-	739	-	-	-	-	739	739	0
ISSP - Maternity (CleverMed)	760		-	760	12	-	-	-	740	752	8
ISSP - HealthViews access to Primary Encounters (GP to Workstations)	300		-	300	69	221	218	3	10	300	(0)
ISSP - LIS Print solution	80		-	80	-	-	-	-	80	80	0
ISSP - HealthViews Internal eReferrals	300		-300	-	-	-	-	-	-	0	0
ISSP - Internal eReferrals			499	499	-	107	99	8	397	504	(5)
ISSP - eOrders	350		-	350	3	0	0	-	347	350	(0)
ISSP - Radiology - PACS/RIS Upgrade 16/17	500	200	-	700	-	-	-	-	653	653	47
ISSP - RIS Upgrade (Project split) (PACS Upgrade 15)	223		-	223	93	84	76	8	51	228	(5)
ISSP - RIS Upgrade 2016	124		-	124	1	38	26	12	84	123	1
ISSP - Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense	250		-	250	-	-	-	-	150	150	100
ISSP - Laboratory Phlebotomy (Te Kuiti)	40		-	40		-	-	-	40	40	0
ISSP - HealthViews - e2e Clinical Documents	350		-	350	53	431	431	-	-	484	(134)
ISSP - Clinical Workstation Metadata Scoping			50	50	1	7	7	-	42	50	(0)
ISSP - Speech Recognition			100	100	1	0	0	-	99	101	(1)
ISSP - Clinical Workflow Integration Work Plan			430	430	-	50	45	5	379	429	1
ISSP - Provation Host Tairawhiti	27		-	27	-	-	-	-	27	27	0
ISSP - Waikato Hauora iHub	-	-	-	-		12	12	-		12	(12)
ISSP - e-Discharge Summaries	100		-100	-	-	-	-	-	-	0	0
CORPORATE SYSTEMS & PROCESSES				-		-	-	-		0	0
ISSP - Smarthealth - System implementation costs			500	500		500	-	500		500	0
SmartHealth Capital Items - software (labour costs)			470	470		470	470			470	(0)
ISSP - Costpro Upgrade		103		103		-	-	-	103	103	0
ISSP - Costpro Upgrade	400		-	400	238	1	1	-	161	400	(0)
ISSP - HRIS Lifecycle Upgrade 15_16		400	-	400	4	50	43	7	346	400	0
ISSP - Lifecycle HRIS / Peoplesoft Workplan		950	-200	750	-	-	-	-	750	750	0
ISSP - HRIS PeopleSoft WorkPlan AWE Calculation Pay Rules			200	200	-	-	-	-	200	200	0
ISSP - HRIS Self Service implementation - payroll improvement	400	-	1,200	1,600	-	1,600	-	1,600		1,600	0
ISSP - Attendants System - enhancements or replacement	-	100	-	100	-	-	-	-	100	100	0
ISSP - Hockin Conversion	21		-	21	12	9	4	5	-	21	0
REGIONAL						-	-	-		0	0
RSSP - Regional Netscaler Reconfiguration	-	33	-	33	-	-	-	-	33	33	0
RSSP - Regioanl Microsoft Reporting Services	-	225	-	225	-	-	-	-	225	225	0
RSSP - SEEMAIL	-	26	-14	12	-	-	-	-	12	12	0
RISSP - HSL - File sharing technology	42			42	-	-	-	-	42	42	0
RISSP - HSL - ANZAC - Q1	40		-	40	-	-	-	-	40	40	0
RISSP - HSL - Core Intrastructure	644			644	-	-	-	-	644	644	0
RISSP - HSL - Enhanced Identity Management	46		-	46	-	-	-	-	46	46	0
RISSP - HSL - Enhanced Regional Integration	502		-	502	-	-	-	-	502	502	0
RISSP - Risk Management Solution (Regional)	369		-	369	306	-	-		63	369	0
MRISSP - Pharmacy System Phase II – Implementation	2,462		-	2,462	2,356	-	-			2,356	106
RISSP - Clinical Workstation - Phase II (License)	500	500	-	1,000	500	500	500	-	-	1,000	0
ISSP - Netscaler Infrastructure			343	343	1	272	249	23	69	342	1
eSPACE							-			0	0

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

CAPITAL PLANS					CASHFLOW FORECAST					FULL PROJECT FORECAST	
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RISSP - HSL - e Space Clinical Workstation	7,831		-	7,831	-	-	-	-	7,831	7,831	0
OTHER PROJECTS				-		-	-	-		0	0
ISSP - Clinical whiteboard - eCWB Infrastructure	442		-	442	128	99	99	-	-	227	215
ISSP - Portfolio Resource Management Upgrade	130		-	130	85	10	10	-	-	95	35
ISSP - Printer Architecture Upgrade	130		-	130	9	21	8	13	99	129	1
ISSP - Application Lifecycle 2014/15 WorkPlan	470			470	454	4	4	-	-	458	12
ISSP - Baseline - Infrastructure Lifecycle Management	465		-	465	318	60	30	30	91	469	(4)
ISSP - Windows 10 COE (Part deduction see below for balance of deduction	45		-	45	27	18	18	-	-	45	0
ISSP - Cobas IT 1000	120		-	120	2	1	1	-	117	120	0
ISSP - Spark Consultancy Services			64	64	-	37	28	9	27	64	(0)
SUB TOTAL INFORMATION SYSTEMS	**28,788**	**38,198**	**3,316**	**70,302**	**6,880**	**10,648**	**8,192**	**2,456**	**51,161**	**68,688**	**1,614**
PROPERTY & INFRASTRUCTURE - PLANT											
Waikato Waiora Chillers	643		-	643	626	2	2	-	-	628	15
Waikato Distribution Board stuff 11/12	250		-	250	196	54	16	38	-	250	0
Waikato Switchboards - Menzies,Kemp,Waiora & ERB	-	600	-	600	-	-	-	-	600	600	0
Theatre - Air conditioning upgrades	-	400	-250	150	-	-	-	-	150	150	0
Kempthorne Plantroom Upgrade	-	-	250	250	-	252	241	11	-	252	(2)
Thames - Air conditioning inpatient unit upgrade	-	200	-	200	-	-	-	-	200	200	0
Carpark Lighting - Upgrade	-	50	-	50	-	50	37	13	-	50	(0)
HV System - upgrade- SCADA to BMS	-	160	-	160	-	-	-	-	160	160	0
Ward 32 - Air conditioning	-	45	-	45	-	-	-	-	45	45	0
Hockin sewage system	-	65	-20	45	-	-	-	-	45	45	0
Hockin Sewer Pumping Stations and Heating Controls	-	-	20	20	-	20	18	2	-	20	0
Marsh Insurance Items	-	150	-	150	-	-	-	-	150	150	0
Mothercraft Fire Panel - upgrade	-	20	-	20	-	-	-	-	20	20	0
NICU ERM's to 4 x 4 upgrade	-	36	-18	18	-	-	-	-	18	18	0
Extension to Current ERM Manifolds for NICU	-	-	18	18	-	18	-	18	-	18	0
Tunnel lighting	-	30	-	30	-	-	-	-	30	30	0
Maternity Refurb / Electrical	-	44	-	44	-	-	-	-	44	44	0
EWIS communications solution	-	170	-	170	-	-	-	-	170	170	0
Lift car upgrades	-	72	-	72	-	-	-	-	72	72	0
ERB chilled water buffer tank installation	-	20	-	20	-	-	-	-	20	20	0
ERB Fire panel upgrade	-	200	-	200	-	-	-	-	200	200	0
Menzies Fire panel upgrade	-	200	-	200	-	-	-	-	200	200	0
Avigilon DVR's in all building x9	-	117	-	117	-	32	32	-	84	116	1
Carpark CCTV	-	300	-87	213	-	-	-	-	213	213	0
Pembroke Street Car Park CCTV			87	87		87	-	87	-	87	
Convert CCTV from analogue to IP	-	60	-	60	-	-	-	-	60	60	0
Develop Web based payment for Multicash	-	150	-48	102	-	-	-	-	102	102	(0)
Change Readers X 125	-	60	-	60	-	27	27	-	33	60	(0)
Gallagher door controllers - upgrade to 6000 model	-	300	-	300	-	100	90	10	200	300	(0)
Virtual controller for Monitoring stations	-	80	-	80	-	-	-	-	80	80	0
Intercoms at all barrier arms	-	110	-	110	-	-	-	-	110	110	0
CCTV for Hockin building	-	80	-54	26	-	-	-	-	26	26	0
CCTV Installations	-	-	54	54		51	51	-	3	54	(0)
Master key - Waikato buildings (2 x bldgs)	-	112	-	112	-	-	-	-	112	112	0
Ward - standard install	-	120	48	168	-	-	-	-	168	168	0
Monitoring centre (setup, 24/7 manning)	-	50	-	50	-	-	-	-	50	50	0
Infrastructure Replacement Pool (15/16)	600			600	358	314	314	-		672	(72)
Infrastructure Replacement Pool (16/17)		600		600	-	318	64	254	215	533	67
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	**1,493**	**4,601**	**-**	**6,094**	**1,180**	**1,325**	**893**	**433**	**3,580**	**6,085**	**9**
PROPERTY PROJECT SERVICES											0
Priority Roading Works		565		565	-	-	-	-	565	565	0
MCC - Edge roof protection		30		30	-	-	-	-	30	30	0
OPRS - Roof access		30		30	-	-	-	-	30	30	0
ERB improvements (counter cold & wind)		150		150		-	-	-	150	150	0
Greening Programme	875	-	-280	595		-	-	-	595	595	0

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

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Concept Design- Oncology/Haematology Facility	300	-	-	300	62	43	43		194	299	1
Virtual Care Office	46	-		46	57	35	35	-		92	(46)
Boiler House Upgrade	1,833	-	-	1,833	1,833	33	33	-		1,866	(33)
Hilda Ross - Remediation	3,403	-	280	3,683	-	1,549	1,449	100	2,135	3,684	(1)
Lift Upgrade	1,835	-	-	1,835	1,610	235	235	-		1,845	(10)
Electrical Systems Improvement	6,889	-	-175	6,714	5,789	164	164	-	781	6,734	(20)
Consolidation of CBD facilities	-	5,557	-	5,557	-	1,388	1,121	267	4,169	5,557	0
Office Relocations	2,000	-	-95	1,905	-	-	-	-	1,905	1,905	0
Hockin - Open planning/ Modernisation of Level 3 Executive Wing			95	95	-	119	119	-		119	(24)
Seismic Remediation	3,207	-		3,207	123	1,357	1,257	100	1,745	3,225	(18)
Internal Reconfiguration - Gallaghers	-	863	-	863	-	146	-	146	645	791	72
Internal Reconfiguration - Room Pressure	-	210	-	210	-	210	191	19		210	0
Internal Reconfiguration - Pain Clinic - L3 Menzies	-	100	-	100	-	-	-	-	100	100	0
Internal Reconfiguration - Coffee outlet L1 MCC	-	75	-	75	-	-	-	-	75	75	0
Internal Reconfiguration - Refurb - Waiora L2	-	200	-	200	-	-	-	-	200	200	0
Outdoor staff facility- Rest & Recovery off red Corridor	-	100	-	100	-	-	-	-	100	100	0
Ward Block A & environs	-	300	-	300	-	-	-	-	300	300	0
Landscape Ward Block A		50		50	-	-	-	-	50	50	0
Tokoroa / Te kuiti / Rhoda Road / Matariki Refurb	-	140	-140	-	-	-	-	-	-	0	0
Combining Matariki and Princess Street Bases			140	140	-	140	114	26		140	0
Legacy SCR - Still Required - decanting	800		-	800	700	4	4	-	-	704	96
SUB TOTAL PROPERTY PROJECT SERVICES	**21,188**	**8,370**	**-175**	**29,383**	**10,173**	**5,424**	**4,765**	**658**	**13,769**	**29,366**	**18**
VEHICLES											0
Vision Hearing Truck (Moblie Ear Clinic)	**200**		47	247	235	3	3	-	-	238	9
Mobile Dental Unit Replacements level 1		700		700		-	-	-	700	700	0
Mobile Dental Unit Replacements level 2	**750**		-	750	-	-	-	-	750	750	0
SUB TOTAL VEHICLES	**950**	**700**	**47**	**1,697**	**235**	**3**	**3**	**-**	**1,450**	**1,688**	**9**
STRATEGIC PROJECT OFFICE											0
Education; Research and supporting amenities	25,000	-		25,000		-	-	-	25000	25,000	0
Mental Health Facility - scoping	77	-	-	77	-	77	17	60	-	77	0
Mental Health Facility	-	60,992	-	60,992	-	-	-	-	60,833	60,833	159
Gallagher Building - Med Store & CSES Clinic				-		-	-			0	0
Gallagher Building - Racking System				-		-	-			0	0
Gallagher Building - Converyor System				-		-	-			0	0
Clinical Skills, Simulation and Research Centre						8	8			8	(8)
SUB TOTAL STRATEGIC PROJECTS	**25,077**	**60,992**	**0**	**86,069**	**0**	**85**	**25**	**60**	**85,833**	**85,918**	**151**
CORPORATE											0
COS - Contingency (was CFO)	1,000		-592	408	-	-	-	-	408	408	0
Catalyst Initiatives	2,500		-574	1,926	-	-	-	-	1,826	1,826	100
Service & Capacity Planning Tool			98	98	-	-	-	-	98	98	0
BPAC eReferral Phase 2			247	247	-	-	-	-	247	247	0
Production & Meal ordering S/W	-	300	-	300	-	-	-	-	300	300	0
Positive NPV Projects	1,000		-	1,000	-	-	-	-	1,000	1,000	0
Oracle - Mop ups and Budgeting solution	-	500	-	500	-	-	-	-	500	500	0
Taleo - Transition module			30	30	-	24	24	-	6	30	(0)
Project Elevate-Upgrade to NOS			118	118	1	227	227			227	(109)
Audio Visual Equipment						116	116	-	-	116	(116)
Transition to National Oracle System	3,500		-118	3,382	-	1,300	-	1,300	2,082	3,382	0
SUB TOTAL CORPORATE PROJECTS	**8,000**	**800**	**-791**	**8,009**	**1**	**1,667**	**367**	**1,300**	**6,467**	**8,135**	**-126**
MOH Projects (funded externally)						-					
National Patient Flow-Phase 2	177		-	177	174	2	2	-	-	177	0
National Patient Flow Phase 3	249			249	23	172	169	3	55	250	(1)
Telestroke Pilot	-	-	-	-	-	42	42	-	-	42	(42)
SUB TOTAL MOH PROJECTS	**426**	**-**	**-**	**426**	**197**	**216**	**213**	**3**	**55**	**469**	**43**
Trust Funded Projects (funded externally)						-					0
15/16 Trust Account	-		476	476	250	226	226	-	-	476	0
16/17 Trust Account			101	101	-	101	101	-	-	101	0

CAPITAL EXPENDITURE AT 31 May 2017 ($000s)

CAPITAL PLANS					CASHFLOW FORECAST					FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 31 May-17 (M)	Planned Expenditure from 1st Jun 17 to 30 Jun-17 (N)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
15/16 Other Donated Assets			89	89	84	5	5	-		89	0
SUB TOTAL TRUST FUNDED PROJECTS	-		577	577	333	332	332	-	-	666	(89)
TOTAL CAPITAL EXPENDITURE						29,724	24,522	5,202	193,088	243,843	1,998
				-				-		0	0
CAPITALISED COMPLETED PROJECTS	4,981		275	5,256	4,297	1,538	1,538			5,835	(580)
REPORT TOTALS	105,658	141,054	4,385	251,097	25,328	31,262	26,060	5,202	193,088	249,678	1,418

Waikato District Health Board

Presentations

Waikato District Health Board

Papers for Information

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 9.1

HEALTH TARGETS REPORT

Purpose	For information.

Most recent results

Table 1 shows a summary of performance for Waikato DHB's health target results including 2016/17 quarter three results. DHB comparison rankings for 2016/17 quarter three performance are included where available. The most recent results in the last column give the most up to date picture of performance.

Table 1- Health targets performance summary

HEALTH TARGETS		15/16 Target	2015/16 Q2 results & ranking	2015/16 Q3 results & ranking	2015/16 Q4 results & ranking	16/17 Target	2016/17 Q1 results & ranking	2016/17 Q2 results	2016/17 Q3 results	Target achieved	2016/17 Most recent result
Shorter stays in emergency departments		**95%**	92% 16th ✗	90% 19th ✗	**91% 18th** ✗	**95%**	89.3% 19th ✗	87.6% 20th ✗	88.4% 20th ✗	X	88.1% May 17 YTD
Improved access to elective surgery		**100%**	120% 2nd ★	120% 2nd ★	**119% 2nd** ★	**100%**	108% 7th ★	106% 10th ●	110% 3rd ★	√	110.2% May 17 YTD
Faster Cancer Treatment (FCT)	Achievement	**85%**	68% 17th ✗	**73%** 13th ●	77% 10th ●	**85%**	81.4% 5th ★	86.1% 5th ★	85.9% 4th ★	√	86% up to 12/6/17
Better Help for Smokers to quit	Primary Care	**90%**	88% 7th ★	**89%** 8th ●	88% 6th ★	**90%**	87% 12th ●	87% 12th ●	86% 13th ●	X	86% 16/17 Q3 result
	Maternity	**90%**	89% 15th ✗	**95%** 13th ●	97% 8th ●	**90%**	93% 12th ●	98% 4th ★	96%	√	96% 16/17 Q3 result
Increased immunisation (8 months)		**95%**	92% 13th ●	91% 15th ✗	**90% 17th** ✗	**95%**	92.3% 13th ●	92% 15th ✗	90% 16th ✗	X	89.2% May 17 3 mth rolling
Raising Healthy Kids[1]			18%	19%	31%	**95%**[1]	47% 11th ●	79% 6th ★	84% 9th ●	X	84% 16/17 Q3 result (6mths to Feb-17 data)

Key: DHB rating		
★ Good	● Average	✗ Below average
Top third of DHBs	Middle group of DHBs	Bottom third of DHBs

[1] Target by Dec 2017

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2017

DHB Q4 result 12/13	DHB Q4 result 13/14	DHB Q4 result 14/15	**DHB Target 15/16**	DHB Q1 result 15/16	DHB Q2 result 15/16	DHB Q3 result 15/16	**DHB Q4 result 15/16**	**Q1 2016/17**	**Q2 2016/17**	**Q3 2016/17**
88.4% 18th ranking	93.0% 16th ranking	94.0% 16th ranking	**95%**	89.5% 18th ranking	91.9% 16th ranking	90.5% 19th ranking	**91%**	**89.3%**	**87.6%**	**88.4%**

Table 3 – 2017 ED results for May

Quarter:	**3 - 2017**		
Quarterly Results – by DHB total population			
	Numerator: The number of ED presentations with a length of stay of less than six hours	**Denominator: Total number of ED presentations**	**Percentage of patients admitted, discharged or transferred from ED in less than six hours**
DHB total:	24040	27202	88.4%
Waikato	15731	18459	85.2%
Taumarunui	1460	1533	95.2%
Thames	4101	4401	93.2%
Tokoroa	2748	2809	97.8%

Table 4 - Emergency Department May 2017 results by site and by clinical unit

	Clinical Unit	Month: May-2017		Year To Date	
		Departures	%	Departures	%
By Specialty/Division (Waikato Hospital Only)	General & Specialty Surgery	939	71.0%	9235	76.8%
	Cardiology	299	55.6%	2867	57.4%
	Cardiothoracic Surgery	13	69.2%	100	87.0%
	Critical Care	0		0	
	Paediatrics	501	89.9%	4606	89.1%
	Emergency Department	3523	93.1%	38631	92.8%
	Internal Medicine	975	68.3%	9273	71.8%
	Womens Care	116	81.0%	1268	79.0%
	Oncology	84	81.0%	822	78.4%
	Orthopaedics	299	72.5%	3029	76.2%
	Renal	63	76.2%	553	81.5%
	Vascular Surgery	35	71.4%	378	86.4%
	Allied health	0		0	
	Community Services	0		0	
	Older Persons	1	100.0%	4	100.0%
	Mental Health	101	84.0%	1003	87.4%
By Site	Waikato Hospital	6949	82.8%	71769	84.8%
	Thames Hospital	1461	93.6%	15985	93.7%
	Tokoroa Hospital	1052	97.5%	11214	97.4%
	Taumarunui Hospital	492	92.6%	5721	96.0%
	Total Health Waikato	**9954**	**86.4%**	**104689**	**88.1%**

Table 4 shows all Health Waikato hospitals emergency department performance up to the latest result of 88.1% for YTD May 2017.

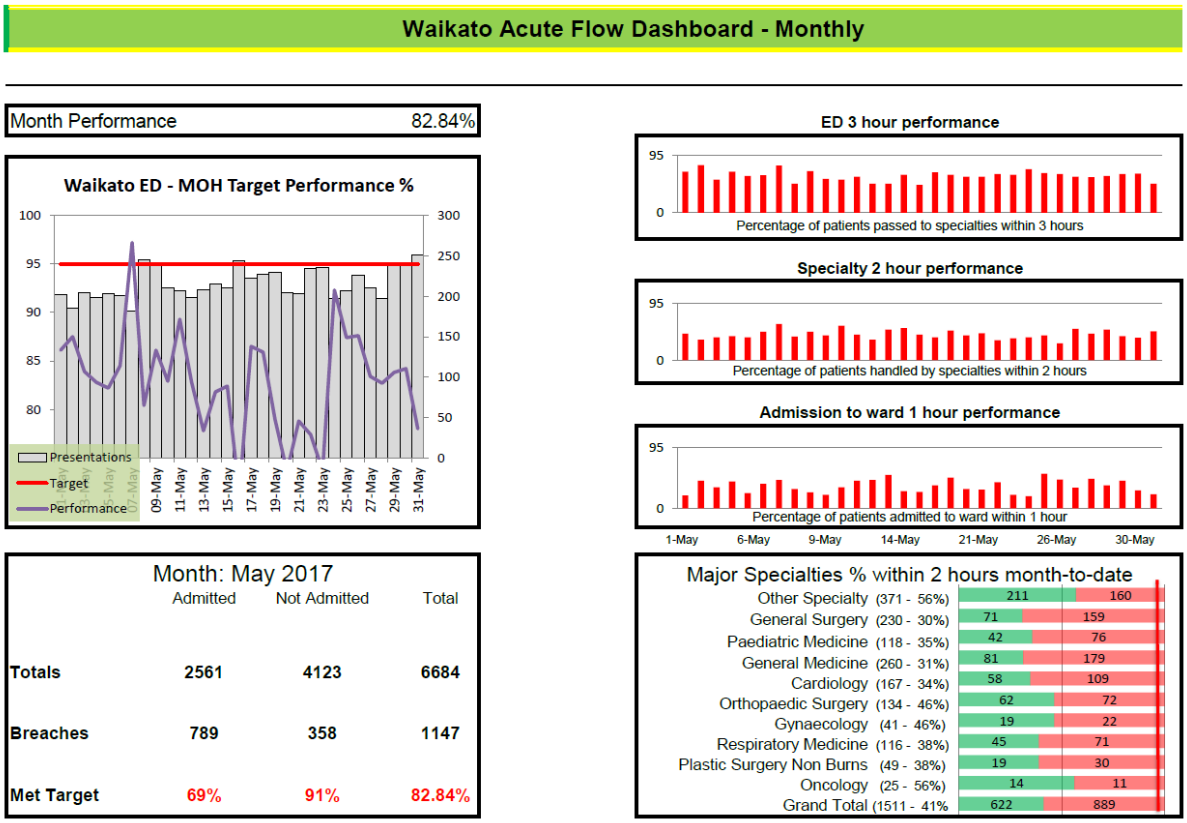
May's in-month 6,958 presentations to Waikato Hospital's Emergency Department is the highest in any month historically, and the year to date presentations of 71,730 is 3.8% greater than last year, continuing the increasing trend in attendances. Similarly, the 2,561 admissions to hospital from ED / Acute Medical Unit in May represented the highest number of admissions from ED / Acute Medical Unit recorded in the Waikato.

As per last month's report the table below indicates the principal challenge for Waikato Hospital remains the admitted pathway. Performance for non-admitted patients, or those treated in ED alone, is at 91%. Given that this is a more straightforward pathway than that for admission the aim is to improve this to well over 95% when the department is fully staffed, aided by the closer working with Medical teams enabled by the new hospital restructure.

In order to address the non-admitted pathway, Emergency Department medical recruitment is on-going. After several rounds of Senior Medical Officer interviews we have managed to appoint to two substantive positions, who will join the department in September. We have also offered jobs to a Medical Officer and two Fellows, as part of the strategy to increase out of hours' medical cover in the department. These appointees will be starting this month.

A dedicated project resource has been employed to assist with addressing the nursing vacancies. A number of recruitment offers have been made in the month, and if all are complete, will reduce the staffing levels to being 5.2 FTE short for Registered Nurses. Although still a gap, this will be a significant improvement on the numbers of nurses employed in ED over the last couple of months.

The principal risk to target achievement remains for admitted patients. Agreement on the opening of OPR5 beds in September will help to alleviate this along with opening of 5 Short Stay unit chairs in ED and the launch of the "SAFER" discharge package in August. The admitted pathway s however predicted to continue to remain challenging through June to August. Further hospital-wide work on improving discharges is currently being planned for this period.



Please note: only MOH target included numbers appear in this data

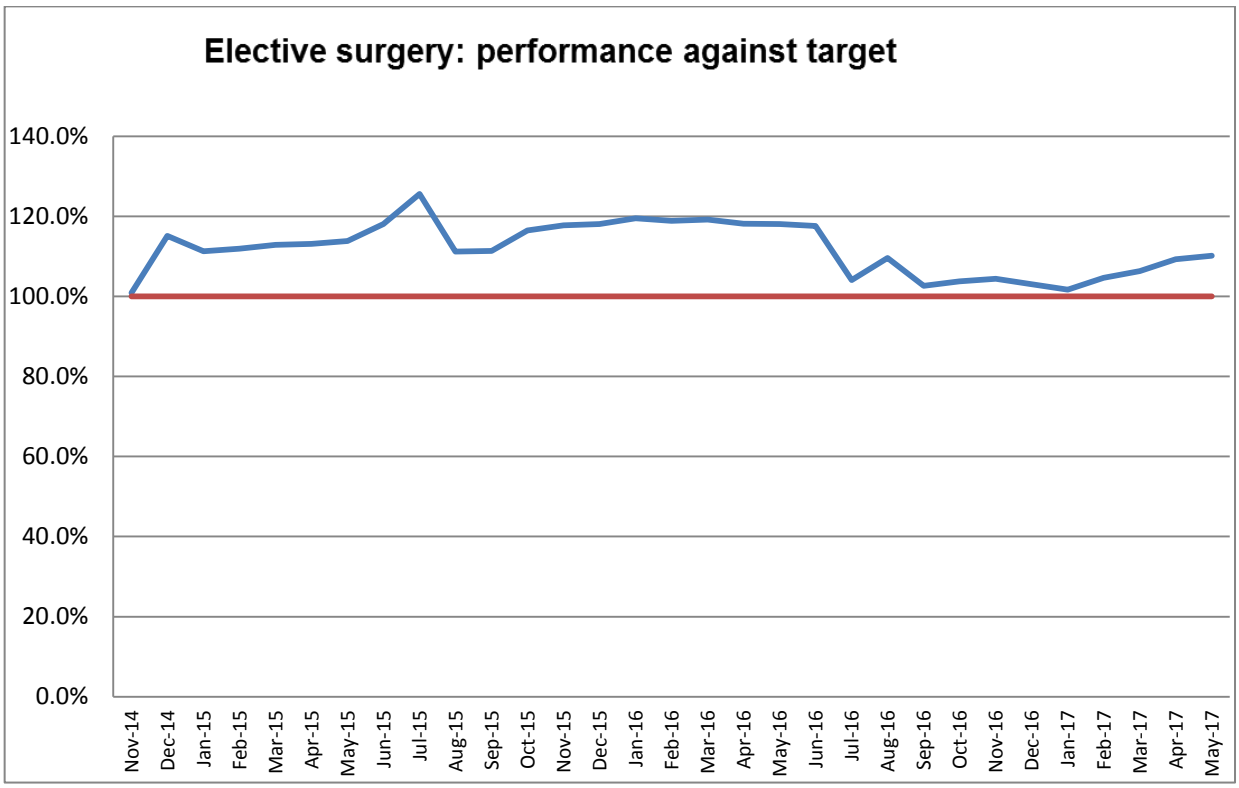
The Medicine, Oncology, Ambulatory and Emergency Services Directorate has successfully appointed a new Service Manager (started 3 May) and a new Clinical Nurse Director (started 15 May) and put in place back-fill arrangements for the Charge Nurse Manager position, thus addressing the operational management vacancies that were reported in April.

Target: Elective Surgery

DHB Q4 result 15/16	**DHB Target 16/17**	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	DHB Q2 result 16/17	**DHB Q3 result 16/17**	**Most recent result**
119% YTD (target 15,858 discharges)	**100%** **(target 16,805 discharges)**	120% YTD 2nd ranking (target 7,858 discharges)	120% YTD 2nd ranking (target 11,546 discharges)	119% YTD (target 15,858 discharges)	108% YTD 7th ranking (target 4,651 discharges)	106% YTD 10th ranking (target 8,966 discharges)	**110.1% YTD** **(target 12,619 discharges)**	**110% YTD May 17** **(target 15,675 discharges)**

The 2016/17 target is 16,805 discharges. Graph 1 below provides the most recent result of 110%, a total of 17,276 actual discharges for the period from 1 July 2016 to 31 May 2017. Our official ranking result for Q3 had Waikato ranked 3rd.

Graph 1 - Waikato DHB's elective surgery performance up to May 2017



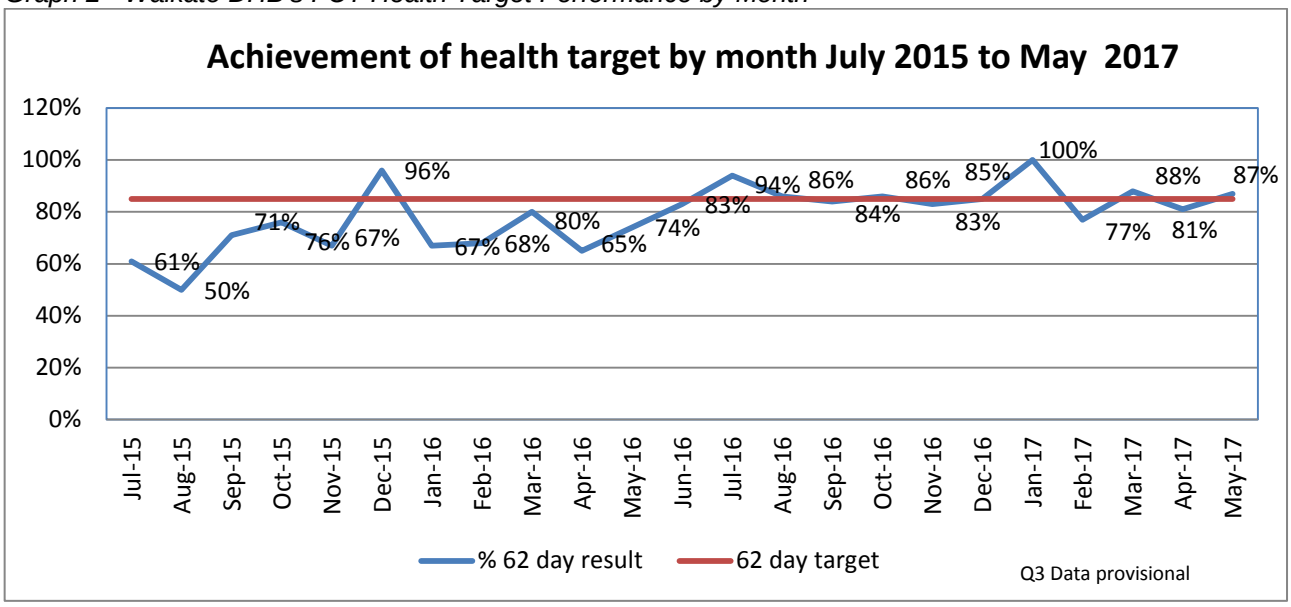
Target: Faster Cancer Treatment (FCT)

FCT 62 DAY HEALTH TARGET										
DHB Target by July 2017	**DHB Current Target**	DHB Q1 Result 15/16*	DHB Q2 Result 15/16	DHB Q3 Result 15/16	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	**DHB Q4 Result 16/17**	**Most recent six monthly result**
90.00%	**85%**	57.0% 17th ranking	68.0% 17th ranking	76.5% 10th ranking	72.6% 14th ranking	81.4% 5th ranking	86.1% 5th ranking	85.9% 4th ranking	**86%** To date 12/6	**86%** **Q4 provisional**
FCT VOLUME TARGET										
DHB Target by July 2017	**DHB Current Target**	DHB Q1 Result 15/16*	DHB Q2 Result 15/16	DHB Q3 Result 15/16	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	**DHB Q4 Result 16/17**	**Most recent six monthly result**
25.00%	**15%**	17% 11th ranking	16% 14th ranking	14% 15th ranking	14%	17%	19%	19%	**22% To date 12/6**	**21%** **Q4 provisional**

The 2016/17 quarter three result of 86% reflects a steady continued improvement in Waikato DHB's Faster Cancer Treatment performance. Provisional result for Q4 is 86% (up to and including 12 June).

The graph below shows the historical monthly percentage performance against the target.

Graph 2 - Waikato DHB's FCT Health Target Performance by Month



It needs to be recognised that the numbers of patients being treated on the 62 day pathway are relatively small and one or two breaches can have a substantial impact on the DHB's overall percentage performance.

Q2 was the first financial quarter we delivered the 85% target for a full quarter, making Waikato DHB one of the first DHB's in the country to achieve >85% for a full quarter. This has been sustained in Q3 with 86% and is currently on track to maintain in Q4.

There are a number of principal reasons for patients these breaching the 62 day pathway:

- Delays are occurring discussing patients at Auckland gynaecology multi-disciplinary meetings, some of the weekly multi-disciplinary meetings are at full capacity thus delaying the presentation of patients by a week. This is being discussed wider through the Midlands Cancer Network, as all DHB's in the region are similarly affected.
- Patient choice.
- Complex pathways.

A number of operational measures are being undertaken to maintain performance:

- FCT Business Manager and Nurse Tracker working very closely with cancer care coordinators and Clinical Nurse Specialist monitoring the patient pathway from initial date of referral.
- Improving the timeliness of gynaecology triaging and first specialist appointment.
- Weekly coordinated meeting with gynaecology Clinical Nurse Specialist and cancer care coordinator to discuss individual patients and tracking pathways to ensure patients are discusses at Auckland multi-disciplinary meetings in a timely manner.
- Midland Cancer Network involved Auckland gynaecology multi-disciplinary meetings to ensure patients are discussed at multi-disciplinary meetings in a timely manner.
- Outpatient clinic commencing late June/early July which will enable patients who are eligible to have hysteroscopy under local anaesthetic, thus freeing up theatre time and improving patient pathways.
- Continue to monitor respiratory triaging and time to FSA.
- Weekly coordinated meeting with upper gastro intestinal surgeons and upper gastro intestinal cancer nurse coordinator to discuss and track individual patients to ensure patients proceed along the pathway in a timely manner.
- Radiology-liaising with interventional radiologists to ensure patients receive their CT biopsy in a timely manner.

- Weekly urology waitlist meeting to discuss any patients triaged onto 62 day pathway.

Graph 3 - Waikato DHB's Faster Cancer Treatment performance (rolling six month result)

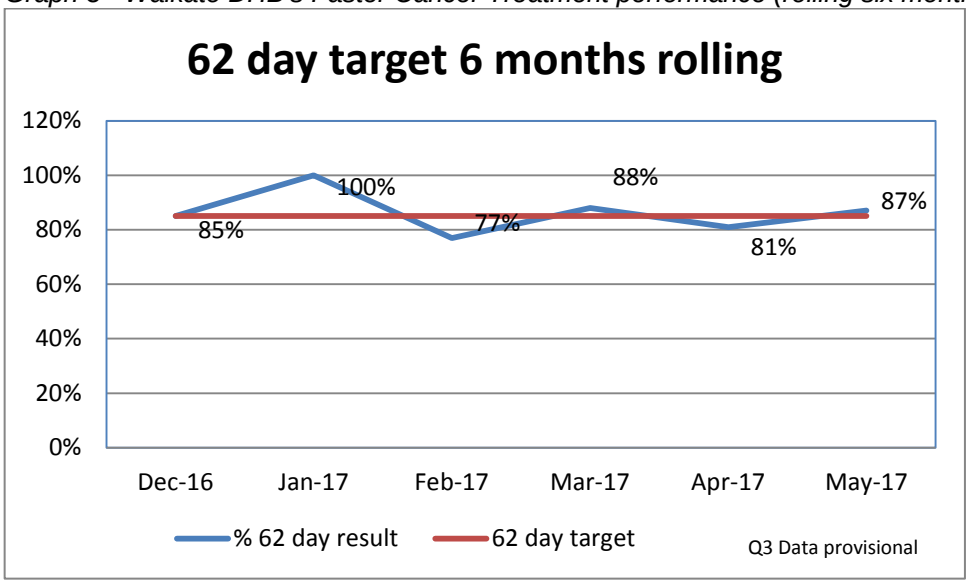


Table 5 – Latest six month data for 62-day Faster Cancer Treatment cohort, by month of first treatment

Local FCT Database	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Total
Number of records submitted	40	20	30	42	31	39	202
Number of records within 62 days	6	20	23	37	25	34	145
% 62 day Target Met (85%)	15%	100%	77%	88%	81%	87%	72%
% Volume Target Met (15%)	25%	12%	19%	26%	19%	24%	21%

Result for the volume measure of 15% of cancer registrations identified as high suspicion of cancer is also included in the table above. This is a check that the referrals that should be identified as high suspicion of cancers are being captured against this measure. Our latest provisional six month volume result is 21%.

Target: Increased immunisations for 8 months

DHB Q4 result 15/16	**DHB Target 16/17**	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	DHB Q2 Result 16/17	**DHB Q3 Result 16/17**	**Most recent 3 monthly result**
89% 17th ranking	**95%**	92% 13th ranking	91% 15th ranking	89% 17th ranking	92% 13th ranking	92% 15th ranking	**90% 16th ranking**	**89% May 17**

Data for this target is reported on a three month rolling basis. Graph 4 shows our most recent result of 89% for the three month period from 1 March 2017 to 31 May 2017.

Waikato DHB has still not met this target despite a range of well-established additional services such as outreach immunisation and the child health coordination services which have been in place for the last five years. Our approach is similar to other funders nationally and internationally taken to address missed immunisation events.

High level activities being implemented under the Waikato Immunisation Resolution Plan include:

- Leadership – clear roles and leads across Waikato DHB and PHOs by the Immunisation Steering Group. Reports and minutes from this group available to Inter Alliance
- Early enrolment of new-borns primary care is a high priority for Waikato Child Health coordination Service and all PHO. New agreements in place with PHO to prove free consultation for unenrolled mothers of new borns to ensue their babies are enrolled and immunised
- Outreach Immunisation Services (OIS) – working with Hauraki PHO to amalgamate subcontracted OIS providers to the PHO to reduce fragmentation and overheads and have one team focusing on hard to reach babies
- Missing events coordination – weekly teleconferences between PHOs, NIR and Outreach Immunisation Service using a traffic light system to immunise babies at risk of missing their immunisation milestones is maintained
- Reduced declines - annual training for health professionals with best practice embedded; and
- Waikato Child Health Co-ordination Service - a key service/contractual change means the provider (Midlands Health Network) has sufficient FTE resource in place to provide a comprehensive missing event's service and KPIs and outputs agreed between the DHB and all PHOs jointly monitored.
- Agreement just in place for national Immunisation Monitoring and Advisory Group (IMAC) to run 6 hours immunisation training session for Lead Maternity Carers at no cost to LMCS
- In depth analysis of immunisation events data by NHO to begin immediately to determine areas of low coverage and determinants of babies who miss immunisation with this information brought the attention of the Immunisation Steering Group to advise solutions

Further discussion has commenced in relation to the declines and whether alternative approaches to communicating with new mums around immunisation may impact on the decline rates.

Graph 4 - Waikato DHB's fully immunised rates for 8 month olds (rolling three month result)

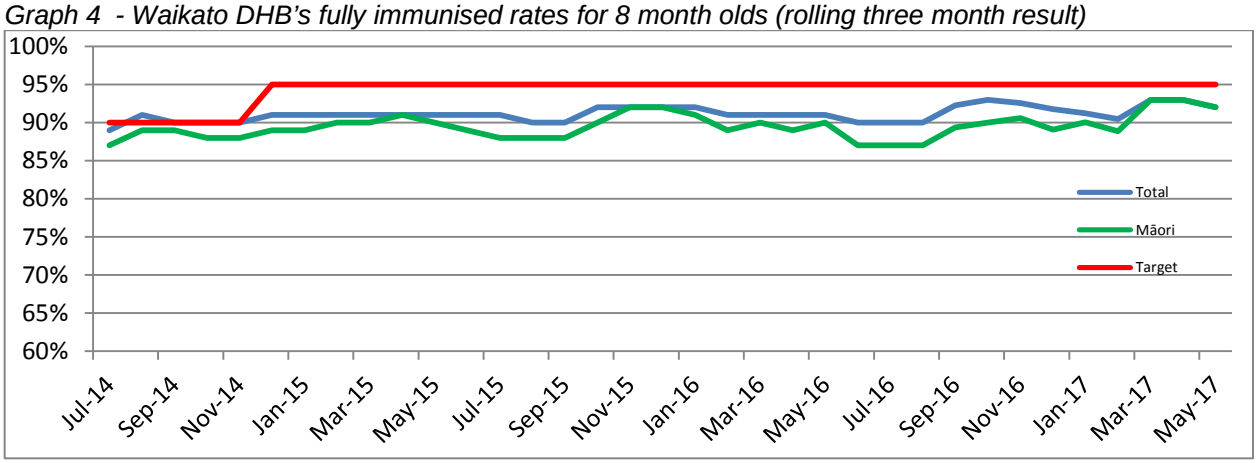


Table 6 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 83 additional children needed to be immunised to meet the 95% target.

Table 6 - Waikato DHB 8 month old immunisations ethnicity breakdown from Mar 2016 to May 2017

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
Asian	184	180	98%	0
Māori	551	475	86%	49
NZ European	508	457	90%	26
Other	119	101	85%	13
Pacific	50	46	92%	2

Total across ethnicities				90
Total	**1,412**	**1,259**	**89.16%**	83
Opt off	6 (0)			
Declined	76 (5.4 %)			

Table 7 below shows the latest immunisation rates for the eight month population for Waikato DHB by PHO and the population not fully enrolled with a Waikato based PHO.

Table 7 - Waikato DHB's PHO level results for 8 month old immunisation from Mar 2017 to May 2017

PHO	**Total population**			**Maori population**		
	No eligible population	*No fully immunised population*	*Percent immunised*	*No eligible population*	*No fully immunised population*	*Percent immunised*
Hauraki PHO	500	458	92%	238	213	89%
Midlands Health Network – Waikato	792	726	92%	243	219	90%
National Hauora Coalition *	21	17	81%	12	9	75%
Enrolled with a PHO outside of Waikato	99	58	59%	58	34	59%
DHB Total	1,412	1,259	89%	551	475	86%

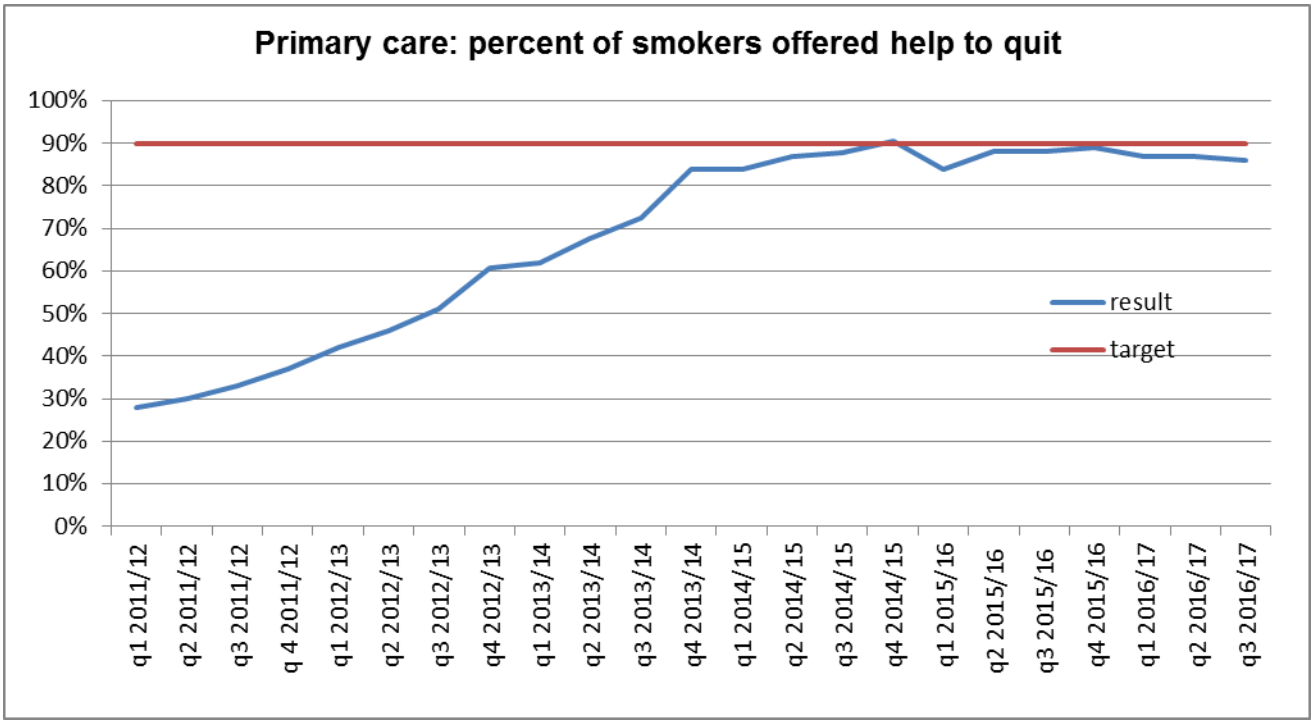
*Note – NHC data not available due to technical issues with the national reporting system so this data is for the 3 months ending March17.

Target: Better help for smokers to quit - primary care

DHB Q4 result 14/15	DHB Q4 result 15/16	**DHB Target 16/17**	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	DHB Q2 result 16/17	**Most recent result Q3 16/17**
90.4% 10th ranking	89% 8th ranking	**90%**	88% 7th ranking	88% 6th ranking	89% 8th ranking	87% 7th ranking	87% 12th ranking	**86% 13th ranking (prelim)**

Graph 5 of the quarter two final result of 86.0% shows Waikato DHB has dropped slightly from the previous quarter.

Graph 5 - Waikato DHB's percentage of smokers offered help to quit in primary care



Communications are occurring with all PHOs in relation to this measure and actions needed to enable the target to be achieved by the end of 2016/17. Following a recent discussion at the Waikato inter-alliance forum we are aware that approaches are occurring in relation to both improving achievement against this target and improving primary care referrals for cessation.

Table 8 shows a breakdown of primary care smoking results by PHOs for 2016/17 quarter three.

Table 8 – 2016/17 Q3 primary care smoking results by PHOs (target 90%)

PHOs	**Tobacco Numerator**	**Tobacco Denominator**	**2016/17 Q3 result**	**2016/17 Q2 result**	**2016/17 Q1 result**	**2015/16 Q4 result**
Midlands Health Network	25,815	29,507	88%	88%	88%	88%
Hauraki PHO	20,067	23,411	86%	86%	86%	86%
National Hauora Coalition	1,182	1,366	87%	86%	87%	92%
Total	46,791	54,204	**86%**	**87%**	**87%**	**89%**

Target: Better help for smokers to quit - maternity

DHB Q4 result 14/15	DHB Q4 result 15/16	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	DHB Q2 16/17	**Most recent result Q3 16/17**
91.2% 14th= ranking	95% 13th ranking	89% 15th ranking	97% 8th ranking	95% 13th ranking	93% 12th Ranking	98% Q2 result 4th Ranking	**96% Q3 result**

Graph 6 quarter two result of 96% shows we continue to met this target. Quarter three ranking is not yet available.

Graph 6 - Waikato DHB's percentage of smokers offered help to quit in maternity

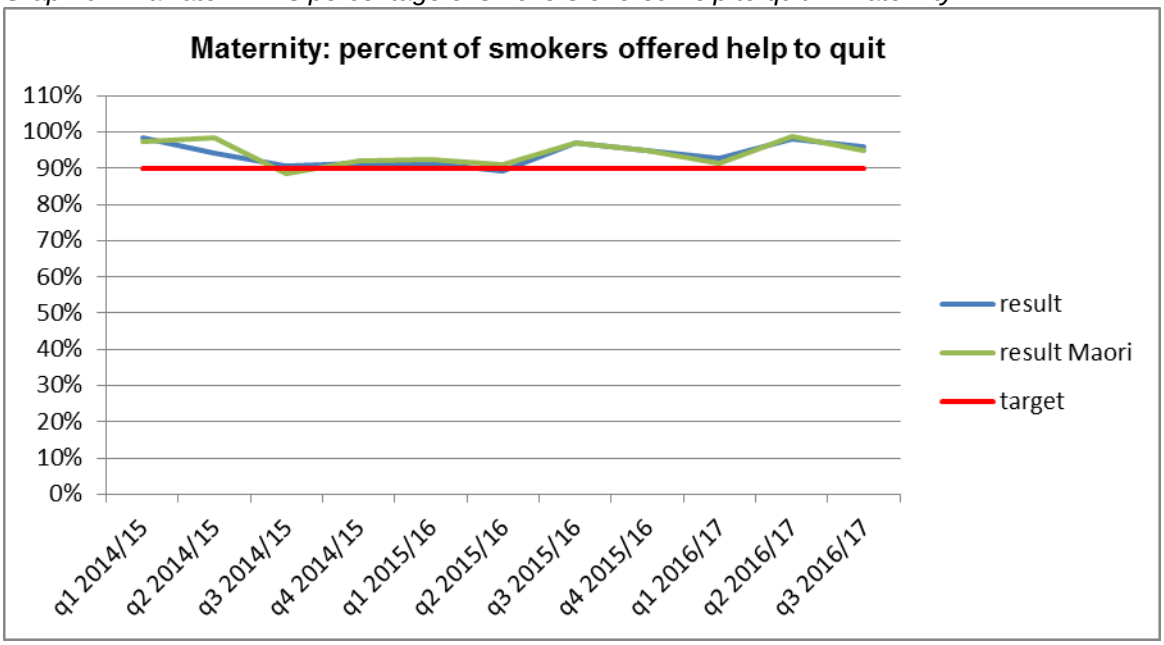


Table 9 shows our quarter three results provided by the Ministry for our total and Maori population.

Table 9 – 2016/17 Q3 maternity smoking status and advice results (target 90%)

	No. women registered *	No. of women identified as smokers	No. people given advice	Smoking prevalence	Percent of smokers offered advice
Maori	150	78	74	52%	94.9%
Total	610	121	116	19.8%	95.9%

**Data comes from three sources: Midwifery and Maternity Providers Organisations (MMPOs), Lead Maternity Carers Services (LMCs) and from DHB employed midwives (if available)*[2]

The information for this measure is received directly from the Ministry of Health. Concerns exist around the completeness of this information given total birth numbers for the Waikato District. Communications have occurred with the Ministry of Health in relation to increasing the completeness of this data.

Target: Raising healthy kids

On 30 June 2016 the Ministry launched the new Raising Healthy Kids health target. The target reads that by December 2017, 95% of obese children identified in the B4 School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Target results only capture children aged four to five who have had a B4SC.

The health target is one of two targeted interventions in the Ministry's Childhood Obesity Plan. The Obesity Plan has three focus areas made up of 22 initiatives across three areas; (1) targeted

[2] Note, Waikato DHB has reported to the Ministry that the data shows significantly less first registrations with a midwife than expected in Waikato. The Ministry has informed us full activity is not reflected in the data for other DHBs also and they are working through the accuracy of information but have yet to resolve the problem.

interventions, (2) increased support and (3) broad population approaches. The two targeted intervention initiatives are Raising Healthy Kids target and access to nutrition and physical activity programmes for families.

Locally the introduction of the target is led out by the Waikato Child Health Network chaired by our primary care clinical lead and GP Child health liaison doctor. The health target is just one part of both a national and district wide multifaceted approach to tackle child hood obesity including amongst others health promotion, Green Prescription, Project Energize, Under-fives Energize and Bodywise. The key aim of the target is that health professionals will manage clinical risks associated with obesity, encourage and support family and whanau to take actions around nutrition, lifestyle and physical activity and importantly regularly monitor children's growth.

Our GP Liaison is working on the referral pathways for children identified as very overweight (BMI> 98 centile). Our scope has been broadened to include BMI >91% centile. As our B4SC checks are done in general practice by the child's usual practice nurse referrals will be made to the family general practitioner within 30 days of the check, recorded formally and reported to the national B4SC system. We are also ensuring that our referral pathways include a missing events service as we anticipate almost all children will be referred but not all will return for and appointment.

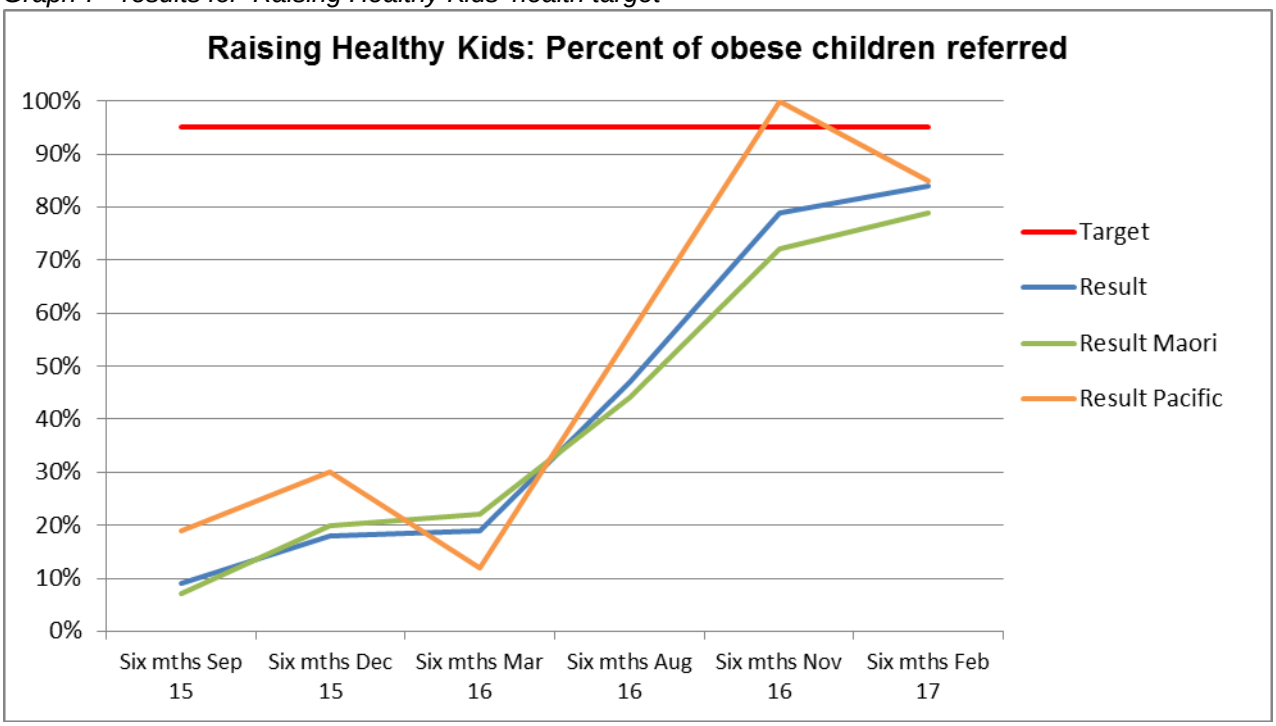
Table 10 – 2016/17 Q2 Raising Healthy Kids Results (target 95%)

		Waikato DHB						**National**
		2015/16 Q2	**2015/16 Q3**	**2015/16 Q4**	**2016/17 Q1**	**2016/17 Q2**	**2016/17 Q3**	**2016/17 Q3**
		Six mths Sep 15	**Six mths Dec 15**	**Six mths Mar 16**	**Six mths Aug 16**	**Six mths Nov 16**	**Six mths Feb 17**	**Six mths Feb 17**
Total	Referral Sent	13%	18%	23%	50%	82% (141)	86% (133)	89%
	Referral Sent and Acknowledged	**9%**	**18%**	**19%**	**47%**	**79% (135)**	**84% (127)**	**86%**
Maori	Referral Sent	12%	21%	30%	49%	76% (63)	82% (65)	86%
	Referral Sent and Acknowledged	**7%**	**20%**	**22%**	**44%**	**72% (58)**	**79% (61)**	**83%**
Pacific	Referral Sent	26%	30%	12%	56%	100% (11)	90% (9)	94%
	Referral Sent and Acknowledged	**19%**	**30%**	**12%**	**56%**	**100% (11)**	**85% (8)**	**92%**

Note that the numbers in brackets in the table are the actual numbers of children in each of the categories

Recent advice has been received from the Ministry of Health in relation to some additional funding that will be provided to support services for the children identified as very overweight through the B4SC process. The approach to how this funding can provide maximum benefit is currently under discussion.

Graph 7 - results for 'Raising Healthy Kids' health target



Data for a 6 month rolling period up to Feb 2017

Recommendation
THAT
The Board receives this report.

BRETT PARADINE
EXECUTIVE DIRECTOR
WAIKATO HOSPITAL SERVICES

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY AND CLINICAL SUPPORT

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 9.2

PROVIDER ARM KEY PERFORMANCE DASHBOARD

Purpose	For information.

The high level provider arm key performance dashboards for May 2017 are attached for the Board's information. This sees three separate dashboards, which cover:

1. Community & Clinical Support
2. Mental Health
3. Waikato Hospital.

Any indicator where performance is below plan by more than 5% is marked red in the "variance" column. For any items marked red in the year to date (YTD) variance column, notes are appended to the report regarding:

- the cause(s) of less than planned performance (where known);
- the approach being taken to address it; and
- an estimate of timeframe for performance to improve.

Recommendation
THAT
The Board notes the report.

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY &
CLINICAL SUPPORT

DEREK WRIGHT
EXECUTIVE DIRECTOR
MENTAL HEALTH

BRETT PARADINE
EXECUTIVE DIRECTOR
WAIKATO HOSPITAL
SERVICES

Key Performance Dashboard

Community & Clinical Support

May 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	94.7	95.0	(0.3)	95.4	95.0	0		
Number of long wait patients on outpatient waiting lists	# > 4 mths	0	0	0	0	0	0		
Number of long wait patients on inpatient waiting lists	# > 4 mths	0	0	0	0	0	0		
CTs reported within 6 weeks of referral	%	81.9	90.0	(8.1)	92.3	90.0	2.3		
MRIs reported within 6 weeks of referral	%	85.7	85.0	0.7	88.5	85.0	3.5		

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department - Number relative to Target growth of 4% p.a.	Numbers	Rolling 12 month measure			34,274	34,059	(215)		
Elective Surgery Volumes vs Elective Health Target	% of target	Under development - see separate Elective Health Target Report							
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			83.2	89.7	(6.5)		1
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			93.0	99.4	(6.4)		2
Laboratory – Histology specimens reported within 7 days of receipt	% for Apr YTD	58.0	80.0	(22.0)	48.1	80.0	(31.9)		3
Pharmacy - Chart turnaround times, % within 2.5 hours	%	86.0	80.0	6.0	91.8	80.0	11.8		
Pharmacy on Meade script turnaround time in minutes	minutes	8.6	10.0	1.4	7.4	10.0	2.7		
Outpatient DNA Rate	%	11.1	10.0	(1.1)	10.8	10.0	(0.8)		4
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	97.2	100.0	(2.8)	96.1	100.0	(3.9)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	105.3	100.0	5.3	93.8	100.0	(6.2)		5
Output Delivery Against Plan - Inpatient CWD Volumes	%	99.9	100.0	(0.1)	92.8	100.0	(7.2)		6
District Nurse Contacts (DHB Purchased)	Numbers	10,964	-		109,776				
District Nurse Contacts (ACC Purchased)	Numbers	2,212	-		23,524				
School Dental Service - Clients assessed and treated	Numbers	Under development							
Radiology - total imaging events	Numbers	Under development							
Lab - total tests	Numbers	Under development							
pharmacy - scripts processed	Numbers	Under development							
pharmacy - medications reconciled	Numbers	Under development							

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			3.38	3.79	0.41		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			1.00	0.96	(0.04)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			0.33	0.39	0.05		
DOM101 Avg Length of Stay	Days	Under development							

Quality and Patient Safety KPI measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	88.2	95.0	(6.8)	90.4	95.0	(4.6)		

Quality Indicators - Patient Safety

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Breast screening Total volumes - Waikato DHB	Numbers	4,203	3,500	703	38,116	37,500	616		
Breast screening Maori volumes - Waikato DHB	Numbers	268	337	(69)	2,333	3,134	(801)		7
Hospital Acquired MRSA (Department)	Numbers	0	0.0	0	0.0	0.0	0		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers (All)	22	8	(14)	155	86	(69)		8
Complaints resolved within 20 wd (1 month lag)	% for Apr-17	60	70	(10)	67	70	(3)		
Falls Resulting in Harm	Numbers	4			22				
Pressure Injuries - Total	Numbers	4	3	(1)	22	47	25		
Patient Feedback	*Not yet collected - in Development*								

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	3,031	2,572	460	29,385	27,010	2,375		
Actual Expenditure vs Budget ($000s)	$000s	13,269	13,075	(194)	138,661	134,921	(3,740)		
Actual Contribution vs Budget ($000s)	$000s	(10,237)	(10,503)	266	(109,276)	(107,911)	(1,365)		
Actual FTEs vs Budget	FTEs	996.9	1,001.8	4.9	999.4	997.3	(2.1)		
Sick Leave	% of paid hours	3.3	2.6	(0.7)	2.9	2.9	(0.1)		
Overtime $'s	$000s	210	179	(31)	1,946	1,541	(405)		9
Annual Leave Taken	% of Budget	Rolling 12 month measure			91.0	100.0	(9.0)		10

Key - MTD Measures
At or above target
Below target by less than 5%
Below target by more than 5%

Key - YTD Measures
At or above target
Below target by less than 5%
Below target by more than 5%; operational plan in place

Key - Trend Measure
Favourable Trend
Unfavourable Trend - but YTD performance has met target
Unfavourable Trend - but YTD performance is below target

KPI Report: Community & Clinical Support

Commentary on the current KPI report is given in the table below.

Note	Indicator	Commentary
1	Elective and Arranged Day Surgery Admissions	Phenomenally good performance in Australasian terms. The is suggesting the mix of same day vs overnight surgery is changing. The KPI target requires resetting.
2	Elective and Arranged Day of Surgery Admissions	Phenomenally good performance in Australasian terms. The KPI target requires resetting.
3	Laboratory – Histology specimens reported within 7 days of receipt	Actual specimens are triaged on the basis of clinical risk. Significant work has been done to successfully improve histology turnaround times. No concerns of significance are noted. The kpi target requires resetting to measure time critical histology only.
4	Outpatient DNA rate	No concerns of note.
5	Output delivery against plan – inpatient episodes	Seasonal demand is now evident.
6	Output delivery against plan – inpatient cwd	Refer above.
7	Breast Screening – Māori volumes	This target will not be met for the year. The change in Support to Screening providers effectively reduced activity for 5-6 months. All of the new Support to Screening providers are now fully operational and the rate of Maori women now being referred to be booked is showing improvement.
8	Complaints	Staff attitudes and clinical treatment are the main themes. Each is being investigated more fully.
9	Overtime $'s	No particular concerns are evident that have not been reported in prior periods.
10	Annual leave taken	No particular concerns are evident that have not been reported in prior periods. A rate of 91% is an exemplary result by national standards across all industries.

Key Performance Dashboard

Mental Health

May 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	81.2	95.0	(13.8)	87.9	95.0	(7)		1

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health seclusion hours	Hours	1,085	371	(715)	10,560	4,078	(6482)		2
Mental health treatment plans	% Cases	84.4	95.0	(10.6)	89.8	95.0	(5.2)		3
Mental health HoNos matched pairs	% Cases	96.9	95.0	1.9	98.6	95.0	3.6		
Mental health inpatient bed occupancy	%	97.0	87.1	(9.9)	93.5	87.1	(6.4)		4
Mental health GP methadone cases	Cases	93.0	76.0	17.0	93.6	76.0	17.6		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health post discharge follow up - % seen in 7 days	%	89.3	90.0	(0.7)	91.1	90.0	1.1		
Mental health follow up - numbers seen in 7 days	Number of Cases	67	67.5	(0.5)	669	660.6	8.4		
Mental health community contract positions filled	% FTEs	88.1	95.0	(6.9)	96.7	95.0	1.7		
Mental health 28 day readmission rate	%	8.6	15.0	6.4	11.8	15.0	3.2		

Quality and Patient Safety KPI measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	98.3	95.0	3.3	98.1	95.0	3.1		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers (All)	8	7	(1)	83	78	(5)		5
Complaints resolved within 20 wd (1 month lag)	% for Apr-17	17	70	(53)	37	70	(33)		6
Falls Resulting in Harm	Numbers	2			14				

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	213	252	(40)	2,295	2,371	(76)		
Actual Expenditure vs Budget ($000s)	$000s	6,632	6,236	(397)	67,358	66,164	(1,194)		
Actual Contribution vs Budget ($000s)	$000s	(6,420)	(5,983)	(437)	(65,062)	(63,793)	(1,270)		
Actual FTEs vs Budget	FTEs	748.7	732.7	(16.0)	739.4	732.4	(7.1)		
Sick Leave	% of paid hours	4.2	2.8	(1.4)	3.4	3.0	(0.3)		7
Overtime $'s	$000s	94	76	(18)	936	834	(102)		8
Annual Leave Taken	% of Budget	Rolling 12 month measure			89.5	100.0	(10.5)		9

Key - MTD Measures	
At or above target	
Below target by less than 5%	
Below target by more than 5%	

Key - YTD Measures	
At or above target	
Below target by less than 5%	
Below target by more than 5%; operational plan in place	

Key - Trend Measure	
Favourable Trend	
Unfavourable Trend - but YTD performance has met target	
Unfavourable Trend - but YTD performance is below target	

KPI Report: Mental Health & Addictions Services May 2017

The following is a current state KPI dashboard for the directorate.

Note	Indicator	Commentary
1	Emergency Hours <6 hours	• 88 MH Presentations for May versus 58 presentations for April • 58% of the MH related presentations arrived in ED after hours • 15 Breaches (versus 7 in April) included individuals presenting with: o 4 overdose o 3 self-harm + 1 suicidal ideation o 3 related to psychosis o 2 related to schizophrenia (paranoid, aggression, non-compliance) o 1 mania presentation o 1 anxiety
2	Seclusion	• Sixteen individuals were secluded during May 2017, • Thirteen of those within the Adult wards • Three within the Forensic wards. • Of the sixteen individuals secluded during May 10 identified as Maori • Adult inpatient: • 9 events started in the afternoon shift (6 events started between 15.30 and 17.30pm) (other three were at 19:10, 19:20 and 21:00) • 6 events started in the morning shift (4 events started between 7.50am and 9.15am) (other two at 11:30am and 14.57pm) • 1 event began during the night shift started at 02.00am • Forensic inpatient : • 2 events started in the morning shift at 11:50am, and 13.20pm, • 3 events started in the afternoon shift at 16:00, 16:40 and 18:30pm Despite a clear strategy to reduce seclusion, a review process, debriefing occurring with service users and a number of workforce initiatives, the rates of seclusion are higher than we consider acceptable. We have approached senior clinical leaders across like sized DHBs to be part of a peer review process. We would like the team to meet with staff and service users to explore what we could be doing more of, what we need to change and what new developments we could try. Currently, we are making some alterations to the Low Stimulus Area which includes a number of seclusion rooms. We are painting the rooms and ensuring that we have separate space for those requiring low stimulus and separate spaces to nurse agitated patients as well as those requiring a quiet space. All those who experience seclusion will have recovery plans that specify how to avoid seclusion into the future, both in terms of their care in the community, but also what their triggers may be in an inpatient setting.

3	Treatment plans	The target of 95% was not met this month. After maintaining good results until the summer period, overall services have struggled to return to high levels of compliance with having a current treatment plan. Whilst a large number of teams did improve in May (by around 5% per service cluster), overall the service was unable to meet this target, the main impediment being clinical demand on those teams.
4	Occupancy	Over occupancy of the HRBC continues to be challenging and additional beds were temporarily opened for 24 hours in a previously used ward, to support individuals who were due to be discharged the following day. There are regularly temporary beds placed in interview or quiet rooms to accommodate for the admissions. All services including older persons (15 beds) and Forensic (50) beds are generally 100% full, further adding to the pressure.
5 & 6	Complaints	The service received 6 complaints in April. The report currently shows only one of these was responded to within 20 working days. However, upon review, 2 have been closed (1 x delay arising from requirement for third party consent). Of the four remaining complaints, all clients have been contacted to discuss their complaints. 1 is awaiting third party consent information. 1 meeting has occurred and 1 meeting is yet to occur. 1 client has not responded to follow up contact. In May the service received 8 complaints.
7	Sick Leave	Sick leave, whilst ahead of target appears to follow the usual seasonal trend for mental health.
8	Overtime	Overtime for nursing overall is below budget, but with some registrar vacancies currently, the overtime spend is in relation to MECA payments which must be followed. All registrar vacancies are now filled and once arrived, overtime for this group is anticipated to drop again.
9	Annual Leave	Annual leave continues to track around the same percentage, despite active annual leave management. It is however well managed and achieving just under 90% of annual leave taken is acceptable to the service.

Key Performance Dashboard

Waikato Hospital Services

May 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	82.8	95.0	(12.2)	84.7	95.0	(10)		1
Faster Cancer Treatment - Referral received to first treatment <= 62 days	% of patients	87.2	85.0	2.2	85.7	85.0	0.7		
Chemotherapy treatment < 4 Weeks Wait	% of patients	100.0	100.0	0.0	100.0	100.0	0.0		
Radiotherapy < 4 Weeks Wait	% of patients	100.0	100.0	0.0	100.0	100.0	0.0		
Number of long wait patients on outpatient waiting lists	# > 4 mths	29	0	(29)	2,473	0	(2473)		2
Number of long wait patients on OPRS outpatient waiting lists	Patients	0	0	0	0	0	0		
Number of long wait patients on inpatient waiting lists	# > 4 mths	86	0	(86)	979	0	(979)		3

Theatre Productivity

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Theatre Utilisation - Elective Sessions	%	76.0	85	(9.0)	76.1	85.0	(8.9)		4
Hospital initiated elective theatre cancellations	%	3.8	2.5	(1.3)	5.7	2.5	(3.2)		5
Waiting Time for acute theatre < 24 hrs	%	76.7	80	(3.3)	73.1	80.0	(6.9)		6
Waiting Time for acute theatre < 48 hrs	%	89.2	100	(10.8)	87.2	100.0	(12.8)		7

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Elective Services Standardised Intervention Rates (SIRs)	Discharges per 10,000 pop	Rolling 12 month measure			268.0				
Elective Surgery Volumes vs Elective Health Target	% of target	Under development - see separate Elective Health Target Report							
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			50.4	51.5	(1.1)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			75.5	81.2	(5.8)		8
Outpatient DNA Rate	%	9.5	10.0	0.5	9.9	10.0	0.1		
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	99.8	100.0	(0.2)	99.0	100.0	(1.0)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	108.6	100.0	8.6	99.8	100.0	(0.2)		
Output Delivery Against Plan - Inpatient CWD Volumes	%	102.7	100.0	2.7	99.4	100.0	(0.6)		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Presentation to ED < 14 Days after discharge as an Acute InPatient	%	Under development							
Acute Readmissions to Hospital	%	Rolling 12 month measure			9.1	8.5	(0.6)		9
Number of long stay patients (>20 days length of stay)	Discharges	82	55	(27)	689	565	(124)		10
Number of long stay patient bed days (>20 days los)	Bed Days	2,569	1,787	(782)	23,308	18,832	(4476)		11
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			4.17	4.01	(0.16)		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			2.14	2.00	(0.14)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			1.03	1.14	0.11		

Quality and Patient Safety KPI measures

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	93.5	95.0	(1.5)	95.1	95.0	0.1		

Organisational Quality Safety Markers

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Patients assessed as being at risk have an individualised care plan which addresses their falls risk.	% for Apr-17	96.6	90.0	6.6	95.4	90.0	5.4		
Compliance with good hand hygiene practice (WDHB Rate)	%	84.0	85.0	(1.0)	85.2	80	5.2		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers (All)	52	63	11	638	691	53		
Complaints resolved within 20 wd (1 month lag)	% for Apr-17	70	70	(0)	58	70	(12)		12
Falls Resulting in Harm	Numbers	10			112				

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	11,693	9,313	2,380	108,924	104,177	4,748		
Actual Expenditure vs Budget ($000s)	$000s	40,693	39,113	(1,580)	413,527	395,008	(18,519)		
Actual FTEs vs Budget	FTEs	3,136.0	3,073.0	(63.1)	3,109.4	3,094.1	(15.3)		
Sick Leave	% of paid hours	3.6	2.6	(1.0)	3.0	2.9	(0.1)		
Overtime $'s	$000s	590	290	(300)	5,086	2,996	(2,090)		13
Annual Leave Taken	% of Budget	Rolling 12 month measure			87.6	100.0	(12.4)		14

Key - MTD Measures	
At or above target	
Below target by less than 5%	
Below target by more than 5%	

Key - YTD Measures	
At or above target	
Below target by less than 5%	
Below target by more than 5%; operational plan in place	

Key - Trend Measure	
Favourable Trend	
Unfavourable Trend - but YTD performance has met target	
Unfavourable Trend - but YTD performance is below target	

Waikato Hospital Services KPI Dashboard

Notes re Operational Plan Items – May 2017

Note	Indicator	Commentary
1	Emergency Department < 6 hours	This target remains challenging as outlined in an excellent presentation to the Performance Monitoring Committee by the Executive Director Operations & Performance and the Director Medicine, Oncology and Emergency services. Waikato Hospital is continuing to experience pressure from increased attendances (+8% when compared to May 2016) and pressure on beds, with the hospital having to invoke an incident management response to address the hospital being overloaded on one occasion. Performance for the non-admitted, or ED only patients, remains consistent at > 90%. The recent difficulties in admitting patients into the hospital have seen the admitted pathway deteriorate to 69%. To achieve a sustained improvement in the 6 hour target, this is where the organisation would achieve the most gain. Plans to open an additional ward in OPR5 are progressing with urgency, alongside a redoubled focus on specialties responding promptly to surges in the ED patient numbers. Additional work is planned at a service leadership group level on improving discharges and expediting discharges to the T hospitals for patients who could be treated in more local facilities. Surgical and CCTVS are participating fully in the Waikato Acute Patient Governance Group (APGG), focusing on two service areas to improve speciality response and reduce wait times in ED – plastic surgery and cardiology. This is starting with daily feedback re performance and understanding the block to speedier patient disposition. The impact of the acute coronary syndrome pathway (which has seen us consistently meet previously elusive revascularisation timeframes) has added to the challenge of improving our performance in this area and is the subject of ongoing discussion.
2	Long wait patients on outpatient waiting lists	Work continues on this on a daily basis with a number of specialities against the MOH ESPI2 target. With initiatives in managing inflows, recruitment and implementation of the orthopaedic action plan we achieved ESPI 2 compliance in April and May.
3	Number of long wait patients on inpatient waiting lists	We achieved an amber result for ESPI in March. As reported to the Board in May the combination of anaesthetic RMO vacancies, demand increase and public holidays meant that the previously identified risk of not achieving ESPI in April was realised. As can be seen from this KPI report we have again breached ESPI 5 in May. The provisional assessment of breach numbers in May (86) is however significantly down from the 144 in April and we are forecasting amber achievement for June and working hard to do the same for July, despite the need for some catch-up which resulted from cancellations due to bed unavailability on 23 May. While there is still a lot more work to do to bed in ESPI improvement the overall position is significantly improved compared to 12 months ago.

Note	Indicator	Commentary
4.	Theatre Utilisation – Elective Sessions	This remains an area of attention. The deficit in budgeted anaesthetic resource will continue to adversely affect this marker in the short term. There is robust weekly management of utilisation against this resource. The high number of public holidays in April impacted on our elective utilisation however this is trending upwards YTD.
5	Hospital Initiated elective theatre cancellations	The paper based audit of reasons for cancellations is still being analysed and the results will be included in the project evaluation of the pre hospital preparedness project due for completion by July.
6.	Waiting time for acute theatre less than 24 hours	This KPI is monitored via our Theatre and Interventional Governance Group (TIGG). The piece of work to develop a business case with some options to address this is within the work plan of this group; currently under development is a plan to right size acute theatre capacity starting with weekends and weekdays in hours.
7.	Waiting time for acute theatre less than 48 hours	As per item 6.
8.	Elective and arranged day of surgery admissions	Although our day stay rates compare favourably there is room for improvement in both day stay and DOSA. Our TIGG has initiated investigation to address this and identified clinical leads to initiate process change across services starting with those procedures identified as being suitable for day stay but where those procedures have incurred an overnight stay. This will be monitored via our Theatre and Interventional Governance Group (TIGG).
9.	Acute Readmissions to hospital	Analysis of Health Round Table data shows that our acute readmission rates post-surgery and post myocardial infarction compare favourably with peers however this KPI is increasing and the causes will be investigated.
10.	Number of long stay patients (> 20 days length of stay)	A DHB wide discharge initiative is being launched in August, led by the Executive Director Operations and Performance with involvement from the Director of Medicine, Oncology, ED and Ambulatory Care and the Director of OPR and Allied Health. This programme includes emphasis on long stay patients, which has been enhanced with weekly reporting to the capacity and demand management forum and higher scrutiny of long stay reasons. There has been some improvement in recent months, however, YTD still higher than target. Resourcing and staffing of regular audits of long stay patients are being considered as part of the patient flow programme, to supplement weekly nursing audit of reasons for long stay.

Note	Indicator	Commentary
11	Number of long stay patient bed days	As per item 10
12	Complaints resolved within 20 working days	The recovery work signalled last month in this area has been successful, with the target achieved for Waikato Hospital this month.
13	Overtime $'s	This has remained steady as a result of regular levels of escalation lists required to support acute service delivery particularly at weekends. This links to # 6. Also an exceptionally busy acute month in the Child Health service within the service resulted in additional staff being rostered after hours/weekends to provide safe staffing to meet demand. Ongoing high vacancies have resulted in the requirements for increased overtime throughout the Womens Health service.
14	Annual leave taken	Year to date performance against this indicator remains very good.

MEMORANDUM TO THE BOARD
28 JUNE 2017

AGENDA ITEM 9.3

STRATEGY AND FUNDING KPI DASHBOARD

Purpose	For information.

The Strategy & Funding KPI dashboard is attached as Appendix A. Items updated are noted on the dashboard and items noted as having negative variances have a commentary provided excluding items already reported on within the health target report.

A revised approach to reporting was discussed at the June committee meeting. This would include additional reporting on key areas on a rolling schedule throughout the year as the majority of items reported are available on a quarterly basis only and often move only gradually over time.

Discussion occurred in relation to areas that may be included in a child and youth suite of indicators at the August performance monitoring committee meeting. This is attached as Appendix A. There was support for this set of measures with a further two indicators proposed and included. The reporting will focus on equity as well as performance against targets (where available) and national rates.

At the August meeting a schedule of future items will be agreed. however it is expected that the next few workshops will include items such as services for older people and mental health and addictions. Following introduction of this new approach consideration will be given to whether there is value in continuing this dashboard except for specific items.

Recommendation
THAT
The report be received.

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY & FUNDING

Emergency Department Presentations (children)
Ambulatory Sensitive Hospitalisations (ASH)
Acute Admissions
Fully Immunised at 6 Months
Fully Immunised at 8 Months
Fully Immunised at 2 Years
Fully Immunised at 5 Years
Raising Health Kids (Obesity HT)
Teenage Births
Teenage termination of pregnancies
Smoking in Pregnancy
B4 School Checks
Well Child Tamariki Ora Enrolment
Well Child Tamariki Ora Core Checks 1-5
Early Enrolment with LMC
PHO Enrolment for 0-24 years
PHO Enrolment of 0-1
Dental Caries Free at 5 yrs
Dental Caries Free at Year 8
Mental Health - access to services 0 - 19 yrs
Did not attend (DNA) rates for 0-19 yrs for specialist clinics
HPV screening rates

Strategy and Funding KPI Dashboard

Note	Indicator	Commentary
1	Proportion of older people waiting greater than 20 days for initial assessment or reassessment	Data shows most recent quarter. This indicator continues to improve but two factors adversely affecting timeliness of assessment have been identified DSL has been working with the change team to use electronic referrals and also capture triaging on IPM. Whilst this stores the referrals in a robust manner they have identified that this has caused delays as RCC batches referrals for loading and DSL can wait 5 or more days to receive a referral. They are working with RCC and the change team to rectify this. 12 of the 14 initial assessments that waited 20 days or more for an initial assessment in May requested a Maori assessor. DSL has a shortage of independent Maori assessors despite actively trying to recruit. A different process is being considered so services are in place sooner.
2	AOD and mental health waiting times (% of new clients seen within 3 and 8weeks of referral	The MOH wait time definition is designed to describe the experience a new client has when interacting with <u>any</u> MH/AOD services for the first time. This can be either via a provider arm service or an NGO service. Wait Times measures the duration in days between the date a referral is accepted and the date of first face to face contact with the client. The wait times measure focuses only on clients NEW to ANY MH or AOD service in the country. i.e. brand new to any service OR has not been seen by any service anywhere in NZ for the past 12 months. Targets are set at 80% of new clients seen in three weeks (wait time of 21 days or less for first face to face activity; and 95% at 8 weeks (56 days or less waited for first face to face activity). As noted previously there have been concerns in relation to performance against this target and the accuracy of information reported. Regular feedback and engagement with outlier providers continues and new strategies for engaging providers are also being considered.
3	2 year old immunisations	Latest 2 year old coverage result is 92% (target 95%). The 3% point gap represents 103 children not immunised on time. For children aged 2 years, this quarter the highest coverage was for Asian children (98%) and lowest for Other (none Maori, Pacific, NZ European, Asian) (85%). Our latest results also show NZ European 5% ahead of Maori for this cohort by 2 years. This measure is a contributory measure in the 16/17 and upcoming 17/18 Service Level Measure Improvement Plan for ASH rates for 0-4 year olds. In line with the approach taken in under 8 month immunisations an initial focus will be on addressing enrolment status of any children not enrolled.
4	Ambulatory sensitive hospitalisations	Quarterly indicator - No updates from previous report

Appendix A **Strategy and Funding KPI RESULTS**

Strategy and Funding - Key Performance Dashboard

May	2017

Health Targets

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Quarter Actual	Target	Variance		Trend
CVD risk assessments	%	↑	Jul-Sep16	No	93%	90%	3%	✓	92%	90%	2%	✓	
8 month old immunisations	%	↑	Rolling 3 months	yes	89%	95%	-6%	✗	90%	95%	-5%	✗	
Better help for smokers to quit (primary care)	%	↑	Mar-17	No	86%	90%	-4%	!	87%	90%	-3%	!	

Finance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Month Actual	Target	Variance		YTD Actual	Target	Variance		Trend
IDF inflow estimate	$		May YTD	Yes	12,556	10,993	1,563	✓	118,612	120,923	-2,311	!	
IDF outflow estimate	$		May YTD	Yes	4,471	4,559	-88	✓	52,318	50,149	2,169	!	

Other Performance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Period Actual	Target	Variance		Trend
AOD waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Feb 17	Yes	74%	80%	-6%	✗	75%	80%	-5%	✗	
MH waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Feb 17	Yes	79%	80%	-1%	!	79%	80%	-1%	!	
AOD waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Feb 17	Yes	94%	95%	-1%	!	94%	95%	-1%	!	
MH waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Feb 17	Yes	92%	95%	-3%	!	93%	95%	-2%	!	
Proportion of Health of Older people initial needs assessments Waiting greater than 20 days	%	↓	Jan-Mar 17	No	11%	0%	-11%	✗	20%	0%	-20%	✗	
Proportion of health of older people need re-assessments Waiting greater than 20 days	%	↓	Jan-Mar 17	No	4%	0%	-4%	✗	7%	0%	-7%	✗	
Proportion of older person funding in community based services	%	↑	Mar YTD	Yes	28%	25%	3%	✓	27%	25%	2%	✓	
Pharmacy Items claimed	Items		Apr-17	Yes	479,252	N/A			559,998	N/A			
Laboratory turnaround tmes	%	↑	Jul-Sep16	No	100%	97%	3%	✓	100%	97%	3%	✓	
Primary options referrals	Referrals				These areas will be reported in the future once expected volumes are seasonalised/targets set								
	%												
Breast Screening (total eligible population)	%	↑	Mar-17	Yes	67%	70%	-3%	!	67%	70%	-3%	!	
Cervical screening (total eligible population)	%	↑	Mar-17	Yes	77%	75%	2%	✓	77%	75%	2%	✓	
Cervical screening (High Need)	%	↑	Mar-17	Yes	68%	75%	-7%	✗	68%	75%	-7%	✗	
2 year old immunisations (total population)	%	↑	Rolling 3 months	Yes	92%	95%	-3%	!	93%	95%	-2%	!	
2 year old immunisations (Maori)	%	↑	Rolling 3 months	Yes	92%	95%	-3%	!	93%	95%	-2%	!	
Green Prescriptions	%	↑	Jan - Mar 17	No	1,656	1,675	-19	!	1,404	1,675	-271	✗	

Ambulatory Sensitive Admissions - Rates per 100,000 Population

Indicator	Unit	⇵	Data period	Updated from prior report	YT Dec 2016				YT Sep 2016				
Ambulatory sensitive admissions 0-4	rate	↓	YT Dec 2016	n	7473	7298	-175	!	7477	7298	-179	!	New ASH Definitions
Ambulatory sensitive admissions 0-4 (Maori)	rate	↓	YT Dec 2016	n	8224	7936	-288	!	8538	7936	-602	✗	New ASH Definitions
Ambulatory sensitive admissions 45-64	rate	↓	YT Dec 2016	n	4167	3936	-231	✗	4089	3936	-153	!	New ASH Definitions
Ambulatory sensitive admissions 45-64 (Maori)	rate	↓	YT Dec 2016	n	7926	5838	-2088	✗	7758	5838	-1920	✗	New ASH Definitions

Key	
At or above target	✓
Below target by less than 5%	!
Below target by more than 5%	✗

S&F Primary Care KPIs

Data updated to end of: May-17

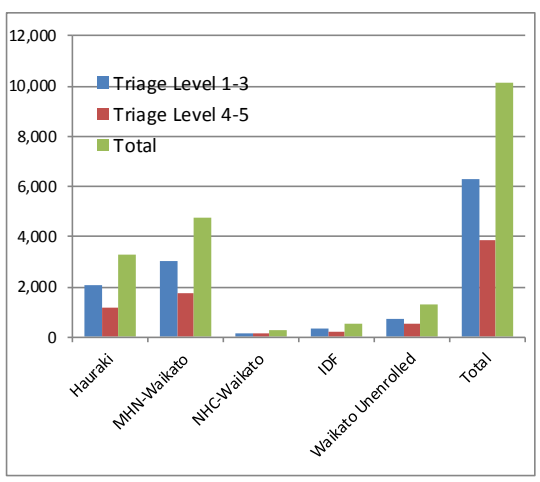
Emergency Department Presentations

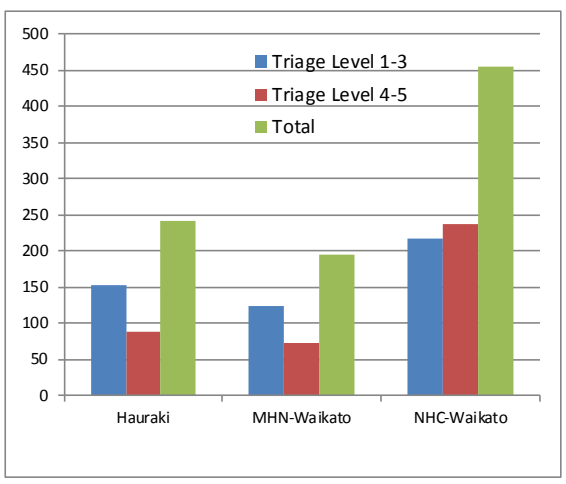
Monthly data for May-17

Total - All Ethnicities

	Volumes			Rates per 10,000 people		
	Triage Level			Triage Level		
PHO	1-3	4-5	Total	1-3	4-5	Total
Hauraki	2,072	1,198	3,270	154	89	243
MHN-Waikato	3,018	1,763	4,781	124	72	196
NHC-Waikato	127	139	266	217	238	455
IDF	319	238	557			
Waikato Unenrolled	729	547	1,276			
Total	**6,265**	**3,885**	**10,150**			

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*

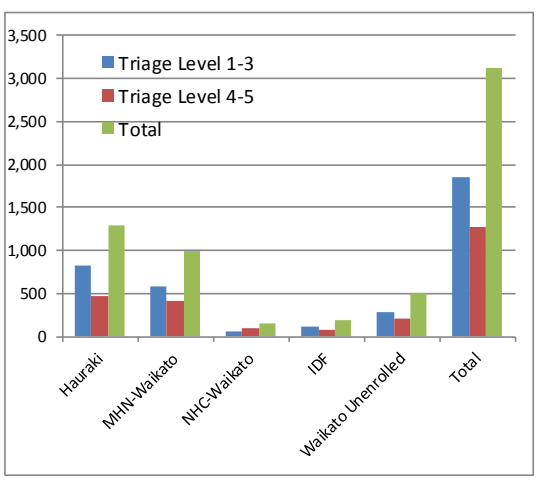


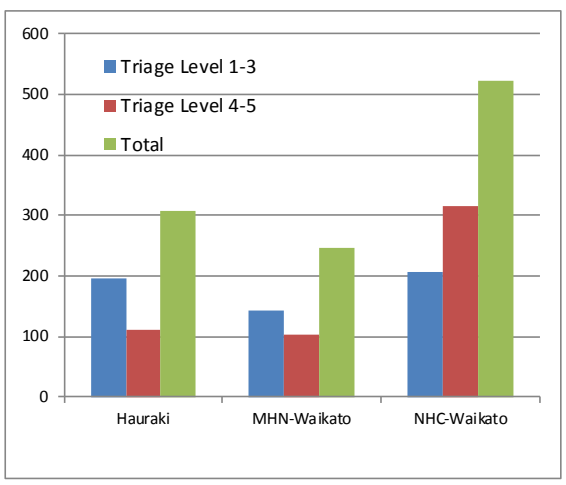


Maori

	Volumes - Maori			Rates per 10,000 people		
	Triage Level			Triage Level		
PHO	1-3	4-5	Total	1-3	4-5	Total
Hauraki	822	470	1,292	196	112	308
MHN-Waikato	578	414	992	143	103	246
NHC-Waikato	61	94	155	206	317	522
IDF	112	75	187			
Waikato Unenrolled	286	217	503			
Total	**1,859**	**1,270**	**3,129**			

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*



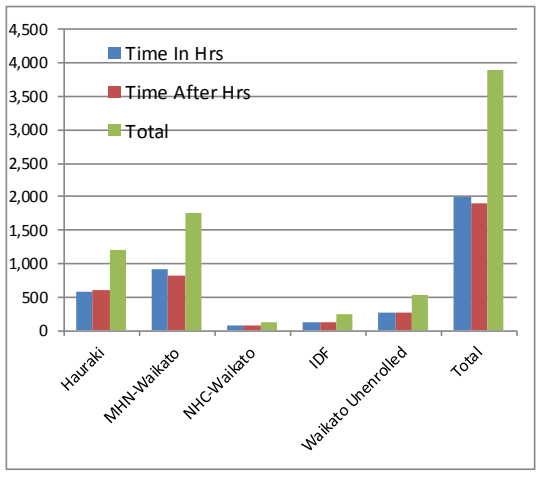


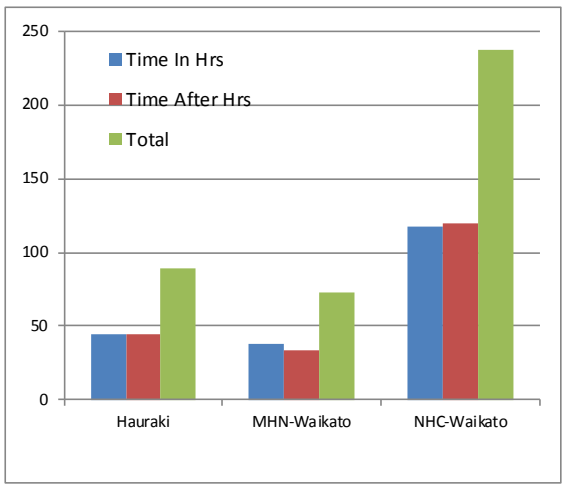
In Hours vs After Hours (Triage 4-5 only)

In Hours = 8am to 5pm Mon-Fri exc public holidays

	Volumes			Rates per 10,000 people		
	Time			Time		
PHO	In Hrs	After Hrs	Total	In Hrs	After Hrs	Total
Hauraki	595	603	1,198	44	45	89
MHN-Waikato	931	832	1,763	38	34	72
NHC-Waikato	69	70	139	118	120	238
IDF	118	120	238			
Waikato Unenrolled	280	267	547			
Total	**1,993**	**1,892**	**3,885**			

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*





Ambulatory Sensitive Hospitalisations (ASH) May-17 (Utilising the new ASH Definitions)

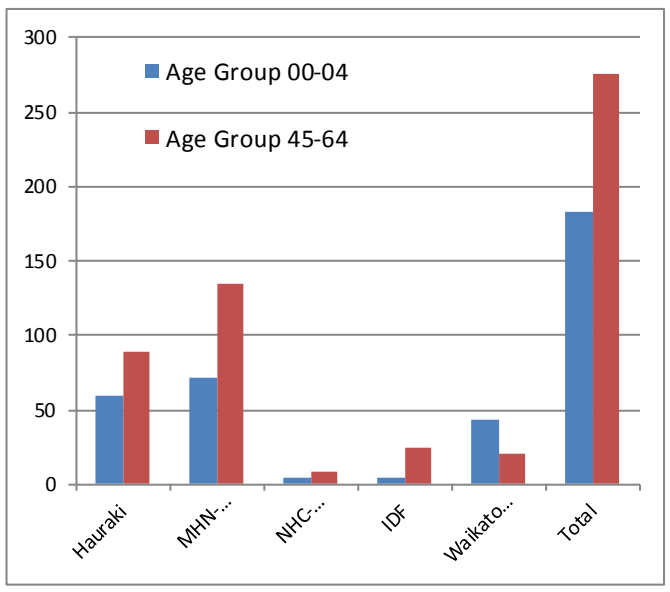
Total - All Ethnicities Monthly data for May-17

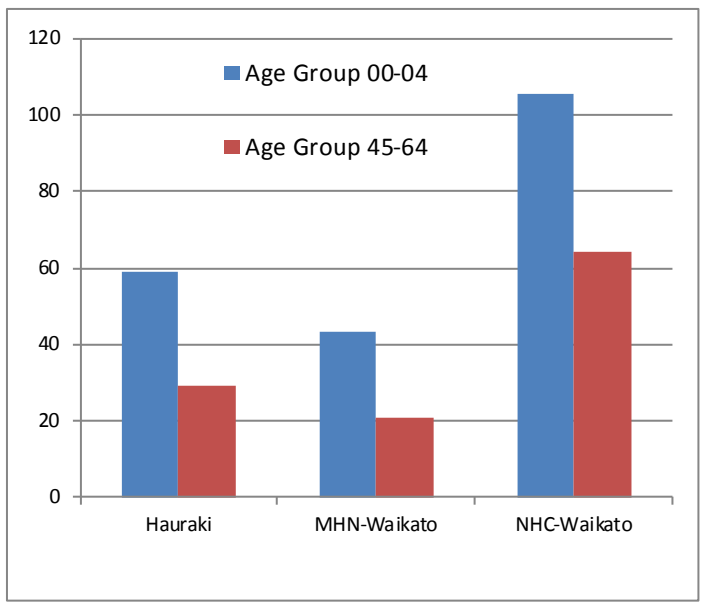
	Volumes - Apr17	
	Age Group	
PHO	00-04	45-64
Hauraki	59	89
MHN-Waikato	71	134
NHC-Waikato	5	8
IDF	5	24
Waikato Unenrolled	43	20
Total	**183**	**275**

Rates per 10,000	
Age Group	
00-04	45-64
59	29
43	21
105	64

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*

** Not Enrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs or from outside the area (i.e. an IDF patient)*





Maori Monthly data for May-17

	Volumes - Maori	
	Age Group	
PHO	00-04	45-64
Hauraki	27	47
MHN-Waikato	27	21
NHC-Waikato	1	4
IDF	4	28
Waikato Unenrolled	23	56
Total	**82**	**156**

Rates per 10,000	
Age Group	
00-04	45-64
62	61
58	27
41	63

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*

** Not Enrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs or from outside the area (i.e. an IDF patient)*