Board Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	24 October 2018	**Time:**	1pm

Board Members	Ms S Webb (Chair) Professor M Wilson (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
In Attendance	Mr K Whelan, Crown Monitor Ms T Thompson-Evans, Chair Iwi Maori Council Mr D Wright, Interim Chief Executive and other Executives as necessary

Next Meeting Date:	28 November 2018	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680
	www.waikatodhb.health.nz	

Our Vision: **Healthy People. Excellent Care**

Our 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**

Board Agenda

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: 26 September 2018
   - 3.2 Committees Minutes:
     - 3.2.1 Iwi Maori Council: 4 October 2018
     - 3.2.2 Maori Strategic Committee: 17 October 2018

4. **INTERIM CHIEF EXECUTIVE REPORT**

5. **QUALITY AND PATIENT SAFETY**
   - 5.1 Using Consumer Stories

6. **FINANCIAL PERFORMANCE MONITORING**
   - 6.1 Finance Report
   - 6.2 Asset Performance Indicator Update

7. **HEALTH TARGETS**

8. **HEALTH AND SAFETY**
   - 8.1 Health and Safety Service Update

9. **SERVICE PERFORMANCE MONITORING**
   - 9.1 Chief Data Officer Directorate (report due in November)
   - 9.2 Interim Chief Operating Officer (report due in November)
   - 9.3 Mental Health and Additions Service (report due in November)
   - 9.4 Strategy and Funding (report due January)
   - 9.5 People and Performance (report due in February)
   - 9.6 Facilities and Business (report due in February)
   - 9.7 IS (report due in February)

10. **PROFESSIONAL ADVISORY REPORTS**
    - 10.1 Chief Nursing & Midwifery Officer
    - 10.2 Chief Medical Officer (report due in January)

11. **DECISION REPORTS**
    - 11.1 Equity Focussed Reporting (October Maori Strategic Committee decision that report be submitted to the November Board agenda)
    - 11.2 Waikato DHB Final Annual Plan 2018/19
    - 11.3 Delegation of Agreements over $10M per annum for Signing
    - 11.4 Building Research for Waikato DHB

Board Agenda

12. SIGNIFICANT PROGRAMMES/PROJECTS

12.1 National Oracle System (presentation on the day)
12.2 Creating our Futures (report due in November)
12.3 CBD Accommodation Project (bimonthly report, due November)
12.4 Regional eSPACE Programme (quarterly report, due January)
12.5 Medical School (no report this month)

13. PAPERS FOR INFORMATION

13.1 State Sector Model Standards – Management of Conflict of Interest

14. PRESENTATIONS

No presentations

15. BOARD MEMBER ITEMS

15.1 The Living Wage (refer item 19 in public excluded)

NEXT MEETING: 28 November 2018

Board Agenda

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

THAT:

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

Item 16: Minutes – Various
(i) Waikato District Health Board for confirmation: Wednesday 26 September 2018 (Items taken with the public excluded)
Item 17: Funding: Equity Requirements and Leasing Options – Public Excluded
Item 18: Year End Matters and 2017/18 Annual Report – Public Excluded
Item 19: The Living Wage – Public Excluded
Item 20: Beattie Varley Report and Lessons for Waikato DHB – Public Excluded

(2) This resolution is made in reliance on Clause 32 of Schedule 3 of the NZ Public Health & Disability Act 2000 in that the public conduct of the whole or the relevant part of the meeting would likely result in the disclosure of information for which good reason for withholding exists under sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

(3) Pursuant to Clause 33 (1) of Schedule 3 of the NZ Public Health & Disability Act 2000 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	SECTION OF THE ACT
Item 16 (i):	Minutes – Public Excluded	Items to be adopted/confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 17:	Funding: Equity and Leasing – Public Excluded	Negotiation with Ministry of Health will be required	Section 9(2)(j)
Item 18:	Year End Matters and 2017/18 Annual Report – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 19:	The Living Wage – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 20:	Beattie Varley Report and Lessons for Waikato DHB – Public Excluded	Negotiation with Ministry of Health will be required	Section 9(2)(j)

Board Agenda

(4) Pursuant to clause 33(3) of the NZ Public Health & Disability Act 2000 Ms Te Pora Thompson-Evans who is the Chair of the Iwi Maori Council is permitted to remain after the public have been excluded because of her knowledge of the aspirations of Maori in the Waikato that is relevant to all matters taken with the public excluded.

(5) Pursuant to clause 33(5) of the NZ Public Health & Disability Act 2000 Ms Te Pora Thompson-Evans must not disclose to anyone not present at the meeting while the public is excluded any information she becomes aware of only at the meeting while the public is excluded and she is present.

Board Agenda

16. MINUTES – PUBLIC EXCLUDED

16.1 Waikato District Health Board: 26 September 2018
To be confirmed: Items taken with the public excluded

17. FUNDING: EQUITY REQUIREMENTS AND LEASING OPTIONS – PUBLIC EXCLUDED

18. YEAR END MATTERS AND 2017/18 ANNUAL REPORT – PUBLIC EXCLUDED

19. THE LIVING WAGE – PUBLIC EXCLUDED

20. BEATTIE VARLEY REPORT AND LESSONS FOR WAIKATO DHG – PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

THAT:

(1) The Public Is Re-Admitted.
(2) The Executive is delegated authority after the meeting to determine which items should be made publicly available for the purposes of publicity or implementation.

Apologies.

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO OCTOBER 2018

Sally Webb

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Chair and Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health Advisory 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	

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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Director, Bridger Beavis & Associates Ltd, management consultancy	Non-Pecuniary	None	
Director, Strategic Lighting Partners 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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Thames Coromandel District Council	TBA	TBA	
Partner, employee of Workwise	Pecuniary	Potential	

Note 1: Interests listed in every agenda.

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

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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Mayor, 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	
Wife employed by Wintec (contracts with Waikato DHB)	Pecuniary	Potential	
Member, Hospital Advisory Committee, Lakes DHB	Pecuniary	Potential	

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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Life Unlimited Charitable Trust	Pecuniary	Perceived	
Member, Public Health Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Disability Support Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Health Strategic Committee, Bay of Plenty DHB	Pecuniary	Potential	

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
Chair, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	
Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None	
Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None	
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None	

Note 1: Interests listed in every agenda.

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

Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None
Member, Whanau Ora Review Panel	Non-Pecuniary	None
Trustee and Shareholder, Whanau.com Trust	TBA	TBA

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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Councillor, Hamilton City Council	Pecuniary	Perceived	
Deputy Chair, Waikato Regional Passenger Transport Committee	Non-Pecuniary	Potential	
Member, Waikato Regional Transport Committee	Non-pecuniary	Potential	
Member, Future Proof Joint Council Committee	Non-pecuniary	None	
Partner is an occasional contractor to Waikato DHB in "Creating our Futures"	TBA	Potential	

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, Community and Public Health Advisory 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	
Member, Community and Public Health Committee, Lakes DHB	Pecuniary	Potential	
Member, Disability Support Advisory Committee, Lakes DHB	Pecuniary	Potential	
Member/DHB Representative, Waikato Regional Plan Leadership Group			

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	

Note 1: Interests listed in every agenda.

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

Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None
Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived
Director/Shareholder, Asher Business Services 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
Daughter is an employee 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, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic 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	
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	
Member, Hospital Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Son, employee of Waikato DHB	Non-Pecuniary	Potential	

Professor Margaret Wilson

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

Note 1: Interests listed in every agenda.

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

SCHEDULE OF INTERESTS FOR CHAIR IWI MAORI COUNCIL AS STANDING ATTENDEE AT BOARD

Te Pora Thompson-Evans

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB **Member, Iwi Maori Council Representative for Waikato-Tainui, Waikato DHB** **Iwi: Ngāti Hauā** **Member, Te Whakakitenga o Waikato** **Trustee, Ngāti Hauā Iwi Trust** **Trustee, Tumuaki Endowment Charitable Trust** **Director, Whai Manawa Limited** **Director/Shareholder, 7 Eight 12 Limited**	Non-Pecuniary	None	Refer Notes 1 and 2

Note 1: Interests listed in every agenda.

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

Conflicts related to items on the agenda.

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 26 September 2018 at 1.00pm in the Board Room, Hockin Building at Waikato Hospital

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

In Attendance:
Ms T Thompson-Evans (Chair, Iwi Maori Council)
Mr K Whelan (Crown Monitor)
Mr D Wright (Interim Chief Executive)

Mr Ken Whelan was welcomed to the meeting. Mr Whelan has been appointed as the Crown Monitor.

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: 22 August 2018

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 22 August 2018 taken with the public present was confirmed as a true and accurate.

3.2 Committee Meeting Minutes

3.2.1 Māori Strategic Committee: 19 September 2018
Ms Hodges, chair of the Māori Strategic Committee updated Board members on the findings of the DNA survey. The Māori Strategic Committee recognised that a coherent organisation wide approach was required to address DNA rates. The Committee would continue to monitor this monthly until the inequity was eliminated.

Resolved
THAT
The Board noted the minutes of these meetings.

ITEM 4: INTERIM CHIEF EXECUTIVE REPORT

Mr D Wright presented this agenda item. The report was taken as read. Of note:

- The monitoring of Capital Projects to be placed on the Board agenda under Item 12 - Significant Programmes/Projects. Board members requested more time to be able to consider capital projects at Board meetings, however, the Chair was conscious of the time constraints at the meetings and did not want to overload the agenda, so deep dives into capital projects might have to be discussed at workshops.

  Resolved
  THAT
  1) eSpace, National Oracle System and the CBD Accommodation Project are included within scope of Item 12 of the Board Agenda with reports to be submitted on quarterly basis in respect of the first two items and every second month in respect of the last item.

  2) The general approach is if a capital item is required to be approved by the Board under the Delegations Policy, it will be reported under Item 12 at a frequency to be determined on a case-by-case basis unless the Board resolves to the contrary (noting that some capital items may require Board approval but are very limited in project terms).

- Waikato Hospital had a busy month with over 8000 patient episodes. Emergency Department and Acute Medicine – 8% higher than August the previous year. The 6 hour target had fallen below 80% at times.

- On-line Voting – Hamilton City Council has agreed to participate in an on-line voting trial. A request had been received for the Board's support or otherwise of on-line voting. It was suggested that the DHB invite a person from Hamilton City Council to speak with the Board about their experience.

- PHO Services Agreement Update – the DHB had worked through outstanding issues and the agreements would be signed soon.

- 2019 Board and Committee Meeting Schedule – a draft schedule was submitted for Board member's consideration.

Resolved
THAT
The Board received the report.

ITEM 5: QUALITY AND PATIENT SAFETY REPORT

There was no Quality and Patient Safety report this month.

ITEM 6: FINANCIAL PERFORMANCE MONITORING

6.1 Finance Report

Mr A McCurdie attended for this item. The financial results summary for the month of August 2018 was presented to the Board. The report was taken as read.

An unfavourable variance to budget of $1.8m was noted mainly due to:

- NZNO MECA and nursing acuity
- Nursing personnel costs (employed and outsourced)
- Clinical supplies were unfavourable mainly due to issues with NOS
- Saving plan being $2.5m unfavourable
- A new Asset Performance Indicator (API) had been added to reflect the age of clinical assets. An update of APIs to be provided to the next Board meeting.
- Slow start to capital planning - moving towards a proactively managed rolling capital plan.
- An update on Care and Capacity Demand Management (CCDM) was requested to be provided next month.

Resolved
THAT
The Board received the Finance Report for the month of August 2018.

6.2 Waikato DHB Deficit 2017/18

Mr A McCurdie attended for this item.
A deficit of $37.2 million had been recorded
A more detailed update report will be provided to next meeting

Resolved
THAT
The Board received the Report

ITEM 7: HEALTH TARGETS

Dr G Howard and Ms T Maloney attended for this item.

The Health Targets report was tabled for the Board's information. The report was taken as read. It was noted:

- Actions taken to improve the results 8 month old immunisation included:
  - The contract with current child health service provider had been terminated
  - More services being developed within provider arm
  - More proactive follow-ups
  - Increased opportunistic immunisations around Waikato hospitals and at community facilities, such as Anglesea clinic
  - Developing capability within pharmacies
  - Examining the reasons for declining and developing an incentive programme
  - Working with the Public Health Department to find way to promote immunisation
  - Working with Dr N Scott to develop a community working
  - Oranga Tamariki Family Start Service

  It was suggested that IWI might be able to assist with improving immunisation uptake numbers and that this topic should be an Agenda at the IWI Maori Council Meetings.

- A report on iHub was requested for next meeting.
- ESPI had been compliant for 9 months
- Emergency Department 6 hour target compliance had fallen below 80%

Resolved
THAT
The Board received the report.

ITEM 8: HEALTH AND SAFETY

The next Health and Safety Services Update is due in October 2018.

ITEM 9: SERVICE PERFORMANCE MONITORING

9.1 People and Performance

Mr G Peploe attended for this item. The report was taken as read. It was noted:

- The members were given the opportunity to review and discuss the Health Round Table Staff Survey 2018 questionnaire that the Midland DHB chief executives have agreed to undertake.
- Recruitment indicators. –activity remained high across all staff groups. A report on recruitment and retention was requested for the next meeting.

Resolved
THAT
The Board received the report.

9.2 Facilities and Business (refer to item 18 in public excluded)

9.3 IS Performance Monitoring

Mr G King attended for this item. The report was taken as read. It was noted:

- Malware and cyber security attacks continued to present increased risk. The team were maintaining focus on developing improved security approaches and controls.
- Disaster recovery needs to be included in future reports.
- The DevOps team were continuing to make improvements.
- Recruitment and retention was an area that was proving difficult to manage due to rises in remuneration in the market generally.

Resolved
THAT
The Board received the report.

9.4 Chief Data Officer Directorate (report due in October)
9.5 Interim Chief Operating Officer (report due in November)
9.6 Mental Health and Addictions Service (report due in November)
9.7 Strategy and Funding (report due January)

ITEM 10: PROFESSIONAL ADVISORY REPORTS

10.1 Chief Nursing and Midwifery Officer (report due in October)

10.2 Chief Medical Officer (report due in January)

ITEM 11: DECISION REPORTS

11.1 Equity Focussed Reporting (report due in October)

11.2 Integrated Community Pharmacy Agreements

Ms T Maloney attended for this item. A new National Integrated Community Pharmacy Agreement had been agreed and due to come into effect on 1 October 2018. The new agreement was an evergreen agreement and the term exceeded the delegations of the Chief Executive who has the delegated authority to sign agreement with a maximum term of 5 years.

The Board were requested to delegate authority to sign the evergreen agreements to the Executive Director Strategy and Funding up to an estimated value of $5m per annum and the Strategy and Funding Manager for agreements with an estimated value of up to $1m per annum.

Resolved
THAT
The Board adopted the above delegations and the Delegation Policy to be amended accordingly.

ITEM 12: SIGNIFICANT PROGRAMMES/PROJECTS

12.1 Medical School (no report this month)

12.2 Creating our Futures (no report this month)

ITEM 13: PAPERS FOR INFORMATION

There were no papers for information this month.

ITEM 14: PRESENTATIONS

14.1 Advancing Telehealth for Waikato DHB

Dr R Large gave a presentation to the Board members on telehealth.

A question raised was now that telehealth is an important part of the health system plan; does the DHB need to consider how it affects staff productivity.

A report on the timing of the business case for the expansion of telehealth along with the issues outlined in the report will be prepared for the next meeting.

Resolved
THAT
The Board:
1) Noted the options presented in the report.
2) Noted that the development of a business case and project plan for the advancement of Telehealth at Waikato DHB is pursued internally as an agreed consequence of ending the HealthTap contract, and will come to the Board in due course.
3) Noted that while it was previously agreed that future development of virtual care would be informed by the Health System Plan and Care in the Community Plan, we now envisage work occurring in the development of Telehealth in parallel to avoid delay.

14.2 eSPACE Programme

Ms M Chrystall, Mr D Page, Ms S Baker and Ms A Slater gave a presentation to the Board to update them on the status of the eSPACE programme and summarised the key risks and benefits.

Resolved
THAT
The Board received the presentation.

ITEM 15: BOARD MEMBER ITEMS

15.1 Car Parking Ticketing Machine Problems – (refer to item 18 in public excluded).

15.2 Living Wage – (report due in October).

EXTRA ITEM - EXECUTIVE RECRUITMENT SEARCH

A Request for Proposal had been released publically to source a preferred agency to assist with the search and selection of the next Chief Executive. It was noted:

- the report proposing the selection of an agency to recruit the next Chief Executive had been considered.
- it had not been included on the agenda because of an oversight.
- that the item could not be held over until a subsequent meeting because of the need to provide certainty to the organisation by putting in place a permanent Chief Executive as quickly as possible.
- nine submissions were received and evaluated by the Board members. Three suppliers were shortlisted.
- it was unanimously agreed that the best supplier to enter into the contract with would be Kerridge and Partners.

Resolved
THAT
The Board

- Approved the selection of Kerridge & Partners to undertake the search and selection of the next Chief Executive, subject to final reference checking and successful contract negotiations.

NEXT MEETING

The next meeting is to be held on Wednesday 24 October 2018 commencing at 1.00 pm at in the Board Room in the Hockin Building, Waikato hospital.

BOARD MINUTES OF 26 SEPTEMBER 2018

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 16: Minutes – Various:

(i) Waikato District Health Board for confirmation: Wednesday 22 August 2018 (Items taken with the public excluded)

(ii) Audit and Corporate Risk Management Committee: Wednesday 22 August 2018: (All items)

Item 17: FUNDING: EQUITY REQUIREMENTS AND LEASING OPTIONS – PUBLIC EXCLUDED

Item 18: SERVICE PERFORMANCE MONITORING – FACILITIES AND BUSINESS MANAGMENT – PUBLIC EXCLUDED

Item 19: PROPERTY AND INFRASTRUCTURE INDICATIVE CAPITAL PLAN AND PROJECT REPRIORITISATION – PUBLIC EXCLUDED

Item 20: WAIKATO DHB 2017-18 ANNUAL REPORT (DRAFT) – PUBLIC EXCLUDED

Item 21: PEOPLE AND PERFORMANCE REPORT – 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	SECTION OF THE OFFICIAL INFORMATION ACT
Item 16: (i-ii): Minutes	Items to be adopted/ confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 17: Funding: Equity Requirements and Leasing Options – public excluded	Negotiations will be required	Section 9(2)(j)
Item 18: Service Performance Monitoring – Facilities and Business options – public excluded	Negotiations will be required	Section 9(2)(j)

Item 19: Property and Infrastructure indicative capital plan and project reprioritisation – Public excluded	**Negotiations will be required**	**Section 9(2)(j)**
Item 20: Waikato DHB 2017-18 Annual Report (Draft) – Public Excluded	**Negotiations will be required**	**Section 9(2)(j)**
Item 21: People and Performance Report – Public Excluded	**Negotiations will be required**	**Section 9(2)(j)**

(3) This resolution is made in reliance on Clause 32 of Schedule 3 of the NZ Public Health & Disability Act 2000 in that the public conduct of the whole or the relevant part of the meeting would likely result in the disclosure of information for which good reason for withholding exists under sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

(4) Pursuant to clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 the Chair of the Iwi Māori Council (or their proxy) is allowed to remain after the public has been excluded because of their knowledge of the aspirations of the Iwi Māori Council specifically and Māori generally which are relevant to all matters taken with the public excluded.

ACTION LIST

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

Agenda Item	Action Agreed	Name of Executive Director Responsible for Action	Month action to be reported to the Board
4	Invite HCC representative to speak to the Board about on line voting when way forward is clearer	Nev Hablous	No earlier than January 2019
7	A report on Hauora iHUB (update to be included in CE's report)	Chris Cardwell	October 2018
9.1	Report on Recruitment/Retention and Sick Leave	Gil Sewell/Gregory Peploe	February 2019
	Report on current status of car parking	Chris Cardwell	February 2019
	Report on status/deficiencies of Food and Nutrition Service	Chris Cardwell	February 2019
	Update on SMO job sizing	Grant Howard/Gil Sewell	November 2018
14.1	Report on timing of business case for the expansion of Telehealth	Nev Hablous	November 2018

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Maori Council / Joint Board Hui

Held: Thursday 4th October 2018 at 9.30am

Venue: Board Room, Hockin Building

Present:	Ms Te Pora Thompson-Evans (Chair)	Waikato-Tainui
	Mr A Chase	Hauraki Maori Trust Board
	Ms M Balzer	Te Rūnanga o Kirikiriroa Trust
	Ms K Hodge	Raukawa Charitable Trust
	Ms P Taiaroa	Whanganui
	Ms C Brears	Whanganui
	Ms T Ake	Tuwharetoa Maori Trust Board
	Ms K McClintock	Waikato-Tainui
	Mr T Turner	Chair Kaunihera Kaumaatua
	Ms T Hodges	Waikato DHB Board member
	Mrs P Mahood	Waikato DHB Board member
Attendees	Ms L Elliott	Executive Director Maori Health
	Ms S Greenwood	Minute taker

Other attendees: Ms J Eketone, Ms J Sewell

ITEM 1 KARAKIA: Mr Taki Turner

ITEM 2 MIHIMIHI: IMC Chair

ITEM 3 APOLOGIES

Ms K Gosman, Mr G Tupuhi, Ms T Moxon, Ms S Hetet, Mr T Bell

It was moved that the apologies be accepted.

Kaituku Mōtini/Moved: Tuuwharetoa
Kaitautoko Mōtini/Seconded: Waikato-Tainui

ITEM 4 CHAIR REPORT

The report was taken as read. The following key points were noted:

- Joint hui at Rangiriri with Board and follow-up
- Recommendation around Whanau Ora was to read all the items coming out of the review before committing to anything.
- Commissioning:
    - What does commissioning mean to us in the Waikato region? We need a discussion around this, either jointly or separately with the Board

- Should commissioning be pulled to pieces and re-evaluated as it is currently a too silo'd approach? Focusing on health alone is not how Maori see it.
- GM Maori's had hui with Ministry to work on commissioning.
- Waikato-Tainui had one recommendation that they become a commissioning body for their people.
- There is no commissioning agency at present, we should be proactive around commissioning and where would that body sit and how would it work and what is the best way forward to the Waikato region.
- Are the government actually prepared to hand over control?
- We should begin with a whanau ora premise. Every service delivered to families is embedded in a whanau ora kaupapa.
- We need to shape how commissioning will look in the future rather than wait to have it 'done to us'.
- An unintended consequences clause to be applied early. There are currently incentives not to look at the 'whole'.
- MSC to do the first round of thinking around commissioning and present that back to IMC/Board.

- Confirming the IMC alternative representative to the Hospital Advisory Committee is Mere Balzer
- Hyperbaric chamber, benefits of the chamber discussed at joint hui.
- Creating our futures korero will be moved to when IMC appointees are in attendance

Chair report received

Kaituku Mōtini/Moved: **Chair**
Kaitautoko Mōtini/Seconded: **Waikato-Tainui**

Action: Commissioning Koorero to be progressed at Maori Strategic Committee and brought back to IMC in due course for discussion
Action: Notify WDHB of IMC alternative representative for HAC

ITEM 5 WHAKAPAKARI TE WHARE

- Change in mileage rate noted
- Calendar of dates for 2019 including the joint meetings between Board and IMC have been proposed.

Action: Dates accepted as markers. Members to confirm by next IMC hui.

ITEM 6 MINUTES AND ACTIONS

6.1 IMC Meeting 2nd August 2018

- Amendments:

- Amend the spelling of Loraine Elliott's name in August minutes.
  -
-
- Are we confident in the current data integrity? How is it collected at its start point? How is the data accessed? We require definitions and applications that are applied.
- Framework for analysis of the data from the Let's Talk hui's
  Noted the framework for the Lets Talk hui analysis and the impetus for the analysis being raw data containing incorrect translations, data missing, translations not done. IMC further noted the software method in which initial analysis conducted denied Kaupapa Maori context. Framework for analysis is based on DHB values and is summarised to:
  - All korero is treated as Taonga.
  - Observe Tikanga and rangatiratanga to give the mana back to the people.
  - Growing relationships between all involved.
  - Visions and aspirations of Maori people to be connected to the wider WDHB visions.
  - This is the framework that will be used to reanalyse the data. And is
  - How is this analysis going to influence as this is all in action. The equity framework needs to apply before the Board is informed.
  - Noted that expertise within TPO have the capacity required to analyse data.
  - Noted that the Chair of Iwi Maori Council is providing oversight

6.2 Joint IMC/Board Hui 6th September 2018

- Amendments:
  - to the Professor M Wilson.
  - Matters arising:

Different forms of racism noted.
TPO need to consider the quality of Maori health data and action required going forward considering data sovereignty

Action List Update

- 2. Is now a tick for completed, ongoing discussion around hyperbaric chambers.
- 4. Letter has been forwarded supporting Mere to the statutory committees.
- 5.Discuss following report from Tio and Jolene.
- WAI-2575 starts in 4 weeks time at Turungawaewae Marae.
- Board Chair and CEO informed
- Noted that the Tribunal hearing dates be sent to all Executive Directors and Board members.

- Noted that Te Puna Oranga have been requested to support the Ministry of Health at the Powhiri.
-
- From the exercise that we did, everyone responded to taking action on institutional racism and their specific role and a commitment to take action

ITEM 7 GOVERNANCE

7.1 MSC Minutes

- Updates around Puna Waiora and getting KPI's into everyone's targets. CE will have KPI's relating to equity for example.
- DNA's - How can we be more responsive and a survey was taken from the 3 poorest performing areas within the WDHB by TPO.
- Formal recommendation went to the Board from the MSC that monitoring to take place.
- Health systems around Care in the Community.
- Chair of the MSC noted the continual absence of Glen Tupuhi.

Resolved:

- **Arama Chase nominated as an alternative representative from IMC to attend.**

Kaituku Mōtini/Moved: **Te Ruunanga o Kirikiriroa**
Kaitautoko Mōtini/Seconded: **Whanganui**

Resolved:

- **The MSC minutes be received.**

Kaituku Mōtini/Moved: **Tuuwharetoa**
Kaitautoko Mōtini/Seconded: **Te Ruunanga o Kirikiriroa**

ITEM 8 STRATEGIC AGENDA ITEMS

8.1 Breast and Cervical Screening Presentation

This presentation was deferred to another day due to presenter, Shona Duxfield, no longer being available.

8.2 Immunisation Action Plan Update

Presentation by Ruth Rhodes, Rachel Poanaki and Karina Elkington to update IMC on the current status and key factors enabling persistent poor immunisation rates in Maori Children. Key points noted were:

- Equity gap is increasing annually
- Ministry of Health(MoH) target is 95%

- Target not reached for approx. 6 years
- There is an estimate of 7% informed, non-consent
- Advice from MoH is to get children referred back to general practice or Outreach
- There is no specific Maori strategy to increase Maori vaccination rates
    - This should be developed
    - Address the challenge of finding whanau and communicating effectively
    - Hapu Wananga will be having an impact on increased vaccination rates.
    - There should be a whanau ora approach.
- It is unknown what motivates the 50% who are being vaccinated.
- The terms of reference of the Immunisation Steering Group needs review and re-think in order for it to be really effective for Maori.
- IMC noted members on the Immunisation Steering Group not in a decision making position.
- There seem to be some concern within the Maori community around what is in vaccinations.
- What focus have we had on midwives?
    - Have been asking for midwives to be able to vaccinate mamas and babies but this hasn't been funded yet.
    - How much funding is in the immunisation space and how much goes to Maori providers? $200k goes to Maori providers out of a total of $700k.
- What is our strategy for dealing with high opportunity / high need whanau across the board?
    - Historically we have been doctor/clinician focused and now that has moved to the provider but we need to be whanau focused.
- The focus for immunisations seems to be on government targets. However no thought is going into who, why and how we are considering the people. The current methods are not working so why does money keep being given as a reward to those who are failing to deliver?

Noted and confirmed that the IMC pro-immunisation.

8.3 MOU report

Taken as read.

8.4 Report from IMC appointees to Creating our Futures Programme Board (Late Item)

Appointees report had been pre-circulated with hard copies available on the day. Tio Sewell, Joeleen Profit, Christine Brears and Taki Turner were all in attendance.

Key points noted:

- IMC had asked for a report back on what is happening with CoF from its appointees - Tio Sewell, Jolene Proffit, Taki Turner and Christine Brears.

- Reporting progress aims to give context to the program and positions appointees have been appointed to and background around that, drawing conclusions and recommendations.
- Framework and analysis around the Let's Talk hui's is still to be completed
- What has been spoken historically to get to the point COF is currently at?
- What matters to Maori isn't immediately obvious in CoF or the business case
- All final decisions rest with the Board and there is a partnership with the IMC. The COF Programme Board appointed membership is informing the IMC.
- Korero around the roles in relation to the project governance and reports to the MH clinical governance Board. Millie Berryman of TPO attends. IMC note that Millie is TPO and not Iwi. Consideration will be given to an Iwi appointeeCOF is a complex programme looking at prioritisation but not losing sight of the wider model of work that needs to happen.
- Submissions to the National MH review panel underpinned from illness to wellness.
- Concerns noted that COF is facilities focussed and not Models of Wellness. Maori Caucus expressed importance of models of care.
- The Programme Board discussed at their last hui that the model of care was the most important issue before building any new buildings.
- In relation to the report and Te Pae Tawhiti work – S&F is an all of system approach, COF is a DHB mental health provider focus.
- Increased levels of groups lessen focus on Maori care.
- Clinical governance must include cultural competencies
- Notion that with two separate systems such as OCF and TPT Maori health can be severely compromised. The equity group should have been present at the outset if there was true equity.
- The Maori equity lens needs to have a consistent presence across the projects as it's not currently reflected in the business case. Project structure needs to be updated to reflect current form to identify areas of partnership and participation.
- COF are working towards the 28th Nov for the indicative business case approval.

Resolved:

- **IMC appointees to the programme Board report be received**
- **That the recommendations from the appointees be endorsed and the recommendations contained at page 3 endorsed**
- **The Me Kōrero Tātou – Let's Talk Kaupapa Māori data analysis findings are completed and tabled with IMC for feedback**

Kaituku Mōtini/Moved: Waikato-Tainui
Kaitautoko Mōtini/Seconded: Te Runanga o Kirikiriroa

Action: IMC member to advise IMC Chair of any other feedback or questions to be be raised at the Board workshop by 9 October
Action: To note these recommendations at the Board workshop on 10 October

ITEM 9 TPO REPORT

Taken as read.

ITEM 10 IMC WORK PLAN

Taken as read.

ITEM 11 GENERAL BUSINESS

- Te Pora Thompson-Evans appointed to HCC community and service sub-committee. Waikato-Tainui has endorsed Kahu for another 3 years on the IMC.

Action: Update interests register.

Hui closed at 1.00pm

Next meeting held on: Thursday 8th November 2018

ACTION POINTS

	Action List	Completed	Who
1.	**Item 4** Commissioning korero to be progressed at MSC to enable an in-depth synergistic approach.		
2.	**Item 5** Confirm joint hui dates in calendar		
3.	**Item 11** Update interests register		
4.	Submit letter to Ministry from IMC on Māori Mental Health. (18th and 27th for consultation).		IMC Chair
5.	Submit letter to Ministry from IMC on Māori Mental Health. (18th and 27th for consultation).	**Completed**	IMC Chair
6.	IMC to write a letter in support of purchasing a new hyperbaric chamber by the WDHB for the prevention of the removal of limbs and death by diabetes.	**Completed**	IMC Chair & Deputy Chair
7.	Chair to follow-up to ensure that the IMC have a lead and alternative representative to the Statutory Committees.	**Completed**	IMC Chair

Meeting Minutes

Meeting name:	Māori Strategic Committee (MSC)		
Location:	Board Room, Hockin Building		
Date:	17/10/2018	**Time:**	10:00AM
Chairperson:	Ms T Hodges	**Minutes by:**	Ms S Greenwood
Attendees:	Ms, T Hodges, Dr C Wade, Mr D Macpherson, Ms T Thompson-Evans (late), Ms M Balzer, Mr A Chase, Mr G Tupuhi,		
Additional Attendees:	Ms L Elliott, Mr H Curtis, Mr N Hablous, Ms J Eketone, Ms J Sewell, Ms J Crittenden		
Apologies:	Ms T Moxon, Mr D Wright, Ms S Christie, Ms R Poaneki		

Item No.	Details
1.	**KARAKIA/MIHI** Mr H Curtis
2.	**APOLOGIES** Apologies received and noted above.
3.	**MINUTES OF MSC MEETING HELD** 19 September 2018 Minutes accepted as true and correct. **Moved:** Mr D Macpherson **Seconded:** Ms T Hodges
4.	**MĀORI DNA INEQUITY ELIMINATION UPDATE** Mr G Howard attended and presented this agenda item. Of note: • A short summary on the change management process that has taken place since assuming his role. • The last few months involved investigating a better system for outpatient services. • A contact centre has been proposed as a mechanism for contacting patients and patients being able to contact the hospital. • The current systems need to be made transparent and reliable. • Anticipates that current outpatient service approach will take 3 months to implement. • Open to a more targeted approach where possible. • Local optimised practices at present but the services need to streamlined for a systematic approach. • Non-traditional methods of operating and contacting patients was suggested, such as social media **Action:** Governance, oversight and performance management will be maintained by MSC. ○ To report monthly to MSC.

Meeting Minutes

5.	**HEALTH SYSTEM PLAN / CARE IN THE COMMUNITY PLAN UPDATE** Mr D Wu attended and presented this agenda item. Please refer to agenda for paper presented. Discussion was invited within the committee. Of note: • Statements within the paper are 'doing to' Māori instead ' with' Māori . • The goals also need to be supported with the infrastructure need to achieve the goals. • Suggestion to attend the current Waitangi Tribunal hearings at Turangawaewae to gain further insight to the current state and solutions. • The HSP Steering group noted that they are interested in a systems approach in responsiveness to Māori . For example, what does equity and good outcomes look like? The two outcomes areas we are interested in are 1.) Clinical outcomes and 2.) whole of health/social economic outcomes. • Community developments are at the top of the priority programme of work for Te Puna Oranga • The community need to be kept abreast of the resulting actions from the community wānanga before the final draft in finalised. **Action:** An invitation will be extended to all IMC, MSC members to attend the workshops that will be taking place in the next steps for the HSP.
6.	**KI TE TAUMATA O PAE ORA-IWI MĀORI HEALTH STRATEGY** Ms L Elliott presented this agenda item. A draft discussion document was presented for comment. See attached. The draft plan will be further workshopped at the November MSC meeting. Discussion of note. • The final draft of Ki te Taumata o Pae Ora will be ready by the end of November. • The question was posed of testing the approach that inequities are the proxy indicators for institutional racism. • Continued recommendation that accessing and understanding the inequity data is paramount and is are analysed through a Māori lens appropriately. • There can be misunderstandings regarding the term 'institutional racism' where some find it offensive, education is the solution for understanding this important issue.
7.	**MSC UPDATE** This agenda item was presented by Ms L Elliott. Discussion of note included: • Successful round of recruitment in the Puna Waiora space. • Approved recruitment of two further Kaiarahi, this is well within budget. • Masters research regarding Māori DNAs will be presented to the Executive Group on 26th October. • Equity focused report is not ready and will be presented to the Board in November. • An update in the priority programme of work was talked through and a regular upate to all items was requested. • Regarding CoF (Creating out Futures) that information going to the Board regarding CoF looks extremely clinically focused and a one size fits all model of care and not specifically looking at Māori and what works for whānau, It also appears to be driven by clinicians' needs. It was suggested that more information come to MSC as the board is not receiving this perspective. • It was noted that IMC have worked extensively in the CoF space and there were concerns that this is not reaching the board table. • The Let's Talk analysis should be completed soon and once those results have come in, it will drive the work that needs to come out of CoF and the transformation of care. • There is still strong recommendation that the model of care needs to be sorted out before the

Meeting Minutes

	facilities. A new building isn't going to lower rates of suicide for example. • The CoF recommendations that were tabled at IMC have resulted in a workshop that will take place. The IMC chair will be providing more information to IMC regarding this. • All recommendations tabled by IMC were answered with assurances to work together. • The next IMC meeting, November 8 will address any concerns regarding CoF.

8.	**GENERAL BUSINESS**
	• Congratulations were given to Ms T Thompson-Evans in her appointment to Community Services and Environmental at HCC.
	• The chair highlighted several areas to be included in the MSC workplan:
	  ○ Committee's position on commissioning for the Waikato DHB region.
	  ○ Strategy is for high needs populations.
	  ○ For members to provide input for 2019 MSC workplan content
	• More information was also requested regarding the current MH&A review.

9.	**KARAKIA WHAKAMUTANGA** Mr G Tupuhi

Meeting Minutes

Actions

	Details	Completed	Who
1.	Māori DNA elimination update due at the next MSC meeting		Mr G Howard
2.	Invitation extended to all IMC, MSC members to be part of the working group for HSP and CCP plans.		Mr D Wu
3.	Ki te Taumata o Pae Ora workshop completed at the next MSC meeting		Ms L Elliott
4.	Commissioning stocktake on government position on commissioning, relevant government review recommendations, literature and current WDHB position	February 2019	Ms L Elliott

Meeting Ended: 12:00 noon
Next Meeting: 21st November 2018

Chief Executive Report

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

DHB Budget issues

As per our discussion at the Board workshop, at the end of last year (2017/18) the DHB had a deficit of $37.4m in part because of significant investments we had made in response to pressure on our services. In preparing our budget for 2018/19 it was clear to all involved that service pressures had not abated. If anything they had increased. As a consequence our draft budget currently envisages a deficit at year's end of around $56M. It is apparent that if this were the outcome, Waikato DHB would be in an extremely difficult position in subsequent years, as each year's deficit builds on earlier ones. Balancing this need to ensure the financial viability of the Waikato DHB against the pressing need to invest is our current challenge.

In this regard we agreed a two-pronged approach.

Firstly, we will not ignore any significant service pressures brought to our attention; we will prioritise them and invest in them as we can. For 2018/19 this means we will invest to address many of the pressures we have identified. The timing of that investment will, however, be staged as a means of reaching a budget outcome better than a deficit of $56M. By this means and a more specific review of expenditure, I am envisaging a final budget outcome higher than last year's $37.4M deficit.

The second prong of our approach involves partnering with the Ministry of Health to establish an independent group of experts to work with us in assessing our service delivery aspects and related cost structure and working out where improvements can be made. This will be dovetailed with the development of our health service plans and our strategic direction. I am very keen that this team involves clinicians. The group's work will be a thorough, medium-term exercise intended to develop, together with our strategy, a three to five year pathway to a more sustainable position.

I have discussed this proposal with the Director General of Health; he was interested in the idea and wanted to discuss this with his Executive Team. I am awaiting a response from him

I will provide more detail of this work as it is developed.

Elective Services Patient Flow Indicators (ESPI) Compliance

Since February the DHB has continued to be ESPI compliant for ESPI 2 and 5, this is against a backdrop of deteriorating ESPI compliance for a number of DHB's since July this year. The issue was raised by the Director General of Health at a recent National Chief Executives meeting. Waikato DHB was identified as a DHB that had maintained good compliance.

Chief Operating Officer (COO)

As you know Dr Grant Howard has been the Interim COO since November 2017. We have now advertised for a substantive COO and interviews are being held on 23 October 2018.

Update on Complaint Related to State of the Toilets on Ward M14

Situation
The DHB was notified of a patient's concern around the cleanliness of the toilets in M14 during her inpatient stay. This concern was received via a newspaper article. A formal complaint was lodged via the DHB system on Monday 1st October.

Background
During the complainant's inpatient stay, the state of the toilets were such that she felt unable to use them. On the patient going to a nurse to express her concerns, the response was to suggest she utilised detergent wipes placed in the toilets to wipe the seat.

The was not the response the patient needed, she was not in a state where she felt she could do this, and expected the nurse to activate a process that would see the toilets cleaned properly and quickly. She complained to a doctor, saying she wanted to be discharged, this option, the doctor explained, would put her at risk and again she received no assurance that action to improve the situation was going to happen.

Assessment
Ward M14 is a mixed gender ward and all toilets and showers are also mixed gender. There are not enough to separate them out.

The ward cleaning regime consists of 7 hours per day, 7 days a week. Toilets are cleaned between 6am – 7am again at 1pm and then another clean between 7pm – 8pm.

There is a process in place that all staff are able to utilise if an active clean is required between those times.

The toilets in this ward are old and while some are stained, this has been caused by the cleaning products, not bodily waste.

The response this patient received was not to the standard we expect.

The formal complaint process is being followed, and this patient has been contacted and is being kept informed.

The nurse involved has been supported to understand how a different response could result in a different outcome, the doctor involved has not been identified.

Next Steps
This complaint is used as a reminder to utilise processes already in place.
Action: intranet notice, discussion point at various appropriate meetings.

Notice placed in the toilets that alerts patients to when last cleaned and who to go to when concerns exist.
Action: Nurses within this ward have now created posters placed in the toilets that show the last time the toilet was cleaned and how to notify staff if there is an issue – with an expected improved response.

Recommendation
THAT
The Board:

1) Receives the summary of the investigation and improvements as an update.
2) Notes the formal complaint process continues.

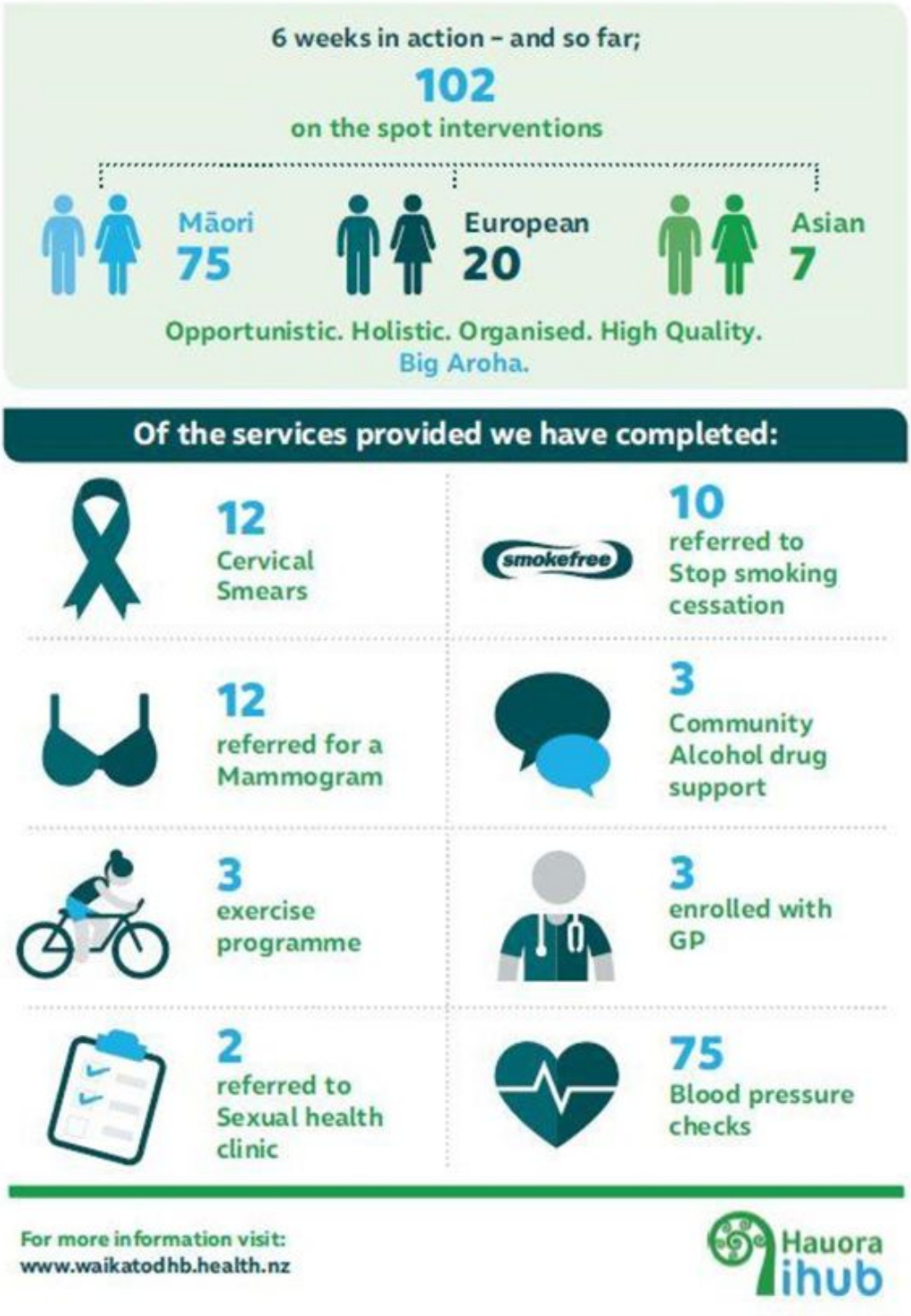
Hauora iHub

At the last meeting the Board asked for an update on the operation of the Hauora iHub. Attached is the latest score card which I will provide with my report periodically in the future, including childhood immunisation data.

Recommendation
THAT
The Board receives this report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

Action on equity: Hauora iHub



Quality and Patient Safety

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 5.1

USING CONSUMER STORIES

Purpose	For approval.

The proposed approach to consumer stories at Board meetings is outlined and the intention of using stories in education and learning opportunities as well as alongside improvement activity in services and departments as part of the consumer engagement framework is reinforced. It is important to remember that a consumer story remains subjective, and reflects the experience of that person at the time they accessed the organisation's services.

The Executive team have discussed the approach and support the use of written stories or video clips at the Board initially as opposed to actual consumers attending, noting that elected Board members also bring community and patient voices to the Board. Seeing a consumer's story told by them, in their own words is compelling. The story is direct and personal, yet the element of distance gained by the video means that viewers do not feel defensive or obliged to react in any expected way.

Stories will be obtained through a variety of sources including directly from the services and also the consumer council to ensure a range of consumer stories that reflects our local community: age; gender; ethnicity; disability, type of healthcare user (particularly, if targeting a particular service or process.). Service providers will be made aware of any stories regarding their service prior to them being shared with the Board.

It is proposed that a consumer story is told every other Board meeting with perhaps a staff story on the alternate months. The first consumer story is planned for the Board in November.

Radical Improvement in Maori Health Outcomes by Eliminating Health Inequities for Maori
Stories from Māori and whānau will support and reinforce this key strategic intent but also ensure a better understanding of a Māori world view and whanaungatanga

Recommendation
THAT
The Board adopts the proposed approach and guideline to consumer stories as part of the overarching consumer engagement framework

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY,

USING CONSUMER STORIES

Why Consumer Stories?

In indigenous culture, stories are a common repository of knowledge and facilitate the process of knowing. To extend this, a Māori approach called Kaupapa Kōrero was developed to gather, present and understand Māori experiences.

Robert Francis QC, Chair of the Mid Staffordshire NHS Foundation Trust UK Inquiry, said *"If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter".*

Introduction

Based on the understanding that consumers are equal partners in the delivery of healthcare services, consumer engagement is increasingly becoming an integral part of the planning process.

Listening to the experiences of health consumers through the story telling process is at the heart of consumer engagement within the health system**.** The stories give staff and decision-makers a window into the consumer's world, their experience of our health service and their perceptions of the quality of care they received.

A very simple story from a consumer about their experience can be a powerful tool to illustrate either the positive or negative aspects of service delivery in our organisation. Consumers may be any member of the community who has accessed services, or their whānau and family.

The primary purpose of gathering stories is for quality improvement and educational development. In this context consumer stories are narrative accounts that help us make sense and develop a better understanding of events that happen to ourselves and others.

Stories should be seen as one mechanism to capture patient, consumer, carer, service user and staff experience.

Waikato DHB is committed to partnering with consumers in order to ensure that DHB services are meeting the needs of our community, especially high-needs groups – in other words, keeping '*People at heart – Te iwi Ngakaunui'.*

This commitment is reflected in the DHB Strategy, particularly in the following areas:

- Whanaketanga – Productive partnerships
- Manaaki – People centred services
- Oranga – Health equity for high needs populations

Guidance and general principles.

The guidance below is to ensure ethical, safe and fair engagement, ensuring cultural respect.

Identifying Consumers

Consumers may be engaged through, but not limited to, the following:

- Patient Experience Week
- Consumer Council networks
- Complaints and feedback received
- Social media appeals
- Community Health Forums
- Te Puna Oranga
- Referrals from services and staff including Board members

Telling of the consumer experience may take different formats, from a consumer providing feedback to inform service design, to telling their story in person, on video, or via a written story. Both the consumer's preference and the nature and audience for the information will be considered.

Principles for engagement

1. Consumer stories should be told by the individual themselves, in their own words, and with the freedom to speak about impact and emotion. Avoid the urge to alter their version; it is their experience
2. Informed consent is vital. Explain how you envisage the story being used, and who the potential audiences may be. Advise the consumer that their story will create understanding of their experience, and will be used for learning to support improving the experience for others.
3. Use the Consent for use of patient/whānau stories and photography form, and enable the consumer to determine for themselves how widely and publically they are comfortable with their story being shared. This includes whether they are comfortable being identified, or prefer an anonymised version.
4. Consider what support the consumer would like when they tell their story; whether they would like a whānau member or support person with them, and what they need to feel safe in sharing their experience. Ensure the consumer's support needs are met.
5. Consider the location, both for the consumer's comfort, and if you are videoing, to ensure an appropriate location without noise and disturbance.
6. Ensure the consumer's cultural and language preferences are met. It may be appropriate to consider support from Te Puna Oranga (Māori Health Service) to ensure a kaupapa Māori safe environment.
7. Ensure that any photographs, filming and written work is shared with the consumer before it is published. The consumer can withdraw their consent at any time prior to publication without consequence, and all copies will be destroyed. It is important that the consumer understands their right to withdraw consent.
8. Ensure safe guardianship of consumer stories. They are a gift and provide a valuable resource for the DHB to understand and learn, but they still belong to the consumer (and their whānau), so must only be used as agreed by the consumer. Remember to ask the consumer if they would like a final copy of whatever is produced. Ensure that, if staff

member/s are mentioned, that they are kept informed and that the completed story is shared with them.

9. The consumer has trusted us with their personal journey and experience. Ensure to handle personal information sensitively and ensure confidentiality at all times.
10. Service providers (ie. senior clinical and managerial team) should be informed about any story regarding their service prior to it being shared. They may have additional context and information including any improvements that have been made to the service

Koha

While it would not normally be appropriate to provide remuneration to the consumer for sharing their story, it is important to ensure that any expenses are reimbursed, including travel and parking costs. If you consider that a koha is appropriate because of some inconvenience to the consumer, consider a small gift.

Sharing the Stories

These stories will form part of a library of consumer insights that, depending on the level of consent, could be used:

- On the intranet to support a specific initiative or change
- Within a service to create awareness from a consumer perspective
- At an Executive or Board level meeting, combined with data and other information, to support a need for change
- On social media to generate discussion
- In public spaces such as posters throughout DHB buildings to create awareness and a feeling of safety
- In the Newsroom as positive stories
- In publications to highlight the emotive perspective of an article
- For training and learning

Contributing Policies

Waikato DHB Informed Consent Policy
Waikato DHB Giving and Receiving Gifts Policy
Waikato DHB Pōwhiri and Whakatau Policy

Finance Performance Monitoring

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 6.1

FINANCE REPORT

Purpose	For information.

The financial result summary is attached for the Board's review.

Recommendations
THAT
The Board receives this report.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Group	Year to Date			Group Budget
Result for September 2018	Group Actual $m	Group Budget $m	Variance $m	Jun-19 $m
Revenue - CFA	320.2	318.4	1.8 F	1,269.2
Revenue - other	55.8	57.7	(1.9) U	229.7
Operating Expenses	(365.6)	(362.3)	(3.3) U	(1,468.2)
IDCC	(20.1)	(21.0)	0.9 F	(86.8)
DHB Surplus/(Deficit)	**(9.7)**	**(7.2)**	**(2.5) U**	**(56.1)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

Waikato DHB Group	Year to Date			Group Budget
Result for September 2018	Group Actual $m	Group Budget $m	Variance $m	Jun-19 $m
Funder	7.5	(0.3)	7.8 F	24.9
Governance	(0.6)	(0.3)	(0.3) U	(1.5)
Provider	(16.4)	(6.5)	(9.9) U	(79.5)
Waikato Health Trust	(0.2)	(0.1)	(0.1) U	(0.0)
DHB Surplus/(Deficit)	**(9.7)**	**(7.2)**	**(2.5) U**	**(56.1)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

Episodes

Acute

September 2018	2019 Actuals	2019 Plan	*Variance to Plan %*	2018 Actuals	*Variance to Prior Year %*
Surgical & CCTVS	4,744	4,288	*10.65%*	4,320	*9.81%*
Internal Medicine	4,905	5,055	*-2.97%*	4,544	*7.94%*
Regional Services	1,215	1,181	*2.88%*	1,141	*6.49%*
Child Health	1,620	1,472	*10.02%*	1,494	*8.43%*
Womens Health	2,251	2,215	*1.63%*	2,144	*4.99%*
TOTAL	**14,735**	**14,211**	***3.69%***	**13,643**	***8.00%***

Elective

September 2018	2019 Actuals	2019 Plan	*Variance to Plan %*	2018 Actuals	*Variance to Prior Year %*
Surgical & CCTVS	4,293	4,116	*4.31%*	3,780	*13.57%*
Internal Medicine	134	244	*-45.06%*	161	*-16.77%*
Regional Services	19	12	*56.97%*	11	*72.73%*
Child Health	178	196	*-9.00%*	183	*-2.73%*
Womens Health	404	313	*28.96%*	271	*49.08%*
TOTAL	**5,028**	**4,881**	***3.02%***	**4,406**	***14.12%***
Total Episodes Acute + Elective	**19,763**	**19,092**	***3.52%***	**18,049**	***9.50%***

Case Weighted Discharges

Acute

September 2018	2019 Actuals	2019 Plan	*Variance to Plan %*	2018 Actuals	*Variance to Prior Year %*
Surgical & CCTVS	8,105	7,489	*8.22%*	7,325	*10.64%*
Internal Medicine	4,343	4,552	*-4.58%*	4,192	*3.61%*
Regional Services	1,354	1,464	*-7.49%*	1,445	*-6.28%*
Child Health	1,926	1,822	*5.70%*	1,732	*11.21%*
Womens Health	1,261	1,260	*0.08%*	1,261	*-0.01%*
TOTAL	**16,989**	**16,587**	***2.42%***	**15,955**	***6.48%***

Elective

September 2018	2019 Actuals	2019 Plan	*Variance to Plan %*	2018 Actuals	*Variance to Prior Year %*
Surgical & CCTVS	5,423	5,870	*-7.63%*	5,793	*-6.39%*
Internal Medicine	89	174	*-48.52%*	113	*-20.77%*
Regional Services	29	25	*20.08%*	18	*67.94%*
Child Health	143	161	*-11.74%*	147	*-2.78%*
Womens Health	332	305	*9.02%*	259	*28.10%*
TOTAL	**6,016**	**6,535**	***-7.93%***	**6,329**	***-4.94%***
Total CWDs Acute + Elective	**23,006**	**23,122**	***-0.50%***	**22,284**	***3.24%***

Bed Days					
September 2018	**2019 Actuals**	**2019 Plan**	***Variance to Plan %***	**2018 Actuals**	***Variance to Prior Year %***
Waikato Inpatient Bed Days	52,629	52,703	*-0.14%*	52,441	*0.36%*
Waikato Other Bed Days	30,856	28,107	*9.78%*	28,107	*9.78%*
T-Hospital Bed Days	7,965	8,629	*-7.70%*	8,629	*-7.70%*
TOTAL	**91,449**	**89,439**	*2.25%*	**89,177**	*2.55%*

September 2018	**2019 Actuals**	**2018 Actuals**	**Variance to Prior Year %**
ED Attends	30,129	29,494	2.15%

MONTHLY COMMENTS

This report includes commentary on current year to date performance for the Waikato DHB Group compared to the budget to September 2018.

Delivery Plan Performance

Please note that episodes are up on plan and prior year. However, CWDs whilst up from the prior year are reflecting as unfavourable against plan. A contributing factor related to this is the higher than usual % of CWD accruals at the beginning of each year, which usually reflects an under coding. We continue to work with Operational Performance & Support to improve the accuracy of these CWD accruals.
We continue to accelerate the work required to allow for more meaningful volume variance analysis and extrapolation into related cost variance analysis. Whilst we have a detailed Price Volume Schedule as our key planned volume document, the level of detail here is not conducive to organisation wide analysis. In addition, a number of aspects require conversion in order to derive an organisation activity measure, such as caseweight equivalents for emergency department events and non caseweighted bed days. In addition, to be meaningful, we will accrue a caseweighted equivalent for patients not yet discharged at each month end – particularly relevant for long stay patients. Once we have this in place at both a planned and actual level, we will be able to better explain volume variances as well as average length of stay variances and the mix impact between planned and actual.

Financial Performance YTD Comment:

For September 2018 we have an unfavourable year to date variance to budget of $2.5m. This includes unfavourable variances arising from the timing of funding related to NZMO MECA and nursing acuity assumed to be receivable ($1.7m) and nursing personnel (employed and outsourced) costs unfavourable ($2.2m) which includes higher NZMO MECA settlement compared to budget ($1.0m), unfavourable annual leave movement, higher than budgeted overtime driven by the new acuity levels for staffing being in place earlier than budgeted and a higher level of mental health inpatient services. Furthermore clinical supplies unfavourable $3.6m which is impacted by the transition to NOS. We are working through transition to NOS including greater transactional clarity which could impact accrual calculations to date, including for clinical supplies. The savings plan to date is $3.7m unfavourable. We are awaiting washups from prior year which may provide a partial favourable offset.

As we are still in the first quarter of the year, and have transitioned to a new financial system (NOS), our best estimate at this stage for forecast remains unchanged from budget.

We recognise the capital expenditure spend as per the Capital Expenditure report (YTD spend of $9,287k) doesn't agree with the Treasury Purchase of Assets amount of $9,115k. This is due to NOS issues that are being worked through. We also recognise that this reflects a very slow start to the capital plan. This is due to a number of factors, including the impact of an "annual" capital plan (which we are very actively moving to a pro-actively managed rolling capital plan) and a shortage of resources, especially IS resources, which is being worked through. We have added in a new Asset Performance Indicator (API) to reflect the age of clinical assets compared to the suppliers expected life expectancy.

Provider:

The Provider is unfavourable to budget $9.9m - see detail for explanations. Variances include:

1. Revenue is unfavourable $5.4m due mainly to unfavourable internal revenue ($4.3m - eliminates against Funder) and timing variances relating to side arm contracts ($1.5m), partly offset by the recovery of NOS costs ($0.8m).
2. Employed personnel cost is favourable to budget $3.2m mainly due to favourable variances relating to Medical, Allied and Management, Administration and Support costs (offset in outsourced services), offset by an unfavourable Nursing variance. Further analysis below.
3. Outsourced personnel cost is unfavourable to budget $4.9m - partly offset in employed personnel cost and NOS costs recovered in other government revenue.
4. Outsourced services is favourable to budget $1.4m - analysis below.
5. Clinical Supplies is unfavourable to budget $3.6m due to the mix of activity. We are also working through the potential impact of the transition to NOS on these costs.
6. Infrastructure and non clinical supplies is unfavourable to budget $1.5m - analysis below.
7. IDCC is favourable to budget $0.9m. This relates mainly to a favourable depreciation variance as a result of the timing of capitalisation of assets.

Funder and Governance:

The results for the Funder is $7.8m favourable to budget. This mainly as a result of favourable internal provider payments ($4.3m) (eliminates against Provider), additional pay equity funding received ($1.8m) and a favourable provider payment variance ($2.4m). This is offset by unfavourable timing variances relating to CFA and side arm revenue receivable ($0.7m). Governance is close to budget.

Waikato Health Trust

The result for the Waikato Health Trust is close to budget.

RECOMMENDATION(S):

That this report for the period ended September 2018 be received.

ANDREW McCURDIE

CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Group Result:		
The Waikato DHB YTD Revenue Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**($0.1) U**	
CFA Revenue		
CFA revenue is favourable to budget mainly due to:		
• CFA revenue $1.8m favourable includes $1.0m additional pay equity funding (offset in NGO payments), and a favourable variance arising from prior year under accrual of elective revenue $0.6m.	$1.8 F	Neutral
Crown Side-Arm Revenue		
• Crown side-arm contracts $1.5m unfavourable to budget which includes Ministry of Health funding yet to be received for acuity and salary costs related to the NZNO MECA (1.7m), with other offsets.	($1.5) U	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is unfavourable to budget mainly due to:		
• Reimbursement of costs associated with the implementation of National Oracle Solution (NOS) $0.8m favourable (offset in Outsourced Personnel $1.1m).	($0.4) U	Neutral
• ACC Income $0.3m unfavourable which includes the annual contract for non acute rehabilitation being less than budget assumption for the year.		
• Trauma service $0.3m unfavourable due to a timing difference for funding received against an annual ACC contract.		
• Inter District Flow (IDF) income from other DHBs $0.6m unfavourable. Volumes by speciality and by DHB continue to fluctuate compared to budget. This includes lower CWDs in July due to the nursing strike.		
Other Revenue		
Other revenue is on budget	$0.0 F	Neutral

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($2.4) U**	
Personnel (employees and outsourced personnel total)	**($1.9) U**	
Employed personnel are favourable to budget mainly due to:		
● Medical personnel are favourable to budget by $2.7m. This includes a higher than expected vacancy level, including delayed implementation of improvement initiatives. This favourable variance is partly offset by outsourced personnel unfavourable variance of $1.2m.	$3.0 F	Neutral
● Nursing personnel are unfavourable to budget by $1.2m. This variance, along with the unfavourable outsourced personnel cost for nursing of $1.0m, includes higher final settlement of the NZNO MECA compared to budget of $1.0m (timing, as to be funded by MoH in October). Other variances include costs of a transferred contract, of $0.3m (offset in NGO providers). The variance also includes the impact of new acuity levels for staffing in place earlier than budgeted, and a higher level of mental health inpatient services. The extra cost includes unfavourable annual leave movement for the year to date, and higher than budget overtime.		Unfavourable
● Allied Health personnel are favourable to budget by $0.3m. The net favourable variance between employed and outsourced is $0.2m favourable and is as a result of higher than expected vacancy levels.		Neutral
● Management, Administration and Support personnel are favourable to budget by $1.3m. Variances are spread across the DHB including clinical support, and are mainly as a result of higher than expected vacancy levels. Part offset in outsourced personnel ($0.8m).		
Outsourced personnel are unfavourable to budget mainly due to:		
● Medical costs are $1.2m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $2.7m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.	($4.9) U	Neutral
● Nursing costs are $1.0m unfavourable. As for nursing personnel this is due to the impact of new acuity levels for staffing in place earlier than budgeted, and a higher level of mental health inpatient services.		Unfavourable
● Allied Health costs are $0.1m unfavourable to budget. The net favourable variance between employed and outsourced is $0.2m favourable and is as a result of higher than expected vacancy levels.		Neutral
● Management, Administration and Support costs are $2.6m unfavourable largely due to contractor costs of $1.1m for the implementation of the new NOS ERP solution ($0.8m of this cost is offset by additional other government revenue), and contractor costs of $0.7m for the patient flow project. The balance of $0.8m covers management, administration and support vacancies (offset in favourable employed personnel variance of $1.3m).		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$1.7 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced Clinical Services are $0.3m favourable to budget. This mainly relates to timing of outsourced elective services as facility lists run through external providers did not reach full capacity.	$1.7 F	Neutral
• Outsourced corporate service costs are $0.4m favourable to budget which includes delays in the implementation of Crown initiated information system changes such as IaaS.		
• Spend against allocated strategic funding is $1.0m favourable to date. This is expected to be a timing difference and includes initiatives related to health system transformation and to health equity.		
Clinical Supplies	**($3.6) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Treatment disposables - unfavourable to budget by $1.8m. This variance, along with the unfavourable instruments and equipment variance ($1.0m) is due to mix of activity (includes total episodes up on budget, despite CWDs being below budget). This includes theatres at 108% of budget. We also continue to have a timing difference arising from the transfer of inventory. We are working through transition to NOS including greater transactional clarity which could impact accrual calculations to date.	($3.6) U	Unfavourable
• Diagnostic and Other Supplies - close to budget at $0.1m unfavourable.		
• Instruments and Equipment - unfavourable to budget by $1.0m. As for treatment disposals, this variance is due to mix of activity (includes total episodes up on budget despite CWDs being below budget), and timing of transfer of products from inventory.		
• Implants and prosthesis - close to budget at $0.1m unfavourable.		
• Pharmaceuticals - unfavourable to budget by $0.6m. This includes timing of savings expected as a result of PHARMAC taking over further hospital drug procurement.		
Infrastructure and non-clinical supplies	**($1.9) U**	
• Favourable variances include a delayed start to building maintenance plan ($0.8m), budgeted surgical services project costs actually included in prior year ($0.6m), delayed commencement of information services projects ($0.3m), and utilities costs under budget for winter months ($0.2m).	$1.8 F	Favourable
• Savings allocation - $3.7m unfavourable variance in infrastructure relates to centrally held savings plan not specifically allocated.	($3.7) U	Unfavourable
NGO Payments	**$2.4 F**	
External Provider payments are favourable to budget mainly due to:		
• Favourable variances arise due to costs not being incurred in line with CFA revenue received, MoH and accrual adjustments relating to prior year funding and $0.3m favourable for a contract transfer (offset in nursing costs). This offset by $1.0m unfavourable to budget for pay equity (offset by CFA revenue).	$2.4 F	Favourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Interest, depreciation and capital charge	**$0.9 F**	
Interest charge is on budget.	$0.0 F	Neutral
Capital charge is close to budget.	($0.1) U	Neutral
Depreciation is favourable to budget due mainly to:		
● Slower than planned capital spend and the timing of capitalisation of assets.	$1.0 F	Neutral

TREASURY

Opinion on Group Result:

Cash flows are unfavourable to budget as detailed below.

YTD Actuals Sep-17 $'000	Waikato DHB Cash flows for year to September 2018	Year to Date Actual $'000	Year to Date Budget $'000	Year to Date Variance $'000	Budget Jun-19 $'000
	Cash flow from operating activities				
333,201	Operating inflows	368,274	377,838	(9,564)	1,497,840
(317,678)	Operating outflows	(359,328)	(358,759)	(569)	(1,484,968)
15,523	**Net cash from operating activities**	**8,946**	**19,079**	**(10,133)**	**12,872**
	Cash flow from investing activities				
391	Interest income and proceeds on disposal of assets	269	299	(30)	1,187
(6,499)	Purchase of assets	(9,155)	(29,352)	20,197	(117,094)
(6,108)	**Net cash from investing activities**	**(8,886)**	**(29,053)**	**20,167**	**(115,907)**
	Cash flow from financing activities				
0	Equity repayment	0	0	0	(2,194)
(2,162)	Interest Paid	(222)	(207)	(15)	(826)
77	Net change in borrowings	(147)	10,071	(10,218)	116,821
(2,085)	**Net cash from financing activities**	**(369)**	**9,864**	**(10,233)**	**113,801**
7,330	**Net increase/(decrease) in cash**	**(309)**	**(110)**	**(199)**	**10,766**
856	Opening cash balance	(2,973)	(2,973)	0	(2,973)
8,186	**Closing cash balance**	**(3,281)**	**(3,083)**	**(199)**	**7,793**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($10.2) U**	
Operating inflows	**($9.6) U**	
• The unfavourable inflow variance is predominantly due to cash receipts budgeted but not received. There is a corresponding increase in Accounts Receivable and Accrued Debtors $9.7m. This relates to a number of accruals including NOS recoveries and unsigned contracts.	($9.6) U	Neutral
Operating outflows	**($0.6) U**	
Operating cash outflows for payroll costs are unfavourable mainly due to:		
• Personnel costs are unfavourable against budget mainly due to NZNO MECA settlement payments.	($3.1) U	Unfavourable
Operating cash outflows for non-payroll costs are favourable mainly due to:		
• Favourable operating costs are largely due to an early payment of June Creditors of $17.8m on 26th June to assist with the NOS transition. This payment was budgeted to be made in July (20th month) resulting in a favourable variance. This offset by unfavourable operating variance of$2.0m and unfavourable payables variance of $2.1m. The remaining variance arises due to the timing of payment runs.	$1.8 F	Favourable
• GST cash movement is favourable due to timing variances on GST transacted.	$0.7 F	Neutral

Cash flow variances resulted from:	Variance $m	Impact on forecast
Net cash flow from Investing Activities	**$20.2 F**	
• Interest charge is on budget.	$0.0 F	Neutral
• Purchase of assets is slower than planned for the year. This is as a result of deferred timing of spend.	$20.2 F	
Net cash flow from Financing Activities	**($10.2) U**	
• Cash flow from financing activities is unfavourable due to the deferment of planned finance leases and budgeted deficit support not received.	($10.2) U	Neutral

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 (EXCLUDING WAIKATO HEALTH TRUST)
CASHFLOW FORECAST (GST INCLUSIVE) $000

As at 30-Sep-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	6,005	4,594	4,594	6,811	3,780	2,800	6,039	4,252	4,708	6,811	6,966	4,680	4,564
Funder inflow (MoH, IDF, etc)	136,771	143,419	132,213	132,213	137,083	132,213	132,213	137,083	132,213	132,213	136,162	136,162	141,032
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	3,989	2,747	2,747	2,387	2,520	2,280	2,520	2,280	2,760	2,280	2,440	2,581	2,463
Rents, ACC, & HealthPac (General Accou	4,098	3,635	3,628	3,533	3,484	3,436	3,481	3,440	3,775	3,433	3,698	3,736	3,549
	150,863	154,395	143,182	144,944	146,867	140,729	144,253	147,055	143,456	144,737	149,266	147,159	151,608
Cash was applied to:													
Personnel Costs (incl PAYE)	(49,763)	(52,799)	(49,897)	(56,639)	(47,788)	(50,022)	(46,726)	(46,168)	(54,771)	(45,654)	(56,668)	(49,746)	(46,593)
Other Operating Costs	(36,429)	(38,624)	(39,026)	(37,218)	(32,620)	(35,520)	(39,122)	(37,820)	(38,974)	(33,420)	(23,580)	(29,926)	(25,678)
Funder outflow	(52,941)	(53,634)	(51,046)	(50,173)	(51,051)	(50,463)	(54,585)	(50,297)	(51,739)	(50,173)	(52,268)	(55,657)	(51,673)
Interest and Finance Costs	(17)	(23)	(23)	(21)	(21)	(21)	(21)	(18)	(13)	(18)	(23)	(23)	(23)
Capital Charge	0	0	0	(18,483)	0	0	0	0	0	(18,711)	0	0	0
GST Payments	(6,744)	(7,210)	(7,210)	0	(13,710)	(9,000)	(7,210)	0	(14,420)	(7,210)	(7,210)	(7,210)	(7,210)
	(145,894)	(152,290)	(147,202)	(162,534)	(145,190)	(145,026)	(147,664)	(134,303)	(159,917)	(155,186)	(139,749)	(142,562)	(131,177)
OPERATING ACTIVITES	**4,969**	**2,105**	**(4,020)**	**(17,590)**	**1,677**	**(4,297)**	**(3,411)**	**12,752**	**(16,461)**	**(10,449)**	**9,517**	**4,597**	**20,431**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	87	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
	87	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(3,325)	(5,000)	(9,000)	(9,000)	(3,500)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(6,000)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(3,325)	(5,000)	(9,000)	(9,000)	(3,500)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(6,000)
INVESTING ACTIVITIES	**(3,238)**	**(4,925)**	**(8,925)**	**(8,925)**	**(3,425)**	**(8,925)**	**(8,925)**	**(8,925)**	**(8,925)**	**(8,925)**	**(8,925)**	**(8,925)**	**(5,925)**
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	30,000	20,000	0	10,000	0	0	20,000	20,000	0	0	0
Finance Lease received	0	0	0	0	0	0	15,000	0	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	30,000	20,000	0	10,000	15,000	0	20,000	20,000	0	0	0
Cash was applied to:													
Capital Repayment	0	0	0	0	0	0	0	0	0	(2,194)	0	0	0
Finance lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	0	(26)	0	0	(26)	0	0	(15)	0	0	(15)	0
Working capital facility repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
FINANCING ACTIVITIES	**0**	**0**	**29,974**	**20,000**	**0**	**9,974**	**15,000**	**0**	**19,985**	**17,806**	**0**	**(15)**	**0**
Opening cash balance	(12,731)	(10,999)	(13,819)	3,210	(3,305)	(5,053)	(8,301)	(5,637)	(1,810)	(7,211)	(8,779)	(8,187)	(12,530)
Overall increase/(decrease) in cash	1,732	(2,820)	17,029	(6,515)	(1,748)	(3,248)	2,664	3,827	(5,401)	(1,568)	592	(4,343)	14,506
CLOSING CASH BALANCE	(10,999)	(13,819)	3,210	(3,305)	(5,053)	(8,301)	(5,637)	(1,810)	(7,211)	(8,779)	(8,187)	(12,530)	1,976
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	0	0	0	0	0	0	0	0	0	0
NZ Health Partnerships Ltd	(10,999)	(13,819)	3,210	(3,305)	(5,053)	(8,301)	(5,637)	(1,810)	(7,211)	(8,779)	(8,187)	(12,530)	1,976
Long-term Loans													
Finance Leases	0	0	0	0	0	0	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)
EECA Loan	(143)	(143)	(117)	(117)	(117)	(91)	(91)	(91)	(76)	(76)	(76)	(61)	(61)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(11,142)	(13,962)	3,093	(3,422)	(5,170)	(8,392)	(20,728)	(16,901)	(22,287)	(23,855)	(23,263)	(27,591)	(13,085)
Working capital facility	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(85,299)	(85,299)	(85,299)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(85,299)	(85,299)	(85,299)

BALANCE SHEET

Opinion on Result:

There are no material concerns on the balance sheet.

Prior Year June 2018 $'000	Waikato DHB Group Financial Position	As at September 2018 Actual $'000	Budget $'000	Variance $'000	Budget Jun-19 $'000
79,945	Total current assets	95,754	86,105	9,649 F	78,872
(197,999)	Total current liabilities	(221,694)	(219,471)	(2,223) U	(208,093)
(118,053)	**Net working capital**	**(125,940)**	**(133,366)**	**7,426 F**	**(129,221)**
722,564	Term assets	720,442	739,654	(19,212) U	787,735
(22,150)	Term liabilities	(21,598)	(24,621)	3,024 F	(32,080)
700,414	**Net term assets**	**698,844**	**715,033**	**(16,189) U**	**755,655**
582,361	**Net assets employed**	**572,904**	**581,666**	**(8,762) U**	**626,434**
582,361	**Total Equity**	**572,904**	**581,666**	**(8,762) U**	**626,434**

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is favourable to budget mainly due to:		
Current Assets		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $0.2m which reflects the product of all cash transactions. This is represented as a $0.2m favourable variance in Current Assets.	**$9.6 F**	Neutral
• Total accounts receivable and accrued debtors is higher than budgeted by $9.7m mainly due to an unbudgeted accrual of NOS recoveries $4.5m and unsigned revenue contracts $3.5m. The remaining variance is as a result off the timing of cash received compared with budget assumptions.		
• Prepayments are higher than budgeted by $0.6 due to payment timing assumption variances actual against budget.		
• Other unfavourable variances across a number of areas $0.5m.		
Current Liabilities		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $0.2m. This is represented as a $0.2m favourable variance in Current Assets. This is due mainly to the favourable variance relating to operating activities($10.1m) and financing activities ($10.2m) offset by an unfavourable investing variance from activities ($20.2m).	**($2.2) U**	Neutral
• Payroll liabilities are $0.3m unfavourable mainly due to the timing of budget assumption relating to pay runs.		
• Income in Advance $0.3m unfavourable to budget mainly due to the unbudgeted Health Workforce NZ contract.		
• GST $0.6m unfavourable to budget mainly due to timing variances on GST transacted.		

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Current Liabilities (continued		Neutral
• Accrued Creditors and Accounts Payable $2.1m unfavourable mainly due to unbudgeted accrual of NOS costs, and higher operational expenses which is evident in the results for the month and the timing of payments.		
• Other Current Liabilities are favourable to budget $1.1m mainly due to the Finance Lease being deferred to later this year.		
Net Term Assets:	**($19.2) U**	
Net Fixed Assets are under budget mainly due to slower than planned capital spend $20.3m, offset by favourable YTD depreciation $1.0m. Please see attached for latest forecast of capital spend for the year for further detail.	($19.3) U	Neutral
Investment in HealthShare has increased by $0.1m due to the share of profits for the 2017/18 year.	$0.1 F	Favourable
Non Current Liabilities:		
Non Current Liabilities are favourable due to deferment of budgeted finance leases.	**$3.0 F**	Neutral
Equity:		
Unfavourable variance driven mainly by budgeted MoH deficit support not received $6.6m and the unfavourable result variance of $2.5m. The remaining favourable variance relates to Waikato Health Trust Partially Reserved Funds movements.	**($8.8) U**	Neutral

CAPITAL EXPENDITURE AT 30 September 2018 ($000s)

Capital Plan					Cash Flow Forecast					Full Project Forecast		
Activity	Total Prior year Board Approvals	New Approvals FY18/19	Transfers During 18/19	Total Board Approved Capital Plans	Prior year expenditure for active Projects	Total Expenditure Forecast FY 18/19 (Actual + Planned)	Actual Expenditure YTD from 1 Jul-18 to 30 Sep 18	Approved and Planned Expenditure 01 Oct 18 - 30 Jun 19	Approved and Planned Spend Subsequent Years	Total Planned Expenditure (Actual + Forecast to Project completion)	Total Planned Expenditure Versus Total Board Approved	Total Commitments
Under $50K Subtotal	0	3,974	0	3,974	0	3,974	982	2,992	0	3,974	0	
Clinical Equipment Subtotal	16,972	41,719	0	58,690	11,406	47,294	4,077	43,217	0	58,701	-11	
Property & Infrastructure Subtotal	32,251	13,417	0	45,668	13,525	25,837	1,425	24,412	6,507	45,869	-201	0
IS Subtotal	18,123	14,706	0	32,829	13,345	19,258	2,682	16,576	0	32,602	227	
Corporate Systems & Processes Subtotal	10,042	320	0	10,362	3,788	6,547	83	6,464	0	10,334	27	
Regional Subtotal	8,216	1,264	0	9,480	1,043	7,678	39	7,639	0	8,721	759	
MOH Subtotal	0	0	0	0	0	0	0	0	0	0	0	
Trust Funded Subtotal	0	0	0	0	0	0	0	0	0	0	0	
REPORT TOTALS	**85,603**	**75,400**	**0**	**161,003**	**43,107**	**110,587**	**9,287**	**101,301**	**6,507**	**160,201**	**801**	

The transition to NOS has resulted in delays in capital reports becoming available. As a result the above data does not reconcile to the accounting records. This is being actively addressed.

Waikato DHB
CAPITAL EXPENDITURE AT 30 September 2018 ($000s)

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
Under $50K Subtotal	3,974	982	2,992	-
Dialysis Machine - Model 5008S -17	527	-	527	-
Dialysis, Hemofiltration Unit	364	-	364	-
Computer Information Sys. - Oncology (Ecilpse & Aria) -1	250	-	250	-
Linarc Accelerator	5,000	-	5,000	-
Blood Culture Analyzer	250	-	250	-
Radg. Unit, (Xray General Ed Room 1)	350	-	350	-
Easy Diagnost (Mcc Room 5)	350	-	350	-
Radg. Unit, Mobile Xray Machine -Mobile	300	-	300	-
Radg. Unit, Trauma Diagnost (Ed Resus)	700	-	700	-
Dual Head Gamma Camera - Hawkeye Infinia	730	-	730	-
Intellivue	364	-	364	-
Mp30 Intellivue	322	-	322	-
Monitor, Cardiac Multi-Parameter	282	-	282	-
Mammotest Breast Biopsy System	680	-	680	-
Monitor, Multi-Parameter	1,053	-	1,053	-
Datex As/3 Monitor 0E3867	320	-	320	-
Pump, Roller, Perfusion System	290	-	290	-
Scanners, Ultrasonic, Cardiac (Ie33)	250	-	250	-
Heart Lung Machine, Stockeret S111	303	-	303	-
Heart Lung Machine	315	-	315	-
Respiratory Function Equipment	299	-	299	-
Electophysiology Equipment	285	-	285	-
Maclab Muse & Haemodynamic System	690	-	690	-
Apex Pro Telemetry System (Including Installation	573	-	573	-
Toshiba Digital Image Processing (Cath Lab 2)	1,143	-	1,143	-
Toshiba Digital Image Processing (Cath Lab)	1,204	-	1,204	-
ICU Monitoring System	1,122	-	1,122	-
Monitoring System Upgrade - Network Project	625	-	625	-
S/5 Aespire 7900 Anaesthetic Machibe E11246	612	-	612	-
Physiologic Monitor Module, Multiparameter	456	-	456	-
Incubators, Infant	294	-	294	-
Incubator/Radiant Warming Unit, Infant, Mobile	330	-	330	-
Monitor, Bedside, Fetal	468	-	468	-
CT Machine Replacement Waikato x3	3,828	3,850	-	(22)
CT Machine Replacement Waikato x1	725	725	-	(0)
Ventilators (Critical Care)	400	-	400	-
Endoscopes	300	197	103	(0)
Replacement Theatre Lights OT 20-25	286	235	51	(0)
Renal Dialysis (CCD) machines x4 Prismaflex	564	601	-	(37)
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	1,096	218	(1)
Mobile Dental Unit Replacements - level 2	600	117	483	(0)
Bed Replacement Programme	400	260	-	140
Digital Mobile X-Ray Project	1,246	1,246	-	(0)
X-ray general (Radiology ED Room 1)	350	-	350	-
X-ray general (Radiology MCC Room 5)	350	-	350	-
Mobile Image Intensifier - Waikato	300	275	25	-
Anaesthetic machine - Aisys Carestation	380	365	15	0
Heart Lung Machines	1,493	1,493	-	0
Vascular & Interventional Replacement	1,750	-	1,750	-
General X-Ray replacement Thames	700	-	700	-
Biochemistry main Analysers	300	-	300	-
Liquid Chromatography Mass Spectometry Analyser	600	531	69	0
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	20	805	(0)
L8 Menzies Surgical Assessment Unit (Acute)	1,561	1,636	-	(75)
Other Clinical Items <$250K	8,844	1,949	6,997	(102)
Unplanned Clinical Items - Bucket	6,155	-	6,155	0
New Clinical Items - required due Activity Growth	3,687	-	3,688	(1)
Projects Removed to be Capitalised	893	887	-	6

Other Clinical items - Reserve funding	4,999		4,999	(0)
Savings required	(5,981)		(6,062)	81
Clinical Equipment Subtotal	**62,664**	**16,466**	**46,210**	**(12)**
Mental Health Facility - Scoping -part 2	2,973	41	2,932	0
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Gallagher Building - Med Store & CSES Clinic	406	402	-	4
Gallagher Building - Racking System	362	522	-	(160)
Gallagher Building - Converyor System	348	356	-	(8)
Waiora Level 1 - ED Acute Observation Unit	650	-	650	-
Waiora Level 1 - Development of MCC L1 Shell space (for other decants from Waiora L1 : atten	750	-	750	-
Waiora Level 1 - Seismic Works *** part of $2m in Capital Plan	500	-	500	-
Waiora Level 4 - Workspace open plan / decant from Waiora L3 (Includes item removed from b	650	-	650	-
Waiora Level 4 - Sleep space expansion	300	-	300	-
Waiora Level 2, 3 & 4 - Decant space development in ERB3 for Waiora L2, L3 & L4	600	-	600	-
Waiora L3 - Laboratory / Histology / Molecular Biology co location	250	-	250	-
Waiora L1, Menzies L8, OPR5 Kitchen Impact : Kitchen & Food Delivery - Refurbishment & extra	1,500	-	1,500	-
Hamilton Consolidation of CBD facilities - 9th Floor	850	850	-	(0)
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	2,623	6,502	(1)
Hamilton CBD - Collingwood Street Development - First Floor	5,584	447	5,337	(200)
Tokoroa / Te Kuiti / Taumarunui Pregnancy Support Facilities (Fitout of leased premises)	300	-	300	-
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	183	367	(0)
Hague road carpark - Seismic and Beam support	2,032	-	2,032	-
Urology to L8 Menzies	320	22	298	(0)
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Waikato Hauora iHub	321	280	41	0
Ward Block A & Environs	250	-	250	-
Waikato switchboard upgrades core buildings	866	90	776	0
Infrastructure Replacement Pool (17/18)	510	542	-	(32)
Infrastructure Replacement Pool (15/16)	600	731	-	(131)
Infrastructure Replacement Pool (16/17)	641	205	436	-
Infrastructure Replacement Pool (18/19)	600	-	600	-
Project Management Resource to deliver BAU Critical Infrastructure projects (2 FTE Equivalent	250	-	250	-
Cooling Tower Dosing System Upgrades (2-plus)	300	-	300	-
Lomas Chillers	390	240	150	0
Fire Protection Upgrade to meet compliance requirements	425	-	425	-
Thames - PHO enabling works	500	-	500	-
Seismic Assessments & Remediation (all campus's not itemised elsewhere)	500	-	500	-
Waikato Distribution Boards	250	213	37	-
Electrical Systems Improvement	6,714	5,969	745	-
Carpark safety improvement (Nets / Cages)	550	-	550	-
Other P&I Projects Budgeted <$250K	4,626	1,140	3,413	73
Projects removed to be capitalise	276	94	-	182
Less: Proceeds on sale of property (206 Collingwood St)	(1,500)	-	(1,500)	-
Savings required	-	-	(71)	71
Property & Infrastructure Subtotal	**45,668**	**14,950**	**30,919**	**(201)**
Information Systems				
ISSP - Clinical and corporate Platform SQL Server consolidation	365	266	99	0
IMPACT Patient Flow Tool	1,534	1,131	402	1
SQL Server 2016 upgrades / Citrix XenApp vS VDI	500	35	465	0
ISSP - Data Warehouse Upgrade (Data Warehouse Phase 1)	387	328	59	0
ISSP- Clinical Photography and Image Management	397	166	231	(0)
ISSP - Communication Room Remediation Lifecyle	368	38	330	(0)
ISSP - Paging System Replacement	290	296	-	(6)
ISSP - Network Remediation Work Package 2015/2016	399	345	54	0
ISSP - WiFi Rollout	487	454	33	0
ISSP - Network Remediation Lifecycle Work Plan 16/17	282	258	24	(0)
LAN / WLAN - IMPLEMENT: Install WAPs (extend Wi-Fi coverage)	997	101	897	(1)
LAN / WLAN - UPGRADE: Wireless LAN Controllers (Address core capacity constraints)	263	202	60	1
LAN / WLAN - UPGRADE: Distribution Switches	750	-	750	-
LAN / WLAN - UPGRADE: Access Switches	1,519	-	1,519	-
NIPS - IaaS Implementation	1,557	1,238	319	(0)
Disaster Recovery Solution	1,800	-	1,800	-
DeskTop WorkPlan 16/17	288	184	104	(0)
End User Devices (<$2k) - now capitalised	1,740	956	784	0
Rollout of devices at point of care (Investment in circa 500 tablets)	491	2	489	(0)
ISSP - Mobile office Productivity & Management	392	186	206	(0)
Tablet rollout (Year 2 of 4 year plan)	500	-	500	-

ISSP - MS Licensing True-Up	476	129	347	-
ISSP - Other Licensing True-Up	349	83	266	-
ISSP - MS Licensing True-Up -2	400	-	400	-
ISSP - Other Licensing True-Up 2	266	-	266	-
ISSP - Enterprise Business Intelligence Tool	305	278	27	(0)
Business Intelligence Data & Reporting	453	53	400	0
Enterprise Service Bus (ESB) Phase II	263	-	263	-
Enterprise Messaging/Communication Solution	350	-	350	-
ISSP - SharePoint Work Pan 16-17	401	351	50	0
ISSP - Rapid Logon	359	36	323	(0)
ISSP - Toolsets (IS Toolsets 15/16)	507	506	-	1
ISSP - Netscaler Infrastructure	301	340	-	(39)
Sharepoint 15/16	350	285	65	(0)
Win 10 Upgrade	500	61	438	1
Mobility & Mobile Apps	371	-	371	0
Patient IS capabilities - Observations Platform	361	30	331	0
ISL merge ANZ version with European version	500	-	500	-
EBI Tool implementation phase 2 (Qlik Sense Licences)	450	-	450	-
Archiving Tool Implementation	378	-	378	-
Office 2016 upgrade	300	5	295	(0)
Windows 2008r2 to 2016 Server upgrades	800	-	800	-
Security Defence in depth	500	70	430	-
Clinical Workflow Integration Work Plan	384	395	-	(11)
Clinical Workstation Core Component Workplan	513	603	-	(90)
Database Replacements	301	81	220	0
iPM upgrade to V10 - after 16/17	484	565	-	(81)
Cat1-5 In-House Developed Applications Work Plan	330	376	-	(46)
Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	259	246	13	(0)
Oral Health system	852	924	-	(72)
eCWB Infrastructure	254	238	16	-
HealthViews access to Primary Encounters (GP to Workstations)	306	304	2	-
eOrders	290	246	44	(0)
Anaesthesia Information System - Implementation	600	-	600	-
Observations Platform (eVitals) - implementation	700	-	700	-
Nutrition & Food Management	932	58	874	(0)
Other IS Projects Budgeted <$250K	8,040	3,001	5,437	(398)
Projects to be Capitalised	1,408	575	-	833
Savings required	(7,070)		(7,205)	135
IS Subtotal	32,829	16,026	16,576	227
Corporate				
HRIS Lifecycle Upgrade 15_16	529	51	478	-
Costpro Upgrade	313	243	70	(0)
HRIS remediation	4,218	-	4,218	-
SmarthHealth devices	320	-	320	-
incl Mobile printing for IOS	600	389	211	(0)
Clinical Device Platform	491	46	446	(1)
SCEP racking - hospital wide	400	-	400	-
PeopleSoft Global Remediation	478	478	-	(0)
MECA and Rule Management	289	289	-	0
PLA and Leave Rule Updates	361	361	-	0
Payroll Process Improvements	480	631	-	(151)
National Patient Flow Phase 3 16/17 & 17/18 & 18/19	385	277	107	1
Other Corporate Projects Budgeted <$250K	1,498	1,105	214	179
Corporate Subtotal	10,362	3,870	6,464	28
MOH & Trust Funded				
HSL - eSpace Programme	6,014	-	6,014	-
National Oracle Solution - Elevate	3,929	1,082	2,088	759
PACS review	392	-	392	-
Telestroke Pilot	321	7	314	-
Other MOH & Trust Funded Projects Budgeted <$250K	872	-	872	-
Savings required	(1,727)		(1,727)	-
(Funded by MOH)	(321)	(7)	(314)	-
MOH & Trust Subtotal	9,480	1,082	7,639	759

Total Projects	**161,003**	**52,394**	**107,808**	**801**

The transition to NOS has resulted in delays in capital reports becoming available. As a result the above data does not reconcile to the accounting records. This is being actively addressed.

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
September 2018

Travel costs include airfare, accommodation, taxis/shuttles and meals. Travel relating to training or conferences does not include the event registration fees.

Travel charges originating from the WDHB travel agent (Tandem Travel) are processed one month in arrears once data is available. In addition, the agent takes an average of 45 days to charge pass on costs such as accommodation. For this reason, costs reflected in this report may relate to prior months' travel.

Travel costs - Executive Group	Month			Year to Date			
September 2018	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AITKEN VICKI	53.00	-	53.00	164.30	-	164.30	
AYDON LYDIA	-	-	-	-	-	-	
CARDWELL CHRIS	-	-	-	-	-	-	
CHRYSTALL MAUREEN	-	-	-	1,019.59	-	1,019.59	
ELLIOTT LORAINE	506.04	-	506.04	506.04	-	506.04	
HABLOUS NEVILLE	177.74	-	177.74	177.74	-	177.74	
HAYWARD SUE	99.91	701.20	801.11	683.17	1,344.98	2,028.15	Int Travel - Quality & Safety in Healthcare forum,
HOPGOOD GARY	425.06	-	425.06	425.06	-	425.06	
HOWARD GRANT	-	-	-	927.18	-	927.18	
MALONEY TANIA	(26.49)	-	(26.49)	1,310.50	-	1,310.50	
NEVILLE MO	150.61	-	150.61	575.08	905.49	1,480.57	Int Travel - Health round table, Sydney
SEWELL GILL	-	-	-	-	-	-	
TAHU SUE	-	-	-	-	-	-	
TAPSELL REES	649.88	-	649.88	667.27	-	667.27	
TER BEEK MARC	60.00	-	60.00	60.00	-	60.00	
TOMIC DAMIAN MR	-	-	-	-	-	-	
WRIGHT DEREK	771.94	-	771.94	923.26	-	923.26	
Grand Total	**2,867.69**	**701.20**	**3,568.89**	**7,439.19**	**2,250.47**	**9,689.66**	

Interim CE Travel Expenditure Derek Wright

Travel costs for the period to 30 September 2018				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
21 February 2018	40.91	Late charge prior year Taxi Fare Health Commissioner	Taxi	Wellington
8 June 2018	45.12	Meet & Welcome new MoH Director General	Taxi	Wellington
June 2018	72.17	3 x meetings in Wellington with MoH in June 2018	Hamilton airport parking x3	Hamilton
18-19 June 2018	40.54	MoH - WDHB annual plan and Budget meeting, meeting Dept. Corrections	Taxi	Wellington
6 August 2018	77.13	Meeting CE and Chair of Counties Manukau DHB	Mileage and parking	Auckland
7 August 2018	70.00	Presented to APEX conference	Mileage	Auckland
9 August 2018	577.38	National DHB CE meeting	Parking, airfare , taxi	Wellington
	923.26			

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 6.2

ASSET PERFORMANCE INDICATOR UPDATE

Purpose	For information.

District Health Boards must provide asset performance information (a requirement from Cabinet) on the following asset performance indicators:

- Utilisation;
- Condition; and
- Functionality (fitness for purpose).

The information is to cover both owned and leased assets, and we have set asset performance targets for each measure. Actual results against targets are to be reported in our annual report.

The attached table reflects our Asset Performance Indicators targets for the 18/19 financial year and September 2018 YTD performance against these. Items highlighted are those where we have not yet achieved the target.

Recommendation
THAT
The Board notes this update of Asset Performance Indicators as at September 2018.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

Asset Performance Indicators

Property and Fleet Performance measures

Asset	Measure	Indicator	Target	2018/19	Target Explained
Waikato Campus buildings	Physical Waikato Campus buildings relative Earthquake risk	Condition	Greater than 77%	68%	Waikato Campus buildings rated greater than score 6 or better per Holmes 2011 report which assessed portfolio for earthquake risk relative to current standard design & detailing. Where 6 = buildings that perform fairly well in an earthquake but have issues / vulnerabilities.
Waikato Campus Buildings - Core services within	Total physical down time (Hrs) for Core services at Waikato DHB as a % of total operating hours per annum	Condition	Less than 1%	0.68%	Unplanned downtime for Core services Infrastructure Plant & Equipment, Lifts, Generators and Boilers at Waikato campus total operating hours calculated as = 8,736 hrs
Waikato Campus Buildings - Core services within	Total hours core services available (net of planned maintenance hours) / Total core services operating hours per annum.	Utilisation	Greater than 99%	99.32%	Available hours less planned downtime Core services Plant & - Lifts, Generators, Boilers, availability at Waikato campus.
Waikato Campus Carparks	For the Waikato Hospital Number of mobility carparks as a % of total public car parking	Functionality	Greater than 5%	5.8%	National standard measure for building functionality : There are 132 disability carparks out of 2280 available carparks across campus

Waikato Campus Buildings - Energy	**Energy Efficiency (savings) E**nergy savings per annum (Kwh /m2/year) across Hamilton campus buildings as a % of targeted consumption)	Functionality	Greater than 7 % saving	7%	The calculation is provided by our energy consultant and presented at the quarterly Energy Management Group meeting. Total power used by all occupied buildings per annum versus Waikato campus buildings managed space usage, as measured Kwh /m2 per annum. Target is 464 Kwh /M2 against historical usage across Hamilton campus of 499 Kwh / M2

Clinical Performance measures

Asset	**Measure**	**Indicator**	**2018/19** Target	Actual	Target explained
CT Scanners & Linear Accelerators (Radiology & Oncology departments)	For Waikato hospital % of CT's and Linear's Accelerator's compliant with manufacturers specifications and Radiation Protection Act	Condition	100% compliant	100%	For all CTs / Linear Accelerators Radiation certifications up to date, are compliant with Radiation Safety Act 2016 act and machines are functioning to manufacturers' specifications - external auditors provide confirmation.
CT Scanners - Radiology	For Waikato hospital Radiology CT planned patients versus actual patients scanned	Utilisation	Greater than 90% of planned volumes in planned time	99%	Two CT Scanners: Mon - Friday 0800 to 16.30 then 1 CT Scanner on call Sat and Sun 0800 to 1700. 1 CT Scanner Mon - Friday 1630 to 1800. Planned utilisation 1 patient every 15 minutes or 74 patients per weekday and 64 patients over weekends. Total planned patients per week = 439 or 514 scans on average per week. A tolerance level of 10% set to allow for setups for non-standard scans.
Linear Accelerators- Oncology	For Waikato hospital Oncology LINAC available hours versus actual hours utilised	Utilisation	Greater than 86.40% of actual operating hours in planned time	78.5%	For the Oncology Linear Accelerators K00364-367, Planned week day operating hours versus actual operating hours = 10 total hours (8am - 6pm) Monday - Friday less preventative maintenance plan per service contract. = 10,400 - 1406 =8,994 hours or 86.4%

Operating Theatres	For the Waikato hospital planned Theatre usage versus actual Theatre usage	Utilisation	Greater than 2016/2017 actual minutes achieved (to be revised once KEEZZ work has been concluded).	444,490 Sept-18 YTD. Extrapolates out to 111% or 1,777,960 for full year.	Day session Monday - Friday, Elective includes day acute list & acute sessions. Planned actual time (minutes) in Main Operating Theatres (22) per day when patient physically enters Op room. Target for 2017/2018 is 100% or better of 2016/2017 actual time.= 1,597,336 mins
Building facilities / theatres / clinical equipment	Outpatient Services across all Waikato facilities. Planned Outpatient services to be delivered versus Actual outpatient attendances	Utilisation	>= 212, 035 outpatient attendances.	51,932 Sept-18 YTD. Extrapolates out to 207,728 for full year.	Number of outpatients attending outpatient services. Planned contract number is 212,035
Beds / Wards	For Waikato hospital Actual beds Occupied versus Planned bed Occupancy	Utilisation	Less than 93%	97%	The data looks at all inpatient wards within CCTV/IM/Surgery/Orthopaedics/ Oncology/Paediatrics/ Women's Health/OPR and excludes Critical Care. Actual beds occupied (days) versus planned bed occupation (days) for 12 months from a total 214,255 available beds.
Theatres / Clinical Equipment	MOH Elective Surgery targets across Waikato DHB versus Actual Elective Surgery completed	Utilisation	Greater than 17,475 discharges	4,656 Sept-18 YTD. Extrapolates out to 18,624 for full year.	Per MOH Elective health target, includes patients who are: Domiciled in Waikato DHB, eligible for publicly funded treatment (not ACC) and are treated electively in any DHB in the relevant health speciality. MOH target is 17,475 patient discharges
CT scanners - Radiology	For Waikato hospital Radiology CT performing operationally to Hospital requirements	Functionality	Greater than 99% performed as per clinicians' requirements.	99%	CT scanners at Waikato Radiology / Oncology / Thames hospital are performing operationally as per clinician requirements, i.e. scan capability = requirements of Clinicians. This is measured through Clinician feedback where a 100% target = no negative feedback on CT capabilities

Waikato DHB All Clinical Assets	Age of Assets. Weighted Average age of assets (Per Fixed Asset & Bio Medical registers) versus Suppliers Weighted Average Life Expectancy.	Condition / Functionality	tbc	Still to be calculated	For Clinical assets, age in service is an indicator of asset condition and whether an asset is fit for purpose. This measure considers the age in service of all Core Critical and Core assets against supplier recommended life (ECRI standards) of each asset. The target is defined as a % of total assets which are within ECRI asset life range of 6 – 9 years.

ICT Performance measures

Asset	**Measure**	**Indicator**	**2018/19**		
			Target	Actual	Target explained
Laptops / Tablets / PC's	Physical % of Computers aged < 5 years	Condition	Greater than 90%	85%	Computers = Tablets / PC's / Laptops. Target adjust due funding constraints "Tablets 11; nil life cycle, but all < 5 years old – 100%: Laptop 899; lifecycle is 3 years, but 883 < 5 years old – 98%: PC 4740; 4402 < 5 years – 92%. Average = 96.66%
Software systems	Physical Availability of Clinical IT systems across Waikato campus as a % of total hours, days per annum	Condition	Greater than 99.90%	99.58%	Critical means Clinical systems: iPM = 100%, CWS = 100%, iSL = 100%, PACS = 99.79%. Average 99.95%.
Software systems	Number of IT system wide critical Priority 1 faults per annum	Condition	Less than 24	3	Priority 1 = Critical business impact - key service areas are unable to work or there is an IT security breach. There is no work around solution available and immediate restoration is required.

Software systems	Number of (relevant) users able to access clinical - non clinical system platforms remotely / total clinical non clinical staff	Utilisation	Greater than 30%	29%	30% of total of 6,622 staff. Remote access = access to WDHB clinical / non clinical systems via Citrix software
Servers & storage facilities	% Of data centre server and storage assets used	Utilisation	Greater than 85%	35%	Data storage target - subject to monthly capacity tracking & growth forecasting
Software & Network Systems	% Peak bandwidth usage	Utilisation	Less than 30%	17.6%	Bandwidth target – Time IT systems running at peak through Core Network switches.
Software & Network Systems	Customer satisfaction with ICT measured on a 1 -10 scale	Functionality	Greater than 75%	75%	6 monthly survey of senior business owners. Target of 75% = 7.5 on the IT customer satisfaction scale.
Software & Network Systems	Percentage of IT systems incidents resolved within agreed department service levels	Functionality	100%	97%	All software and Wide Area Network bandwidth related incidents resolved as reported by Cherwell system

Health Targets

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 7

HEALTH TARGETS REPORT

Purpose	For information.

Most Recent Results

The most recent official results on the (former) Health Targets were presented previously as the Quarter 1 results are not available until late October 2018. The only new data available on the health targets is the monthly elective surgery result, the three-month rolling immunisation (8 months) result and the Raising Healthy Kids result as shown in Table 1.

Table 1- Health targets performance summary

HEALTH TARGETS		16/17 Target	2016/17 Q1 results	2016/17 Q2 results	2016/17 Q3 results	2016/17 Q4 results	17/18 & 18/19 Target	2017/18 Q1 results	2017/18 Q2 results	2017/18 Q3 results	2017/18 Q4 results	2018/19 Q1 results	Target achieved	Most recent result
Shorter stays in emergency departments		**95%**	89.3% 19th ✗	87.6% 20th ✗	88.4% 20th ✗	86% 20th ✗	**95%**	82% 20th ✗	89% 20th ✗	86% 19th ✗	84% 19th ✗	Unavailable	X	83% Jul-18 YTD*
Improved access to elective surgery		**100%**	108% 7th ★	106% 10th ●	110% 3rd ★	114% 2nd ★	**100%**	111% 5th ★	104% 8th ●	105% 6th ★	105% 7th ★	Unavailable	√	101% Sep-18
Faster Cancer Treatment (FCT)	Achievement	**85%**	81.4% 5th ★	85.9% 4th ★	86.1% 5th ★	86% 2nd ★	**90%**	98% 1st ★	98% 2nd ★	97% 3rd ★	96% 3rd ★	92% Provisional	√	96% Aug - 18
Better Help for Smokers to quit	Primary Care	**90%**	87% 12th ●	86% 13th ●	87% 12th ●	88% 15th ✗	**90%**	88% 14th ●	89% 12th ●	88% 14th ●	87% 16th ✗	Unavailable	X	87% 17/18 Q4 result
	Maternity	**90%**	93% 12th ●	96% 4th ★	98% 4th ★	95% 8th ●	**90%**	94% 8th ●	97% 4th ★	99% 3rd ★	87% 14th ●	Unavailable	X	87% 17/18 Q4 result
Increased immunisation (8 months)		**95%**	92.3% 13th ●	92% 15th ✗	90% 16th ✗	89% 15th ✗	**95%**	88% 15th ✗	90% 15th ✗	89% 14th ●	88% 14th ●	87% 16th ✗	X	88% Sep-18 3 mth rolling
Raising Healthy Kids		**95%**	47% 11th ●	79% 6th ★	84% 9th ●	81% 14th ●	**95%**	76% 19th ✗	100% 1st ★	100% 1st ★	100% 1st ★	100% 1st ★	√	100% 6 mths Aug 18

Key: DHB rating		
★ **Good**	● **Average**	✗ **Below average**
Top third of DHBs	Middle group of DHBs	Bottom third of DHBs

*Changes in IPM and patient flow process has resulted in coding changes that need to be addressed, thus Aug & Sep result unavailable until rectified.

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2017/18 – Q1 2018/19 not available

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
82.1%	88.8%	85.8%	83.6

Table 3 - Emergency Department Q4 results by site and by clinical unit – Q1 2018/19 not available

Total		
Numerator: Number of Patient Presentations to ED with Length of Stay < 6 Hours		Percentage of Patient Events Admitted, Discharged or Transferred from ED within 6 hours
23,968	28,653	83.6%
16,214	20,323	79.8%
3,613	4,049	89.2%
2,868	2,962	96.8%
1,273	1,319	96.5%

		Maori			Pacific		
DHB	Individual ED Facilities	Numerator: Number of Patient Presentations to ED with Length of Stay < 6 Hours	Denominator: Number of Patient Presentations to the ED	Percentage of Patient Events Admitted, Discharged or Transferred from ED within 6 hours	Numerator: Number of Patient Presentations to ED with Length of Stay < 6 Hours	Denominator: Number of Patient Presentations to the ED	Percentage of Patient Events Admitted, Discharged or Transferred from ED within 6 hours
Waikato DHB	Combined DHB	7,541	8,845	85.3%	643	751	85.6%
	Waikato	4,984	6,157	80.9%	480	581	82.6%
	Thames	662	735	90.1%	10	10	100.0%
	Tokoroa	1,300	1,342	96.9%	57	62	91.9%
	Taumarunui	595	611	97.4%	96	98	98.0%

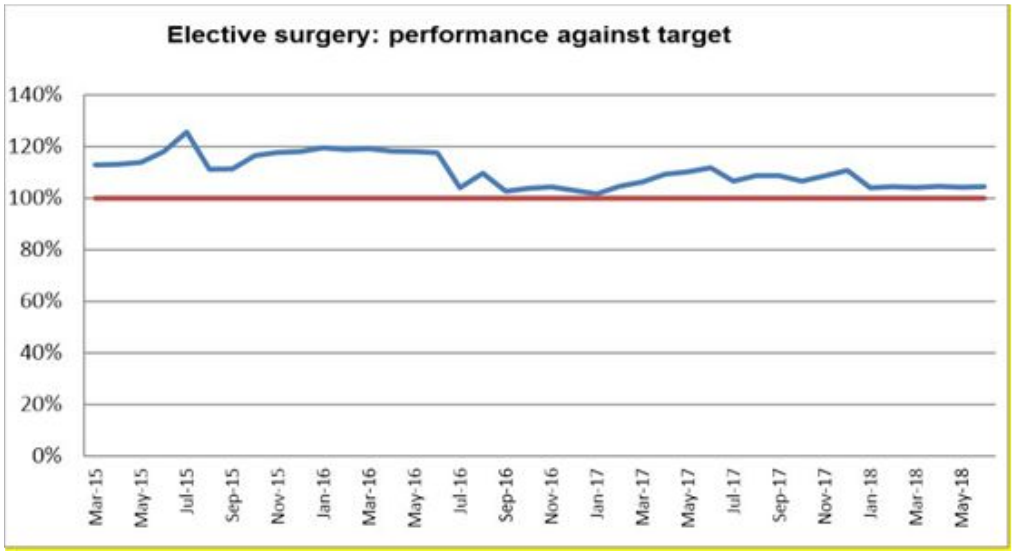
Target: Elective Surgery

Table 4 – Elective Surgery Results by Quarter

Quarter	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
Result	102.6%	103.1%	106.3%	111.8%	111%	104%	105%	105%	100.8%
Ranking	7	10	3	2	5	8	6	7	Not available

Graph 1 below provides result of 104.5% to June 2018.

Graph 1 - Waikato DHB's elective surgery performance up to Jun 2018



Target: Faster Cancer Treatment (FCT)

Table 5 - Summary of achievement against the FCT health target from July 2015 to September 2018

FCT 62 DAY HEALTH TARGET									
DHB Current Target	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	DHB Q3 Result 17/18	DHB Q4 Result 17/18	DHB Q1 18/19
90%	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 3rd equal ranking	96.6% 3rd equal ranking	99.0% 3rd Ranking	95.5% 3rd ranking	92%
FCT VOLUME TARGET									
DHB Current Target	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	DHB Q3 Result 17/18	DHB Q4 Result 17/18	DHB Q1 18/19
25%	17%	19%	19%	22%	14%	14%	14%	18%	18%

Graph 2 - Historical achievement against the FCT health target by month

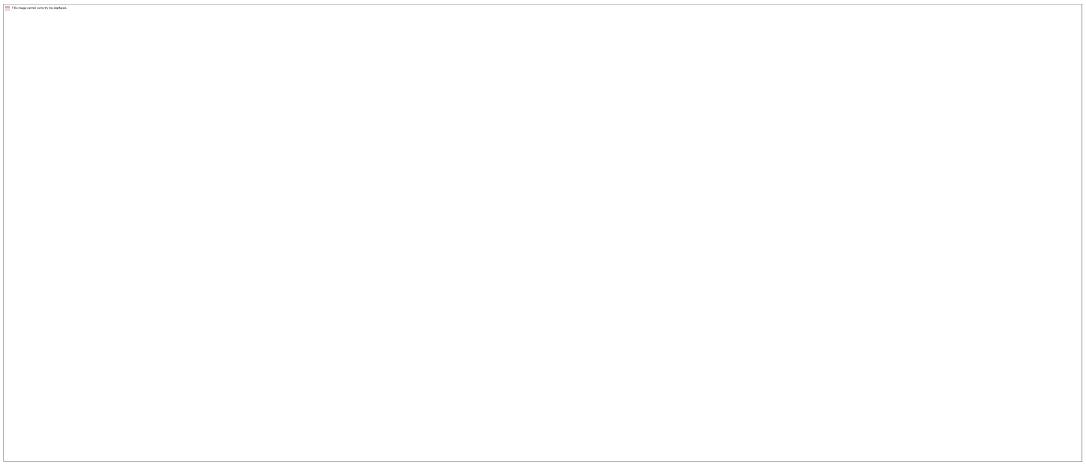


Table 6

Local FCT Database	**Jul-18**	**Aug-18**	**Sep-18**	**Total**
Number of records submitted	30	28	20	78
Number of records within 62 days	27	27	18	72
% 62 day Target Met (90%)	90%	96%	90%	92%
% Volume Target Met (15%)	19%	17%	12%	16%

Target: Increase in 8 month olds fully immunised

Table 7 – Eight month Milestone Immunisation Results by Quarter

Quarter	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Result	**90%**	**89%**	**88%**	**90%**	**89%**	**88%**
Māori	**89%**	**86%**	**82%**	**86%**	**83%**	**82%**
Ranking	**16**	**15**	**15**	**15**	**14**	**14**

Graph 3 - Waikato DHB's fully immunised rates for 8 month olds (rolling three month result)

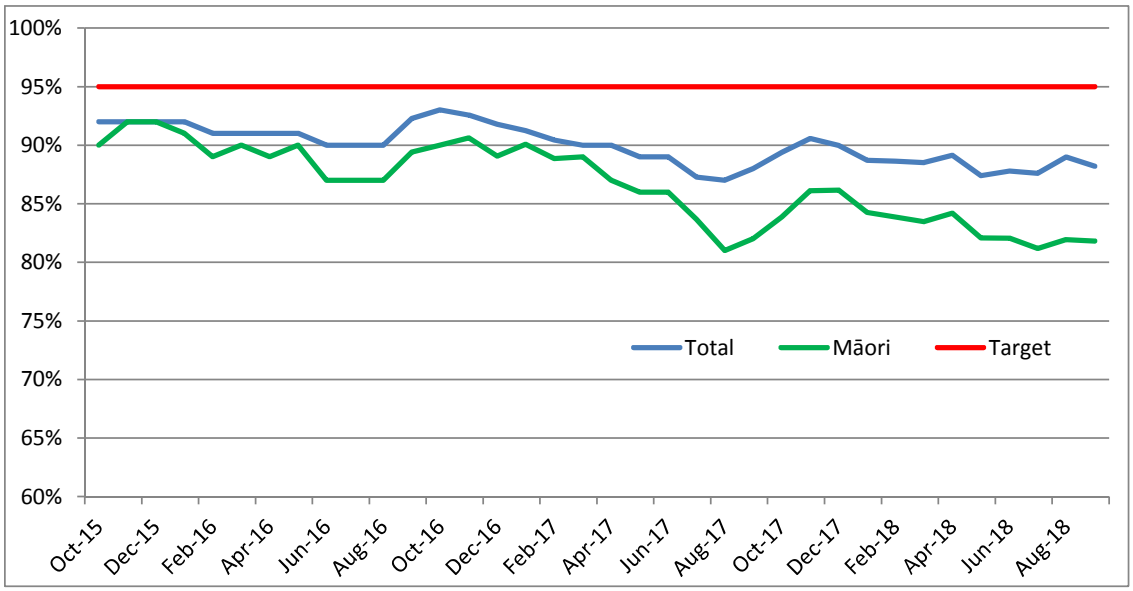


Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from Jul 2018 to Sep 2018

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	518	478	92%	15
Māori	511	418	82%	68
Pacific	56	46	82%	8
Asian	178	171	96%	0
Other	92	82	89%	6
Total across ethnicities				97
Total	1,355	1,195	88%	93

Target: Better help for smokers to quit - primary care

Table 9 – Quarterly Results

	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Total	87%	86%	88%	88%	89%	88%	87%
Total Ranking	12	13	15	14	12	14	16
Māori						87%	85%
Māori Ranking						13	15

Ethnicity splits only provided from Q3 17/18

Target: Better help for smokers to quit - maternity

Table 10 – Quarterly Results

	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Total	98%	96%	95%	94%	97%	99%	87%
Total Ranking	4	12	8	8	4	3	14
Māori	99%	95%	96%	93%	97%	98%	83%
Maori Ranking	5	12	10	10	8	2	13

Caution must be exercised when interpreting results as the sample population is extremely small

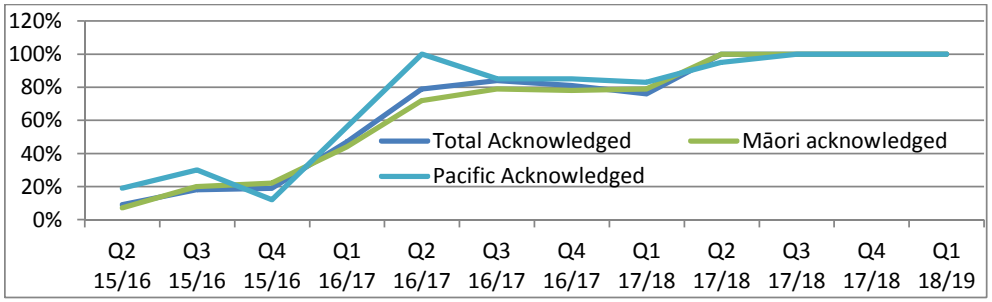
Target: Raising healthy kids

Table 11 – 2018/19 Q1 Raising Healthy Kids Results (target 95%)

		Waikato					National
		2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q1
		Six mths Aug 17	Six mths Nov 17	Six mths Feb 18	Six mths May18	Six mths Aug 18	Six mths Aug 18
Total	Referral Sent	77% (93)	100% (144)	100% (142)	100% (158)	100% (169)	99% (1,460)
	Referral Sent and Acknowledged	**76% (91)**	**100% (144)**	**100% (142)**	**100% (158)**	**100% (169)**	**98% (1,439)**
Māori	Referral Sent	79% (36)	100% (69)	100% (70)	100% (79)	100% (85)	99% (504)
	Referral Sent and Acknowledged	**79% (36)**	**100% (69)**	**100% (70)**	**100% (79)**	**100% (85)**	**98% (497)**
Pacific	Referral Sent	87% (13)	95% (12)	100% (14)	100% (14)	100% (12)	100% (425)
	Referral Sent and Acknowledged	**83% (12)**	**95% (12)**	**100% (14)**	**100% (14)**	**100% (12)**	**99% (422)**

Note that the numbers in brackets in the table are the actual numbers of children in each of the categories.

Graph 4 - Results for 'Raising Healthy Kids' health target
Data for a 6 month rolling period up to Aug 2018



Recommendation
THAT
The Board receives this report.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER

Health and Safety

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 8

HEALTH AND SAFETY SERVICE UPDATE

Purpose	For information.

There are four branches to Principles of Due Diligence in Health and Safety Governance:

- Policy and Planning
- Monitor
- Delivery
- Review.

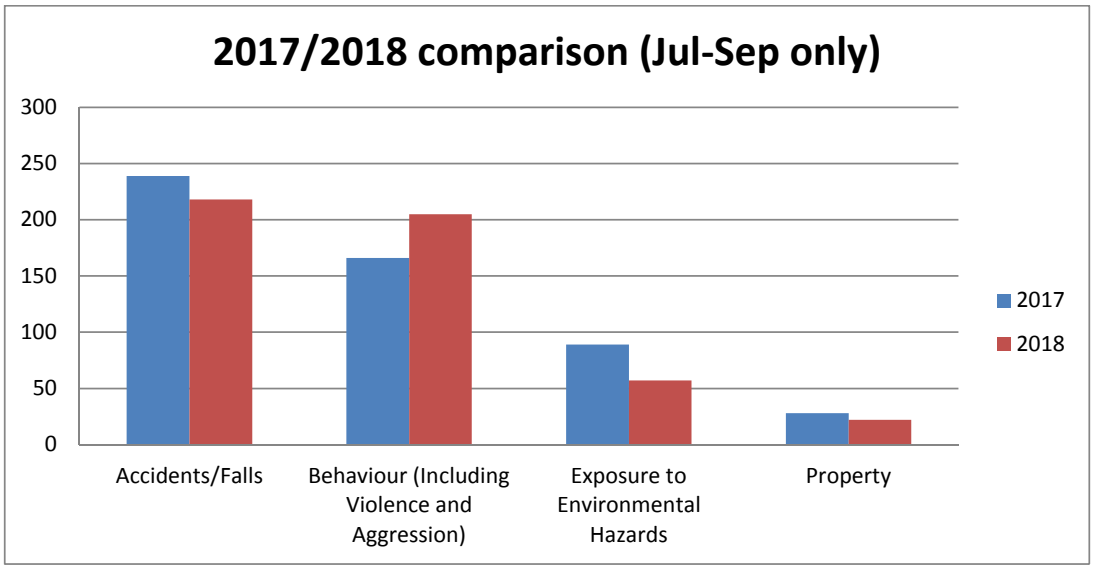
Incidents Reported to WorkSafe NZ year to date

	Year to date
Total Incidents reported	**3**

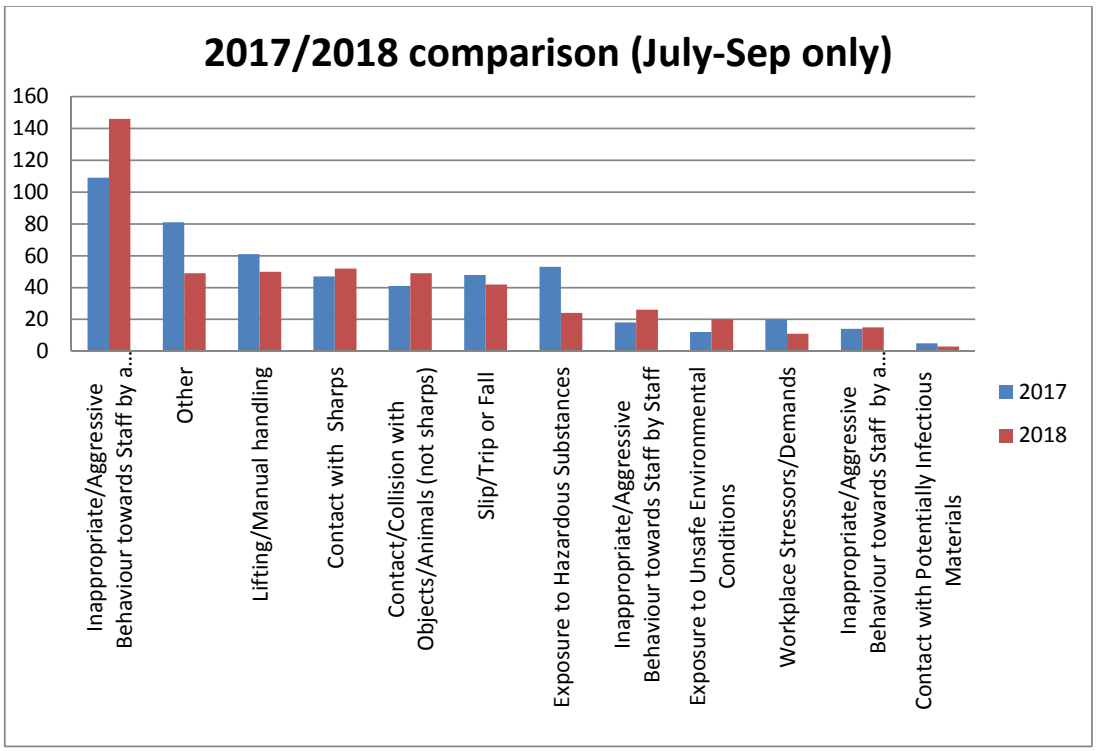
- Employee collapsed in carpark displaced fracture to right Leg – March 2018
- Employee tripped on stairs and sustained fractured right leg – May 2018
- Contractor sustained electric shock-nil injuries sustained – June 2018.

DATIX Incidents (Health & Safety)

Incidents reported in Datix by incident type tier 1, comparison between 2017 and 2018 for the period July to September.



Incidents by incident type tier 2 for the same period (showing top 12 only)



Annual Influenza Programme - 2018
Waikato DHBs Health Care Workers

DHB Employees	Nurses[a]	1940	72.42%
	Doctors[b]	632	62.7%
	Midwives[c]	59	44.03%
	Allied staff[d]	718	63.2%
	Healthcare assistants	237	67.52%
	Other Employees[e]	1377	63.33%
	Total	**4963**	**66.33%**
DHB Employees Vaccinated Elsewhere eg at GP practice	Nurses[a]	13	0.48%
	Doctors[b]	3	0.29%
	Midwives[c]	0	0.00%
	Allied staff[d]	3	0.26%
	Healthcare assistants	4	0.85%
	Other Employees[e]	16	0.73%
	Total	**39**	**0.52%**
Non-employees	Students	326	
	Contractors	341	
	Locums		
	Other nurses	45	
	Other doctors	11	
	Other healthcare assistants		
	Other midwives[f]	12	
	Volunteers/Others	27	
	University Staff		
	Other		
	Total	**862**	

Comments

Key	
a	Includes registered and enrolled nurses.
b	Includes registered doctors.
c	Includes registered midwives.
d	Includes but not exclusive to physiotherapist, laboratory technicians, occupational therapists, dieticians, social workers, pharmacists, speech language therapist.
e	May include, but not limited to cleaners, orderlies, administrators, management etc.
f	Includes registered midwives not employed by DHB but who have contracted access to DHB facilities.

Employee Assistance Programme 01 July 2018 to 30 September 2018

During the report period one hundred and eight (108) clients used the employee assistance programme.

Programme usage is based on an approximate employee headcount of 6700 employees. The National Usage Rate is shown as a percentage for a 12 month period however the Usage Rate percentage is for the period of this report i.e. quarterly or six monthly.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
115	0	7	108	1.61%	8.10%

Session Data
The following table details the number of sessions each client has attended, within the report period.

Total Clients	Total Sessions	Sessional Average	National Average
108	228.25	2.11	2.70

Impact Level Assessments
The table shows impact levels as determined by the EAP Professional when the client first presents. The purpose of the 'impact level' is to assist in determining any health and safety risks resulting from clients' issues.

Levels	*No. of Clients*	*Description of Levels*
Level 1	*10*	*Practical assistance required*
Level 2	*25*	*Work could be impacted if issues not dealt with*
Level 3	*59*	*Work performance is affected*
Level 4	*11*	*Work performance is affected and starting to take days off*
Level 5	*3*	*Client severely affected and unable to function in the workplace*

Referral Source
The following information indicates the source of referrals to the Programme. Please note most referrals were self referrals, however we acknowledge that some referrals indicated as self referral, may have been prompted by managers.

Self Referral	Management Suggested	Management Formal
84	23	1

Occupational Groupings

The following information shows the workplace grouping status of the referring clients, as advised by the clients and compares these with our national average.

Work Force	Management	Supervisory	Family Member
97	6	5	0

Total Actual Issues

The following information shows the predominant concerns/issues discussed by clients during their counselling sessions. In our experience it is more common for a higher percentage of clients to access the Employee Assistance Programme for personal issues as opposed to work. This report details up to three (3) major issues per client.

Total Issues	Personal Issues	Workplace Issues
309	228	81

All Personal Issues

The table below shows all issues that clients have presented and the graph shows the top three (3) issues as presented compared with our national average.

Personal Issues	Total	Percentage
Alcohol	3	1.32%
Anger	9	3.95%
Anxiety	34	14.91%
Children	19	8.33%
Confidence	7	3.07%
Cultural Differences	5	2.19%
Depression	12	5.26%
Domestic Violence	3	1.32%
Drugs	2	0.88%
Family	20	8.77%
Financial	3	1.32%
Gambling	1	0.44%
Grief	37	16.23%
Health/Medical	14	6.14%

Legal	2	0.88%
Low Self Esteem	1	0.44%
OCD	1	0.44%
Parenting	5	2.19%
Relationships	33	14.47%
Sleep	9	3.95%
Suicide	1	0.44%
Trauma	7	3.07%

All Workplace Issues

Where clients present with workplace issues, the professional's primary role is to assist the client with personal coping strategies. In addition our professional's guidance will include advising the client to raise the issue with their Manager, Team Leader, Health and Safety or Human Resources representative.

Work Issues	Total	Percentage
Bullying	5	6.17%
Career	9	11.11%
Conditions	8	9.88%
Discipline	4	4.94%
Discrimination	1	1.23%
Environment	4	4.94%
Harassment	3	3.70%
Performance	6	7.41%
Redundancy	1	1.23%
Relationship with Co-Worker	12	14.81%
Relationship with Manager	8	9.88%
Restructuring	2	2.47%
Safety	4	4.94%
Trauma	4	4.94%

Work Hours	3	3.70%
Workload	7	8.64%

Recommendation
THAT
The Board receives the report.

GREGORY PEPLOE
DIRECTOR PEOPLE AND PERFORMANCE

Service Performance Monitoring

No Service Performance Monitoring reports this month.

Professional Advisory Reports

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 10.1

CHIEF NURSING & MIDWIFERY OFFICER REPORT

Purpose	For information.

The attached report provides a broad brush update with a focus on nursing across the Waikato DHB.

Recommendation
THAT
The Board receives the report.

SUE HAYWARD
CHIEF NURSING AND MIDWIFERY OFFICER

Nursing at Waikato DHB

Expectations, professional development frameworks and strategic aims are outlined in the Nursing at Waikato DHB 2017-2021 document.

All activities are aligned to the four aims as described in this document, and while from time to time extra patient safety programmes will be entered into invariably these can be matched to either the DHB's strategy or as a result of a gap in care delivery.

All nurses, whether practicing in acute, rural, aged care or primary, have access to standardised evidence based electronic procedures. These are also accessed and used by WINTEC to teach the student nurses. The success of this has seen the majority of other DHBs follow suit.

There is a clear post graduate pathway for nurses wanting to advance their career whether in clinical expertise, education or leadership and management. The funding for this comes from Health Workforce NZ (HWNZ).

For other education and conference leave each service carries out a needs assessment, prioritises the courses required and then funding is provided using the Nursing and Midwifery Education Fund.

Driving quality improvement is very much from the floor where front line ownership is displayed within the Releasing Time to Care programme.

Nursing Post Strike

The agreement signed by Ministry of Health, District Health Boards and NZ Nurse Organisation to implement the whole Care Capacity Demand Management programme will result in a high degree of activity to ensure we achieve full implementation by 2021.

The four components of the programme are:

1. **Governance:** Care Capacity Demand Management is a permanent operational structure with processes and tools for allocating safe staffing and healthy workplaces.
2. **Core Data Set**: an established set of 23 measures with equal priority placed on quality patient care, quality work environment and best use of health resources.
3. **FTE Calculation**: the FTE calculation is a systematic validated method for generating the roster.
4. **Variance Response**: this is a set of tools and processes for organisational visibility of Care Capacity Demand Management. Includes an operations centre, electronic data, staffing alerts and standardised operating procedures.

The most predominant focus following the strike has been and will be increasing the number of nurses. Recruiting the numbers required will be a challenge and all DHBs will be in the same situation. Innovative ways of recruiting are now being actioned. Putting in place:

- Return to Nursing supportive pathway.
- Supporting non New Zealand residents with a New Zealand Bachelor of Nursing degree and registered with NZ Nursing Council, into our NETP (New Entrant to Practice) programme and absorbing the cost.

- Actively supporting WINTEC to run a competency assessment programme that attracts and assists international qualified nurses achieve NZ Nursing Council registration.

Challenges on the Horizon

- Across the country DHB Directors of Nursing have been actively moving towards employing all newly graduated nurses, facilitating this employment into acute, aged care and PHO settings. September 2018 has seen this come to fruition however this leaves the country at risk of having very little ability to employ more new registered nurses as we move into autumn/winter 2019. This is most likely related to a downturn in new students during 2016. The good news is that 2019 applications are being reported as being the highest for the last 5 years.

- With the commitment to employ newly graduated nurses the balance between non-experienced (novices) and experienced (experts) needs to be actively managed.

- Vacancy levels are always difficult to manage and while our turnover rate remains at 11% the reality to consistently manage this can be frustrating for all.

Workforce initiatives

- Implemented registered nurses working within the expanded scope as defined by Nursing Council NZ:
  - Registered Nurse Surgical First Assist
  - Nurse Endoscopist
  - Nurse Opthalmology
  - Nurse Colposcopist (in training).

- Increasing the number of nurses under the registered nurse designated nurse prescriber scope. The DHB has 10 working in this scope.

- Continue to develop Nurse Practitioner roles, with a focus on community, chronic conditions and the older adult.

- Employing newly graduated enrolled nurses and supporting them to transition into practice utilising a standardised nationally developed Orientation Programme.

Long term pipe line workforce initiatives/plan

- Launching a graduate entry into nursing next year with WINTEC. If the applicant has an existing degree they will undertake a 2 year programme to become a newly registered nurse, and exit with a Masters in Health.

- Agreement has been reached with Midwifery Council for WINTEC to provide a minimum 18 month duration programme for a registered nurse to transition into and achieve registered midwifery qualification. Recognition of prior learning will be utilised to establish actual length required.

Chief Medical Officer: report due in January.

Decision Reports

Equity Focussed Reporting: report due in November.

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 11.2

WAIKATO DHB FINAL ANNUAL PLAN 2018/19 UPDATE

Purpose	To provide members with the final 2018/19: • Annual Plan • Statement of Performance Expectations. • System Level Measure Improvement Plan.

This paper follows on from the paper in the June 2018 agenda presenting the draft Annual Plan for 18/19. Provided is the final Annual Plan 2018/19 following the feedback received on the 10 September from the Ministry.

Background

- The working draft Waikato DHB Annual Plan 2018/19 was included with the June 2018 Board agenda for review and feedback.
- The draft Statement of Performance Expectations (SPE) was sent to the Ministry at the end of June 2018.
- The draft Waikato DHB Annual Plan 2018/19 was submitted to the Ministry of Health at the end of July 2018.
- The System Level Measure Plan was approved by Ministry on the 13th August, 2018.
- Feedback from the Ministry of Health on the draft Annual Plan and SPE was received on the 10th of September.
- The final version of the Annual Plan including SPE is due to the Ministry on the 1 November 2018.
- In terms of Section 149C of the Crown entities Act 2004, a Crown Entity must prepare and finalise a Statement of Performance Expectations before the start of each financial year. Whilst the timelines for completion above are in line with Ministry of Health's expectations, we are in breach of the Crown Entities Act and this has been disclosed in the Annual Report for the year ended 30 June 2018.

Recommendation
THAT
The Board

1) Receives the report.
2) Approves the 2018/19 Annual Plan and Statement of Performance Expectations.
3) Notes the System Level Measure Improvement Plan.

KATHRYN FROMONT
PLANNING MANAGER

Waikato District Health Board

2018-19 ANNUAL PLAN

INCORPORATING THE 2018-19 STATEMENT OF PERFORMANCE EXPECTATIONS AND 2018-19 SYSTEM LEVEL MEASURE IMPROVEMENT PLAN

Waikato District Health Board

Contents

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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 me te whare o te Kahui ariki whānau whanui tonu	Including Kiingi Tuheitia his family and the royal household
Paimarire.	Paimarire.
Kahuri ki te korowai aitua	We turn to acknowledge those
O ratou ko wehi ki te po	Who have passed beyond the veil
Takoto mai, moe mai koutou	Rest in peaceful slumber.
Haere, haere, haere atu raa.	Haere, haere, haere atu raa
Noreira, ka puari te kuaha pounamu	Therefore the green stone door
Mahana kia taatou katoa.	Opens wide with a very warm greeting to us all
“Mehemea ka moemoeaa ahau	“If I am to dream
Ko au anake	I dream alone
Mehemea ka moemoeaa e taatou,	If we all dream together
ka taea e taatou”	Then we will achieve”

Minister's 2018/19 letter of approval to Waikato DHB

(Placeholder for Annual Plan approval letter.)

SECTION 1: Overview of strategic priorities

1.1 Strategic intentions/priorities

This Annual Plan articulates Waikato DHB's commitment to meeting the expectations of the Minister of Health, and to our Board's vision of '**Healthy People. Excellent Care**'. The plan also meets the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, and Public Finance Act.

This Annual Plan is a high-level document but still provides a strong focus on improved performance and access, financial viability, health equity and service performance to meet legislative requirements. More detailed reporting, including Financial Performance, our Statement of Performance Expectations for 2018/19, and our System Level Measure Plan are contained in the appendices.

1.1.1 National

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

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

The Healthy 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.

1.1.2 Regional

Legislation requires the DHBs to collaborate regionally and for each of the four region of DHBs to develop a Regional Services Plan (RSP). The RSP is a companion plan to DHB Annual Plans. HealthShare Ltd, the Midland DHBs' shared services agency, is tasked with developing the Midland RSP, on their behalf. This work is carried out in consultation with the Midland DHBs Annual Plan Writers Group and DHB Executive Groups to ensure collaboration and 'line of sight' (alignment) between the region and DHB planning.

In the 2018/19 guidance the Ministry has placed greater emphasis on the Regional Enablers, i.e. Equitable Access and Outcomes, Workforce, Technology and Digital Services, Quality, Clinical Leadership, and Pathways. The implementation of an Integrated Hepatitis C Assessment and Treatment Service across community, primary and secondary care services has also been signalled as a regional priority. The RSP also contains the regional clinical networks and action groups work programmes which are agreed regionally and reported against each quarter to the MoH. The priority areas are cancer services, cardiac services, child health services, elective services, hepatitis C regional service, healthy ageing, mental health and addiction services, radiology services, stroke services, and trauma services. Refer to the 2018-21 Midland Regional Services Plan (Strategic Direction and Initiatives and Activities) for full details.

1.1.3 Local

Waikato DHB is the Government's funder and provider of health services to an estimated 417,130 residents living in the Waikato district, covering almost 9 percent of New Zealand's population, the fifth largest DHB in the country. The DHB has a larger proportion of people living in areas of high deprivation than in areas of low deprivation, with the population becoming proportionally older (the 65 plus age group is projected to increase by 40 percent between 2017/18 and 2028). This will increase chronic and complex health conditions and informs many of the strategies being put in place to meet future health needs.

23 percent of the population are Māori compared with the national average of 15 percent. The Māori population are significantly impacted by many chronic conditions such as diabetes and smoking related diseases and are disproportionally presented in adverse health statistics. These facts, combined with the acknowledgment of the status of iwi in the Waikato, provides a strong driver to include and engage Māori in health service decision making, and to deliver health information and health services in a culturally appropriate way.

The Pacific population also make up almost 3 percent of the DHB population, as a result this group is targeted with specific appropriate health initiatives also.

Direction and strategy

The key areas of focus for Waikato DHB for 18/19 are:

- **Equity**
  Waikato DHB has seven localities Hamilton, Matamata, the Northern Corridor, Taumarunui, Te Kuiti, Thames and Tokoroa with populations of different size, ethnicity and deprivation. As a DHB we plan to focus on tailoring services and models of care to the needs of the population in each locality with a particular focus on rural services and Māori, child health and Long Term Conditions.
- **Primary and community care**
  Moving to a focus on wellness, prevention and delivering services closer to home, we will look at innovative models of care including setting up multi-disciplinary teams co-located with primary care, increased use of nurse practitioners, and providing services in community settings. The health care homes model will be utilised, ensuring it is flexible enough to target high needs populations. Ongoing issues with GP access and workforce shortages need to be addressed.
- **Commissioning**
  The DHB will take a more strategic approach to contracting and look at different models for funding and service provision, including contracting for outcomes. Contracting models will be more flexible and able to target high-needs groups to improve equity.
- **Sustainability**
  A focus on ensuring services are sustainable (mental health and addictions, acute/elective provision, tertiary services) and there is appropriate workforce, funding and infrastructure to support the needs of the local population.
- **Patient flow**
  Working to improve patient flow through the hospital especially through Emergency Department and surgical waiting lists

- **Workforce**
  With difficulties recruiting and retaining clinical and non-clinical workforce, there are a number of long term hard to fill vacancies.

  Workforce hot spots are radiology, midwifery, mental health nursing.

- **Mental Health**
  The DHB's mental health access rates are high. There are high rates of methamphetamine use in the region and the DHB is planning a methamphetamine harm reduction pilot. Work is also underway with the Ministry of Corrections to identify a model of care for 100 mental health spaces in Waikaeria prison.

Waikato DHB Strategy

During 2016/17 Waikato DHB rolled out our new strategy driven by our Board which 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

"Mehemea ka moemoeā ahau. Ko au anake
Mehemea ka moemoeā e tātou, Ka taea e tā tou"

"If I am to dream. I dream alone
If we all dream together, Then we will achieve"

Te Puea Herangi

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

Population performance

The Waikato DHB is committed to taking a life course approach improving the heath of its population. Those life course groupings and an example of this approach are outlined below:

Life course group	One significant action that is to be delivered in 2018/19
Pregnancy	Review of pregnancy and parenting education programme to increase access and coverage for Māori and Pacific women.
Early years and childhood	Comprehensively review services to improve child health outcomes with respect to: • enrollments • immunisation; and • oral health.
Adolescence and young adulthood	The DHB is committed to improved Mental Heath outcomes for Waikato Youth. An enhanced focus on self harm and suicide prevention will be driven through our System Level Measure Programme.
Adulthood	Increase the percentage of Māori men aged 35 - 44 years who have had their cardiovascular risk assessed in the last 5 year s. This will take an outreach approach via sports clubs, workplaces, Marae and Kapa Haka in partnership with PHO's.
Older people	START service expansion to reduce avoidable Emergency Department presentations and hospital admissions.

1.2 Message from the Chair – Sally Webb

More and more in today's health system we are under pressure to find new, innovative ways to provide services within our revenue however as we look forward to the year ahead at the Waikato DHB it's important not to lose sight of why we exist.

We are committed to our best endeavours to achieve the outcomes outlined in the Minister's Letter of Expectation but we must never forget that it's the people who are important - both the people of Waikato and the Midland region who we provide services to and the people who work in our organisation - living our values will enable us to meet the needs of both.

This year Māori Health is a key focus for our strategic planning. It's important to us that everyone receives excellent care when they or their whānau are in contact with our health system.

Our newly appointed Consumer Council will help give people who don't normally have a voice in the planning and delivery of health services, an opportunity to partner with the DHB to improve how we do things.

Our relationships with primary care and NGOs are also vital in providing that comprehensive care and I look forward to improving our relationships with all our partners.

This year is one for looking to the future and ensuring we rebuild the reputation of our DHB. We have a great opportunity to show that as a DHB with one the largest rural populations in the country we can rebuild the trust of our community and deliver the health services they need.

1.3 Message from the Interim Chief Executive – Derek Wright

This Annual Plan sets out the direction and priorities for the coming 2018/19 year for the Waikato DHB.

This DHB has had many challenges over the last year but we now have an opportunity to become a leader in a number of areas. We will be focusing on strengthening our relationships across the Midland region and looking for new and innovative ways of working to deliver the best healthcare for the communities we serve that we can.

2018 will be a busy year with many people across the organisation engaged in the development of a 10 year Health Systems Plan. This will provide a strategic overview of how the complex web of services the DHB both provides and funds will be delivered over the next ten years.

The focus will be on reducing health inequalities – particularly for Māori - improving integration of services and making sure we deliver services in the most sustainable way – ensuring Waikato people have access to the highest quality health services no matter where they live.

This year will also see the input of a Consumer Council into how we plan and deliver services at the DHB.

The Consumer Council will work in partnership with the DHB to provide a consumer perspective and help make sure our services meet the needs of Waikato communities. It will provide advice to the Board and senior management on the DHB's strategic priorities and improving aspects of DHB services.

This is an exciting time for the DHB as we move towards true partnership with the community. The council will challenge us about how we provide some of our services and hopefully move us out of our comfort zone and we welcome that.

We also have 7,000 dedicated and hardworking staff who are more than willing to step up to the challenge ahead - delivering more healthcare both in our hospitals and in the community and living our vision of Healthy people Excellent care.

1.4 Signatories

Agreement for the Waikato DHB 2018/19 Annual Plan

between

Hon Dr David Clark
Minister of Health

Date: XX XXX 2018

Sally Webb
Chair
Waikato DHB

Date: XX XXX 2018

Professor Margaret Wilson
Deputy Chair
Waikato DHB

Date: XX XXX 2018

Derek Wright
Interim Chief Executive
Waikato DHB

Waikato DHB

Date: XX XXX 2018

Letter of expectations for DHB

Hon Dr David Clark

MP for Dunedin North
Minister of Health
Associate Minister of Finance

Dear Chair

Letter of expectations for District Health Boards and Subsidiary Entities for 2018/19

This letter sets out the Government's expectations for District Health Boards (DHBs) and their subsidiary entities for 2018/19.

The Government wishes to signal an increased priority for primary care, mental health, public delivery of health services, and a strong focus on improving equity in health outcomes.

This Government listened to New Zealanders, and campaigned on these concerns. We will deliver on our democratic mandate to ensure New Zealand has a strong and effective public health service that we can all be proud of. To achieve this we want the public health service to be accessible and affordable for all New Zealanders, and to ensure that appropriate services are provided in the right locations at the right times.

Our Approach

Our Government wants to improve population health. Population health approaches and services are essential components of strategies to address determinants of health and achieve better health equity and wellbeing. I expect DHBs to work closely with and support their local public health units and health promotion providers. New Zealanders have made it clear that they are concerned about the increasing unaffordability of primary health services, regional inequity of access to secondary health services, and inadequate mental health service provision nationwide.

Our Government takes a longer term view. To this end, we will review the primary care funding formula and DHB targets, as well as wider sector settings. The Ministerial Advisory Group will also advise me on further opportunities to improve equitable health outcomes for all New Zealanders including how the system needs to change to enable those improvements. It is expected that you will be fully supportive of this work, and where appropriate will provide direct contribution.

We intend to better resource primary care in order to deliver better health outcomes, and to reduce the growing pressure on emergency services. In Budget 2018, we will lay out our plan to reduce the cost of access to primary care for New Zealanders.

In our first 100 days we have introduced legislation to increase access to medicinal cannabis, and launched the Government Inquiry into Mental Health and Addiction. We expect your staff and members of your community to participate in the Inquiry and I expect you will encourage your people to do this.

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SECTION 2: Delivering on priorities

Waikato DHB is committed to delivering on the Minister's Letter of Expectations and to the agreed Planning Priorities.

2.1 Health Equity

Strong planning and collaboration is critical to achieving health equity for all New Zealanders. The Ministry of Health is committed to achieving Māori health equity. Waikato DHB is also committed to improving health equity for our Māori population and our other priority populations of Pacifica, rural and disability.
This includes condition specific activity, but also includes actions to resolve inequities of access to and utilisation of health services more generally. We will achieve this through effective, whānau centred, universal services, as well as tailored or targeted interventions.

To help identify areas of focus for health equity, we consider the characteristics of the current and future population of the district, including demography, socioeconomic determinants, health status, geographic location, and demand for health services within the district.

Annual activities, as well as a longer term approach within our 10 year Health System Plan, include but are not limited to:

- Promoting screening services for our priority populations to increase early detection of disease, for example, increasing the percentage of Māori men aged 35-44 years who have had their cardio vascular risk assessed in the last five years;
- Implementing services that target communities with identified health inequalities;
- Setting targets by ethnicity and monitoring performance;
- Supporting kaupapa Māori services and 'for Pacific by Pacific' services;
- Increasing the capability and capacity of the Māori and Pacific workforce across our district;
- Applying an equity lens as part of decision-making processes (e.g. the Health Equity Assessment Tool);
- Engaging with our Disability Support Advisory Committee and developing a disability responsiveness plan
- Engaging with Iwi Māori Council to provide advice and inform decision making;
- Engaging with community health forums and expert advisory groups to provide and receive advice (e.g. our AgeWISE advisory group and our rural health advisory group).

We have included at least one equity action focused on our Māori and Pacific populations across our identified planning priorities. Throughout this document we have flagged these with a tag "EOA" (Equitable Outcome Action). These are intended to help the reader identify those actions intended to reduce equity gaps.

2.1.1 Health Equity Tools

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

- The Health Equity Assessment Tool (HEAT). This tool will be updated after working with Te Puna Oranga and Iwi Māori Council (IMC) to ensure it is made more relevant for Waikato DHB;
- He Pikinga Waiora Implementation Framework;
- 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 as guidance for service design and development.

Our DHB Public Health unit has significant expertise in understanding population needs. This unit is currently being integrated in the DHB Strategy and Funding directorate to enhance system development and service responsiveness, particularly for Māori and other priority populations.

2.2 Responding to the guidance

Waikato DHB's 2018/19 Annual Plan is a further refinement of the 2017/18 Plan, however it includes a number of new priorities established by the Minister. Engagement with relevant stakeholders including our primary care partners has been undertaken in developing this document.

2.3 Government Planning Priorities

The 2018/19 Planning Priorities are:

Primary Care Access
Mental Health
Public Delivery of Health Services
Access to Elective Service
Child Health
School-Based Health Services
Healthy Ageing
Disability Support Services
Pharmacy Action Plan
Improving Quality
Climate Change
Waste Disposal
Fiscal Responsibility

In addition, Waikato DHB has identified our actions to deliver on the Regional Service Plan (RSP) priorities.

Government planning priorities

Government Planning Priority		Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Mental Health (both Māori and Pacific focussed equity actions are expected in this priority area)	Population Mental Health	One team	Productive partnerrships	Waikato DHB is committed to improving our populations mental health and addictions, especially for priority populations including vulnerable children, youth, Māori and Pacifica by: 1. Enhanced system responsiveness for front door, acute services and beyond discharge a. Work with stakeholders across the mental health continuum to support and develop options to help ensure early intervention and continuity of care and particularly for "front door" responsiveness b. Improve options for acute responses including improving crisis team responses, improved respite options and working with Emergency Department to enhance opportunities c. Improve co-existing problem responses via improved integration and collaboration between other health and social services d. Reducing inequities including reducing the rate of Māori and Pasifica under community treatment orders by undertaking a caseload review process of high service users for two years or longer which are subject to treatment orders – many are Māori and Pasifica. To consider barriers impacting discharge and to work to support recovery. Monitoring transition process for the identified client group, including ethnicity information closely (EOA) e. Key stakeholders in the Integrated Safety Response to Family Violence – representing health in the inter-sector collaborative initiative. Continued development of health representation and intervention to achieve earlier intervention and improved outcomes. 2. Health promotion and community engagement a. The Waikato DHB Suicide Prevention and Postvention action plan has been developed for the next three years with strong community engagement as well as clinical input. Suicide prevention and postvention to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives (ie, bereavement counselling, 'Lets Talk Wellbeing' hui) and integration of mental health and addiction services b. There is a System Level Measure group in the Waikato focussing on intentional self-harm and suicide prevention. 'Young people (≤24 years) with repeat self-harm injuries are assessed by the mental health services' is a target for the Youth SLM. (see SLM section for further information) c. Ongoing contribution to community engagement as a priority to support mental health awareness, understanding and to better understand and enable responsive service informed by need. 3. Support the regional work to improve health outcomes for Māori which are (EOA): a. undertaking of in-depth analysis of ethnicity data to identify projects for 2018-20 b. identifying exemplar services and examine what works and how lessons learned can be transferred c. ensuring all projects undertaken have an equity section that is ratified by Clinical Governance and Te Huinga o Nga Pou Hauora (Māori Leadership Network) d. working in partnership with GMs Māori Health to ensure that Mental Health and Addictions continue to develop robust equity strategies. 4. The Waikato DHB Mental Health and Addictions service is currently in a transformational change programme – Creating our Futures. The key principle of the change is the need to put people at the heart of everything we do. We recognise the significance of whanau and are developing a holistic model of care. Plans are in progress to develop dedicated whanau advisory resource to support the service in policy and service model development A pivotal element in the whanau centric approach is the safety, security and recognition of the support required by tangata whaiora to care for their children. Additionally the following reflect our commitment to Supporting Parents Healthy Children (SPHC). a. Parenting and a young carers groups in partnership with NGO's being established b. Monthly mandatory training 'Family Whanau that covers SPHC c. Strong interface established in collaboration with local and regional child services d. Active commitment to the Integrated Safety Response, as health is represented by Mental Health and Addictions. This creates opportunity for pro-active support of our service users and their children.	1a. Commenced and ongoing. b. Commenced, by end of Q3 c. By end of Q4 d. By end of Q4 e. Ongoing, increasing wider health engagement anticipated by Q3 2a.By the end of Q4. b. By end of Q4 c. On-going 3a. By Q1 b. By Q2 c. On-going d. On-going 4a. By Q4 b. Reviewed annually c. Ongoing d. Ongoing	PP43: Population mental health PP6 : Improving the health status of people with severe mental illness through improved access PP7: Improving mental health services using wellness and transition discharge planning PP36: Reduce the rate of Māori under the Mental health Act: section 29 community treatment orders

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				Activity	Milestones	
Mental Health (both Māori and Pacific focussed equity actions are expected in this priority area) (continue)	Population Mental Health	One team		Waikato DHB is committed to encouraging staff and community to participate in the Government Inquiry into Mental Health and Addictions by: 1. the Mental Health Inquiry has confirmed the dates for planned visits to Hamilton. The Panel has requested the support of the DHB in arranging a number of sessions with identified groups including: Providers, Planners and Funders, Social Sector Partners, Community and Consumer Groups. As part of assisting the Inquiry Panel we have provided detailed information in relation to current services and planned developments for the future. The Panel will be providing documentation and information for the public and staff to access and we will be sharing this widely across our networks, in addition to facilitating and attending specific sessions with the Panel 2. at the same time, advising and encouraging our staff to attend the forums open to them to meet the Panel and the process for individual or group submissions. Collateral information from the Panel has yet to be provided, however once we have received the information we will be sharing this information with consumers and networks via posters, fliers, etc. 3. "Lets Talk" hui being held around the localities in our district. This information is being collated, and will be utilised more formally to contribute from a Mental Health and Addictions, Waikato DHB service response to the Government Inquiry into Mental Health and Addictions (EOA) 4. Support and promote opportunities for people who use our services, to contribute to the Government Inquiry.	1.18 June Inquiry Panel visit to WDHB 2 July Timetable for wider engagement and access to the Panel developed 2. On-going 3. Hui completed by 4. On-going	Report on activities in the Annual Plan
	Mental Health and Addictions Improvement Activities	One team	Productive partnerrships	Waikato DHB is committed to the Health Quality Safety Commission (HQSC) mental health and addictions improvement activities: 1. Part of the zero seclusion initiative via the National Healthy Quality Safety group, Waikato DHB Mental Health Addiction Service is highly engaged in the collaborative work focused on elimination of seclusion. A multi-disciplinary team including consumer input is focused on working with the HSQC group and participating in the collaboration 2. Continued roll-out of the Mental health Integrated Transition Project via the Mental Health Integrated Co-ordination Care Team. This is transitioning mental health patients from secondary to primary mental health services with free and extended general practice visits and a key worker for 12 months to help move the patient closer to home and reduce the incidence of readmission. To set up a network of General Practitioners to refer to who have a special interest in mental health 3. Update the current dashboard to include an equity focus in order to identify inequities with Māori and Pasifica patients. (EOA) 4. Scope up a pilot for a Stepped Care Model utilising a psychogist in General Practice with a focus on developing 'skills' for coping rather than 'pills'.	1. On-going 2. General Practitier network to be set up by Q3 3. Completed by end of Q3 4. Scoped by end of Q2	PP26: The Mental Health and Addiction Service Development Plan PP7: Improving mental health services using wellness and transition discharge planning
	Addictions	Value and high performance	Effective and efficient care and services	As of January 2018 we are currently meeting PP8 targets.		PP8: Shorter waits for non-urgent mental health and addiction services for 0-19

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Primary Health Care (both Māori and Pacific focussed equity actions are expected in this priority area)	Access	Closer to home	Safe, quality health services for all	Waikato DHB is committed to improving access by 1. Ensuring 95% of eligible children up to the age of 14 years have zero fee access: a. For in hours care it is expected that the expansion to under 14s will be similar to the extension to under 13s. We will work with PHOs to encourage wide uptake by general practice. We will communicate widely with community pharmacies to make them aware of the changes in criteria as we did with the previous extension in age group b. For after hours, we will negotiate current contracts to extend the access criteria with Anglesea Accident and Medical and two PHOs. Current access for under 13s exceeds 95%. We will extend the criteria with pharmacy providers who charge additional after hours fees c. Working with PHO partners to make sure the public has best possible access to fees information via the web. 2. Reduce fees for community service card holders by: a. Linking with our PHO's who have the key role in working with their General Practices on the change for non-VCLA practices as the capitalisation funding increase flows directly to PHO's by Q2 b. Implementing the new PHO services agreement amendment protocol when available by the end of Q2	1a. By end of Q3 b. By end of Q3 c. By end of Q3 2a. By end of Q2 b. By end of Q2	Report on activities in Annual Plan
	Integration	Closer to home	Safe, quality health services for all	Waikato DHB is committed to working with our alliance partners to improve integration of services by: 1. In addition to the existing alliance structure, the DHB establish a Health System Development Group with a wider representation than existing Alliances. This group will include Primary Care, Pharmacy, St John, Waikato Hospital services, Aged Care, Maternity and Mental Health. This group will focus on developing an improved Waikato Healthcare System delivering enhanced sustainability and health outcomes. (EOA) 2. The Alliance Work Programme will be driven by evidenced based decision making. The Health System Alliance is performing the functions of the Alliance until the plan is published with a number of work programmes, one main area being the Primary Options review to drive more integration. 3. Our Health System Plan which is under development along with the Māori Health Plan, will look for integration opportunities across workforces of varying contributing sectors with a key focus on reducing the equity gap for both Māori and Pasifica populations. (EAO) 4. There will be a focus on overseeing on-going service development in the following groups – Demand Management Group, Child and Youth Health Network, Mental Health, primary and secondary integration. (EOA) 5. We will develop a work programme supported by a number of working groups to take responsibility for System Level Measures and other system development. Other sector participants will be brought in as required.This piece of work will focus mainly on Māori and Pacific (EOA) 6. The utilisation of Health Care assistants in primary health settings to allow the Registered Healthcare Practitioners to work top of scope. 7. Expanded Health Practitioner roles being rolled out to increase prescribers - pharmacists and nurses as well as nurse practitioners. 8 . To continue to increase timely newborn enrolment into Primary Care, we intend to roll out the electronic newborn enrolment project into all Waikato birthing facilities via National Child Health Information Platform (NCHIP). The Child and Youth Coordination service will follow up any unenrolled children. There is also a proposal to integrate the Midland Clinical Portal with NCHIP to identify children not enrolled with Primary Care and electronically enrol.	1. By Q3 2. By Q2 3. By Q3 4. On-going 5. On-going 6. By Q3 7. By Q2 8. By Q2	PP22: Delivery of actions to improve system integration including SLM's SI18: Improving newborn enrolment in General Practice

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Government Planning Priority		Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Primary Health Care (both Māori and Pacific focussed equity actions are expected in this priority area)	System Level Measures	Value and high performance	Effective and efficient care and services	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	By end of Q4	SI7: SLM total acute hospital bed days per capita SI8: SLM Patient experience of care SI9: SLM amenable mortality SI12:SLM youth access and utilisation of youth appropriate health services SI13:SLM number of babies who live in smokefree households at 6 weeks postnatal
Primary Health Care (both Māori and Pacific focussed equity actions are expected in this priority area) (continue)	CVD and diabetes risk assessment	One team	Productive partnerrships	**Waikato DHB is committed to maintaining a rate of 90% in undertaking CVD and Diabetes Risk Assessments for our eligible population.** We are currently meeting this target for our total population, however for 18/19 will focus on our Māori population to reach a 90% target by: (EOA) 1. The PHOs have developed their own plans to more effectively reach our Māori population: a. For Pinnacle Midland Health Network PHO the activities will take an outreach approach – going to where Māori men are ie sports clubs, workplaces, Kapa Haka. b. Hauraki PHO is providing the Manawanui Whai Ora Kaitiaki (MWOK) programme – the workplace health and wellbeing partnership. The MWOK team consists of a Registered Nurse and Kaiawhina/Health Navigator working in partnership to empower people with Long Term Conditions (LTC) or to assist in opportunistic screening of people who may potentially have an undiagnosed LTC and/or to improve health literacy within the community to prevent LTC. Three priority areas being undertaken for quality improvement within diabetes care are 1. Reducing the equity gap for Māori. Members of the Diabetes Service are planning a clinical audit to identify any disparity between Māori and non-Māori utilisation of continuous subcutaneous insulin infusion (CSII) within the Waikato DHB Type 1 diabetes population. If this is identified, as other studies have shown, analysis to investigate factors influencing uptake will be reviewed. The ultimate objective is to identify and remediate modifiable factors with the goal of equitable access. 2. Priority areas of greatest need are Diabetes in Pregnancy & Gestational Diabetes Mellitus and High Risk Foot both of which has experienced continued significant growth rates beyond service capabilities. We are continuing to implement the following projects to date: • Education is being provided to Lead Maternity Carers and midwives in the management of diabetes in pregnancy by our specialised Diabetes in Pregnancy Team across the Waikato area. • Work in partnership with WINTEC to facilitate clinical placement of student midwives with the Diabetes Service. • The Podiatry Team is working towards using virtual health systems to assist in the care and treatment planning of those with high risk active foot conditions – especially in the clinician to clinician field of care. 3. Development and implementation of an improved diabetes database is well underway with the database Replacement Project Team. The aim is to facilitate accurate and timely dissemination of information to all health care professionals involved in patient care, and to relieve some of the duplicate documentation burden from clinicians. • Retinal photo screening results are now able to be seen by General Practitioners via CWS. • Patient appointments for retinal photo screening can now be viewed in IPM.	1a. Sports Clubs & Wananga - July – Sep 2018 Kapa Haka – Oct – Dec 2018 Workplaces – Jan 19 – June 2019 b. On-going roll-out onto further workplaces by Q4 1. By Q4 2. By Q2 3. By Q4	PP20: Improved management of long-term conditions (focus CVD and diabetes)

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				Activity	Milestones	
Primary Health Care (both Māori and Pacific focussed equity actions are expected in this priority area) (continue)	Pharmacy Action Plan	One team	Productive partnerrships	Waikato DHB supports the focus within the pharmacy action plan and enhanced pharmacist services by: 1. Participation in the implementation of the new Integrated Community Pharmacy Service Agreement (ICPSA). The ICPSA arrangements will enable Waikato DHB to implement the long-term vision for integrated pharmacist services in the community and move from a system that funds pharmacists on transaction-based medicine delivery with limited patient-centric service delivery and funding, to one that: • is flexible enough to meet local DHB population and consumer need • enhances the healthcare and medicines management expertise delivered by pharmacists • supports pharmacists to work as one team with other primary care services to benefit the wider health care system and population health. The ICPSA will provide Waikato DHB flexibility to provide our local communities with equity of access specifically for Māori to different types of pharmacist services, tailored to individual need while addressing the four target population groups (frail elderly, vulnerable children, mental health and chronic conditions) (EOA). 2. Develop local pharmacist services strategies which align with the Pharmacy Action Plan and the 'Integrated Pharmacist Services in the Community' vision. They will continue to develop and implement consumer-focused services and better integration with wider community-based interdisciplinary teams. 3. Currently there is limited access to the Waikato DHB clinical work station for community pharmacies, there will be work undertaken to improve this and to identify opportunities for secondary care to access community pharmacy dispensing information 4. Waikato DHB will work with Midland Community Pharmacy Group to develop a Cultural training program for Waikato Community Pharmacies based around the He Ritenga Self-assessment tool (EOA).	1. The current Community Pharmacy Services Agreement will expire 30 September 2018. The ICPSA will be effective 1 October 2018 2. By the end of Q4 3. By the end of Q3 4. By the end of Q4	Report on activities in the Annual Plan
	Support to quit smoking	One team	Productive partnerrships	Waikato DHB is committed to delivery of smoking ABC in primary care by supporting stop smoking services with a particular focus on reaching Māori, pregnant women, and mental health consummers: 1. Increase the number of hospital and primary care referrals to quit providers by 10% 2. Increase the number of tobacco control sector staff across the district by 10% who attend Stop Smoking training 3. Increase the number of LMCs/midwives trained in ABCs and Stop Smoking by 10%	1. By end of Q4 2. By end of Q4 3. By end of Q4	Better help for smokers to quit in primary care
Child Health (both Māori and Pacific focussed equity actions are expected in this priority area)	Child Wellbeing	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to improving child wellbeing, which includes maternal and youth health that realises a measurable improvement in equity for Waikato DHB by: 1. Supporting high needs populations - women and children by: • Investigating the use of a maternity coordinator to focus on family violence prevention, child protection and facilitation of health and social services for the vulnerable unborn/baby during pregnancy/postnatally. (EOA) • Planning for a more holistic process to supporting children's health needs. Pilot of the Harti Hauora tool in the children's team. The pilot will have a formal evaluation. This will identify how it is making a difference and which areas if any require refinement. (EOA) • Investigate a maternity Harti tool for the community. (EOA) • Continued focus on rheumatic fever reduction following an increase in incidences. Continue provision of rapid response clinics for sore throat management of eligible populations, and continue gap analysis of new cases of acute rheumatic fever to identify potential areas for service improvement and improvements in future patient outcomes 2. Supporting rural women and children • Roll out the Southern Rural Maternity Project to increase access for rural women and children via the rural maternal/baby health and social sector hubs. The hubs will be a central location where women and their whānau can access services from a variety of maternal and child health providers, along with referals to social sector providers if required. The Southern Rural Maternity Project will also undergo an evaluation to identify success. Measures of success are being developed. (EOA)	1a. By Q2 b. By Q3 c. By Q3 d. On-going 2. Te Kuiti Hub to be launched by Q3	PP27: Supporting child well-being

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<tr><th colspan="2" rowspan="2">Government Planning Priority</th><th rowspan="2">Link to NZ Health Strategy</th><th rowspan="2">Link to Waikato DHB Strategy</th><th colspan="2">DHB Key Response Actions to Deliver Improved Performance</th><th rowspan="2">Measures</th></tr>
<tr><th>Activity</th><th>Milestones</th></tr>
<tr><td rowspan="2">Child Health
(both Māori and Pacific focussed equity actions are expected in this priority area) (continued)</td><td>Maternal Mental Health Services</td><td>Closer to home</td><td>Safe, quality health services for all</td><td>Waikato DHB is committed to addressing primary maternity mental health needs by:
1. Providing a mixture of perinatal FTE (including Senior Medical Officer) to support community-based maternal mental health services. (EOA)
2. Consultation, liaison and advisory function along with shared care and joint planning with other health and social services is available to support the mental wellbeing of mothers and infants in the community. (EOA)
3. Following referral direct specialist perinatal mental health care is available and provided by senior medical staff, nurses and allied health. (EOA)
4. The development of a postpartum depression referral pathway from possible depression to risk of self harm, ensuring the use of appropriate Māori and Pasifica providers. (EOA)
5. Complete a stock-take of community-based maternal mental health services currently funded by the DHB, both antenatal and postpartum. This will include funding provided to PHOs specifically to address primary mental health needs for pregnant women and women and men following the birth of their baby. (EOA)
6. Identify, and report on the number of women accessing primary maternal mental health services both through PHO contracts that the DHB holds and, through any other DHB funded primary mental health service. (EOA)</td><td>1. On-going
2. On-going
3. On-going
4. Developed by Q4
5. By end of Q2
6. By End of Q4</td><td>PP44: Maternal mental health</td></tr>
<tr><td>Supporting Health in Schools</td><td>Closer to home</td><td>Safe, quality health services for all</td><td>Waikato DHB is committed to supporting health in schools by:
1. There has been an increase in self harm presentations via the school clinics. This has been linked into the Youth Access to Health services SLM work. Sessions are planned for clinicians around suicide and self harm management. (By Q2)
2. Our public health team have rolled out the HPV vaccination for boys to a slect number of high schools, this will be rolled out further in 18/19.
3. Carrying out the initiatives listed in the below table
<table>
<tr><th>Initiative</th><th>Aim</th><th>Age group</th></tr>
<tr><td>Under 5 Energize</td><td>Improve nutrition and activity for pre-schoolers</td><td>All under 5's in Early Childhood Education Centres</td></tr>
<tr><td>Oral Health Initiative (Sport Waikato)</td><td>Improving Oral Health for pre-schoolers</td><td>All pre-schoolers in Early Childhood Education Centres</td></tr>
<tr><td>Vision Hearing Programme</td><td>All children are checked for vision and hearing issues and referred on if required</td><td>All 4 years old through the B4 School Check (GP)</td></tr>
<tr><td>Project Energize</td><td>Improve nutrition and activity for primary school children</td><td>All primary school children</td></tr>
<tr><td>Access to Public Health Nurses on referral</td><td>Provide access for children with unmet health needs to health services</td><td>All primary school children with unmet health needs</td></tr>
<tr><td>Community Oral Health Services</td><td>Provide free annual oral health check and treatment through (publically funded)</td><td>All pre-school, primary and middle school children</td></tr>
<tr><td>School Based Health Services
• Nursing services in deciles 1 – 3
• GP's in decile 4 – 7, This includes wharekura, alternative education centres and teen parent unit</td><td>School based health services to improve access to primary care for secondary age students eg sexual health, mental health, injuries, general medicine, smoking cessation</td><td>Secondary school aged children/adolescence within decile areas identified</td></tr>
<tr><td>Mobile Dental Services for 'hard to reach secondary schoolers'</td><td>Visit various secondary schools to provide free annual oral health check and treatment</td><td>Hard to reach secondary school children</td></tr>
<tr><td>Free Secondary School Dental Services</td><td>Free annual oral health check and treatment through dentist</td><td>Secondary school students up to 18 years old</td></tr>
<tr><td>HPV and Boostrix vaccinations</td><td>Vaccination (Diphtheria, tetanus and whooping cough) and HPV vaccination to be administered at school following consent of parents by Public Health Nurses</td><td>All year 7 students - boostrix vaccination

All year 8 students - HPV</td></tr>
<tr><td>Youth Intact</td><td>A new approach to service delivery for rangatahi/young people with problematic to severe alcohol and/or other drug use. Offering easily accessible school and community based assessment and treatment services that are wraparound, holistic and culturally responsive</td><td>Focused on youth - 12-19 year olds</td></tr>
</table></td><td>PP39: Supporting Health in Schools</td></tr>
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				Activity	Milestones	
Child Health (both Māori and Pacific focussed equity actions are expected in this priority area) (continued)	School-Based Health Services (SBHS)	Closer to home	Safe, quality health services for all	Waikato DHB is committed to School Based Health Services by: 1. Complete a stocktake of health services in public secondary schools in the DHB catchment 2. Develop an implementation plan including timeframes and an equity focus for how SBHS will be expanded to all public secondary schools in the DHB catchment (EOA).	1. By end of Q2 2. Plan developed by end of Q4	PP25: Youth mental health initiatives PP27: Supporting child wellbeing
	Immunisation	One team	Productive partnerrships	Waikato DHB continues to proactively work with all key partners to significantly improve the Districts performance and ensure at least 90% of our children are immunised on time. Furthermore, additional activity is planned to push this to 95% with a particular focus on Māori and Pacifica infants and their whānau: 1. Opportunistic and outreach immunisation services (EOA) • Monitor the effectiveness of Outreach Immunisation Service (OIS) s across the Waikato district • Ensure opportunistic immunisation are offered at every contact with the health care system including afterhours • Opportunistic is looking at all that are not immunised and the majority are Māori according to our performance. 2. Family Start inter sectoral collaboration, Family Start is targeted at high need and Māori families (EOA) • Work with Oranga Tamariki as the funder of Family Start to ensure all children enrolled in Family Start are fully immunised on time (EOA) • Access anonymised data from Family Start as to what percentage of children are immunised or enrolled with a GP who are in Family Start care • Facilitate ongoing management meetings with Oranga Tamariki 3. Investigate financial incentives for families/whānau who complete their child's immunisations on time (EOA) 4. Complete the build and roll out of the Hauora iHub within the hospital to offer opportunistic immunisations for all children who are inpatients or passing through the hospital with whānau. The Hauora ihub id targeted at high need and Māori families (EOA)	1a. On-going b. By Q1 2. By Q3 3. By Q3 4. By Q2	HT: Increase immunisations at 8 months PP21: Immunisation coverage PP27: Supporting child wellbeing
	Responding to childhood obesity	Value and high performance	Effective and efficient care and services	1. Roll out education and clinical tools for weight management of children a. Deliver Be Smarter 'train the trainer' education to Sport Waikato staff to enable them to coordinate wider distribution and education of the Be Smarter resource b. Roll out local distribution and education of the Be Smarter resource to priority workforce (general practitioners, practice nurses, public health nurses, Well Child Tamariki Ora providers) c. 12 sector workforce training sessions delivered including: • Challenging conversations • Key lifestyle messages • Importance growth reviews • Referral algorithm • Be Smarter resource • Clinical pathways • Resource/programmes available 2. Deliver the extension of Active Families programme across the Waikato region a. Programme training delivered to contracted provider's staff b. Provide ongoing clinical oversight to the new programme c. 200 clients to be accepted to the service with a minimum of 75% service users enrolled to be Māori, Pacific or high needs (quintile 5) 3. Build in evaluation, measure effectiveness, and monitor outcomes of RHK activity over time. a. System in place to capture new programme evaluation parameters b. System in place to collect reporting from primary care healthy weight consults advanced form c. Qualitative research on declines completed d. Evaluate initial findings from new programme and primary care healthy weight consult including a comparison of effectiveness and costings across interventions	1. a. By Q2 b. By Q4 c. By Q4 2. a. By Q1 c. By Q4 3. a. By Q1. b. By Q2 c. By Q3 d. By Q4	PP27: Supporting child wellbeing

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System Settings (both Māori and Pacific focussed equity actions are expected in this priority area)	Strengthen public delivery of health services	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to public delievery of health services by: 1. The DHB is currently undertaking Health System Planning to invest in prevention and early intervention approaches to keep people well in the community, while better utilising health services across the system	1. By Q2	SI16: Strengthening public delivery of health services
	Access to Elective Service	Value and High Performance	Effective and Efficient Care and Services	Waikato DHB is committed to delivering our agreed number of Elective discharges, in a way that meets timliness and prioritisation requirements and improves equity of access to services by: 1. Implementing the elective planning tools designed under the KEEZZ project in respect of increasing the planning and booking horizon and increasing the internal delivery volumes 2. Streamlining the process to ensure a patient is fit, willing and able to receive surgery 3. Improving projections of future elective volumes through specialty based clinical service plans 4. Developing tools to monitor CPAC scoring patterns 5. Support regional vascular services work focussed on improving equity for Māori and Pacific by: • collect data by ethnicity, location and deprivation where this is available. • supporting standardised processes to improve equity, quality and outcomes • improve the patient journey through supporting the development of an information pack to support clinical decision making and equity of access (EOA)	1. By September 2018 2. By December 2018 3. By March 2018 4. By December 2018 5. By end of Q4	Number of Elective Discharges SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Elective Services Patient Flow Indicators
	Cancer Services	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to improving cancer services particularily around Māori health gain by: 1. Rolling out the Early Detection of Lung Cancer pilot with a specific focus on Māori. This will include development of an integrated pathway with PHO for faster diagnosis of lung cancer patients to reduce ED admissions and improve patient outcomes via the SLM Amenable Mortality work. (EOA) 2. To engage with Te Puna Oranga across all cancer pathways 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 Specialist Equity and Access to identify DNA's, reasons for DNAing, breakdown barriers and re-engage with the services to ensure patients are seen in a timely manner (EOA) 3. Implement the prostate cancer decision support tool to improve the referral pathway across primary and secondary services. Clinical Nurse Specialist (CNS) for Urogenital cancer will continue to be involved in the development of national prostate cancer tumour stream. Our CNS for urogenital cancer will be part of a working group for improving Māori health access and treatment for Prostate cancer 4. We will provide support to people following their cancer treatment (survivorship) by • Providing a dedicated CNS for Urology, Continence, and Urotherapist and a CNS for urogenital cancer patients • Setting up an education session for prostate cancer patients • Providing preoperative education sessions and post operative education as required for specific conditions eg Radial prostatectomies, Trans Urethral Resection of Prostate (TURPs), Testicular cancer • Update patient education pamphlets for all conditions. Access to nurses via phone for support for patients who ring with queries. • Link patients with the cancer society and prostate cancer support groups	1. By the end of Q4 2. By the end of Q2 3. By the end of Q4 4. By the end of Q4	SI9: SLM amenable mortality HT: Faster Cancer Treatments PP29: Improving waiting times for diagnostic services PP30: Faster cancer treaments
	Disability Support Services	One team	Productive partnerrships	Waikato DHB is committed to Disability Support Services by: 1. Developing e-learning (or other) training for front line staff and clinicians that provides advice and information on what might be important to consider when interacting with a person with a disability. 2. Report on what percentage of staff have completed the training.	1. Roll out end of Q2 2. Report at end of Q4	SI14: Disabilty support services
	Healthy Ageing	Closer to home	Safe, quality health services for all	Waikato DHB is committed to 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. 2. Continue to work with Accident Compensation Corporation (ACC), Health Quality Safety Committee (HQSC), and the Ministry of Health, monitor and measure the progress of our integrated falls and fracture prevention services 3. Implement agreed activity from the In-between Travel (IBT) settlement Part 2	1. By end of Q2 2. On-going 3. ongoing and awaiting further information from the MoH 'Future Models of Care' project	

Government Planning Priority		Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
System Settings (both Māori and Pacific focussed equity actions are expected in this priority area) (continued)	Healthy Ageing	Closer to home	Safe, quality health services for all	4. InterRAI Data: • Work with Midland DHBs to ensure InterRAI assessment data is used to identify quality indicators, and service development opportunities. Agree pathways where data identifies need • Prioritise implementation of access to inteRAI data at National Health Index (NHI) level across primary and secondary Equity issue identified – equitable access to Needs Assessment and Service Coordination by Waikato Kaumatua (EOA) 5. Contribute to DHB and Ministry led development of Future Models of Care for home and community support services 6. Support the regional services plan work of: • Consolidation of components of the dementia pathway Ensure family and whānau carers have access to support and education programmes 7. Rollout the START service expension to prevent readmissions from primary care to acute care through early identification and intervention 8. Implementation of a frailty assessment tool at emergency department to identify patients 75+ years for on-going assessment and support ie early detection 9. Equity - We are specifically targeting Pacific and Māori within our Falls and Fracture Prevention programme by: a. Promoting the programme using Māori NASC and Māori/Pacific networks to facilitate access to strength and balance services b. Work with Rauawaawa, Kaumatua programmes, Te Korowai, South Waikato Pacific Island Community Services (SWPIC), and K'aute Pasifika to facilitate Māori/Pacific access to strength and balance referrals through PHO's and Waikato DHB 10. Acute demand - Working along-side the acute demand and chronic conditions team to identify intervention points and appropriate interventions to better manage complex conditions of frailty in the community by: a. significantly increasing the number of clients that are returning the same day following presentation from hospital. This has been most successful in the 75-90 age band with clients accessing acute home supports and supported discharge and rehab b. Clinical Nurse Specialist and Geriatrician establishing a regular presence in ED. Using a common sense approach to returning a patient home with a targeted follow up there after c. NASC utilising interRAI scores as a predictor of ED and Hospital admission, refering direct to START (Supported Discharge Model) to reverse the issues and prevent admission.	4. Quality indicators to be developed and utilised for service improvement by Q3 Access is implemented by Q4 5. On-going 6. On-going 7. By end of Q1 8. By end of Q1 9. a. By Q4 b. By Q3 10. a. By Q3 b. By Q2 c. By Q3	PP23: Implementing the Healthy Aging Strategy
	Improving Quality	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to improving patient experience by: 1. Support the newly formed Waikato DHB consumer council with the three identified work streams - rural services, Māori inequity, disability access. 2. Develop an end of life care framework for Waikato DHB: Roll out the train the trainer approach for Advance Care Planning (ACP) across district in line with the HQSC five year strategy. 3. Work to improve equity in outcomes as measured by the Atlas of Healthcare Variation in asthma. Evaluation will include uptake and outcomes. A programme evaluation framework will measure the impact of the programme on respiratory illness care delivery and outcomes to include: • % of patients with a known diagnosis of asthma. Classifications in Medtech and in hospital data • % of patients who have had an ED presentation • % of patients who have had a hospital admission • % of patients currently using steroids • % of patients waiting for an OP appt (FSA) with asthma related issues (EOA) 4. The last 1000 days project will be developed and implemented. 5. Patient Experience SLM work - this year we have an emphasis on medication safety and health literacy. Work will include the implementation of a Safer Discharge Checklist pilot project in Waikato DHB inpatient.	1a. Consumer council action plan developed and approved by Q2 b. Consumer council member on each of the DHB committees driving rural, Māori equity and disability access by Q4 2a. Trainers identified and trained by end of October 2018 b. At least 4 local training sessions completed by Dec 2018, with a further 4 by end of June 2019 3. By end Q4 4. Development Q2, implementation Q4 5. Initail pilot and evaluation completed Q4	SI17: Improving quality
	Climate Change	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to collectively reducing carbon emissions by: 1. Individually and collectively make efforts to reduce carbon emissions and, where appropriate, promote the adoption of CEMARS (or other carbon neutral scheme) by: • Increasing investment into energy saving initiatives. • Removal of non-recyclable and non-compostable cups. • Accelerate reduction in waste to landfill. 2. Undertake a stocktake to be reported in quarter 2 to identify activity/ actions being delivered, including procurement, that are expected to positively mitigate or adapt to the effects of climate change.	1. By end of Q4 2. Stocktake reported in Q2	PP40: Responding to climate change
	Waste Disposal	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to reducing pharmaceutical waste by: 1. Undertake a stocktake to identify: a. The disposal arrangements currently in place for both community and hospital waste, specifically including cytotoxic waste b.The DHB's understanding of the environmental and sustainability impacts of the waste disposed through these arrangements c. Any actions underway to improve the environmental and sustainability impacts of the waste disposed. 2. Identify activity/actions to support the environmental disposal of hospital and community waste products	1. By end of Q2 2. By Q3	PP41: Waste disposal

Table continues over page

Table continued from previous page

<table>
<tr><th rowspan="2">Government Planning Priority</th><th rowspan="2">Link to NZ Health Strategy</th><th rowspan="2">Link to Waikato DHB Strategy</th><th colspan="2">DHB Key Response Actions to Deliver Improved Performance</th><th rowspan="2">Measures</th></tr>
<tr><th>Activity</th><th>Milestones</th></tr>
<tr><td>Fiscal responsibility</td><td>Value and high performance</td><td>Effective and efficient care and services</td><td>Waikato DHB is committed to deliver best value for money by managing our finances in line with the Minister's expectations.
Local improvement activities to respond to Government intentions (DHBs required to include actions in this sections will be advised)</td><td>On-going</td><td>Report on activities in the Annual Plan</td></tr>
<tr><td>Delivery of Regional Services Plan</td><td>One team</td><td>Productive partnerrships</td><td colspan="3">
Waikato DHB support our staff to meet and undertake work as members of the regional clinical network/action groups detailed in the individual 2018-21 Regional Services Plan work plans
Our Waikato DHB actions to support planned elective activity within vascular services, breast reconstruction and ophthalmology includes:
<table>
<tr><th>Network name</th><th>18/19 work plan initiative name</th><th>Action/activity detail eg 1.1</th><th>Milestone</th><th>Measure</th></tr>
<tr><td rowspan="5">Mental Health and Addictions</td><td>Eating Disorders</td><td>Implementation of EDS Model of Care</td><td>Q4</td><td>Service Level Agreements are in place</td></tr>
<tr><td>Substance Abuse Legislation</td><td>Implementation of SACAT Model of Care</td><td>Q4</td><td>Local MOC is developed and implemented</td></tr>
<tr><td>National MH Inquiry</td><td>Implement recommendations from the Inquiry report</td><td>Q4</td><td>Regional agreements are decided and projects are put into place</td></tr>
<tr><td>Health Equity for Māori</td><td>Working with GMS Māori to develop Equity framework</td><td>Q4</td><td>Agreed equity measures are in place for MH&A</td></tr>
<tr><td>Workforce Capacity and Capability</td><td>Provide regional and local support to the Quality Safety & Health Commission projects</td><td>Q4</td><td>Implement consistent pathways for the Zero Seclusion and Transition projects</td></tr>
<tr><td>Midland Trauma System</td><td>2.8 Stage 2 Build of the TQUAL relational platform</td><td>Waikato DHB IS support to complete project within timeframe</td><td>Q3</td><td>TQUAL stage 2 fully functional</td></tr>
</table>
Workforce enabler:
Identify the actions that the region will undertake to maximise workforce resources. And development of long-term recruitment plan for vulnerable or hard-to-recruit roles.
By:
• Provide vacancy data to Healthshare to identify professional groupings whose characteristics, numbers, vacancy rates, turnover rates, or age profile within the DHB, may pose a risk to ongoing service delivery
• support collaboration across Midland DHBs to create and access material for long term recruitment strategies.
Orthopaedics:
• support the regional review of current orthopaedic workforce resources, factoring in subspecialty capability. Support the development and implementation of a regional orthopedic workforce implementation plan (based on the regional review).
By:
• providing data for Healthshare to undertake an orthopaedic workforce stocktake, gap analysis, and identify issues. This activity is dependent on additional resourcing.
Refer to Elective services (Elective Services Network) 18-19 work plan. Note: orthopaedic workforce is not detailed and would be subject to additional resourcing.
Quality enabler:
When developing and implementing regional models of care for Vascular, and Breast Reconstruction and regional collaboration on Ophthalmology (Age-Related Macular Degeneration (AMD) and Glaucoma) service development, there will be a clear link to quality improvements and standards, particularly in relation to unwarranted variation in patterns of care and improving health equity.
Refer to Elective services (Elective Services Network) 18-19 work plan initiative 1: Vascular services.
Refer to notes in Elective services (Elective Services Network) 18-19 work plan initiative 2 Breast Reconstruction and initiative 3: Ophthalmology re constraints.
Clinical Leadership enabler:
Refer to Elective services (Elective Services Network) 18-19 work plan:
Initiative 1: Vascular services – led by Thodur Vasudevan and Mark Morgan.
Focus is on improving the delivery of vascular services for the population of the Midland region.
Actions related to clinical leadership include:
• Support the assessment and confirmation of DHB service levels
• Support the development acute and elective pathways
• Workforce benchmarking is undertaken and opportunities to develop workforce and technology solutions are identified and progressed.
Initiative 2: Breast reconstruction services – note that the anticipated 18/19 work relating to improving access, and consistency of access, to plastics and reconstructive services. Midland Elective Services Network will engage with the national service improvement programme as actions are developed and will support regional implementation, as required by Waikato DHB.
Initiative 3: Ophthalmology services – note that the anticipated 18/19 work relating to improving access, and consistency of access, to Age-Related Macular Degeneration (AMD) and Glaucoma pathways. Midland Elective Services Network will engage with the national service improvement programme when guidelines are completed and as actions are developed and will support regional implementation, as required by Waikato DHB.
Pathways enabler:
Support the development and implementation of regional models of care to support better flows between secondary and tertiary service providers and between community and secondary care. This will enable a streamlined journey for the patient in order to achieve better patient outcomes.
Key areas identified for 2018/19 are:
• Vascular
• Breast Reconstruction
• Ophthalmology
</td></tr>
</table>

Financial performance summary

(Refer to Appendix One for further detail)

Table: Statement of Prospective Comprehensive Income

Forecast Statement of Comprehensive Income	2016/17 $000 ACTUAL	2017/18 $000 FORECAST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
REVENUE						
Patient care revenue	1,339,628	1,422,904	1,479,452	1,527,486	1,578,530	1,630,854
Other operating income	17,756	18,244	18,308	22,648	23,400	23,943
Finance income	1,839	1,714	1,187	1,216	1,245	1,274
TOTAL REVENUE	1,359,223	1,442,862	1,498,947	1,551,350	1,603,175	1,656,071
EXPENSES						
Personnel costs	537,041	573,756	643,358	674,727	709,437	728,418
Depreciation	34,954	46,399	45,103	47,488	51,515	55,571
Amortisation	5,260	5,319	6,830	11,783	12,782	13,788
Outsourced services	78,419	92,926	78,866	79,716	81,036	82,667
Clinical supplies	135,537	144,849	149,769	153,320	157,674	161,181
Infrastructure & non-clinical expenses	82,486	84,800	76,981	70,808	72,059	73,678
Other district health boards	56,643	61,130	62,103	63,843	65,594	67,366
Non-health board provider expenses	407,106	433,665	457,108	473,515	486,400	499,448
Finance Costs	4,974	116	192	193	195	198
Capital Charge	15,188	37,124	34,708	37,586	39,256	41,210
TOTAL EXPENSES	1,357,610	1,480,084	1,555,018	1,612,979	1,675,948	1,723,525
Share of profit/(deficit) of Associates and Joint venture	(3)	72	-	-	-	-
SURPLUS/(DEFICIT)	1,610	(37,150)	(56,071)	(61,629)	(72,773)	(67,454)
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve	176,237	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	177,847	(37,150)	(56,071)	(61,629)	(72,773)	(67,454)

Table: Revenue and expenditure by Output class

Forecast Statement of Cost and Revenue	2018/19 $000 PLANNED	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED
REVENUE				
Prevention	28,111	29,094	30,066	31,058
Early Detection and Management	279,786	289,567	299,240	309,114
Intensive Assessment and Treatment	1,023,717	1,059,506	1,094,901	1,131,026
Support and Rehabilitation	167,333	173,183	178,968	184,873
TOTAL REVENUE	**1,498,947**	**1,551,350**	**1,603,175**	**1,656,071**
EXPENDITURE				
Prevention	24,559	25,475	26,468	27,220
Early Detection and Management	260,616	270,330	280,884	288,857
Intensive Assessment and Treatment	1,104,985	1,146,171	1,190,918	1,224,726
Support and Rehabilitation	164,858	171,003	177,678	182,722
TOTAL EXPENSES	**1,555,018**	**1,612,979**	**1,675,948**	**1,723,525**
SURPLUS/DEFICIT	**(56,071)**	**(61,629)**	**(72,773)**	**(67,454)**

SECTION 3: Service configuration

3.1 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 2018/19.

3.2 Service change

The table below describes all service reviews and service changes that have been approved or proposed for implementation in 2018/19.

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 • Induction of labour rooms • Reconfiguration of women's health wards	• 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 also 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 • Child oral health (dentistry under GA) • Urgent care services (primary and secondary) • Inpatient services • Community based (non-hospital) services • Rural laboratory services • Service changes associated with service redesign to support the development of integrated rural health and social services in Ruapehu, South Waikato, King Country, Thames and Coromandel, and North Waikato • Service changes to support enhanced workforce development in rural settings	• Improved access • Earlier intervention • Better co-ordinated and integrated services	Local with some inter-DHB (sub-regional) aspects at the DHB boundaries
Mental Health and Addictions	Completing Te Pae Tawhiti service review commissioning plan in 18/19 and out years. Finalising capital planning and replacement of Henry Bennett. Developing stronger links with primary care and NGO's for design of services.	• Improved access • Earlier intervention • Better co-ordinated and integrated services	Local
Primary care integration	Development of the Care in the community Plan with the intent to improve primary care and other community services at a locality level. Review Primary Option services to ensure accurate service mix to reduce ED and ASH admissions Establish Waikato District Alliance to incorporate clinicians and managers across the system to enhance primary care services for our local population	• Increased integration between primary and secondary services • Increased clinical leadership • Enhanced sustainability of rural services	Local
Community Pharmacy and Pharmacist services	Potential change in model of service delivery using framework of new contract. Work towards different contracting arrangements for the provision of community pharmacist services by working with consumers and other stakeholders within the framework of the new contract to develop and agree local service options, including potential options for consumer-focused pharmacist service delivery, with wider community- based inter-disciplinary teams.	• More integration across the primary care team • Enhanced services for consumers • Improved access to pharmacist services by consumers • Consumer empowerment • Safe supply of medicines to the consumer • Improved support for vulnerable populations • More use of pharmacists as a first point of contact within primary care.	National and local

SECTION 4: Stewardship

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

4.1 Managing our business

4.1.1 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

4.1.2 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 2018/19 and out years is contained in the Financial Performance Summary section of this document on page 22, and in Appendix A: Statement of Performance Expectations.

4.1.3 Investment and asset management

Waikato DHBs will develop a 10 year Health System Plan and 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.

4.1.4 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.

4.1.5 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).

4.1.6 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.

4.2 Building capability

Waikato DHB is currently developing our Health System Plans across the whole of the DHB. It is anticipated that capabilities will be identified from this process for the next three to five years.

4.2.1 Capital and infrastructure development

Business case expecting approval in 2018/19 includes TBC
Business cases due for completion in 2018/19 include TBC
Business cases that will be started in 2018/19 include the TBC

4.2.2 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 2018/19 Midland Regional Service Plan, and on page 43.

4.2.3 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. Further 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:

- 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. Virtual Health – 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.

4.2.4 Co-operative developments

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

- Ministry of Education,
- Ministry of Justice,
- Corrections
- Police,
- Ministry of Social Development,
- Local Government

4.3 Workforce

4.3.1 Healthy ageing workforce

The 18-19 District Annual Plan builds on foundations set out in the 17-18 Midland Regional Services Plan (RSP). The primary piece of work in the 17-18 Midland RSP related to identifying workforces working with older people and their whānau, and developing a sustainable mechanism for collecting a minimum workforce data set outside of the DHBs provider functions. Following discussion with the Ministry of Health in August 2017 it was agreed that Central Tasman (CTAS) shared service agency would take the national lead for this work. CTAS is the national DHB workforce data repository as well as providing analytics and reporting from that data set. Since 2017 a national project group has been formed led by CTAS which includes a major sector service provider. The group is identifying the data set, reporting timeframes, collection process, data repository, and analytics and reporting. A business case is being drafted to request additional resourcing to progress this work.
Midlands DHBs will utilise the outcome from the national work to develop any sector wide workforce plans for the older persons' workforce. Waikato DHB is committed to identifying work force requirements around the service delivery needs of older persons. In the first two years of the Health Ageing Strategy 2016 (2017-219) the accountability for implementing objective 9c) 'the Kaiāwhina Workforce Action Plan' rests with the Office of the Chief Nurse; Health Workforce NZ; Careerforce; and Health of Older People service providers. Providers also have a contractual accountability to ensure their workforce is appropriately registered (as applicable); trained; orientated; and supported to deliver the services required under their agreement. Waikato DHB offers a comprehensive menu of training and support targeting both the regulated and non-regulated workforce in the care of older people.

This includes the following areas:

Additional work includes:

1) Work alongside our regional partners and Healthshare to roll out the elements within the Regional Service Plan for the older people workforce development work
2) Continue to comply with obligations to improve conditions for the Kaiāwhina workforce through implementation of both the In-Between Travel, and the Pay Equity legislation, at DHB level
3) Develop a local workforce plan to identify the care and support skills and competencies needed for older people living well with long-term conditions inclusive of:
   a. Workforce requirements for service models targeting older people with chronic health conditions
   b. Support for informal caregivers caring for older people with chronic health conditions
   c. Opportunities for volunteers to supplement and enrich service models for older people living well with chronic health conditions
   d. Investigate a Māori kaupapa initiative

4.3.2 Health literacy

Health literacy skills within the workforce

Waikato DHB recognises the importance of promoting and co-ordinating actions to raise awareness of and to build skills in health literacy practice amongst the health workforce and across the health system and for this reason a number of professional development programmes are run for staff. These include building the capacity of the health workforce to use plain language and proven health literacy practices by training managers and senior clinical staff on holding difficult conversations. These conversations include difficult clinical decisions, discussing prognosis and outcomes, when errors may have occurred in the course of treatment which have caused adverse outcomes, or handling difficult/serious complaints.

Health literacy practices

It is accepted that most individuals and whānau will at times have difficulty understanding and applying complex health information, for this reason Waikato DHB has recently reviewed and redesigned the public website to improve information quality and usability.

The principles followed were:

- Mobile first – over 50% of people view the website on their phones or smart devices and that is expected to grow.
- Written for search engine optimisation (SEO) - the vast majority of people come to the site via a search engine like Google
- User-centric – content that the user wants, written and displayed in a way that's helpful and easy to find and navigate to
- Best practice – Utilisation of the latest techniques for website navigation and design e.g. search functions, accordions, mega menus
- Keeping it dynamic and up to date – An automatic pull through of stories from the Newsroom site which means the latest news about services is continually displayed on the web page
- Clean slate – Starting fresh with content and didn't migrate any old content across to eliminate out of date information.

The use of social media to provide engaging information in smaller easier to understand bites. Emergency Department clinician input in writing Facebook post, to enable more engaging content aimed at educating the public on medication and first aid. Waikato DHB will also work towards reviewing the status of health literacy within the organisation using the six dimensions of a health literate organisation along with cultural literacy.

4.3.3 Midwifery workforce

Waikato DHB is considered "hard to staff" DHB regarding the midwifery workforce, and for reason a recruitment and retention focus is underway. The strategies involve consideration of the entire midwifery pipeline from the quality of clinical learning experiences provided, to undergraduate student midwives, to the authority and leadership in midwifery practice within the organisation. Recruitment strategies will include a focus on Māori responsiveness and support for Māori midwives.

Recruitment strategies include:

- Close relationship with Wintec ensuring that student midwives provided consistent clinical experience in all areas of the DHB. Placements are worked around DHB orientating staff so that there is always a preceptor dedicated to the student. Feedback from students and Wintec teaching staff is that placements are of a high calibre
- Comprehensive orientation plan (extended in 2018) for all Midwifery First Year Practice graduate midwives
- Advertising via local, national and international channels for staff
- Six-week orientation plan (but tailored to fit the individual) for all new experienced midwifery staff
- Assistance with relocation expenses (with a bond of two years employment required) for overseas staff
- Assistance with costs for internationally-qualified midwives education requirements with Midwifery Council
- Regular presentations by educators and senior midwifery managers to third year student midwives to encourage roles within the DHB
- Encouragement and support for LMCs who wish to work with us to become comfortable in the tertiary setting – in addition to orientation – casual staff are given orientation and assistance

Retention strategies include:

- Opportunities for experienced staff to become shift coordinators – paid allowance for this responsibility
- Opportunities for senior midwives to apply to the ACMM team when vacancies arise, this team has been increased to provide almost 24/7 cover of shifts in Birthing Suite
- Support for Quality Leadership Pathway (QLP) from educators and Professional Development Unit (PDU)
- A new initiative to second four midwives into a job-shared role for orientation to relieve ward staff/educators of all the responsibilities of preceptoring new staff, and provide leadership and facilitating experience for these midwives
- Pebbles project – The Pebbles programme is a professional development programme for clinically-based registered health professionals provided by the Waikato DHB. Open to health professionals working within the DHB or contracted services. It introduces purposeful development strategies for health professionals to extend clinical leadership expertise and/or prepare for senior roles. The programme recognises and builds on the contribution health professionals make in the provision of safe, effective, quality, person- centred healthcare.
- Leadership in Practice Programme - A Midland initiative which provides learning opportunities for leaders / managers in the Midland DHBs - Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato.
  This programme is for those looking for a practical leadership programme covering current theory and practice applicable to your everyday context. Participants can be new and/or experienced managers, or those with leadership potential. Midwives are supported to apply for this programme – the number of applicants exceeds places available

It has been identified that Waikato DHB has midwifery workforce challenges, this will be monitored on an ongoing basis.

4.3.4 Information Technology (IT)

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

The Midland region, through the 2017-21 Midland Region Information Services Plan (MRISP), has an established IS regional strategy aligned to the New Zealand Health Strategy direction, which has set a goal of a people-powered, smart health system by 2025. The MRISP underpins the Information Services work of the Midland Region and guides our priorities and approach. It is informed by, and supports, the Midland Regional Services Plan, Government ICT Strategy and Ministry of Health Strategies, specifically Digital Health 2020.

There are six key objectives of focus with the MRISP;

- eSPACE Programme (MRISP initiatives 1 to 6)
- Effective Decision Making (MRISP initiatives 7 to 9)
- HealthCare Integration (MRISP initiatives 10)
- Digital Hospitals (MRISP initiatives 11)
- Virtual HealthCare (MRISP initiatives 12)
- IT Enablement (MRISP initiatives 13 to 18)

In addition to the before mentioned regional initiatives the DHB has a developed roadmap for improving digital capabilities, empowering clinicians & nurses, and delivering efficiency & patient safety improvements which are realised through a portfolio of lifecycle upgrades, enhancements, and innovation projects. The proposed 2018/19 funding envelope for these initiatives being $19m. Major initiatives being undertaken include; regional PACS/ RIS consolidation, IaaS, Windows 10, Office 2016, Patient Flow, eOrders, Business Intelligence Data & Reporting, Disaster Recovery Solution, Theatres - Booking & Scheduling, Observations Platform (eVitals), Enterprise Messaging/Communication Solution, Clinician/Nurse workforce mobility enablers (WiFi, End User Devices, Applications, Security), Integration/Enterprise Service Bus, Food & Nutrition solution, Attendant Job Allocation solution, & lifecycle upgrades (across infrastructure, applications, & end user devices).

The DHB plans to continue the work establishing a robust Application Portfolio Management framework, with a focus on appropriate lifecycle management of existing ICT assets. Historical funding for ICT has been constrained to annual depreciation, which has funded asset replacement, enhancements, & innovation. As per previous reporting to the ministry the DHB has, as a result of the historical funding mechanism and financial constraints, a ~$28m deferred maintenance (technical debt) which it has proposed to address through increased ICT capital funding over each of the next 5 years.

The DHB has an approved business case and approved funding, dating back to 2015, to implement the National Maternity System. The implementation was put on hold at the request of the Ministry and the DHB's Maternity Service team is working with the Ministry team on the timelines for the resolution of issues/defects/enhancements and the appropriate window for implementation, which we understand is likely to be circa 2019.

The DHB has an Information Security and Privacy Governance Group (ISPG) in place which is chaired by the Director of Board Governance and membership includes the; CIO, Chief Data Officer, Privacy Officer, Risk Officer, and DHB Executive Group. The primary role of the ISPG is the ensure that Information Security and Privacy are an integrated and integral part of the mission of the DHB. The ISPG specifically includes a commitment to ensure the DHB meets its; HISO 10029 (Health Information Security Framework), HISO 10064 (Health Information Privacy Guideline), HIPC (Health Information Privacy Code), Privacy Act, & NZISM (New Zealand Information Security Manual) obligations. Further the DHB has a Security Manager in place and an active, positive, & constructive engagement with Nick Baty (the Ministries Chief Security Advisor). All of which will continue.

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			18/19
	Age 0 - 19	Māori	4.73%
		Other	4.15%
		Total	4.36%
	Age 20 - 64	Māori	8.77%
		Other	3.79%
		Total	4.81%
	Age 65+	Māori	2.39%
		Other	2.08%
		Total	2.11%
PP7: Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
	95% of audited files meet accepted good practice.		
	Report on activities in the Annual 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.		
	Report on activities in the Annual Plan		
PP10: Oral Health- Mean DMFT score at Year 8	Year 1	Māori	0.92
		Other	0.92
		Total	0.92
	Year 2	Māori	0.92
		Other	0.92
		Total	0.92
PP11: Children caries-free at five years of age	Year 1	Māori	64%
		Other	64%
		Total	64%
	Year 2	Māori	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	Māori	90%
		Other	90%
		Total	90%
	Year 2	Māori	90%
		Other	90%
		Total	90%

Performance measure	Performance expectation		
PP13: Improving the number of children enrolled in DHB funded dental services (0-4 years)	Year 1	Māori	≥95%
		Other	≥95%
		Total	≥95%
	Year 2	Māori	≥95%
		Other	≥95%
		Total	≥95%
PP13: Improving the number of children enrolled in DHB funded dental services, (children not examined 0-12)	Year 1	Māori	≤10%
		Other	≤10%
		Total	≤10%
	Year 2	Māori	≤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.		
	90% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years.		
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.		
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF		
Focus Area 5: Stroke services	10% 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.		
	60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team ie RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.		
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		
	Report on activities in the Annual Plan		
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.		
	Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4 – 6 for assessment urgency		
PP25: Youth mental health Initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.		
	Initiative 3: Youth Primary Mental Health. 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.		

Performance measure	Performance expectation	
PP26: The Mental Health and 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 child well-being	Report on activities in the Annual Plan.	
PP28: Reducing Rheumatic fever	Focus Area 1: Reducing the Incidence of First Episode Rheumatic Fever	
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	
	95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	
	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 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.	
	Report on activities in the Annual Plan.	
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%.	
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	70% of infants are exclusively or fully breastfed at three months	
PP39 Supporting Health in Schools	Report on activities in the Annual Plan.	
PP40 Responding to climate change	Report on activities in the Annual Plan.	
PP41 Waste disposal	Report on activities in the Annual Plan.	
PP43 Population mental health	Report on activities in the Annual Plan.	
PP44 Maternal mental health	Report on activities in the Annual Plan.	
PP45: Elective surgical discharges	18,037 of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	
SI1: Ambulatory Sensitive Hospitalisations	0-4 years	As specified in the jointly agreed (by district alliances) SLM Improvement Plan
	46 – 64 years	Māori
		Pacific
		Other
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 32 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.	

Performance measure	Performance expectation	
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.	
SI12: SLM youth access to and utilisation of youth appropriate health services	As specified in the jointly agreed (by district alliances) SLM Improvement Plan	
SI13: SLM number of babies who live in a smoke-free household at six weeks post natal	As specified in the jointly agreed (by district alliances) SLM Improvement Plan	
SI14: Disability support services	Report on activities in the Annual Plan	
SI15: Addressing local population challenges by life course	Report on activities in the Annual Plan	
SI16: Strengthening Public Delivery of Health Services	Report on activities in the Annual Plan	
SI17: Improving quality	Report on activities in the Annual Plan	
SI18: Improving newborn enrolment in General Practice	Report on activities in the Annual Plan	
OS3: Inpatient Average Length of Stay (LOS)	Elective LOS suggested target is 1.47 days, which represents the 75th centile of national performance.	1.54 days
	Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.	2.40 days
OS8: Reducing Acute Readmissions to Hospital	TBA – indicator definition currently in draft.	
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%
	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.	

APPENDIX A:
2018-19 Statement of Performance Expectations

Waikato District Health Board

2018-19 STATEMENT OF PERFORMANCE EXPECTATIONS

PRESENTED TO THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 149(L) OF THE CROWN ENTITIES ACT 2004

Waikato District Health Board

Contents

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Signatories

Agreement for the Waikato DHB 2018/19 Statement of Performance Expectations.

The Statement of Performance Expectations is an integral part of the Annual Plan and in order to meet the requirements of Section 149(I) of the Crown Entities Act 2004, we present the following information which forms the Statement of Performance Expectations.

Sally Webb Chair Waikato DHB	Professor Margaret Wilson Deputy Chair Waikato DHB
Date:	Date:

Introduction

This Statement of Performance Expectations articulates Waikato District Health Board's (DHB) commitment to make positive changes in the health status of our population.
We have worked with a number of key stakeholders to develop the Statement of Performance Expectations 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 2018/19.
The following performance story diagram shows the links between what we do to enable and support our performance (stewardship), and our service performance (outputs class, impacts and output activity).

Our performance story

National performance story

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

Regional performance story

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

Waikato DHB performance story

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

Service performance

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

Stewardship

Stewardship	Workforce	Organisational performance management	Clinical integration/ Collaboration/Partnerships	Information

* These are only an example of the outputs.

The performance measures chosen are not an exhaustive list of all of our activity, but they provide a good representation of the full range of outputs that we fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, we have included with each measure past performance as baseline data.

IMPACTS

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

IMPACT MEASURES – MEASURES OF PERFORMANCE

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

LONG-TERM IMPACT 1: PEOPLE ARE SUPPORTED TO TAKE GREATER RESPONSIBILITY FOR THEIR HEALTH

We encourage people to take responsibility for their health by making healthy lifestyle choices and engaging in preventative strategies, such as childhood immunisation programmes and promoting access to smoking cessation services. Tobacco smoking, inactivity, and poor nutrition are major risk factors for a number of the most prevalent long-term conditions. These are avoidable risk factors and can be reduced through supportive environments, improved awareness, and personal responsibility for health and wellbeing. Supporting people to make healthier choices will improve the quality of life and health status of our population and reduce avoidable demand and pressure on our health system.

LONG-TERM IMPACT 2: PEOPLE STAY WELL IN THEIR HOMES AND COMMUNITIES

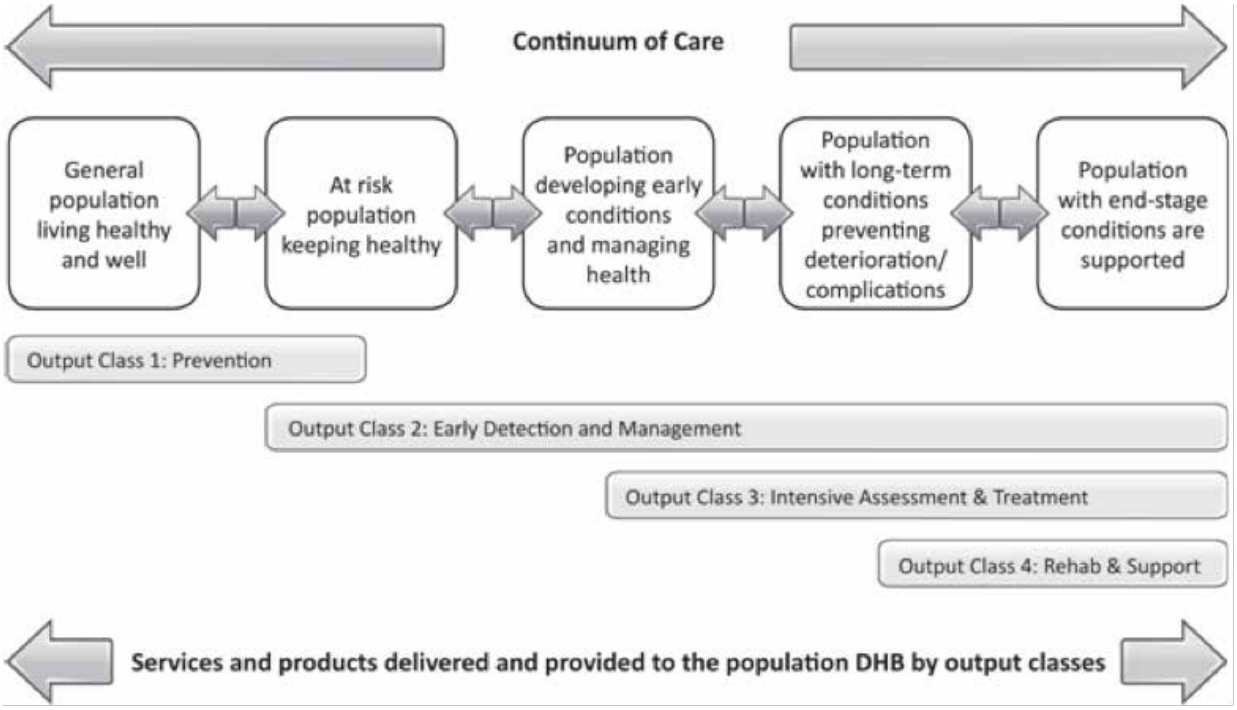
When people are supported to stay well and can access the care they need closer to home and in the community, they are less likely to need hospital-level or long-stay interventions. This is not only a better health outcome, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes at a lower cost, than countries with systems that focus more heavily on a specialist or hospital level response.
Our investment in general practice and community health services is enabling the DHB to deliver services closer to home, with improved access leading to early detection, diagnosis and management.
Health services also play a role in supporting people to remain independent for longer.

LONG-TERM IMPACT 3: PEOPLE RECEIVE TIMELY AND APPROPRIATE SPECIALIST CARE

For people who do need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand by managing the flow of patients between services and moving the point of intervention to earlier in the path of illness.
As providers of hospital and specialist services, this goal also reflects the effectiveness and the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions and complications that have a negative impact on the health of our population, people’s experience of care and their confidence in the health system. Ineffective or poor quality treatment and long waits also waste resources and add unnecessary cost into the system.

OUTPUT MEASURES

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



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

OUTPUT CLASS

Prevention

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.
Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.
Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation.
On a continuum of care these services are public wide preventative services.

Early detection and management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.
These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.
On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

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

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

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

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

SETTING TARGETS

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

WHERE DOES THE MONEY GO?

Table 1: Revenue and expenditure by Output class

Forecast Statement of Cost and Revenue	2018/19 $000 PLANNED	2019/20 $000 PLANNED	2020/21 $000 PLANNED	2021/22 $000 PLANNED
REVENUE				
Prevention	28,111	29,094	30,066	31,058
Early Detection and Management	279,786	289,567	299,240	309,114
Intensive Assessment and Treatment	1,023,717	1,059,506	1,094,901	1,131,026
Support and Rehabilitation	167,333	173,183	178,968	184,873
TOTAL REVENUE	**1,498,947**	**1,551,350**	**1,603,175**	**1,656,071**
EXPENDITURE				
Prevention	24,559	25,475	26,468	27,220
Early Detection and Management	260,616	270,330	280,884	288,857
Intensive Assessment and Treatment	1,104,985	1,146,171	1,190,918	1,224,726
Support and Rehabilitation	164,858	171,003	177,678	182,722
TOTAL EXPENSES	**1,555,018**	**1,612,979**	**1,675,948**	**1,723,525**
SURPLUS/DEFICIT	**(56,071)**	**(61,629)**	**(72,773)**	**(67,454)**

The output class financial reporting for 2018-19 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code (purchase unit code mapping to output class as per data dictionary version 22). The out years are based on the same cost and revenue ratios being applied to total cost and revenue.

People are supported to take greater responsibility for their health

Long term impact	Intermediate impacts	Impact and outputs
People are supported to take greater responsibility for their health	Fewer people smoke	Percentage of Year 10 students who have never smoked
		Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking
		Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
		Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking
	Reduction in vaccine preventable diseases	Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds
		Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time
		Percentage of two year olds are fully immunised and coverage is maintained
		Percentage of eligible children fully immunised at 5 years of age
		Percentage of eligible 12 year old girls have received HPV dose two
		Seasonal influenza immunisation rates in the eligible population (65 years and over)
	Improving health behaviours	95 percent of obese children identified in the Before School check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017)
		The number of people participating in Green Prescription programmes
		Percentage of Kura Kaupapa Māori primary schools participating in Project Energize
		Percentage of total primary schools participating in Project Energize

Fewer people smoke

Impact Measure	Baseline 2014	Target 2018/19	Target 2019/20	Target 2020/21
Percentage of year 10 students who have never smoked[1]				
Total[2]	74%	≥ 80%	≥ 82%	≥ 83%

Output Measure	Output class	Measure type	Baseline 2014/15	Target 2018/19
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	1	Qn		
Māori			94%	95%
Pacific			100%	95%
Other			91%	95%
Total			94%	95%
Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	1	Qn		
Māori			92%	90%
Pacific			91%	90%
Other			89%	90%
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			64%	90%
Pacific			Not available	90%
Other			66%	90%
Total			95%	90%

[1]Reporting based on school year and based on surveying a sample of schools in New Zealand
[2]Collected by total only as no ethnicity data available yet

Reduction in vaccine preventable diseases

Impact Measure	Baseline 2014	Target 2018/19	Target 2019/20	Target 2020/21
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds			Reduction in admissions for vaccine preventable diseases	
Māori	19.4	<8.8		
Pacific	0			
Other	4.5			
Total	8.8			

Output Measure	Output class	Measure type	Baseline 2014/15	Target 2018/19
Percentage of eight month olds will have their primary course of immunisations (six weeks, three months and five months immunisation events) on time	1	Qn		
Māori			90%	95%
Pacific			95%	95%
Other			83%	95%
Total			91%	95%
Percentage of two year olds are fully immunised and coverage is maintained	1	Qn		
Māori			91%	95%
Pacific			95%	95%
Other			91%	95%
Total			90%	95%
Percentage of eligible children fully immunised at 5 years of age	1	Qn		
Māori			73%	95%
Pacific			78%	95%
Other			76%	95%
Total			73%	95%
Percentage of eligible 12 year old girls have received HPV dose two[3]	1	Qn		
Māori			70%	75%
Pacific			106%	
Other			62%	
Total			66%	
Seasonal influenza immunisation rates in the eligible population (65 years and over)[4]	1	Qn/T		
Māori			46%	75%
Pacific			49%	
Other			53%	
Total			52%	

Improving health behaviours

Impact Measure	Baseline 2015	Target 2018/19	Target 2019/20	Target 2020/21
Percentage of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention[5]				
Māori	7%	95%	95%	95%
Pacific	19%	95%	95%	95%
Other	8%	95%	95%	95%
Total	9%	95%	95%	95%

Output Measure	Output class	Measure type	Baseline 2014/15	Target 2018/19
The number of people participating in Green Prescription programmes	1	Qn		
Total			5802	6700
Percentage of primary schools participating in Project Energize	1	Qn		
Kura Kaupapa Māori primary schools			100%	100%
Total primary schools			100%	100%

[3]For 2017/18 it is the 2004 birth cohort measured as ethnicity data now available
[4]Ethnicity data now available
[5]New target baseline 6 months ending September 2015

People stay well in their homes and communities

Long term impact	Intermediate impacts	Impact and outputs
People stay well in their homes and communities	An improvement in childhood oral health	Mean decayed missing and filled teeth score of Year 8 children Percentage of children (0-4) enrolled in DHB funded dental services Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination Percentage of adolescent utilisation of DHB funded dental services
	Long-term conditions are detected early and managed well	Percent of the eligible population who have had their cardiovascular risk assessed in the last five years Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months Percentage of eligible women aged 50 to 69 who have a Breast Screen Aotearoa mammogram every two years
	Fewer people are admitted to hospital for avoidable conditions	Ambulatory sensitive hospitalisation rate per 100,000 for the following age group: 45-64 year olds Percentage of eligible population who have had their B4 School checks completed Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)
	More people maintain their functional independence	Average age of entry to aged related residential care Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan Percentage of people enrolled with a primary health organisation Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days

An improvement in childhood oral health[6]

Impact Measure	Baseline 2014	Target 2018/19	Target 2019/20	Target 2020/21
Mean decayed missing and filled teeth score of Year 8 children				
Māori	1.65	0.92	Decrease	TBC
Pacific	1.40	0.92		
Other	0.87	0.92		
Total	1.08	0.92		

Output Measure	Output class	Measure type	Baseline	Target 2018/19
Percentage of children (0-4) enrolled in DHB funded dental services[7]	2	Qn		
Māori			72%	≥95%
Pacific			72%	≥95%
Other			72%	≥95%
Total			72%	≥95%

Output Measure	Output class	Measure type	Baseline	Target 2018/19
Percentage of enrolled pre-school and primary school children (0-12) overdue their scheduled dental examination[8]	2	Qn/T		
Māori			18%	≤10%
Pacific			20%	
Other			25%	
Total			18%	
Percentage of adolescent utilisation of DHB funded dental services[9]	2	Qn		
Māori			45%	90%
Pacific			53%	90%
Other			80%	90%
Total			70%	90%

[6]Childhood oral health measures are for a calendar year
[7]2016/17 ethnicity data not available
[8]From 1 January 2017-31 Decmber 2017 ethnicity data available
[9]From 1 January 2017-31 Decmber 2017 ethnicity data available

Long-term conditions are detected early and managed well

Impact Measure	Baseline	Target 2018/19	Target 2019/20	Target 2020/21
To be confirmed				

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of the eligible population who have had their cardiovascular risk assessed in the last five years		2	Qn		
	Māori			87%	90%
	Pacific			88%	90%
	Other			91%	90%
	Total			90%	90%
Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past five years[10]		2	Qn	74%	90%
Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months		2	Qn/T		
	Māori			60%	80%
	Pacific			65%	80%
	Other			80%	80%
	Total			74%	80%
Percentage of eligible women aged 50-69 who have a Breast Screen Aotearoa mammogram in the last two years		2	Qn/T		
	Māori			58%	70%
	Pacific			60%	70%
	Other			70%	70%
	Total			68%	70%

Fewer people are admitted to hospital for avoidable conditions

Impact Measure		Baseline 2017	Target 2018/19	Target 2019/20	Target 2020/21
Ambulatory sensitive hospitalisation rate per 100,000 of the following age group 45-64 years old[11]				Decrease	
	Māori	9,314	8,942		
	Pacific	6,636	6,371		
	Other	3,426	3,357		

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of eligible population who have had their before school check completed		1	Qn/T		
	Māori			77%	90%
	Pacific			83%	90%
	Other			98%	90%
	Total			90%	90%
Acute rheumatic fever initial hospitalisation rate		2 and 3	Qn		
	Total			3.9/ 100,000	1.2/ 100,000

People maintain their functional independence

Impact Measure		Baseline	Target 2018/19	Target 2019/20	Target 2020/21
Average age of entry to aged related residential care					
	Resthome	85 years,	>84 years	To be allocated	
	Dementia	83 years	>80 years		
	Hospital	86 years	>85 years		

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan		4	Qn/T		
	Total			100%	100%
Percentage of people enrolled with a primary health organisation		2	Qn/T		
	Māori			91%	95%
	Pacific			88%	95%
	Other			66%	95%
	Total			95%	95%
Percentage of needs assessment and service coordination waiting times for new assessments within 20 working days					
	Total			62%	100%

[10]Baseline 16/17
[11]Baseline used by Ministry is 12 months to Sep 2016

People receive timely and appropriate specialist care

Long term impact	Intermediate impacts	Impact and outputs
People receive timely and appropriate specialist care	People receive prompt and appropriate acute and arranged care	Percentage of patients admitted, discharged, or transferred from emergency departments within six hours
		90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks
		Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries
	People have appropriate access to elective services	Standardised intervention rates (per 10,000)
		Percentage of patients waiting longer than four months for their first specialist assessment
		Improved access to elective surgery, health target, agreed discharge volumes
		Did-not-attend percentage for outpatient services
		Acute inpatient average length of stay
		Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates
		Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks
		Percentage of child and youth with a transition (discharge) plan
		Average length of acute inpatient stay
		Rates of post-discharge community care
		Improving the health status of people with severe mental illness through improved access
	More people with end stage conditions are supported appropriately	Percentage of aged residential care facilities utilising advance directives
		Number of new patients seen by the Waikato Hospital palliative care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
		Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)
		Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days)
		Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)
		Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 2015-16) within 42 days
		Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date
		Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

People receive prompt and appropriate acute and arranged care

Impact Measure		Baseline	Target 2018/19	Target 2019/20	Target 2020/21
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours					
	Māori	92%	95%	To be allocated	
	Pacific	91%	95%		
	Other	91%	95%		
	Total	94 %	95%		

Output Measure	Output class	Measure type	Baseline	Target 2018/19
Patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	3	Qn/T		
Total			56%	90%

People have appropriate access to elective services

Impact Measure		Baseline	Target 2018/19	Target 2019/20	Target 2020/21
Standardised intervention rates (per 10,000) for:				To be allocated	
Major joint replacement procedures					
	Total	27	21		
Cataract procedures					
	Total	25	32		
Cardiac surgery					
	Total	7.3	6.5		
Percutaneous revascularisation					
	Total	11.4	12.5		
Coronary angiography services					
	Total	33.9	34.7		

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of patients waiting longer than four months for their first specialist assessment		3	Qn/T		
	Total			2.7%	0%
Improved access to elective surgery, health target, agreed discharge volumes		3	Qn		
	Total			15,693	18,037
Did not attend percentage for outpatient services		3	Qn/T		
	Māori			21%	10%
	Pacific			18%	10%
	Other			7%	10%
	Total			10%	10%
Inpatient average length of stay (Elective)		3	Qn/T		
	Total			1.71 days	1.54 days
Inpatient average length of stay (Acute)		3	Qn/T		
	Total			3.89 days	2.40 days

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

Impact Measure		Baseline	Target 2018/19	Target 2019/20	Target 2020/21
28 day readmission rate					
	Māori	14%	≤15%	To be allocated	
	Pacific	8%	≤15%		
	Other	12%	≤15%		
	Total	12%	≤15%		

Output Measure			Output class	Measure type	Baseline	Target 2018/19
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within:						
Three weeks		Māori			82%	80%
		Pacific			86%	80%
		Other			72%	80%
		Total			75%	80%
Eight weeks		Māori			93%	95%
		Pacific			95%	95%
		Other			90%	95%
		Total			91%	95%
Percentage of clients discharged from community mental health and addiction services with a transition/wellness plan[12]			3	QnT		
		Total			37%	95%

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Average length of acute inpatient stay (mental health)		3	Qn/T/QI		
	Māori			14.51 days	Between 14 and 21 days
	Pacific			10.79 days	
	Other			13.16 days	
	Total			14.41 days	

[12]Ethnicity data not available

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Rates of post-discharge community care		3	Qn/T/QI		
	Māori			69%	Between 90% and 100%
	Pacific			73%	
	Other			72%	
	Total			87%	
Improving the health status of people with severe mental illness through improved access		3	Qn		
0-19 years	Māori			2.89%	4.73%
	Pacific			1.96%	3.13%
	Other			3.07%	4.23%
	Total			2.97%	4.36%
20-64 years	Māori			7.12%	8.77%
	Pacific			4.34%	4.07%
	Other			3.60%	3.78%
	Total			4.33%	4.81%
65+ years	Māori			2.12%	2.39%
	Pacific			2.13%	1.69%
	Other			2.28%	2.09%
	Total			2.27%	2.11%

More people with end stage conditions are supported appropriately

Impact Measure	Baseline	Target 2018/19	Target 2019/20	Target 2020/21
Measure to be developed				

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of aged residential care facilities utilising advance directives		3	Qn		
	Total			100%	100%
Number of new patients seen by the Waikato Hospital palliative care services		3	Qn		
	Total			652	1,000

Support services

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)		3	Qn/T		
	Total			94%	95%
Percentage of accepted referrals for CT scans will receive their scan within 6 weeks (42 days)		2	T		
	Māori			92%	95%
	Pacific			100%	95%
	Other			90%	95%
	Total			90%	95%
Percentage of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)		2	T		
	Māori			55%	90%
	Pacific			53%	90%
	Other			52%	90%
	Total			48%	90%

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of people accepted for an **urgent** diagnostic colonoscopy will receive their procedure within[13] two weeks (14 calendar days, inclusive)		2	T		
	Total			78%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days		2	T		
	Total			49%	70%
Percentage of people waiting for a **surveillance** colonoscopy will wait no longer than 84 days beyond the planned date[14]		2	T		
	Total			70%	70%
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt		2	T		
				100%	100%

[13]Baseline 15/16
[14]Baseline 16/17

Financial performance

Table: Statement of Prospective Comprehensive Income

Forecast Statement of Comprehensive Income	2016/17 $000 ACTUAL	2017/18 $000 FORECAST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
REVENUE						
Patient care revenue	1,339,628	1,422,904	1,479,452	1,527,486	1,578,530	1,630,854
Other operating income	17,756	18,244	18,308	22,648	23,400	23,943
Finance income	1,839	1,714	1,187	1,216	1,245	1,274
TOTAL REVENUE	1,359,223	1,442,862	1,498,947	1,551,350	1,603,175	1,656,071
EXPENSES						
Personnel costs	537,041	573,756	643,358	674,727	709,437	728,418
Depreciation	34,954	46,399	45,103	47,488	51,515	55,571
Amortisation	5,260	5,319	6,830	11,783	12,782	13,788
Outsourced services	78,419	92,926	78,866	79,716	81,036	82,667
Clinical supplies	135,537	144,849	149,769	153,320	157,674	161,181
Infrastructure & non-clinical expenses	82,486	84,800	76,981	70,808	72,059	73,678
Other district health boards	56,643	61,130	62,103	63,843	65,594	67,366
Non-health board provider expenses	407,106	433,665	457,108	473,515	486,400	499,448
Finance Costs	4,974	116	192	193	195	198
Capital Charge	15,188	37,124	34,708	37,586	39,256	41,210
TOTAL EXPENSES	1,357,610	1,480,084	1,555,018	1,612,979	1,675,948	1,723,525
Share of profit/(deficit) of Associates and Joint venture	(3)	72	-	-	-	-
SURPLUS/(DEFICIT)	1,610	(37,150)	(56,071)	(61,629)	(72,773)	(67,454)
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve	176,237	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	177,847	(37,150)	(56,071)	(61,629)	(72,773)	(67,454)

The 18/19 budget has been developed based on a range of detailed analyses of the cost of appropriate service delivery for the expected volumes. It has included a fairly broad spectrum of resource adjustments in order to rectify a legacy of assets and people sweated to an unacceptable degree. A structured process is in place to ensure that all resource adjustments are thoroughly challenged and thus adjustments made are well justified. Included in the 18/19 budget is $15m of savings which have to be identified as specific initiatives and thus is high risk. In addition, we have a number of other downside risks, such as the flow on impact of the NZNO MECA settlement.
The forecast for subsequent years has leveraged off the work done for our Long Term Investment Plan where costs have been extended into the future and productivity and efficiency gains have been assumed based on a whole of system change perspective. The strategy work now underway has the challenge of determining how such gains will actually be achieved.

Table: Statement of Prospective Position

Forecast Statement of Financial Position	2016/17 $000 ACTUAL	2017/18 $000 FORECAST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
CROWN EQUITY	622,676	582,389	626,434	654,270	686,838	790,383
CURRENT ASSETS:						
Bank balances, deposits and cash	9,577	7,870	8,022	7,219	7,747	8,291
Receivables	67,933	60,624	59,251	58,721	59,720	60,734
Inventory	11,006	11,453	11,601	11,797	11,997	12,201
	88,516	79,947	78,874	77,737	79,464	81,226
CURRENT LIABILITIES:						
Bank overdraft	-	10,845	229	5,031	14,808	12,778
Short Term Loans	324	313	5,095	10,096	15,098	15,100
Payables and Accruals	96,773	95,639	107,174	113,902	115,661	117,450
Payroll Accruals	84,307	91,203	95,596	95,754	97,383	99,040
	181,404	198,000	208,094	224,783	242,950	244,368
Net Working Capital	(92,888)	(118,053)	(129,220)	(147,046)	(163,486)	(163,142)
NON CURRENT ASSETS:						
Fixed Assets	729,367	715,828	781,000	836,023	895,770	1,001,495
Investments	7,251	6,737	6,737	6,737	6,737	6,737
	736,618	722,565	787,737	842,760	902,507	1,008,232
NON CURRENT LIABILITIES:						
Payroll Liabilities	13,773	14,212	14,446	14,684	14,925	15,170
Term Loans	7,281	7,911	17,637	26,760	37,258	39,537
	21,054	22,123	32,083	41,444	52,183	54,707
NET ASSETS	622,676	582,389	626,434	654,270	686,838	790,383

Table: Statement of Prospective Movements in Equity

Forecast Statement of Movements in Equity	2016/17 $000 ACTUAL	2017/18 $000 FORECAST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
Crown equity at start of period	236,111	622,676	582,389	626,434	654,270	686,838
Surplus/(Deficit) for the period	1,610	(37,150)	(56,071)	(61,629)	(72,773)	(67,454)
Increase in Revaluation Reserve	176,237	-	-	-	-	-
Equity Injection from Crown	211,659	-	102,547	91,656	107,523	173,177
Distributions to Crown	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other movements in Equity	(747)	(943)	(237)	3	12	16
Crown equity at end of period	622,676	582,389	626,434	654,270	686,838	790,383

Note: Assumed equity injection required for a number of material capital items, such as the Adult Mental Health Building and Ward Block A - Adult (see Strategic capital spend 1.2 Capital Expenditure/Investment).

Table: Statement of Prospective Cashflow

Forecast Statement of Cashflows	2016/17 $000 ACTUAL	2017/18 $000 FORECAST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
OPERATING CASHFLOWS						
Cash was provided from Crown Agencies and other income sources	1,348,237	1,438,988	1,497,849	1,550,798	1,601,071	1,653,923
Cash was disbursed to employees, suppliers and payment of finance charges	(1,313,631)	(1,412,343)	(1,484,966)	(1,547,431)	(1,607,515)	(1,649,957)
	34,606	26,645	12,883	3,367	(6,444)	3,966
INVESTING CASHFLOWS						
Cash was provided from assets and equity	2,000	1,744	1,187	1,217	1,245	1,274
Cash was disbursed to purchase of assets and investments	(32,207)	(37,604)	(117,104)	(114,294)	(124,046)	(175,082)
	(30,207)	(35,860)	(115,917)	(113,077)	(122,801)	(173,808)
FINANCING CASHFLOWS						
Cash was provided from proceeds of borrowings and equity movements	600	2	116,945	106,598	122,510	174,929
Cash was disbursed to repayment of borrowings	(2,468)	(3,339)	(3,143)	(2,493)	(2,514)	(2,512)
	(1,868)	(3,337)	113,802	104,105	119,996	172,417
Net increase/(decrease) in cash held	2,531	(12,552)	10,768	(5,605)	(9,249)	2,575
Add Opening cash balance	7,046	9,577	(2,975)	7,793	2,188	(7,061)
CLOSING CASH BALANCE	9,577	(2,975)	7,793	2,188	(7,061)	(4,486)
Made up from:						
Bank balances, deposits and cash	9,577	(2,975)	7,793	2,188	(7,061)	(4,486)

1.1 Fixed assets

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

- ### 1.1.1 Disposal of Land

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

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

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

1.2 Capital expenditure / investment

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

New Capital Expenditure	2017/18 $M	2018/2019 $M	2019/2020 $M	2020/2021 $M
Under $50,000	4	4	4	4
Over $50,000	112	109	119	170
Contingency	1	1	1	1
Total Capital Expenditure	117	114	124	175

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

Strategic capital spend includes:

Project Name	Business Case Start Date	Business Case Completion Date	Business Case Expected Approval Date	Approx. $	Crown Cap Requirement
Adult Mental Health	2016/17	2018/19	2018/19	$154.8m	$123.8m
Carpark - multi level	2018/19	2019/20	2019/20	$25.5m	$20.4m
Taumarunui development	2019/20	2020/21	2020/21	$10m	$8m
Tokoroa and Te Kuiti development	2019/20	2020/21	2020/21	$20m	$16m
Ward Block A – Adult	2018/19	2019/20	2019/20	$126m	$75m

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

1.3 Planned financial performance by division

Table: Prospective Financial Targets and Measures DHB Provider

DHB Provider Forecast Statement of Financial Performance	2016/17 $000 ACTUAL	2017/18 $000 FORECAST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
REVENUE						
Patient care revenue	832,904	896,013	929,780	956,075	982,540	1,008,926
Other operating income	17,780	18,488	18,308	22,648	23,400	23,943
Finance income	1,839	1,714	1,187	1,216	1,245	1,274
TOTAL REVENUE	852,523	916,215	949,275	979,939	1,007,185	1,034,143
EXPENSES						
Personnel costs	535,122	571,562	640,586	671,905	706,569	725,502
Outsourced Services	78,034	92,386	77,463	78,308	79,616	81,219
Clinical Supplies and Patient Costs	148,433	156,568	161,824	171,319	177,200	182,244
Infrastructure & Non-clinical Supplies	128,940	161,736	151,211	149,308	155,724	162,814
Internal Recharges	(2,324)	(2,322)	(2,321)	(2,330)	(2,354)	(2,401)
TOTAL EXPENSES	888,205	979,930	1,028,763	1,068,510	1,116,755	1,149,378
SURPLUS/(DEFICIT)	(35,682)	(63,715)	(79,488)	(88,571)	(109,570)	(115,235)

Table: Prospective Financial Targets and Measures DHB Governance

DHB Governance Forecast Statement of Financial Performance	2016/17 $000 ACTUAL	2017/18 $000 FORECAST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
REVENUE						
Patient care revenue	5,289	5,466	5,574	5,731	5,888	6,047
Other operating income	5	18	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	5,294	5,484	5,574	5,731	5,888	6,047
EXPENSES						
Personnel costs	1,918	2,194	2,773	2,822	2,869	2,918
Outsourced Services	385	540	1,402	1,407	1,421	1,450
Clinical Supplies and Patient Costs	1	-	-	-	-	-
Infrastructure & Non-clinical Supplies	1,058	495	549	551	557	568
Internal Recharges	2,324	2,322	2,321	2,330	2,354	2,400
TOTAL EXPENSES	5,686	5,551	7,045	7,110	7,201	7,336
SURPLUS/(DEFICIT)	(392)	(67)	(1,471)	(1,379)	(1,313)	(1,289)

Table: Prospective Financial Targets and Measures DHB Funding

DHB Funding Forecast Statement of Financial Performance	2016/17 $000 ACTUAL	2017/18 $000 FORECAST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
REVENUE						
Patient care revenue	1,274,051	1,356,114	1,409,917	1,455,761	1,504,588	1,555,080
Other operating income	-	-	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	1,274,051	1,356,114	1,409,917	1,455,761	1,504,588	1,555,080
EXPENSES						
Governance Administration	5,289	5,467	5,574	5,731	5,889	6,047
Personal Health	955,029	1,018,371	1,056,399	1,086,000	1,115,778	1,145,931
Mental Health	129,344	133,918	141,570	149,137	153,127	157,168
Disability Support	138,113	163,468	172,600	177,436	182,301	187,228
Public Health	3,248	2,661	3,036	3,121	3,206	3,293
Maori Services	5,346	5,597	5,850	6,014	6,179	6,346
TOTAL EXPENSES	1,236,369	1,329,482	1,385,029	1,427,439	1,466,480	1,506,013
SURPLUS/(DEFICIT)	37,682	26,632	24,888	28,322	38,108	49,067

1.4 Significant assumptions

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

Key Assumptions	2018/19	2019/20	2020/21
CFA revenue growth assumptions are in line with information provided in the funding envelope and includes cost pressure and demographic growth	4.2%	3.5%	3.5%
Employee agreement assumptions	2.6%	2.6%	2.6%
Payments to NGO's (cost pressure)	1.99%	1.99%	1.99%
Payments to suppliers	0.4%	0.4%	0.4%
Capital charge – fixed rate	6.0%	6.0%	6.0%

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

Major Risks	Mitigation Strategy
The $15m savings plan requires specificity in terms of how it will be achieved – at this stage it is considered to be high risk	• Work with the management team to identify areas and plans in order to actively progress aspects in order to achieve these savings • Ensure strong focus on accurate forecasting
The employee relations environment presents uncertainty in terms of potential increases in employee remuneration packages, especially as a flow on from the NZNO settlement. Although a wage increase percentage has been included in the assumptions, some employee representatives may have an expectation of wage increases that differ from the budgeted levels. A one percent increase or decrease in wage rates equates to approximately $6.4 million in additional payroll costs	Potential strategies include: • These are driven by centrally negotiated MECA increases and thus are beyond our control – thus mitigation is discussions with the Ministry of Health to ensure that funding increases match these cost increases
There is risk that cost increases for the provider arm purchasing of goods and services will exceed the assumed percentage increases based on the inherent uncertainty of future inflationary pressures. A one percent increase or decrease in the cost of provider arm goods and services equates to approximately $3.8 million in additional expenditure.	• Review contracting arrangements and negotiate more favourable terms • Participate in national procurement initiatives to take advantage of bulk purchasing
There is financial risk in terms of the inherent uncertainty as to the total amount of funding that will be appropriated to health beyond the current year and how this funding will be allocated by the Population Based Funding (PBF) formula. In addition, PBF is a fixed annual funding allocation in an environment where the DHB funds demand driven contracts that have the risk of the demand exceeding the forecast levels.	• Actively encourage and participate in central discussions to define appropriate and fair funding for the future

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

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

1.6 Subsidiaries

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

APPENDIX B:
2018-19 System Level Measure Improvement Plan

Waikato District Health Board

2018-19 SYSTEM LEVEL MEASURE IMPROVEMENT PLAN

Pinnacle Midlands Health Network

HAURAKI PHO HAURAKI PRIMARY HEALTH ORGANISATION NETWORK

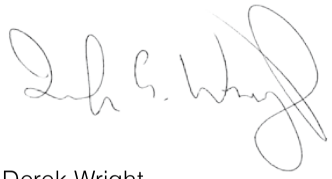
National Hauora Coalition

Contents

Introduction

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

The 2018/19 milestones, contributory measures and activities have been decided and agreed by the below parties.



Derek Wright
Interim Chief Executive Officer
Waikato DHB

David Oldershaw
Chief Executive Officer
Pinnacle Midlands Health Network

Hugh Kininmonth
Chief Executive Officer
Hauraki PHO

Simon Royal
Chief Executive Officer
National Hauora Coalition

Cath Knapton
Chief Executive Officer
Midlands Pharmacy Group

Lindsey Webber
Deputy CEO
Hauraki PHO

Background

Development and implementation of the 17/18 SLM Improvement Plan saw the roll out of six SLM working groups each containing a clinical lead and project manager, the technical reference group and overall SLM Project Manager within the Waikato district. The working groups were committed to working together to achieve results.

Moving into planning for the 2018/19 year saw lessons learned undertaken with some key areas identified as working well and other areas for improvement.

Key lessons learned from 17/18:

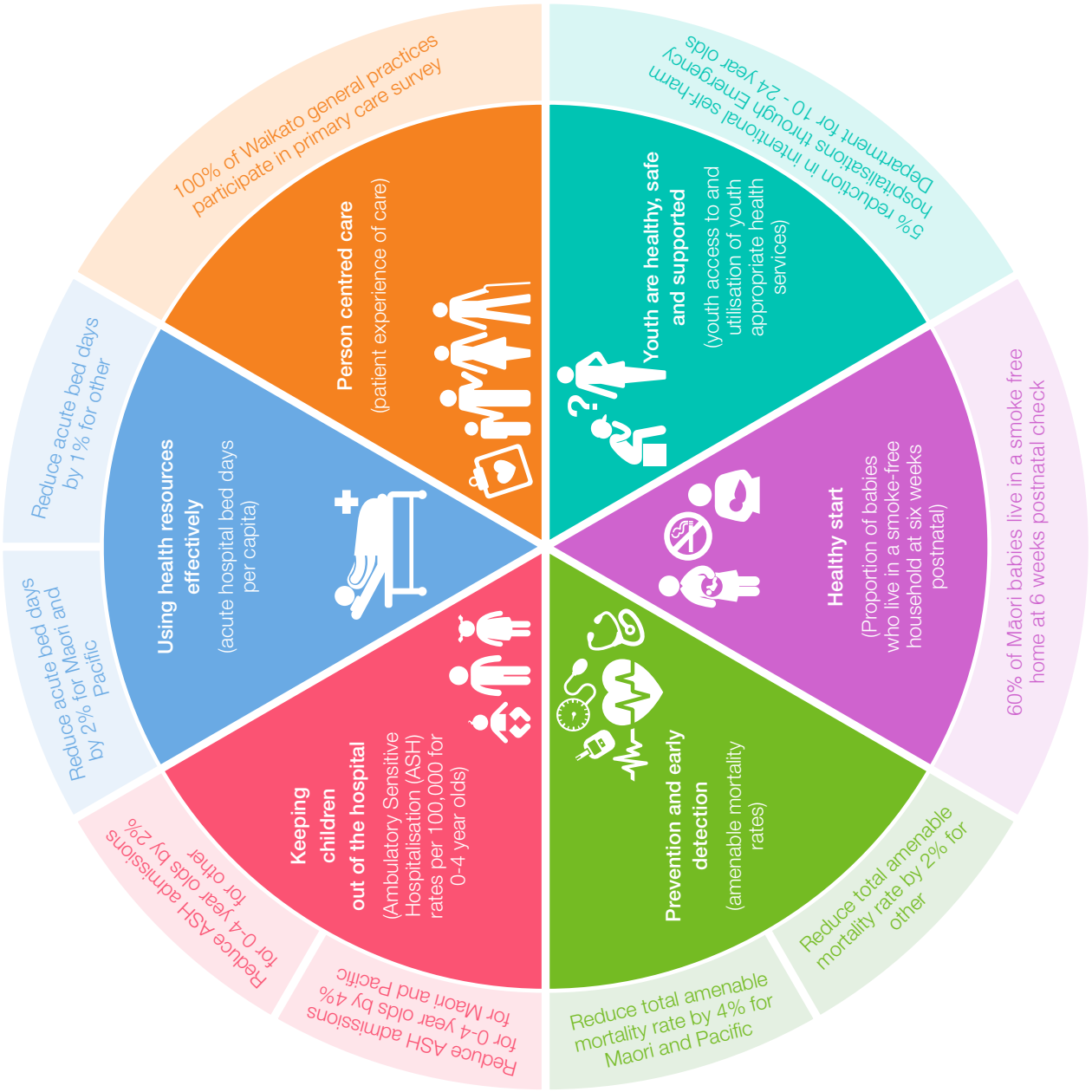
- Include a programme approach to the current SLM structure for Waikato and tighten up terms of reference around accountability and escalation
- Continue to utilise data and root cause analysis to systematically identify gaps and the areas that warrant the most attention. This has enabled us to become very familiar with our population's data so we can see where we are doing well, and where extra effort is needed
- Focus on a small number of key projects that the group can control and manage
- Identify synergies across SLM's in order to work together e.g. ASH 0-4 years and acute bed days (ASH adults)
- Build on consistent communication framework across primary, secondary and community along with patient good news stories
- Stakeholders more accountable for completing work allocated
- Continue and tighten formal reporting framework
- Ensure continuous quality improvement methodology is embedded

Structure

The current SLM structure has been reviewed and now included a programme approach managed by the Director of Integration. This role will provide leadership and support to the Chairs and PMs Leading the individual SLMs and will report progress to the Executive leads and quarterly reports to the Waikato Inter Alliance.

Communication framework

To assist with developing consistent communications across community, primary and hospital, a communication team was developed along with a communication plan and framework. The Waikato DHB has developed an integration section on their website with the Primary Health Organisation's linking to it. 2018/19 will see regular patient good news stories added to the website along with any appropriate communications that relate to the integration work. The diagram below has been designed and will be used consistently across the organisations when communicating.


Person centred care
(patient experience of care)
100% of Waikato general practices participate in primary care survey
Youth are healthy, safe and supported
(youth access to and utilisation of youth appropriate health services)
5% reduction in intentional self-harm hospitalisations through Emergency Department for 10 - 24 year olds
Healthy start
(Proportion of babies who live in a smoke-free household at six weeks postnatal)
60% of Māori babies live in a smoke free home at 6 weeks postnatal check
Prevention and early detection
(amenable mortality rates)
Reduce total amenable mortality rate by 2% for other
Reduce total amenable mortality rate by 4% for Maori and Pacific
Keeping children out of the hospital
(Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds)
Reduce ASH admissions for 0-4 year olds by 4% for Maori and Pacific
Reduce ASH admissions for 0-4 year olds by 2% for other
Using health resources effectively
(acute hospital bed days per capita)
Reduce acute bed days by 2% for Maori and Pacific
Reduce acute bed days by 1% for other

System level measure overview

System level measure	Baseline data	Improvement milestone 18/19 target	Contributory measures
1. ASH 0-4 years	• Māori – 9,415 per 100,000 population. • Pacific – 9,084 per 100,000 population. • "Other" –7,474 per 100,000 population. • Total –8,284 per 100,000 population. (Baseline set from 12 months, December 2017)	• Reduce ASH admissions for 0 - 4 year olds by 4% for Māori (9,038 per 100,000) • Reduce ASH admission for 0 – 4 year olds by 4% for Pacific (8,721 per 100,000) • Reduce ASH admissions for 0 - 4 year olds by 2% for other (7,325 per 100,000) across the DHB in order to reduce inequity	• Number of repeat (5+) Māori and Pacific 0-4 ASH respiratory presentations • Number of upper and ENT respiratory infections • Influenza vaccination rates of Māori and Pacific children • 0-4 ASH gastroenteritis rate • 0-4 Māori and Pacific ASH cellulitis/dermatitis/ eczema rate
2. Acute bed days	• Maori - 457 per 1,000 population. • Pacific - 372 per 1,000 population. • "Other" - 522 per 1,000 population. • Total - 502 per 1,000 population. (Baseline set from unstandardized data- 12 months to March 2018)	• Reduce acute bed days by 2% and maintain for Maori (448 per 1,000) by 30 June 2019 • Reduce acute bed days by 2% and maintain for Pacific (365 per 1,000) by 30 June 2019 • Reduce acute bed days by 1% and maintain for 'other' (517 per 1,000) by 30 June 2019	• Māori/Pacific cellulitis ASH rate 45-64 age group • Numbers of education and treatment packs distributed to Māori/Pacific whanau • Māori/Pacific COPD ASH rate 45-64 yrs • Numbers of Māori/Pacific patients referred to COPD Homebased support team • Asthma Māori/Pacific ASH rate 45-64 yrs • Number of Māori/Pacific asthma patients with completed GASP assessment and asthma plan • Number of Māori/Pacific and other non-fracture fall admissions • Number of Māori/Pacific and other fracture neck of femur admissions • Number of Māori/Pacific patients referred to strength and balance services
3. Patient experience of care	• Number of responses sent out - 4550	• Increase volume of surveys sent out by 10% for Primary Care Surveys • Implementation of pilot project for Safer Discharge Checklist for Waikato DHB Inpatient	• Volume of surveys sent out • Volume of practices trained • Number of wards that have implemented Safer Discharge Checklist

System level measure	Baseline data	Improvement milestone 18/19 target	Contributory measures
4. Amenable mortality	• Māori –247 per 100,000 • Pacific –204 per 100,000 • "Other" –85 per 100,000 • Total – 110 per 100,000 (Baseline data set from 5 years to Dec 14)	• Reduce total amenable mortality rate by 4% for Māori by 2022 • Reduce total amenable mortality rate by 4% for Pacific by 2022 • Reduce total amenable mortality rate by 2% for 'other' across the DHB in order to reduce inequity by 2022	• Patients discharged from Waikato Hospital following a CVD event not on triple therapy. • Percentage of Māori men aged 35-44 who have a CVD risk assessment. • Pilot proposal for Alliance to investigate early detection of suicide risk in primary care
5. Infants who live in smokefree households	• The percentage of smoking status reported by WCTO providers at first core check – 88% (Baseline data set from 6 months to Dec17)	• 60% of Māori Babies live in a smoke free home at 6 weeks postnatal check	• Māori and Pacific patients who smoke are referred to stop smoking services. • Pregnant Māori and Pacific women who smoke are referred to stop smoking services by LMC or GP • Māori and Pacific women enrolled in pregnancy and parenting programmes • 95% smoke free status is documented by WCTO providers at first core check
6. Youth access to health services	Self-harm Patient had contact from MH following event within 20 days • 85% (Baseline data set from 3 years to Mar 18)	• 5% reduction in intentional self harm hospitalisations including short stay hospital admissions through Emergency Department for 10-24 year olds	• 95% of patients with a recurrent self-harm admission have timely (within 20 days) contact with an appropriate health provider • 100% of eligible Year 9 students are offered a psychosocial assessment by a health care professional • Number of youth that receive new opportunistic youth assessment and wellbeing support programmes • Number of staff who receive standardised training packages regarding depression screening, suicide risk screening and safety

System Level Measure 1:
ASH rates in 0-4 year olds: Reduce hospital admissions rates for conditions avoidable through prevention or management in primary care

Improvement milestones:
- Reduce by 4% for Māori and Pacific and
- Reduce by 2% for 'other' across the DHB

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

Respiratory

	Contributory measures	Rationale	Activity
1.	Number of repeat (5+) Māori and Pacific 0-4 ASH respiratory presentations	Nearly half of 0-4 ASH admissions are for respiratory conditions Rates for admissions are higher for Māori. In 2017, 5+ admissions show 93% were Māori or Pacific whānau. Successful interventions targeting Māori and will have a proportionally greater benefit for Māori. The benefits of using a Harti tool are increased screening, interventions and referrals made to appropriate services and enhanced clinician skills and expertise when working with vulnerable children with a particular focus on Māori and Pacific whānau	• Review of admissions and support in place with a specific focus on Maori and Pacific children, to develop local actions and referral processes to reduce this measure in Waikato DHB • Waikato DHB Harti Hauora paediatric inpatient assessment pilot implemented.
2.	Number of upper and ENT respiratory infections	This is our predominant respiratory increase with unspecified upper respiratory condition increasing. Rates for admissions are higher for Māori. 2017/18 Q4 Waikato's 0-4 ASH non standardised ASH rate per 100,000 for upper and ENT respiratory infections; Māori 2,853, Pacific 2,029 and Other 2,461.	• Retrospective audit (ED) completed and recommendations implemented via Waikato DHB

	Contributory measures	Rationale	Activity
3.	Influenza vaccination rates of Māori and Pacific children	Low rates of influenza vaccinations for eligible children. A large proportion of Māori ASH admissions are repeat presentations. Ensuring that Māori children with a respiratory condition are protected from the influenza virus every year will contribute to reducing the respiratory ASH rate. Opportunistic flu vaccination represents an opportunity to reduce inequality showing that Māori are less likely to decline opportunistic immunization	• Implement flu recall system targeting Māori and Pacific children with respiratory conditions for all PHOs. • Increase number of sites delivering opportunistic immunisation
Gastroenteritis			
	Contributory measures	**Rationale**	**Activity**
4	0-4 ASH gastroenteritis rate	Top 5 0-4 ASH conditions with local feedback identifying need for improved access to prevention treatment and education.	• Primary options/pathways for gastroenteritis in all PHOs • Community pharmacy pilot for Gastroenteritis (to be piloted in 2-3 low decile high Māori and Pacific populations).
Skin Conditions			
	Contributory measures	**Rationale**	**Activity**
5	0-4 Māori and Pacific ASH cellulitis/ dermatitis/eczema rate	Top 5 0-4 ASH conditions with local feedback identifying need for improved access to prevention treatment and education. Rates for admissions are higher for Māori and Pacific: 2017/18 Q4 Waikato's 0-4 ASH non standardised ASH rate per 100,000 for cellulitis/dermatitis/eczema; Māori 711, Pacific 870 and Other 408. Successful interventions targeting Māori and Pacific will have a proportionally greater benefit for Māori and Pacific.	• Primary options/pathways for skin conditions targeting Māori and Pacific children with cellulitis/dermatitis/eczema for all PHOs • Community pharmacy pilot for skin conditions (to be piloted in 2-3 low decile high Māori populations).

System Level Measure 2:

Acute bed days: Improved management of demand for acute care

Improvement milestones:

- Reduce acute bed days by 2% for Māori and Pacific by 30 June 2019
- Reduce acute bed days by 1% for 'other' by 30 June 2019

Baseline data analysis:

- The overall top issues by bed duration are Stroke, Respiratory, Hip fractures and heart failure.
- Top issues for each ethnicity vary from the total and include Cellulitis of lower limbs for Māori and Chronic obstructive pulmonary disease.

	Contributory measure	Rationale	Activity
Cellulitis			
1.	• Māori/Pacific cellulitis ASH rate 45-64 age group • Numbers of education and treatment packs distributed to Māori/Pacific whanau	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• Publicise the new cellulitis community pathway to all PHOs and Waikato DHB ED • All departments to use the community pathway for self-presenting patients as the primary process • Review data from Māori/Pacific patients who are assessed in ED or are admitted. Then distribute to Māori/Pacific whanau a primary care and pharmacy developed information and treatment pack containing education materials and simple creams/antiseptics within all PHOs
COPD			
2.	• Māori/Pacific COPD ASH rate 45-64 yrs • Numbers of Māori/Pacific patients referred to COPD Homebased support team	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• COPD Homebased Support Team new integrated care model initiative in the community. Implementation and evaluation of 15 month pilot. This will place respiratory nurse specialists in Waikato DHB, Hauraki PHO, and Pinnacle PHO who will work together with general practice and ambulance service to reduce COPD admissions targeting Māori/Pacific populations
Asthma			
3.	• Asthma Māori/Pacific ASH rate 45-64 yrs • Number of Māori/Pacific asthma patients with completed GASP assessment and asthma plan	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• GASP programme introduced for asthma patients targeting Māori/Pacific. This provides asthma assessment and education at the point of care and provides health care professionals with skills and knowledge to undertake structured asthma assessments. Patients are empowered through the development of an asthma care plan to enhance self-management capability though Hauraki PHO

Falls and Fragility Fractures		
Contributory measure	Rationale	Activity
4. • Number of Māori/Pacific and other non-fracture fall admissions • Number of Māori/Pacific and other fracture neck of femur admissions • Number of Māori/Pacific patients referred to strength and balance services	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• Waikato Falls and Fragility Fracture Prevention Programme will be promoted using Māori NASC and Māori/Pacific networks to facilitate access to strength and balance services. Work with Rauawaawa, Kaumatua programmes, Te Korowai, SWIPIC and K'aute Pasifika to facilitate Māori/Pacific access to strength and balance referrals through all PHOs and Waikato DHB.

System Level Measure 3:

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

Improvement milestone:

- 100% of Waikato general practices to participate in the Primary Care Surveys

Baseline data analysis:

- Waikato inpatient patient experience survey has now been running for four years. The response rate Q3 17/18 was 40%.
- Currently 86.5% of Waikato practices are participating in the Primary care survey which has now been running for two quarters with a response rate of 22%.
- The key themes from feedback are not being told about medication side effects to look out for at home, not being given the choice of different medication options and not receiving enough information about how to manage conditions after discharge.

Increasing volumes of GP surveys			
	Contributory measures	Rationale	Activity

1.	Volume of surveys sent out	Provides the ability for practices to understand and improve the patient experience	• Increasing volume of surveys sent out through up to date email addresses. This requires general practice to capture accurate email addresses.
			• Training and support for general practice in use of primary care patient survey
			• Monitoring of uptake –
			  • Review across practices, share best practice from those with high response rate
			  • Develop an recognition process for practices with highest response
			• Communication and training plan with general practices, hospital, patients and community

2.	Volume of practices trained	Provides practices with up to date contact details and email addresses this will improve response rates. This will also increase patient's access to their health information and increase transparency.	• Training and support for practises about patient portals • Monitoring of uptake • Communication and training plan with general practices, hospital, patients and community
Pilot project for Safer Discharge Checklist for Waikato DHB Inpatient			
	Contributory measures	Rationale	Activity

3.	Number of wards that have implemented Safer Discharge Checklist	This has consistently been a key theme from inpatient surveys	• Pilot of Safer Discharge Checklist to be implemented in 18/19 in Waikato DHB Inpatient (HQSC supported nudge project)
			  • Baseline survey of patients pre introduction of checklist
			  • Introduce checklist for one week / one ward
			  • Post introduction patient survey
			  • Amend checklist if required
			  • Maintain on one ward / one month – resurvey
			  • Discuss possible rollout

System Level Measure 4:

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

Improvement milestones:

- For Māori and Pacific reduce total amenable mortality rates by 4% and sustain by 30 June 2022
- For other reduce total amenable mortality rates by 2% and sustain by 30 June 2022

Baseline data analysis:

- Increase the proportion of patients assessed for risk of suicide in primary care
- Risk reduction in those with a CVD RA score of ≥ 20%

Coronary/CVD

	Contributory measures	Rationale	Activity
1.	Patients discharged from Waikato Hospital following a CVD event not on triple therapy. Percentage of Māori men aged 35-44 who have a CVD risk assessment.	With Māori men being at high risk for CVD this work will specifically target this population group. Modification of risk factors through self-management, lifestyle and pharmaceutical interventions has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD and diabetes.	• Waikato DHB to carry out chart audit of all patients at a NHI level who have had a CVD event and not prescribed triple therapy; specific activities are to be agreed based on the audit outcomes • Hauraki PHO will scope and implement a Health Action in the Workplace pilot– Aim to partner with workplaces with a screening, risk reduction and prevention of diabetes/CVD focus • Link with community Diabetes screening programme to deliver Heart Disease checks at the same time through all PHOs • Co-design project with Māori men aged 35-44 to deliver CVD checks at a community level through all PHOs

Suicide

	Contributory measures	Rationale	Activity
2.	Pilot proposal for Alliance to investigate early detection of suicide risk in primary care.	Suicide is a leading cause of amenable mortality.	• Investigate an 'Early Detection of Suicide Risk in Primary Care' pilot within Hauraki PHO, to gather evidence to better understand how tools used in general practice could impact people's well-being. With the design, test and write up of findings for a suicide pathway for Waikato University Staff and Students. • Develop a screening tool in Hauraki PHO as a result of the findings, through programmes such as Hapu Wananga and the first 1000 days antenatal parenting classes where, we can target young Māori men

System Level Measure 5:
Babies living in smoke free homes: Reduction in the number of maternal smoking as well as the home and whānau/family environment

Improvement milestone:

- 60% of Māori Babies live in a smoke free home at 6 weeks postnatal check

Baseline data analysis:

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

Pre pregnancy and household contacts

	Contributory measures	Rationale	Activity

1.	Māori and Pacific patients who smoke are referred to stop smoking services.
	
	*(**Numerator**; number of Māori PHO enrolled patients who smoke who are referred to stop smoking services, **Denominator**; number of Māori PHO enrolled patients who smoke)*
		Whānau engagement: Population measure to capture the wider household population
		
		Equity: Significant equity gap between Māori and NZ European. This measure targets Māori results to enhance equity focus for monitoring and activity.
		
		Utilisation and access: Low numbers referred to stop smoking services
		
		Data quality improvement: Data reports only the number of smoking given brief advice and does not report the number referred and does not provide ethnicity breakdown.
			• Systems in place to report on referral data by ethnicity and equity gap within primary and secondary care
			• Actions to increase Māori and Pacific referral to cessation services.
			  • All PHOs; roll out practice level education and training delivered to all practices to ensure awareness of the smoking cessation programme, including the referral pathway and the need to prioritise Māori patients and whanau.
			  • Waikato DHB; All identified Māori and Pacific patients will be offered Smoking Cessation services whilst in hospital.

Early pregnancy			
	Contributory measures	Rationale	Activity

2.	Pregnant Māori and Pacific women who smoke are referred to stop smoking services by LMC or GP (***Numerator***; *pregnant Māori women who smoke who are referred to stop smoking services by an LMC or GP.* **Denominator**; *Pregnant Māori women who smoke.)*	**Provider relationships:** Early pathway intervention measure focused on provision of high quality care by LMCs and general practice
		
		Data quality improvement: Data comes from two sources, MMPO and from DHB employed midwives. Due to issues with data collection, available data is not complete
		
		Equity: Significant equity gap between Māori and NZ European. This measure targets Māori results to enhance equity focus for monitoring and activity.
		
		Utilisation and access: Low numbers accepting referrals to smoking services
			• Waikato DHB and all PHOs to:
			  • Report on referral data by ethnicity and equity gap
			  • Communicate incentive scheme for pregnant women to the midwifery community via MQSP communication channels and general practice via PHO communication channels.
			  • Communicate referral rates for pregnant women each month to midwifery community and general practice.
			  • Communicate information on best practice information and training as available to the midwifery community.
			  • Work with Clinical Pathway (Health Pathway) authors and the project team to determine how this can be promoted amongst practitioners who work with Māori pregnant women

Pregnant			
	Contributory measures	Rationale	Activity
3.	Māori and Pacific women enrolled in pregnancy and parenting programmes (**Numerator**; pregnant Māori women enrolled in publically funded pregnancy and parenting programmes per year Waikato **Denominator**; Pregnant Māori women per year Waikato	**Whanau engagement:** Opportunity to focus on total wellbeing. Local pregnancy and parenting workshops include wider whanau **Data quality improvement:** No baseline data **Equity:** Anecdotal evidence suggests low enrolment of Māori women in pregnancy and parenting programmes.	• Waikato DHB Pregnancy and Parenting Programmes data collected including ethnicity and smoking status • Promotion of stop smoking services will be targeted in Waikato DHB Kaupapa Māori Hapū Wānanga pregnancy and parenting programme which focuses on Māori women and whānau . Over 400 pregnant Māori women in the Waikato attend a Hapū Wānanga annually. Most women are young (<25), and living in high Deprivation areas.

Lifespan			
	Contributory measures	Rationale	Activity

4.	95% smoke free status is documented by WCTO providers at first core check
	Numerator; Number of new babies with "Yes" or "No" recorded for 'Is there anyone in the house who is a tobacco smoker?' for their WCTO 1st Core Contact (up to 56 days of age)
	Denominator; Total number of babies enrolled with WCTO providers who have had a first core contact
		Focusing attention on maternal smoking as well as home and family/ whanau environment.
		Promoting opportunistic screening and follow up by existing providers/ services working with families and pregnant women
		Placing the spot-light on particular data sets has resulted in data quality improvement in the past and it is anticipated this will occur for these datasets as well. Locally we have limited across sector access to regular robust data and the focus for 2018/19 activity is on data quality and monitoring to capture our denominator data accurately and consistently across providers
			• Waikato DHB to work with :
			  • WCTO providers to continue to improve data quality to 95% of smoke free status documented
			  • WCTO providers provide smoke free advice when a household member smokes.

System Level Measure 6:
Youth: Intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year olds'.

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

Baseline data analysis:
- Waikato rates are generally increasing and Waikato's rate is higher than the national rates

Youth engagement			
	Contributory measures	Rationale	Activity
1.	95% of patients with a recurrent self-harm admission have timely (within 20 days) contact with an appropriate health provider	For the 36 month period to March 2018, 96% of recurrent intentional self-harm admissions had contact from DHB mental health services. The timeliness of contact is not yet known. Focus is on data improvement with poor data quality and inconsistent reporting. Clear and consistent measure of outcome data is required to achieve equity Timely delivery of effective and appropriate care to those with recurrent self-harm admissions will reduce further self-harm attempts	• All PHOs and Waikato DHB to disseminate and share on NHI-level recurrent self-harm data (36 month period to June 2017) • Waikato DHB to link date-stamped data across providers to determine the proportion of youth with a recurrent self-harm admission who have had timely (within 20 days) contact with an appropriate health provider • Waikato DHB complete detailed audit of clinical records for youth with a recurrent self-harm admission

2.	100% of eligible Year 9 students are offered a psychosocial assessment by a health care professional	Poor understanding of current youth service availability and quality. To achieve health equity for youth, primary to tertiary services need to be accessible, appropriate and effective.
		
		The Waikato DHB region has no up to date needs assessment for youth in our region
			• Pinnacle and Waikato DHB to:
			  • Map secondary school based health services
			  • Stocktake of primary care and community youth services
			• Develop comprehensive youth wellbeing tool Harti Hauora Rangatahi

3.	Enhance opportunities for youth engagement and strengthened awareness of existing youth reference groups	Improved access to quality of care is required for youth in the Waikato region Focus is on increased collaboration, enhanced understanding of youth needs and youth service provision, and increasing opportunities for	• Pilot comprehensive youth wellbeing tool Harti Hauora with priority population through Waikato University • Hauraki PHO Pilot youth mental wellness programme for the University of Waikato Health service and community and business case completed and submitted for a youth focused mental wellness model of care with recommendations for new community psychologists role and existing Brief Intervention Therapist roles
4.	Number of youth that receive new opportunistic youth assessment and wellbeing support programmes		• All PHOs to deliver two standardised training packages regarding depression screening, suicide risk screening and safety planning for clinical staff

Appendix

2018/19 SYSTEM LEVEL MEASURES (SLM) WORKING GROUP TERMS OF REFERENCE AND MEMBERSHIP

Purpose

The purpose of the SLM working group is to bring together local experts across the sector to collaborate and recommend the following for their 2018/19 measure

- An improvement milestone
- contributory measures and milestones;
- Quality improvement activities to achieve contributory measures and therefore SLM.

Specific responsibilities

- Review analysis of local data supplied by the TRG to identify main contributors

(Where we are now)

- Identifying improvement milestone

(Where we want to be)

- Selecting the most relevant contributory measures
- Identifying wider supporting measures which assist the delivery of the system level measure but are not the nominated contributory measures
- Identifying activity and provider that will impact the contributory milestones and supporting measures. This could be current, planned i.e. listed in annual plan or new activities ideas

(How will we get there?)

- Oversee activity agreed that will impact the milestones
- Report on activity progress to the identified governance group (this will be alongside the technical reference group who will report on performance)

Outside of scope

- Waikato's System Level Measure Plan sign off
- Funding related decisions

Linkages

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

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

Formation details
The working group were established in May 2017

Terms of membership
The length of term for each member (designated role) will be 13 months until end of June 2019. Each PHOs operating in the Waikato District have been asked to provide a representative. DHB representatives and wider providers are included as appropriate. Appendix one has a list of members for each working group. Membership may change dependent on each organisations desired attendee. A delegate may represent members on the proviso that the delegate has the ability to report to their own services/organisations and can make informed contribution to discussions.

Meetings
Working groups meeting will vary and the frequency is led by the Chair.
Working groups to report to their governance groups at a minimum quarterly.

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

Governance
Waikato DHB's executive leads for SLM are
- Damian Tomic - Clinical Director Primary and Integrated Care and
- Tanya Maloney, Executive Director Strategy and Funding.

The Waikato Inter-alliance will have oversight for Waikato system level measures.
The working group will all report to one of the two following groups or straight to Inter-Alliance

1. Waikato Child and Youth Health Network
   - Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds;
   - Proportion of babies who live in a smoke-free household at six weeks post-natal
   - Youth access to and utilisation of youth-appropriate health services
2. Demand Management Advisory
   - Acute hospital bed days per capita;
   - Amenable mortality
3. Inter-Alliance
   - Patient Experience of Care

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

Decision making

The working group are chaired by the DHB clinical lead for each SLM (see appendix one). If the Chair resigns from the working group during this period another member of working group will be appointed by the DHB SLM executives.

A quorum for the group will be at least the chair or delegated chair and 50% of permanent members.
Due to tight timeframes, engagement and agreement may be made via email as appropriate

The working group role is to put forward recommendation to the group they report to as above. The working group Chair will strive to seek consensus from the group on recommendations put forward. Final decisions on recommendations put forward to the Waikato Inter Alliance group will be decided by the Waikato Child health Network or DMG as appropriate. Please note Patient experience of care reports to Waikato Inter-Alliance.

Issues with recommendation to be escalated through each organisations management structure

Membership

Technical Reference Group		
Regan Webb	Jo Scott-Jones	NHC tbc
Katpaham Kasipillai/ Peter Hemming	Stephen Ayliffe	
Michelle Bayley	Reuben Kendall	
Acute hospital bed days per capita (i.e. using health resources effectively) *Reports to Demand Management Advisory Group*		
Damian Tomic (Waikato DHB) –lead	Cath Knapton (Midland Pharmacy Group)	Nina Scott (Waikato DHB)
Jo-Anne Deane (Project Manager)	Graham Guy (Waikato DHB)	Puamiria Maaka (MHN)
Andrea Coxhead (Waikato DHB)	Lorraine Hetaraka-Stevens (NHC)	Stephen Ayliffe (Hauraki)
Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (i.e., keeping children out of hospital) *Reports to Waikato Child and Youth Health Network*		
David Graham (Waikato DHB Women's and Children's) - Clinical Lead/Chair	Jo-Anne Deane (Waikato DHB Integrated Care)	Lorraine Hetaraka-Stevens (National Hauora Coalition)
Kath Yuill-Proctor (Waikato DHB Women's and Children's) – Project Manager	Karina Elkington (Waikato DHB Strategy and Funding) – Portfolio Manager	Stephen Ayliffe (Hauraki Primary Health Organisation)
Cath Knapton (Midland Community Pharmacy Group)	Katie Ayers (Oral Health Midland Clinical Advisor)	TBC (Waikato DHB ED Hospital Services)
Felicity Dumble (Waikato DHB Population Health)	Katpaham Kasipillai (Waikato DHB Strategy and Funding) – Analyst	Tracey Jackson (Pinnacle Midlands Health Network)
Geraldine Tennet (Waikato DHB Child Health GP Liaison)	Kui White (Raukura – Well Child Tamariki Ora)	
Patient experience of care (i.e., person-centered care) *Reports to Inter-Alliance*		
Mo Neville (Waikato DHB) lead	Jo-Anne Deane (Waikato DHB)	Stephen Ayliffe (Hauraki)
Cait Cresswell (Project Manager)	Lorraine Hetaraka-Stevens (NHC)	Trish Anderson (Hauraki)
Cath Knapton (Midland Pharmacy Group)	Michelle Bayley (MHN)	
Janet Ball (Waikato DHB)	Reuben Kendall (Hauraki)	

Amenable mortality rates (i.e., prevention and early detection)
Reports to Inter-Alliance

Doug Stephenson (Waikato DHB) lead	Justina Wu (Waikato DHB)	Ross Lawrenson (Waikato DHB)
Cara Dibble (Project Manager)	Loraine Elliot (Waikato DHB)	Shona Haggart (Waikato DHB)
Clare Simcock (Waikato DHB)	Lorraine Hetaraka-Stevens (NHC)	Stephen Ayliffe (Hauraki)
Fraser Hamilton (GP/Waikato DHB)	Nina Scott (Waikato DHB)	
Jo-Anne Deane (Waikato DHB)	Puamiria Maaka (MHN)	

Proportion of babies who live in a smoke-free household at six weeks post-natal (i.e., healthy start)
Reports to Waikato Child and Youth Health Network

Nina Scott (Waikato DHB) –lead	Jo-Anne Deane (Waikato DHB)	LMC provider tbc
Dallas Honey (Project Manager)	Karina Elkington – Strategy and Funding (Waikato DHB)	Michelle Rohleder (Hauraki)
Cath Knapton (MCPG)	Kate Dallas (Waikato DHB)	Plunket provider
Dallas Honey – Strategy and Funding (Waikato DHB)	Kelly Spriggs – TPO (Waikato DHB)	Ruth Galvin – Women's Health (Waikato DHB)
Dave Graham (Waikato DHB)	Kym Tipene (Well child provider)	Selena Batt (MHN)

Youth System Level Measure (i.e., youth are healthy, safe and supported)
Reports to Waikato Child and Youth Health Network

Polly Atatoa Carr (Waikato DHB Women's and Children's) – Clinical Lead/Chair	Frances Robbins (General Practitioner – Youth Special Interest)	Naomi Knight (Waikato DHB Emergency Hospital Services)
Kath Yuill Proctor (Waikato DHB Women's and Children's) – Project Manager	Jo-Anne Deane (Waikato DHB Integrated Care)	Rachael Aitchison (Waikato DHB Mental Health and Additions)
Amanda Bradley (Pinnacle Midlands Health Network)	Jolene Profitt (Hauora Waikato)	Rachel Haswell (Youth Intact)
Bronwyn Campbell (Pinnacle Midlands Health Network School based health service)	Katpaham Kasipillai (Waikato DHB Strategy and Funding) – Analyst	Stephen Ayliffe (Hauraki Primary Health Organisation)
Cath Knapton (Midland Community Pharmacy Group)	Larry Clarke (Waikato DHB Strategy and Funding) – Portfolio Manager	Tracy Jackson (Pinnacle Midlands Health Network)
Clare Simcock (Waikato DHB Quality and Patient Safety – Suicide Prevention and Postvention Coordinator)	Lorraine Hetaraka-Stevens (National Hauora Coalition)	Wendy Carroll (Hauraki Primary Health Organisation)

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 11.3

DELEGATION OF AGREEMENTS OVER $10M PER ANNUM FOR SIGNING

Purpose	For approval.

The Crown Funding Agreement and PHO Services Agreements Version 5.1 listed below are due for signing within the next month. The value for these agreements are over $10m per annum which is above the Chief Executive's delegated financial authority, thus need to be signed or sub-delegated by the Board.

PHO Services Agreement Variations

At the July 2018 Board meeting the Board designated signing of the PHO Services Agreements Version 5 to the Interim Chief Executive. The PHOs are:

- Hauraki PHO
- Midlands Regional Health Network Charitable Trust (MRHNCT).

Estimated annual funding for Hauraki PHO is $31.3m and annual Waikato DHB funding for MRHNCT is $50.2m.

Both PHOs have signed Version 5 which means the next agreement variations (Version 5.1) need to be signed. This variation includes nationally agreed amendments as follows:

- New capitation payment rates from 1 July 2018
- Payments for assessments under the Substance Addiction Act 2017
- Payment for Zoster (shingles) vaccine where administered on the same occasion as the influenza vaccine
- Minor clause changes.

We have already received version 5.1 from Hauraki and expect the MRHNCT agreement shortly. Both these national agreements variations have a start date of 01 July 2018 with an end date of 31 November 2018 and are unchanged from Version 5.

On 1 December 2018 there will be an entirely new national agreement version with both PHOs (Version 6) which incorporates the Government policy changes for the reduction in general practice co-payment fees for Community Service Cards holders and extending free under 13s consultations to free under 14s. We anticipate Version 6, which will include agreed flexible funding plans for 2018/19, will come to the November Board meeting for approval and signatory.

Crown Funding Agreement (CFA)

The 19th Omnibus Variation for to the Crown Funding Agreement has also been received. This omnibus variation includes 2018/19 revenue agreements for the following areas:

- Primary Health Care Services – including revenue for top-sliced funding streams (Very Low Cost Access subsidy, Under 13s subsidy, Care Plus funding, System Level Measure framework) - $17,584,402
- Well Child Tamariki Ora Services - $1,362,841
- B4 School Check funding - $953,667
- Maternity Quality and Safety Programme - $208,454 per annum for two years
- Disability Support Services - $4,062,253
- Cancer psychological and social support workers - $302,776 per annum for two years
- Cancer psychological and social support regional leads - $133,334 per annum for two years.

The combined total for the complete Omnibus is $24,607,727 for 2018/19 and $644,564 for 2019/20.

Service schedules have been checked and approved by the relevant service managers and portfolio managers responsible.

Radical Improvement in Māori Health Outcomes by Eliminating Health Inequities for Maori

Revenue from services identified above are applied with a clear focus on improving equity. Primary Care, Well Child Tamariki Ora, and B4 School in particular have heavy weighting in the calculations and make-up of the revenue funding for Māori.

Recommendation
THAT
The Board:

1) Delegates authority to the interim Chief Executive to sign both PHO Services Agreements Version 5.1.
2) Delegates the authority to the interim chief Executive to sign the 19th Omnibus Variation to the Crown Funding Agreement

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR
STRATEGY, FUNDING, AND PUBLIC HEALTH

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 11.4

BUILDING RESEACH FOR WAIKATO DHB

Purpose	For Board assessment and input.

The following provides information to the Board on the research that is currently undertaken at Waikato DHB, and outlines proposals to assist in meeting the DHB strategic goal of becoming a leading centre for research, innovation and health improvement.

Radical Improvement in Maori Health Outcomes by Eliminating Health Inequities for Maori

Research is a key contributor to making improvement in Maori Health outcomes. The Waikato DHB research approval process includes Maori Research Review, where proposals are reviewed for their impact on Maori health.

Recommendation
THAT
The Board:

1) Notes the update on research being undertaken within the DHB.
2) Approves the proposed direction going forward.

ROSS LAWRENSON
CHAIR
RESEARCH ADVISORY GROUP

MO NEVILLE
DIRECTOR
QUALITY & PATIENT SAFETY

Building Research for Waikato DHB

Background

The Waikato DHB is aiming to become a leading centre for research, innovation and health improvement. Research is one of the strategic enablers of the Waikato DHB 10 year plan developed in 2017. Being treated in a hospital that is research active is associated with better outcomes for patients and is a surrogate marker of an institute's quality. (1) The Waikato DHB goal aligns strongly with the Ministry of Health New Zealand Health Research Strategy (2017) . The Government's vision is for New Zealand to have a world leading health research and innovation system that is founded on excellent research and improves the health and wellbeing of all New Zealanders. A set of guiding principles, strategic priorities and immediate actions has been suggested to help to achieve this vision by 2027. The plan outlines four strategic priorities:

(1) investing in research that addresses the health needs of New Zealanders;

(2) creating a vibrant research environment in the health sector;

(3) building and strengthening pathways for translating research findings into policy and practice;

(4) advancing innovative ideas and commercial opportunities.

Waikato DHB is a research active organisation with a number of research and clinical trials groups (see Waikato Research Report 2017). We have strong individual interest groups (for example, endocrinology, anaesthetics, oncology, and rheumatology) and these may benefit from organisational influence to guide research towards our DHB strategic priorities. Over the past 15 years the DHB has made strategic research investments into areas such as psychiatry, geriatrics and primary care, by jointly funding key strategic roles, as a way to drive better quality of care and to support clinical leadership. Other planned investments in community child health and diabetes research did not come to fruition.

Our links with tertiary providers include the University of Auckland, who fund some medical academic research appointments through the Faculty of Health and Medical Science as well as having an Academic Centre as part of their Waikato Clinical Campus; nursing links with the University of Auckland and Wintec, and links with the University of Waikato which have been strengthened with the establishment of the University of Waikato Medical Research Centre which includes a number of joint appointments.

Our ability to secure research funding from the main sources within NZ has been limited. The majority of Government priority for investment is conducted through contestable funding from the Health Research Council (HRC) and the Ministry for Business, Innovation and Enterprise (MBIE). The Region with the greatest health need – the Midland Region, attracts the least research funding. For instance in 2018 the HRC research funding so far has totalled $91.9M of which $44.9M (48.9%) went to the Northern Region (Auckland) $2.0M (2.2%) to Midland, $15.1M (16.4%) to Mid Central and $29.9M (32.5%) to the Southern Region. Most of this funding goes to the University of Auckland and the University of Otago – including $1.4M of the Midland funding which was to the University of Auckland. The Ministry of Health is aware of these differences in health research investment to DHBs, and have indicated they may provide some research infrastructure to DHBs to enable us to provide some support for our clinicians.

There is an opportunity for research to have more prominence within the DHB, alongside the development of the NZ Health Research Strategy, the demands of the Long Term Investment Plan, and our strategic priority to become a centre of excellence in learning, training, research and innovation.

As a first step, a Waikato DHB Research Advisory Group (RAG) was initiated last year (terms of reference are attached). One goal is to develop a Waikato Research, Innovation and Improvement Hub which will provide a tangible space in which research can flourish. The hub could have a number of roles including providing support for research training of staff, horizon scanning for clinically important research findings, support for our clinical trials infrastructure, promoting dissemination of research, and with our tertiary providers provide support for our clinicians in attracting funding and undertaking quality research relevant to their clinical areas of work. In addition, to encourage and increase engagement with clinical services, we envisage that each clinical department within the DHB has a dedicated portfolio within which responsibility for co-ordinating research lies; ensuring that research answers clinically important questions for their departments and makes sure that there is oversight of the clinical trials activities in their areas. In this way, the research culture of the DHB can grow.

To build a DHB into a successful and active research centre of excellence, one that uses evidence to guide improvements in health care, four key objectives have been identified:

1. Develop DHB research priorities that meet the needs of the NZ Health Research Strategy. This must include a focus on understanding and improving Māori health outcomes.
2. Create a vibrant research environment ensuring that staff in all sectors of the DHB have the opportunity to be research active
3. Ensure that research findings are translated into action, including evaluation, across the health sector.
4. Explore ways to commercialise Waikato derived innovations

1) DHB Research Strategy/Priorities

The RAG has identified some key areas for research across the DHB. Each of these must include a strong equity lens relating to Māori health. We also believe that the DHB should look at the equity of delivery of services to our rural populations.

Based on health need and expected demographic changes, the following are recommended:

- Child health
- Chronic disease especially cardiovascular disease and diabetes
- Care of older people and rehabilitation
- Cancer
- Mental health
- Disability research
- Trauma

Consideration must also be given to the use of health technologies – research in this field is seen as being essential if the DHB is to be at the forefront of innovation. While not a health need, it identifies a platform in which health engagement is being developed.

2) A vibrant research environment

Waikato DHB already has a good research environment. Research is supported by an effective governance framework and associations with University partners. The DHB supports research activities through funding of postgraduate research opportunities and through an active summer student program. Our research is highlighted by the Bi-annual Research Seminars (published in the NZMJ) and through the Kudos Science awards. Both of these concentrate on academic research, nevertheless, establishing an inclusive research culture supports and encourages everybody to have the ability to participate.

An active research environment requires time and staff. Support for applications for funding, ethics approval and peer review is lacking. In addition, access to biostatistical expertise and research office functions enjoyed by other DHBs are not available. A research-engaged environment supports junior staff to learn from the experts in a supportive, rather than ad hoc, manner. It is proposed that we need a full-time research facilitator (or similar role) to provide support to researchers and those wishing to contribute to research across the DHB.

3) Research into practice

Not all winning ideas and innovations lead to high-value health care. One of the main drivers of research is to improve health outcomes and the quality of care. Research set within a carefully contained environment needs to translate into 'real world' settings. Just as significant as the implementation of research into practice is de-implementation based on research -reducing or stopping the use of a health service or practice, which may have gained traction over the years but is ineffective, unproven, harmful, overused, inappropriate, and/or low-value to health services and more importantly to the patient. Of equal importance to clinical trials are the observational studies to evaluate the effectiveness of health care. This research translation is an important part of the health service and is a key priority for the Health Research Strategy as well as providing a better understanding of the care we give. Initiatives, such as Choosing Wisely - a globally recognised strategy, link translational research and quality in health care. Ensuring the focus of our research culture ensures that clinicians are using evidence to drive practice is a win-win for everybody and shows the strong interplay between research and quality improvement activities.

Further supporting research into practice are our Grand Rounds and departmental journal clubs, which are clinically-based and are intended to disseminate best practice using the latest research in their field.

4) Commercialisation

Health services can deliver tremendous economic and social value by commercialising the research knowledge developed by their researchers. Knowledge transfer can include a broad range of activities from research to teaching to undertaking community services. Transferring this knowledge to the marketplace is referred to as commercialisation in which research knowledge becomes a 'product'. The DHB have been involved in a number of commercialisation opportunities from our staff, including the development of a vascular training suite, work with the Auckland UniServices on the development of a ketamine analogue and the recent trial of the pepi splint (for safe stabilisation of IV sites in neonates). The Waikato legal services have been helpful in supporting clinical trials but the Board do not have expertise on patent advice, more readily available at Universities. Further support is needed if the DHB are to be able to benefit from commercialisation opportunities.

With regards the opportunities for innovation we have already noted the need for research into the use of health technologies. Operations management and improving supply changes may be another area where the Board could be a leading innovator.

Proposal

- Support the proposed priorities for research

- Coordinating and networking enables a platform to build research capacity. We propose each division within the DHB establishes a dedicated lead to coordinate their research activities. This individual/group would also be responsible for the development of the divisional strategy for implementing research into practice. Each division would have a representative on the Waikato DHB Research Advisory Group.

- The DHB establish a Waikato Research, Innovation and Improvement Hub to foster collaboration and a culture of research. Initially this could be a virtual hub but the long term vision is for this to be a physical centre linked with the DHB education facilities.

- The development of a Research, Innovation and Improvement Hub will require additional administrative and research expertise. It is suggested this resource could be partially funded through the clinical trials activities within the DHB

Ross Lawrenson

October 2019

Research Advisory Group
Terms of Reference

TERMS OF REFERENCE
1. Committee Name **Research Advisory Group (RAG) for the Waikato DHB Region**
2. Background Waikato DHB recently published its updated Vision and Strategy. One arm of the strategy is *A centre of excellence in learning, training, research and innovation / Pae taumata* The four priorities for this strategic imperative are: • 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
3. Purpose / Scope • To provide high level leadership, governance, strategic direction and oversight of research activity at Waikato DHB. • To promote and develop Waikato DHB's research culture by ensuring a transparent, supportive and appropriate research environment and infrastructure; and by nurturing and enhancing research capability, capacity and performance. • To promote and develop a centre of excellence for Maori Health and health equity research and innovation which will build close and enduring relationships with Maori health researchers and Maori organisations and community in the Waikato. • To ensure research undertaken within Waikato District Health Board is scientifically valid, is carried out in a co-ordinated manner, follows policy and has the potential to improve service delivery, personal health outcomes or population health. • To ensure results of research undertaken is disseminated appropriately. • Increase the focus on translational research (research into practice); service delivery research •
4. Objectives • To provide leadership and encourage participation in research at Waikato DHB, while maintaining safety and effectiveness. • To promote evidence based practice and innovation through research. • To identify areas of potential growth in high quality research relevant to our population and to promote mechanisms to stimulate appropriate research programmes in such areas • Identify 4-5 themes and explicitly support these • To oversee organisational research / innovation to change models of care • To provide a conduit for the accountability of researchers to the Executive Group

Waikato District Health Board

TERMS OF REFERENCE

- To oversee the publication of the annual research report
- To receive and consider reports on the research undertaken at Waikato DHB.
- To assist in the decision making process regarding ethical issues pertaining to clinical situations. The Committee may co-opt other appropriate representation and will report through appropriate channels on completion of its deliberation. The committee can be convened at the discretion of the chair as and when required.
- To provide advice on matters relating to research at Waikato DHB, including policies and strategies for fostering and advancing research and innovation.
- Grow research with a view to widening to include community and region.
- To provide advice on research strategy and policy direction to Board.
- To increase external funding for research
- To consider and report on any matter concerning research referred to it by the Executive Group and/or researchers.

5. Chairperson

Clinical Director, Strategy & Funding

Deputy Chair

Director, Quality & Patient Safety

6. Membership

Waikato DHB

Chief Executive	Director Quality & Patient Safety
Executive Director – Office of CE	Exec Director Corporate Services
Exec Director Maori Health	Chief Nursing & Midwifery Officer
Chief Medical Officer	Chief Data Officer
Clinical Director Information Services and Virtual Healthcare	Clinical Director Strategy & Funding / Integrated Care

Representatives from/of:

Waikato Clinical School	University of Waikato
Wintec	Allied Health
3 x Waikato DHB Researchers*	Clinical Trials*
Primary Health Organisations	

*These representatives will be appointed for a 24 month period.

Note: Some people represent multiple roles.
Others invited as appropriate

7. Governance

- Reports to : Executive Group
- Quorum : Eight, with one of those being the Chair or deputy Chair

8. Frequency of meetings

Quarterly meetings; although may be more frequent if required.

9. Location of minutes

TERMS OF REFERENCE
Research office, shared drive
10. Resources Administration by Coordinator - Governance
11. Review date Annual

Authorised by:

_____ _____

Executive Director, Office of the Chief Executive **Date**

Research in WDHB

Ross Lawrenson
Quality & Patient Safety

On behalf of Mo Neville, Sarah Brodnax and Research Advisory Group

October 2018

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – Building Healthy Communities

Board Strategy

- **A centre of excellence in learning, training, research, and innovation**
- Build close and enduring relationships with local, national, and international research 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

New Zealand Health Research Strategy

- **The plan outlines four strategic priorities:**
- (1) investing in research that addresses the health needs of New Zealanders;
- (2) creating a vibrant research environment in the health sector;
- (3) building and strengthening pathways for translating research findings into policy and practice;
- (4) advancing innovative ideas and commercial opportunities.

Research Advisory Group

- Started in 2017
- Part of Quality and Patient Safety
- The membership of RAG includes executive staff from Waikato DHB plus representatives from key stakeholders : University of Waikato, University of Auckland, Wintec and Primary Health Organisations
- Meets quarterly

RAG - Terms of Reference

- To provide high level leadership, governance, strategic direction and oversight of research activity at Waikato DHB.
- To promote and develop Waikato DHB's research culture by ensuring a transparent, supportive and appropriate research environment and infrastructure; and by nurturing and enhancing research capability, capacity and performance.
- To promote and develop a centre of excellence for Maori Health and health equity research and innovation which will build close and enduring relationships with Maori health researchers and Maori organisations and community in the Waikato.
- To ensure research undertaken within Waikato District Health Board is scientifically valid, is carried out in a co-ordinated manner, follows policy and has the potential to improve service delivery, personal health outcomes or population health.
- To ensure results of research undertaken is disseminated appropriately.
- Increase the focus on translational research (research into practice); service delivery research
- **CHALLENGE is to raise Quality of our Research/Researchers**

Clinical Trials

- **There are a number of dedicated clinical trial research units within Waikato DHB**
  - Anaesthesia
  - Critical Care/ICU
  - Respiratory & Gastroenterology
  - Cardiology
  - Neurology
  - Rheumatology
  - Cancer and Blood
  - Breast Cancer
  - Diabetes
  - Renal

Clinical Trials

Year	Number of Active Clinical Trials	Number Recruited	Number of Maori Recruited	Number Withdrawn
2016-2017	**166**	**3419**	**181**	**50**
2017-2018 *	**168**	**4091**	**690**	**12**

Other Research

- Observational studies
- Qualitative Research
- Supporting academic training (e.g. Masters projects)
- Nursing and Allied Health
- Summer students
- Published over 130 peer reviewed papers in 2017

Research priorities

- Research into Māori inequities is a central goal of our research strategy.
- We also believe that a rural lens is needed for the DHBs research.
- These priorities in no way should diminish the support we provide for our leading research teams in other areas.
- We also recommend a focus on health technologies – research in this field is seen as being essential if the DHB is to be at the forefront of innovation

Research priorities – based on clinical priorities

- Child health
- Chronic disease especially cardiovascular disease and diabetes
- Care of older people and rehabilitation
- Cancer
- Mental health
- Disability research
- Trauma

Recommendations

1. Agree Waikato DHB research priorities

2. Each Division appoints a Research lead to support CUL/Ops/Nurse director in its clinical governance framework

3. Build a Waikato Research, Innovation and Improvement Hub (Virtual hub initially but eventually co-located)
    - We need additional people resource to support the development of the hub.

Significant Programmes/Projects

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 12.1

PRESENTATION ON NATIONAL ORACLE SYSTEM

Purpose	For information.

We will be giving an update on the National Oracle System project from both the local perspective (how has the local implementation of the national programme gone) and from the national perspective (what has happened to the national programme and what does the future look like).

Recommendation
THAT
The presentation be received.

NEVILLE HABLOUS
EXECUTIVE DIRECTOR/CHIEF EXECUTIVES OFFICE

Creating our Futures: report due in November.

CBD Accommodation Project: report due in November.

Regional eSPACE Progamme: report due in January.

Medical School: no report this month.

Papers for Information

MEMORANDUM TO THE BOARD
24 OCTOBER 2018

AGENDA ITEM 13.1

STATE SECTOR MODEL STANDARDS – MANAGEMENT OF CONFICT OF INTEREST

Purpose	For information.

The State Services Commission issued in late May 2018, new model standards for the management of conflict of interests in the State Sector. These standards have been issued pursuant to s.57(4) State Sector Act 1988. Section 57 provides for the Commissioner to set minimum standards for the State Sector including Crown Entities.

A complete copy of the standards can be found here:
http://www.ssc.govt.nz/sites/all/files/conflicts-of-interest-model-standards.pdf

A summary of the model is contained in the table attached.

Waikato DHB has a current comprehensive organisational policy on the management of conflicts of interests; however, a new policy is currently being drafted, the policy will incorporate the SSC model, and should be signed off, subject to Board of Clinical Governance approval prior November 2018. Currently, all new employees are required to fill out a declaration prior to commencement, though not prior to an offer. The declaration should be recompleted either on an annual basis or when they become aware of a conflict if earlier. When completing annual performance appraisals, Managers verify that an up-to-date conflict of interest form is completed.

In addition to the Conflict of Interest policy, other key policies are:

- Waikato DHB Receiving and Giving of Gifts (1829)
- Waikato DHB Procurement and Contracts Policy (0170).

In 2014, Internal Audit reviewed the organisation's approach to managing conflicts.

Notwithstanding the above, while Waikato DHB current practices align with the new standard there are gaps. The new policy will address some of these issues.

(i) Getting conflicts of interest declarations from prospective employees
(ii) Training for managers around the management of conflicts
(iii) Having a central repository/register of declared conflicts, the mitigation put in place to manage such conflicts, and any concerns raised around the particular conflict.

Point (iii) should be addressed as part of the introduction of a new HRIS system for which a business case is currently being prepared.

Recommendation
THAT
The Board receives this report.

GREGORY PEPLOE
DIRECTOR PEOPLE AND PERFORMANCE

CONFLICT OF INTEREST MODEL STANDARDS	
Foundation	**Model Standard**
Organisational commitment, leadership and culture	• Organisations need regular statements from senior leadership of their expectations of people within the organisation to act honestly and ethically, and to fully and openly disclose conflicts of interest.
Appointment and engagement	• Organisations ensure that candidates are alert to the possibility of conflicts of interest and its expectations that people will act honestly and ethically, and fully and openly disclose actual and potential conflicts of interest and this is formally recorded.
	• Organisations have procedures to allow candidates to review and disclose potential conflicts of interest as part of the pre-selection process
	• Expectations relating to conflicts of interest are explicitly referred to and recorded in contractual agreements; individuals are required to sign that they have read and understood the expectations and accept responsibility for identifying and recording their relevant private interests.
Training and awareness	• There are processes in all organisations for ensuring that existing and potential staff understand and are alert to the possibility of conflicts of interest and the requirement to disclose them.
	• Training on recognising and disclosing conflicts of interest is covered in induction for staff and contractors, as well as following any changes to policies or procedures, supported by regular reminders of individuals' responsibility to identify and disclose.
	• Training for managers includes receiving and dealing with disclosures of conflicts of interest, knowing how and when to access professional advice and support, and handling complaints or breaches of the policy.
	• There are designated people or teams that staff can talk to when they think they may have a conflict of interest.
	• All conflicts of interest disclosed to an organisation are assessed and either

	avoided or actively managed in a timely way.
Senior Leaders / Partnerships with other stakeholders	• Internal policies and processes designate clear roles and responsibilities and are readily available for people to access.
	• Internal policies provide clear rules that define inappropriate conflicts, such as involvement in the appointment of a family member.
	• There is a mechanism for recording private interests that may give rise to a conflict of interest, which is frequently updated and monitored while appropriately protecting privacy.
	• The policy makes it clear that the disclosure of a private interest does not in itself resolve a conflict and measures to resolve or manage the conflict must be considered.
	• When a conflict of interest is suspected to involve criminal activity, organisations will report the matter to the Police or the Serious Fraud Office.
Managing conflicts	• There are policies and processes in place for disclosing, recording and responding to conflicts of interest. Policies and processes reflect the organisation's particular functions, context and statutory requirements.
	• There is a process for managing conflicts of interest which includes what constitutes a conflict, options for managing it (including considering whether or not an individual should continue to be involved with work in the potential area of conflict), who makes decisions, and potential consequences of non-compliance.
	• There are clear and documented responsibilities and actions for managers receiving, assessing, managing and monitoring disclosed conflicts of interest.
	• There are support mechanisms for assisting managers in reviewing and improving their skills in identifying and avoiding or managing conflicts.
	• The arrangements for dealing with conflicts are clearly recorded in formal documents to enable the organisation concerned to demonstrate, if necessary, that a specific conflict has been appropriately identified and managed.
	• Decision-making processes at all stages can be audited and justified.
Monitoring and evaluating	• All conflicts of interest are centrally recorded and organisations have designated people responsible for tracking, monitoring and reporting to senior leadership.
	• Conflicts of interest are included in organisation's risk management programmes and reporting,

	including any internal or external risk and assurance committees.
	• There are training and systems in place to enable centralised tracking, monitoring, auditing practices and continuous improvement of policies and processes.
	• The conflict of interest register is regularly reviewed, updated and included as part of the organisation's audit programme.
	• Monitoring agencies regularly review Crown entities' conflict of interest policies, procedures and registers.
Raising concerns	• Internal policies and processes include mechanisms to allow individuals to raise concerns about how the organisation is managing their declared interest.
	• All concerns raised about management of declared interests are assessed, recorded and acted on in a timely way.
	• There is appropriate separation of duties and well defined roles that underpin organisations' processes in relation to concerns raised by individuals.

Presentations

No presentations.

Board Member Items

The Living Wage (refer item 19 in public excluded).

Next Board Meeting: 28 November 2018.