Waikato District Health Board

MEMORANDUM

TO: Board Members

FROM: Donna Straiton

DATE: 12 June 2018

SUBJECT: **Board Meeting – 27 June 2018**

1100: Board Workshop: Equity and Systemic Racism
Venue: Board room, level 1, Hockin building

1200: Board Members/Interim Chief Executive Meeting (and Working Lunch)
Venue: Committee room, level 1, Hockin building

1300: Board Meeting
Venue: Board room, level 1, Hockin building

Board Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	27 June 2018	**Time:**	1pm

Board Members:	Ms S Webb (Acting 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:	Ms T Thompson-Evans, Chair Iwi Maori Council Mr D Wright, Interim Chief Executive and other Executives as necessary

Next Meeting Date:	25 July 2018	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680

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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: 23 May 2018
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 7 June 2018
  - 3.2.2 Hospitals Advisory Committee: 13 June 2018
  - 3.2.3 Community and Public Health Advisory Committee: 13 June 2018
  - 3.2.4 Maori Strategic Committee: 20 June 2018

4. **INTERIM CHIEF EXECUTIVE REPORT**

5. **QUALITY AND PATIENT SAFETY**
- 5.1 Quality and Patient Safety Report
- 5.2 Report from the Health and Disability Commission – DHB Complaints Report, July to December 2017

6. **FINANCIAL PERFORMANCE MONITORING**
- 6.1 Finance Report

7. **HEALTH TARGETS**

8. **HEALTH AND SAFETY** (report due July)

9. **SERVICE PERFORMANCE MONITORING**
- 9.1 Chief Data Officer Directorate
- 9.1 Waikato Hospital Services (report due in July)
- 9.3 Community and Clinical Support (report due in July)
- 9.4 Mental Health and Addictions Service (report due in July)
- 9.5 Strategy and Funding (report due in August)
- 9.6 People and Performance (report due in September)
- 9.7 Facilities and Business (report due in September)
- 9.8 IS (report due in September)

10. **DECISION REPORTS**
- 10.1 Equity Focussed Reporting
- 10.2 Why Ora Business Case
- 10.3 NZ Health Partnerships Statement of Performance Expectations 2018/19
- 10.4 Midland Regional Services Plan 2018/21
- 10.5 Waikato DHB Working Draft Annual Plan 2018/19

Board Agenda

11. SIGNIFICANT PROGRAMMES/PROJECTS

- 11.1 Virtual Health
  - 11.1.1 Update on Disengagement from HealthTap
- 11.2 Medical School (refer agenda item 4)
- 11.3 Creating our Futures (report due in July)

12. PAPERS FOR INFORMATION

No papers

13. PRESENTATIONS

- 13.1 Health of the Nation Outcomes Scale Presentation

Dr Rees Tapsell to attend at 2.30pm

14. NEXT MEETING: 25 July 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 15: Minutes – Various
- (i) Waikato District Health Board for confirmation: Wednesday 23 May 2018 (Items taken with the public excluded)
- (ii) Hospitals Advisory Committee – to be adopted: Wednesday 13 June 2018
- (iii) Midland Regional Governance Group – to be received: Friday 1 June 2018

Item 16: HealthTap Lessons Learnt Report – Public Excluded
Item 17: Oncology Facility Development (New Building Interim Facility) – Public Excluded
Item 18: Hague Road Car Park Upgrading Works – Public Excluded
Item 19: Renewal of PathLab Agreement – Public Excluded
Item 20: All of Government Microsoft Negotiations – Public Excluded
Item 21: Appointment of Consumer Council Nominees to Hospitals Advisory Committee and Community and Public Health Advisory Committee – 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 15 (i-iii):	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 16:	HealthTap lessons learnt – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 17:	Oncology facility development – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 18:	Upgrading works for car park building – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 19:	Renewal of Pathlab agreement – Public Excluded	Negotiation will be required	Section 9(2)(j)

Board Agenda

Item 20:	Microsoft negotiations – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 21:	Consumer Council members appointments to Statutory Committees – Public Excluded	Protect an individual's privacy	Section 9(2)(a)

(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

15. MINUTES – PUBLIC EXCLUDED

15.1 Waikato District Health Board: 23 May 2018
To be confirmed: Items taken with the public excluded

15.2 Hospitals Advisory Committee: 13 June 2018
To be adopted: Item 7

15.3 Midland Regional Governance Group: 1 June 2018
To be received: All items

16. HEALTHTAP LESSONS LEARNT REPORT – PUBLIC EXCLUDED

17. ONCOLOGY FACILITY DEVELOPMENT (NEW BUILD INTERIM FACILITY) – PUBLIC EXCLUDED

18. HAGUE ROAD CAR PARK UPGRADING WORKS – PUBLIC EXCLUDED

19. RENEWAL OF PATHLAB AGREEMENT – PUBLIC EXCLUDED

20. ALL OF GOVERNMENT (AOG) MICROSOFT NEGOTIATIONS – PUBLIC EXCLUDED

21. APPOINTMENT OF CONSUMER COUNCIL NOMINEES TO HOSPITALS ADVISORY COMMITTEE AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE – 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 JUNE 2018

Sally Webb

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Acting 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	
Member, Sustainability 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, Chief Executive Performance Review 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	
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) with some contract work for Selwyn Foundation	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	
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	

Note 1: Interests listed in every agenda.

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

Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None
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	

Note 1: Interests listed in every agenda.

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

Sharon Mariu

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, 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	

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 23 May 2018 commencing at 1.00pm in the Board Room, Hockin Building at Waikato Hospital

Present:
Ms S Webb (Acting Chair)
Ms S Christie
Mr M Gallagher
Ms M A Gill
Ms T Hodges
Mr D Macpherson
Mrs P Mahood
Ms S Mariu
Dr C Wade
Ms T Thompson-Evan

In Attendance:
Mr D Wright (Interim Chief Executive)
Mr N Hablous (Chief of Staff)
Dr G Howard (Acting Executive Director, Waikato Hospital Services)
Ms M Chrystall (Executive Director, Corporate Services)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Ms L Elliott (Executive Director, Maori Health)
Mrs V Aitken (Acting Executive Director, Mental Health and Addictions Service)
Mr M Spittal (Executive Director, Community and Clinical Support)
Ms T Maloney (Executive Director, Strategy and Funding)
Dr D Tomic (Clinical Director, Primary and Integrated Care)
Mr A McCurdie (Chief Financial Officer) part of the meeting
Ms M Neville (Director, Quality and Patient Safety)
Mr D Hackett (Executive Director, Virtual Health)

Ms S Webb welcomed Ms T Thompson-Evan, chair of the IWI Maori Council to the meeting. Ms Thompson-Evan will attend the DHB Board meetings from now on.

ITEM 1: APOLOGIES FOR ABSENCE

An apology for absence was received from Ms C Beavis.
An apology for lateness was received from Ms P Mahood.

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: 24 April 2018

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 24 April 2018 taken with the public present were confirmed as a true and accurate record subject to one amendment being made:

- 10.1 Ethnicity based KPI reporting to be referred to as equity focused KPIs and the reporting to be presented to the Maori Strategic Committee.

3.2 Committee Meeting Minutes

3.2.1 Maori Strategic Committee: 16 May 2018

Resolved
THAT
The Board noted the minutes of this meeting

ITEM 4: INTERIM CHIEF EXECUTIVE REPORT

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

- Mark Spittal's resignation – the Board recognised and thanked Mr Spittal for all he had done for the Waikato DHB and for the people of the Waikato region. The Board wished him well for the future.
- Regional opportunities – the Chief Executive was working with other DHBs to consider how they could work together.
- The executive restructure had been completed.
- Board Training session on Systemic Racism and Health Equity for Māori will be held on 27 June 2018, facilitated by Dr Heather Cane. Treaty and Tikanga Best Practice and Powhiri training will be held at Turangawaewae Marae on 6 September 2018. Iwi Māori council members will also attend.
- Trial of Online voting – Matamata-Piako District Council have invited Waikato DHB to be part of a pilot scheme to support online voting at the 2019 local elections. The Board members said that they would not want anyone who does not have internet access to be disadvantaged by this approach and also they expect this to be cost neutral to the DHB.
- Surgical Reinvention Project – the DHB had been compliant with ESPI 5 for three months.

Resolved
THAT
The Board received the report.

ITEM 5: QUALITY AND SAFETY REPORT

Ms M Neville presented this agenda item. The report was taken as read. Of note:

- The development of the new national health system quality dashboard is to go live in August.
- Work continued to increase the use of the health round table forum.
- The learnings from the Southland DHB Ophthalmology Service Review were to be the focus for discussion at Grand Round. Any risks for the Waikato DHB will be included in the risk register.

Resolved
THAT
The Board received the report.

ITEM 6: FINANCIAL PERFORMANCE MONITORING

6.1 Finance Report

Mrs M Chrystall and Mr R Cramond attended for this agenda item. The report for the month of April 2018 was taken as read highlighting the following:

- An unfavourable variance to budget of $13m for April
- 1% over plan on electives

Resolved
THAT
The Board:
1) Received this report.
2) Approved that a 2017/18 forecast deficit of $29.5m be tabled with the Ministry of Health.

ITEM 7: HEALTH TARGETS

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

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

- Emergency Department – this target was still an issue. Trials to find improvements were taking place. The opening of the Acute Surgical Unit on level 8 of Menzies was expected to have a positive effect.
- Elective Surgery – showed a result of 105%.
- Faster Cancer Treatment – continued to deliver sustained results against the target. Quarter Three showed a result of 99%.
- Increase in 8 month olds being fully immunised – Following a disappointing result the DHB continues to work with PHOs to reduce "decliners" and "delayers", increasing opportunistic immunisations, and ensuring outreach immunisation services focussed on unenrolled children. Working with Family Start and LMCs to facilitate early

enrolment with general practice. Whilst a lot of activity was happening within primary care to increase the results, it could take six months for those results to make a difference to the target. Concern was expressed about opportunistic screening and that behaviour change was preferable. The management team were looking at research and reasons and the long term target for working with these populations.

- Maternity: percentage of smokers offered help to quit – it was suggested that a project on assisting Māori to quit smoking was required this year from this year's budget. A tobacco control plan will be tabled at the next CPHAC.

Resolved
THAT
The Board received the report.

Mrs P Mahood joined the meeting at 1.30 pm.

ITEM 8: HEALTH AND SAFETY

There was no report this month. Next report is due in July.

ITEM 9: SERVICE PERFORMANCE MONITORING

9.1 People and Performance Report

Ms M Chrystal and Ms A Welsh attended for this item. The report was taken as read. It was noted:

- Workplace Support Person – an initiative launched in October 2017 showed slow but promising action and results to address uncivil behaviour in the workplace.
- WorkWell – an initiative to support the wellbeing of staff – consideration was being given to extending this initiative to other willing sites and services across the DHB.
- Influenza Vaccinations – aiming for 80% of staff being vaccinated. Two people who had been vaccinated had indicated allergic reactions.
- Staff Service Recognition Initiative – a staff survey to be undertaken to choose the final badge designs. Board members would like contractors to be included in the service recognition programme.

Resolved
THAT
The Board received the report.

9.2 Facilities and Business Report

Mr C Cardwell attended for this item. The report was taken as read. It was noted:

- Maintenance – Waikato DHB assets are in comparatively good shape at the current time. However a focus on maintenance and

asset investment spending would be required over the next few years as the assets age.

- $13.5 million per annum was spent on planned maintenance including a targeted asset maintenance program of $2 million focussed on building and plant life cycle extension projects.
- Business Support:
  - Food and Nutrition Service – growing patient volumes are having a direct impact on the service. A review of capacity would be required in the next 12/18 months' time.
  - Minimum and Living Wage – increases in labour costs are passed on to the DHB in their contracts. These costs affect the OPEX budget. The group of staff affected were attendants, kitchen, cleaning and laundry staff.
  - Recruitment vs market conditions vs retention – concerns expressed about the DHB's ability to recruit and retain staff with its wages being lower than many other business and in some cases, below the living wage.
  - Sustainability – waste management and energy improvements were being implemented.

Resolved
THAT
The Board received the report

9.3 IS Performance Monitoring Report

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

Resolved
THAT
The Board received the report.

9.4 Waikato Hospital Services (report due in June)
9.5 Mental Health and Addictions Service (report due in June)
9.6 Operations and Performance (report due in June)
9.7 Community and Clinical Support (report due in July)
9.8 Strategy and Funding (report due in July)

ITEM 10: DECISION REPORTS

10.1 Ethnicity Based KPI Reporting (report due in June)

ITEM 11: SIGNIFICANT PROGRAMMES/PROJECTS

11.1 Virtual Health

11.1.1 After Hours Services Recommendation

Mr D Hackett attended for this item. The report was taken as read. It was noted:

The short term solution to maintain a virtual after hour's doctor service had identified two questions:

1. Are there technologies available to replace the HealthTap application with minimal disruption?
2. Are we clear whether any of those options align with our preferred direction for the wider sector?

Resolved
THAT
1) The Board received the report.
2) The DHB does not set up a new service to replace SmartHelth afterhours in the near term.

11.2 Medical School (report due in June)
11.3 Creating our Futures (report due in June)

ITEM 12: PAPERS FOR INFORMATION

There were no papers for information this month.

ITEM 13: PRESENTATIONS

13.1 Hauora iHub

Dr Nina Scott, Ms Melinda Ch'ng and Ms Natalie Lewis attended for this item. It was noted:

- The Hauora ihub will be a one stop shop offering to everyone wellness information and services. It will provide opportunistic screening such as cervical and breast screening, blood pressure monitoring, immunisation, smoking cessation, family violence advice and sore throats.

Resolved
THAT
The Board received the presentation.

ITEM 14: GENERAL BUSINESS

14.1 Transport Strategy

Mr Macpherson tabled an item for discussion - transport to and from the hospital campus. The Chief Executive asked Mr Cardwell and Mr Hablous to set up a group to consider a DHB transport strategy. Ms Gill expressed interested in being part of this group.

Resolved
THAT
The Board received the report.

ITEM 15: NEXT MEETING

The next meeting is to be held on Wednesday 27 June 2018 commencing at 1.00 pm at in the Board Room in the Hockin Building, Waikato hospital.

BOARD MINUTES OF 23 April 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 15: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 24 April 2018 (Items taken with the public excluded).**
- **(ii) Audit and Corporate Risk Management Committee: Wednesday 23 April 2018 verbal update: (All items)**
- **(iii) Midland Regional Governance Group – Friday 4 May 2018: to be received (All items)**
- **(iv) Remuneration Committee – to be adopted:**
  - **Friday 29 September 2017 (all items)**
  - **Tuesday 14 November 2017 (all items)**

Item 16: Ernst & Young Report on HealthTap – Public Excluded

Item 17: FY 2018/19 Capital Plan, Asset Performance Indicators, Operting Budget and Long Term Forecast – Public Excluded

Item 18: People and Performance Report – Public Excluded

Item 19: Appointment of Bay of Plenty DHB Representative to Waikato DHB Statutory Committee – Public Excluded

Item 20: Appointment of External Members to Committees – 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 ACT
Item 15 (i-iv): Minutes	Items to be adopted/ confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 16: Ernst & Young Report on HealthTap Report	Negotiations will be required	Section 9(2)(j)
Item 17: FY 2018/19 Capital Plan, Assets, Operating Budget and Long Term Forecast	Negotiations will be required	Section 9(2)(j)
Item 18: Employee Relations - People and Performance Report	Negotiations will be required	Section 9(2)(j)
Item 19: Appointment of Bay of Plenty DHB Representative Waikato DHB Statutory Committee	Protect an Individuals Privacy	Section 9(2)(a)

Item 20: Appointment of External members to Committees	**Protect an Individuals Privacy**	**Section 9(2)(a)**

(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 Maori Council (or their proxy) is allowed to remain after the public has been excluded because of their knowledge of the aspirations of the Iwi Maori Council specifically and Maori 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)

ACTION	BY	WHEN
• Item 16 – Ernst & Young Report on HealthTap – report back on lessons learned	Darrin Hackett	June 2018
• Item 17 – Budget – need a workshop in July	Derek Wright	July 2018

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Māori Council

Held: Thursday 7th June 2018 at 9.30am

Venue: Board Room, Hockin Building, Waikato Hospital

Present:	Te Pora Thompson-Evans	Chair
	Mr T. Turner	Kaunihera Kaumātua Chair
	Mr A. Chase	Hauraki Māori Trust Board
	Ms M Balzer	Te Rūnanga o Kirikiriroa Trust
	Ms K McClintock	Waikato-Tainui
	Mr T Bell	Maniapoto Māori Trust Board
	Ms S Hetet	Maniapoto Māori Trust Board
	Mr B Bryan	Raukawa Charitable Trust
	Ms P Taiaroa	Whanganui
	Ms C Brears	Whanganui
	Ms T Ake	Tūwharetoa Māori Trust Board
	Ms K Gosman	Tūwharetoa Māori Trust Board
	Ms L Elliot	Executive Director – Māori Health
	Ms P Mahood	Waikato DHB Board
	Ms S Greenwood	Minute taker

Other attendees: Nina Scott, Natalie Lewis, Hemi Curtis

ITEM 1 **KARAKIA:** Matua Hemi Curtis

ITEM 2 **MIHI WHAKATAU:** T. Turner undertook whakatau for the new members to IMC Arama Chase, Christine Brears, Trudy Ake. Whakatau was also extended to returning members to IMC and those who previously had not received whakatau.

ITEM 3 **APOLOGIES:**

S. Webb, D. Wright, G. Tupuhi, T. Moxon, K, Hodge, T. Hodges, M. Gallagher

ITEM 4 **WHAKAWHĀNAUNGATANGA**: All present.

ITEM 5 **CHAIR REPORT:**

- TP Thompson-Evans outlined four key areas of focus over the first 6-12 months as Chair. These are: Strengthening the infrastructure of IMC, Understanding the full strategic business of DHB/IMC, enhancing IMC Relationships and ensuring that IMC has Visibility and representation where appropriate. ō
- Through the MOU, the IMC Chair may sit as ex-officio on the DHB Board. – The Chair will do this as often as possible to ensure Iwi Māori interests are being represented. The Chair noted that in reporting back to the IMC, Public excluded items will not be shared.
- The Chair encouraged that we use Te Reo Māori more often during hui and noted we lead the way by doing and setting best example.

- K. McClintock noted that the Chair was invited to be a member of the Advisory Group for the Māori Mental Health and Addictions Strategy. Further noted, there are things we should be doing to make a difference such as being bold and courageous to make changes that are needed within that strategy.

Kaituku Mōtini/Moved: P Taiaroa
Kaitautoko Mōtini/Second: P Mahood

ITEM 6 WHAKAPAKARI TE WHARE

- Conflict of interest forms need to be completed, two options of doing this.
- Opportunity to declare these at the beginning of IMC hui.

ITEM 7 MINUTES OF LAST MEETING

3rd May Joint IMC/Board Minutes

- Ammendment Page 30. Under Te Rūnanga o Kirikiriroa. Oliver Charter to Ottawa Charter

Subject to amendments, move the minutes are received and correct.

Kaituku Mōtini/Moved: P Mahood
Kaitautoko Mōtini/Seconded: C Brears

5th April IMC Minutes

- K McClintock asked what is happening with new Chair and CEO?
- P Mahood responded that enquiries are going out amongst the Board around what they are looking for in a CEO. S Webb (acting Chair of the Board) would be able to give further information around this. K McClintock asked that the Board review processes around the selection of a new CEO are clear and shared with the IMC.
- The Chair noted as per the MOU that quarterly hui IMC Chair and Deputy with Board Chair and CEO.
- M Balzer suggested IMC submit to the Board what the IMC requirement are in a CEO and what proven experience they have in supporting Māori.

Moved the minutes are received and correct.

Kaituku Mōtini/Moved: K McClintock
Kaitautoko Mōtini/Seconded: T Ake

18th April and 16th May MSC Minutes

- K McClintock Performance and monitoring group need to share their funding and processes with IMC regarding mental health and addictions. Creating our Futures should also come back and present to IMC, Submission to the Mental Health Inquiry should quote the two articles of indigenous populations.

Moved the minutes are received and correct.

Kaituku Mōtini/Moved: K McClintock
Kaitautoko Mōtini/Seconded: T Ake

ITEM 8 PRESENTATIONS

HAUORA iHUB UPDATE – Nina Scott, Natalie Lewis (Clinical Nurse Specialist).

- Natalie will be running the Hauora iHub.
- Opening Event - 27th June 3pm opening, invitations will be sent to IMC and Kaunihera Kaumātua.
- The Hauora iHub is: Opportunistic and holistic, pilot project. Capturing whānau/young people and referring to services such as breast/cervical screening, smoking cessation, vaccinations, mental health, and rheumatic fever. Not currently targeted at rural yet but will capture rural people when attending/visiting Waikato hospital. Potential to roll out to rural areas, could include interconnectivity with rural GP's and rural providers.
- C Brears asked how many other conversations have happened already with other providers to engage whānau and who wants to have breast screening done when in hospital visiting sick whānau?
    - L Elliott responded that the data collected already suggests that 20% of women coming to hospital who are offered other services will take them up. These women would not otherwise have engaged in these services.
- T Ake asked if Screening for bowel cancer would be included?
    - N Scott noted that other services could be offered later as this is rolled out.
- M Balzer asked if there would be Māori volunteers?
    - N Lewis noted that there are currently 3 wāhine Māori volunteers and a female, Pacific volunteer.
- T Ake asked if there were any tāne Māori volunteers and how do we target and invest in Māori men as volunteers to support Māori men?
- K McClintock asked where does the data for the iHub go?
    - N Lewis noted that the first set of data will be available in 3 months and will be shared with IMC.

TE ROOPU TAUTOKO KI WAIKATO - Tio Sewell, Moe Milne and Taipu Moana

Te Roopu Tautoko ki Waikato presented their Wānanga Outcomes Report. Shared their view of what needs to happen in this review to improve mental health services for Māori going forward. Noted that there are both challenges and opportunities for Mental Health. Noted that Mental health needs to come from a place of Oranga which includes:

- Long term vision versus short term goals.
- Whānau led mental health
- Tikanga in hospital services
- Cultural practices are normalised and resourced
- Rehabilitation/wellness could take place within homes, marae or in-patient
- Accountable leadership

Discussion and questions:

- K McClintock noted that we agreed there is a right time with regards to the MOU. We have a strategic plan which is signed off around radical change. However, in some areas we are going backwards, kaupapa Māori is disappearing. We add to the korero we have already had.
- C Brears noted that a model of whānau Ora was accepted in the past but Māori need to lead this out and agree at all levels. We have the means to achieve but need better resourcing.
- A study around Seclusion and physical restraint of patients showed that Māori were the most secluded and restrained population in the world. WDHB has the highest population of

Māori of any DHB. So Waikato needs to set the benchmark. If we are to look at new programme of mental health policy of zero seclusion and zero suicide, what needs to happen in the design and development of the building, model of care, and workforce in order to achieve this?

- To increase Māori health outcomes. Leadership and partner paradigm shift and educate our colleagues in order to implement change.
- MOU 5.9 the Board acknowledges that consultation will happen with iwi. Consumer voices have been sought.
- The Chair sought feedback from members to endorse the voice of Te Roopu Tautoko and noted that there are other voices to come.
- K McClintock supported endorsement and noted that you can't move forward without data and statistics. IMC have the facility to provide that.
- M Balzer supports any research which provides the data that supports this kaupapa.
- P Taiaroa noted that we need to saturate all areas at all levels with the same korero so that it is noted.
- K McClintock noted that Te Pae Tawhiti roopu is made up of two of the biggest providers. Queried data from Ross and Derek and asked it applies to Waikato?

All members presented supported the endorsement of Te Roopu Tautoko ki Waikato as a Māori Mental Health and Addictions voice.

Kaituku Mōtini/Moved: K McClintock
Kaitautoko Mōtini Seconded: A Chase

ITEM 9 GOVERNANCE

UPDATE ON HOSPITAL ADVISORY COMMITTEE - Kahu McClintock

There were two main issues to be addressed:

1.) Forensics, some staff and in patients had an idea of moving them all to Waikeria with the big rebuild. Select committee had complaints about this. So no Henry Bennett patients will be transferred to Waikeria. WDHB were funding nursing positions at Waikeria Corrections Facility.
2.) Build of the HRBC – although there had been some input from various units, nothing came through the IMC. This is where we have high numbers of Māori people so Māori input must be sought both through IMC and KK.

UPDATE ON COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE – Te Pora Thompson-Evans

Noted that this meeting happens the week after the IMC meeting so information is lagging. Checking the public forum to view agenda and minutes can take place prior to the next IMC meeting. Any queries or comments can be raised with TP Thompson-Evans as she is the IMC representative on this Committee. Two main areas of note:

1.) Disability responsiveness plan – S&F was putting together a working group and will present to the committee next week.
2.) Health system plan –report on midwifery shortage and setting on community health forums.

ITEM 10 STRATEGY

- The three principals for HSP and Ki Te Taumata o Pae Ora to be discussed.

- T Ake suggested that the language used needs to be addressed in order to give strength to our purpose.
- Ethnicity Based KPI Reporting.

MOU Reporting Template

- Tables at joint meeting in May. No changes have been made and noted that the template will be presented in this form. but wanted noting that the template will come to you in this form.
- Provider contract KPI's have already started and are about to start on IEA's.
- T Ake noted that the Board report is starting to show progress. However it will be up to IMC to track progress and ensure MOU adhered to.
- TP Thompson-Evans noted that we are tracking along well in terms of meeting each our obligations under the MOU.

Kaituku Mōtini/Moved: T Ake
Kaitautoko Mōtini/Seconded: K Gosman

ITEM 11 TE PUNA ORANGA UPDATE REPORT

UPDATE PROGRESS REPORT:

- The change is going to happen in the DHB. It's not just IMC that are changing its every business unit.
- A workshop will be delivered to the Board around Institutional racism/unconscious bias.
- IMC Work Plan.
- K McClintock suggested that a recommendation for more strategic positions within the TPO team with additional resourcing required. So far the new strategic positions within TPO have made a huge difference.
- Māori workforce data will go through NGO's and the Tumuwhakarae and all Boards they have contact with. Are they being supported culturally? Do you have links across your region? Engagement with Iwi and Marae. This to be sent out be end June.

PRESENTATION OF RESULTS

- Where and how our consultation happens

ITEM 12 GENERAL BUSINESS

- There needs to be discussion again around why IMC are being omitted from discussions taking place around the hospital.
- P Taiaroa noted that Lung cancer research team referred her to IMC. There are 6 other pilot projects currently in action. DNA wanting to identify difference between rural and urban DNA. Text messaging doesn't work for rural and disadvantaged Māori often change their phone numbers often.
- P Mahood acknowledged C Brears recent honour as an Officer of the New Zealand Order of Merit (ONZM).
- In regard to submission of letter to the Ministry around Māori mental health and the 18th and 27th June consultation with them:
    - It was noted that early engagement with Māori has been poor as there has been little to no consultation.

- Submissions can be from organisations or Iwi.
- Submission was made by Rees Tapsell.
- Rural areas need a voice.
- IMC should look at systemic issues such as the incentive of becoming sicker before receiving help and no support given to whānau who are often primary carers.

ITEM 13 Hui Whakakapi: Meeting closed at 1.35pm

Next meeting held on: Thursday 5th July 2018

	Action List	Completed	Action by:
1.	Summary of HSC agenda for commentary for IMC.		Te Pora
2.	Submit letter to Ministry from IMC on Māori Mental Health. (18th and 27th for consultation).		Glen, Kahu, Harry
3.	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.		IMC
4.	Is there any data broken down by ethnicity around numbers of diabetes patients losing limbs or dying?		Janise
5.	Interests Register to be followed up and completed		Loraine / IMC

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Hospitals Advisory Committee Meeting Held on Wednesday 13 June 2018 Commencing at 8.30am

Present:
Ms S Christie (Chair)
Ms C Beavis (Deputy Chair)
Ms S Webb
Mr M Gallagher
Mrs MA Gill
Mr R Scott
Ms C Rankin

In Attendance:
Dr C Wade, Board member
Dr P Malpass, Consumer Council member
Dr G Howard, Interim Chief Operating Officer, Waikato Hospital
Ms L Aydon, Executive Director, Public and Organisational Affairs
Mr N Hablous, Executive Director, Office of the Chief Executive
Ms M Neville, Director, Quality & Patient Safety
Ms H McConnell, Director, Community and Clinical Support
Ms S Hayward, Chief Nursing and Midwifery Officer
Mr M ter Beek, Chief Data Officer
Ms B Garbutt, Director, Older Persons, Rehabilitation and Allied Health
Prof M Parsons, Gerontology
Mr G Guy, Manager, Disability Support Link, START and REACH
Mr L Wilson, Business Manager, Older Persons, Rehabilitation and Allied Health
Dr S Fowler, Clinical Unit Leader, Older Persons, Rehabilitation and Allied Health
Ms C Hartley, Nurse Director, Waikato Hospital

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

ITEM 1: APOLOGIES

Apologies were received from Mr D Macpherson and Dr K McClintock.

ITEM 2: INTRODUCTIONS

The Hospitals Advisory Committee (HAC) Chair welcomed and introduced the following people:

- Mr Ron Scott, new Hospital Advisory Committee member.
- Dr Paul Malpass, a member of the Consumer Council.

- Ms Hayley McConnell, Director of Community & Clinical Support.
- Ms Shona Pinny, PA to Dr Grant Howard and Minute Secretary.

The HAC Chair proposed sharing stories of living the values of the Waikato DHB at future Committee meetings and this was supported by the Committee. Ms C Beavis volunteered to bring a value story to next meeting.

ITEM 3: INTERESTS

3.1 Schedule of Interests

3.2 Conflicts Related to Items on the Agenda

No conflicts of interest.

ITEM 4: MINUTES AND MATTERS ARISING

4.1 Hospitals Advisory Committee Minutes: 11 April 2018

Resolved
THAT
The Hospitals Advisory Committee meeting minutes on 11 April 2018 are confirmed as true and correct.

The Committee requested an update on item 5.1, regarding the Waikeria Prison expansion.

The Committee acknowledged the work Mr M Spittal had done for the DHB and the Waikato region and wished him well for his new role in Australia.

4.2 Bay of Plenty DHB – Hospital Advisory Committee: 2 May 2018

Minutes were noted.

The presentation by Mr P Chandler on Adverse Child Experiences (ACEs) was noted as a highlight of the BOP Committee meeting.

4.3 Lakes DHB – Hospital Advisory Committee: 28 May 2018

Minutes were noted.

ITEM 5: QUALITY AND PATIENT SAFETY

5.1 Quality and Patient Safety report

Ms M Neville presented this agenda item.

- The committee received the report.
- Dr Clyde Wade raised the issue of increased standardized mortality rates (SMR) and requested feedback on progress to address these.

- Ms Neville reported the SMR had improved overall, and that in the recent past coding variances of the clinical record had been found to explain some of the variance.
- Work is being done around data accuracy as this relates to SMR and identification of issues, particularly drilling down to the service level performance for SMR.
- Four services have been invited to present to the Mortality committee on SMR and related outcome data.
- Ms Neville further raised the issue of clarity being required on the role of the Board of Clinical Governance (BoCG) and the relation between this body and the Board.
- The larger quality and safety environment in New Zealand was discussed in context, in particular the role of the Health Quality and Safety Commission (HQSC). A Workshop around governing for quality for Board and Executives is scheduled for 26 September 2018 in conjunction with the HSQC.

Resolved
THAT
The Committee received the report.

ITEM 6: SERVICES CHALLENGES

6.1 Waikato Hospital Services

Dr G Howard presented this agenda item.

- Dr Howard suggested in preamble that the HAC receive reporting rounds in turn from the Waikato Hospital, Mental Health and Addiction Services, and Community and Clinical Support.
- The Waikato Hospital Services report looked at data 10 years apart to provide a mid-to-long term overview of where we have come from and current challenges to be considered for future.
- Notable trends in the last five years include:
  - Growth in in-centre dialysis – greater than 60%
  - Growth in ED short stay episodes – approx. 50%
  - Little change in pregnancy related admissions.
- Committee members reiterated a concern with regard access to services and support to address factors leading to renal disease in rural and Maori and assurance was sought that the relevant issues were being considered and planned for. Dr Howard provided advice that the clinical service plan would cover these issues, and was underway.
- Dr Paul Malpass requested that consumer engagement be kept to the fore, and that a focus was placed on rural and Maori as at risk populations.
- The Committee sought advice on when the current trends would become unsustainable. Dr Howard suggested that we have already reached that point.
- Note was made of the need for the Board and staff to work closely together to develop a view of future service provision that would be sustainable.

Resolved
THAT
The Committee received the report.
The Committee agree to the meeting format of a focus on each of the three major parts of the health services as suggested in the preamble, with Mental Health and Addictions Service reporting to the HAC next.

6.2 Care Capacity Demand Management (CCDM)
Ms S Hayward presented this agenda item.

- The utilisation of the acuity tool Assignment Workload Manager (AWM) measures the workload of nurses and midwives, and outcomes will inform the appropriate hours per patient per patient day (HPPD) required for safe practice and care delivered.
- AWM is now in place in majority of wards with an expected completion date of rollout June 2019.
- An AWM exemplar report was provided across three areas / wards clearly indicated, by colours: red, amber or green, where workload was considered high, reasonable or deficient.
- Although the exemplar report showed results for three wards only, the majority of wards are in fact showing as red. Whilst these first reports are to be considered as preliminary, they should also be taken as consistent with feedback at ward level.
- Note was made that wards that are shown to be short of nursing resource using the AWM may be indicating a need to change the experience and skill mix, and/or the availability of other professional groups.
- At face value the AWM results suggest a further 50 FTE of nursing would be required at a present cost of approximately $4 million.
- This cost may well be offset by the liability currently being incurred with respect to annual leave being earned but not being able to be taken by nursing staff.

Resolved
THAT
The Committee received the report.

6.3 Improving the Lives of Older People in their last 1000 Days
Ms B Garbutt and Prof M Parsons presented this agenda item.

- Professor Parsons presented data on survival of people in the Waikato following a review by Disability Support Link (DSL) using tools such as the International Resident Assessment Instrument (Inter-RAI).
- Two issues were considered using the mortality of people following Inter-RAI assessment at various levels of frailty:

    - the ability to use this data to help people engage with advanced care planning processes in the community, and,
    - the development of a screening tool to be used to guide treatment discussions when a person presents to a hospital or other agent for acute care.
- The Committee discussed the issues and the need to coordinate where and how discussions with regard advanced care directives took place. At present the DHB has more than one approach, and caution was expressed with regard the ability of the primary care sector to facilitate more, and more intensive, discussions with families.
- At present only a very small percentage of patients attending the emergency department have advanced care plans in place.
- Mrs Barb Garbutt requested the support of the Committee to develop a business case for Board approval to address the approaches outlined in the presentation.

Resolved
THAT
The Committee received the report.
The Committee supports the development of a business case to proceed to the Board in principle.

6.4 KEEZZ Update

Dr Grant Howard presented this agenda item.

- The report was for information purposes, providing background to KEEZZ project, outcomes and performance to date, and intended as a lead in to the tour of the Surgical Operations Centre.

Surgical Operations Centre Tour notes:

- Committee members attended the surgical operations centre and were provided with an overview of the systems and practices being developed to provide an end-to-end view of each patient.

Resolved
THAT
The Committee received the report.

ITEM 8: NEXT MEETING: 8 August 2018

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Community and Public Health Advisory Committee held on 13 June 2018 commencing at 12.35pm

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

In Attendance:
Ms T Maloney, Executive Director, Strategy & Funding
Mr W Skipage, Strategy and Funding
Mrs MA Gill, Waikato DHB Board member
Mr M Gallagher, Waikato DHB Board member
Dr D Tomic, Clinical Director Primary and Integrated Care
Ms A Barnett, Consumer Council
Ms M Neville, Director Quality and Patient Safety

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

The Chair acknowledged Ms J Small, attending on behalf of the Consumer Council. A nominated representative from the Consumer Council will be part of the Community and Public Health Advisory Committee pending Waikato DHB Board approval of the nominee.

ITEM 1: APOLOGIES

Apologies from Ms S Mariu, and Mr F Mhlanga were received.

Resolved
THAT
The apologies were received.

ITEM 2: INTERESTS

2.1 Register of Interests
There were no changes made to the Interests register.

2.2 Conflicts Relating to Items on the Agenda
No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 3: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Ms MA Gill highlighted the Silver Economy presentation given at the Bay of Plenty DHB 4 April meeting regarding the value of the aged 65+ population on the economy. It was suggested it could fit well with the future Community and Public Health Advisory Committee update on aging and older people.

Clarification was sought by the Chair on the prudence of having an evergreen national pharmacy contract. Ms T Maloney confirmed that the old contract had been extended by three months to allow for further consultation on implementing an evergreen contract.

Resolved
THAT

1) The minutes of a meeting of the Waikato DHB Community and Public Health Advisory Committee held on 11 April 2018 be confirmed as a true and correct record.
2) The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 9 April and the Lakes DHB Disability Support advisory Committee held on 7 May 2018 be noted.
3) The minutes of a meeting of the Bay of Plenty DHB combined Community & Public Health Advisory Committee and Disability Advisory Service Committee held on 4 April 2018 be noted.

ITEM 4: DISABILITY SERVICES

4.1 Waikato DHB Disability Responsiveness Plan Terms of Reference

The Terms of Reference for the Waikato DHB Disability Responsiveness Plan were discussed by the Committee which included the following feedback/comments:

- The Disability Responsiveness Plan would be an enabler to the Health Systems Plan.
- Engagement had occurred with Consumer Council but would also occur with Iwi Māori Council.
- There is no “generic” type of person with disabilities; a Māori person with disabilities may have different needs to a non-Māori with disabilities. The Ministry of Health’s Maori Disability Action Plan (Whāia Te Ao Mārama 2018 to 2022) framework included whānau ora principles and may provide suggestions to consider plan development from a different perspective.
- Consideration to be given to including DHB employees in the scope.
- The framework should be aligned with what the disabled community were striving for.
- Confirmation to be sought regarding whether the Ministry was still undertaking a programme regarding intellectual disability, and if so the Disability Responsiveness Plan should be linked to it.

Resolved
THAT
The Committee approved the Terms of Reference pending modifications as outlined above, particularly with respect to alignment with Whāia Te Ao Mārama 2018 to 2022.

ITEM 5: WORKPLAN

5.1 Work Programme

Mr W Skipage attended for this item. An updated draft work plan which was now aligned with the strategic imperatives of the DHB was presented to the Committee.

It was emphasised that nutrition is a significant issue and requires strategic focus. It should be included in the Care in the Community Plan. It was noted that Public Health have developed a Nutrition and Activity Strategy. A copy of the Strategy would be circulated to members for their information.

The impact of diabetes and oral hygiene on health was highlighted. Members requested an update be provided within the Community and Public Health Advisory Committee workplan on current activities and the feasibility of producing strategies on these topics taking into account other areas of work currently underway.

At the request of the Committee, the progress update on the Care in the Community Plan scheduled for August would now be provided at the August Committee.

Resolved
THAT
The Committee noted the work programme for 2018.

ITEM 6: PAPERS FOR DECISION

6.1 Waikato DHB Tobacco Control Plan

Presented by Mr W Skippage, the Committee were provided with an overview of the Waikato DHB Tobacco Control Plan.

Points highlighted included:

- Acknowledgement that the census statistics used were five years old but were considered to be the most accurate data available.
- The importance of engaging directly with the community who fit the risk profile demographic and focusing the plan on feedback from these people.
- The need to obtain input from Māori providers who are successfully working in this area.

- An increased focus on reducing smoking initiation which may involve education.
- The need to focus the Plan on the groups who are at most risk; Māori and people with mental health and addiction issues.

Mr W Skippage agreed to confirm the number of staff recently recruited into this area who are Māori.

Resolved
THAT
The Waikato DHB Tobacco Control Plan be brought to the August Community and Public Health Committee meeting with details of initiation strategies and target groups.

ITEM 7: PAPERS FOR INFORMATION

7.1 Waikato DHB Annual Plan 2018/19

An update on the 2018/19 Annual Planning process was provided. The challenge of obtaining approval of Annual Plans and Statements of Performance Expectations mid-way through the respective year was highlighted. The Annual Plan Financial templates would be submitted separately at a later date.

Resolved
THAT
The Committee noted the paper

7.2 Health System Plan

Present by Mr D Wu, the Committee were provided with an update on the Health System Plan and the supporting Care in the Community Plan.

It was noted that the correct name of the Māori Health Strategy is Ki te Taumata o Pae Ora.

Resolved
THAT
The Committee noted the update on actions and timelines to develop a Health System Plan.

ITEM 8: PRESENTATIONS

8.1 Work Plan, and Priorities, Consumer Council

Ms A Barnett presented this item on behalf of Ms G Pomeroy and Ms Louise Were (Consumer Council co-chairs) who were unable to attend. An update on the Consumer Council progress on the development of its Draft Plan to Address Priority Issues was provided.

A copy of the presentation would be circulated to Committee members.

The Consumer Council provide updates to the Waikato DHB Board via the Waikato DHB Chief Executive, with the Co-chairs attending Board meetings as and when necessary.

Resolved
THAT
The Committee noted the presentation.

8.2 Community Engagement, Developing a DHB Approach

Presented by Mr W Skipage, a discussion was held on Waikato DHBs engagement approach.

Points highlighted included:

- Ensure that expectations of the purpose of engagement are clear; is it to inform or to empower to work together.
- Ensure engagement is with the right groups and should and should include the "hard to reach".
- Observance of Iwi Māori Council Memorandum of Understanding with respect to engagement and participation.
- Undertake "active listening"; listen for outside scope issues that could be used in other areas of work.
- Consider inviting and identifying champions who want to talk from different groups.
- Acknowledgement that a number of groups have engagement fatigue.

Resolved
THA
The Committee noted that their input will be incorporated into the development of a community engagement policy for Waikato DHB.

ITEM 9: GENERAL BUSINESS

There were no general business items raised.

ITEM 10: DATE OF NEXT MEETING

8 August 2018

Meeting finished at 2:40 pm

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Māori Strategic Committee held on Wednesday 20 May 2018 commencing at 10:00am in the Board Room, Hockin Building

Present:
Ms T Hodges (Chair)
Dr C Wade (Deputy Chair)
Ms S Christie
Ms T Thompson-Evans
Ms M Balzer
Mr D Macpherson
Mr G Tupuhi

In Attendance:
Mr D Wright
Ms L Elliott
Mr N Hablous
Mr H Curtis
Ms L Were
Ms N Te Ahu
Dr N Scott
Prof J Oetzel
Ms J Sewell (Minutes)

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Mr H Curtis.

Ms T Hodges welcomed all attendees, with particular acknowledgement of Ms L Were and Ms N Te Ahu from the Consumer Council Māori Caucus.

ITEM 2: APOLOGIES

Apologies were received from Ms T Moxon.

ITEM 3: MINUTES OF 16 MAY 2018

Action list noted as complete.

Amendments to minutes to correct spelling of Ms T Thompson-Evans, and to amend apologies by changing Mrs S Webb to Ms S Christie, and to also add Mr G Tupuhi as an apology.

Minutes moved and accepted with above amendments.

ITEM 4: ANNUAL REVIEW OF MSC

Ms T Hodges led the discussion for the annual review of Māori Strategic Committee and asked for general feedback regarding progress of Committee to date.

Summary of feedback included:

- General reflection that the Māori Strategic Committee is making traction with some good programmes in place working toward radical improvements in Māori health and in supporting Te Puna Oranga with work that needs to be actioned.
- There was also agreement that there is frustration that the discussions being undertaken within the Māori Strategic Committee are not being translated outside of the group and to the ground level of operations.
- It was acknowledged that at some point in the organisational process the translation is being blocked.
- That Te Puna Oranga need to continue with capacity building and be given the authority to drive change. This drive needs to come from senior strategic leadership which has already been identified in the Te Puna Oranga programme of work.
- That the processes in HR and across the organisation need to be proactive recruiting Māori and building capacity, which could have immediate impact.
- Why Ora was signalled as one tool that will be implemented to address Māori capacity, but is a long term strategy.
- That the Māori Strategic Committee to have the reputation for getting things done.
- That all papers presented to the Board must demonstrate radical improvements in Māori health by eliminating health inequities for Māori, otherwise they shouldn't be tabled.
- To identify how the structure of Māori Strategic Committee aligns to the Hospital Advisory Committee and the Community & Public Health Advisory Committee.
- Significant impact to radical improvements in Māori health can be made by making changes to business as usual processes (such as DNA).
- Māori Strategic Committee have the responsibility to drive radical improvements in Māori health and need to influence how the paradigm can be shifted to influence the wider system.
- That the Māori Strategic Committee make clear actions to Board and executive work and uses their collective influence for transformative change.

Mr C Wade arrived at 10.14am

Resolved
THAT

1) The frequency of monthly meetings is reflective of the current need in the scope of the current strategic work taking place within the organisation with the view to review the frequency in six months.
2) Terms of reference updates will be circulated as an electronic document through the Committee for presentation and approval at the next Committee meeting.
3) Recommendation to the Waikato DHB Board that all papers presented to the Board must demonstrate how it achieves radical improvements in Māori health by eliminating health inequities for Māori.

ITEM 5: MSC UPDATES

Ms L Elliot provided a progress update on this standard agenda item.

5.1. Ki te Taumata o Pae Ora Update

Ms T Hodges asked for the background regarding the name "Ki te Taumata o Pae Ora". The whakapapa was provided from the previous Te Puna Oranga strategic plan and also the link the Waikato DHB Māori Health Policy and Te Korowai Oranga the national Māori health strategy.

Advisory Groups
It was suggested to consider how the advisory groups fit in the bigger picture and how they are feeding back. It was suggested that the advisory groups have a relationship with the Iwi Māori Council as a support base.

Resolved
THAT

The current progress of Ki te Taumata o Pae Ora was noted.

5.2. Health System Plan Update

Resolved
THAT

The current progress of Health System Plan was noted.

5.3. Equity Focused Reporting Update

The focus of this report was the DNA deep dive. It was discussed that DNA is an ongoing piece of work included in Te Puna Oranga's programme of work. Current capacity needs within the organisation to be reorganised and prioritised to address the DNAs.

Discussion amongst the Committee acknowledged that there are many areas within the system that offer opportunities for DNA to be addressed. Dr C Wade presented a white board representation the DNA system breakdown and identified that DNA is an area which can be radically improved. It was also discussed that something needs to happen now, and previously commitment had already been made within the Committee to address this issue. Dr C Wade and Ms T Thompson-Evans have offered to assist with getting feedback from service users and those that did not attend.

Action
Ms L Elliott and Mr D Wright will identify an approach to target the DNA issues and present at the next Māori Strategic Committee meeting.

Resolved
THAT

The Māori Strategic Committee received the report.

5.4. Programme of Work Update

Resolved
THAT

The programme of work update was noted.

ITEM 6: HE PIKINGA WAIORA

Prof J Oetzel and Dr N Scott presented an overview of the He Pikinga Waiora framework (see presentation attached). Discussion developed regarding the use of the tool in the organisation capacity as opposed to a community research capacity where is currently being utilised.

The Committee saw great potential in the tool as an overall generic framework that could be modified for specific work scopes, especially for the Care in the Community Plan.

Action

1. That Te Puna Oranga consider
    a. How He Pikinga Waiora can be implemented and actioned within Waikato DHB.
    b. Identify the steps for implementation.
2. That Dr N Scott present to Iwi Māori Council with a view of testing the tool with Iwi.
3. That Dr N Scott liaises with the Consumer Council Māori Caucus for presentation of this tool to their group for the equity focused work programmes they are currently undertaking.
4. That is any groups interested in using He Pikinga Waiora can contact Dr N Scott.

Resolved
THAT

The Māori Strategic committee receives this information.

ITEM 7: GENERAL BUSINESS

There was no general business.

ITEM 8: DATE OF NEXT MEETING

Wednesday 18 July 2018

ITEM 9: KARAKIA WHAKAMUTUNGA

Karakia whakamutanga by Mr H Curtis.

Chairperson: _____

Date: _____

Meeting closed at 11:47 am.

ACTION POINTS

	Action List	Completed	Who
1.	Agenda Item 4: Terms of reference updates will be circulated as an electronic document through the Committee for presentation and approval at the next Committee meeting		Ms L Elliott
2.	Agenda Item 5.3: Identify an approach to target the DNA issues and present at the next Māori Strategic Committee meeting.		Ms L Elliott Mr D Wright
3.	Agenda Item 6: 1. That Te Puna Oranga consider: a. How He Pikinga Waiora can be implemented and actioned within Waikato DHB. b. Identify the steps for implementation.		Ms L Elliott
	1. That Dr N Scott present to Iwi Māori Council with a view of testing the tool with Iwi. 2. That Dr N Scott liaises with the Consumer Council Māori Caucus for presentation of this tool to their group for equity focused work programmes they are currently undertaking. 3. That is any groups interested in using He Pikinga Waiora can contact Dr N Scott.		Dr N Scott

National SCIENCE Challenges

Healthier Lives for all New Zealanders

HEALTHIER LIVES

He Oranga Hauora

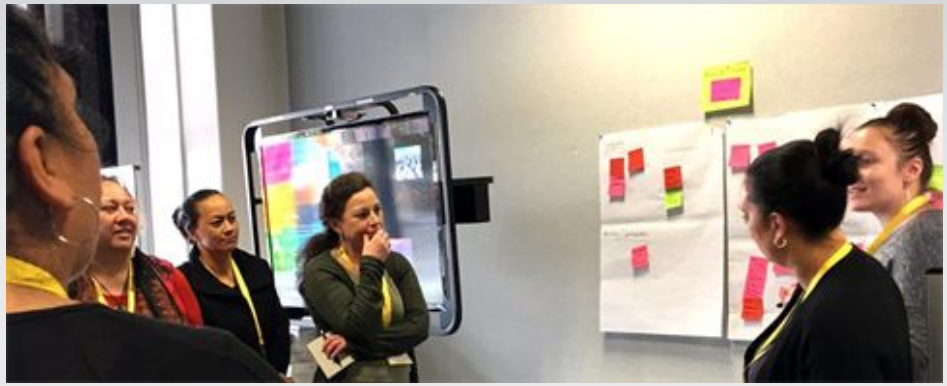
He Pikinga Waiora Implementation Framework

Strategies for Enactment and Evaluation

Dr Nina Scott, Prof John Oetzel, Dr Bridgette Masters-Awatere, Moana Rarere,
Dr Jeff Foote, Dr Angela Beaton

Implementation guide for radically improving Māori health

HE PIKINGA WAIORA



- It emphasises the importance of engaging with communities and end users (and evaluating that engagement) for implementation effectiveness
- It is Kaupapa Māori centred and evidence based

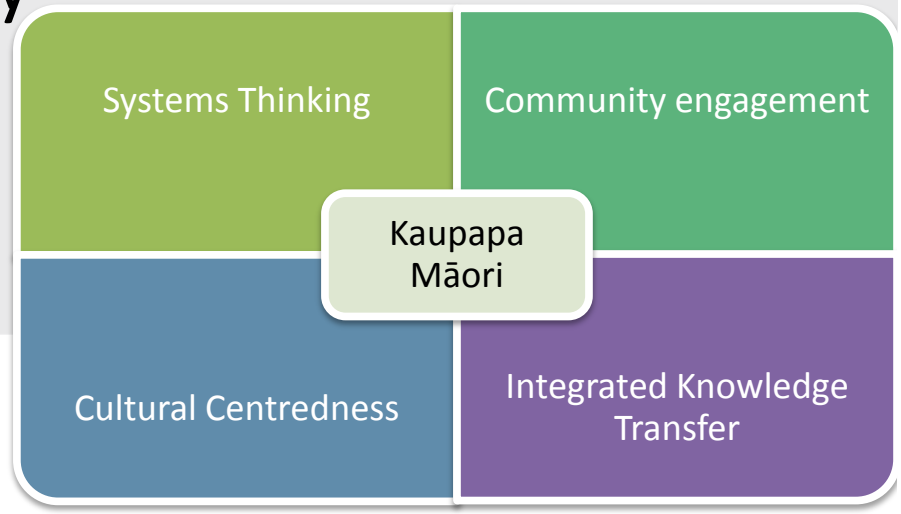
National SCIENCE Challenges

Indigenous Implementation Science

HEALTHIER LIVES

He Oranga Hauora

- Creating best practice models for working with Māori communities so that effective interventions are developed and then implemented successfully



HE PIKINGA WAIORA IMPLEMENTATION FRAMEWORK

CULTURAL - CENTEREDNESS

Ko tōku reo, tōku ohooho,
Ko tōku reo, tōku Māpihi Maurea

Community voice

Community is involved in defining the problem and developing the solution.

Reflexivity

Implementation team is reflexive and identifies adjustments to the intervention as a result.

Structural transformation and resources

The intervention results in significant structural transformation and resources which are sustainable over time.

COMMUNITY ENGAGEMENT

He urunga tangata he urunga pāhekeheke,
he urunga oneone mau tonu

Partnering between researchers and community members/ organizations in all phases of the project. Guided by principles of action, social justice, and power sharing.

Decision-making and communication is shared and a strong partnership is identified throughout the intervention process. Relationships build capacity of communities and researchers.

KAUPAPA MĀORI

He oranga ngakau, he pikinga waiora

The Framework has indigenous self-determination at its core. All four elements have conceptual fit with Kaupapa Māori aspirations and all have demonstrated evidence of positive implementation outcomes.

A coding scheme derived from the Framework was applied to 13 studies of diabetes prevention in indigenous communities in Australia, Canada, New Zealand, and the United States. Cross-tabulations demonstrated that cultural centeredness (p=.008) and community engagement (p=.009) explained differences in diabetes outcomes and community engagement (p=.098) explained difference in blood pressure outcomes.

The Framework is intended as a planning tool to guide the successful development and implementation of interventions. Funders can use the Framework to assess the likely effectiveness of proposed interventions. Community organizations can use the Framework to work with researchers or policy makers to strengthen each of the four elements.

Please let us know how you are using the Framework and any feedback you may have:
hpwadmin@waikato.ac.nz

HEALTHIER LIVES | He Oranga Hauora | National SCIENCE Challenges

SYSTEMS THINKING

He tina ki runga, he tāmore ki raro

Systems perspectives

Intervention considers multiple perspectives, world views, and values. It considers multiple causes, has a broad focus and offers multiple solutions.

System relationships

Demonstrates strong understanding of the complex relationships between variables including feedback loops, time delays and multi-level effects.

Systems levels

Intervention targets change at the macro, meso and micro levels.

INTEGRATED KNOWLEDGE TRANSLATION

Toi te kupu, toi te mana, toi te whenua

Integration of knowledge translation activities within the context of the community in which the knowledge is to be applied.

There is a process of bi-directional learning established so that information is tailored to knowledge users needs.

Kōrero Tahi October 2016

HE PIKINGA WAIORA IMPLEMENTATION FRAMEWORK

	Variable	High	Medium	Low	Negative
Cultural Centeredness	Community voice How groups, that the intervention is focused on are involved in defining the problem and solutions.	Community involved in defining the problem and developing the solution.	Community involved in either defining the problem or developing the solution.	Community only informed but has no direct involvement in the definition of problem or solution development.	Intervention implemented in the face of significant community opposition.
	Reflexivity How the power and privilege of the researcher, relative to the community, is recognised and dealt with.	The implementation team explicitly states their reflexivity and identifies adjustments to the intervention as a result.	The implementation team identifies efforts to engage in reflexivity or states they were aware of it; adjustments to the intervention are unclear.	No evidence that the team was reflexive about its processes or no changes made in response to team learnings.	Victim blaming, unintended bias or overt racism in intervention design, implementation or evaluation.
	Structural transformation and resources How much the system is improved to better fit community needs.	Significant structural transformation and resources which are sustainable over time.	Intervention receives significant resources but has a limited focus on structural transformation.	Intervention receives minimal resources and is only sustainable over a short term.	Less resources available or lower quality resources as a result of the intervention compared with no intervention.
Community Engagement	**Community engagement** The level of involvement, impact, trust and communication with community members.	Strong community or bi-directional leadership. Decision-making and communication is shared and strong partnership is identified throughout the intervention process.	Communication is two-way and there is co-operation to implement the intervention with a partnership becoming apparent.	Communication primarily flows from intervention team to community and the intervention team has ultimate control over the intervention and relevant communication.	Intervention is placed in the community with no consultation with community organizations or stakeholders responsible for implementation.
IKT	**Integrated knowledge translation** How involved the people delivering the intervention (knowledge users) are in designing the intervention.	There is a process of mutual or bi-directional learning established so that information is tailored to knowledge users needs.	Medium level support for knowledge user by intervention team for implementing the intervention. Intervention is not tailored to the knowledge user.	Minimal or no support for implementing intervention or outsiders implement the intervention for the knowledge users.	Knowledge users have major concerns which they are not able to discuss with the intervention team.
Systems Thinking	System perspectives How much the team show they understand that there are multiple ways of viewing issues and solutions.	Intervention includes all three of the following: 1) multiple causes, 2) broad focus/multiple solutions; and 3) multiple perspectives, world views, and values of multiple actors.	Intervention includes only 2 of the 3 factors in the high category.	Intervention includes only 1 or none of the 3 factors in the high category.	Intervention has a negative impact due to a lack of consideration of multiple perspectives necessary to support implementation.
	System relationships The degree that relationships between variables/factors are prioritised.	Demonstrates a strong understanding of the complex relationships between variables including feedback loops, time delays and multi-level effects.	Demonstrates moderate understanding of the complex relationships between variables including feedback loops, time delays and multi-level effects.	Limited or weak understanding of the complex relationships between variables including feedback loops, time delays and multi-level effects.	Intervention has a negative impact due to lack of consideration of system relationships important for implementation.
	System levels The degree to which different levels of analysis are taken into account.	The intervention targets change at the macro, meso and micro levels, and provides sufficient rationale and context for each level.	The intervention targets change at 2 levels with some rationale and context for each level.	The intervention targets change at 2 levels or less without providing rationale and context.	Intervention has a negative impact due to lack of consideration of systems levels necessary to support implementation.

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Kaupapa Māori

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He Oranga Hauora

- Emphasises local context and self-determination by prioritizing indigenous history, development, and aspirations

- Key issues:
  a) Address unequal power
  b) Reaffirm tikanga and mātauranga
  c) Promote greater participation

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Kaupapa Māori Testimonial

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Culture Centredness

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He Oranga Hauora

- Ensuring community and cultural perspectives are reflected in implementation

- Key issues:
  a) Community voice
  b) Structural and resource changes
  c) Regular reflexivity

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Community Engagement

HEALTHIER LIVES

He Oranga Hauora

- Ensuring community members are partners in the development and implementation of the intervention (all phases)

- Key issues:
  a) Community approval
  b) Sharing resources and decision-making
  c) Community representation

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Culture Centredness Testimonial

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Community Engagement Testimonial

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Integrated Knowledge Translation

- **Knowledge users** – *people who can use the research results to make changes at a policy, programme or practice level*

- Identify a range early on
- Develop collaborative relationships
- Work in partnership throughout research process
- Plan knowledge exchange activities together and revisit continually
- Information tailored to knowledge users needs
- Evaluate IKT

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IKT Testimonial

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Systems Thinking

HEALTHIER LIVES

He Oranga Hauora

- Systems thinking is a way to consider the problems that involves multiple perspectives, multiple levels and relationships

e.g. Kai Pai Kai Tokoroa – supply chain

- Key Issues
  a) Engage with diverse perspectives
  b) Build up a 'rich picture'
  c) Reflect on the different understandings
  d) Identify key issues for stakeholders

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Systems Thinking Testimonial

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Visioning Tool

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He Oranga Hauora

- Reflect and fill in the Visioning Tool individually
- Meet with partners and reflect on similarities and differences
- Plan next steps together
- After a period of time review processes together to see if you are following intentions

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Visioning Testimonial

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Evaluation following the Framework

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- Process Evaluation
  - Process evaluation tool
  - Stakeholder hui evaluation
- Summative Evaluation

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Process Evaluation

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He Oranga Hauora

- Enhances reflexivity and staying true to guiding principles

- Tools
  - Stakeholder hui evaluation
  - Survey/open-ended questions

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Summative Evaluation

HEALTHIER LIVES

He Oranga Hauora

- Outcome evaluation framework
  - Selecting outcomes measures appropriate for the research aims
  - Multi-level measures
  - Implementation measures

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Key Messages

HEALTHIER LIVES

He Oranga Hauora

- HPW Framework is effective for implementation; there is a rich evidence base supporting it
- Sustainability and reach of research will be enhanced with HPW framework
- How you do implementation is just as important as what you do

Kia ora and thank you from us

The He Pikinga Waiora team

Chief Executive Report

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

Proposed Medical School

There is no further update on the third Medical School other than an indication that the Government will not make any decision on this until later in 2019.

Darrin Hackett

With the DHB ceasing the work with HealthTap, the position of Executive Director Virtual Care and Innovation, is no longer required. I have made this position redundant and Darrin will leave the DHB at the end of June.

I want to thank Darrin for all the work he did in what proved to be a very difficult project.

Board Training and Workshops

There are a number of training and workshop sessions scheduled for Board members for the balance of this year which are listed below.

Care in the Community – direction setting workshop

As part of the development of the DHB's Care in the Community plan a direction setting workshop will be held for the Board, Iwi Maori Council, DHB staff and other stakeholders in July. This workshop will be facilitated by Ernst & Young.

The proposed workshop date is Wednesday 25 July, 9am to 12pm. My personal assistant will make contact with Board members to ascertain their availability.

Health Quality and Safety Commission: Clinical Governance Workshop for Board members

The focus of this workshop is on the Boards role in quality improvement and patient safety. It will cover what informed Boards should receive from the management team to help them understand if their DHBs services are safe and improving.

It is important Board members attend because the Board members / you have suggested at recent meetings that they do not feel they receive the right information to be assured of the safety or quality of the all the services provided / contracted by the DHB. There have also been recent conversations around capability and capacity for quality improvement and how the Board might better support this.

The workshop will be facilitated by Gillian Bohm and Iwona Stolarek from the Health Quality Safety Commission

Duration of this workshop is 2.5 hours and is scheduled from 9.30am to 12pm on Wednesday 26 September 2018. A calendar invite will be sent to Board members.

DHB Executives will also be in attendance.

Te Tiriti O Waitangi, and Tikanga Best Practice and Powhiri Training

This matter was raised in my last report to the Board and I can advise that training has been scheduled for 6 September 2018 and will be held at Turangawaewae Marae. Iwi Maori Council members and DHB Executives will be invited to attend.

Midland DHB Board Development Days

Advice has been received that the Midland DHB Board Development Days have been scheduled for 6 and 7 December 2018 and will be held in Tauranga. Initial planning is underway. A calendar invite will be sent to Board members.

Culture, Promoting Professional Accountability and Cognitive Institute

We had planned for the Cognitive Institute to facilitate sessions with the Board and DHB staff on 4 and 5 July, however it was decided to reschedule these to a later date given the impending strike action. We have been working with the Cognitive Institute to secure new dates and are now looking at the facilitated sessions being held in February 2019. This will also ensure that the new Chief Medical Officer, Chief Advisor Allied Health Scientific and Technical and Executive Director for Human Resources and Organisational Development are in place.

Further details will be sent to Board members in due course.

Why Ora Business Case

On this agenda is a proposal for the Board to fund Why Ora. The timing of this proposal is unusual in that we have not yet completed the prioritisation of new initiatives for 2018/19 either as an Executive or between the Executive and Board and on first principles it is preferable for proposals to be weighed up against each other rather than considered in isolation. By submitted the proposal on its own, I am therefore not providing the context you would normally expect.

The reason I have made an exception in this case is because of the clear message from the last Board meeting that the Board expects the Executive to recognise our highest priority early in putting together the budget. Moreover myself and the Executive generally are well aware that inequity is objectively one of our greatest challenges.

If the Board supports this proposal it would be helpful if it could make clear whether it is supporting it subject to wider consideration of the budget and priorities within it, including other Maori Health gain priority initiatives, or whether it wishes the proposal to be considered “firm” for the 2018/19 year.

Annual Planning meeting with Ministry of Health

Last week we had a very constructive meeting with senior staff from the Ministry of Health. This meeting included Sally Webb, Maureen Chrystall and Tanya Maloney. The newly appointed Director General of Health was also present. The Ministry are meeting with all twenty DHBs to better understand the issues DHBs are facing and also the demand pressures currently being experienced by services.

This meeting demonstrated a "new way "of working together between DHBs and the Ministry.

Fieldays

Waikato DHB was prominent in this year's Fieldays Health Hub with DHB staff from Cardiology, Critical Care & Mental Health. We also had staff present at the Rural Doctors stand, so a good showing from the DHB.

Staff really appreciated the support they received from the Board members, Clyde was there as part of the team and Mary-Anne popped in to say hello and lend support, not sure if any of the other Board members were there, so apologies if you were and I missed your name off.

The Fieldays were good positive exposure for the DHB and we already have a number of services expressing an interest in being involved in next year's Fieldays.

NZ Nurses Organisation Strike

On 20 June 2018 we received a letter from NZNO advising us of their member's intention to take strike action from 7am on Thursday 5 July until 7am on Friday 6 July. It is expected that we will receive a further strike notice for 12 July.

We are moving to mediation/facilitation but in the meantime our contingency planning is progressing.

Health Volunteer of the Year

Congratulations to Kim Gosman (Iwi Maori Council member representing Ngati Tuwharetoa) on receiving the 2018 Health Volunteer of the Year Award and Individual Maori Volunteer of the Year Award.

Kim has been involved in voluntary work in the health sector since 1974, initially in Porirua and then in Turangi. Over that time she has been a strong advocate and voice of the health and wellbeing of people within her community, at both a governance and clinical level.

Originally from a nursing background, her voluntary work has included maternity services, marae-based ear health clinics, and extended and improved development of a wide range of health services. She is described by Lakes District Health Board as being a champion of improving Māori health outcomes and reducing inequalities.

Observations from 2016/17 Central Government Audits

A letter from the Office of the Auditor General setting out their observations of common issues and noteworthy practice from their 2016/17 annual audits is attached for Board members' information.

Recommendation
THAT
The Board receives this report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

OFFICE OF THE AUDITOR-GENERAL
Te Mana Arotake

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PO Box 3928, Wellington 6140, New Zealand

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Website: www.oag.govt.nz

16 May 2018

Tēnā koe

OBSERVATIONS FROM OUR 2016/17 CENTRAL GOVERNMENT AUDITS

I am writing to you and all other chief executives of government departments and Crown entities to share some observations on common issues and noteworthy practice from our 2016/17 annual audits.

As you know, the public sector environment is rapidly changing, including changes in public expectations and technology. There is also a stronger focus on cross-sector outcomes. Doing the basics well in this fast-paced and changing environment is challenging. Our audits indicate that, collectively, chief executives have done a good job maintaining a high standard of public sector management. However, there are some matters that need attention.

The fundamentals are working well

Most central government entities continue to have sound management and financial control environments. Our auditors reported, overall, that entities are better prepared than previous years and provided information on time for audit.

However, there are aspects that some entities need to focus more on:

- Strategic financial management remains one of the bigger challenges. We encourage entities to share their practice and, where possible, work together to improve capability.
- Staff who use the financial system in your organisation, particularly those holding financial and operating delegations, need a clear understanding of their entity's internal control framework, including their roles and responsibilities.
- New entities, or entities that take on new functions, need to make financial management integral, rather than considering it as an afterthought. There were instances where entities realised this too late with functions or assets that they took on.
- Throughout the public sector, there are still significant challenges related to resolving historical holiday pay issues. Although we accepted entities recording contingent liabilities when the holiday pay obligation could not be reliably measured, it would be preferable if entities could quickly bring this issue to a conclusion.
- We recommend that entities have a system that enables transparent and reliable reporting on a day-to-day basis, supported by a process of checking for exceptions by experts. Our auditors noted that some independent reviews of financial transactions were handled too casually, not done, done manually, or not documented in a timely fashion.
- Supporting documentation for journals needs improvement and we encourage entities to have processes in place to ensure that all journals are appropriately supported. Journals are at risk of manipulation because they can be used to mask other transactions.
- Reconciliations of important control accounts are not being universally done well, which makes budget monitoring more challenging.
- Revenue recognition caused difficulties for several entities. In some instances, this was related to externally funded projects.

Information communications technology presents risks

Information Communications Technology (ICT) deserves a special mention, in part because our auditors continue to find basic issues, but also because of the growing seriousness of ICT-related risks and their potentially pervasive adverse impact. Our auditors found that entities have a greater awareness of cyber security and fraud access issues and have generally improved their practices. However, on the whole, entities would benefit from enhanced controls when it comes to preventing Information Technology (IT) fraud and mitigating risks of business interruption.

Some entities rely too much on contractors to manage ICT risks. Using external expertise should support internal capability, not replace it. Entities are still accountable for the risks. We suggest that entities spend time and resources on identifying their highest ICT risks. Some of this might require detailed work, for example, conducting an independent review of all virus signature updates.

Governance is generally sound

Many entities have appropriate governance arrangements, and the benefits are apparent in day-to-day operational oversight, reporting, and risk management. Significant change projects have also run well in part because of strong governance arrangements.

Good governance for large projects enables better oversight

Robust governance processes help ensure oversight at the main stages of project delivery. This includes the complicated area of IT project management. An appropriate governance setup might include an investment board, external risk and assurance committee, a focus on integrating risk management in the investment portfolio, and developing benefits reporting.

Managing change

Even when significant organisational changes were being implemented, our auditors found that most entities managed the immediate transition well. Financial and general IT controls that we rely on for our audit work continued to operate during the organisational changes. The long-term challenge is benefits realisation. We are less certain about whether entities are always clear about what they want to achieve and are appropriately measuring benefits.

Below we make some observations on good practice in managing change:

- Entities need to have a good understanding of the risks that changes could present to the control environment and ensure that there are effective control and assurance measures in place to prevent and detect unauthorised or inappropriate activity. This applies particularly if there is significant change to staff roles and the operating culture.
- When core corporate teams (Finance, Human Resources, and Risk Assurance) are heavily affected by organisational changes, entities need to be aware of the particular risks that come from this, including the loss of critical institutional and financial knowledge.
- Taking a staged approach to managing change can help manage the risks inherent in delivering complex programmes compared to implementing change all at once.
- When restructuring is likely to result in liabilities, entities need to remain alert to the threshold for recognition of a liability being met, because this matter is likely to have implications for financial reporting in future periods.
- Entities need to be aware of the need to have sound processes for severance payments.

Performance reporting

Effective performance reporting has become a more complex task in an environment where organisations are seeking to achieve sector and system outcomes with other agencies. We are seeing some good examples of individual performance frameworks, but a lot more remains to be done to report effectively on outcomes achieved by more than one entity.

Below we make some observations on good practice in performance reporting:

- Performance reporting needs to align with the main strategies, and work is needed to improve the links between strategic priorities and measures of success.
- Entities should identify the main measures that reflect their overarching focus and objectives. If it is not clear to the reader what service an entity delivers, then important information is missing.
- Good performance reporting often needs to draw on a combination of data, case studies, and commentary integrated in the performance story.
- External measures and measures used for management decision-making should align.
- There needs to be an appropriate balance of timeliness, quantity, quality and, where appropriate, cost effectiveness measures.
- Sophisticated performance reporting provides trends over time and uses well calibrated benchmarks for performance, where possible drawing on comparator entities.
- Compiling a data dictionary can help entities understand if measures are fit for purpose.
- If your performance measures rely on third-party information, ensure that the information is independently verified and appropriate controls are in place.

Asset valuations

We have concerns about some entities' asset valuation practices. These concerns are less about actual control deficiencies and more about entities' substantive assessment of what they own and look after. Valuations are important for some entities because of the size of the asset, which feeds into the Crown's balance sheet.

Even for entities without significant asset valuation issues, there are some general lessons that might usefully be applied to other functional aspects:

- The quality of information matters.
- Data collected needs to be suitable for the purpose it is collected.
- Methodologies are important for assessing condition, planning maintenance, and expenditure.
- Maintain ownership. You might contract out an activity such as asset valuations, but you are still accountable. We suggest that you mitigate the risk by keeping in touch with the contractor to ensure the resulting valuation reflects the environment in which you are operating.
- Maintain organisational oversight, consider an analytical review of main assets, and explain significant movements or lack of expected movements. This will help identify potential errors.
- If there is a time-lapse between asset valuations, we suggest entities analyse where values may have moved significantly and whether this could be material.

Procurement – reflecting on current strengths and what might still need attention

Our Office proposes to start a multi-year work programme on procurement in 2018/19. Our 2016/17 audits confirmed that entities generally follow appropriate procurement and contracting practices and have adequate processes for doing so. However, we are less certain that procurement is well embedded in entities' strategic planning. For our future work programme, we intend to focus more on how entities' decisions reflect their strategic direction. We will also look at whether entities are clear about the benefits sought, well placed to monitor and report on benefits realisation, and making any needed changes to procurement arrangements.

We are aware of the changes in delivery models. Some entities have expanded their capability, including using private sector expertise so they can have more effective relationships with partners from the private sector and non-governmental organisations. However, recruiting staff who are new to the public sector poses challenges. We encourage entities to put in place thorough induction processes and ongoing support for these staff to ensure that private expertise can be harnessed effectively.

Below we list some of the foundations for effective procurement:

- Robust governance, independent assurance, and monitoring. There is a strong relationship between good governance, project management, and ability to conduct procurement effectively.
- Pre-tender market engagement that is commensurate with the complexity and risks of the envisaged commissioning.
- An overriding framework, supported by guidelines, which allows all the parties to procurement contracts to measure their performance consistently and accurately.
- Initiatives to build internal capability, such as undertaking procurement "health checks" throughout the organisation and creating a "community" of people who are regularly involved in procurement to analyse and learn from their practices.
- For complex procurement cases, preparing for possible outcomes and test whether the evaluation process and criteria are indeed suitable for securing desirable outcomes.

We have emphasised in the past our expectation to see procurement expertise embedded throughout entities as part of a core skill set. This will allow specialists to focus on difficult or highly technical cases. It is also becoming more important to have commercial and technical expertise on decision-making panels for large projects, especially for ICT infrastructure.

Grants

Because there is no specific accounting standard for grant accounting, policies have been prepared using other accounting standards and liability definition and recognition principles. This has resulted in different accounting practices for similar grant arrangements in the public sector. We acknowledge the challenges this has posed, but we encourage public entities to improve their management of grants. When grants are seen as not constituting procurement, they are often not treated with the same rigour, yet there are often significant amounts of money involved. Two main deficiencies we have found relate to:

- a lack of clear policies and guidance for grant activity; and
- failure to exercise an overview across different operating functions.

Please stay in touch

I encourage you to discuss this letter with your appointed auditor. I would also welcome dialogue with our Office. I suggest you contact the relevant sector manager in the first instance.

Nāku noa, nā

Greg Schollum
Deputy Controller and Auditor-General

Quality and Patient Safety

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 5.1

QUALITY AND PATIENT SAFETY REPORT

Purpose	For information.

This paper outlines to the Board elements of quality performance for the DHB. Of particular note this month is the launch of the new national dashboard (from the Health Quality Safety Commission) which includes wider measures of quality (rather than adult inpatient focused) – there will be additional indicators added in August.

Recommendation
THAT
The report be received.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

Quality and Patient Safety report – June 2018

1. Quality indicators

Work continues to increase the use of the health round table (HRT) data and the business support unit have committed to reporting the key safety markers within HRT monthly to the Board of Clinical Governance monthly.

Indicator	Tolerance per Month	February	April	May
HDSMR (mortality)	<100	Amber (108)	Amber (109)	Amber (105)
Attributable Grade 3 & 4 Pressure Ulcers	Zero	Green (0)	Green (0)	Green (0)
Patients with a fractured hip as a result of a fall	<2	Green (0)	Green (0)	Green (0)
Staph Aureus Bacteraemia (SAB) per 1000 bed days	< 0.1	Red (0.2%)	Amber (0.1%)	Amber (0.1%)
Complaints (responded to within 20 working days)	70%	Amber (64%)	Amber (67%)	Amber (66%)
National Patient Survey response	> 30%	n/a	Green (40%)	n/a
Policy / guideline compliance	> 95%	Red (73%)	Red (71%)	Red (68%)
Always report event (previously known as never events)	Zero	Red (1)	Green (0)	Green (0)
Hand hygiene	> 85%	Green (85.2%)	Green (89%)	Amber (84%)

2. Policy and guideline currency - a stubborn red

A key requirement of surveillance and certification audit standards is to have up to date policies and guidelines – we are not achieving this and have a further corrective action following the surveillance audit. As at the end of May 2018 our compliance was worsening –

Waikato DHB Wide

Document Type	Currency	Number
Policies	76%	104/137
Guidelines	71%	22/31
Procedures	85%	53/62
Protocols	98%	44/45
Total	**81%**	**223/275**

Drug Documents

Document Type	Currency	Number
Drug Guidelines	62%	46/74
Standing Orders	52%	36/69
Total	**57%**	**82/143**

Clinical Management

Business Area	Currency	Number
Community and Clinical Support	82%	386/470
Medicine and Oncology	50%	217/437
Mental Health and Addictions	82%	37/45
Older Persons and Allied Health	98%	91/93

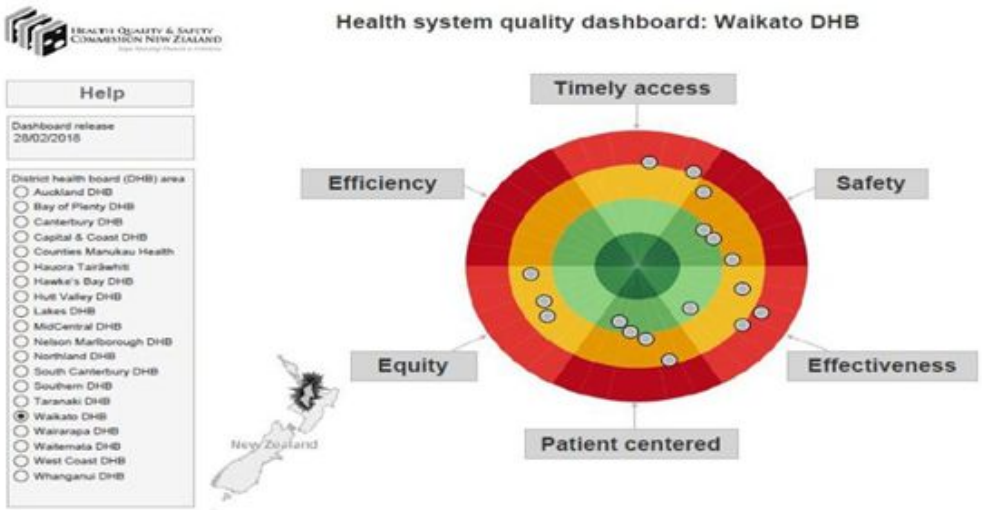
Surgery, Critical Care	59%	192/328	
Women's and Children's Health	64%	145/244	
Other*	83%	15/18	
Total	**67%**	**1093/1635**	

Action:
- Executive Directors have been asked to review ownership, need, and duplication etc. of the corporate policies by end of June
- Paper to BoCG June, to agree new endorsement process for clinical policies and guidelines
- Directors have been targeted in the areas where compliance is poor to develop actions to improve performance – these will be monitored through BoCG

3.0 National Dashboard (HQSC)

This new dashboard went live at the end of May 2018 and is available on our DHB website. Additional indicators will be available in August. https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-dashboards/dashboard-of-health-system-quality The May dashboard shows Waikato has work to do across a number of indicators if it is to be 'better than the national average' particularly around effectiveness / equity

- ASH rates 0-4 year old admissions per 100,000 population / upper ENT and respiratory admissions
- Acute hospital bed days per 1000 population
- Age standardised amendable mortality
- Gout and allopurinol dispensed Maori / European



4.0 National quality and safety marker (QSM) report

No report this month – due publication nationally 29 June 2018

5.0 Health and Disability Complaints (HDC)

Learning from others – none identified this month

Local activity

100% of complaints were responded to on time during this month.

During April, there was one breach decision. The breach concerns a doctor. HDC did not find Waikato DHB in breach. Other decisions and recommendations are in the table below –

Department/s	**Complaint Summary** (this is a summary of the complaint from the patient or complainant's perspective)	**HDC Decision & Recommendations**
C4TV	Concerns raised by complainant's husband about follow up care and communication.	No further action.
Transit Lounge	Complaint relates to care of late uncle at Waikato Hospital. Waikato DHB to reply directly to complainant.	No further follow-up is required.
Respiratory	Complainant is concerned about the mental health symptoms suffered as a result of the effects of medication.	No further action.
Women's	Complicated labour and haemorrhaging after surgery resulting in hysterectomy.	No further action.
Women's	In April 2018, the Commissioner separated the obstetric complaint from a complaint about the death of a baby at 3 months old (this investigation remains ongoing).	Provisional decision for obstetric case - No further action.
Thames	Parent unhappy with care her son received from Doctor at Thames Hospital. Concerns that method for removal of skin lesion and anaesthetic used were inappropriate.	HDC formed their provisional decision and propose to find Dr X breach of the Code of Health and Disability Services Consumers' Rights
ICU	Anonymous concerns regarding care provided to patient on ICU who was transferred from Tokoroa Hospital. Care was withdrawn and patient passed away.	No further action required – family satisfied with care and do not wish to make a complaint.

New complaints received

Six (compared to 3 received in April) new complaints were received – 3 in Surgery / Critical Care and 2 in Medicine, one in Community / clinical support. One of these HDC referred for Waikato to respond directly to complainant

Department	Complaint as outlined by the patient / complainant
Neurology	Patient concerned about treatment received from doctor which was different from her treatment plan.
Respiratory / Thames	Daughter of patient (dec) raises concerns about care provided at Thames and Waikato Hospital. Concerns include lack of communication with family, delayed diagnosis, and lack of treatment options.
Orthopaedics	Concerns about late wife's care following an accident. Concerns include incorrect treatment and management of Achilles injury and support for anxiety.
Orthopaedics	Multiple concerns raised about medical and nursing care provided following a fall.
Urology	Patient had surgery postponed after he had been prepped. No information given regarding next steps.
DSL	Patient did not meet the eligibility requirements for DSL support. HDC sent for information only – no action required.

Investigations

Ten investigations are currently underway (a decrease of 1 on previous month). The investigations are underway in the following areas –

- Woman's Health – 3
- Child Health – 1
- Thames – 3
- Orthopaedics – 2
- Emergency department / radiology – 1

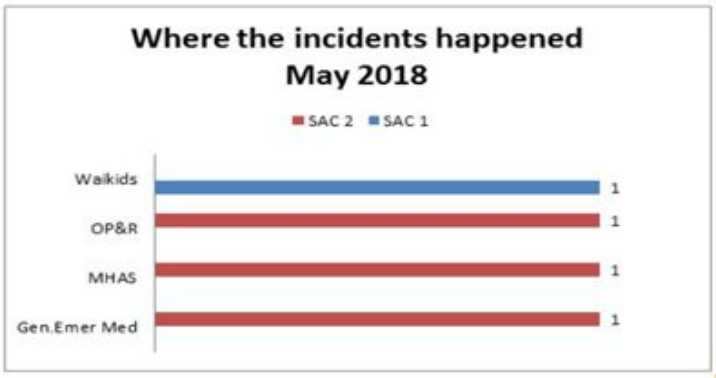
6.0 Coroner / inquest recommendations

Nothing to report

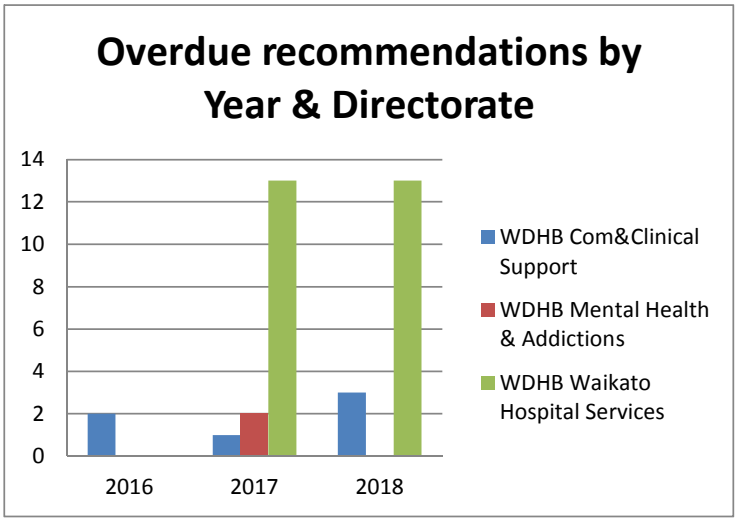
7.0 Serious events

4 events were notified in May 2018 as follows:

- SAC 1 - Baby 37/40 weeks was born at another DHB, retrieval carried out by Waikato, baby died unexpectedly in NICU. *The other DHB is also carrying out a Serious Adverse Event review into their care.*
- SAC 2 – includes a delay CT colonography



Overdue recommendations



8.0 Patient Safety Program

When the themes from serious events, complaints, trigger tools along with areas of concern in the health round table data are reviewed, a number of areas for improvement have been identified. These are outlined in the quality account priority areas

The following programs are currently underway, led by QPS patient safety facilitators. Progress is reported 6 monthly through the patient safety program group and onward to the BoCG

End of life program

- Advance care planning -train the trainer approach being developed and trainers for 'serious illness conversations' identified. Electronic solution to sharing ACP between primary and secondary care should be in place by July 2018
- Bereavement service – baseline stocktake being undertaken as part of an evaluation study with Communio / Counties Manukau. Report will be available in December 2018

Early Detection of deteriorating patients

- 'Sepsis 6' bundle roll out scheduled for September in line with World sepsis day
- National Early Warning Score and observation chart in place across DHB, business case for e vitals / observations being developed

9.0 Areas of concern

- The Health Quality and Safety commission (HQSC) has developed three new quality safety markers for implementation from June 2018. The Opioid QSM raises particular concern as opioid bundle has not been implemented at Waikato and no work scheduled

- Complication and mortality rate for DHB. Flagged services are presenting findings and 'deep dive' at mortality and morbidity committee

- Responsiveness to complaints including not undertaking a local review when necessary

- Floor to Board transparency and lack of governance processes. A revised reporting schedule being developed to assure BoCG / Board

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 5.2

REPORT FROM THE HEALTH AND DISABILITY COMMISSION (HDC) – DHB COMPLAINTS REPORT, JULY TO DECEMBER 2017

Purpose	For information. This is a six monthly report from HDC outlining the trends in complaints received by HDC about DHBs nationally and Waikato DHB in the above time period.

Nationally, the total number of complaints to HDC about all DHBs received in July-December 2017 (439) shows an increase of 5% over the average number of complaints received in the previous for periods, but a decrease of 8% over the number of complaints received in the previous six month period.

The most commonly complained about services continue to be surgical, mental health and general medicine services. Issues complained about in relation to DHB services tend to fall into the categories of care/treatment, communication, consent/information and access/funding, with a failure to communicate effectively with the consumer being the most common issue in complaints.

In around a fifth of complaints about DHBs, complainants raised concerns regarding coordination of care. Additionally, inadequate coordination of care is a common finding on HDC's assessment of complaints about DHBs. Issues commonly seen include: deficiencies in handover between and within teams; inadequate escalation of care to senior staff; deficiencies in documentation hindering continuity of care; and a lack of clarity around roles and responsibilities.

Locally, 39 complaints were received for Waikato DHB during the report period. Our rate of complaints to HDC was 80.40 per 100,000 discharges (lower than the national rate of 88.48). Waikato DHB ranked ninth against this measure. In the previous six month period Waikato DHB ranked seventh. There was a decrease of 10% over the average rate of complaints received for the previous four report periods.

When compared with our regional colleagues we have the highest rate (regional range excluding Waikato 37.5 – 63.8) but when compared with similar size DHBs we have tracked favourably.

Similar to national trends, surgery (33.3%) and general medicine (28.2%) were the most commonly complained about services at Waikato DHB in July-December 2017. Waikato DHB received a higher proportion of complaints about paediatrics in July-December 2017 than was seen nationally or last period at Waikato DHB.

Similar to national trends, the most common primary complaint issue category for Waikato DHB was care/treatment (61.5%), and the most common specific primary

issues were 'missed / incorrect / delayed diagnosis' (20.5%) and 'inadequate / inappropriate treatment' (17.9%).

Broadly similar to what was seen last period at Waikato DHB, on analysis of all specific issues in complaints about Waikato DHB, the most common issues were 'inadequate/inappropriate clinical treatment' (41.0%), 'failure to communicate effectively with consumer' (33.3%), 'delay in treatment' (30.8%), failure to communicate effectively with family' (30.8%) 'inadequate / inappropriate examination/ assessment' (28.2%) and 'missed / incorrect / delayed diagnosis (28.2%).

Update: The National section of this report will be published on the HDC website on Monday 18 June 2018. The rate of complaints to HDC per 100,000 discharges has been updated for publication purposes based on revised discharge numbers. Based on this update, Waikato DHB ranks as DHB ten. Updated information is presented below and replaces Table 4 of the attached report.

Table 4. Number and rate of complaints received for each DHB in July-Dec 2017.

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	67	62550	107.11
Bay of Plenty	17	26749	63.55
Canterbury	56	58748	95.32
Capital and Coast	31	30048	103.17
Counties Manukau	33	52490	62.87
Hawke's Bay	18	17346	103.77
Hutt Valley	19	16788	113.18
Lakes	6	12374	48.49
MidCentral	22	15892	138.43
Nelson Marlborough	14	12013	116.54
Northland	11	20781	52.93
South Canterbury	5	6244	80.08
Southern	44	27831	158.10
Tairawhiti	2	5460	36.63
Taranaki	5	13321	37.53
Waikato	39	48543	80.34
Wairarapa	7	4735	147.84
Waitemata	43	54246	79.27
West Coast	4	3436	116.41
Whanganui	5	6562	76.20

Recommendation
THAT
The Board receives this report.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

CONFIDENTIAL

Complaints to HDC involving District Health Boards

Waikato DHB

Report and Analysis for period 1 July to 31 December 2017

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Commissioner's Foreword

I am pleased to present you with HDC's six monthly DHB complaint report for July-December 2017. This report details the trends in complaints received by HDC about DHBs between 1 July and 31 December 2017.

The number of complaints received about DHBs in July-December 2017 is very similar to the average number of complaints received over the past four six month periods. The trends detailed in this report also remain broadly consistent with the trends reported across previous six month periods. The most commonly complained about service types continue to be surgical, mental health and general medicine services. Issues complained about in relation to DHB services tend to fall into the categories of care/treatment, communication, consent/information and access/funding, with a failure to communicate effectively with the consumer being the most common issue in complaints.

In around a fifth of complaints about DHBs complainants raised concerns regarding coordination of care. Additionally, inadequate coordination of care is a common finding on HDC's assessment of complaints about DHBs. Under Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code) every consumer has the right to co-operation among providers to ensure quality and continuity of services. Issues I commonly see around coordination of care in DHBs include: deficiencies in handover between and within teams; inadequate escalation of care to senior staff; deficiencies in documentation hindering continuity of care; and a lack of clarity around roles and responsibilities. It is important that the system supports staff to work together effectively, allowing them to foster good working relationships and clear lines of communication.

I trust this report will prove useful in continuing to promote learning and ongoing quality improvement.

Anthony Hill
Health and Disability Commissioner

National Data for all District Health Boards

1.0 Number of complaints received

1.1 Raw number of complaints received

In the period Jul–Dec 2017, HDC received a total of **440**[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six month periods are reported in Table 1.

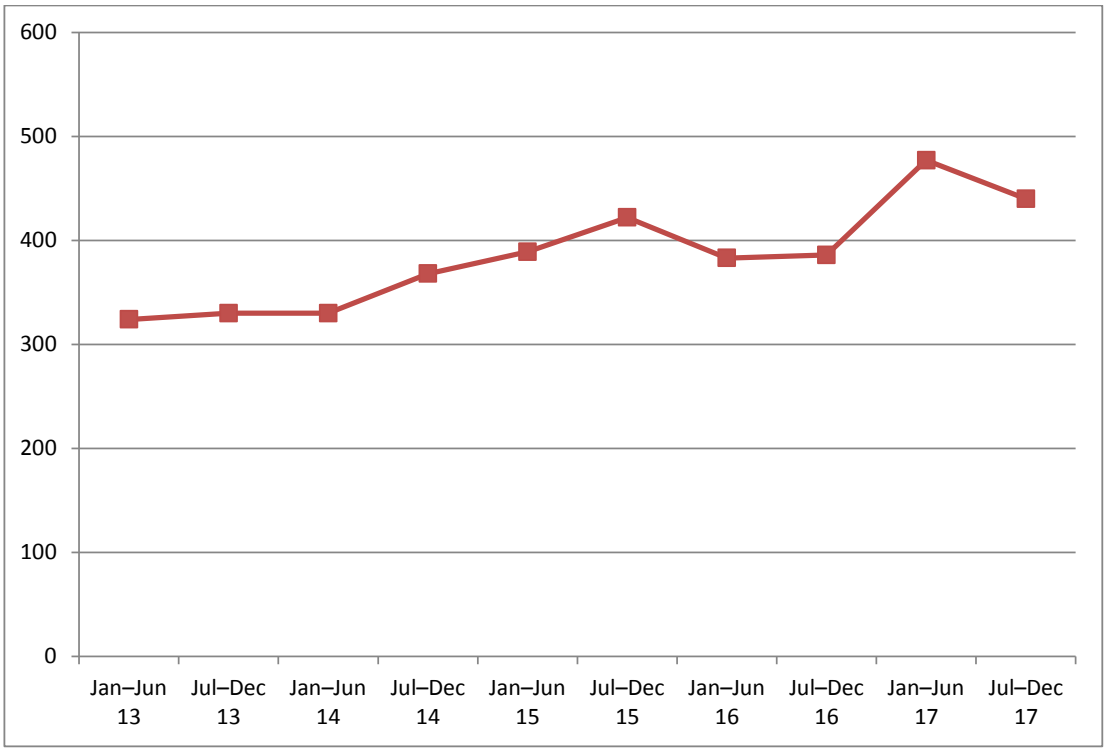
Table 1. Number of complaints received in the last five years

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Average of last 4 6-month periods	Jul–Dec 17
Number of complaints	324	330	330	368	389	422	383	386	477	**417**	**440**

The total number of complaints received in Jul–Dec 2017 (440) shows an increase of 6% over the average number of complaints received in the previous four periods, but a decrease of 8% over the number of complaints received in the previous six month period.

The number of complaints received in Jul–Dec 2017 and previous six month periods are also displayed below in Figure 1.

Figure 1. Number of complaints received



[1] Provisional as of date of extraction (19 January 2018).

1.2 Rate of complaints received

When numbers of complaints to HDC are expressed as a rate per 100,000 discharges, comparisons can be made between DHBs, and within DHBs over time, enabling any trends to be observed.

Rate of complaints calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (9 February 2018) and is likely incomplete, it will be updated in the next 6-monthly report. It should be noted that this discharge data excludes short stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges during Jul–Dec 2017

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
440	490,113	**89.78**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jul–Dec 2017 and previous six month periods.

Table 3. Rate of complaints received in last five years

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17[2]	Average of last 4 6-month periods	Jul–Dec 17
Rate per 100,000 discharges	72.67	71.15	72.99	76.65	84.60	87.57	81.44	78.79	99.08	**86.72**	**89.78**

The rate of complaints received during Jul–Dec 2017 (89.78) shows a 4% increase over the average rate of complaints received for the previous four periods, but a decrease of 9% over the rate of complaints received in the previous six month period.

Table 4 shows the number and rate of complaints received by HDC for each DHB[3].

[2] The rate for Jan–Jun 2017 has been recalculated based on the most recent discharge data.

[3] Please note that some complaints will involve more than one DHB, therefore the total number of complaints received for each DHB will be larger than the number of complaints received about care provided by DHBs.

Table 4. Number and rate of complaints received for each DHB in Jul-Dec 2017

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	68	62621	108.59
Bay of Plenty	17	26692	63.69
Canterbury	56	54826	102.14
Capital and Coast	31	32515	95.34
Counties Manukau	33	51621	63.93
Hawke's Bay	18	17343	103.79
Hutt Valley	19	16921	112.29
Lakes	6	12374	48.49
MidCentral	22	14239	154.51
Nelson Marlborough	14	9168	152.71
Northland	11	20304	54.18
South Canterbury	5	6018	83.08
Southern	44	27821	158.15
Tairawhiti	2	5242	38.15
Taranaki	5	13307	37.57
Waikato	39	48507	80.4
Wairarapa	7	4735	147.84
Waitemata	43	55868	76.97
West Coast	4	3431	116.58
Whanganui	5	6560	76.22

Notes on DHB's number and rate of complaints

It should be noted that a DHB's number and rate of complaints can vary considerably from one six month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six month period. For smaller DHBs, a very small absolute increase or decrease in the number of complaints received can dramatically affect the rate of complaints. Accordingly, much of the value in this data lies in how it changes over time, as such analysis allows trends to emerge which may point to areas that require further attention.

It is also important to note that numbers of complaints received by HDC is not always a good proxy for quality of care provided and may instead, for example, be an indicator of the effectiveness of a DHB's complaint system or features of the consumer population in a particular area. Additionally, complaints received within a single 6 month period will, sometimes, relate to care provided within quite a different time period. From time to time, some DHBs may also be the subject of a number of complaints from a single complainant within one reporting period. This is important context that is taken into account by DHBs when considering their own complaint patterns.

2.0 Service types complained about

2.1 Service type category

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 440 complaints about DHBs, 452 services were complained about.

Surgical services (31.6%) received the greatest number of complaints in Jul-Dec 2017, with orthopaedics and urology (6.9% each) being the surgical specialties most commonly complained about. Other commonly complained about services included mental health (19.7%), general medicine (16.6%), emergency departments (11.9%) and maternity services (8.2%). This is broadly similar to what has been seen in previous periods.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Aged care	**2**	**0.4%**
Alcohol and drug	**4**	**0.9%**
Anaesthetics/pain medicine	**1**	**0.2%**
Dental	**1**	**0.2%**
Diagnostics	**6**	**1.3%**
Disability services	**8**	**1.8%**
District nursing	**2**	**0.4%**
Emergency department	**54**	**11.9%**
General medicine	**75**	**16.6%**
Cardiology	15	3.3%
Endocrinology	4	0.9%
Gastroenterology	7	1.5%
Geriatric medicine	10	2.2%
Haematology	2	0.4%
Infectious diseases	1	0.2%
Neurology	9	2.0%
Oncology	6	1.3%
Palliative care	1	0.2%
Renal/nephrology	1	0.2%
Respiratory	3	0.7%
Rheumatology	2	0.4%
Other/unspecified	14	3.1%
Hearing services	**1**	**0.2%**
Intensive care/critical care	**2**	**0.4%**
Maternity	**37**	**8.2%**
Mental health	**89**	**19.7%**
Occupational therapy	**1**	**0.2%**
Paediatrics (not surgical)	**15**	**3.3%**
Pharmacy	**1**	**0.2%**
Rehabilitation services	**1**	**0.2%**
Sexual health	**1**	**0.2%**
Surgery	**143**	**31.6%**
Cardiothoracic	5	1.1%
General	27	6.0%
Gynaecology	15	3.3%
Neurosurgery	5	1.1%
Ophthalmology	15	3.3%
Orthopaedics	31	6.9%
Otolaryngology	5	1.1%
Plastic and Reconstructive	5	1.1%
Urology	31	6.9%
Vascular	3	0.7%
Unknown	1	0.2%
Other/unknown health service	**8**	**1.8%**
TOTAL	**452**	

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jul–Dec 2017 are listed in Table 6. It should be noted that the issues included are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues can still provide a valuable insight into the consumer's experience of the services provided and the issues they care most about.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***73***	***16.6%***
Lack of access to services	26	5.9%
Lack of access to subsidies/funding	2	0.5%
Waiting list/prioritisation issue	45	10.2%
Boundary violation	***1***	***0.2%***
Care/Treatment	***208***	***47.3%***
Delay in treatment	14	3.2%
Delayed/inadequate/inappropriate referral	2	0.5%
Inadequate coordination of care/treatment	9	2.0%
Inadequate/inappropriate clinical treatment	29	6.6%
Inadequate/inappropriate examination/assessment	10	2.3%
Inadequate/inappropriate follow-up	4	0.9%
Inadequate/inappropriate monitoring	9	2.0%
Inadequate/inappropriate non-clinical care	11	2.5%
Inadequate/inappropriate testing	1	0.2%
Inappropriate/delayed discharge/transfer	14	3.2%
Inappropriate withdrawal of treatment	7	1.6%
Missed/incorrect/delayed diagnosis	54	12.3%
Personal privacy not respected	1	0.2%
Refusal to treat	5	1.1%
Rough/painful care or treatment	3	0.7%
Unexpected treatment outcome	35	8.0%
Communication	***35***	***8.0%***
Disrespectful manner/attitude	16	3.6%
Failure to communicate openly/honestly/effectively with consumer	8	1.8%
Failure to communicate openly/honestly/effectively with family	8	1.8%
Insensitive/inappropriate comments	3	0.7%
Complaints process	***2***	***0.5%***
Inadequate response to complaint	2	0.5%
Consent/Information	***55***	***12.5%***
Consent not obtained/adequate	9	2.0%
Inadequate information provided regarding condition	4	0.9%
Inadequate information provided regarding fees/costs	3	0.7%
Inadequate information provided regarding options	7	1.6%
Inadequate information provided regarding provider	1	0.2%
Inadequate information provided regarding results	2	0.5%
Inadequate information provided regarding treatment	9	2.0%

Primary issue in complaints	Number of complaints	Percentage
Incorrect/misleading information provided	1	0.2%
Issues with involuntary admission/treatment	19	4.3%
Documentation	***4***	***0.9%***
Inadequate/inaccurate documentation	2	0.5%
Other	2	0.5%
Facility issues	***26***	***5.9%***
Cleanliness/hygiene issue	2	0.5%
General safety issue for consumer in facility	14	3.2%
Inadequate/inappropriate policies/procedures	3	0.7%
Staffing/rostering/other HR issue	3	0.7%
Waiting times	3	0.7%
Other	1	0.2%
Medication	***19***	***4.3%***
Administration error	1	0.2%
Dispensing error	1	0.2%
Inappropriate administration	1	0.2%
Inappropriate prescribing	11	2.5%
Refusal to prescribe/dispense/supply	5	1.1%
Reports/Certificates	***3***	***0.7%***
Inaccurate report/certificate	3	0.7%
Other professional conduct issues	***10***	***2.5%***
Inappropriate collection/use/disclosure of information	7	1.6%
Other	3	0.7%
Disability-related issues	***4***	***0.9%***
TOTAL	**440**	

The most common primary issue categories concerned care/treatment (47.3%), access/funding (16.6%), consent/information (12.5%) and communication (8.0%). Among these, the most common specific primary issues in complaints about DHBs were 'missed/incorrect/delayed diagnosis' (12.3%), 'waiting list/prioritisation issue' (10.2%), 'unexpected treatment outcome' (8.0%), 'inadequate/inappropriate clinical treatment' (6.6%) and 'lack of access to services' (5.9%). This is broadly similar to what was seen last period.

Table 7 shows a comparison over time for the top five primary issues complained about. The top five primary issues have remained broadly consistent over time.

Table 7. Top five primary issues in complaints received over the last four six month periods

Top five primary issues in all complaints (%)							
Jan–Jun 16 n=381		**Jul–Dec 16 n=386**		**Jan–Jun 17 n=477**		**Jul–Dec 17 n=440**	
Misdiagnosis	16%	Misdiagnosis	15%	Misdiagnosis	15%	Misdiagnosis	12%
Inadequate treatment	9%	Unexpected treatment outcome	8%	Waiting list/ Prioritisation	10%	Waiting list/ prioritisation	10%
Unexpected treatment outcome	8%	Inadequate treatment	8%	Unexpected treatment outcome	9%	Unexpected treatment outcome	8%
Lack of access to services	6%	Lack of access to services	8%	Inadequate treatment	6%	Inadequate treatment	7%
Waiting list/ prioritisation	5%	Waiting list/ prioritisation	7%	Lack of access to services	6%	Lack of access to services	6%

3.2 All complaint issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Table 8 includes these additional complaint issues, as well as the primary complaint issues, to show all issues identified in complaints received.

On analysis of all issues identified in complaints about DHBs, the most common complaint issue categories were care/treatment (present for 77.7% of all complaints), communication (present for 57.5% of all complaints), consent/information (present for 25.9% of all complaints) and access/funding (present for 25.5% of all complaints).

The most common specific issues were 'failure to communicate effectively with consumer' (37.5%), 'inadequate/inappropriate clinical treatment' (33.4%) 'inadequate/inappropriate examination/assessment' (22.3%), 'delay in treatment' (20.2%), 'missed/incorrect/delayed diagnosis' (19.8%), 'inadequate response to the consumer's complaint by the DHB' (17.5%), 'failure to communicate effectively with family' (17.0%), 'disrespectful manner/attitude' (17.0%) 'inadequate coordination of care/treatment' (16.4%) and 'unexpected treatment outcome' (15.0%). This is broadly similar to what was seen last period.

Also similar to the last six-month period, many complaints involved issues with a consumer's care/treatment, such as 'inadequate/inappropriate follow-up' (10.0%), 'inappropriate/delayed discharge/transfer' (9.8%), 'inadequate/inappropriate monitoring (8.2%) and 'inadequate/inappropriate testing' (7.7%).

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	***112***	***25.5%***
ACC compensation issue	1	0.2%
Lack of access to services	48	10.9%
Lack of access to subsidies/funding	8	1.8%
Waiting list/prioritisation issue	61	13.9%
Boundary violation	***2***	***0.5%***
Care/Treatment	***342***	***77.7%***
Delay in treatment	89	20.2%
Delayed/inadequate/inappropriate referral	22	5.0%
Inadequate coordination of care/treatment	72	16.4%
Inadequate/inappropriate clinical treatment	147	33.4%
Inadequate/inappropriate examination/assessment	98	22.3%
Inadequate/inappropriate follow-up	44	10.0%
Inadequate/inappropriate monitoring	36	8.2%
Inadequate/inappropriate non-clinical care	27	6.1%
Inadequate/inappropriate testing	34	7.7%
Inappropriate admission/failure to admit	11	2.5%
Inappropriate/delayed discharge/transfer	43	9.8%
Inappropriate withdrawal of treatment	8	1.8%
Missed/incorrect/delayed diagnosis	87	19.8%
Personal privacy not respected	5	1.1%
Refusal to assist/attend	11	2.5%
Refusal to treat	10	2.3%
Rough/painful care or treatment	20	4.5%
Unexpected treatment outcome	66	15.0%
Unnecessary treatment/over-servicing	5	1.1%
Communication	***253***	***57.5%***
Disrespectful manner/attitude	75	17.0%
Failure to accommodate cultural/language needs	2	0.5%
Failure to communicate openly/honestly/effectively with consumer	165	37.5%
Failure to communicate openly/honestly/effectively with family	75	17.0%
Insensitive/inappropriate comments	13	3.0%
Complaints process	***78***	***17.7%***
Inadequate response to complaint	77	17.5%
Retaliation/discrimination as a result of a complaint	1	0.2%
Consent/Information	***114***	***25.9%***
Consent not obtained/adequate	27	6.1%
Inadequate information provided regarding adverse event	5	1.1%
Inadequate information provided regarding condition	16	3.6%
Inadequate information provided regarding fees/costs	5	1.1%
Inadequate information provided regarding options	18	4.1%
Inadequate information provided regarding provider	3	0.7%
Inadequate information provided regarding results	6	1.4%
Inadequate information provided regarding treatment	36	8.2%
Incorrect/misleading information provided	11	2.5%

All issues in complaints	Number of complaints	Percentage
Issues with involuntary admission/treatment	20	4.5%
Other	3	0.7%
Documentation	***36***	***8.2%***
Delay/failure to disclose documentation	3	0.7%
Delay/failure to transfer documentation	2	0.5%
Inadequate/inaccurate documentation	29	6.6%
Intentionally misleading/altered documentation	3	0.7%
Facility issues	***75***	***17.0%***
Cleanliness/hygiene issue	7	1.6%
Failure to follow policies/procedures	5	1.1%
General safety issue for consumer in facility	25	5.7%
Inadequate/inappropriate policies/procedures	20	4.5%
Issue with sharing facility with other consumers	8	1.8%
Issue with quality of aids/equipment	7	1.6%
Staffing/rostering/other HR issue	9	2.0%
Waiting times	7	1.6%
Other	2	
Medication	***45***	***10.2%***
Administration error	5	1.1%
Inappropriate administration	6	1.4%
Inappropriate prescribing	23	5.2%
Refusal to prescribe/dispense/supply	11	2.5%
Other	2	
Reports/Certificates	***6***	***1.4%***
Inaccurate report/certificate	4	0.9%
Refusal to complete report/certificate	2	0.5%
Teamwork/supervision	***8***	***1.8%***
Inadequate supervision/oversight	8	1.8%
Other professional conduct issues	***26***	***5.9%***
Disrespectful behaviour	11	2.5%
Inappropriate collection/use/disclosure of information	12	2.7%
Threatening/bullying/harassing behaviour	4	0.9%
Other	4	
Disability-related issues	***7***	
Other issues	***13***	

3.3 Service type and primary issues

Table 9 shows the top three primary issues in complaints concerning the most commonly complained about service types. This is broadly similar to what was seen in the last six-month period. However, issues regarding safety in inpatient facilities became more prominent for mental health services and inadequate/inappropriate monitoring became more prominent for maternity services in Jul-Dec 2017.

Table 9. Three most common primary issues in complaints by service type

Surgery n=143		**Mental Health n=89**		**General medicine n=75**		**Emergency department n=54**		**Maternity n=37**	
Unexpected treatment outcome	19%	Issues with involuntary admission/ treatment	21%	Waiting list/ prioritisation issue	12%	Missed/ incorrect/ delayed diagnosis	37%	Inadequate/ inappropriate treatment	24%
Waiting list/ prioritisation issue	19%	General safety issue for consumer in facility	13%	Missed/ incorrect/ delayed diagnosis	11%	Disrespectful manner/ attitude	9%	Inadequate/ inappropriate monitoring	16%
Missed/ incorrect/ delayed diagnosis	9%	Failure to communicate effectively with consumer	7%	Inadequate/ inappropriate care	8%	Waiting list/ prioritisation issue	7%	Consent not obtained/ adequate	14%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **383**[4] complaints involving DHBs in the period Jul–Dec 2017. Table 10 shows the number of complaints closed in previous six month periods.

Table 10. Number of complaints about DHBs closed in last five years

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Average of last 4 6-month periods	Jul–Dec 17
Number of complaints closed	337	280	411	344	410	365	482	316	465	**407**	**383**

4.2 Outcomes of complaints closed

Complaints that are within HDC's jurisdiction are classified into two groups according to the manner of resolution — whether formal investigation or other resolution. Within each classification, there is a variety of possible outcomes. Once HDC has notified a DHB that a complaint concerning that DHB is to be investigated, the complaint remains classified as an investigation, even though an alternative manner of resolution may subsequently be adopted. Notification of investigation generally indicates more serious or complex issues.

In the Jul–Dec 2017 period, **12** DHBs had no investigations closed, **3** DHBs had one investigation closed, **3** DHBs had two investigations closed and **2** DHBs had three investigations closed by HDC.

The manner of resolution and outcomes of all complaints about DHBs closed in Jul–Dec 2017 is shown in Table 11.

[4] Note that complaints may be received in one six month period and closed in another six month period — therefore, the number of complaints received will not correlate with the number of complaints closed.

Table 11. Outcome for DHBs of complaints closed by complaint type[5]

Outcome for DHBs	Number of complaints closed
Investigation	***13***
Breach finding	4
No further action with follow-up or educational comment	6
No further action	1
No breach finding	2
Other resolution following assessment	***359***
No further action[6] with follow-up or educational comment	70
Referred to Ministry of Health	5
Referred to District Inspector	14
Referred to other agency	5
Referred to DHB[7]	81
Referred to Advocacy	65
No further action	108
Withdrawn	11
Outside jurisdiction	***11***
TOTAL	**383**

[5] Note that outcomes are displayed in descending order. If there is more than one outcome for a DHB upon resolution of a complaint then only the outcome which is listed highest in the table is included.

[6] The Commissioner has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of formal investigation, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. This may happen, for example, where a DHB has carefully reviewed the case itself and no further value would be added by HDC investigating, or where another agency is reviewing, or has carefully reviewed the matter (for example, the Coroner, the Director-General of Health, or a District Inspector). Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice.

[7] In line with their responsibilities under the Code, DHBs have developed systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

4.3 Recommendations made to DHBs following a complaint

Regardless of whether or not a complaint has been investigated, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted upon. Table 12 shows the recommendations made to DHBs in complaints closed in Jul–Dec 2017. Please note that more than one recommendation may be made in relation to a single complaint.

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	7
Audit	12
Presentation/discussion of complaint with others	7
Provision of evidence of change to HDC	31
Reflection	8
Review/implementation of policies/procedures	35
Training/professional development	18
Total	**118**

The most common recommendation made to DHBs was that they conduct a review of their policies/procedures or implement new policies/procedures (35 recommendations), followed by providing evidence to HDC of the changes they had made in response to the issues raised by the complaint (31 recommendations). Staff training was also often recommended (18 recommendations), this was most commonly in relation to clinical issues. On some occasions, HDC also recommended that an anonymised version of the complaint be used as a training tool for staff.

5.0 Learning from complaints — HDC case reports

Incorrect dose of citalopram administered to elderly woman (16HDC00072)

Background

Mrs A, aged 88 years, was admitted to the orthopaedic ward at a public hospital following a fall at her rest home. Documentation from the rest home showed Mrs A's daily dose of an antidepressant (citalopram) as 10mg per day, half a 20mg tablet. Orthopaedic house officer, Dr D, prescribed Mrs A citalopram 10mg daily by writing on a paper medication chart. However, initially he wrote "20mg" and then immediately realised that the dose was half of a 20mg tablet, so changed the prescription to "10mg" by writing over the "2". Dr D did not rewrite the prescription, as required by the DHB's policy.

The hospital ward pharmacist, Ms L, undertook a reconciliation for Mrs A's medication. Ms L documented the daily dose of citalopram as 10mg and annotated the paper medication chart by writing "½ x 20mg" underneath the prescription of citalopram. Throughout Mrs A's admission to hospital, no staff rewrote Dr D's prescriptions of citalopram or asked him to do so.

Mrs A was transferred to another hospital. Another orthopaedic house officer, Dr E, completed the electronic discharge summary. Dr E misread the altered dose of citalopram on the paper medication chart as 40mg and listed Mrs A's dose of citalopram as 40mg on the discharge summary.

Geriatric medicine house officer, Dr G, admitted Mrs A to the second hospital. Dr G electronically prescribed Mrs A 40mg daily based on the discharge summary. Following, Mrs A's admission, a ward pharmacist, Ms J, reviewed Mrs A's medication. Ms J compared the medication entry to the discharge summary from the previous hospital. Ms J thought that the dose of citalopram was high for an elderly person, but not unusual, so it was not a red flag for her.

Mrs A was given 40mg citalopram daily for over a week. During this time, she had periods of suspicion, paranoia, delusion and confusion. None of the staff caring for Mrs A identified the citalopram dosage error. A nurse practitioner reviewed Mrs A for a mental health assessment, and identified the error. Mrs A's citalopram dose was immediately reduced to 10mg.

Findings

The Commissioner considered that the following accumulation of apparently innocuous actions or inactions, none of which, taken individually, were a material lapse in care, added up to a failure on behalf of the DHB:

- the original prescription was amended rather than re-written in contravention of the DHB's policy;
- the prescription was then annotated by the pharmacist to clarify the required dose, but no action was taken to seek to have the prescription re-written;
- numerous staff were involved in the administration of the medications, none of whom sought to have the prescription re-written;
- the house officer preparing the discharge summary made a transcribing error, having misinterpreted the corrected dose on the prescription;
- on admission to the second hospital the transcribing error became a prescribing error, as the 40mg dose was prescribed based on the discharge summary; and
- the pharmacist at the second hospital undertook the full medicine reconciliation on Mrs A's admission but, while she considered the dose to be high in an elderly patient, she did not investigate further, preferring to wait until Mrs A was stable rather than alert medical staff to her concerns.

In addition to these specific examples, the Commissioner considered there were numerous opportunities for the error in the dosage to be identified, or at the very least queried, at the second

hospital, from the pharmacist who suspected the dose was high, to the medical and nursing staff who were caring for Mrs A. None of these individuals took the opportunity to question the dose of 40mg, despite acknowledgement from various practitioners that it was a high dose for someone of Mrs A's age, and given the fact of Mrs A's deterioration. The Commissioner was concerned at the lack of critical thinking exhibited in this case.

The Commissioner held that the DHB failed to provide services with reasonable care and skill in relation to the prescribing and administration of citalopram, and breached Right 4(1) of the Code

Recommendations

The Commissioner noted that the DHB had put in place a system by which a transfer reconciliation will be performed by a pharmacist at the receiving service using additional sources of information, and considered such action to be an appropriate step in light of the issues highlighted in this case.

The Commissioner recommended that the DHB:

- use this case an anonymised case study for the education of staff;
- conduct a random audit of the transfer reconciliations performed by pharmacists at the receiving service over a three-month period, and report back to HDC on the effectiveness of the new process in identifying errors in discharge summaries; and
- report to HDC on the implementation of electronic prescribing at the first hospital.

Assessment and management of orthopaedic patient (14HDC00134)

Background

Mr A, a 75-year-old man, was referred to a public hospital for knee surgery. Mr A had previously had a hip dislocation following which he suffered a large gastrointestinal (GI) bleed secondary to use of non-steroidal anti-inflammatory drugs (NSAIDs).

Mr A attended an outpatient appointment with an orthopaedic registrar and a pre-admission clinic where he was assessed by a house officer and a consultant anaesthetist. Neither the orthopaedic registrar, house officer, nor the anaesthetist reviewed the previous clinical records or documented the past history of the GI bleed.

Mr A underwent total knee joint replacement surgery at the hospital, undertaken by an orthopaedic surgeon, who had previous knowledge of Mr A and his history. A surgical checklist and a surgical time-out protocol was completed but neither recorded the GI history. The anaesthetist on the day of surgery (who was not the anaesthetist at the pre-admission clinic) was not made aware of the history of a GI bleed. Postoperatively, with the orthopaedic surgeon's knowledge, the anaesthetist charted pain relief that included ibuprofen, an NSAID.

The orthopaedic surgeon reviewed Mr A and expected him to be discharged home in four or five days' time. The orthopaedic surgeon went on leave, but the handover that took place was not documented. No other orthopaedic staff member was specified in Mr A's clinical record as being the responsible clinician for the leave period.

Mr A then showed signs of deterioration. An on-call house officer reviewed Mr A and queried a peptic ulcer. The house officer stopped the ibuprofen and diagnosed renal impairment. Another house officer reviewed Mr A and telephoned the on-call medical registrar. The medical registrar considered that Mr A required further fluid resuscitation and reassessment prior to any escalation of care.

The medical registrar was the first doctor in a role above house officer to review Mr A. No examination findings were recorded. The medical registrar concluded that Mr A had sepsis secondary to pneumonia and acute kidney injury. The medical registrar did not seek advice from a more senior

clinician. No follow-up plans, further investigation, or recommendations to the orthopaedic team were documented.

A second medical registrar performed an examination and concluded that Mr A was acutely unwell with chest sepsis and renal injury. He anticipated that Mr A might need higher care intervention and planned further review. Mr A deteriorated, and the second medical registrar escalated Mr A's case and contacted a consultant. A transfer to ICU was agreed. Sadly, Mr A died.

Findings

The Commissioner noted that Mr A's case serves as a salutary reminder of the importance of due consideration of a consumer's clinical record and past clinical history, and clear and accurate communication and documentation. The Commissioner commented that: "Healthcare teams must consistently communicate well with one another, and ensure that there is accurate documentation. These functions form two of the layers of protection that aid the delivery of seamless care. When any one or more of those layers do not operate optimally, there is potential for the patient to be harmed."

The Commissioner was critical of the orthopaedic registrar, and the anaesthetist and house officer at the pre-admission clinic, for not reviewing Mr A's clinical record and recording the relevant patient history in the contemporaneous record.

The orthopaedic surgeon acknowledged that he was familiar with Mr A's clinical history and that he proceeded cognisant of that. However, he did not enter Mr A's GI history into the contemporaneous record. Mr A was later prescribed NSAID medication with the orthopaedic surgeon's oversight, without the relevant past clinical history being documented. Additionally, Mr A's handover was not documented. The Commissioner considered that the orthopaedic surgeon failed to ensure quality and continuity of services, in breach of Right 4(5) of the Code.

The first medical registrar did not provide appropriate advice or perform an adequate initial assessment of Mr A in a timely manner, and failed to seek advice from a senior colleague when Mr A's condition warranted it. The Commissioner considered therefore, that the medical registrar did not provide Mr A with services with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner was critical of the second medical registrar for not making contact with a senior colleague earlier.

The Commissioner considered that Mr A's case highlighted the following DHB systems issues, which contributed to his suboptimal care:

- The DHB's primarily paper-based records system did not assist staff to facilitate effective review of patient history, and there was no alert process or system for significant patient co-morbidities.
- The wording and nature of several of the questions on the DHB pre-assessment patient questionnaire may have been subject to misinterpretation.
- There was a lack of clarity about the person to whom oversight of the Mr A's care had passed, particularly once the orthopaedic surgeon went on leave, and the Orthopaedic Department did not, at that time, have a policy relating to the handover of patients.
- Many staff in this case did not adhere to Early Warning Score (EWS) protocols appropriately.
- Escalation to more senior staff did not occur appropriately when Mr A deteriorated.

For these above reasons, the Commissioner considered that the DHB did not provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code.

In respect of the DHB's failings in this case, HDC's expert advisor noted that: "Direct clinical oversight particularly over weekends and nightshifts will always be a challenge with senior staff relying on the judgement of junior staff on when it is appropriate to seek guidance. Factors such as organisational

culture, perceived approachability of senior staff and junior staff awareness of any delegated authority policy can all be influencing factors. Safety 'check points' such as the EWS which allow for a protocol driven backup outside of individuals' judgement should be well understood by clinical staff using such tools and not circumvented."

Recommendations

The Commissioner recommended that the orthopaedic surgeon: provide details on the steps he had taken to formalise handover of his own surgical inpatients to orthopaedic colleagues in the event of taking leave; provide an update on his active participation in the changes made to the surgical safety checklist and procedures following this complaint; and provide an update on the changes made to the mechanisms of handover between consultants and the documentation of patient management instructions. It was recommended that the first medical registrar provide evidence to HDC of undergoing further education on the application of the EWS, the deteriorating patient and the escalation of care to senior colleagues in the event of patient deterioration.

The Commissioner made a number of recommendations to the DHB, including that it:

- prepare or modify a policy or guidelines to clarify roles and responsibilities of staff and outline precisely when in the patient surgical pathway, and by whom, the patient's clinical history and records are to be reviewed and significant issues communicated;
- provide a detailed update in relation to its development of electronic patient records;
- implement an electronic alert process or system in the patient record for clear flagging of significant patient co-morbidities and clinical history;
- provide a copy of its critically appraised and modified preoperative screening questionnaire form;
- provide details of the steps taken to allow treating clinicians to re-check all patient hard copy records, electronic records and medications immediately prior out surgery;
- provide detail of mechanisms being pursued for ensuring an appropriate medical response to an EWS trigger, and for ensuring that DHB junior doctors are confident and supported to escalate concerns about deteriorating patients to senior colleagues; and
- detail changes made to increase the robustness of transfer of care within the Orthopaedic Service, including extra medical and elder health support for orthopaedic patients.

Inadequate coordination of mental health care (14HDC01343)

Background

Mrs A, aged in her 60s, experienced a decline in her mental health following an accident in which she suffered physical injuries.

Mrs A self-referred to Mental Health Services (MHS) at a DHB where she was reviewed by a consultant psychiatrist, Dr B, who diagnosed a major depressive episode and prescribed antidepressants and sleeping medication. Dr B was Mrs A's lead clinician, and a nurse, RN C, was Mrs A's key worker. Following this review, Mrs A received regular input from MHS. She was also being seen by her GP and by a medical team for the injuries sustained in her accident.

Two months later, Mrs A self-harmed and was taken to the Emergency Department. Subsequently, she was admitted to an inpatient mental health service (the inpatient service). Mrs A refused regular antidepressant medication and denied suicidal intent. She was discharged six days later. Mrs A was readmitted to the inpatient service the following day after a further incident of self-harm. She denied thoughts of self-harm, and about a week later she was discharged with key worker follow-up.

A few weeks later, Mrs A was reviewed by RN C, and then the following day reviewed by Dr B and RN C. The plan was for daily key worker contact following the review, but this did not occur. There was confusion about the key worker arrangements for Mrs A. RN C worked three days a week, and told HDC that she shared the key worker role for Mrs A with another nurse, RN D. RN D stated that she was not asked by anyone at any time to be part of the delivery of clinical services to Mrs A. There is no documented record that RN D was asked to share the role with RN C.

Mrs A died a few days later.

Findings

The Mental Health Commissioner considered that overall the treatment planning for Mrs A was lacking, and there was a lack of evidence to show that Mrs A's particular risks were considered adequately in order to form treatment plans to guide all staff and support persons involved in Mrs A's care.

In respect of the confusion around the key worker arrangements for Mrs A, HDC's expert advisor stated that "Clarity of role is an important component of care. Failure to be explicit and ensure that all parties are aware of their roles and subsequent responsibilities and duties can cause treatment plans to not be enacted which may have serious consequences … As more staff age and plan for retirement by reducing working hours this will become a more common occurrence and needs explicit direction rather than relying on less formal practices of colleagues covering days off." The Mental Health Commissioner considered that the coordination of Mrs A's key worker care in this situation was inadequate, and that it was the DHB's responsibility to have clear processes in place to ensure that Mrs A received appropriate continuity of care.

The Mental Health Commissioner noted that between the Mrs A's first and last engagements with the MHS, there were a number of inadequacies in the coordination of her care, which were attributable to the DHB — most notably, the failures in treatment planning and the poor coordination of key worker care. Therefore, the DHB was found in breach of Right 4(5) for not ensuring continuity of care for Mrs A.

The Mental Health Commissioner considered that there were numerous aspects of Mrs A's care from Dr B that were inadequate, and she failed to provide services of an appropriate standard to Mrs A, in breach of Right 4(1) of the Code. In particular, he considered that the decision to discharge Mrs A from the inpatient service the second time was inappropriate, there was an inadequate risk assessment during Dr B's last clinical review of Mrs A and the documentation for this was poor, and there was a lack of documentation regarding Dr B's decision not to use Mental Health (Compulsory Assessment and Treatment) Act 1992 provisions to treat Mrs A.

The Mental Health Commissioner was critical of RN C's communication of her expectations to RN D, and of her documentation.

Recommendations

The Mental Health Commissioner recommended that the DHB develop clear protocols for circumstances where key worker care may be shared in relation to a mental health consumer, including a clear method of documenting the care arrangement and the role of each key worker in the circumstances. He also recommended that the DHB use this case as an anonymised case study for education of its key worker and psychiatrist staff, including in relation to their respective roles.

The Mental Health Commissioner recommended that, in the event that Dr B returned to practise medicine, the Medical Council of New Zealand consider whether a review of her competence was warranted. He also recommended that, if RN C returned to practice nursing, that she undertake a course on documentation.

Inadequate care provided to baby in hospital (15HDC01330)

Background

At seven days old, Baby A was admitted to a public hospital with 11% weight loss since birth, jaundice and reduced feeding. She was treated with phototherapy on the children's ward.

Baby A's temperature spiked the following day. The consultant paediatrician ordered investigations to try and determine the cause, and decided to commence intravenous (IV) fluids and antibiotics. A junior paediatric registrar prescribed the antibiotics and IV fluids. The registrar prescribed IV fluids at a rate of 180ml/kg/day, which was higher than the amount recommended by the DHB's policy and other national guidelines.

A registered nurse, RN B, cared for Baby A on the following evening shift. During this shift, RN B administered Baby A's antibiotics, and then recommenced the IV fluids. At about 8.30pm the IV monitor began to flash, saying there was a "downward occlusion". RN B and a senior nurse investigated the line and the IV site, but did not find any obvious issues. RN B did not clearly document the issues she had with the IV line during the shift, nor did she hand these over to the following shift.

Another registered nurse, RN C, took over Baby A's care at 11.15pm for the night shift, but she did not review Baby A for nearly two hours. At around 2.30am, Baby A was due for her next antibiotics. RN C said there were no signs of phlebitis or tissue infiltration when she commenced the first IV antibiotic. During the administration of the antibiotic, Baby A's mother noted a blister forming on Baby A's arm, and the arm swelled immediately. RN C stopped the antibiotic infusion and called for assistance. Baby A was reviewed by a senior house officer and treated for an extravasation injury.

The paediatric fluid balance charts from throughout Baby A's hospital admission were not filled in regularly by staff in accordance with the DHB's policy.

Findings

The Deputy Commissioner found there were a number of failings in the care provided to Baby A by the DHB, including:

- the DHB did not have a clear consensus on which IV fluid guidelines were to take priority;
- the registrar's orientation to the IV fluid guidelines was inadequate;
- multiple staff reviewed Baby A, but did not recognise that her IV fluid prescription was too high; and
- multiple staff did not fill in the Baby A's fluid balance chart in accordance with policy requirements.

The Deputy Commissioner considered that, cumulatively, these factors painted a picture of poor care, and accordingly, the DHB failed to ensure that services were provided to Baby A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner considered that by: failing to comply with the DHB's policy regarding hourly IV site monitoring and documentation; not documenting an accurate description of the issues she encountered or the actions she took in response to the IV pump alarm; and not handing over the issues she had with the IV pump to the following shift, RN B did not provide services to Baby A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner also considered that by failing to review the baby's IV site for two hours at the start of her shift, and by failing to document the phlebitis and infiltration scores in accordance with the DHB's policy, RN C did not provide services to Baby A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner was critical of the registrar for prescribing a rate of IV fluids that was higher than the amount recommended by guidelines.

Recommendations

The Deputy Commissioner made a number of recommendations to the DHB, including that it:

- establish a clear consensus on which guidelines are to be followed when prescribing IV fluid to neonates, and ensure that this is documented clearly in existing policy or in a new policy document;
- provide HDC with the results of its six most recent monthly audits of IV access;
- use this case as an anonymised case study during induction of nursing and medical staff to the Children's Ward and neonatal unit; and
- provide HDC with confirmation that the actions taken to meet the recommendations made in the DHB's internal investigation are continuing.

The Deputy Commissioner recommended that RN B undertake an audit of her compliance with fluid balance recording standards. She also recommended that, in the event that RN C holds a nursing position in future where she is responsible for administering IV fluids to her patients, that she undertake a self-audit of the standard of her fluid balance chart documentation.

Data for Waikato District Health Board

Please note that data reported captures only those complaints in which the DHB was identified as a provider by the complainant or was subsequently identified by HDC as a party. Where a complaint is made about an individual practitioner at a DHB and the DHB is not identified, the complaint may not be included in these reports.

6.0 Complaints received about Waikato DHB

In the period Jul–Dec 2017, HDC received a total of **39**[8] complaints about care provided by Waikato District Health Board.

6.1 Rate of complaints received

Table 13 shows the rate of complaints to HDC per total discharges from Waikato DHB (48,507) compared to the rate of complaints per total discharges nationally (490,113).

The number of total discharges excludes short-stay discharges from emergency departments, and patients attending outpatient units and clinics.

Table 13. Number and rate of complaints per total discharges

Waikato DHB			National (All DHBs)
Number of complaints	**Number of discharges**	**Rate per 100,000 discharges**	**Rate per 100,000 discharges**
39	48,507	80.40	89.78

When DHBs were ranked according to their rate of complaints, Waikato DHB was **DHB 9**. Waikato DHB was DHB 7 in the previous six month period. As can be seen from the above table, Waikato DHB's complaint rate for Jul–Dec 2017 was lower than that of the national complaint rate for the same period.

Table 14 shows the number and rate of complaints about Waikato DHB received by HDC per 100,000 discharges, for Jul–Dec 2017 and previous six month periods.

Table 14. Number and rate of complaints received in last five years

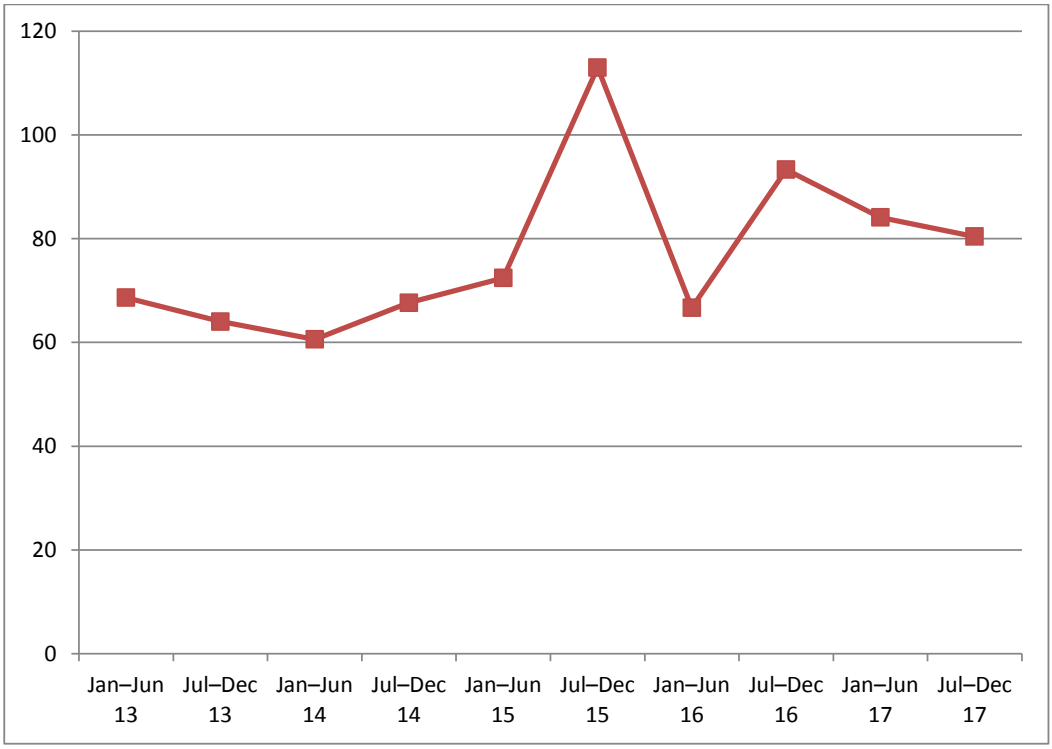
	Jan–Jun 13	**Jul–Dec 13**	**Jan–Jun 14**	**Jul–Dec 14**	**Jan–Jun 15**	**Jul–Dec 15**	**Jan–Jun 16**	**Jul–Dec 16**	**Jan–Jun 17**[9]	**Average of last 4 6-month periods**	**Jul–Dec 17**
Complaints received	28	27	25	31	32	52	30	44	40	**42**	**39**
Rate per 100,000 discharges	68.63	64.01	60.59	67.64	72.43	112.97	66.66	93.31	84.09	**89.26**	**80.40**

[8] Provisional as of date of extraction (19 January 2018).
[9] The rate for Jan–Jun 2017 has been recalculated based on the most recent discharge data.

The rate for Jul–Dec 2017 (80.40) shows a decrease of 10% over the average rate of complaints received for the previous four periods.

Figure 2 shows the rate of complaints received about Waikato DHB for Jul–Dec 2017 and previous six month periods.

Figure 2. Rate of complaints received per 100,000 discharges in last five years



7.0 Service types complained about at Waikato DHB

7.1 Service type

For the complaints received, the services concerned, and numbers of complaints within these services, are shown in Table 15.

Similar to national trends and what was seen last period at Waikato DHB, surgery (33.3%) and general medicine (28.2%) were the most commonly complained about service types at Waikato DHB in Jul-Dec 2017. Waikato DHB received a higher proportion of complaints about paediatrics in Jul-Dec 2017 than was seen nationally or last period at Waikato DHB.

Table 15. Service types complained about

Service type	Number of complaints	Percentage
District nursing	**1**	**2.6%**
Emergency department	**3**	**7.7%**
General medicine	**11**	**28.2%**
Cardiology	4	10.3%
Gastroenterology	2	5.1%
Geriatric medicine	1	2.6%
Neurology	1	2.6%
Oncology	1	2.6%
Other/unknown	2	5.1%
Maternity	**2**	**5.1%**
Mental health	**4**	**10.3%**
Paediatrics (not surgical)	**5**	**12.8%**
Surgery	**13**	**33.3%**
General	3	7.7%
Orthopaedics	5	12.8%
Plastic and reconstructive	1	5.1%
Urology	4	10.3%
TOTAL	**39**	

7.2 Department/facility and service type complained about

The service types complained about within each department/facility are shown in Table 16.

Table 16. Department/facility and service type complained about

Department/facility subject to complaint	Number of complaints
Thames Hospital	***1***
Surgery – Orthopaedics	**1**
Waikato Hospital	***35***
District nursing	**1**
Emergency department	**3**
General medicine	**11**
Cardiology	4
Gastroenterology	2
Geriatric medicine	1
Neurology	1
Oncology	1
Other/unknown	2
Maternity	**2**
Mental health	**1**
Paediatrics	**5**
Surgery	**12**
General	3
Orthopaedics	4
Plastic and reconstructive	1
Urology	4
Not specified	***3***
Mental health	**3**
TOTAL	**39**

8.0 Issues complained about at Waikato DHB

8.1 Primary issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received about Waikato DHB are listed in Table 17.

Similar to national trends, the most common primary complaint issue category for Waikato DHB was care/treatment (61.5%), and the most common specific primary issues were 'missed/incorrect/delayed diagnosis' (20.5%) and 'inadequate/inappropriate treatment' (17.9%).

Table 17. Primary issues complained about

Primary Issue	Number of complaints	Percentage
Access/funding	**7**	**17.9%**
Lack of access to services	2	5.1%
Waiting list/prioritisation issue	5	12.8%
Care/treatment	**24**	**61.5%**
Inadequate coordination of care/treatment	1	2.6%
Inadequate/inappropriate clinical treatment	7	17.9%
Inadequate/inappropriate examination/assessment	2	5.1%
Inadequate/inappropriate non-clinical care	1	2.6%
Inappropriate/delayed discharge/transfer	1	2.6%
Missed/incorrect/delayed diagnosis	8	20.5%
Rough/painful care/treatment	1	2.6%
Unexpected treatment outcome	3	7.7%
Communication	**1**	**2.6%**
Failure to communicate openly/honestly/effectively with consumer	1	2.6%
Consent/information	**3**	**7.7%**
Inadequate information provided regarding condition	1	2.6%
Inadequate information provided regarding treatment	1	2.6%
Issues with involuntary admission/treatment	1	2.6%
Documentation	**1**	**2.6%**
Inadequate/inaccurate documentation	1	2.6%
Facility issues	**1**	**2.6%**
Inadequate/inappropriate policies/procedures	1	2.6%
Medication	**2**	**5.1%**
Inappropriate prescribing	1	2.6%
Refusal to prescribe/dispense/supply	1	2.6%
TOTAL	**39**	

8.2 All issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Table 18 includes these additional complaint issues as well as the primary complaint issues to show all issues identified in complaints received about Waikato DHB.

Table 18. All issues complained about

All issues	Number of complaints	Percentage
Access/funding	**10**	**25.6%**
Lack of access to services	3	7.7%
Waiting list/prioritisation issue	7	17.9%
Care/treatment	**33**	**84.6%**
Delay in treatment	12	30.8%
Delayed/inadequate/inappropriate referral	1	2.6%
Inadequate coordination of care/treatment	6	15.4%
Inadequate/inappropriate clinical treatment	16	41.0%
Inadequate/inappropriate examination/assessment	11	28.2%
Inadequate/inappropriate follow-up	5	12.8%
Inadequate/inappropriate monitoring	1	2.6%
Inadequate/inappropriate non-clinical care	1	2.6%
Inadequate/inappropriate testing	3	7.7%
Inappropriate admission/failure to admit	1	2.6%
Inappropriate/delayed discharge/transfer	4	10.3%
Missed/incorrect/delayed diagnosis	11	28.2%
Refusal to assist/attend	1	2.6%
Rough/painful care/treatment	1	2.6%
Unexpected treatment outcome	6	15.4%
Unnecessary treatment/over-servicing	1	2.6%
Communication	**24**	**61.5%**
Disrespectful manner/attitude	4	10.3%
Failure to accommodate cultural/language needs	1	2.6%
Failure to communicate openly/honestly/effectively with consumer	13	33.3%
Failure to communicate openly/honestly/effectively with family	12	30.8%
Complaints process	**4**	**10.3%**
Inadequate response to complaint	4	10.3%
Consent/information	**9**	**23.1%**
Consent not obtained/adequate	3	7.7%
Inadequate information provided regarding condition	1	2.6%
Inadequate information provided regarding results	1	2.6%
Inadequate information provided regarding treatment	5	12.8%
Incorrect/misleading information provided	2	5.1%
Issues with involuntary admission/treatment	1	2.6%
Documentation	**8**	**20.5%**
Delay/failure to disclose documentation	1	2.6%
Inadequate/inaccurate documentation	7	17.9%
Facility issues	**8**	**20.5%**
General safety issue for consumer in facility	3	7.7%
Inadequate/inappropriate policies/procedures	3	7.7%
Issue with quality of aids/equipment	2	5.1%
Staffing/rostering/other HR issue	1	2.6%
Medication	**3**	**7.7%**
Inappropriate prescribing	2	5.1%
Refusal to prescribe/dispense/supply	1	2.6%
Other issues	5	

Similar to national trends and what was seen last period at Waikato DHB, on analysis of all complaint issue categories identified in complaints about Waikato DHB, the most common categories were care/treatment (present for 84.6% of complaints) and communication (present for 61.5% of complaints)

Broadly similar to what was seen last period at Waikato DHB, on analysis of all specific issues in complaints about Waikato DHB, the most common issues were 'inadequate/inappropriate clinical treatment' (41.0%), 'failure to communicate effectively with consumer' (33.3%), 'delay in treatment' (30.8%), 'failure to communicate effectively with family' (30.8%) 'inadequate/inappropriate examination/assessment' (28.2%) and 'missed/incorrect/delayed diagnosis (28.2%).

8.3 Service type and primary issues

The primary issues complained about in relation to each service are set out in Table 19.

Table 19. Primary issues complained about by service type

Service type	Number of complaints	Primary issues identified in each complaint
District nursing	1	Inadequate/inappropriate treatment
Emergency department	3	Waiting list/prioritisation issue Missed/incorrect/delayed diagnosis Inadequate/inaccurate documentation
General medicine – Cardiology	4	Inadequate/inappropriate examination/assessment Missed/incorrect/delayed diagnosis Failure to communicate effectively with consumer Inappropriate prescribing
General medicine – Gastroenterology	2	Inadequate coordination of care/treatment Refusal to prescribe/dispense/supply medication
General medicine – Geriatric medicine	1	Inappropriate/delayed discharge/transfer
General medicine – Neurology	1	Missed/incorrect/delayed diagnosis
General medicine – Oncology	1	Missed/incorrect/delayed diagnosis
General medicine – Other/unknown	2	Waiting list/prioritisation issue Inadequate/inappropriate non-clinical care
Maternity	2	Inadequate/inappropriate treatment x2
Mental health	4	Inadequate/inappropriate examination/assessment Inadequate/inappropriate treatment Issues with involuntary admission/treatment Inadequate/inappropriate policies/procedures
Paediatrics	5	Lack of access to services Inadequate/inappropriate treatment Missed/incorrect/delayed diagnosis x2 Inadequate information provided regarding condition
Surgery – General	3	Unexpected treatment outcome x2 Inadequate information provided regarding treatment
Surgery – Orthopaedics	5	Waiting list/prioritisation issue x2 Inadequate/inappropriate treatment x2 Missed/incorrect/delayed diagnosis
Surgery – Plastic and reconstructive	1	Waiting list/prioritisation issue
Surgery – Urology	4	Lack of access to services Missed/incorrect/delayed diagnosis Rough/painful care/treatment Unexpected treatment outcome

9.0 Closed complaints about Waikato DHB

9.1 Number of complaints closed

HDC closed **29** complaints about Waikato DHB in Jul–Dec 2017. HDC closed **3** complaints about Waikato DHB following investigation in this period.

Table 20 shows the total number of complaints closed and complaints closed following investigation for Jul–Dec 2017 and previous six month periods.

Table 20. Total number of complaints and formal investigations closed in last five years

	Waikato DHB											**All DHBs**
	Jan–Jun 13	**Jul–Dec 13**	**Jan–Jun 14**	**Jul–Dec 14**	**Jan–Jun 15**	**Jul–Dec 15**	**Jan–Jun 16**	**Jul–Dec 16**	**Jan–Jun 17**	**Average of last 4 6-month periods**	**Jul–Dec 17**	**Jul–Dec 17**
Total complaints closed	27	22	40	26	32	42	42	37	39	**40**	**29**	**383**
Investigations closed	1	1	2	2	2	1	4	1	2	**2**	**3**	**13**

9.2 Outcomes of complaints closed

The outcomes of all complaints closed about Waikato DHB in Jul–Dec 2017 are shown in Table 21.

Table 21. Outcomes for Waikato DHB of complaints closed[10]

Outcome for Waikato DHB	**Number of complaints**
Investigation	***3***
Breach finding	2
No further action with follow-up or educational comment	1
Other resolution following assessment	***26***
No further action with follow-up or educational comment	7
Referred to District Inspector	1
Referred to Other Agency	1
Referred to DHB	3
Referred to Advocacy	5
No further action	8
Withdrawn	1
TOTAL	**29**

[10] Note that outcomes are displayed in descending order. If there is more than one outcome for a DHB upon resolution of a complaint then only the outcome listed highest up in the table is included.

Finance Performance Monitoring

MEMORANDUM TO THE BOARD
27 JUNE 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 Result for May 2018	Year to Date Group Actual $m	 Group Budget $m	 Variance $m	Group Budget Jun-18 $m
Funder	26.1	31.0	(4.9) U	34.0
Governance	0.1	0.1	0.0 F	0.2
Provider	(53.2)	(38.4)	(14.8) U	(44.7)
Waikato Health Trust	(0.1)	0.2	(0.3) U	0.5
DHB Surplus/(Deficit)	**(27.1)**	**(7.1)**	**(20.0) U**	**(10.0)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

Episodes	May 2018 YTD				
Acute	**Actual May 2018**	**Plan**	**Variance to Plan %**	**Actual May 2017**	**Variance to Prior year %**
Surgical & CCTVS	16,298	16,264	0.2%	16,114	1.1%
Medicine & Oncology	20,234	19,191	5.4%	18,832	7.4%
Child Health	4,961	4,507	10.1%	4,401	12.7%
Women's Health	8,192	8,577	-4.5%	8,315	-1.5%
TOTAL	49,685	48,539	2.4%	47,662	4.2%
Elective	**Actual May 2018**	**Plan**	**Variance %**	**Actual May 2017**	**Variance to Prior year %**
Surgical & CCTVS	14,057	14,274	-1.5%	12,814	9.7%
Medicine & Oncology	603	985	-38.8%	927	-35.0%
Child Health	641	690	-7.1%	668	-4.0%
Women's Health	1,132	955	18.5%	1,067	6.1%
TOTAL	16,433	16,904	-2.8%	15,476	6.2%
Total Episodes - Acute plus Electives	**66,118**	**65,443**	1.0%	**63,138**	4.7%

CWDS	May 2018 YTD				
Acute	**Actual May 2018**	**Plan**	**Variance to Plan %**	**Actual May 2017**	**Variance to Prior year %**
Surgical & CCTVS	28,119	27,828	1.0%	28,113	0.0%
Medicine & Oncology	18,985	18,274	3.9%	18,059	5.1%
Child Health	6,272	5,727	9.5%	5,592	12.2%
Women's Health	4,605	4,533	1.6%	4,289	7.4%
TOTAL	57,981	56,362	2.9%	56,053	3.4%
Elective	**Actual May 2018**	**Plan**	**Variance %**	**Actual May 2017**	**Variance to Prior year %**
Surgical & CCTVS	20,027	20,273	-1.2%	17,561	14.0%
Medicine & Oncology	463	574	-19.3%	584	-20.7%
Child Health	521	624	-16.5%	553	-5.8%
Women's Health	1,056	1,032	2.3%	998	5.8%
TOTAL	22,067	22,503	-1.9%	19,696	12.0%
Total CWDS - Acute plus Electives	**80,048**	**78,865**	1.5%	**75,749**	5.7%

May 2018 YTD	**Actual**	**Prior year**	**Change**
ED Attends	107,300	102,193	5.0%
Beddays	209,165	199,969	4.6%

MONTHLY COMMENTS

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

Delivery Plan Performance

We continue to make progress on getting to a point of clarity re overall Planned volumes for future years in order 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.
The volumes achieved in the current year have increased against the prior year for acute, elective, ED attends and Beddays which is reflected in a number of unfavourable YTD cost variances.

Financial Performance Monthly Comment:

For May 2018 YTD we have an unfavourable variance to budget of $20.0m. This includes an unbudgeted accrual for estimated additional costs which are expected to arise from nursing MECA negotiations based on the latest offer ($4.0m). Further key YTD variances relate to the impact of increased hospital activity including consequential unfavourable leave movements, and the under delivery of some centrally held high risk savings plans.
The forecast position for the full year communicated to the Ministry is a deficit of $29.5m. This forecast includes the potential impact of nursing MECA negotiations $4.0m, increased pharmaceutical costs $1.7m and unachieved savings plan $2.0m.

Provider:

The Provider is unfavourable to budget $14.8m - see detail for explanations. Variances include:

1. Revenue $16.9m favourable to budget due mainly to favourable internal revenue (eliminates against Funder), a favourable acute volume variance, IDF in and the reimbursement of NOS costs.
2. Employed personnel costs favourable to budget $5.6m - analysis below.
3. Outsourced Personnel costs unfavourable $14.9m, the dominant variances relate to medical locums ($5.9m partly offset by savings in medical personnel costs), nursing personnel ($2.6m) and Management and Administration $5.6m ($3.7m NOS costs recovered in other government revenue).
4. Outsourced Services favourable $2.8m - analysis below.
5. Clinical supplies unfavourable to budget $9.1m - analysis below.
6. Infrastructure & Non Clinical supplies are unfavourable to budget $17.5m - analysis below.
7. Interest, depreciation and capital charge favourable to budget $1.5m due mainly to depreciation as a result of lower capital spend.
8. Loss on disposal of fixed assets unbudgeted $0.1m.

Funder and Governance:

The results for the Funder is $4.9m unfavourable to budget. This mainly as a result of unfavourable internal provider payments (eliminates against Provider). This is partially offset by higher additional funding received across a number of areas. Governance is on budget.

Waikato Health Trust

The result for the Waikato Health Trust is unfavourable to budget mainly due to unfavourable grants variance arising from increased grants paid against budget assumptions.

RECOMMENDATION(S):

That this report for May 2018 year to date 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	**$7.4 F**	
CFA Revenue		
● CFA revenue $0.9m favourable to budget which includes increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year). Current year funds are on-paid to providers (offset in NGO payments).	$0.9 F	Neutral
Crown Side-Arm Revenue		
● Crown side-arm revenue $0.8m favourable to budget which includes increased contract revenue for DSS U65 inpatient and outpatient ($0.3m above budget), and variability of volumes compared to budget for breast screening ($0.3m above budget).	$0.8 F	Favourable
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is favourable to budget mainly due to:		
● Reimbursement of costs associated with the implementation of National Oracle Solution (NOS) $3.7m favourable (offset in Outsourced Personnel $3.9m).	$5.5 F	Neutral
● ACC income $0.9m favourable which includes increases in income as a result of a change to a new annual contract ($0.3m) along with gains from improved processes ($0.6m).		
● Return to Employment project income $1.0m unfavourable due to lower referrals from MSD for enrolment. This variance is partly offset by lower outsourcing, clinical supplies and infrastructure costs $0.7m.		
● Inter District Flow (IDF) income from other DHBs $0.2m unfavourable. Volumes by speciality and by DHB continue to fluctuate compared to budget.		
● Inter District Flow (IDF) income relating to 2016/17 $1.8m favourable. This is as a result of the annual wash up of IDF activity across all DHBs. The final adjustment is not known until coding of all activity across all DHBs is completed. This variance is partly offset by an unfavourable variance on the IDF outflow wash up ($0.8m), which is included in NGO payments.		Favourable
Other Revenue		
Other revenue is close to budget.	$0.2 F	Favourable

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($27.4) U**	
Personnel (employees and outsourced personnel total)	**($9.4) U**	
Employed personnel are favourable to budget mainly due to:	$5.5 F	
● Medical personnel are favourable to budget by $7.9m. This includes a higher than expected vacancy level, partly offset by an unfavourable annual leave movement for the year to date. This favourable variance is partly offset by outsourced personnel unfavourable variance $5.9m.		Neutral
● Nursing personnel are unfavourable to budget by $5.5m. This variance, along with the unfavourable outsourced personnel cost for nursing of $2.6m, is due to accrued estimated costs for MECA rate changes ($4.0m), unfavourable annual leave movement for the year to date and higher than budget overtime. The variance also includes the impact of higher beddays (4.6%), and a higher level of mental health inpatient services and acuity.		Unfavourable
● Allied Health personnel are favourable to budget by $1.2m. Variances continue to be mainly as a result of higher than expected vacancy levels. The net favourable variance of $0.6m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.3% of total allied health personnel budget to date.		Neutral
● Management, Administration and Support personnel are favourable to budget by $1.9m. Variances are spread across the DHB including clinical support, and are mainly as a result of higher than expected vacancy levels. Partially offset in Outsourced Personnel ($1.7m).		
Outsourced personnel are unfavourable to budget mainly due to:	($14.9) U	
● Medical costs are $5.9m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $7.9m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.		Neutral
● Nursing costs are $2.6m unfavourable. As for employed nursing personnel this is due to the impact of higher beddays (4.6%), a higher level of mental health inpatient services and acuity and higher than budgeted patient watches.		Unfavourable
● Allied health costs are $0.6m unfavourable. The net favourable variance of $0.6m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.3% of total allied health personnel budget to date.		Neutral
● Management, Administration and Support costs are $5.6m unfavourable largely due to contractor costs of $3.9m for the implementation of the new NOS ERP solution (to date $3.7m of this cost is offset by additional other government revenue) and $1.7m to cover management, administration and support vacancies (offset in favourable employed personnel variance).		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$2.8 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced clinical service costs are $2.0m favourable. This dominantly due to Virtual Health costs $4.0m favourable to budget. This is a prior period correction to Health Tap costs, as these costs were allocated in advance of the contract starting. Unfavourable offsetting variances include $1.4m for higher demand for diagnostic services as a result of higher usage of scans as part of determining treatment plans. The remaining unfavourable variances are spread across a number of areas. Facility lists are now close to budget due to additional activity to meet elective service targets.	$2.8 F	Favourable
• Outsourced corporate service costs are $0.8m favourable to budget due mainly to a delay in commencing Information Systems outsourcing including a new national IS infrastructure.		
Clinical Supplies	**($9.0) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Instruments and equipment – favourable to budget by $1.1m. These particular supplies are not volume related. The variance is due to timing of ordering, as well as coding of some costs as treatment disposals (i.e. part offset to the treatment disposals unfavourable variance).	$1.1 F	Neutral
• Implants and Prosthesis is close to budget.	($0.1) U	Neutral
• Treatment disposables - unfavourable to budget by $6.0m (11.1% of budgeted costs). Savings plans related to clinical supplies are allocated against treatment disposals, and total $2.2m year to date. High cost areas include theatres (mix including high cost specialities of orthopaedics and neurosurgery), blood services (high product demand within the hospital), renal dialysis (volumes 8% up on budget), and respiratory patients (case weights 8% up on plan).	($6.0) U	Unfavourable
• Pharmaceuticals - unfavourable to budget by $3.7m. Relates mainly to $2.3m unbudgeted increase in oncology drug costs. The initial Pharmac forecast included a lower usage assumption for new melanoma drugs. The variance includes a favourable offset of $0.4m in December due to a rebate adjustment for the increase in costs in 2017/18.	($3.5) U	Unfavourable
• Pharmaceuticals rebate adjustment relating to 2016/17 $0.2m favourable to budget. This is a wash up amount relating to prior year costs that we were notified of in December 17.		Favourable
• Diagnostic Supplies & Other Clinical Supplies are close to budget.	($0.5) U	Unfavourable
Infrastructure and non-clinical supplies	**($17.5) U**	
• Favourable variance including savings as a result of delays in moving in to new buildings - $3.5m. The net variance includes ongoing additional costs due to extended leases in existing buildings. Maintenance costs are $1.6m favourable. This includes timing differences which are forecast to be incurred in June 2018.	$5.1 F	Favourable
• Savings plan - $22.6m unfavourable variance in infrastructure relates to centrally held savings plan not specifically allocated. Whilst savings have been achieved across the business, certain high risk initiatives have under delivered against projected outcomes.	($22.6) U	Unfavourable

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$4.3 F**	
External Provider payments are favourable to budget mainly due to:		
• Payments to providers are $4.2m favourable. Payments to mental health providers are favourable to budget by $2.9m due to a delay in commencement of NGO contracts. Other variances arise due to costs not being incurred in line with CFA revenue received, MoH and accrual adjustments relating to prior year funding and costs arising from additional targeted revenue from MoH.	$4.3 F	Favourable
• IDF out payments for 2017/18 are $0.9m favourable. This relates mainly to lower volumes for personal health services.		
• IDF out payments for 2016/17 are $0.8m unfavourable. As for IDF in receipts, this relates to the annual wash up of IDF activity across all DHBs. This final adjustment is not known until coding of all activity across all DHBs is completed. Variance is offset by a favourable variance on the IDF inflow wash up ($1.8m), which is included in Other Government and Crown Agencies Revenue.		
Interest, depreciation and capital charge	**$1.5 F**	
Interest charge is close to budget.	$0.1 F	Favourable
Capital charge is on budget.	$0.0 F	Neutral
Depreciation is favourable to budget due mainly to slower than planned capital spend and the timing of capitalisation of IS projects.	$1.4 F	Favourable
Extraordinary costs	**($0.1) U**	
Loss on disposal of fixed assets - not budgeted.	($0.1) U	Unfavourable

TREASURY

Opinion on Group Result:

Cash flows are favourable to budget as detailed below.

YTD Actuals May-17 $'000	Waikato DHB Cash flows for year to May 2018	Year to Date Actual $'000	Year to Date Budget $'000	Year to Date Variance $'000	Budget Jun-18 $'000
	Cash flow from operating activities				
1,229,840	Operating inflows	1,326,351	1,307,190	19,160	1,438,154
(1,184,160)	Operating outflows	(1,278,732)	(1,260,417)	(18,315)	(1,396,156)
45,680	**Net cash from operating activities**	**47,619**	**46,773**	**845**	**41,998**
	Cash flow from investing activities				
1,453	Interest income and proceeds on disposal of assets	1,453	1,071	381	1,170
(25,873)	Purchase of assets	(30,971)	(50,452)	19,481	(55,056)
(24,420)	**Net cash from investing activities**	**(29,519)**	**(49,381)**	**19,862**	**(53,886)**
	Cash flow from financing activities				
0	Equity repayment	(0)	0	(0)	(2,194)
(6,764)	Interest Paid	(740)	(736)	(4)	(810)
348	Net change in loans	(544)	10,112	(10,656)	12,700
(6,416)	**Net cash from financing activities**	**(1,284)**	**9,376**	**(10,660)**	**9,696**
14,844	**Net increase/**(decrease) in cash	**16,816**	**6,767**	**10,047**	**(2,192)**
856	Opening cash balance	9,577	9,577	(0)	9,577
15,700	**Closing cash balance**	**26,393**	**16,344**	**10,047**	**7,385**

Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Total Net cash flow from Operating Activities	**$0.9 F**	
Operating inflows	**$19.2 F**	
Operating inflow is favourable to budget mainly due to:	$19.2 F	
o Unbudgeted IDF wash-up revenue received in December $2.0m.		Favourable
o Crown side-arm revenue $0.8m favourable to budget which includes increased contract revenue for DSS U65 inpatient and outpatient ($0.3m) and for breast screening ($0.3m).		Neutral
o ACC income $0.9m favourable to budget which includes increases in income as a result of a change to a new annual contract ($0.3m) along with gains from improved processes ($0.6m).		
o CFA revenue $0.9m favourable to budget which includes increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year).		
o Return to Employment project income $1.0m unfavourable due to lower referrals from MSD for enrolment.		
o Income in Advance inflows are $1.6m favourable to budget mainly due to unbudgeted quarterly pay equity funding received.		
o The balance of the operating inflow variance relates to timing of actual cash inflows compared with budget assumptions. Budget assumptions phase most income evenly. Timing of actual receipts for certain revenue is impacted by invoicing, contract signing date or periodic payment agreements. The favourable inflow variance is further evidenced in the Balance Sheet variance relating to receiveables ($5.0m U) and a higher cash balance ($10.0m).		

Cash flow variances resulted from:	Variance $m	Impact on forecast
Operating outflows	**($18.3) U**	
Operating cash outflows for payroll costs are favourable mainly due to:		
o Personnel costs are favourable against budget mainly due to higher than planned vacancies. Vacant positions are in many instances filled by outsourced personnel. Offset in unfavourable non payroll cash flows.	$14.7 F	Neutral
Operating cash outflows for non-payroll costs are unfavourable largely as a result of:		
o Unfavourable operating costs including outsourced personnel (offset in personnel cost), outsourced services, clinical supplies, infrastructure & non clinical supplies and provider payments (net -$34.3m).	($35.2) U	Neutral
o Higher prepayment balance due to timing of payments $2.4m - largely IS contracts.		
o The actual timing of vendor payments against budget assumptions.		
o GST cash movement is favourable due to timing variances on GST transacted.	$2.2 F	Neutral
Net cash flow from Investing Activities	**$19.9 F**	
o Interest received is close to budget.	$0.4 F	Favourable
o Capital spend is slower than planned YTD. This is as a result of deferred timing of spend.	$19.5 F	Favourable
Net cash flow from Financing Activities	**($10.7) U**	
o Cash flow from financing activities is unfavourable due to the deferment of planned finance leases.	($10.7) U	Unfavourable

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 31-May-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	1,790	4,228	6,764	4,708	4,366	5,855	4,594	4,468	6,650	3,252	4,480	6,422	4,708
Funder inflow (MoH, IDF, etc)	126,677	133,552	131,880	131,880	136,560	131,880	131,880	136,750	131,880	131,880	136,750	131,880	131,880
Donations and Bequests	232	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	3,138	2,942	3,060	2,757	2,412	2,642	2,642	2,297	2,415	2,185	2,415	2,185	2,645
Rents, ACC, & HealthPac (General Accou	3,495	2,588	2,736	2,886	2,645	2,760	2,751	2,658	2,676	2,562	2,739	2,547	2,889
	135,332	143,310	144,440	142,231	145,983	143,137	141,867	146,173	143,621	139,879	146,384	143,034	142,122
Cash was applied to:													
Personnel Costs (incl PAYE)	(49,767)	(49,569)	(46,541)	(60,005)	(46,808)	(52,587)	(49,497)	(56,609)	(47,788)	(49,992)	(46,696)	(46,168)	(54,771)
Other Operating Costs	(30,369)	(37,900)	(36,026)	(34,924)	(36,222)	(31,124)	(35,826)	(30,720)	(30,720)	(31,620)	(36,422)	(34,820)	(34,524)
Funder outflow	(51,252)	(45,700)	(47,192)	(51,287)	(46,532)	(47,517)	(47,192)	(46,202)	(46,958)	(46,431)	(50,370)	(46,270)	(47,618)
Interest and Finance Costs	(12)	(10)	(15)	(12)	(20)	(15)	(12)	(10)	(15)	(10)	(10)	(10)	(10)
Capital Charge	0	(18,483)	0	0	0	0	0	(18,483)	0	0	0	0	0
GST Payments	(14,252)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(13,710)	(9,000)	(7,210)	0	(14,420)
	(145,652)	(158,872)	(136,984)	(153,438)	(136,792)	(138,453)	(139,737)	(152,024)	(139,191)	(137,053)	(140,708)	(127,268)	(151,343)
OPERATING ACTIVITES	**(10,320)**	**(15,562)**	**7,456**	**(11,207)**	**9,191**	**4,684**	**2,130**	**(5,851)**	**4,430**	**2,826**	**5,676**	**15,766**	**(9,221)**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	81	90	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
	81	90	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(3,488)	(3,500)	(3,500)	(4,000)	(4,000)	(5,000)	(3,500)	(5,500)	(3,500)	(5,000)	(4,000)	(4,500)	(5,500)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(3,488)	(3,500)	(3,500)	(4,000)	(4,000)	(5,000)	(3,500)	(5,500)	(3,500)	(5,000)	(4,000)	(4,500)	(5,500)
INVESTING ACTIVITIES	**(3,407)**	**(3,410)**	**(3,425)**	**(3,925)**	**(3,925)**	**(4,925)**	**(3,425)**	**(5,425)**	**(3,425)**	**(4,925)**	**(3,925)**	**(4,425)**	**(5,425)**
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance Lease received	0	0	0	0	2,600	2,600	2,600	2,600	2,600	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	2,600	2,600	2,600	2,600	2,600	0	0	0	0
Cash was applied to:													
Capital Repayment	0	(2,194)	0	0	0	0	0	0	0	0	0	0	0
Finance lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0	0	(15)
Working capital facility repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
FINANCING ACTIVITIES	**(26)**	**(2,194)**	**0**	**(26)**	**2,600**	**2,600**	**2,574**	**2,600**	**2,600**	**(26)**	**0**	**0**	**(15)**
Opening cash balance	33,258	19,505	(1,662)	2,368	(12,790)	(4,925)	(2,568)	(1,290)	(9,967)	(6,363)	(8,489)	(6,738)	4,602
Overall increase/(decrease) in cash	(13,753)	(21,167)	4,031	(15,159)	7,865	2,357	1,278	(8,677)	3,604	(2,126)	1,751	11,340	(14,662)
CLOSING CASH BALANCE	19,505	(1,662)	2,369	(12,791)	(4,925)	(2,568)	(1,290)	(9,967)	(6,363)	(8,489)	(6,738)	4,602	(10,060)
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	19,505	(1,840)	2,191	(12,968)	(5,102)	(2,745)	(1,467)	(10,144)	(6,540)	(8,666)	(6,915)	4,425	(10,237)
Long-term Loans													
Finance Leases	0	0	0	0	(2,600)	(5,200)	(7,800)	(10,400)	(13,000)	(13,000)	(13,000)	(13,000)	(13,000)
EECA Loan	(169)	(169)	(169)	(143)	(143)	(143)	(117)	(117)	(117)	(91)	(91)	(91)	(76)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	19,336	(2,009)	2,022	(13,111)	(7,845)	(8,088)	(9,384)	(20,661)	(19,657)	(21,757)	(20,006)	(8,666)	(23,313)
Working capital facility	(70,937)	(70,937)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(70,937)	(70,937)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)

BALANCE SHEET

Opinion on Result:

There are no material concerns on the balance sheet.

Prior Year June 2017 $'000	Waikato DHB Group Financial Position	As at May 2018 Actual $'000	Budget $'000	Variance $'000	Budget Jun-18 $'000
88,517	Total current assets	94,282	86,641	7,641 F	65,434
(181,405)	Total current liabilities	(200,882)	(179,952)	(20,930) U	(160,570)
(92,888)	**Net working capital**	**(106,600)**	**(93,311)**	**(13,289) U**	**(95,136)**
736,618	Term assets	721,698	739,873	(18,175) U	739,628
(21,053)	Term liabilities	(19,719)	(31,018)	11,299 F	(34,411)
715,565	**Net term assets**	**701,979**	**708,855**	**(6,876) U**	**705,217**
622,677	**Net assets employed**	**595,379**	**615,544**	**(20,165) U**	**610,081**
622,677	**Total Equity**	**595,379**	**615,544**	**(20,165) U**	**610,081**

Balance Sheet variance's resulted from:	**Variance $m**	**Impact on forecast**
Net Working Capital:		
Net working capital is unfavourable to budget mainly due to:		
Current Assets		
• Cash held with New Zealand Health Partnership Limited is higher than budget by $10m due mainly to the favourable variance relating to operating activities($0.8m) and investing activities ($19.9m) offset by an unfavourable variance from financing activities ($10.7m).	**$7.6 F**	Neutral due to timing
• Total accounts receivable and accrued debtors is lower than budgeted by $5.0m mainly due to the timing of cash received compared with budget assumptions, offset by the unbudgeted accrual of NOS recoveries.		
• Prepayments are higher than planned by $2.4 mainly due to timing of payment of e-Space prepaid license to use.		
• Other favourable variances across a number of areas $0.2m.		
Current Liabilities		
• Payroll liabilities are $10.1m unfavourable mainly due to accrual for the potential liability arising from a Nursing MECA settlement, MECA increases and timing of pay runs (PAYE & leave) as compared with the phasing of the budget.	**($20.9) U**	Neutral due to timing
• Income in Advance $1.6m unfavourable to budget mainly due to unbudgeted quarterly pay equity funding received.		
• GST $2.2m unfavourable to budget mainly due to the timing of processing of vendor invoices and unbudgeted income received.		
• Accrued Creditors $6.7 unfavourable mainly due to unbudgeted accrual of NOS costs, higher operational expenses which is evident in the results for the month and the timing of payments. This unfavourable variance is partially offset by a higher cash balance.		
• Other Current Liabilities are favourable to budget $0.3m mainly due to the variances arising from the actual timing of transactions compared with budget assumptions.		

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $19.6m and favourable YTD depreciation $1.4m. Please see attached for latest forecast of capital spend for the year for further detail.	**($18.2) U**	Unfavourable
Non Current Liabilities:		
Non Current Liabilities are favourable due to deferment of budgeted finance leases.	**$11.3 F**	Favourable
Equity:		
Driven mainly by variance in overall results.	**($20.2) U**	Unfavourable

Final

CAPITAL EXPENDITURE AT 31 May 2018 ($000s)

Capital Plan					Cash Flow Forecast					Full Project Forecast		
Activity	Total Prior year Board Approvals	New Approvals FY17/18	Transfers During 17/18	Total Board Approved Capital Plans	Prior year expenditure for active Projects	Total Expenditure Forecast FY 17/18 (Actual + Planned)	Actual Expenditure YTD from 1 Jul-17 to 31 May 18	Approved and Planned Expenditure 01 Jun 18 - 30 Jun 18	Approved and Planned Spend Subsequent Years	Total Planned Expenditure (Actual + Forecast to Project completion)	Total Planned Expenditure Versus Total Board Approved	Commitments
Under $50K Subtotal		3,000	-	3,000		3701	2,701	1,000	0	3,701	-701	921
Clinical Equipment Subtotal	12,725	20,354	3,672	36,751	2,562	13,130	11,757	1,373	20,975	36,667	83	4,519
Property & Infrastructure Subtotal	44,007	8,022	-686	51,343	19,371	9,985	8,886	1,098	20,774	50,129	1,214	2,455
IS Subtotal	20,082	8,600	109	28,790	8,315	6,424	6,066	358	12,071	26,810	1,980	2,270
Corporate Systems & Processes Subtotal	3,326	8,325	68	11,719	450	3,088	3,029	59	8,301	11,839	-120	51
Regional Subtotal	4,425	798	0	5,223	270	763	693	70	2,951	3,984	1,239	70
MOH Subtotal	0	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	55
REPORT TOTALS	84,565	49,099	3,163	136,826	30,968	37,090	33,132	3,958	65,072	133,130	3,697	10,341

Waikato DHB
CAPITAL EXPENDITURE AT 31 May 2018 ($000s)

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
CT Machine Replacement Waikato x3	3,828	3,846	6	(24)
CT Machine Replacement Waikato x1	725	725	1	(1)
Ventilators (Critical Care)	400	-	400	-
Endoscopes	300	-	300	-
Replacement Theatre Lights OT 20-25	286	235	51	(0)
Glucose meters	275	-	275	-
Renal Dialysis (CCD) machines x4 Prismaflex	564	601	-	(38)
Other items - identfied per Clinical asset review	781	-	-	781
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	550	763	(0)
Mobile Dental Unit Replacements - level 2	600	34	566	0
Bed Replacement Programme	400	-	400	-
Digital Mobile X-Ray	351	-	351	(0)
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	-	300	-
Microscope - Platics- Plastics Theatre	300	-	300	-
Linear Accelerator (replacement)	4,000	-	4,000	-
Anaesthetic machine - Aisys Carestation	380	-	365	15
Heart Lung Machines	1,493	995	498	(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	496	6	98
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	21	805	(1)
Trauma Gantry (radiology)	350	-	350	-
L8 Menzies Surgical Assessment Unit (Acute)	1,561	20	1,542	(0)
Projects Removed to be Capitalised	4,880	5,636	-	(756)
Other Clinical Services Projects Budgeted <$250K	9,823	3,861	6,653	(690)
Clinical Equipment Subtotal	39,751	17,020	23,348	(617)
Property and Infrastructure				
Mental Health Facility - part 2	1,513	-	1,248	265
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Gallagher Build - Fitout	4,238	3,875	56	308
Gallagher Building - Med Store & CSES Clinic	406	402	-	4
Gallagher Building - Racking System	362	522	-	(160)
Gallagher Building - Converyor System	348	356	-	(8)
SCEP racking - hospital wide	400	-	400	-
Hamilton Consolidation of CBD facilities - 9th Floor	850	850	-	(0)
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	1,875	7,463	(214)
Hamilton CBD - Collingwood Street Development - First Floor	5,584	263	4,361	960
ED - Reconfiguration of entry / Front of House (Potential substitution for ED Expansion)	400	-	400	-
Menzies L3 development (Potential substitution for ED Expansion)	450	-	450	-
Pain Clinic to L8 Menzies (Potential substitution for ED Expansion)	450	-	450	-
Hilda Ross - Phase 1	2,801	3,134	-	(333)
Hilda Ross - Remediation	3,683	3,226	280	177
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	5	550	(5)
Hague road carpark - Seismic and Beam support	375	-	375	-
Urology to L8 Menzies	320	22	298	0
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Waikato Hauora iHub	321	57	264	(0)
Waikato switchboard upgrades core buildings	675	10	665	0
Infrastructure Replacement Pool (17/18)	510	161	202	147
Infrastructure Replacement Pool (15/16)	600	731	3	(134)
Infrastructure Replacement Pool (16/17)	641	205	100	336
OCB Replacements	350	-	350	-
Waikato Distribution Boards	250	213	37	(0)
Lift car upgrades (Stage 1)	1,835	2,059	-	(224)
Electrical Systems Improvement	6,714	5,969	745	0
	-	-	-	-

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
Projects Removed to be capitalised	3,165	3,175	-	(10)
Projects no longer in flight with expenditure	274	-	-	274
Other P&I Projects Budgeted <$250K	3,604	1,149	2,625	(169)
Property & Infrastructure Subtotal	**51,343**	**28,257**	**21,872**	**1,214**
Regional				
National Oracle Solution - Elevate	4,399	963	2,197	1,239
Other Regional Projects Budgeted <$250K	824	-	824	-
Regional Subtotal	**5,223**	**963**	**3,021**	**1,239**
MOH & Trust Funded				
National Patient Flow Phase 3 16/17	257	267	-	(10)
Telestroke Pilot	321	49	272	-
16/17 Trust Account	303	303	-	(0)
Other MOH & Trust Funded Projects Budgeted <$250K	(881)	(619)	(272)	10
MOH & Trust Subtotal	-	(0)	-	0
Information Systems				
Platform	2,688	775	1,847	66
Storage & Reporting	1,125	534	574	17
Network & Communications	3,658	1,794	1,764	100
IAAS	1,686	942	743	1
Devices	2,225	878	1,348	(2)
Licensing	1,125	212	913	(0)
Enterprise Service Business	937	312	625	0
Tools	3,134	1,534	1,637	(37)
Security	817	105	712	(0)
Clinical Systems	6,835	4,193	2,784	(142)
Other Projects	1,343	153	282	908
Corporate Systems	11,719	3,479	8,360	(120)
Projects to be Capitalised	3,218	2,949	-	269
Adjustment to reflect capacity to deploy			(800)	800
IS Subtotal	40,509	17,861	20,789	1,860
Grand total	**136,826**	**64,100**	**69,029**	**3,697**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
May 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			
May 2018	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AYDON LYDIA HELEN MS	311.44	-	311.44	1,572.39	-	1,572.39	
AITKEN VICKI ANN	-	-	-	1,558.25	-	1,558.25	
CHRYSTALL MAUREEN MS	-	-	-	1,099.89	-	1,099.89	
ELLIOTT LORAINE	-	-	-	937.10	-	937.10	
HABLOUS NEVILLE MR - Acting CE	-	-	-	557.25	-	557.25	Detail below
HACKETT DARRIN MR	-	-	-	126.35	-	126.35	
HAYWARD SUSAN MRS	505.60	-	505.60	5,305.90	3,444.96	8,750.86	Training related $3,445
LAWRENSON ROSS PROF	-	-	-	353.63	-	353.63	
MALONEY TANYA	-	-	-	280.12	4,157.48	4,437.60	Training related $4,157
MURRAY NIGEL MR	-	-	-	6,829.52	(499.90)	6,329.62	Detail below
NEVILLE MAUREEN MS	-	-	-	1,877.26	-	1,877.26	
PARADINE BRETT MR	-	-	-	312.26	-	312.26	
SPITTAL MARK MR	-	-	-	2,001.87	-	2,001.87	
TAPSELL REES	-	-	-	517.48	1,759.00	2,276.48	
TER BEEK MARC MR	194.87	-	194.87	802.54	-	802.54	
TOMIC DAMIAN MR	9.57	690.43	700.00	3,206.32	690.43	3,896.75	
WATSON TOM MR	-	-	-	1,292.58	-	1,292.58	
WILSON JULIE MS	-	-	-	4,474.24	-	4,474.24	
WOLSTENCROFT IAN	-	-	-	146.96	-	146.96	
WRIGHT DEREK MR - Executive	-	-	-	1,302.35	63.48	1,365.83	
WRIGHT DEREK MR - Interim CE	1,025.11	-	1,025.11	5,088.05	-	5,088.05	Detail below
Grand Total	**2,046.59**	**690.43**	**2,737.02**	**39,642.31**	**9,615.45**	**49,257.76**	

CE Travel Expenditure: Nigel Murray

Travel costs for the period to 31 October 2017				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
8 to 12 April 2017	1,084.40	CEO activity	Accommodation 4 nights	Auckland
20 to 23 April 2017	940.12	Meetings with officials and organisations re Waikato Med School	Accommodation, 3 nights	Wellington
27 April to 1 May 2017	275.70	Cairns - Waikato Med School, Sydney - Theatres/surgical performance	Accommodation, 1 night	Sydney
7 to 9 May 2017	430.09	Waikato Medical School	Accommodation, 2 nights	Wellington
18 to 20 May 2017	330.68	Speaker - Healthcare Reform conference	Accommodation, 2 nights	Wellington
14 to 15 June 2017	744.86	Presentation Medical School to DHB Chairs/CEs	Airfare (return), accommodation, 1 night	Wellington
25 to 26 June 2017	1,433.59	Meeting with Lance O'Sullivan re Smart health	Airfare (return), accommodation, 3 nights	Kaitaia
2 to 4 May 2017	665.31	Meetings re Smarthealth (2/5) and Medical School (3/5)	Accommodation, 2 nights	Auckland
25 to 26 May 2017	478.05	Procurement meeting 25/5, Pharmac 26/5, returned late to Auckland	Accommodation, 2 nights	Auckland
Aug 2017	(403.81)	Corrections from Tandem Travel	Airfares - corrections to original charges Sept 16	Sydney
June 2017	350.63	Use of domestic taxi chits	Taxi chits	Domestic
	6,329.62			

Acting CE Travel Expenditure Neville Hablous

Travel costs for the period July to October 2017				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
7 Sept 2017	**557.25**	National DHB CE meeting	Airfare (return)	Wellington

Interim CE Travel Expenditure Derek Wright

Travel costs for the period October 2017 to May 2018				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
November 2017	69.57	Conference cost	Nga Tumanako Conference	Ngaruawahia
November 2017	77.83	Mental Health and Addictions Services NGO Commissioning workshop	Mileage and parking expenses	Auckland
December 2017	702.42	DHB CE Meeting & MoH DG Health	Airfare (return), taxi	Wellington
December 2017	471.44	DHB CE Meeting - RMO bargaining strategy	Airfare (return)	Wellington
December 2017	73.48	Mental Health and Addictions Services NGO Commissioning workshop	Mileage and parking expenses	Auckland
February 2018	199.13	Midlands DHBs regional meetings	Accommodation	Auckland
February 2018	692.90	National DHB CE meeting	Airfares, taxi and parking	Wellington
February 2018	584.90	Health Select Committee, Ministry of Health executives, Health and Disability Commissioner	Airfares, parking and taxi	Wellington
March 2018	130.43	Midland United Regional Integration Alliance Leadership Team, Midland Regional meetings	Accommodation	Tauranga
March 2018	990.84	Oranga Mahi Governance Board meeting, National Chair and DHB meetings	Accommodation, Taxi, parking and airfare	Wellington
April 2018	70.00	Midlands CE,eSpace CEO Governance, HealthShare Board and Midland Regional Governance Group meetings	Mileage	Rotorua
3-4 May 2018	766.35	Midland Regional Meetings	Airfares, mileage to airport, taxi and parking	Gisborne
10 May 2018	104.85	National DHB CE meeting	Taxi - other costs not yet charged	Wellington
12-13 May 2018	153.91	Education Summit	Mileage and parking expenses	Auckland
	5,088.05			

Health Targets

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 7

HEALTH TARGETS REPORT

Purpose	For information.

Most Recent Results

Table 1 shows a summary of the officially published performance for Waikato DHB's health target results including 2017/18 quarter three results where available. These results are still provisional as the Ministry of Health has not yet obtained final approval from the Minister to publish them. The most recent results in the last column give the most up to date picture of performance using local data where available. Work is currently underway to redesign this report to clearly show the equity gap for Māori in line with the Board's focus on this priority area.

Table 1- Health targets performance summary

HEALTH TARGETS		16/17 Target	2016/17 Q1 results & ranking	2016/17 Q2 results	2016/17 Q3 results	2016/17 Q4 results	17/18 Target	2017/18 Q1 results	2017/18 Q2 results	2017/18 Q3 results (provisional)	Target achieved	2017/18 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% 19 ✗	X	85% May-18 YTD
Improved access to elective surgery		100%	108% 7th ★	106% 10th ●	110% 3rd ★	114% 2nd ★	100%	111% 5th ★	104% 8th ●	105% 6th ★	√	105.4% May-18 YTD
Faster Cancer Treatment (FCT)	Achievement	85%	81.4% 5th ★	85.9% 4th ★	86.1% 5th ★	86% 2nd ★	85%	98% 1st ★	98% 2nd ★	97% 3rd ★	√	93% May-18
Better Help for Smokers to quit	Primary Care	90%	87% 12th ●	86% 13th ●	87% 12th ●	88% 15th ✗	90%	88% 14th ●	89% 12th ●	88% Ranking unavailable	X	88% 17/18 Q3 result
	Maternity	90%	93% 12th ●	96%	98% 4th ★	95% 8th ●	90%	94% 8th ●	97% 4th ★	99% Ranking unavailable	√	99% 17/18 Q3 result
Increased immunisation (8 months)		95%	92.3% 13th ●	92% 15th ✗	90% 16th ✗	89% 15th ✗	95%	88% 15th ✗	90% 15th ✗	89% 14th ✗	X	87% May 18 3 mth rolling
Raising Healthy Kids[1]		95%	47% 11th ●	79% 6th ★	84% 9th ●	81% 14th ●	95%	76% 19th ✗	100% 1st ★	100% 1st ★	√	100% 6 mths Apr 18

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

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2018

Q1 17/18	Q2 17/18	Q3 17/18
82.1%	**88.8%**	**85.8%**

Table 3 - Emergency Department Q3 results by site and by clinical unit

Shorter Stays in Emergency Departments (EDs) health target
DHB name: Waikato
Quarter: 3 - 2018

Quarterly Results – by DHB total population

	Numerator: The number of ED presentations with a length of stay of less than six hours	Denominator: Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	24834	28940	85.8%
Waikato	16556	20055	82.6%
Taumarunui	1423	1462	97.3%
Thames	3833	4327	88.6%
Tokoroa	3022	3096	97.6%

Quarterly results – by ethnicity

- Please use the ethnicity provided at the time of the ED presentation. Where that is not available, please use the ethnicity listed on the patient's NHI.

	Māori Ethnicity			Pacific Ethnicity		
	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	6918	7851	88.1%	641	862	74.4%
Waikato	4552	5388	84.5%	474	671	70.6%
Taumarunui	570	587	97.1%	19	22	86.4%
Thames	612	667	91.8%	33	48	68.8%
Tokoroa	1184	1209	97.9%	115	121	95.0%

Waikato Hospital

Waikato Hospital's ED May 2018 experienced a 3.4% increase on last year with the average daily presentations up from 227 to 235. 10 days over the month saw above 250 presentations, well beyond current staffing levels.

As in the previous report to the Board, the hospital's acute bed capacity has invariably been under significant and sustained pressure, operating at, or near, capacity most days. The numbers of patients awaiting beds in ED each morning is increasing due to bed constraints, which has a corresponding negative impact upon the 6 hour target.

Actions currently being taken in Waikato Hospital:

- Rapid Cycle Tests of Change (RCTC) events in the Emergency Department has focussed on decreasing the initial time to be seen by a doctor. This has involved establishing up of a "10 bed hot zone" model with all patients flowing through this area, undertaking an assessment and developing a plan, before moving on to another area in the department. This has seen a significant reduction of waiting 'time to be seen' and earlier referral to other specialties.

Pressure on night handovers has also been reduced. This trial has been extended for three weeks in order to evaluate all constraints prior to probably embedding as business as usual.

- Medicine has continued to be able to achieve empty beds almost every morning to enable flow, unfortunately Surgical, CCTV and Orthopaedics ward volumes have again been very high in April, which has led to delays in bed placement and overflow into Medical areas. There is likely to be limited ability to do this for the next few months as winter equates to greater pressure on medical beds.

- Medicine are also undertaking a two week trial for patient flow directly to AMU, with more timely senior clinician input.

- Respiratory will be moving to a ward based model on 11 June in collaboration with General Medicine in a trial to change models of care and cover the expected significant increase in Respiratory workload over the winter. The Respiratory team are currently facing an acute crisis through resignations in their team, so General Medicine have been asked to share the workload in support of their colleagues for the winter months. Backfill arrangements are being put in place cover the outpatient work to optimise inpatient SMO FTE.

- GP enrolments agreement with the funder that we would continue to undertake this work in the ED.

- Review of ED staffing model underway with consideration of moving to Nurse practitioner cover 24/7 within 12 months. This is dependent on funding being secured in next years' service pressures list, although early indications are that sadly this has not been included in the final list of approved projects.

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- Recruitment of one further MOSS position still to be completed to ensure regular senior medical cover overnight during the busier nights of the week, that traditionally have had less staff rostered on.

- Continuing work for the opening of a 26 bedded Acute Surgical Unit (ASU) on Level 8, Menzies in order to fast track acute surgical admissions. August opening indicated to date.

Thames, Tokoroa and Taumarunui Hospitals

The Clinical Nurse Specialist pilot is continuing. It has been very well received by everyone in ED and patients are appreciative of a shorter waiting time. The early figures show that CNS saw 19% of attendees (an average of 7-9 patients per shift). The CNS does all follow up of nurse initiated X-rays which is much faster than waiting for medical assessment. The full data from the pilot and its impact on reducing waiting times will become available at the end of June.

All other issues and tactical plans related to the four rural EDs are as reported last month. The Single Point of Entry and primary care projects at Taumarunui and Thames respectively are progressing as planned.

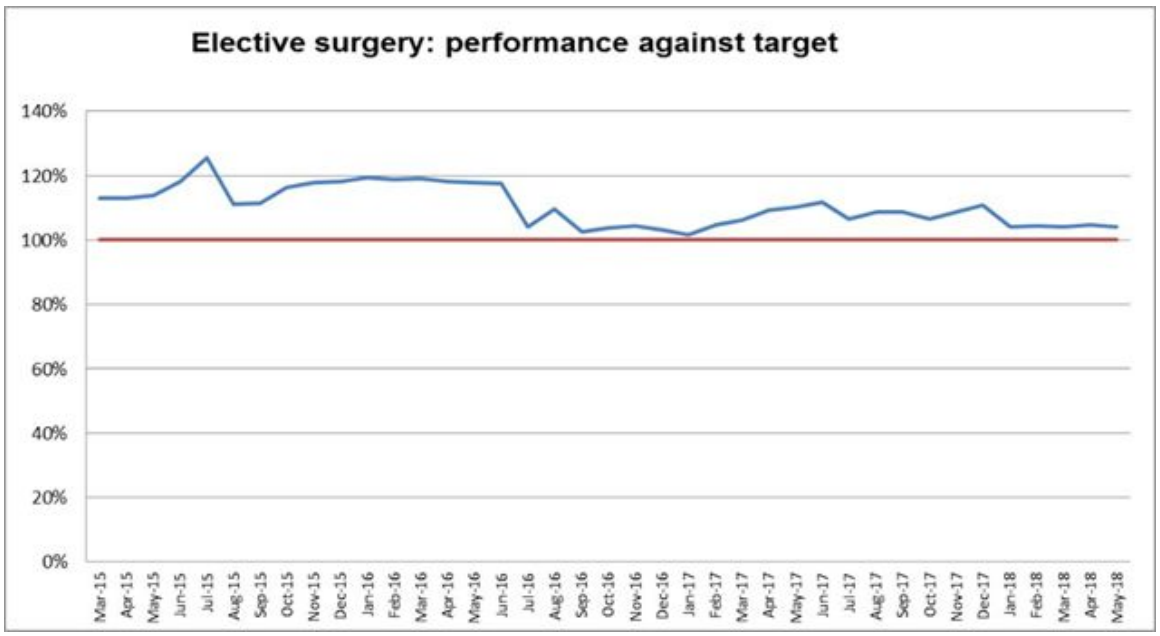
Target: Elective Surgery

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 provisional
Result	102.6%	103.1%	106.3%	111.8%	111%	104%	105%	104%
Ranking	**7**	**10**	**3**	**2**	**5th**	**8th**	6th	

Graph 1 below provides the most recent result of 104%.

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



Target: Faster Cancer Treatment (FCT)

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

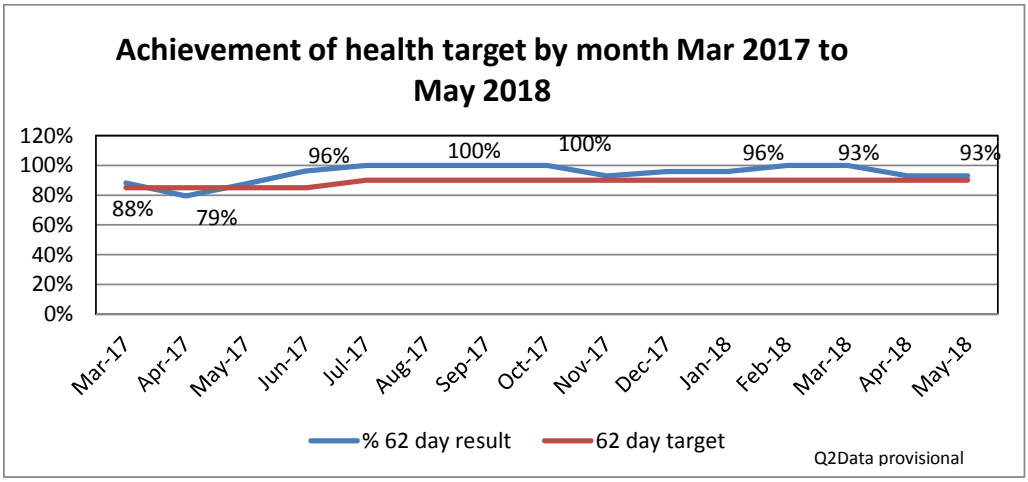
FCT 62 DAY HEALTH TARGET								
DHB Current Target	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	DHB Q3 Result 17/18	**DHB Q4 Result Provisional**
90%	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 3rd equal ranking	96.6% 2nd ranking	99.0% 3rd ranking	93%

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	**DHB Q4 Result Provisional**
25%	17%	19%	19%	22%	14%	14%	14%	20%

Waikato has continued to deliver sustained achievement against the 90% FCT health target. We are pleased to report that we continue to be ranked in the top 3 nationally. Quarter 4 shows a provisional result of 93%.

The chart below shows the historical monthly percentage performance against the target.

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



It needs to be recognised that the numbers of patients being treated on the 62 day pathway are relatively small and one or two breaches can have a substantial impact on the DHBs overall percentage and performance.

In Q3 we achieved a record high of 99%, but unfortunately had a decline in May with a provisional result of 93%. There are a number of reasons for these breaches.

- Shortage of interventional radiologists, thus causing delays in CT biopsies for lung cancer and other cancers requiring interventional radiology biopsies.
- Currently there are concerns with the pressure on the breast care service, with a number of breaches predicted over the next few months which will impact on the DHBs performance and the 6 month rolling average. Breast surgery has reached capacity until the 9th July with patients still to be offered a surgical date. Additional theatre slots had been offered but no surgeon available to cover due to clinical commitments.
- Due to vacant FTE in radiation oncology delays to radiation oncology FSA are occurring. Extra clinics are in place to try and reduce the backlog.

A number of operational measures continue to be undertaken to maintain performance:

- FCT Business Manager and FCT Nurse Tracker are working very closely with cancer care coordinators and clinical nurse specialists to monitor patient pathways from initial date of referral.
- Improving the timeliness of gynaecology triaging, first specialist appointment and timeliness to imaging.
- Weekly coordinated meeting with the gynaecology clinical nurse specialist and cancer care coordinator to discuss individual patients and tracking pathways to ensure patients are discussed at Auckland multi-disciplinary meetings in a timely manner.
- Ongoing monitoring of respiratory triaging and time to FSA.
- Liaising with interventional radiologists to ensure patients receive their CT biopsy in a timely manner.
- Weekly urology waitlist meeting to discuss any patients triaged onto 62 day pathway.
- Engagement with Te Puna Oranga to minimise inequity in FCT, including addressing DNAs and identifying barriers.
- Daily reports are now being generated to highlight any DNAs for FCT patients.
- Early detection of lung cancer - A small working group is being established to look at identifying and supporting patients with early lung cancer to reduce admissions into ED and poor outcomes. First meeting held in April 2018.
- Good communication with manager elective services to discuss how to ensure FCT patients receive surgery within time frames.

Table 6

Local FCT Database	**Mar-18**	**Apr-18**	**May-18**	**Total**
Number of records submitted	23	27	38	86
Number of records within 62 days	23	25	41	91
% 62 day Target Met (90%)	100%	93%	93%	97%
% Volume Target Met (15%)	14%	17%	24%	14%

Target: Increased 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
Result	**90%**	**89%**	**88%**	**90%**	**89%**
Māori	**89%**	**86%**	**82%**	**86%**	**83%**
Ranking	**16**	**15**	**15**	**15**	**14**

The data above has not been updated by the Ministry of Health since the last report to the Board.

Last month we reported that we had finalised the Immunisation Action Plan and submitted it to the Ministry of Health. In accordance with the plan, we are about to commence a review and redesign of immunisation and related services including the role of the Waikato Child Health Coordination Service.

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

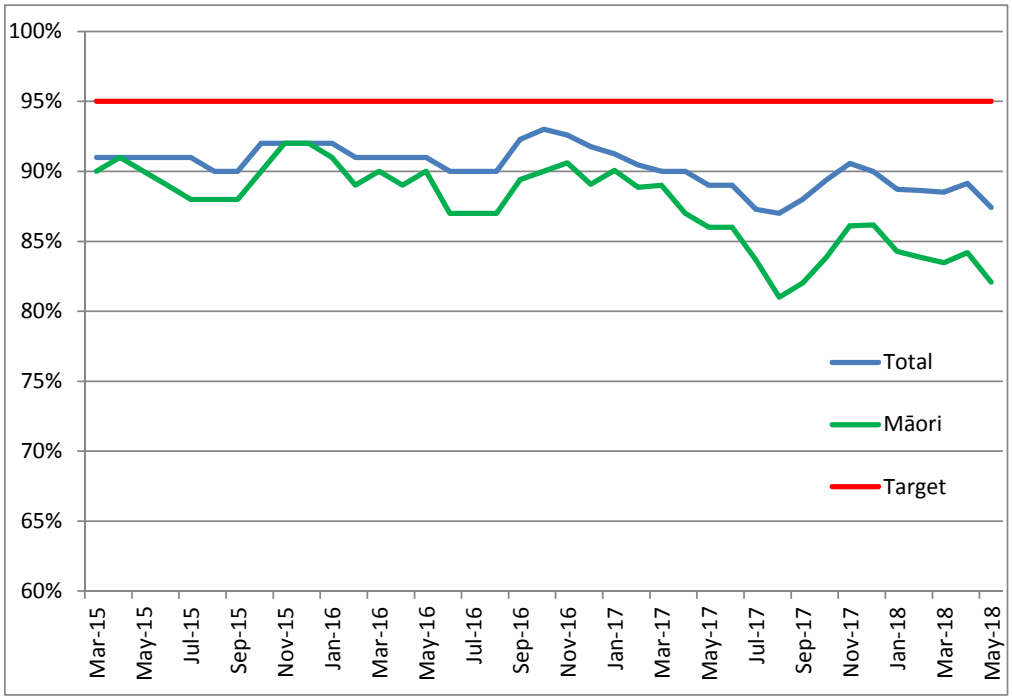


Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from Mar 2018 to May 2018

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	589	537	91%	23
Māori	519	426	82%	68
Pacific	54	52	96%	0
Asian	130	121	93%	3
Other	82	65	79%	13
Total across ethnicities				107
Total	1,374	1,201	87%	105

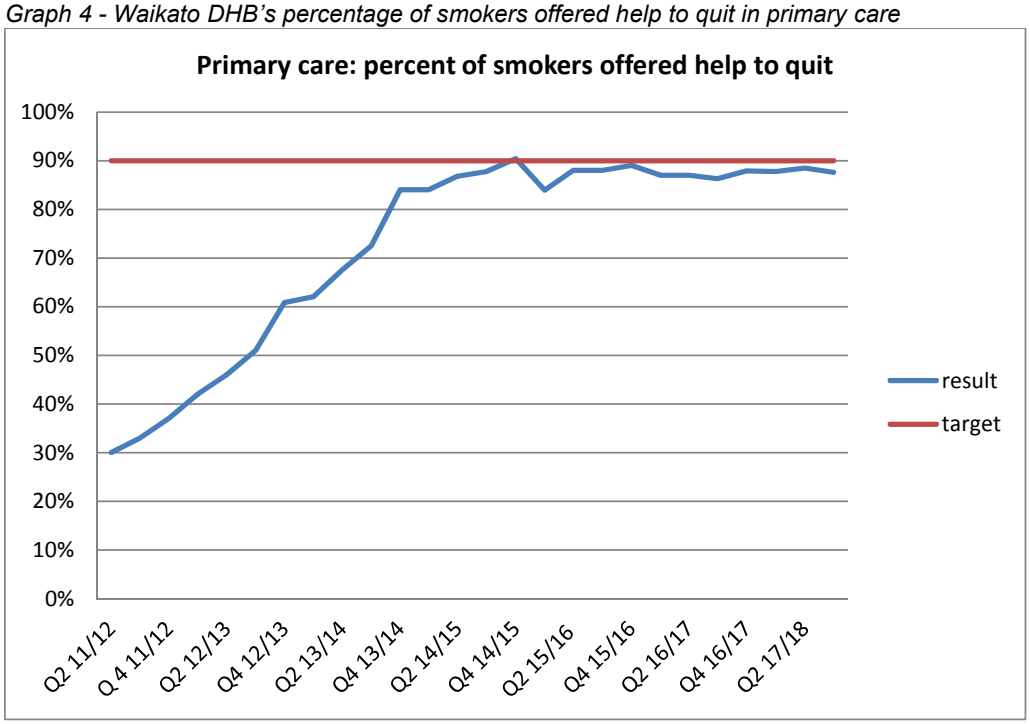
Target: Better help for smokers to quit - primary care

Table 9 – Quarterly Results

Q1 result 16/17	Q2 result 16/17	Q3 result 16/17	Q4 result 16/17	Q1 result 17/18	Q2 17/18	**Q3 17/18**
87% 7th ranking	87% 12th ranking	86% 13th ranking	88% 15th ranking	88% 14th ranking	89% 12th ranking	**88% Ranking unavailable**

Graph 4 showing data up to the quarter three 17/18 result of 88% shows Waikato DHB has declined by 1% in the last quarter.

Graph 4 - Waikato DHB's percentage of smokers offered help to quit in primary care



It is disappointing to note that our performance has not quite met the target with a slight decrease in the percentage of smokers offered help to quit this quarter. All PHOs have confrmed their practice management teams have regular contact with practices to ensure general practitioners and practice nurses remind and prompt patients to take up the services available to quit smoking. Each general practice has an indentified Smokerfree Champion who ensures team members are upskilled in this area and shares PHO smoking data reports. We will continue to work with our PHO colleagues this quarter as it is our expectation the ongoing focus will improve our overall results next quarter.

Target: Better help for smokers to quit - maternity

Table 11 – Quarterly Results

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	**Q3 17/18**
93% 12th Ranking	98% 4th Ranking	96% 12th Ranking	95% 8th Ranking	94% 8th Ranking	97% 4th Ranking	**99% *Ranking unavailable**

Graph 5 shows a result of 98.5% for Quarter 3. It is reassuring to see that we continue to meet this target.

Graph 5 - Waikato DHB's percentage of smokers offered help to quit in maternity

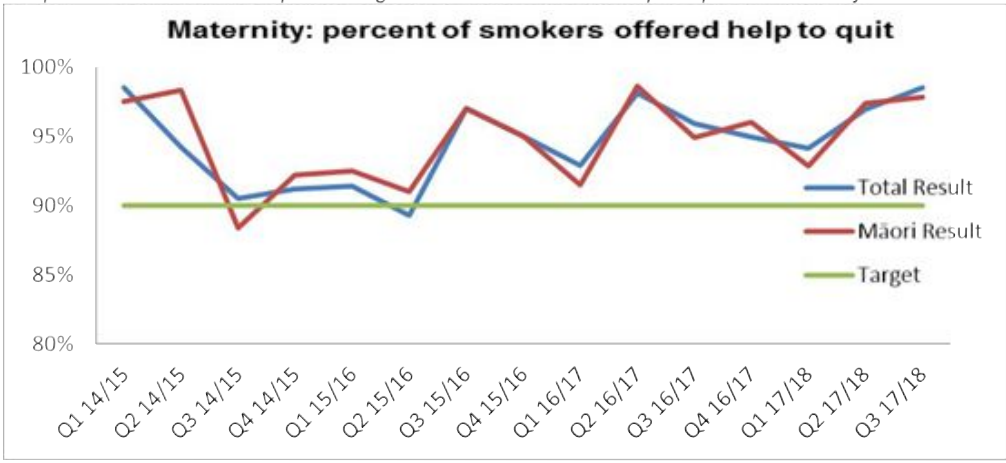


Table 12 shows the quarter three results provided by the Ministry for our total and Māori population.

Table 12 – 2017/18 Q3 maternity smoking status and advice (target 90%)

	No. women registered	**No. of women identified as smokers**	**No. people given advice**	**Smoking prevalence**	**Percent of smokers offered advice**
Māori	89	45	44	50.6%	97.8%
Total	359	67	66	18.7%	98.5%

**Data comes from three sources: Midwifery and Maternity Providers Organisations (MMPOs), Lead Maternity Carers Services (LMCs) and from DHB employed midwives (if available).*

The information for this measure is received directly from the Ministry of Health. Waikato DHB is performing well against this target. The stop smoking service incentives scheme for pregnant women is promoted and appears at this early stage to be having postive results in terms of improving access. However, the high maternal smoking for Maori contines to be of concern.

Target: Raising healthy kids

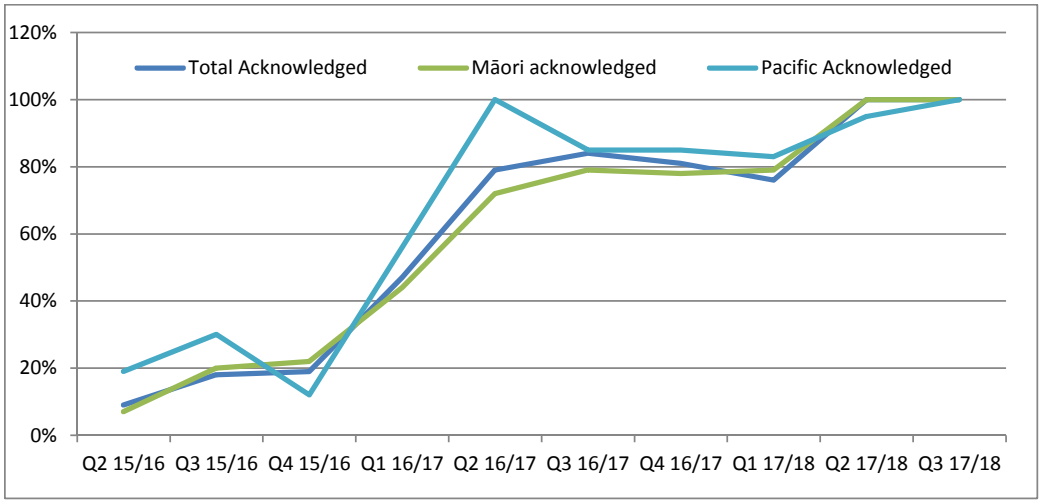
We have achieved a perfect result (100%) for this target this quarter. This means all obese children identified in the Before School Check (B4SC) programme were referred to a health professional for clinical assessment followed by a further referral to a family based nutrition, activity and lifestyle service delivered by Sport Waikato. We also have lower rates of declined referrals at 17% compared to the national average of 24%.

Table 13 – 2017/18 Q3 Raising Healthy Kids Results (target 95%)

		Waikato						National
		2016/17 Q1	**2016/17 Q3**	**2016/17 Q4**	**2017/18 Q1**	**2017/18 Q2**	**2017/18 Q3**	**2017/18 Q3**
		Six mths Aug 16	**Six mths Feb 17**	**Six mths May17**	**Six mths Aug 17**	**Six mths Nov 17**	**Six mths Feb 18**	**Six mths Feb 18**
Total	Referral Sent	50%	86% (133)	83% (102)	77% (93)	100% (144)	100% (142)	99% (1,321)
	Referral Sent and Acknowledged	**47%**	**84% (127)**	**81% (98)**	**76% (91)**	**100% (144)**	**100% (142)**	**98% (1,313)**
Māori	Referral Sent	49%	82% (65)	80% (43)	79% (36)	100% (69)	100% (70)	99% (440)
	Referral Sent and Acknowledged	**44%**	**79% (61)**	**78% (41)**	**79% (36)**	**100% (69)**	**100% (70)**	**98% (435)**
Pacific	Referral Sent	56%	90% (9)	88% (10)	87% (13)	95% (12)	100% (14)	100% (362)
	Referral Sent and Acknowledged	**56%**	**85% (8)**	**75% (8)**	**83% (12)**	**95% (12)**	**100% (14)**	**99% (360)**

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

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



Recommendation
THAT
The Board receives this report.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

DAMIAN TOMIC
CLINICAL DIRECTOR
PRIMARY & INTEGRATED CARE

GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER

Health and Safety

Service Performance Monitoring

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 9.1

CHIEF DATA OFFICER DIRECTORATE

Purpose	For information.

Introduction
As part of the executive restructure earlier this year, a Chief Data Officer (CDO) position was created. The CDO is a member of the DHB's Executive Leadership Team, providing strategic leadership with specific responsibility for providing single source of truth for (non-financial) data and performance information to inform planning, evidence based decision making, service design and quality improvement. The goal is to lead the organisation to adopt a data-driven, evidence based, decision making culture.

The changing role of data and analytics in health
Health systems across the world are starting to recognize the potential value of their enormous data sets, and there are numerous healthcare systems who have invested in establishing advanced data analytics capabilities to support clinical and management decision making.

The use of combined data sets, particularly Health outcomes data, patient experience data and (end-to-end) costing data, is a powerful and compelling way to inform care design and improvement decisions at three key levels: the individual clinician level, the service level, and the funder level:

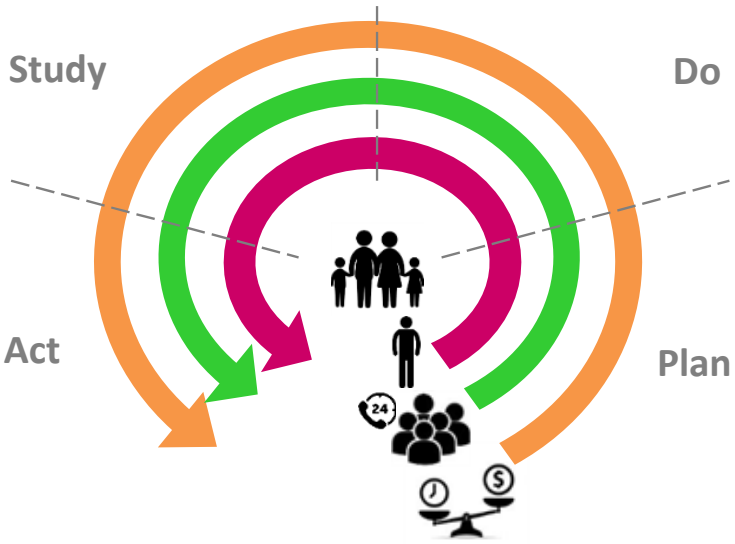


Figure 1: Learning feedback cycles informed by measures and data at three levels: clinician level, service level, funder level.

A typical improvement/learning cycle of Plan-Do-Study-Act (PDSA) is supported by data and performance measures, in particular during the 'Plan' stage and the 'Study' stage of the improvement.

At clinician level, improved data availability about the effectiveness of patient interventions as measured in improvement of desired health outcomes, absence of adverse outcomes, patient experience level and costs of delivery of the service can inform clinical practice changes. Especially when sharing data between peer clinicians, this creates an opportunity for comparison and group learning by comparing and contrasting results.

At service planning level, improved data availability can help with service design and staff planning decisions for future service delivery. At an operational level, performance monitoring informs operational decision making around service delivery – i.e. redirecting resource to address bottlenecks in patient flow.

At funder level, measurement and ongoing monitoring of population outcomes data, in conjunction with end to end costing data, can inform future service needs, patient pathway designs, definition and introduction of new services and technology as well as the desired business models to deliver and support these.

In New Zealand, there are several National initiatives underway to improve the access and use of data for analysis purposes. Some examples are the Health Quality Safety Commission's work on Atlas of Healthcare variation, the Quality dashboards and quality safety markers and Health Round Table analysis on a range of operational and clinical measures. Furthermore, a national DHB service programme is underway to review the Health System Performance measures used and revise these, moving from largely volume and target driven measures, to more system-wide and health outcomes measures.

For Waikato DHB, as is the case for other DHBs, the main gaps are 1) *availability of high quality and relevant health outcomes data*, 2) the *ability for the users to interact with the data and drill down to patient level detail* to look at specific patient cohorts, and 3) the *ability to combine data from various local sources easily.*

Some examples of where data can help inform better care for our patients and population are reducing unwarranted variation in patient outcomes and cost of care (i.e. Choosing Wisely), better understanding of root causes and drivers for performance and improved planning through better forecasting and modelling of future scenarios. Longer term, the possibilities for better use of data are in the fields of innovation and applying artificial intelligence, Machine Learning and other Big Data algorithms to derive insights.

CDO responsibilities

The CDO is responsible for what happens with data once it is secured and available, although it is anticipated that data management policies will extend into transactional IT systems in the future. The CDO helps DHB leaders access captured (non-financial) information and use it to make better, more timely business decisions. Specific responsibilities of the position fall into three categories: data management, data analytics and technology.

For data management, these include data governance and standards, data architecture and technology, data analytics, meeting regulatory data requirements (Ministry of Health, ACC, Health Quality & Safety Commission, others).

For data analytics, responsibilities include performance reporting, forecasting and planning and modelling, and service improvement.

For technology, responsibilities include development of data architecture and implementation of the appropriate technology for data storage, data management and data analysis.

The position will build on the current teams of Clinical Coding, Clinical Records and Operational Performance & Support, to provide the DHB with reliable data and meaningful analysis to inform decision making at strategic, tactical and operational levels. From there, the aim is to establish synergies between various analysis teams within the organisation and their data sets. Currently, there are multiple analyst teams in IS, Strategy & Funding, Te Puna Oranga and the goal is to standardise data sources and definitions, agree roles more clearly to avoid duplication and overlap. Furthermore, the team will work with other providers in our region (e.g. primary care, NGO), as well as other agencies with data that can enhance our insights (e.g. social development, housing) to bring together relevant data sets for joined-up analysis. It will be imperative that data security and data privacy policies and procedures are defined and implemented as part of the data governance work.

Directorate FY19 priorities
For next year, key priorities for the new Directorate are to:

Data management	Data analytics	Technology
Establish data governance board	Complete second pilot of QlikSense dashboards	Develop data and analysis systems architecture
Establish Information Community of Excellence with analysts organisation-wide	Consolidate and reduce number of existing intranet based reports (Enterprise Reports)	Develop technical standards for data management
Commence development of data dictionary and measure library.	Design and develop DHB wide performance framework and balanced scorecard	
Development of data strategy to support the DHB strategy and future Health Systems Plan.		

Team overview report – period ending May 2018

Team: Operational Performance and Support (OP&S)

Initiatives and Highlights

QlikSense

- QlikSense Pilot Applications for Mental Health Inpatients (Seclusion, Occupancy and Readmissions) validated and presented to Mental Health staff. Deployment to small management team being planned.
- Third application on Post-Discharge Follow-up is in development, final visualisation changes to be developed in June.
- Planning for second QlikSense pilot underway and a number of areas have been identified: ED, Medical Clinical Forward Load, Population Demographics, ED ASH and PHO data, performance reporting to production plan, cardio clinical audits.
- QlikSense training scheduled – two sessions, first at end of June and end of July. This will give more analysts (including those in Strategy and Funding and IS) skills in QlikSense application development.
- QlikSense production servers installation nearly complete.

Production Planning

- Delivery plans reviewed and updated based on feedback.
- Final demands for Beds Required/Radiology/Theatre production plans have been completed and sent to finance and services.
- WIES case-weight calculation changes from Ministry of Health applied.
- Price Volume Schedule (PVS) being created in collaboration with Strategy and Funding team.
- Awaiting delivery of Elective Funding Schedule from Ministry of Health, which will require adjustment of several plans.

Other

- National Patient Flow. Quality of Oncology data is of concern, as it is not stored in core iPM system and difficult to integrate with iPM referrals. Clinical Physiology service requirements scoped and defined, and currently with vendor for implementation. Ophthalmology discovery process underway at present. New analyst starting to make headway.
- National Patient Flow project management transferred to OP&S team, to accommodate prioritisation of reduced staff levels in Change Team due to vacancies.
- Equity focused KPI development started and report with Outpatient DNA focus will be presented to the Board this month.

Emerging issues and risks

- Organisational structure changes leading to some uncertainty regarding roles and responsibilities, as well as potential need for changes to existing data reports.
- Care Capacity Demand Management reporting project being scoped and defined – significant extra volume of analysis and reporting work in this.

Next period focus areas

Production planning

- Adjustment of plans based on Elective Funding Schedule, and delivery of final production plans to finance for budget and District Annual Plan (DAP).

QlikSense

- Training of analysts in QlikSense.
- Data Governance Framework to continue to evolve – and work being tied into definition and shape of the new Chief Data Officer's role.

Team: Clinical Records

Initiatives and Highlights

- New staff recruited to the team and these are now being trained.

Emerging issues and risks

- Team is busy due to a number of unfilled vacancies and sickness impacting on the Department.
- Shelves in department are over full resulting in records being placed on their side. Some staff will do some overtime to try and remediate the worst areas.
- Kofax scanning software had a planned upgrade but there were issues so it was rolled back to the previous version. The upgrade will need to happen once the issues are resolved.
- An average of 16,000 documents are now scanned every month. Demand for scanning is increasing but lack of resource means that additional scanning cannot be undertaken at this present time. Unfortunately new scanned documents are typically in addition to paper-based clinical records, and are not reducing the manual handling of these by the Clinical Records team.

Next period focus areas

- Ensure two current vacancies are filled and staff are trained.
- Install new shelving to assist with shortfall.

Team: Clinical Coding

Initiatives and Highlights

- Accelerated Coding Education (ACE) course commenced 7 May for 12 students. Generating $26,880 revenue for Waikato DHB and providing a pool of trainee coders for future employment, which will help to address the national shortage of Clinical Coders.
- Delivery of education sessions to clinicians at Thames Hospital to improve quality of clinical documentation. Good clinical documentation enables accurate coding, and Diagnostic Related Group (DRG) assignment which in turn maximises funding and ensures Health Round Table comparative data analysis and mortality ratios are reliable.
- Development of reports and tools to ensure that theatre sessions are correctly coded and reported to the MOH, to ensure elective surgical performance is accurately reported.
- The National Booking Reporting System (NBRS) and National Minimum Data Set (NMDS) data is aligned and Costing has an exception report to explain discrepancies.
- Attended a National Clinical Coding Managers forum in Wellington to address recruitment and retention, and education of Clinical Coders, Inter District Flow optimisation strategies and MOH month end coding and other MOH KPI requirements. Comparison with other DHB's coding teams provided good insight into the positive team culture and good performance of team at Waikato.

Emerging issues and risks

- Current location of Clinical Coding in Portacoms D15 & D16 external to Clinical Records Department is ongoing risk for staff health and safety, transporting and accessing records especially after hours. Some recent issues with the building's exterior roofing and electrical appliances have exacerbated this concern.
- The team location is inadequate for storage of records and access to clinical records for month end coding and for conducting audits with Clinicians.
- Retirement of Senior Coder/ Auditor to code Tokoroa discharges, in absence of the part time coder at that facility is putting some pressure on the team in meeting Ministry of Health KPI for timely month-end coding.

Next period focus areas

- Successful delivery of ACE course.
- To find a suitable location for Clinical Coding to relocate to.
- To scan all Tokoroa discharges and deliver all Coding from the Waikato site.
- Coding Manager to complete Internal Audit of Clinical documentation/ Coding as requested by Waikato DHB Audit & Corporate Risk Management Committee.

Recommendation
THAT
The report be received

MARC TER BEEK
CHIEF DATA OFFICER

Decision Reports

MEMORANDUM TO THE BOARD
20 JUNE 2018

AGENDA ITEM 10.1

EQUITY FOCUSED REPORT

Purpose	For endorsement of reporting and improvement approach.

Background
Equity focused reporting is provided to the Board on a quarterly basis.
It is intended that this work will be:

- Extended to include measures from across the health system
- Used as a tool to identify inequities and formulate a coordinated remediation response

In the April Board meeting, a request was made to clarify what actions are taken to address identified inequities in performance indicators. In addition, the Board requested a Deep-Dive analysis into inequities in Outpatient Did Not Attend (OP DNA) rates.

This report, which will be further refined (monthly) is a joint initiative from Te Puna Oranga (TPO) and the Operational Performance and Support teams and includes the findings from the analysis and information about work underway and proposed for the future.

April KPI report – key findings
Trends from the March report have continued for all key measures (Appendix I).

- Māori are more likely to be discharged from ED within 6 hours.
- The outpatient DNA rate for Māori is significantly higher than for non-Māori.
- Māori are more likely to be offered advice to stop smoking.
- Māori have more admissions to the Renal service.
- Other measures included in the April report do not show a statistical difference between Māori and non-Māori.

Outpatient DNA rates - Deep Dive analysis
The key findings from the Outpatient DNA Deep Dive (Appendix II) show that the outpatient DNA rate for Māori is significantly higher than for non-Māori and has been consistently so for a long time. There does not appear to be an obvious driving factor for the differences in OP DNA rates observed between Māori and non- Māori. Differential rates between Māori and non- Māori patients are consistent, regardless of patient age, patient gender, patient domicile, hospital site and hospital specialty. Further analysis reveals that there is however relatively good performance in the Oncology services, where both Māori and non-Māori DNA rates are below the required 10% target (8.7% and 3.5% respectively). Oncology currently has an equity and access clinical nurse specialist that works specifically in the DNA space and these specific results may be a direct result of this dedicated focus and resource.

Further research into literature and root-cause analysis will be required to understand driving factors that can be addressed in a meaningful manner to reduce the difference in OP DNA rates between Māori and non- Māori. This should take into account work already underway to address DNA rates, such as the Harti Hauora Tamariki programme in Paediatric Services.

Inequity elimination approach
Waikato DHB is committed to eliminating health inequities for Māori as outlined in our strategy and as specified in the Memorandum of Understanding between Waikato DHB and Iwi within its district.

The proposed approach to support the elimination of inequities observed in key measures is multi-pronged. Proposed actions to support elimination of the inequity in outpatient DNA rates have been included as example. These actions have built upon the Te Puna Oranga Programme of Work 2018-2019 which has identified the need for a coordinated response to follow-up and support patients who do not attend outpatient appointments (see Te Puna Oranga Programme of Work – Part Two 2018 – 2019):

1) Establish accountability at service level. It is proposed that key measures where significant inequity at a DHB level has been observed, are included on service specific KPI Dashboards. The measures will be included under a new category “Equity focussed Reporting”. The first measure to be included is the ratio of Outpatient DNA rate for Māori and non- Māori.
2) Establish an improvement project, led by the logical business owner for a key measure. This project follows a structured performance improvement approach and the project lead receives continuous improvement capability training and/or support from staff with expertise in continuous quality improvement. For Outpatient DNA rates, the proposed business owner is the manager of Outpatient Services in Waikato Hospital.
3) Te Puna Oranga (TPO) to provide expertise, evidence and best practice advice to the relevant business owner for each improvement project. The assistance provided by TPO includes the collation of best practice, review of evidence.

Next steps
Over the next period, further KPI measures will be added to this report progressively. To get traction for a system wide approach recent reports presented to Board have been analysed for equity data and appended to this report (Appendix III). It is intended that further collaboration with Strategy & Funding will take place to incorporate these measures into the Equity Focused Report.

Recommendation
THAT
The Board:

1) Receives the report.
2) Supports the approach for improvement of inequities in performance measures.
3) Note that this work will form the foundation of the outcomes measurement framework in the Iwi Māori Health Strategy (Ki te Taumata o Pae Ora).

LORAINE ELLIOTT
EXECUTIVE DIRECTOR MĀORI HEALTH

MARC TER BEEK
CHIEF DATA OFFICER

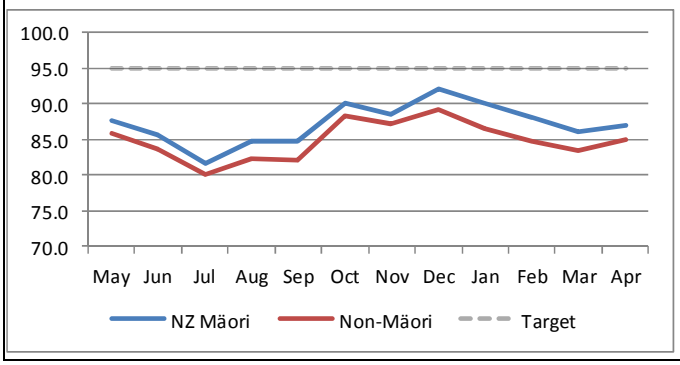
Appendix I: Equity Focused Report - April 2018

Below summarises the results for the first 13 of the proposed 24 performance indicators. Further work is underway to finalise the results for the remaining measures and to incorporate further system wide equity data in collaboration with Strategy and Funding.

Measure Title	Included	Type
Emergency Department < 6 Hours	Yes	Access
Faster Cancer Treatment - Referral received to first treatment <= 62 days	Yes	Access
Faster Cancer Treatment - DTT to first treatment <= 31 days	Yes	Access
Number of long wait patients on outpatient waiting lists	To be refined	Access
Number of long wait patients on OPRS outpatient waiting lists	To be refined	Access
Number of long wait patients on inpatient waiting lists	To be refined	Access
Waiting Time for acute theatre < 24 hrs	Yes	Access
Waiting Time for acute theatre < 48 hrs	Yes	Access
Mental health seclusion hours	To be refined	Usage
Mental health recovery plans	To be refined	Usage
Mental health HoNos matched pairs	To be refined	Usage
Mental health inpatient bed occupancy	To be refined	Usage
Outpatient DNA Rate	Yes	Access
Number of long stay patients (>20 days length of stay)	Yes	Usage
Number of long stay patient bed days (>20 days los)	Yes	Usage
Mental health average length of stay	To be added	Usage
Average length of stay (Specialty excl AoD)	To be added	Usage
Mental health post discharge follow up - % seen in 7 days	Yes	Access
Mental health follow up - numbers seen in 7 days	To be added	Usage
Mental health community contract positions filled	To be refined	Usage
Mental health 28 day readmission rate	Yes	Usage
Better help for smokers to quit	Yes	Access
Admissions to respiratory service	Yes	Usage
Admissions to renal service	Yes	Usage

Measure details

Emergency Department < 6 Hours

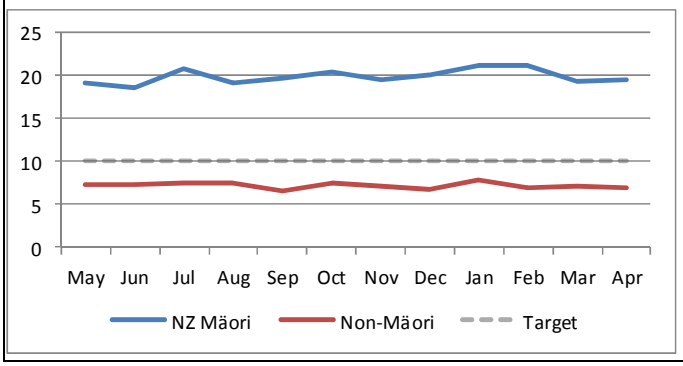


	Maori	Non-Maori
2018-Apr	86.9	84.9
Target	95.0	95.0
Variance	-8.1	-10.1
Number	2619	6762
YTD	87.2	84.9
Target	0.0	0.0
Variance	87.2	84.9
Number	32930	82187

Statistical Difference

Māori are more likely to be discharged from ED within 6 hours.

Outpatient DNA Rate

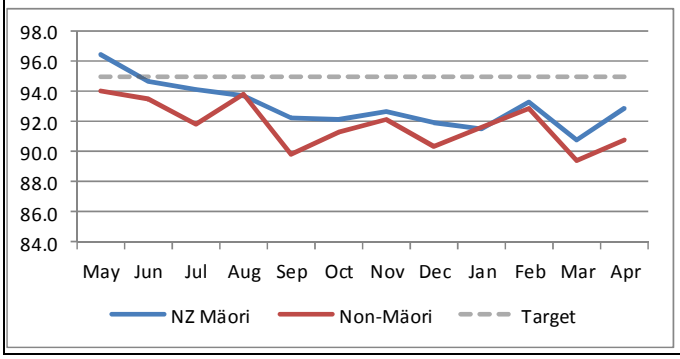


	Maori	Non-Maori
2018-Apr	19.4	6.9
Target	10.0	10.0
Variance	9.4	-3.1
Number	2919	11745
YTD	19.8	7.2
Target	0.0	0.0
Variance	19.8	7.2
Number	38487	151592

Strong Statistical Difference

Outpatient DNA rate for Māori is significantly higher than for non-Māori, at almost three times the rate. See appendix II for Deep Dive analysis into this measure.

Better help for smokers to quit

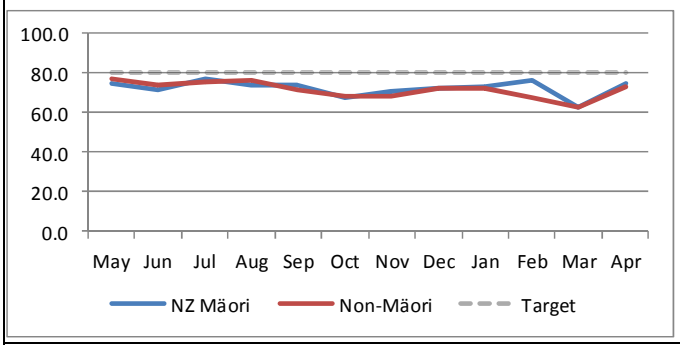


	Maori	Non-Maori
2018-Apr	92.9	90.8
Target	95.0	95.0
Variance	-2.1	-4.2
Number	253	316
YTD	93.1	91.9
Target	0.0	0.0
Variance	93.1	91.9
Number	5781	7127

Statistical Difference

Māori are more likely to be provided with advice to quit smoking.

Waiting Time for acute theatre < 24 hrs

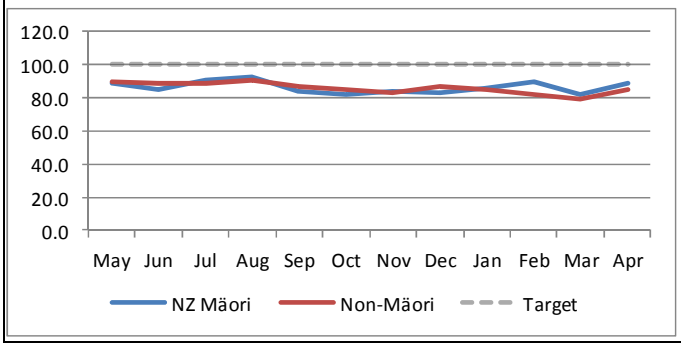


	Maori	Non-Maori
2018-Apr	74.5	72.9
Target	80.0	80.0
Variance	-5.5	-7.1
Number	196	542
YTD	72.2	71.5
Target	0.0	0.0
Variance	72.2	71.5
Number	2493	6521

No Statistical Difference

There is no difference in proportion of patients waiting less than 24 hours for acute theatre.

Waiting Time for acute theatre < 48 hrs

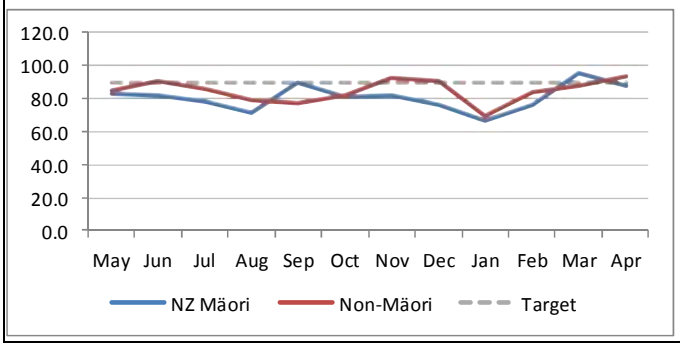


	Maori	Non-Maori
2018-Apr	88.3	84.9
Target	100.0	100.0
Variance	-11.7	-15.1
Number	196	542
YTD	86.2	85.7
Target	0.0	0.0
Variance	86.2	85.7
Number	2493	6521

No Statistical Difference

There is no difference in proportion of patients waiting less than 48 hours for acute theatre.

Mental health post discharge follow up - % seen in 7 days

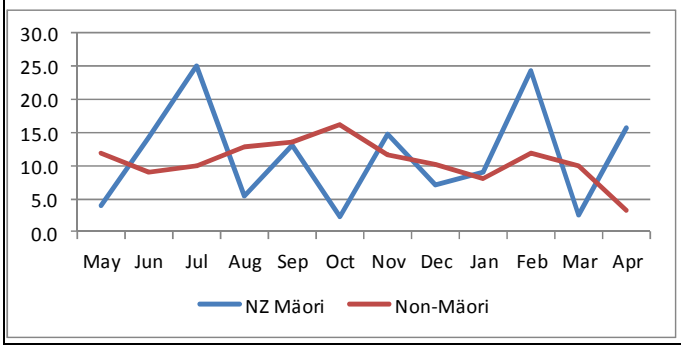


	Maori	Non-Maori
2018-Apr	88.0	93.0
Target	90.0	90.0
Variance	-2.0	3.0
Number	25	43
YTD	80.9	84.7
Target	0.0	0.0
Variance	80.9	84.7
Number	320	537

No Statistical Difference

There is no difference in proportion of MH patient follow ups seen in 7 days.

Mental health 28 day readmission rate

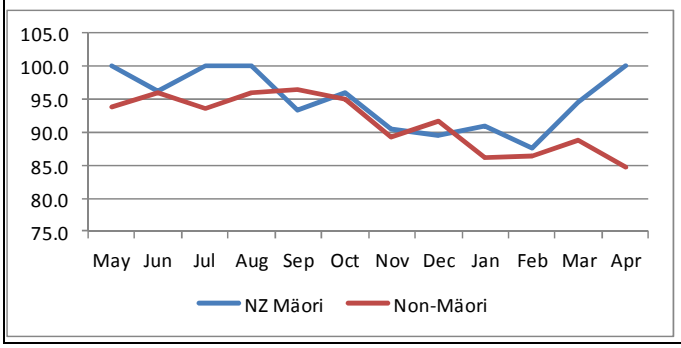


	Maori	Non-Maori
2018-Apr	15.6	3.3
Number	5	2
YTD	10.7	10.9
Number	55	93

No Statistical Difference

There is no difference in 28 day readmission rate between Māori and non-Māori.

Faster Cancer Treatment - DTT to first treatment <= 31 days

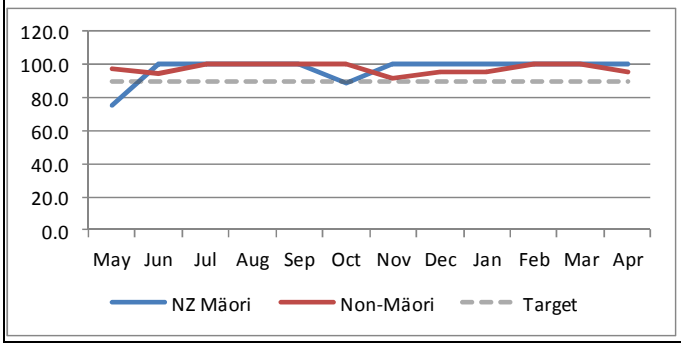


	Maori	Non-Maori
2018-Apr	100.0	84.6
Number	11	52
YTD	95.1	91.9
Number	244	1192

No Statistical Difference

There is no statistical difference in the proportion of Māori and non-Māori patients treated within 31 days from decision to treat.

Faster Cancer Treatment - Referral received to first treatment <= 62 days

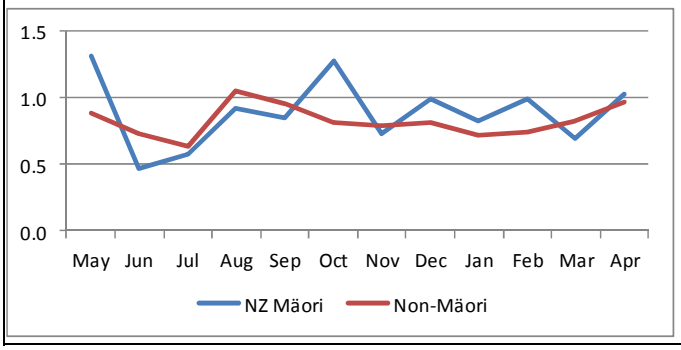


	Maori	Non-Maori
2018-Apr	100.0	95.0
Target	90.0	90.0
Variance	10.0	5.0
Number	4	20
YTD	96.9	97.4
Target	0.0	0.0
Variance	96.9	97.4
Number	64	270

No Statistical Difference

There is no difference in proportion of patients waiting less than 62 days from referral.

Number of long stay patients (>20 days length of stay) per 100 discharges

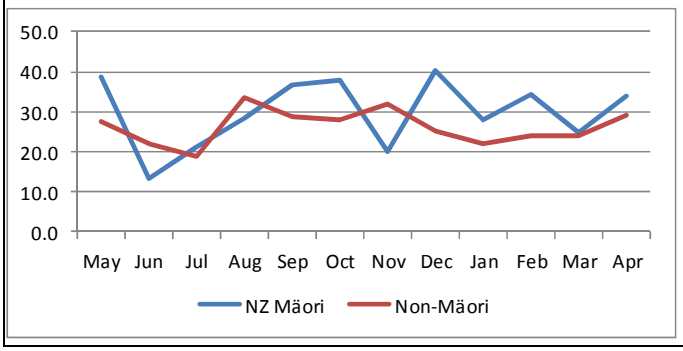


	Maori	Non-Maori
2018-Apr	1.0	1.0
Number	20	56
YTD	0.9	0.8
Number	205	590

No Statistical Difference

There is no difference in proportion of admitted patients with a length of stay >20 days.

Number of long stay patient bed days (>20 days los) per 100 discharges

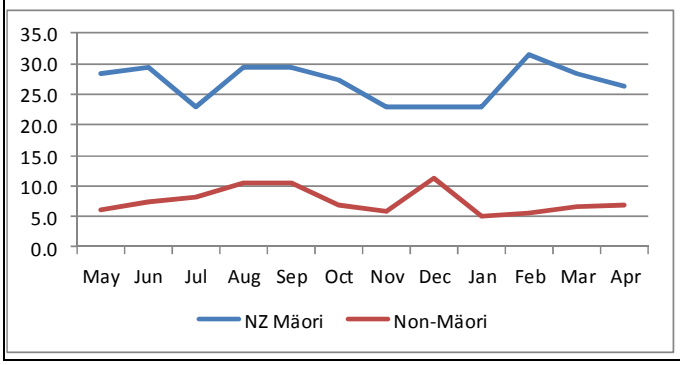


	Maori	Non-Maori
2018-Apr	34.0	29.1
Number	658	1687
YTD	29.5	26.2
Number	6830	18694

No Statistical Difference

There is no difference in average LOS for patients with a length of stay >20 days.

Renal Admissions per 100,000 Population

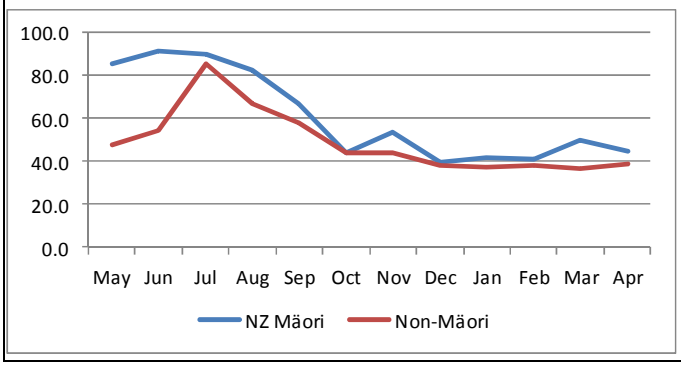


	Maori	Non-Maori
2018-Apr	26.1	6.8
Number	25	22
YTD	321.1	90.5
Number	307	292

Strong Statistical Difference

Renal admission rate in Māori population are much higher than in non-Māori population.

Respiratory Admissions per 100,000 Population



	Maori	Non-Maori
2018-Apr	45.0	38.7
Number	43	125
YTD	731.1	588.3
Number	699	1898

No Statistical Difference

Respiratory admission rate for Māori population is not statistically different from non-Māori.

Appendix II: Deep-Dive analysis Outpatient Did Not Attend (OP DNA) rate
The Outpatient DNA rates have been consistently inequitable between Māori and non-Māori for over fours years, with the rate showing highly significant differentials.

There does not appear to be an obvious driving factor for the differences in OP DNA rates observed between Māori and non- Māori based on the analysed dataset. Further research into literature and root-cause analysis will be required to understand driving factors that can be addressed in a meaningful manner.

Data source for KPI measure Outpatient DNA: CostPro database, outpatient FSA and Follow-up appointments from 2014-2018. Excludes appointment in Mental Health, Disability services, Breast Screening and Maternity (as per DHB KPI report).

1. Overall OP DNA rate:
The OP DNA rate and difference between Māori and non-Māori has been static for the last 4 years.

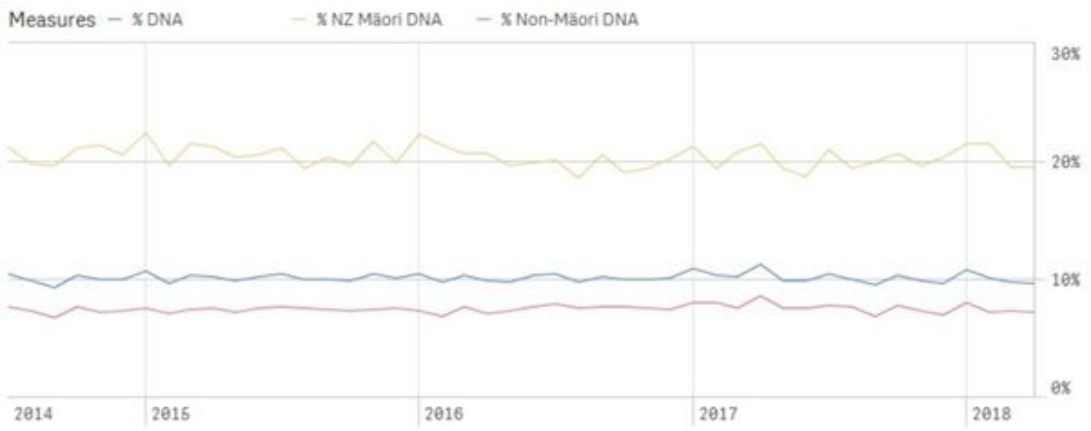


Figure 1: Overall Outpatient DNA Rates 2014 – 2018

2. By hospital site, gender and patient age group:

DNA rates are lowest in Taumarunui and Te Kuiti hospitals. Māori DNA rates are higher than non-Māori in all hospitals. The differential between Māori and non- Māori also appears the greatest in Taumarunui and Te Kuiti hospitals.

DNA rates are higher for male patients. The differential between Māori and non-Māori patients is similar for male and female patients.

Māori DNA rates are higher than non-Māori in all age groups. Differential rates appear to be greatest for patients over 65 years of age.

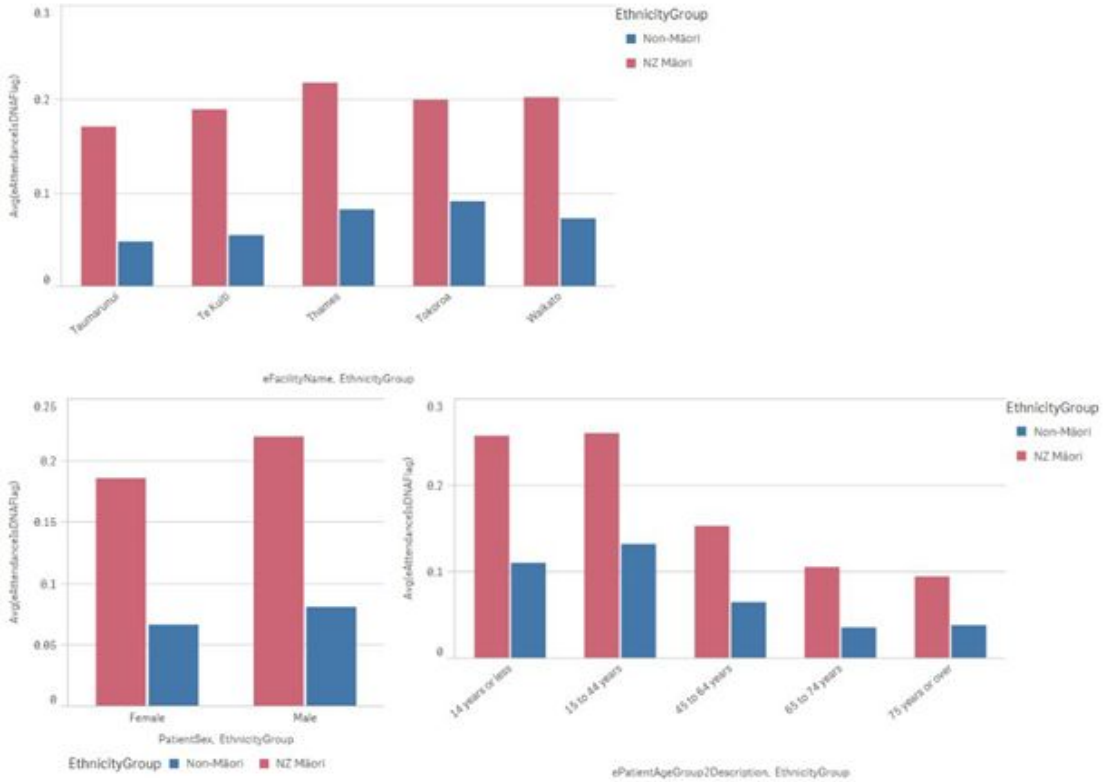


Figure 2: Outpatient DNA Rates by Location, Gender and Age (2014 – 2018 data)

3. By specialty:
In Figure 3 each specialty has a measure where the left indicates non-Māori OP DNA rates and the right indicates Māori OP DNA rates. OP DNA rates are higher for Māori in all specialties.

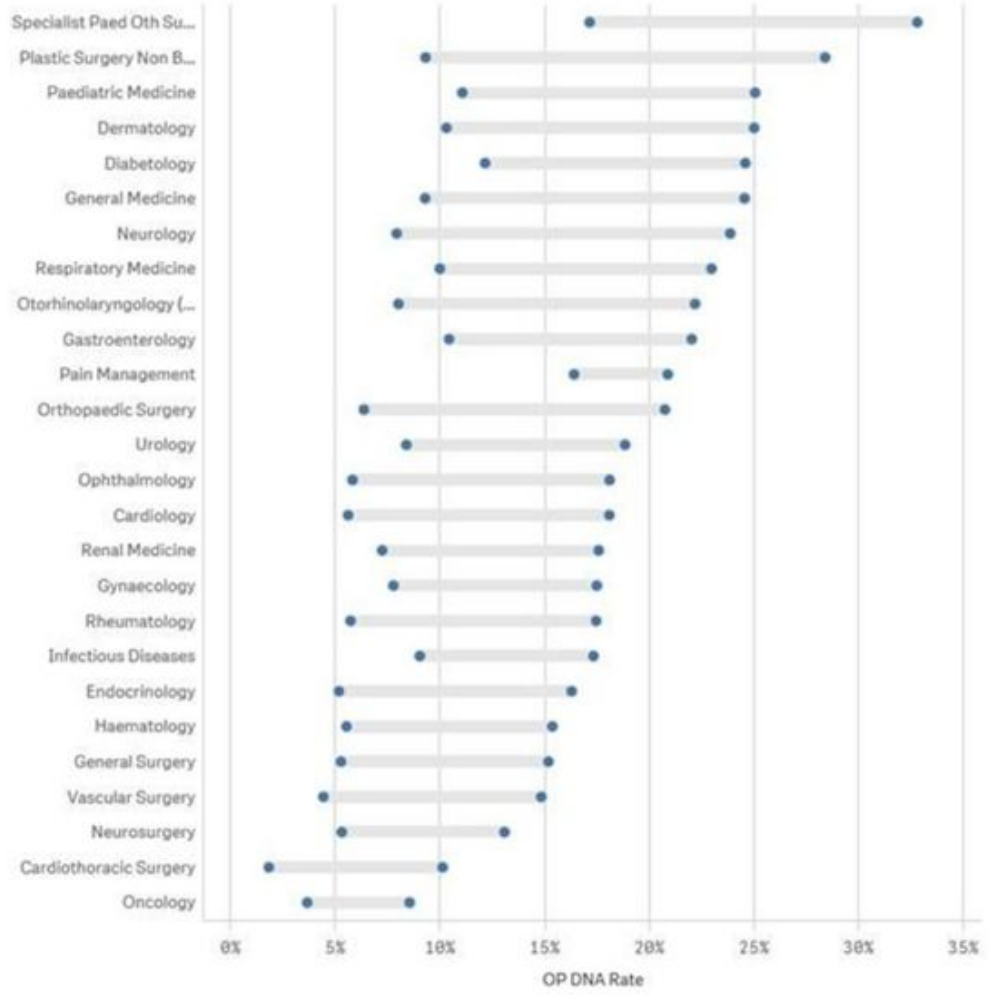


Figure 3: OP DNA Rates by Speciality (2014 – 2018 data)

Table 1: OP DNA Rates and Count by and Specialty (2014 -2018 data)

	Non-Māori		NZ Māori	
	Count	DNA Rate	Count	DNA Rate
Cardiology	17,593	5.6%	4,400	18.1%
Cardiothoracic Surgery	2,412	1.8%	721	10.1%
Dermatology	17,027	10.3%	4,170	25.0%
Diabetology	9,591	12.2%	2,777	24.6%
Endocrinology	11,784	5.2%	3,947	16.3%
Gastroenterology	10,636	10.4%	1,657	22.0%
General Medicine	4,273	9.3%	729	24.6%
General Surgery	36,392	5.3%	8,839	15.2%
Gynaecology	18,834	7.8%	6,699	17.5%

Haematology	17,690	5.5%	3,168	15.4%
Infectious Diseases	1,527	9.0%	300	17.3%
Neurology	15,522	7.9%	3,460	23.9%
Neurosurgery	6,115	5.3%	1,872	13.1%
Oncology	48,372	3.7%	10,398	8.5%
Ophthalmology	74,474	5.8%	14,789	18.1%
Orthopaedic Surgery	77,108	6.4%	20,538	20.8%
Otorhinolaryngology (ENT)	27,656	8.0%	11,658	22.2%
Paediatric Medicine	21,077	11.1%	8,965	25.1%
Pain Management	7,258	16.4%	1,063	20.9%
Plastic Surgery Non Burns	64,684	9.3%	13,498	28.4%
Renal Medicine	11,425	7.2%	5,920	17.6%
Respiratory Medicine	19,398	10.0%	6,377	23.0%
Rheumatology	17,761	5.7%	2,262	17.5%
Specialist Paed Oth Surg	8,190	17.2%	3,185	32.8%
Urology	6,264	8.4%	934	18.8%
Vascular Surgery	10,874	4.4%	2,042	14.8%
Total	**563,937**		**144,368**	

4. By patient domicile:

Figures 4 and 5 show (2014-2018) OP DNA rates are higher in some domiciles than in others, high DNA rates are observed both in rural as well as urban Hamilton areas. Māori patients in all areas have higher DNA rates than non- Māori.

Waikato DHB Catchment:

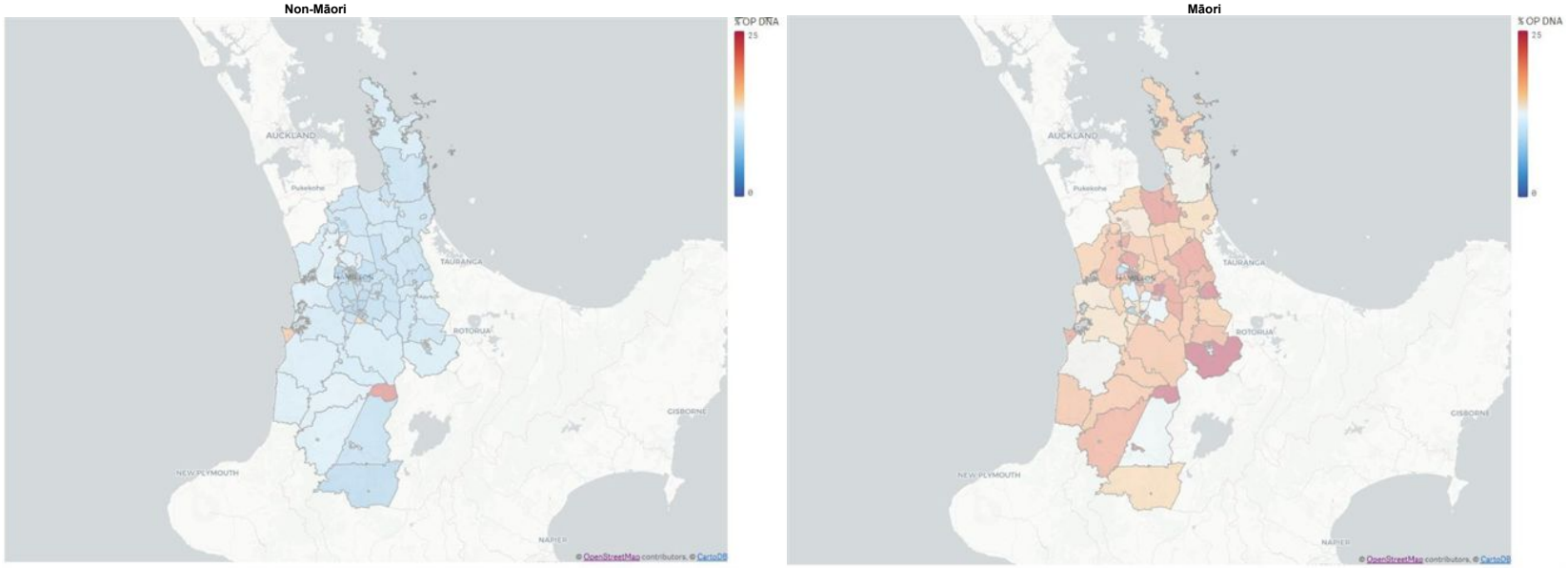


Figure 4: OP DNA Rates by Domicile – Waikato DHB Catchment Area

Hamilton urban areas:

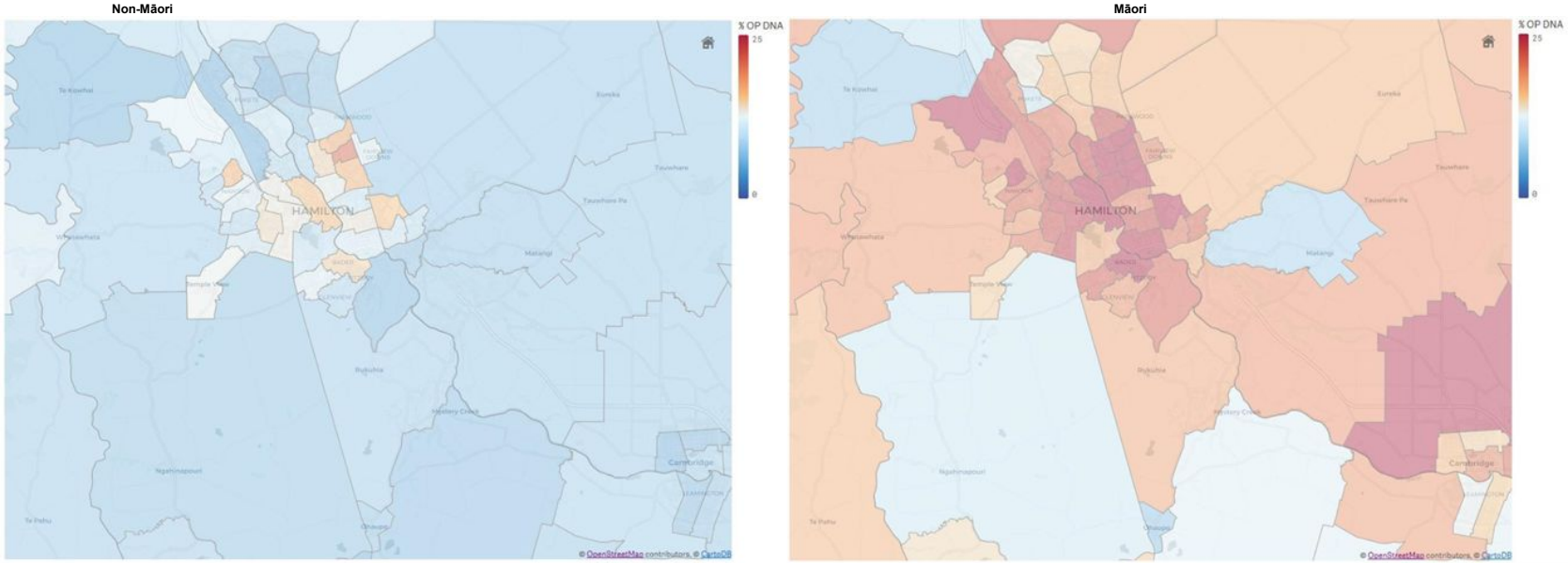


Figure 5: OP DNA Rates by Domicile – Hamilton Urban Areas

Appendix III: Health System Targets – Equity Focused

N.B This information is provided as contribution from Strategy & Funding to the Equity Focused Report (EFR). The information is taken directly from the May and April 2018 Board Health Target Reports and included below are the measures that currently provide Māori and non-Maori data. The information reported going forward will be further refined as the EFR progresses.

HealthTarget: Increased 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
Result	**90%**	**89%**	**88%**	**90%**	**89%**
Māori	**89%**	**86%**	**82%**	**86%**	**83%**
Ranking	**16**	**15**	**15**	**15**	**14**

Data for this target is reported on a three month rolling basis. The table above and Graph 3 shows our most recent result of 89% for the three month period from 1 February 2018 to 30 April 2018.

It is disappointing to see that we have continued to perform below the 95% with the most recent result being 89% for all and 83% for Maori.

The further decrease in infant immunisation coverage this quarter is frustrating in the context of concentrated efforts and investment to improve coverage for both Māori and other infants. Five percent (80 children) of the total eligible infant population were missed in the last quarter. Our PHOs report this is due to “delayers” and is an area of focus for all general practices in the district.
We have finalised our new Immunisation Action Plan (the plan) and submitted it to the Ministry of Health, following sign off by the Immunisation Steering Group. This group will report regularly on progress to the Waikato Child Health Network. The representatives from PHOs, Public Health, and the Immunisation Advisory Centre and Strategy and Funding have committed to the plan and will be jointly accountable for delivery of the agreed actions.

In summary the plan includes working with PHOs to reduce declines and delayers, increasing opportunistic immunisations, ensuring outreach immunisation services focus on unenrolled children, and working more closely with Family Start and LMCs to facilitate early enrolments with general practice. The ministry is also seeking to continue to work with us to support implementation of the plan, and discuss whether a review/redesign of immunisation services for the Waikato region is needed.

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

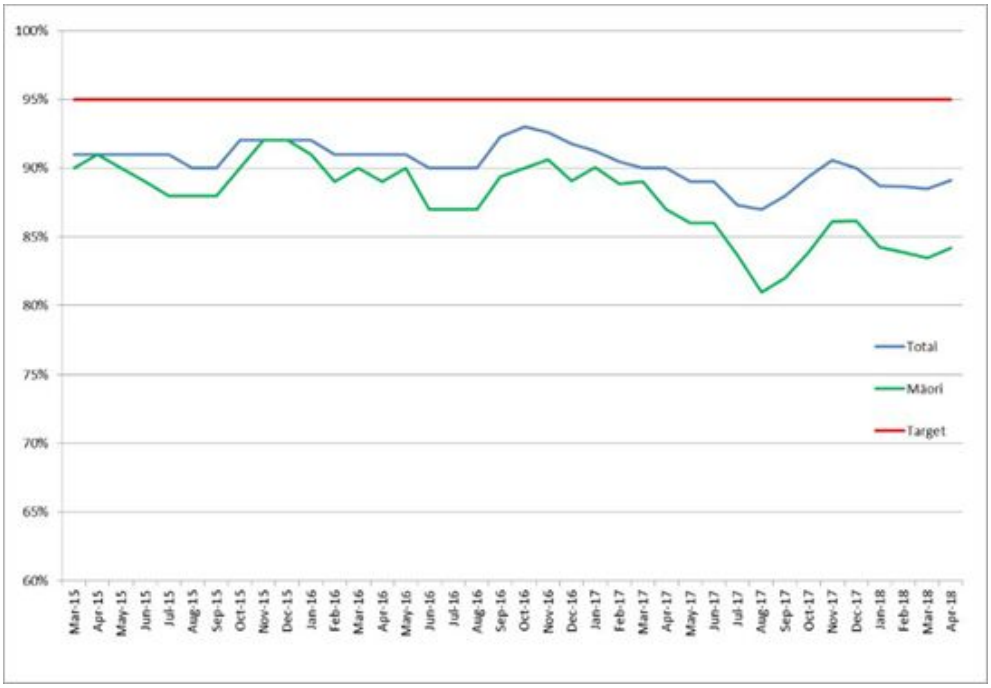


Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from Jan 2018 to Mar 2018

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	567	528	93%	11
Māori	512	431	84%	56
Pacific	52	50	96%	0
Asian	141	133	94%	1
Other	80	63	79%	13
Total	1,352	1,205	89%	80

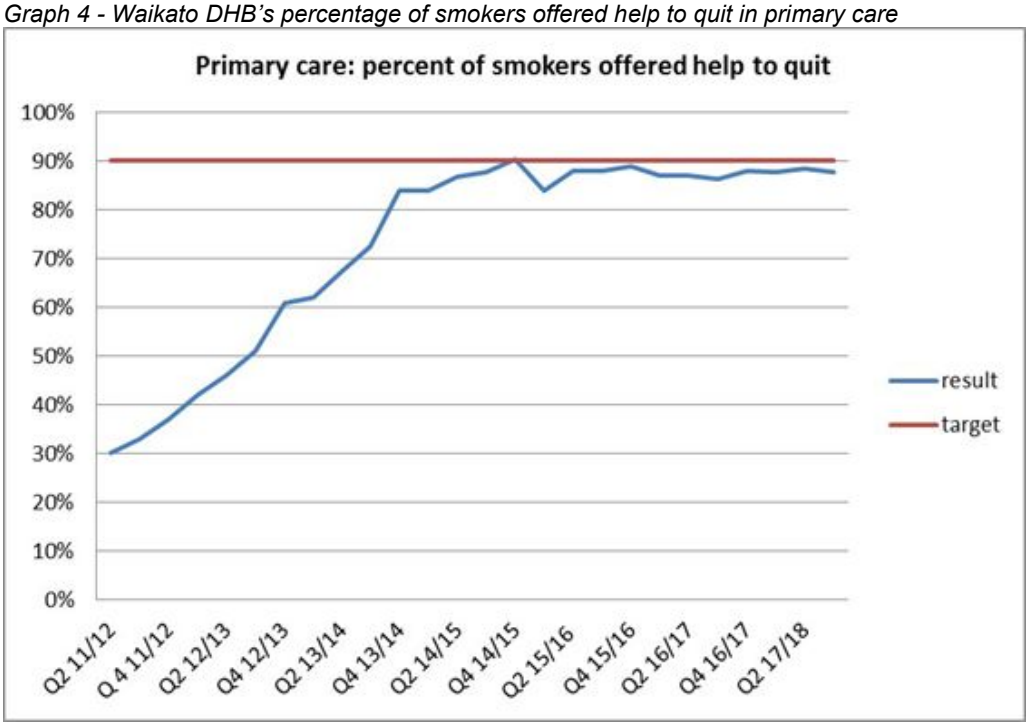
Target: Better help for smokers to quit - primary care

Table 9 – Quarterly Results

Q1 result 16/17	Q2 result 16/17	Q3 result 16/17	Q4 result 16/17	Q1 result 17/18	Q2 17/18	**Q3 17/18**
87% 7th ranking	87% 12th ranking	86% 13th ranking	88% 15th ranking	88% 14th ranking	89% 12th ranking	**88% Ranking unavailable**

Graph 4 showing data up to the quarter three 17/18 result of 88% shows Waikato DHB has declined by 1% in the last quarter

Graph 4 - Waikato DHB's percentage of smokers offered help to quit in primary care



It is disappointing to note that our performance has not quite met the target with a slight decrease in the percentage of smokers offered help to quit this quarter. All PHOs have confirmed their practice management teams have regular contact with practices to ensure general practitioners and practice nurses remind and prompt patients to take up the services available to quit smoking. Each general practice has an identified Smokefree Champion who ensures team members are upskilled in this area and shares PHO smoking data reports. We will continue to work with our PHO colleagues this quarter as it is our expectation the ongoing focus will improve our overall results next quarter.

Target: Better help for smokers to quit - maternity

Graph 5 shows a result of 98.5% for Quarter 3. It is reassuring to see that we continue to meet this target.

Graph 5 - Waikato DHB's percentage of smokers offered help to quit in maternity

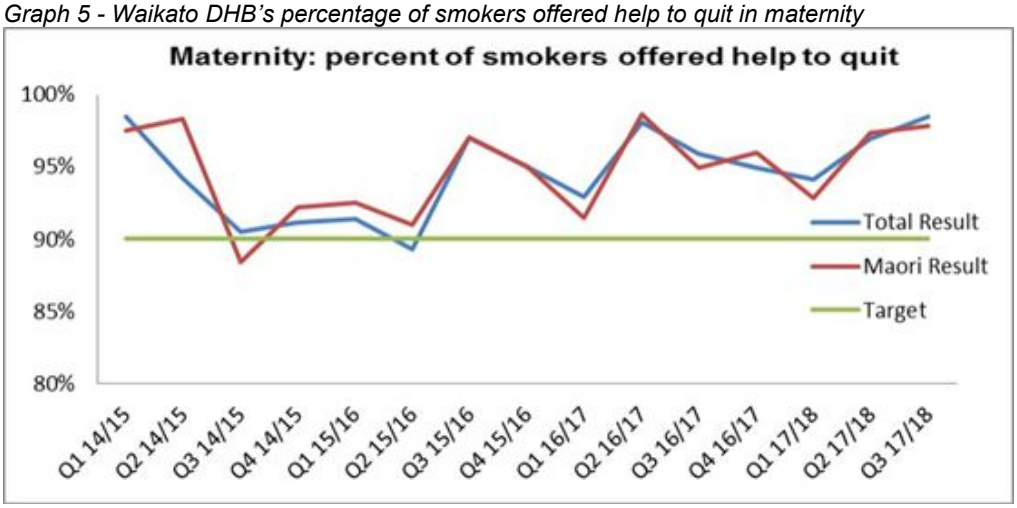


Table 12 shows our quarter three results provided by the Ministry for our total and Māori population.

Table 12 – 2017/18 Q3 maternity smoking status and advice (target 90%)

	No. women registered	No. of women identified as smokers	No. people given advice	Smoking prevalence	Percent of smokers offered advice
Māori	89	45	44	50.6%	97.8%
Total	359	67	66	18.7%	98.5%

**Data comes from three sources: Midwifery and Maternity Providers Organisations (MMPOs), Lead Maternity Carers Services (LMCs) and from DHB employed midwives (if available).*

The information for this measure is received directly from the Ministry of Health. Waikato DHB is performing well against this target. The stop smoking service incentives scheme for pregnant women is promoted and appears at this early stage to be having positive results in terms of improving access.

Target: Raising healthy kids

We have achieved a perfect result (100%) for this target this quarter. This means all obese children identified in the Before School Check (B4SC) programme were referred to a health professional for clinical assessment followed by a further referral to a family based nutrition, activity and lifestyle service delivered by Sport Waikato. We also have lower rates of declined referrals at 17% compared to the national average of 24%

The Sport Waikato programme was launched on Saturday 12 May 2018. This programme is individualised for each family and whānau for up to six months. The service aims to assist families and whānau to talk about healthy food options, getting children moving and learning good sleeping habits.

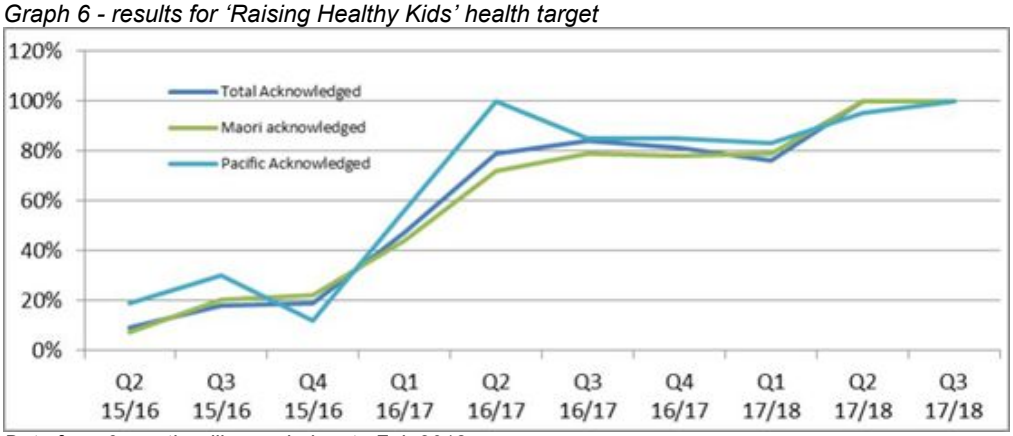
Table 13 – 2017/18 Q3 Raising Healthy Kids Results (target 95%)

	Waikato						National
	2016/17	**2016/17**	**2016/17**	**2017/18**	**2017/18**	**2017/18**	**2017/18**

		Q1	Q3	Q4	Q1	Q2	Q3	Q3
		Six mths Aug 16	**Six mths Feb 17**	**Six mths May17**	**Six mths Aug 17**	**Six mths Nov 17**	**Six mths Feb 18**	**Six mths Feb 18**
Total	Referral Sent	50%	86% (133)	83% (102)	77% (93)	100% (144)	100% (142)	99% (1,321)
	Referral Sent and Acknowledged	**47%**	**84% (127)**	**81% (98)**	**76% (91)**	**100% (144)**	**100% (142)**	**98% (1,313)**
Māori	Referral Sent	49%	82% (65)	80% (43)	79% (36)	100% (69)	100% (70)	99% (440)
	Referral Sent and Acknowledged	**44%**	**79% (61)**	**78% (41)**	**79% (36)**	**100% (69)**	**100% (70)**	**98% (435)**
Pacific	Referral Sent	56%	90% (9)	88% (10)	87% (13)	95% (12)	100% (14)	100% (362)
	Referral Sent and Acknowledged	**56%**	**85% (8)**	**75% (8)**	**83% (12)**	**95% (12)**	**100% (14)**	**99% (360)**

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

Graph 6 - results for 'Raising Healthy Kids' health target



Data for a 6 month rolling period up to Feb 2018

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 10.2

WHY ORA BUSINESS CASE

Purpose	Approval of the Why Ora Business Case**.**

Why Ora is a proposed programme of work led by Te Puna Oranga to pipeline rangatahi Māori into health careers. Access to rangatahi Māori is achieved by recruitment of wharekura (secondary schools) and whare wānanga (tertiary providers) into the Why Ora programme and enrolment of rangatahi Māori and their whānau. Why Ora provides individualised plans, mentoring and pastoral care alongside wānanga series to provide rangatahi and their whānau with the tools required to achieve meaningful employment in the health sector. The programme links with existing services operating in this space to provide a more coordinated approach for rangatahi and their whānau.

Please find attached the refreshed Why Ora business case that reflects the feedback provided by the Māori Strategic Committee in May. The proposed Why Ora programme has been endorsed by:

- Māori Strategic Committee
- The Waikato DHB executive group
- Waikato Tainui
- Why Ora Taranaki
- Iwi Māori Council.

The proposed budget for this business case 18/19 has been set aside waiting for approval.

Recommendation
THAT
The Board approves and financially supports the Why Ora Programme.

LORAINE ELLIOTT
EXECUTIVE DIRECTOR OF MĀORI HEALTH

Business Case

Waikato DHB Te Puna Oranga
Why Ora Programme

Prepared by:	Te Puna Oranga (Māori Health Service)
Project Code:	CP1809-001-01
Date:	21 June 2018
Version:	V1.0
Status:	Complete

Table of Contents

1. Proposal

This business case proposes a tailored fit for purpose Waikato DHB-led remediation response to Māori health workforce inequities between Māori and non-Māori. The programme is called Why Ora and has been modified from a similar programme currently operating across the Taranaki DHB catchment.

Te Puna Oranga acknowledges Why Ora Taranaki for their support and openly sharing their information and processes. Their learnings and successes have been the building blocks for this business case.

1.1. Purpose & Objectives

The purpose of Why Ora is ***to pipeline rangatahi Māori into the health workforce*** with the primary objectives of Why Ora being:

- To contribute towards Strategic Priority 1.1 - the radical improvement in Māori health by eliminating health inequities as these relate to Māori patient / whānau satisfaction and engagement with health services
- To contribute toward Strategic Priority 1.4 – enable a workforce to deliver culturally appropriate services by increasing the percentage and number of Māori in the health workforce
- To contribute towards raising the household income of Māori within the Waikato DHB catchment
- To link with existing rangatahi Māori workforce development initiatives within the Waikato DHB catchment

1.3 Programme Scope

Why Ora is programme that targets rangatahi Māori either:

- attending a wharekura / secondary school within the Waikato DHB catchment; or
- enrolled in a health related programme with a tertiary provider

The full scope of the programme, each stream and the linkages with existing initiatives is outlined in Figure 1. Rangatahi Māori can enter Why Ora through one of the three streams:

- Stream 1 : Wharekura / Secondary School
- Stream 2 : Whare Wānanga / Tertiary
- Stream 3 : Mahi / Employment

It has been important to understand the existing initiatives in order to ensure there is little to no duplication or overlapping with Why Ora. Further to this, an understanding enables Why Ora to link rangatahi Māori with these opportunities. For example, Waikato DHB is a Gateway provider. In 2018 there were 50 gateway applications and 15 were from rangatahi Māori. This suggests there are many rangatahi Māori missing this opportunity.

It should be noted that along with the existing initiatives provided by Waikato-Tainui, the Iwi has provided formal written support for this Why Ora programme. With this support Waikato- Tainui has also offered to leverage its strategic relationships with wharekura / secondary schools within the Waikato DHB catchment for Why Ora.

1.4 Programme Establishment

The establishment plan for the programme is outlined in Figure 2. Establishment has been phased over three years.

With 47 wharekura / secondary schools and more than 7000 rangatahi Māori in the catchment the first 20 wharekura / secondary schools to be approached are those that:

- are registered for Gateway and have a strategic relationship with Waikato-Tainui i.e. have a signed MOU; or
- have a high percentage (50% or more) of rangatahi Māori on their roll

As per the establishment plan, the governance arrangements are intended to start with a Waikato DHB governance group and end in year 3 with a separate trust developed from a considered review undertaken in Year 1.

Figure 1: Why Ora programme outline and linkage with existing services

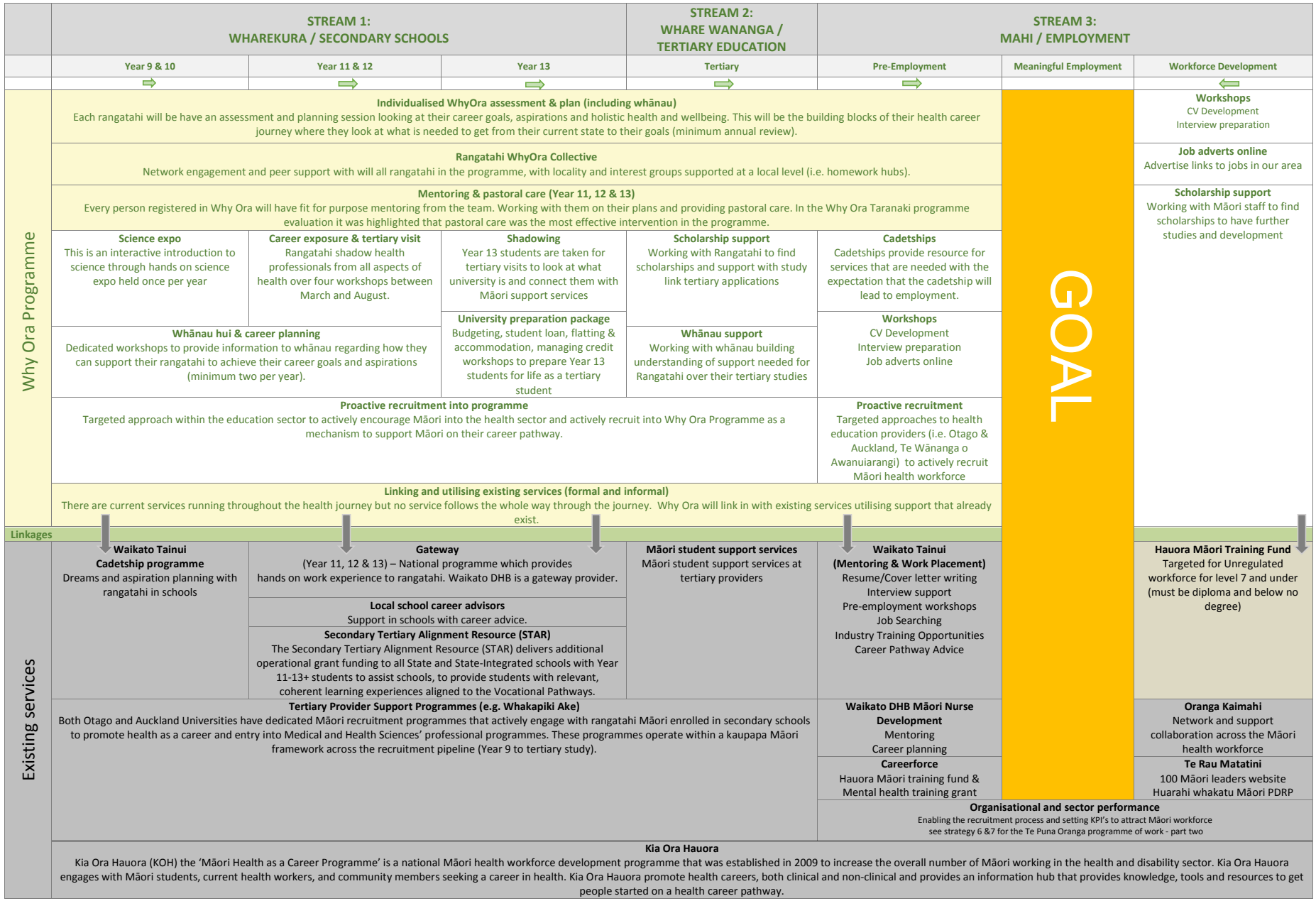


Figure 2: Why Ora establishment plan

ESTABLISHMENT PLAN					
Year 1		**Year 2**		**Year 3**	
1	**Establish governance structure** Interim governance with review of the governance structure to be completed (i.e separate trust established versus remaining with Waikato DHB governance).	1	**Affirm governance structure** Reviewed governance structure implemented.	1	**Monitor governance structure** Continuous improvement processes developed to ensure the governance structure continues to strategically direct WhyOra for the future.
2	**Key stakeholder relationships** Establish relationships in the Waikato DHB catchment area and nationally where applicable to develop WhyOra. • Wharekura • Tertiary providers • Funders ▪ Philanthropic funders, Te Puni Kōkiri, Ministry of Education, Ministry of Social Development, Ministry of Justice, Ministry of Health • Iwi ▪ Waikato, Maniapoto, Whanganui, Tuwharetoa, Raukawa, Hauraki • Workforce development providers ▪ Why Ora Taranaki, Te Rau Matatini, Careerforce, Health Workforce New Zealand	2	**Key stakeholder relationships** Maintained with continuous improvement processes in place.	2	**Key stakeholder relationships** Maintained with continuous improvement processes in place.
3	**Recruitment of wharekura and whare wānanga (secondary schools and tertiary providers)** • Confirm 10 kura • Tertiary providers focused on medical and allied health providers	3	**Recruitment of wharekura and whare wānanga** • Confirm additional 5 kura (15 total) • Tertiary relationships, focused on allied health and kaupapa Māori tertiary providers	3	**Recruitment of wharekura and whare wānanga** • Confirm additional 5 kura (20 total) • Tertiary relationships, nursing and all other health tertiary providers
4	**Enrolment of rangatahi** • Database developed • Assessment plan templates developed • Mentoring and pastoral care scope developed • 150 rangatahi Māori -wharekura • 50 rangatahi Māori – tertiary	4	**Enrolment of rangatahi** • 150 rangatahi Māori -wharekura • 50 rangatahi Māori – tertiary	4	**Enrolment of rangatahi** • 150 rangatahi Māori -wharekura • 50 rangatahi Māori – tertiary
5	**Wānanga series** • Development of wānanga series ▪ Science Expo ▪ Whānau hui and career planning ▪ Career exposure and tertiary visits ▪ Shadowing ▪ University preparation ▪ Scholarships ▪ Whānau support ▪ Cadetships ▪ Employment preparation • Delivery of wānanga series	5	**Wānanga series** • Delivery of wānanga series	5	**Wānanga series** • Delivery of wānanga series
6	**Funding** • Develop funding case • Source and secure philanthropic funding (1/3 of total cost of WhyOra Programme for Year 2) • Investigate trust setup and benefit analysis of most effective governance structure for WhyOra	6	**Funding** • Source and secure philanthropic funding (2/3 of total cost of WhyOra Programme for Year 3 and ongoing) • Contingency – governance to determine what streams of WhyOra to prioritise and continue	6	**Funding** • Maintain funding model • Contingency – governance to determine what streams of WhyOra to prioritise and continue
7	**Linkages** Establish linkages with existing programmes in the Waikato DHB catchment for streams 1 - 3. • STAR • Kia Ora Hauora • Gateway • Waikato Tainui ▪ Cadetship programme ▪ Mentoring & work placement • Career advisors • Tertiary provider health career support programmes • Waikato DHB work programmes • Tertiary Māori support programmes	7	**Linkages** • Maintained with continuous improvement processes in place. • Implement stream 4 ▪ Te Rau Matatini ▪ Hauora Māori Training Fund ▪ Oranga kaimahi	7	**Linkages** Maintained with continuous improvement processes in place.

2. Reasons

There are a range of key drivers underlying the rationale for establishing a programme such as Why Ora. All relate to the matter of equity.

Equity is described as protecting the most vulnerable members in society[1]. Equitable opportunities in health are about helping people get what they need when they need it, so they are well[2].

The World Health Organization defines equity as the absence of avoidable or remediable differences among groups of people. The concept acknowledges that not only are differences in health status unfair and unjust, but they are also the result of differential access to the resources necessary for people to lead healthy lives[3].

2.1. Reason 1: Māori health inequities

Māori living in the Waikato DHB catchment experience higher mortality and morbidity rates compared with non-Māori. This leads to increased complexity at presentation, longer length of stay and increased costs to the DHB. In turn, this results in:

i. inequitable access to health and social services,
ii. inequitable rates of intervention and treatment,
iii. inequitably poor experiences with the quality and safety of the services they do engage with, and
iv. inequitable health outcomes

Waikato DHB is committed to radical improvement in Māori health outcomes by eliminating inequities for Māori.

2.2. Reason 2: Māori inequity in health workforce

Māori health workforce development is a key enabler of health outcomes[4].

The Waikato DHB catchment has the highest population of Māori in the country; 23% in 2013, yet only 8.7% of the Waikato DHB workforce is Māori (as per Figure 3). The current Waikato DHB workforce is not reflective of communities it serves.

	Clinical			Clinical Total	Non-clinical		Non-clinical Total	Grand Total
Ethnic Group	**Allied**	**Medical**	**Nursing**		**Mngt/Admin**	**Support**		
NZ Māori	117	13	262	392	134	73	207	599
NZ Māori (%)	*(9.5%)*	*(1.6%)*	*(8.2%)*	*(7.5%)*	*(10.7%)*	*(17.8%)*	*(12.5%)*	*(8.7%)*
Others	1097	776	2874	4747	1094	329	1423	6170
Others (%)	*(88.8%)*	*(94.74%)*	*(89.9%)*	*(90.4%)*	*(87.5%)*	*(80.2%)*	*(85.7%)*	*(89.3%)*
Not identified	21	30	59	110	22	8	30	140
Not identified (%)	*(1.7%)*	*(3.6%)*	*(1.8%)*	*(2.1%)*	*(1.7%)*	*(1.9%)*	*(1.8%)*	*(2.0%)*
Grand Total	**1235**	**819**	**3195**	**5249**	**1250**	**410**	**1660**	**6909**

Figure 3: Number and percentage of Māori employed by Waikato DHB November 2017

[1] Increasing Equity Background Paper, Treasury's Living Standards Framework Papers, December 2015

[2] http://toitangata.co.nz

[3] https://www.health.govt.nz/our-work/populations/Māori-health/he-korowai-oranga/key-threads/equity

[4] https://www.health.govt.nz/system/files/documents/publications/whakapuawaitia-ngai-Māori-2030-thriving-as-Māori-report.pdf

Research shows that having a more representative workforce results in better health equity for all ethnic groups. Figure 4 provides a picture of the proportion of Māori Waikato DHB staff by occupation. The highest proportion of Māori staff are employed in support roles, while the lowest proportions are employed in medical roles.

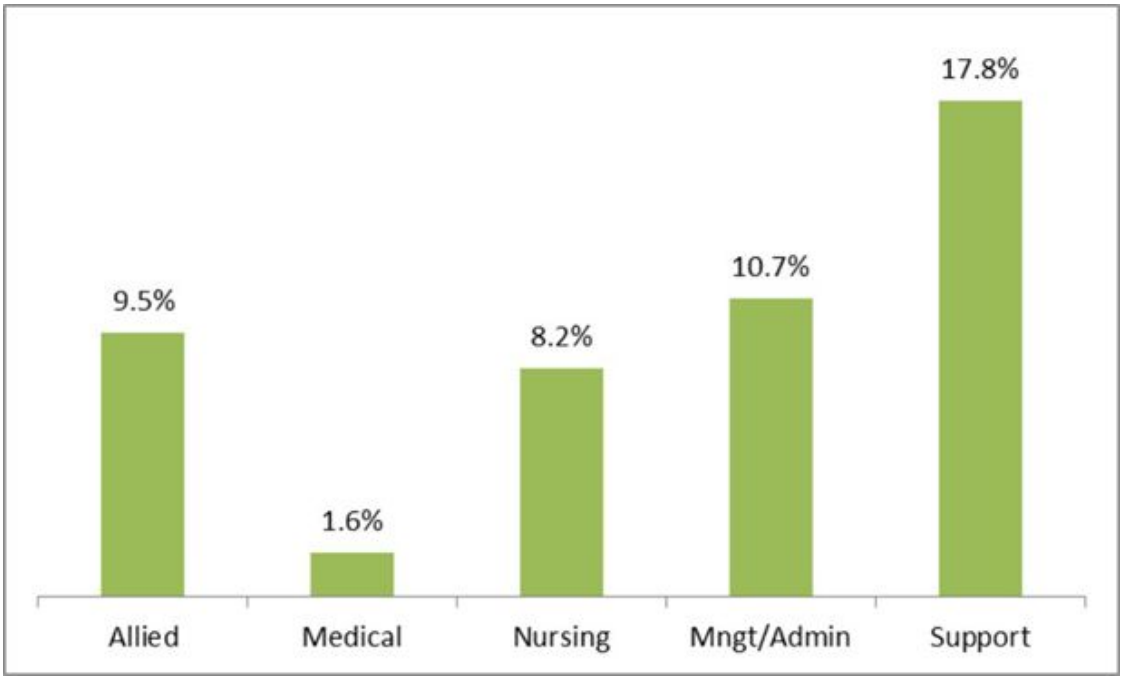


Figure 4: Proportion of Māori by occupation at Waikato DHB (Data Source, People and Performance Waikato DHB as at November 2017)

While there are some workforce projects in place within the Waikato DHB catchment i.e. the existing initiatives, Māori inequity in the health workforce continues. This suggests another approach is required. Why Ora is the proposed complimentary approach.

Currently New Zealand society expects and supports Māori to adhere to stereotypical areas of success including sport and the arts[5]. Rangatahi Māori are not being encouraged to take science, math and other "academic" and specialised disciplines[6]. There are many examples that show Māori succeed not only in these areas but that Māori success is wide and varied.

Why Ora aims to engage with rangatahi at their tipping point around the age of 13[7] to unleash their ambition for high achievement and to change the platform for the realisation of their goals.

https://www.youtube.com/watch?v=oF5_P951uMM

[5] Hokowhitu, B. (203). 'Physical Beings': Stereotypes, Sport and the 'Physical Education' of New Zealand Māori. *Sport in Society.* doi: 10.1080/14610980312331271599

[6] Erueti, BB., & Palmer, FR. (2015). Te Whariki Tuakiri (the identity mat): Māori elite athletes and the expression of ethno-cultural identity in global sport. In K. Liston, & P. Dolan (Eds.) Sport, race and ethnicity: The scope of belonging : Routledge

[7] https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj10/christchurch-health-and-development-study.html

The number of Māori that need to be recruited in the health workforce in order to close the equity gap is presented in Figure 5. The numbers needed are not insignificant.

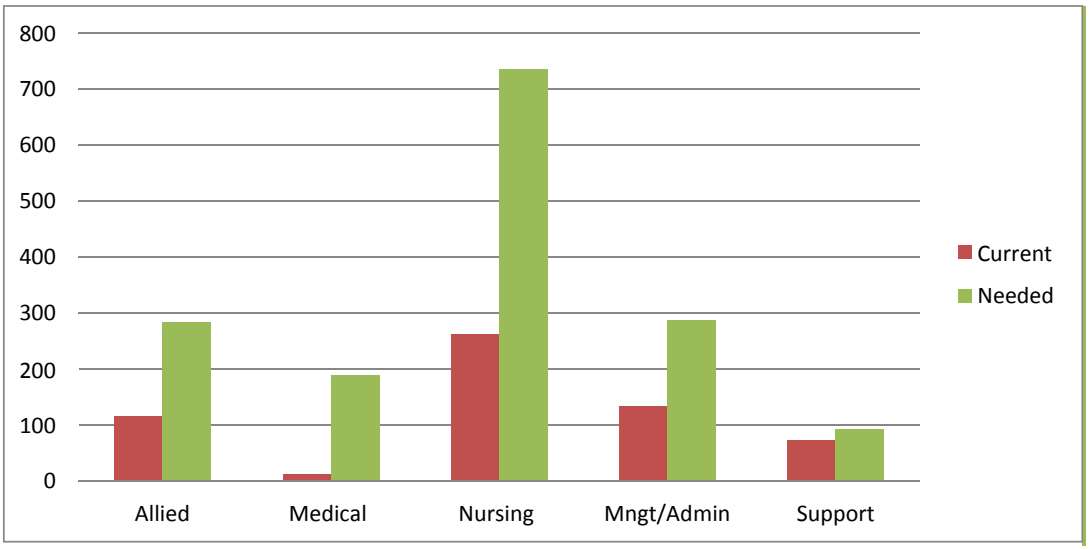


Figure 5: Current number of Māori employed by Waikato DHB vs number of Māori employed by Waikato DHB required for population representation (Data Source, People and Performance Waikato DHB as at November 2017; Needed is based up 23% Māori population representation).

2.3. Reason 3: Māori inequity in household income

A recent report released by BERL shows that inequity in Māori incomes is currently costing the New Zealand economy $2.6b and if this issue is not remedied it will increase every year to $4.3b in 2040[8]. Household income (i.e. economic prosperity) is one of the measures of disparity and closing aligned with health outcomes. The more deprived a community the higher the health inequity.

3. Key Performance Indicators

The key performance indicators (KPIs) for Why Ora are outlined in Figure 6.

KPI	Year 1	Year 2	Year 3
1. Wharekura/ Secondary Schools recruited	10	15 (10+5)	20 (15+5)
2. Rangatahi Māori in Wharekura / secondary school enrolled	150	300 (150+150)	450 (300+150)
3. Enrol tertiary and graduate students into the programme (with a strong focus on doctors and allied roles)	50	100 (50+50)	150 (100+50)
4. Enrolled rangatahi Māori and their whanau have completed health assessments	100%	100%	100%
5. Eligible enrolled rangatahi Māori complete the Gateway programme	100%	100%	100%
6. Enrolled rangatahi Māori graduating placed in employment (percentage of 3. above)	10%	10%	10%

Figure 6: Number and percentage of Māori employed by Waikato DHB November 2017

[8] http://www.stuff.co.nz/business/102643651/inequality-depriving-mori-and-the-economy-of-26b-every-year

4. Major Risks

ID#	Risk description	Risk Response	Probability	Impact
1	Number of Māori trainees with no job opportunities may increase if DHB does not coordinate its approach	Manager will ensure adequate placements for all trainees and will work with services to improve succession planning with new Māori recruits	40% unlikely	2
2	Education providers don't engage with the programme	Manager will build and leverage high level relationships with tertiary and secondary schools to ensure engagement is successful	20% Rare	2
3	Insufficient philanthropic funding	Funding and relationship support FTE will work towards supporting this function If situation continues the Streams will require review and downsizing.	20% Rare	3
Legend:		**Threat**: Avoid, Reduce, Fallback, Transfer, Accept **Opportunity**: Exploit, Enhance, Reject	20% Rare 40% Unlikely 60% Possible 80% Likely 100% Almost Certain	1:Minimal 2:Minor 3:Moderate 4:Major 5:Extreme

5. Strategic Alignment

1. Health equity for high needs populations:			
#		Alignment rationale	Alignment
1.1	Radical improvements in Māori health outcomes by eliminating health inequities for Māori	This project will have an immediate impact on health care quality. By supporting Māori into the health workforce it will deepen the knowledge and understanding of Māori cultural practices in both the clinical and non-clinical settings. This will create employment opportunity, effective engagement and meaningful relationships for ultimately improving Māori health outcomes.	✓✓
1.2	Eliminate health inequities for people in rural communities	More than 70% of Māori population in Waikato DHB live rurally. Increased Māori patient satisfaction and engagement with services will lead to improved health outcomes for rural populations as well.	✓✓
1.3	Remove barriers for people experiencing disabilities	Through increased employment of Māori, the specific needs of Māori living with disabilities will be met more consistently by culturally competent staff. Rangatahi experiencing disabilities would also be given greater opportunities to pursue careers in the health sector.	✓✓
1.4	Enable a workforce to deliver culturally appropriate services	Legislation and professional standards of practice for clinical health professionals requires employees to deliver culturally competent and culturally safe care for those accessing health services. This project will support more employees who have the knowledge and skills to effectively communicate and build therapeutic relationships and work in partnership with Māori patients and their whānau.	✓✓

2. Safe, quality health services for all:			
#		Alignment rationale	Alignment
2.1	Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement and innovation	Why Ora is an innovative programme that will result in higher quality, culturally safe patient care being delivered to all patients. The rangatahi supported through this programme will bring a culture of improvement and accountability to the Waikato DHB and the health system as a whole.	✓✓
2.2	Prioritise fit-for-purpose care environments	Greater Māori representation in all aspects of the health workforce will lead to improved care environments, as new areas are designed or changed by Māori for Māori.	✓✓
2.3	Early intervention for services in need	This programme will support succession planning, especially in nursing and medical staff groups, which have an ageing workforce.	✓✓
2.4	Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives	This programme will support a pathway for Māori into health careers. With an increase in Māori workforce staff can deliver appropriate services that meet the needs of Māori whānau at all stages of their lives. Māori have instilled values that will contribute positively to the care and wellbeing of populations at any stage of their lives.	✓✓

3. People centred services:			
#		Alignment rationale	Alignment
3.1	Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services	With more Māori employed in all aspects of the workforce future service designs will better meet the needs of Māori patients and whānau	✓✓
3.2	Provide care and services that are respectful and responsive to individual and whānau needs and values	This programme will create opportunity for staff who have the expertise on how to develop and deliver respectful and responsive care and services, specifically to Māori patients and their whānau.	✓✓
3.3	Enable a culture of professional cooperation to deliver services	Aligns to priority.	✓
3.4	Promote health services and information to our diverse population to increase health literacy	Having more Māori in the workforce will lead to greater information availability in Te Reo Māori who will help improve health literacy for Māori patients and whānau.	✓✓

4. Effective and efficient care and services:			
#		Alignment rationale	Alignment
4.1	Live within our means	Aligns to priority.	✓
4.2	Achieve and maintain a sustainable workforce	This programme gets more young Māori into the health workforce. Through involvement at every stage in their health education and early career it can be ensured that they are entering areas of high need and are filling vital gaps. By having more Māori in the workforce it will create a supportive environment for all Māori staff and will result in greater retention of Māori staff.	✓✓
4.3	Redesign services to be effective and efficient without compromising the care delivered	Aligns to priority.	✓
4.4	Enable a culture of innovation to achieve excellence in health and care services	This programme will create excellence within the health and care services based on cultural value and engagement with whānau. This will result in quicker, more effective services for all. This innovative proactive approach to Māori workforce development would make Waikato DHB a leader in this field.	✓✓

5. A centre of excellent in learning, training, research and innovation:			
#		Alignment rationale	Alignment
5.1	Build close and enduring relationships with local, national, and international education providers	This programme will be building strong relationships at with secondary and tertiary education providers at both the local and national level.	✓✓
5.2	Attract doctors, nurses and allied health staff to the Waikato through high quality training and research	This programme will not only grow new Māori staff but will also attract Māori staff through an improved culture and support system.	✓✓
5.3	Cultivate a culture of innovation, research, learning and training across the organisation	This programme presents opportunities for evaluation and research regarding Māori workforce development, which Waikato DHB could use to become a centre of excellence	✓✓
5.4	Foster a research environment that is responsive to the needs of our population	This programme would encourage Māori to become not only health professionals but also health researchers, meaning our research would better meet the needs of our population.	✓✓

6. Productive partnerships:			
#		Alignment rationale	Alignment
6.1	Incorporate Te Tiriti o Waitangi in everything we do	As indicated in the Waikato DHB Māori health policy The Treaty of Waitangi (Te Tiriti o Waitangi) principles of partnership, participation and active protection must guide the way in which the Waikato DHB responds to Māori health care issues.	✓✓
6.2	Authentic collaboration with partner agencies and communities	This programme relies heavily on partnership with the education sector.	✓✓
6.3	Focus on effective community interventions using community development and prevention strategies	This programme focuses on engaging young Māori in their local communities.	✓✓
6.4	Work towards integration between health and social care services	Why Ora will allow rangatahi from more diverse backgrounds to pursue health careers. The connections they bring and the experiences they've had will enhance connections with the social sector. The programmes partnership with education will also improve health system collaboration with other sectors.	✓✓

6. Costs

Task #	Task Name	Unit Rate	units	18/19	units	19/20	units	20/21	Ongoing	Comments
				YEAR 1		**YEAR 2**		**YEAR 3**		
1	Staff resource									
1.01	Manager	$92,000.00	0.3	$27,600.00	0.3	$27,600.00	0.3	$27,600.00	$27,600.00	Management of team and work allocation, internal mechanisms
1.02	Funding & Relationship Coordinator	$80,000.00	1	$80,000.00	1	$80,000.00	1	$80,000.00	$80,000.00	Programme relationship coordination & funding
1.03	Tertiary Recruitment and Employment Placement Coordinator	$70,000.00	1	$70,000.00	1	$70,000.00	1	$70,000.00	$70,000.00	Mahi/employment & kaimahi component
1.04	Rangatahi Recruitment Coordinator	$55,000.00	3	$165,000.00	3	$165,000.00	3	$165,000.00	$165,000.00	Recruitment and support for rangatahi in wharekura/ secondary school component
1.05	Admin	$44,000.00	1	$44,000.00	1	$44,000.00	1	$44,000.00	$44,000.00	Website and social media management, registrations,email, phone and travel management
		Total	6.3	$386,600.00	6.3	$386,600.00	6.3	$386,600.00	$386,600.00	
2	Programme expense									
2.01	Why Ora Wānanga	$15,000.00	1	$15,000.00	1	$15,000.00	1	$15,000.00	$15,000.00	Wānanga series (see implementation plan)
2.02	Cadetships	$30,000.00	0	$0.00	4	$120,000.00	4	$120,000.00	$120,000.00	A paid internship to incentivise employers to hire rangatahi with the expectation they will be absorbed after the paid internship has finished
2.03	Hard ship student support	$2,500.00	0	$0.00	1	$2,500.00	1	$2,500.00	$2,500.00	Exception one-off hardship support for registered rangatahi
				$15,000.00		$137,500.00		$137,500.00	$137,500.00	
3	One off set up cost									
3.01	Desk	$900.00	7	$6,300.00	0	$0.00	0	$0.00	$0.00	Desk
3.02	Desktop	$1,719.28	7	$12,034.96	0	$0.00	0	$0.00	$0.00	Screen, CPU, keyboard & Mouse
3.03	Laptop	$1,435.00	3	$4,305.00	0	$0.00	0	$0.00	$0.00	Laptop for off site work
3.04	Ipad	$1,000.00	4	$4,000.00	0	$0.00	0	$0.00	$0.00	Ipad to register rangatahi virtually
3.05	Phones	$350.00	6	$2,100.00	0	$0.00	0	$0.00	$0.00	Phones
3.06	Website	$24,000.00	1	$24,000.00	0	$0.00	0	$0.00	$0.00	Why Ora website set up
			Total	$52,739.96		$0.00		$0.00	$0.00	
4	MISC									
4.01	Travel	$10,000.00	1.2	$12,000.00	1.2	$12,000.00	1.2	$12,000.00	$12,000.00	
4.02	Accomodation	$5,000.00	1	$5,000.00	1	$5,000.00	1	$5,000.00	$5,000.00	
4.03	Meals	$500.00	1	$500.00	1	$500.00	1	$500.00	$500.00	
4.04	Stationery and Marketing	$2,500.00	1	$2,500.00	1	$2,500.00	1	$2,500.00	$2,500.00	
4.05	Staff Development	$2,000.00	6.3	$12,600.00	6.3	$12,600.00	6.3	$12,600.00	$12,600.00	
4.06	Database	$5,000.00	1	$5,000.00	1	$5,000.00	1	$5,000.00	$5,000.00	Database to register rangatahi and hold information
			Total	$32,600.00		$32,600.00		$32,600.00	$32,600.00	
5	CONTINGENCY									
7.01	General expenses	$5,000.00	0.5	$5,000.00	1	$5,000.00	1	$5,000.00	$5,000.00	
7.03	Overheads	$10,000.00	1	$10,000.00	1	$10,000.00	1	$10,000.00	$10,000.00	
7.04	Inflation (1.5% of previous year)		0	$0.00	1	$7,529.10	1	$8,688.44	$8,705.83	
			Total	$15,000.00		$22,529.10		$23,688.44	$23,688.44	
			Total	**$501,939.96**		**$579,229.10**		**$580,388.44**	**$580,388.44**	
	Income from DHB			**$501,939.96**		**$386,152.73**		**$193,462.81**	**$193,462.81**	Ongoing cost to DHB ~ $193,462.81
	Income from other					$193,076.37		$386,925.62	$386,925.62	
	Total overall DHB commitment (3 years)			**$1,081,555.51**						

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 10.3

NZ HEALTH PARTNERSHIPS STATEMENT OF PERFORMANCE EXPECTATIONS 2018/19

Purpose	For decision.

Background

NZ Health Partnerships is required to prepare a Statement of Performance Expectations (SPE) and Annual Plan every year. The SPE is delivered to the Hon Dr David Clark, Minister of Health, the Ministry of Health, and the Annual Plan to NZ Health Partnerships' Shareholders.

Together the SPE and Annual Plan accountability documents provide a base against which NZ Health Partnerships' actual intentions will be assessed, including its performance expectations and financial forecasts for the year ahead. These two documents are combined into one standalone SPE publication, for their common communication, monitoring, reporting and auditing requirements. The SPE is tabled in the House of Representatives, and published on the NZ Health Partnerships website.

Statement of Performance Expectation

The points below provide an overview of the SPE content:

a. *Basis* – NZ Health Partnerships focus for 2018/19 is to drive value through:

   i. Delivering the National Oracle Solution (NOS) to plan, budget and scope including agreeing with the sector any additional deliverables resulting from the Cabinet decision process

   ii. Delivering value from procurement services

   iii. Building on the mature Shared Banking and Collective Insurance services to drive greater value for DHBs.

b. *Measures, targets and rationale* - The number of Shareholder agreed measures and targets are reduced from 29 in 2017/18 to 14 in 2018/19, with a strategic level focus on delivery and return on investment. This is in line with other Crown Entities approach to the SPE. Performance against these will be reported to the NZ Health Partnerships Board and Shareholders each quarter.

c. *Key Performance Indicators* - In the NZ Health Partnerships' Performance Framework, the SPE measures and targets are underpinned by Key Performance Indicators (KPIs), which will inform their assessment of achievement against them. Performance against these KPIs will also be shared with relevant stakeholders through various reporting channels.

d. *Shareholders* - The draft measures were circulated to Shareholders on 21 March and feedback has been incorporated into the final set of measures and targets.

The Statement of Performance Expectation 2018/19 is provided in Appendix 1.

Key Performance Indicators

As highlighted above, the SPE measures are underpinned by KPIs, which are agreed with and reported to relevant stakeholders. This gives flexibility in year to respond to changes and ensure NZ Health Partnerships performance and statutory reporting remains relevant.

NZ Health Partnerships are in the process of finalising the KPIs, but have provided the drafts in Appendix 2 to give context. To ensure these reflect Shareholder expectations, these are in the process of being agreed with the relevant stakeholder groups:

a. National Procurement - approval via the Annual Procurement Plan process

b. NOS - these were effectively approved via the Change Control Report process. However, they are now pending revision as a result of the delays in Cabinet approval

c. Shared Banking and Collective Insurance - to be approved via the Shared Banking and Collective Insurance Services Performance Group.

Next Steps

The NZ Health Partnerships Board will receive the final SPE for approval (19 June).

The approved SPE will be sent to the Minister of Health, House of Representatives, Minister of Health and all DHBs (30 June).

The SPE will be published on the NZ Health Partnerships website (30 June).

Recommendation
THAT
The Board:

1) Approves the NZ Health Partnerships Statement of Performance Expectations 2018/19 and provides written confirmation of this to Megan Main, Chief Executive, no later than 30 June 2018.
2) Notes progress on the development of the NZ Health Partnerships key performance indicators to support the Statement of Performance Expectations 2018/19.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

NZ HEALTH PARTNERSHIPS

Statement of Performance Expectations 2018/19

For Shareholder Approval

May 2018

Note to our shareholders

Annual Plan

In accordance with our Shareholders' Agreement, NZ Health Partnerships also presents this document as the Annual Plan 2018/19 including the Annual Budget 2018/19 for written approval before the commencement of our next financial year on 1 July 2018.

Contents

Who we are

Our purpose

NZ Health Partnerships is a multi-parent Crown-entity subsidiary. Owned by and working in partnership with all DHBs, we build and deliver shared services supporting them to provide quality healthcare to their communities.

What we do

We collaborate with DHBs as our shareholders, co-creators and customers. In partnership we identify, develop and implement initiatives for the sector's mutual benefit.

With an aging population, increasing cost of new clinical equipment, and rising public demand, our initiatives are focused on creating financial efficiencies for DHBs.

By thinking, acting and investing collaboratively DHBs are able to achieve greater benefits than they would by operating independently.

However, what we do is about more than cost reduction. While the company's primary focus is on administrative, support and procurement activities, our work can have direct or indirect clinical implications. Ultimately, we aim to support DHBs to provide excellent patient outcomes.

Governance and accountability

NZ Health Partnerships works in a commercial manner within a public sector environment. The company operates under a Board, as well as programme and service governance structures with strong DHB representation. The Board comprises three independent Directors, and four regional DHB Chairs. It is chaired by an independent Director.

New Zealand Health Partnerships Board:

- Peter Anderson, Chair and Independent Director
- Terry McLaughlin, Independent Director
- Joanne Hogan, Independent Director
- Kevin Atkinson, DHB Director (Central Region)
- Pauline Lockett, DHB Director (Midlands Region)
- Rabin Rabindran, DHB Director (Northern Region)
- Ron Luxton, DHB Director (Southern Region)

Alongside NZ Health Partnerships Chief Executive, Megan Main, each programme and service has a DHB Chief Executive Sponsor. These Sponsors help drive strategic delivery and support performance through the promotion of strong stakeholder engagement.

Strategic partnerships

NZ Health Partnerships actively works to foster strategic relationships across the sector. Organisations with which we work closely include the Ministry of Health, PHARMAC, Ministry of Business, Innovation and Employment, Treasury, Department of Internal Affairs, commercial organisations and other health-sector shared services organisations.

Statutory and compliance requirements

As a Crown Entity subsidiary and limited liability company, NZ Health Partnerships is required to comply with a variety of legislation including but not limited to:

- Commerce Act 1986
- Companies Act 1993
- Crown Entities Act 2004
- Employment Relations Act 2000 and the Human Rights Act 1993, Holidays Act 2003 etc
- Health and Safety at Work Act 2015
- New Zealand Public Health and Disability Act 2000
- Official Information Act 1982
- Ombudsmen Act 1975
- Privacy Act 1993 and related codes ie Health Information Privacy Code 1994
- Protected Disclosures Act 2000
- Public Audit Act 2001
- Public Finance Act 1989
- Public Records Act 2005

Risk management

NZ Health Partnerships recognises that risk and issue management is essential for the delivery of its programmes and services. The aims of our risk and issues management processes are to improve the quality of decision making to minimise and manage adverse impacts

.

Future direction

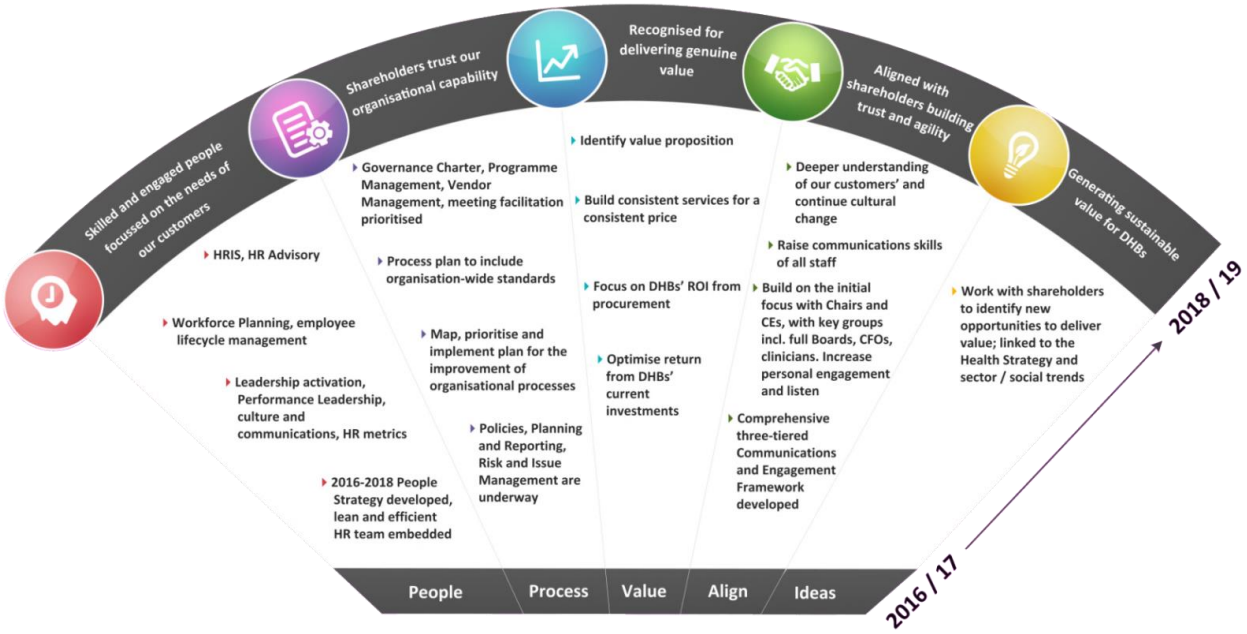
NZ Health Partnerships will focus on delivery to generate maximum value for shareholders

We will continue our progress on the Strategic Business Plan which commenced in 2016/17. Through the five key work streams detailed below, we aim to increase our organisational performance, continue to improve alignment with our shareholders and to deliver value now and in the future.

As 2018/19 is the final year of our Strategic Business Plan, we will be working with our shareholders to develop our strategy and roadmap to 2022. Our intent is to build on our existing programmes and services to generate greater value for DHBs.

1. People
2. Process
3. Value
4. Alignment
5. Opportunities and Ideas

Diagram 1 - NZ Health Partnerships Strategic Business Plan



Strategic work streams

All work streams, even those ostensibly with an internal emphasis, are focusing on delivering value for shareholders.

1. People

Outcome: Skilled and engaged people focused on the needs of our customers (DHBs)

We will employ people with not just technical skills but the ability to build relationships and communicate clearly. We will create a culture that ensures our people are motivated, listen to their customers and remain focussed on the commitments we make to our shareholders in planning documents and day-to-day interactions. We will further embed and promote good workplace health and safety practices.

2. Process

Outcome: Shareholders trust our organisational capability

We intend to build on process improvement successes already achieved and identify, prioritise and implement further targeted process improvements, adopting a continual improvement mindset. This will include consulting with our shareholders on a refreshed Governance Charter designed to clarify delegated authorities and speed up decision making.

3. Value

Outcome: Delivering genuine value now

We will maximise the value generated from DHBs' investment in NZ Health Partnerships by continuing to put delivery of objectives, agreed with our shareholders, at the centre of what we do. Implementation and embedding of the Value Framework, developed in 2017/18 following feedback from our shareholders, will be a key focus in 2018/19.

4. Alignment

Outcome: Aligned with shareholders building trust and agility

In 2018/19 we will focus on understanding the unique drivers and circumstances of each DHB to help inform decision making processes. Widespread consultation is planned as we develop a strategic roadmap to 2022; while communications remains an organisational priority.

5. Opportunities (Ideas)

Outcome: Generating sustainable value for DHBs

We will work with our shareholders to identify the challenges and opportunities that will benefit from a nationally coordinated DHB-driven response. Without losing focus on our current work, we will engage with the sector to identify ways to innovate or leverage greater value from our current services. There may be fresh areas of opportunity to explore, although this will be a secondary focus.

Strategic Alignment

NZ Health Partnerships looks forward to working with the new government as its tackles the challenge required to reduce inequalities and deliver a modern health system.

As a sector we are entrusted with spending public money effectively to ensure we best meet the unique needs of each DHB's local community as well as the New Zealand taxpayer. One way we can achieve this is through working collaboratively.

DHBs are charged with providing the best possible care to their local communities. NZ Health Partnerships' focus is on bringing all DHBs together to look at the national picture, share collective best practice, improve productivity and leverage our combined scale to unlock tangible, measurable value.

Our programme, services and management

Programme

NZ Health Partnerships, in collaboration with DHBs, manages delivery of the National Oracle Solution (NOS) programme. DHB experts and leaders make up a significant proportion of the programme team and NOS governance groups, including the Joint Design Council, NOS Programme Board and NOS Executive Steering Committee.

NATIONAL ORACLE SOLUTION

Every year, DHBs spend about $1.4 billion buying goods and services, including everything from cotton wool buds through to hospital beds. Traditionally the purchasing of these goods and services has been done in a variety of ways across the 20 DHBs, with no single register or process for handling the transactions.

NOS is the sector-approved solution to replace DHBs' finance and supply chain systems many of which are ageing and unsupported. It is a standardised, sector-designed, nationally consistent, common Oracle system for all 20 DHBs. NOS is also the key enabler for the delivery of procurement benefits.

At a functional level it delivers a large number of business activities including receivables and debt collection, payables, invoice processing and electronic payments, general ledger accounting, national month end processing, project and asset accounting, requisitions and purchasing, inventory management and replenishment, national catalogue and contract management, and financial and management reporting.

NOS will provide the data, processes and controls to support procurement which is the sector's biggest opportunity to reduce non labour costs, and in doing so improve patient care and equity of access to technology.

Focus for 2018/19
In 2018/19 the first wave of DHBs will go live. Wave 1 DHBs are Bay of Plenty, Canterbury, Waikato and the West Coast. The programme's priority will be to support Wave 1 post go-live, bed in the system, and prepare for the next DHB implementation. In parallel with this, the build of the National Technology Solution designed during 2017, will commence in preparation for DHBs to migrate to. Throughout the year, support will be provided for DHB implementation activities and the ongoing national support model will be established.

In 2018/19 we will also work with DHBs to implement agreed actions in response to the Ministry of Health's review of the NOS programme and any conditions of the anticipated Cabinet approval.

Performance Measures and Targets	Type	Date
1. **Governance** - An effective and industry standard governance process is in place and maintained throughout the life of the project	Quality Timeliness	30 June
Rationale - Effective governance ensures the programme is well positioned to, and is, delivering on its commitments. It is a link between the programme and DHB leadership, monitoring the quality of deliverables, timelines and cost		
2. **Programme Scope** - The National Oracle Solution programme is delivered, within the agreed scope and is subject to a formal change control process	Quality Timeliness	30 June
3. **Programme Budget** - The National Oracle Solution programme is delivered, within the agreed budget and is subject to a formal change control process	Quality Timeliness Financial	30 June
4. **Programme Timeline -** The National Oracle Solution programme is delivered, within the agreed timeline and is subject to a formal change control process	Quality Timeliness	30 June
Rationale - Shareholders can measure success by: (a) delivery of what was set out to be delivered, (b) delivery within the agreed cost, and (c) delivery to schedule. The change control process will ensure that any change in these three areas is understood from the perspective of root cause, risks, benefits, and impact on the programme's scope, budget and timeline.		

Services

PROCUREMENT

Procurement

In May 2016, the DHB Procurement Strategy was unanimously approved by all 20 DHBs setting the framework to support delivery of benefits to DHBs from procurement activities. NZ Health Partnerships was given responsibility by the DHBs to establish the DHB National Procurement Service from 1 May 17. Part of this was the establishment of the Operating Model which covers approach, functions and roles, and guides how the Procurement Strategy will be operationalised.

Focus for 2018/19
The focus for the 2017/18 year was on transitioning the national procurement activities from healthAlliance (FPSC) to NZ Health Partnerships, establishing frameworks, and assessing the current state whilst also not losing momentum on "in flight" national and some local activities.

Building on the foundation of the Procurement Strategy and Operating Model, a new Annual Procurement Plan (APP) has been established for 2018/19. This is a multi-year plan which incorporates all procurement activities within the procurement life cycle, in particular, focusing on developing and integrating key enablers identified in the operating model.

Under the APP 2018/19, there is a significant focus on developing national strategies for capital equipment, performing key sourcing events, improving reporting to support implementation and managing contracts to maintain value delivery. NOS is one of the key enablers identified in the Operating Model and ensuring Procurement is ready to leverage NOS data will be a significant focus for procurement in 2018/19.

Performance Measures and Targets	Type	Date
5. **Operating Model Enablers** - Formal engagement with DHBs and their agents in the end-to-end procurement cycle for improved collaboration and operating processes	Quality Timeliness	30 June
Rationale - A formal customer engagement process underpins the ability for procurement to achieve the DHBs strategic principles. A strong customer engagement process will ensure alignment of goals, demonstrate commitment, drive standardisation and most importantly, ensure the outcomes are patient focused.		
6. **Operating Model Enablers** - Data and technology enhanced to support the Procurement Operating Model	Quality Timeliness	30 June
Rationale - Information management is a key enabler for any procurement process. Having the right data management and business analytics tools will support better reporting, decision making and opportunity identification.		

Performance Measures and Targets	Type	Date
7. **Governance and Management Alignment** - Support national procurement governance to align with the DHB Procurement Strategy, the Procurement Operating Model and the Health Sector Procurement Policy	Quality Timeliness	30 June
Rationale - One of the key enablers identified under the Procurement Operating Model is to ensure there is compliance in the procurement process. This echoes good procurement practice, as contract compliance has a direct correlation to procurement outcomes.		
8. **National Procurement Delivery -** Delivery of value-add national procurement services to DHBs, including total benefits as per the approved Annual Procurement Plan	Quality Financial	30 June
Rationale - Procurement as a service must deliver value and return on investment for DHBs.		

SHARED BANKING

Shared Banking

On any given day NZ Health Partnerships manages a cash balance of between $300m to $1.4b for the sector. Unlike the other services where we act as a vendor manager, NZ Health Partnerships delivers the banking service itself. We invest funds held in a range of low risk investments to optimise the return on funds and minimise fees, while ensuring sufficient cash is available to meet all DHBs' needs.

Focus for 2018/19
We will finalise the transition to BNZ, facilitating transfer for the four remaining DHBs. However the key focus for the year is working with DHBs and BNZ as our strategic partner, to improve processes and maximise the value DHBs derive from this mature service.

Performance Measures and Targets	Type	Date
9. **Shared Banking Delivery** - An efficient, value-add Shared Banking service to DHBs, delivering benefits as agreed by the Banking and Insurance Service Performance Group	Financial	30 June
Rationale - Ensure there is a return for the Shared Banking approach, over and above what could be achieved locally. It excludes the influence of external factors such as availability of cash in the sector and Official Cash Rate fluctuations. Benefits are the difference between estimated financial flows on self-managed treasury services and actual financial flows through the national Shared Banking service.		
10. **Risk Management and Governance** - Deliver a quality Shared Banking service, effectively managing risk and ensure appropriate reporting and governance is provided	Quality Timeliness	30 June
Rationale - Effective management of the relationship with the transactional banking service provider, providing appropriate reporting to stakeholders and ensuring effective governance is in place to minimise risk are key success factors for this service.		

COLLECTIVE INSURANCE

Collective Insurance

Together DHBs have assets valued around $18b. On behalf of DHBs, NZ Health Partnerships seeks to negotiate the best insurance deal available on a collective basis.

Working together means the sector can offer insurers a portfolio that is geographically spread with a high level of risk identification and management processes in place. Substantial cover is gained as a result from a comparatively lower premium, compared to if each DHB were to insure on an individual basis.

Focus for 2018/19
Collaborate with DHBs, Marsh, Ministry of Health, MBIE and insurers to develop the DHBs long term risk management strategy and support DHBs to maximise the value from their mature and well managed portfolio of risks.

Performance Measures and Targets	Type	Date
11. **Collective Insurance Delivery** - An efficient, value-add and fit for purpose Collective Insurance service. Ensuring DHBs are engaged and informed and the service delivers the value (financial and non-financial) agreed by the Banking and Insurance Service Performance Group	Financial	30 June
Rationale - There is financial and non-financial value in the collective insurance approach, ultimately reducing cost for the national good. The counterpart to this is ensuring that DHBs are engaged in, and informed about, their insurance coverage, so they can make good local decisions. Financial benefits exclude the influence of external factors such as increasing asset values or global loss trends, which impact the absolute cost of insurance.		
12. **Risk Management and Governance** - Deliver a quality Collective Insurance service, effectively managing the relationship with Insurance Broker and DHBs, ensuring appropriate reporting and governance is provided	Quality Timeliness	30 June
Rationale - Effective management of the relationship with the Insurance Broker, providing appropriate reporting into the DHB Boards and ensuring effective governance is in place to minimise risk are key success factors for this service.		

Management

ORGANISATIONAL CAPABILITY

NZ Health Partnerships' work is supported by a lean team providing a range of core functions including Finance, Risk Management, Legal, Audit and Compliance; as well as Strategy, Business Performance, Human Resources, Change Management, Communications and Engagement. These are collectively known as Organisational Capability.

Focus for 2018/19
Specific areas of focus this year include working with our shareholders to develop the strategy and roadmap to 2022, and embedding a framework to improve governance transparency and accountability, while streamlining decision making across all of our programmes and service. Our established risk management approach will take on a more strategic focus, while continuous improvement in our processes and the way we communicate and engage with shareholders will always remain a core focus.

Performance Measures and Targets	Type	Date
13. **Strategic Plan** - NZ Health Partnerships' Strategy and Roadmap to 2022 developed and approved	Quality Timeliness	30 June
Rationale - NZ Health Partnerships will optimise and build on its existing programme and services to generate increased and sustainable value for our shareholders.		
14. **Communications and Engagement Strategy** - Communications and engagement enhanced to support effective delivery of Programmes and Services	Quality Timeliness	31 December
Rationale - Building the trust and confidence of DHBs is fundamental to NZ Health Partnerships' sustainability and success. Central to this is transparent and timely communications, as well as on-going engagement that enable us to leverage the skills and experience of our shareholders.		

Benefits

Supporting DHBs through providing value add services are at the heart of NZ Health Partnerships' purpose. In collaboration with our DHB shareholders, activities are identified, assessed, prioritised, developed and implemented with the purpose of providing opportunities for DHBs to generate financial and non-financial benefits, thereby contributing to the health and wellbeing of New Zealanders.

A benefit is defined as a clear financial or performance improvement. This may include building organisational capabilities, delivering efficiencies or effectiveness, or clinical improvements. Whether financial or performance-based all benefits ultimately contribute to better health outcomes. As such, "value" is a term that better captures the breadth of gains that can be made across the sector.

The implementation and embedding of a more holistic Benefits Management Framework, approved in 2017/18 following feedback from our shareholders, will be a key focus in 2018/19.

In 2018/19 NZ Health Partnerships will report to DHBs. The benefits derived from the programmes and services we manage on their behalf. We will also advise DHBs of benefits they are receiving from third party provides such as PHARMAC and Ministry of Business Innovation and Employment (MBIE).

DEFINITIONS

Benefits management refers to the identification, definition, tracking, realisation and optimisation of benefits. Benefits can be made up of two parts: Budgetary and Non-Budgetary.

BUDGETARY BENEFITS

Budgetary benefits are defined as the incremental annual change, primarily cash, which has a clearly defined impact on the Statement of Comprehensive Income. These benefits result in a budget line reduction, compared with the prior year.

NON-BUDGETARY BENEFITS

Non-Budgetary benefits are defined as those that form part of the business case that do not meet the definition of Budgetary. There are three general components:

- **Cost avoidance:** Cash that would have been spent is now totally avoided or reallocated as a result of the business case.
- **Cumulative benefits:** are those that are carried forward from previous years, whether they were originally budgetary or non-budgetary in nature.
- **Qualitative benefits:** accrue from associated activity as a result of a business case and need to be reported in some way. Also referred to as non-financial benefits, in some cases it may be too difficult to quantify these reliably.

Financial statements

Prospective Statement of Financial Performance by Output Class

For the year ending 30 June 2019

	2016/17 Actual $000	2017/18 Forecast $000	2018/19 Budget $000
Revenue:			
Output Class 1: Programmes	11,236	7,861	9,036
Output Class 2: Services	39,305	28,216	21,813
Total Revenue by Output Class	50,541	36,077	30,849
Expenditure:			
Output Class 1: Programmes	10,929	7,627	9,036
Output Class 2: Services	38,618	27,787	21,813
Total Expenditure by Output Class	49,547	35,414	30,849
Surplus/ (Deficit)	**994**	**663**	**0**

Prospective Statement of Comprehensive Revenue and Expense

For the year ending 30 June 2019

	2016/17 Actual $000	2017/18 Forecast $000	2018/19 Budget $000
Revenue:			
Revenue from DHBs	26,372	15,952	17,812
Interest revenue - NZ Health Partnerships	48	24	15
- Shared banking	20,630	18,840	12,521
Other revenue	3,491	1,261	501
Total Revenue	50,541	36,077	30,849
Expenditure:			
Personnel costs	3,295	4,692	5,121
Depreciation and amortisation expense	437	385	100
Finance costs - NZ Health Partnerships	344	501	501
- Shared banking	20,579	18,762	12,521
Other expenses	24,892	11,074	12,606
Total Expenditure	49,547	35,414	30,849
Surplus/ (Deficit)	**944**	**663**	**0**
Other Comprehensive revenue and expense	0	0	0
Total Other Comprehensive Revenue and Expense	**0**	0	0
TOTAL COMPREHENSIVE REVENUE AND EXPENSE	**944**	**663**	**0**

Prospective Statement of Financial Position

For the year ending 30 June 2019

	2016/17 Actual $000	2017/18 Forecast $000	2018/19 Budget $000
ASSETS			
Current Assets:			
Cash and cash equivalents (incl. Shared Banking)	86,758	112,354	74,060
Receivables	9,118	5,148	4,928
Investments – DHB shared banking Facility	130,000	75,000	0
Prepayments	537	550	550
DHB Shared Banking Facility	50,840	108,476	219,513
Total Current Assets	277,253	301,528	299,051
Non-Current Assets:			
Receivables	4,520	3,888	3,647
Investment - DHB Shared banking Facility	0	0	0
Property, plant, and equipment	57	52	38
Intangible assets	64,082	70,101	86,917
Total Non-Current Assets	68,659	74,041	90,602
Total Assets	**345,912**	**375,569**	**389,653**
LIABILITIES			
Current Liabilities:			
Payables	11,962	15,661	12,041
DHB Shared Banking Facility	264,462	273,037	289,233
Employee entitlements	176	200	200
Income in Advance	256	669	256
Total Current Liabilities	276,856	289,567	301,730
Non-Current Liabilities:			
Payables	6,555	4,559	2,436
Employee entitlements	0	0	0
Income in Advance	689	433	177
Total Non-Current Liabilities	7,244	4,992	2,613
Total Liabilities	**284,100**	**294,559**	**304,343**
Net Assets	**61,812**	**81,010**	**85,310**

	2016/17 Actual $000	2017/18 Forecast $000	2018/19 Budget $000
Contributed Capital	64,916	83,451	87,751
Accumulated surplus / (deficit)	(3,104)	(2,441)	(2,441)
Total Equity	**61,812**	**81,010**	**85,310**

Prospective Statement of Changes in Equity

For the year ending 30 June 2019

	2016/17 Actual $000	2017/18 Forecast $000	2018/19 Budget $000
Balance at 1 July	**60,818**	**61,812**	**81,010**
Total Comprehensive Revenue and Expense for the year	994	663	0
Owner Transactions			
Contributed Capital	0	18,535	4,300
Balance at 30 June	**61,812**	**81,010**	**85,310**

Prospective Statement of Cash Flows

For the year ending 30 June 2019

	2016/17 Actual $000	2017/18 Forecast $000	2018/19 Budget $000
Cash flows from Operating Activities:			
Receipts from DHBs	30,072	18,644	17,592
Receipts from other revenue	2,864	1,914	200
Interest received	23,140	18,722	12,521
Payments to suppliers	(24,662)	(13,515)	(16,262)
Payments to employees	(3,296)	(4,310)	(5,310)
Interest paid	(24,419)	(18,542)	(12,341)
Net DHB Sweep account movements with DHBs	(29,156)	(44,717)	(97,062)
Goods and services tax (net)	390	(106)	(106)
Net Cash Flow from Operating Activities	(25,067)	(41,910)	(100,768)
Cash flows from Investing Activities:			
Funds from Deposit	2,021,000	789,000	865,000
Purchase of property, plant, and equipment	(10)	(10)	(10)
Purchase of intangible assets	(8,731)	(6,019)	(16,816)
Funds to Deposit	(2,011,000)	(734,000)	(790,000)
Net Cash Flow from Investing Activities	1,259	48,971	58,174
Cash flows from Financing Activities:			
NOS Capital injection	0	18,535	4,300
Proceeds from borrowings	0	0	0
Repayment Interest	0	0	0
Net Cash Flow from Financing Activities	0	18,535	4,300
Net (decrease)/increase in cash and cash equivalents	(23,808)	25,596	(38,294)
Cash and cash equivalents at the beginning of the year	110,566	86,758	112,354
Cash and cash equivalents at the end of the year	**86,758**	**112,354**	**74,060**

Notes to the Prospective Financial Statements

Statement of Accounting Policies

REPORTING ENTITY

NZ Health Partnerships Limited is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing NZ Health Partnerships operations include the Crown Entities Act 2004. NZ Health Partnerships is a multi-parent Crown subsidiary, owned by the 20 District Health Boards, which have equal Class A shareholding and voting rights.

NZ Health Partnerships' primary objective is to operate as a co-operative undertaking, and enable DHBs to collectively maximise shared services opportunities for the national good. NZ Health Partnerships does not operate to make financial return.

NZ Health Partnerships has designated itself as a public benefit entity (PBE) for financial reporting purposes.

BASIS OF PREPARATION

The prospective financial statements are based on policies and approvals in place as at 1 July 2018. The prospective financial statements set out NZ Health Partnerships activities and planned performance. The use of this information for other purposes may not be appropriate. These prospective financial statements have been prepared on the basis of assumptions of future events that NZ Health Partnerships reasonably expects to occur and associated actions that NZ Health Partnerships reasonably expects to take at the date that this information was prepared.

STATEMENT OF COMPLIANCE

These prospective financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZ GAAP).

The prospective financial statements have been prepared to comply with PBE Standards for a Tier 1 entity.

The prospective financial statements have been prepared for the special purpose of the Statement of Performance Expectations 2018/19 of NZ Health Partnerships shareholders. They have not been prepared for any other purpose and should not be relied upon for any other purpose.

These statements will be used in our Annual Report as the budgeted figures. The Statement of Performance Expectations narrative informs the prospective financial statements and the document should be read as a whole.

The preparation of prospective financial statements in conformity with PBE FRS 42 requires the Board and management to make good judgements, estimates, and assumptions that affect the application of policies and reported amounts of assets and liabilities, income, and expenses.

The prospective financial statements were approved by NZ Health Partnerships Board on 8 May 2018. The Board is responsible for the prospective financial statements presented, including the assumptions underlying the prospective financial statements and all other disclosures. The Statement of Performance Expectations is prospective and as such contains no actual operating results. It is not intended that these prospective financial statements will be updated.

MEASUREMENT BASE

The prospective financial statements have been prepared on a historical cost basis.

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

Significant Accounting Policies

REVENUE

Interest Revenue
Interest revenue is recognised using the effective interest method. Interest revenue on an impaired financial asset is recognised using the original effective interest rate.

EXPENDITURE

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

Goods and Service Tax
All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense. The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed exclusive of GST.

Income Tax
NZ Health Partnerships is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

Critical Accounting Estimates and Assumptions

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

Critical Judgment in Applying Accounting Policies

Management has exercised critical judgements in applying accounting policies:

- capitalisation of the National Oracle Solution (NOS) programme (previously known as Finance, Procurement, and Supply Chain programme)
- impairment of NOS assets, and
- treatment of contractual settlement with third party provider of Infrastructure as a Service.

Accounting Policy

REVENUE

Funding from DHBs
NZ Health Partnerships is funded through revenue received from the DHBs, which is restricted in its use for the purpose of NZ Health Partnerships meeting its objectives as specified in the Statement of Intent 2017 - 2021. The breakdown of revenue of different output class is on page 16. Revenue is recognised as revenue when earned and is reported in the financial period to which it relates.

PERSONNEL COSTS

Superannuation schemes

Defined benefit schemes
NZ Health Partnerships has no obligations to contribute to any defined benefit superannuation funds.

Defined contribution schemes
Obligations for contributions to Kiwi Saver are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

OTHER EXPENSES

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight - line basis over the lease term. Lease incentives received are recognised in the surplus/deficit as a reduction of rental expense over the lease term.

CASH AND CASH EQUIVALENTS

Cash and cash equivalents include cash on hand, deposits held at call with banks and other short-term highly liquid investments with original maturities of three months or less. All investments are held in New Zealand. These include the DHB Shared Banking sweep account and NZ Health Partnerships operational account.

RECEIVABLES

Receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. The fair value of service credits, included within the receivables balance have been determined using cash flow discounted at a market rate of 6.44%.

INVESTMENTS

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

PROPERTY, PLANT AND EQUIPMENT

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

1. Leasehold improvements
2. Furniture, and office equipment
3. Information technology.

Property, plant and equipment are shown at cost, less any accumulated depreciation and impairment losses.

Additions
The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to NZ Health Partnerships and the cost of the item can be measured reliably.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Disposals
Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset and are reported in the surplus or deficit.

Depreciation
Depreciation is provided on a straight-line basis on all property, plant and equipment, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values

over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant and equipment have been estimated as follows:

Asset Type	Useful Life	Rate
Leasehold improvements	5 – 14 years	7% - 20%
Furniture and office equipment	1.5 – 9.5 years	10.5% - 67%
IT Hardware	2.5 – 5 years	20% - 40%

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

Impairment of property, plant and equipment

Cash generating assets
NZ Health Partnerships does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash generating assets
Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

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

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

INTANGIBLE ASSETS

Software acquisition and development
Computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with development and maintenance of NZ Health Partnerships' website is recognised as an expense when incurred. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development employee costs and an appropriate portion of relevant overheads.

The NOS programme (previously known as Finance Procurement and Supply Chain (FPSC) programme) is a national initiative funded by DHBs and facilitated by NZ Health Partnerships

to deliver sector wide benefits. NZ Health Partnerships holds an intangible asset recognised at the capital cost of development relating to this programme.

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

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

Intangible Asset Type	Useful Life	Rate
National Oracle Solution	15 years	6.7%
Acquired computer software	2.5 – 3 years	33% - 40%

Impairment of intangible assets
Refer to the policy for impairment of property, plant, and equipment. The same approach applies to the impairment of intangible assets.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Work in Progress - Capitalisation of National Oracle Solution
The NOS programme is aimed at reducing costs in administrative support and procurement for the public health sector. A national approach to these services will combine the purchasing power of DHBs, create visibility of stock and ensure a common financial language across the health sector.

The assets that are created by the programme are held in Work in Progress (WIP). The NOS programme is not a single asset, but a bundle of assets relating to Finance, Procurement and Supply Chain. These are both tangible such as IT hardware and intangible, such as software, standard operating procedures and intellectual property.

The costs that are directly associated with the development of the NOS programme are recognised as tangible or intangible assets when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. Direct costs include project development employees, contractors, consultants and apportionment of the relevant overheads.

Indirect costs are recognised as expenses when incurred and include depreciation, software licenses and software maintenance costs.

Amortisation
The amortisation of the assets will begin once the asset is available for use (commissioned into the fixed asset register) and will cease at the date that the asset is derecognised. The carrying value of an intangible asset with a finite life is amortised on a straight line basis over its useful life. The useful lives of NOS intangible assets have been estimated to be 15 years.

Impairment of NOS assets
NZ Health Partnerships is required to consider impairment of the NOS programme assets on an annual basis under the applicable accounting standards, specifically PBE IPSAS 21 Impairment of Non-Cash-Generating Assets and conducts an impairment review annually.

Payables
Short-term payables are recorded at their face value. Long term payables which includes treatment of contractual settlement with third party provider of Infrastructure as a Service at fair value. The fair value of Service Provider fees has been determined using contractual cash flows discounted using a market based rate of 6.44%.

Employee entitlements

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

A liability and an expense is recognised where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements
NZ Health Partnerships does not have any employment agreements containing long service leave entitlements.

Equity
Equity is measured as the difference between total assets and total liabilities.

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

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

Financial instrument risks
NZ Health Partnerships activities expose is to credit risk, cash flow risk and liquidity risk. NZ Health Partnerships policy does not allow any transactions that are speculative in nature to be entered into. It has policies and procedures to ensure risks are low.

Monitoring and reporting our performance

The NZ Health Partnerships Performance Management Framework is designed to make sure that staff is well managed and supported, and able to do their jobs to the best of their ability. By doing this, NZ Health Partnerships can deliver the best possible Programmes and Services, create the best value for our DHB shareholders and stakeholders, and make the best use of public money.

Our Performance Management Framework aligns our strategic goals, measures and targets to our key performance indicators and organisational goals. The financial and non-financial measures and targets in this document shall be monitored and reported on a quarterly basis, and culminated in an annual report. Our performance will be assessed against the following five ratings categories, and against the following three performance perspectives:

Table 1: Performance assessment ratings

Performance Rating	Description
Achieved/Achieving	Target is being met/has been met or exceeded
Substantially achieved	Target has not been met by a very slim margin
Progressing	Target has not been on-track, but work is underway and going well
Not Started	Work has not started but due to start, as planned
Not Achieved	Target not achieved

Table 2: Performance perspectives

Perspective	Description
Quality	This will measure the quality of the delivery of programmes and services. Measures may be related to post-implementation reviews, quality assurance reviews, peer reviews, and stakeholder and shareholder engagement.
Financial	This will report performance against the projected costs and benefits for financial measures.
Timeliness	The programmes and services will have progress measured against agreed milestones to determine if they are delivery on schedule.

Directory

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Appendix 2

Statement of Performance Expectations 2018/19 - Measures and Targets
Key Performance Indicators
For information only

National Oracle Solution

Measure and Target	Type	When
1. **Governance** - An effective and industry standard governance process is in place and maintained throughout the life of the project	Quality Timeliness	30 June
Rationale - Effective governance ensures the programme is well positioned to, and is, delivering on its commitments. It is a link between the programme and DHB leadership, monitoring the quality of deliverables, timelines and cost		
2. **Programme Scope** - The National Oracle Solution programme is delivered, within the agreed scope and is subject to a formal change control process	Quality Timeliness	30 June
3. **Programme Budget** - The National Oracle Solution programme is delivered, within the agreed budget and is subject to a formal change control process	Quality Timeliness Financial	30 June
4. **Programme Timeline** - The National Oracle Solution programme is delivered, within the agreed timeline and is subject to a formal change control process	Quality Timeliness	30 June
Rationale - Shareholders can measure success by: (a) delivery of what was set out to be delivered, (b) delivery within the agreed cost, and (c) delivery to schedule. The change control process will ensure that any change in these three areas is understood from the perspective of root cause, risks, benefits, and impact on the programme's scope, budget and timeline		
KPIs	**All National Oracle Solution KPIs pending resolution of Cabinet Approval**	

NZ HEALTH PARTNERSHIPS

Procurement

Measure and Target	Type	When
5. **Operating Model Enablers** - Formal engagement with DHBs and their agents in the end-to-end procurement cycle for improved collaboration and operating processes	Quality Timeliness	30 June
Rationale - A formal customer engagement process underpins the ability for procurement to achieve the DHBs strategic principles. A strong customer engagement process will ensure alignment of goals, demonstrate commitment, drive standardisation and most importantly, ensure the outcomes patient focused.		
KPIs: 5.1 Establish National Procurement Reference Groups, for each national sourcing event, to develop specifications and evaluate all national procurement sourcing activities, with appropriate representation from the sector		
KPIs: 5.2 Provide quarterly customer engagement reports to the Joint Procurement Authority		
KPIs: 5.3 Undertake additional ad hoc procurement activities as agreed with DHBs throughout the year		
6. **Operating Model Enablers** - Data and technology enhanced to support the Procurement Operating Model	Quality Timeliness	30 June
Rationale - Information management is a key enabler for any procurement process. Having the right data management and business analytics tools will support better reporting, decision making and opportunity identification.		
KPIs: 6.1 100% of national contracts and pricing schedules are available in NOS, with all national contracts and pricing schedules loaded into the National Oracle Solution for contract management use and an ongoing process to maintain 100% compliance developed, by September 2018		
KPIs: 6.2 Information reporting format developed with DHBs and quarterly reporting process commenced by September 2018		
KPIs: 6.3 Supplier data obtained and added to Datahub for all new sourcing events		
7. **Governance and Management Alignment** - Support national procurement governance to align with the DHB Procurement Strategy, the Procurement Operating Model and the Health Sector Procurement Policy.	Quality Timeliness	30 June
Rationale - One of the key enablers identified under the Operating Model is to ensure there is compliance in a procurement process. This echoes good procurement practice, as contract compliance has a direct correlation to procurement outcomes.		
KPIs: 7.1 Health Sector Procurement Policy adopted and sector adoption reported by March 2019		
KPIs: 7.2 Arrange a minimum of two national procurement planning sessions with Procurement Operating Advisory Group and Procurement Leads in year		

Procurement continued

8.	**National Procurement Delivery -** Delivery of value-add national procurement services to DHBs, including total benefits as per the approved Annual Procurement Plan	Quality Financial	30 June
	Rationale - National Procurement as a service that must deliver value and return on investment for DHBs.		
KPIs	8.1 Deliver service within agreed budget for the 2018/19 financial year and achieve $5.2m in annualised budgetary benefits and $4.14m in annualised non-budgetary benefits, as per the Annual Procurement Plan, with a minimum of $2.8m of in-year budgetary benefits delivered by 30 June, subject to DHBs' approval to any Annual Procurement Plan amendment(s)		
	8.2 Based on the Annual Procurement Plan, provide quarterly Benefits reports to DHBs including budgetary and non-budgetary benefits		
	8.3 In addition to sourcing events, undertake targeted activities to deliver in-year benefits, so that total in-year benefits for each DHB at least equals their 2018/19 financial year cost of the National Procurement Service		

Shared Banking

Measure and Target	Type	When
9. **Shared Banking Delivery** - An efficient, value-add Shared Banking service to DHBs delivering benefits or delivering a return on investment, as agreed by the Banking and Insurance Service Performance Group	Financial	30 June
Rationale - Ensure there is a good return for the Shared Banking approach, over and above what could be achieved locally. It excludes the influence of external factors such as availability of cash in the sector, of the Official Cash Rate fluctuations. Benefits are the difference between estimated financial flows on self-managed treasury services and actual financial flows through the national shared banking service		
KPIs: 9.1 Deliver service within agreed budget for the 2018/19 financial year and deliver $Xm benefits and X.X% margin over the Official Cash Rate effective interest rate, over the Shared Banking portfolio for 2018/19 [Amount of $ benefits and margin to be agreed with B&ISPG]		
KPIs: 9.2 Undertake process improvement activities to reduce total sector hours of effort on Shared Banking Service, through NZ Health Partnerships initiated activities, including Offset Account arrangement, as measured through the Shared Banking customer questionnaire [Reduction in hours to be agreed with B&ISPG, following survey results. Survey released April 2018]		
KPIs: 9.3 Add value through completion of activities agreed with the Banking and Insurance Service Performance Group, including completing BNZ transition, by agreed timescales		
10. **Risk Management and Governance** - Deliver a quality Shared Banking service, effectively managing risk and ensure appropriate reporting and governance is provided	Quality Timeliness	30 June
Rationale: Effective management of the relationship with the Transactional Banking Service(s) provider; providing appropriate reporting into the DHB Boards and ensuring effective governance is in place to minimise risk.		
KPIs: 10.1 Contract management meetings with BNZ held regularly, with a minimum of five times a year		
KPIs: 10.2 Appropriate and timely reviews, including a Shared Banking internal audit and policy review undertaken in the 2018/19 year		
KPIs: 10.3 Implement a Shared Banking Service risk register by end of quarter 1 and ensure that actions are implemented as agreed by the Finance, Risk and Audit Committee and escalated to the Corporate Risk Register, as appropriate		

Collective Insurance

Measure and Target	Type	When
11. **Collective Insurance Delivery** - An efficient, value-add and fit for purpose Collective Insurance service. Ensuring DHBs are engaged and informed and the service delivers the value (financial and non-financial) agreed by the Banking and Insurance Service Performance Group	Financial	30 June
Rationale - There is financial and non-financial value in the collective insurance approach, and policy risk, ultimately reducing cost for the national good. The counterpart to this is ensuring that DHBs are engaged in and informed about their insurance coverage, so they can make good local decisions. Financial benefits exclude the influence of external factors such as increasing asset values or global loss trends, which impact the absolute cost of insurance.		
KPIs: 11.1 Deliver within agreed budget for the 2018/19 financial year and provide $Xm of benefits from the 2018/19 placement [Amount of $ benefits to be agreed with B&ISPG]		
KPIs: 11.2 Ensure DHBs are engaged in their insurance coverage for the 2018/19 and 2019/20 placements, including having an annual Collective Insurance Forum		
KPIs: 11.3 Develop a long term Insurance Strategy by June 2019, in consultation with, and as agreed by DHBs		
12. **Risk Management and Governance** - Deliver a quality Collective Insurance service, effectively managing risk and ensure appropriate reporting and governance is provided	Quality Timeliness	30 June
Rationale: Effective management of the relationship with the Insurance Broker; providing appropriate reporting into the DHB Boards and ensuring effective governance is in place to minimise risk.		
KPIs: 12.1 DHB engagement through delivery of the activities agreed with the Banking and Insurance Service Performance Group. This is to include collaboration on the development of the DHBs long term risk management strategy		
KPIs: 12.2 Implement a Collective Insurance Service risk register by end of quarter 1, and ensure that actions are implemented, as agreed by the Finance, Risk and Audit Committee and escalated to the Corporate Risk Register, as appropriate		
KPIs: 12.3 Contract management meetings with Marsh held regularly including a minimum of eight times a year. The Insurance Broker to be held to account for delivery of 2018/19 milestones identified in the Marsh Route to 2021 and engagement letter document		

NZ HEALTH PARTNERSHIPS

Organisational Performance

Measure and Target	Type	When
13. **Strategy** - NZ Health Partnerships' Strategy and Roadmap to 2022 developed and approved	Quality Timeliness	30 June
Rationale - NZ Health Partnerships will optimise and build on its existing programme and services to generate both increased and sustainable value for our shareholders.		
KPIs 13.1 Shareholders and other stakeholders are widely consulted throughout the development of the Strategy		
KPIs 13.2 The Strategy and high-level Roadmap are approved by the NZ Health Partnerships' Board and shareholders		
14. **Communications and Engagement** - Communications and engagement enhanced to support effective delivery of Programmes and Services	Quality Timeliness	31 December
Rationale - Building the trust and confidence of DHBs is fundamental to NZ Health Partnerships' sustainability and success. Central to this is transparent and timely communications, as well as on-going engagement that enable us to leverage the skills and experience of our shareholders.		
KPIs 14.1 Develop and implement NZ Health Partnerships' overarching Stakeholder Communication and Engagement Plan 2018 - 2020		
KPIs 14.2 Progress and Performance updates are provided across the portfolio, as well as to key NZ Health Partnerships' governance -level updates, in line with our Board meeting cycle i.e. approximately every six weeks		
KPIs 14.3 A high-level review of portfolio-level governance and advisory group participation is conducted in Quarter Four to ensure appropriate representation and engagement from all DHBs and regions		

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 10.4

MIDLAND REGIONAL SERVICES PLAN 2018/21

Purpose	For decision.

Legislation requires 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 done 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 this year's 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 Equitable Access and Outcomes section is being developed by the GMs Māori Health, in consultation with the regional clinical groups and enablers.

The following documents are attached for the Board's review and feedback:

1. 2018-21 Midland Regional Services Plan (first draft) [Strategic Direction]
2. 2018-21 Midland Regional Services Plan (first draft) [Initiatives and Activities].

Andrew Campbell-Stokes, HealthShare Chief Executive, will attend the Board meeting to receive feedback from the Board.

Timeline

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

Activity	Date	Progress
DHBs advise Relationship Managers of proposals for service change	11 May 2018	Complete
Planning Package received from Ministry of Health	14 May 2018	Complete
Annual Planners teleconference meeting	16 May 2018	Complete
2018/19 Regional Service Plan Guidelines (updated)	25 May 2018	Complete
Drafting of Annual Plans, Regional Services Plan and Public Health Unit Plans	14 May – 1 June 2018	Complete
Midland DHB Annual Plan and Regional Services Plan Writers Group – face to face meeting (KPMG Building, Level 9 – Whakapakari Meeting Room)	11 June 2018	Complete
Updates and amendments to Annual Plans and Regional Services Plan following feedback received from Executive Groups and Writers Group meetings		
Submit draft Annual Plans, Regional Services Plan and Public		

Activity	Date	Progress
Health Unit Plans to Midland District Health Boards for approval: • Bay of Plenty DHB (papers due: 8 June 2018) • Lakes DHB (papers due:14 June 2018) • Hauora Tairāwhiti (papers due:15 June 2018) • Waikato DHB (papers due:18 June 2018) • Taranaki DHB (papers due:18 June 2018)	20 June 2018 22 June 2018 26 June 2018 27 June 2018 28 June 2018	
Updates and amendments to Annual Plans and Regional Services Plan following feedback received from Midland District Health Boards		
DHBs are to provide the **final Statement of Performance Expectations**	**by 29 June 2018**	
DHBs send draft System Level Measure Improvement Plan to Regional Services Plan Writer for incorporation into final Regional Services Plan	2 July 2018	
Submit **final draft System Level Measure Improvement Plan**	**by 2 July 2018**	
DHBs submit **draft Annual Plans, including budgets, updated Statements of Performance Expectations, Regional Service Plans, and Public Health Unit Annual Plans** to the Ministry	**16 July 2018**	
System Level Plan approved	31 July 2018	
Ministry expects to provide informal feedback to DHB and Regional Planners	from Monday 13 August 2018	
Ministry expects to facilitate formal feedback on DHBs draft Annual Plans, Regional Service Plans and, Public Health Unit Annual Plans	week beginning Monday 3 September 2018	

Key: Grey = MoH draft timeline activities

Recommendation
THAT
The Board:

1) Notes that the 2018/21 Midland Regional Services Plan (Strategic Directions, and Initiatives and Activities documents) are 'work in progress' and subject to further refinement following feedback from Boards, DHB Executives and clinicians, and the Ministry of Health.
2) Endorses the 2018/21 Midland Regional Services Plan (Strategic Directions and Initiatives and Activities documents) for submission to the Ministry of Health for review.
3) Approves delegated approval of the 2018/21 Midland Regional Services Plan (Strategic Directions and Initiatives and Activities documents) to Midland DHB Chairs and Chief Executives. If changes to these documents are deemed to be material then the documents will be provided to DHB Boards again for consideration.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

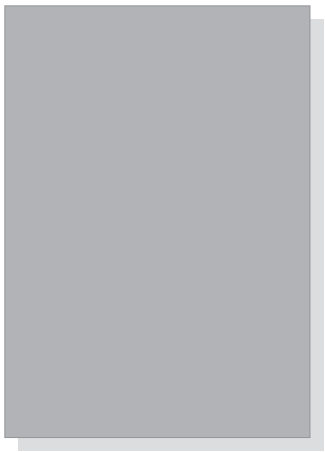
2018 - 2021

Regional Services Plan
Strategic Direction

Midland District Health Boards
www.midlanddhbs.health.nz

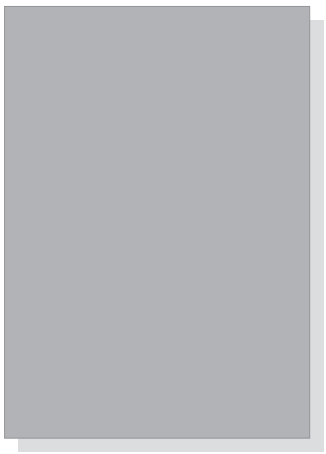
Midland DHBs Annual Plans

BAY OF PLENTY

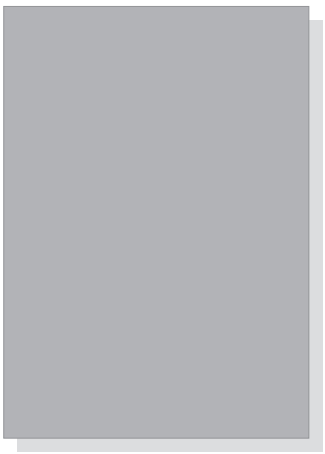


HAUORA TAIRĀWHITI

LAKES



TARANAKI



WAIKATO

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

Endorsement by Minister

Endorsement to go here

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

Name Surname
Job Title

Name Surname
Job Title

BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI

Name Surname
Job Title

Name Surname
Job Title

Hauora Tairāwhiti

Name Surname
Job Title

Name Surname
Job Title

LAKES DISTRICT HEALTH BOARD

Name Surname
Job Title

Name Surname
Job Title

TARANAKI DISTRICT HEALTH BOARD

Name Surname
Job Title

Name Surname
Job Title

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

Introduction

The 2018-21 Regional Services Plan (RSP) continues to focus on the greater achievement of health and wellbeing for the populations served by the Midland DHBs.

Pauline Lockett
Chair, Midland Region Governance Group (DHB Board Chairs)

Introduction text to be supplied

Introduction text to be supplied

Our National Vision
Tā Mātou Moemoea

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

Our Goal > Wellness

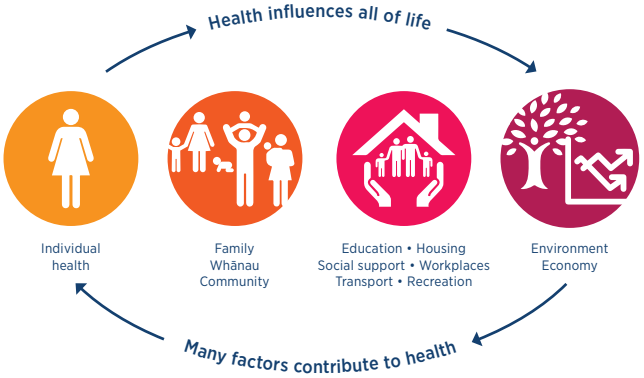
NZ Health Strategy 2016
Strategic Themes

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

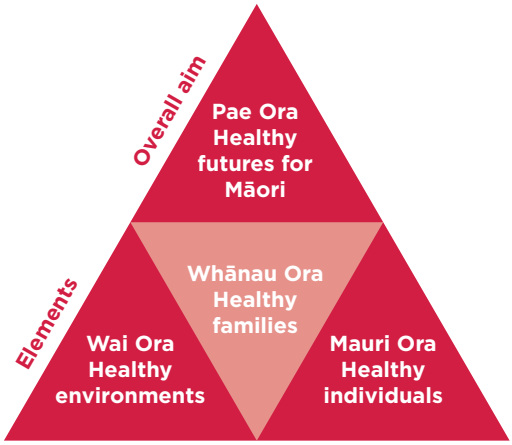
Particular examples of integration in the health system include:

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

Health in the wider context of people's lives



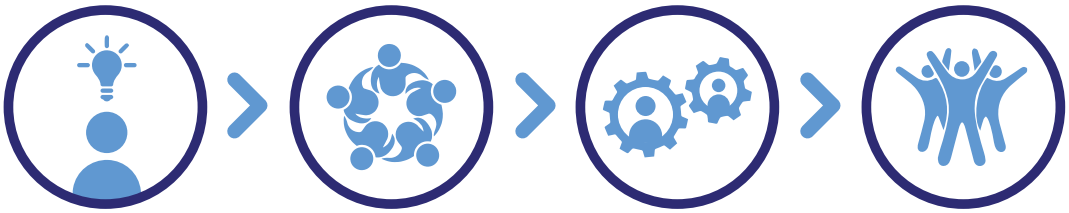
Pae Ora (Healthy Futures)



REFRESHED GUIDING PRINCIPLES FOR THE HEALTH SYSTEM

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

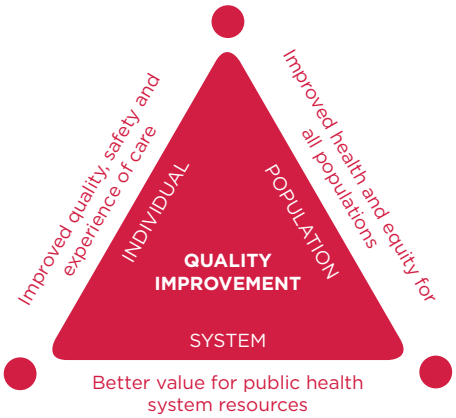
Investment approach



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

The NZ Triple Aim

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



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

National Health Targets

A set of national performance measures specifically designed to improve performance of health services that reflect significant public and government priorities.

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

The volume of elective surgery will be increased by an average of 4,000 discharges per year

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

95% of infants will have their primary course of immunisation (6 weeks, 3 months and 5 months) on time

90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.

95 percent of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

About us

21%

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

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

5 DHBs

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

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

924,165 people (2017/18 population projections), including 237,020 Māori (26%) and 43 local iwi groups.

DHB	PHO Name
Bay of Plenty	Eastern Bay Primary Health Alliance Nga Mataapuna Oranga Ltd Western Bay of Plenty Primary Health Organisation Ltd
Lakes	Pinnacle - Lakes Rotorua Area Primary Health Services Ltd
Hauora Tairāwhiti	Pinnacle - Tairāwhiti Ngati Porou Hauora Charitable Trust
Taranaki	Pinnacle - Taranaki
Waikato	Hauraki PHO Pinnacle - Waikato *National Hauora Coalition

**MOH categorises Counties Manukau DHB as the lead DHB for the National Hauora Coalition (NHC), which excludes NHC from the Midland DHB list, however NHC figures have been added into the above table for Waikato DHB - where NHC provides a locally based service.*

Midland region Iwi

Māori population of DHB region

Bay of Plenty DHB

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

25%

Lakes DHB

Te Arawa, Ngāti Tuwharetoa, Ngati Kahungunu ki Wairarapa

35%

Hauora Tairāwhiti

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

50%

Taranaki DHB

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

19%

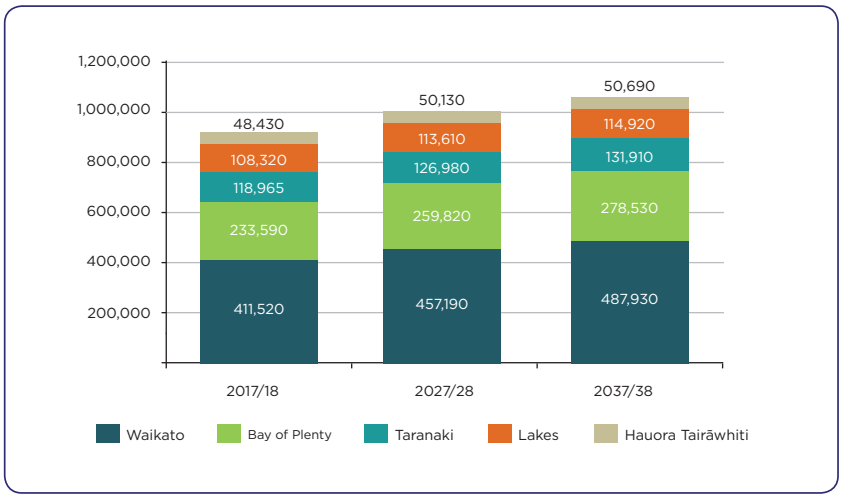
Waikato DHB

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

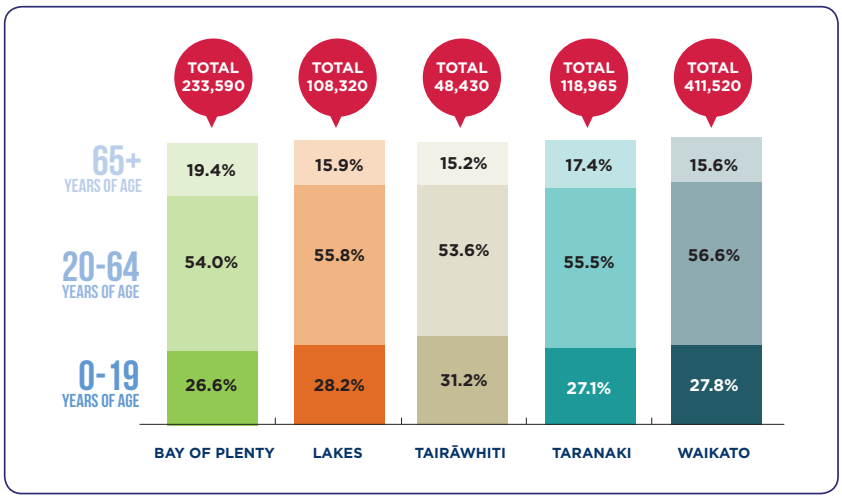
23%

Midland DHB populations

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

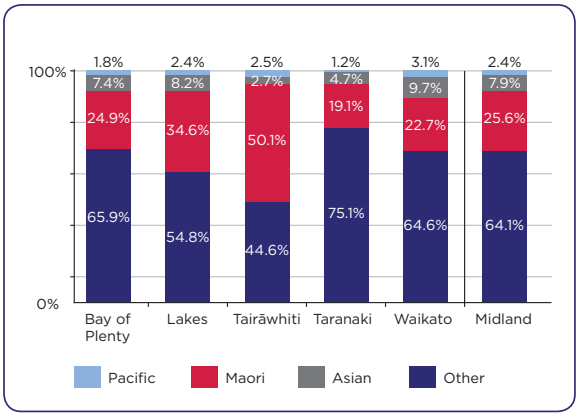


Source: Statistics NZ: Projected Population Tables (released Nov 2016)

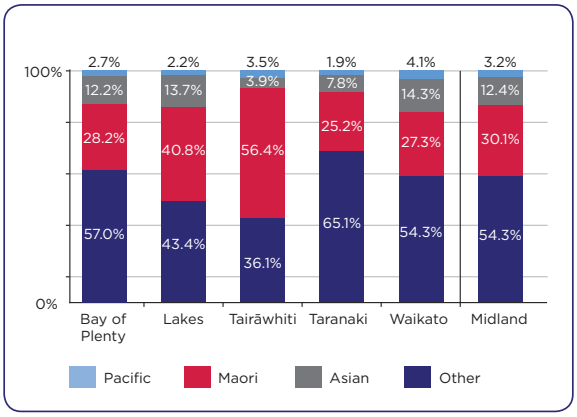


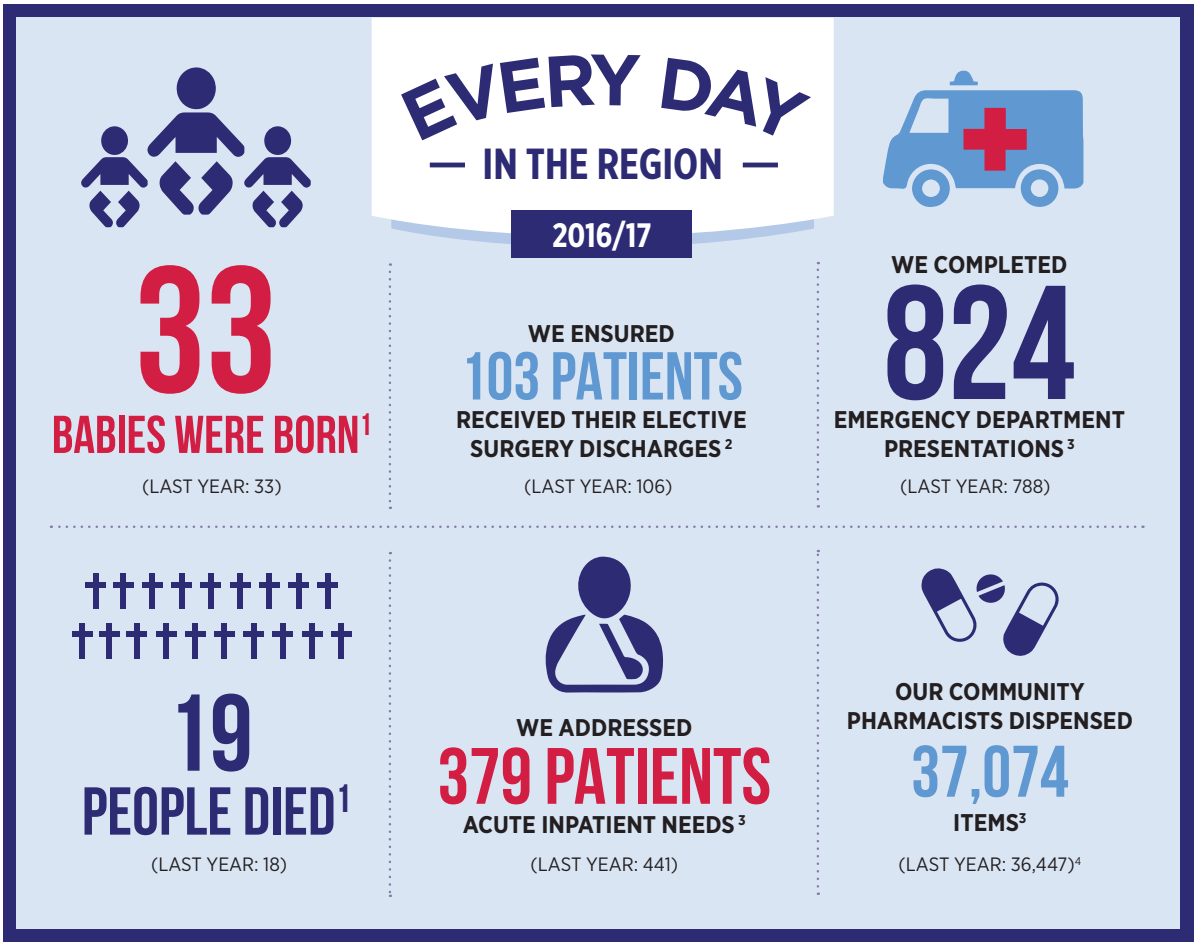
Projected change in population distribution from 2017/18 to 2037/38

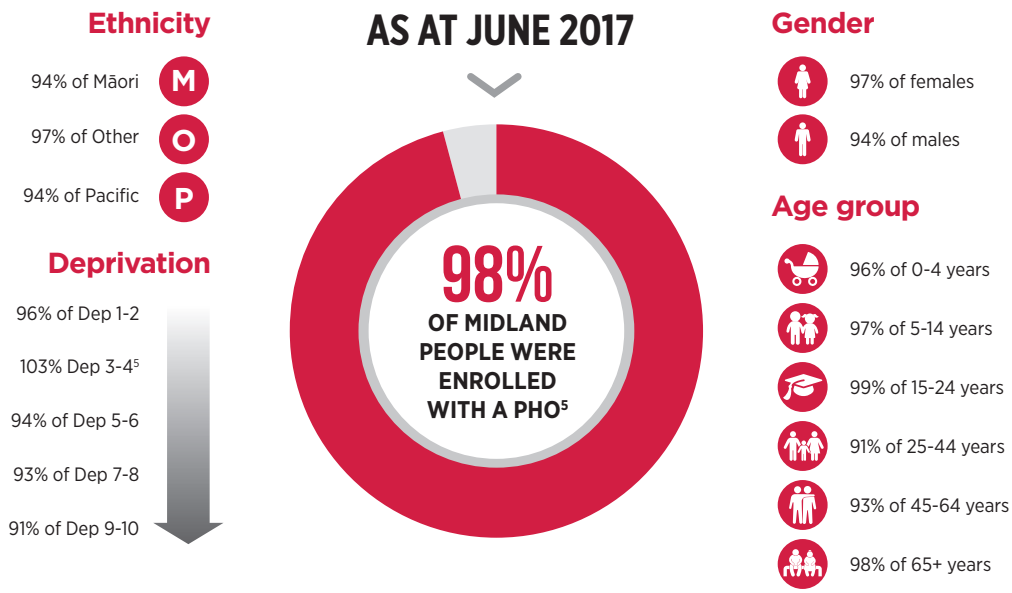
2017/18 Midland Total Projected Population by four main ethnicities



2037/38 Midland Total Projected Population by four main ethnicities







Notes

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

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

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

[4] 2015/16 Pharmacy figure has been updated

[5] The estimated percentage of those who are enrolled in a PHO may exceed 100% as numerators and denominators are sourced from two different places (Ministry of Health & StatsNZ).

Our Strategic Outcomes

1 Improve the health of the Midland populations

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

2 Eliminate health inequality

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

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

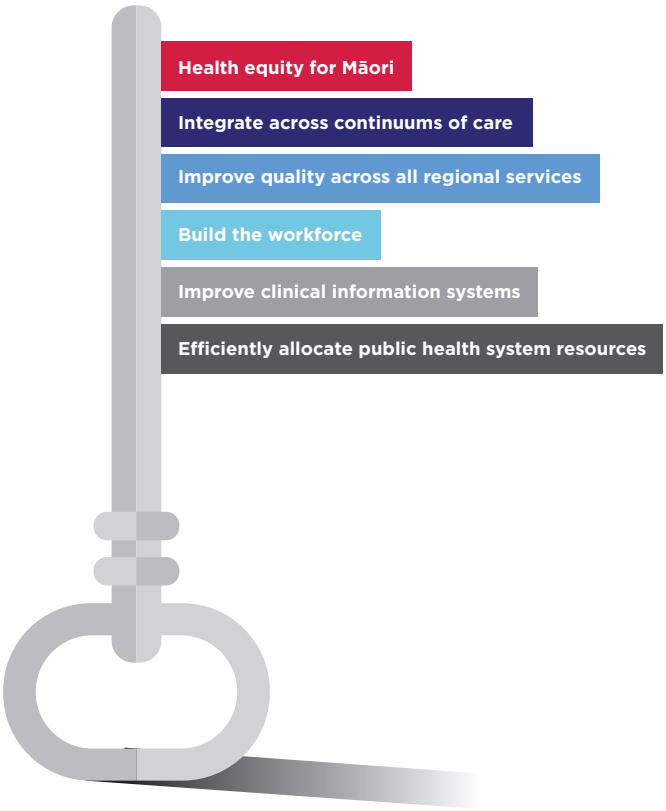
EQUALITY VERSUS EQUITY

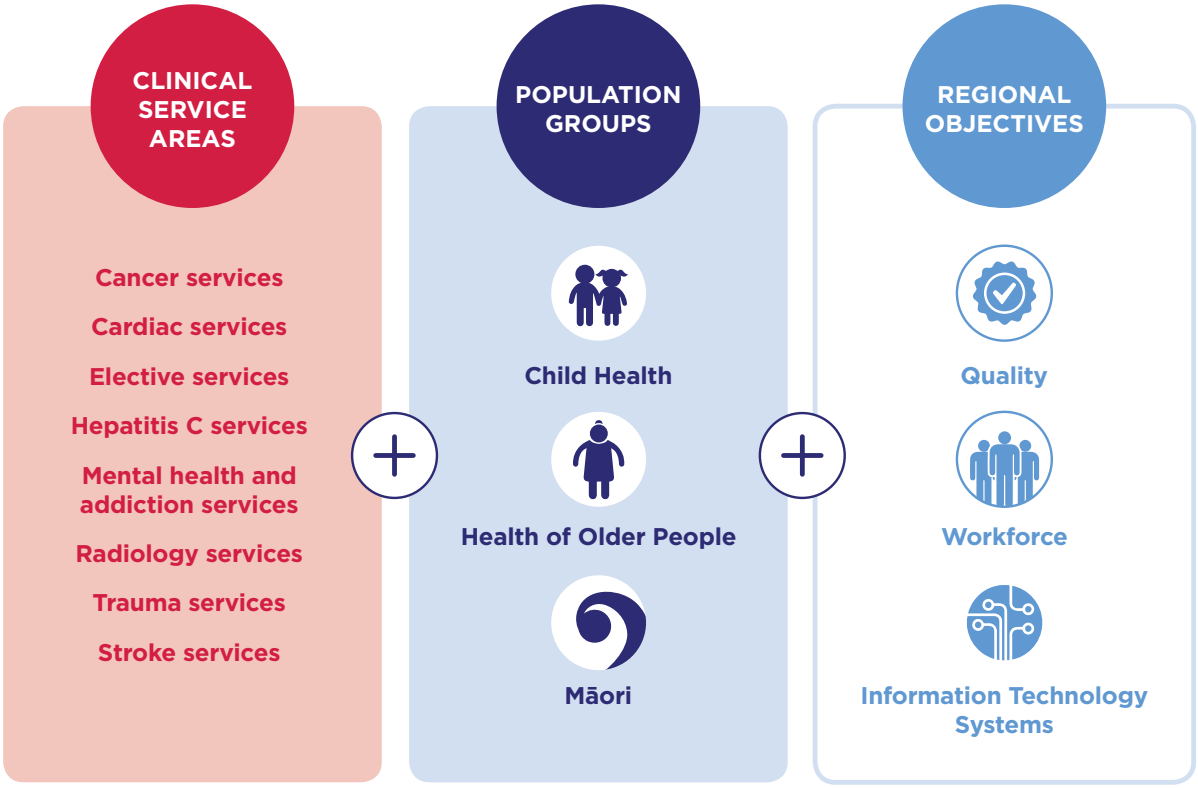
In the first image, it is assumed that everyone will benefit from the same supports. They are being treated equally.

In the second image, individuals are given different supports to make it possible for them to have equal access to the game. They are being treated equitably.

In the third image, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The systemic barrier has been removed.

Regional Initiatives to Achieve Our Regional Objectives





The full document is available on the HealthShare website:

www.healthshare.co.nz

Published in June 2017 by HealthShare Ltd for the Midland DHBs
Address: 16 Clarence Street, Hamilton 3240

See also DHB Annual Plans (incorporating Māori Health Plans) and Public Health Unit Plans

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2018 - 2021

Regional Services Plan
Initiatives and Activities

First Draft

Midland
District Health Boards
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Note: The *'2018-2021 Regional Services Plan - Initiatives and Activities'* is a companion document to the *'2018-2021 Regional Services Plan – Strategic Direction*' which sets out at a high level the vision, strategy themes, priorities and objectives of the Midland District Health Boards (DHBs). These documents should be read in conjunction with the Midland District Health Boards' District Annual Plans, and the Regional Public Health Units' Plans.

1. Strategic position

1.1 Linkages

Midland's six regional objectives

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

1. Health equity for Māori
2. Integrate across continuums of care
3. Improve quality across all regional services
4. Build the workforce
5. Improve clinical information systems
6. Efficiently allocate public health system resources.

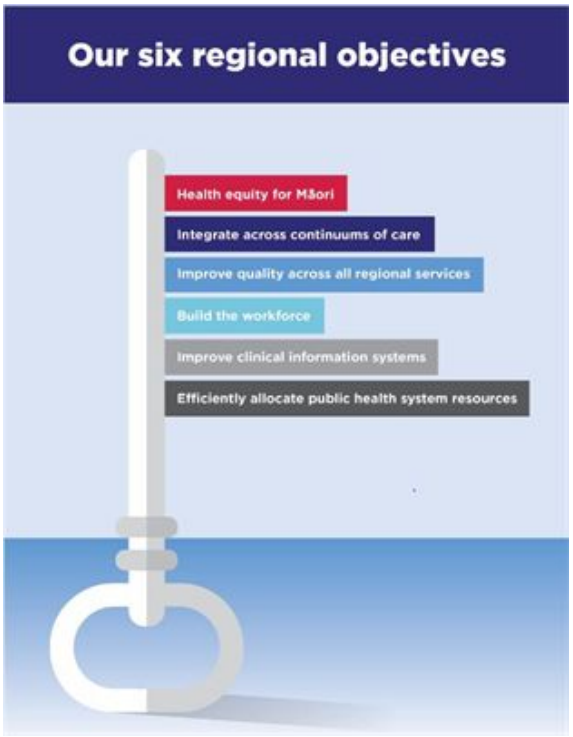

Figure 1: Midland DHBs six regional objectives

Work programmes are developed by the regional clinical networks and action groups; the regional enablers, and also by services provided by HealthShare (the Midland DHBs' shared services agency), ie Third Party Provider Audit & Assurance Service, the Regional Internal Audit Service. Alignment with national and regional strategic direction is provided against each work programme's initiatives, ie, the New Zealand Health Strategy's five strategic themes; the national System Level Measures, and Midland's six regional strategic objectives. Resourcing for delivery of approved work programmes is regionally agreed, budgeted and approved.

The regional strategic objectives were reviewed by the Midland Region Governance Group (MRGG) in December 2013 and endorsed with a sixth objective agreed. In 2017 the Midland Iwi Relationship Board (MIRB) and Nga Toka Hauora (the Midland DHB GMs Māori Health) requested that the first regional objective's wording be changed to: 'Health equity for Māori'. The Midland DHB CEs and Midland DHB Boards formally confirmed this change in June 2017. This enables the Midland region's strategic objectives to align well with the NZ Triple Aim Framework.

The regional clinical network and action group work programmes are making a difference in delivering health services in the Midland region. Each year the regional groups identify their priority initiative for delivery, making visible their focus and progress from 1 July 2016 towards delivery at year end 30 June 2018 (see **Table 1** over page).

Table 1: **Priority initiative** for delivery from 1 July 2016 – 1 July 2018 for each regional clinical group

Regional Network	2016/17 Priority Initiative	2016/17 Quantitative Measure of Success	2017/18 Priority Initiative	2017/18 Quantitative Measure of Success
Cancer	Midland Cancer Network initiatives that support the Midland DHBs to achieve the Faster Cancer Treatment Health Target	90% of patients referred with a high suspicion of cancer and a need to be seen within 2 weeks have their first treatment (or other management) within 62 days by June 2017.	Midland Cancer Network initiatives that support the Midland DHBs to: • Achieve the Faster Cancer Treatment Health Target; and • Prepare for roll out of the national bowel screening programme.	90% of patients referred with a high suspicion of cancer and a need to be seen within 2 weeks have their first treatment (or other management) within 62 days by June 2017.
Cardiac	To meet MOH ACS Cath lab timeliness priority through implementing and continuously improving a production planning process for the region to deliver timely access to catheter lab facilities for angiograms	70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') by ethnicity.	Achieve equality for Māori in key rates of diagnostic and interventional cardiac services per DHB for KPIs that can be measured.	Standard Intervention Rates (SIR) for Angiography, Angioplasty, Cardiac Surgery.
Child Health	The wider implementation of the Harti Hauora tool into Midland DHBs	Harti Hauora reviewed and available for wider implementation DHBs.	Childhood obesity and oral health • Work with DHBs to promote that oral health databases are linked with NCHIP • Support and encourage further action to address childhood obesity in DHBs including facilitating sharing and implementation of evidence based lifestyle programmes in the region for children and families	• NCHIP linked to oral health databases (where implemented) • All DHBs will have access to an evidence based lifestyle programme for at risk children/families identified in the obesity pathway • Childhood obesity care pathway (Map of Medicine) will be in use across the region

Regional Network	2016/17 Priority Initiative	2016/17 Quantitative Measure of Success	2017/18 Priority Initiative	2017/18 Quantitative Measure of Success
Child Health (cont.)			• Oversee and provide support for the implementation of the childhood obesity care pathway (Map of Medicine) • Support a regional Sugar Sweetened Beverages policy/position statement/plan of action in conjunction with the region's Public Health units and actions to implement.	• Broader implementation of the SSB policy/position statement/plan of action.
Electives	Applying to ENT the principles and lessons from the successful implementation of the regional localised Paediatric Surgery model	ENT clinicians are moving between regional DHBs or DHB patients are actively being decanted to neighbouring DHBs to maximise capacity (minimum of 50 patients treated under this model).	A specialty based, regional electives initiative will be developed and implemented to support the delivery of health target discharges, waiting time requirements, improved equity of access, resource utilisation and pathway of care.	Regional delivery of a specialty based electives service.
Health of Older People	In addition to meeting Ministry expectations for dementia and InterRAI reporting, to develop an analytical method to identify frail elderly in primary care at risk of falls	• Dementia and InterRAI expectations met with reports available to Midland DHBs and Action Group members • Define frailty within analytical data attained from a minimum of one DHB and highlight key indicators which demonstrate falls risks.	Consolidate work on dementia through the strengthening of components of the dementia pathway and ensuring family and whanau carers of people with dementia have access to support and education programmes.	Increased referrals from GP practices to Alzheimer's and Dementia organisations Standardised training is available on a consistent basis for family and whanau carers.

Regional Network	2016/17 Priority Initiative	2016/17 Quantitative Measure of Success	2017/18 Priority Initiative	2017/18 Quantitative Measure of Success
Maternity	Develop a Midland Breastfeeding Framework to inform and prioritise breastfeeding initiatives in the Midland region	Midland DHBs are provided with a Midland Breastfeeding Framework to inform and prioritise breastfeeding initiatives in the region going forward.	N/A	N/A
Mental Health & Addictions	Supporting Clinical Networks and Clinical Leadership • identify how the region is planning to work with clinical leaders to make better use of clinical networks to support improved clinical and financial sustainability of services • identify services within the region that may benefit from the development of a regional clinical network	Midland DHBs are provided with strong clinical governance leadership in mental health and addictions.	Implementation of the Substance Abuse Legislation (SAL) across the Midland region • Develop funding proposal for the MoH • Identify workforce development priorities • Develop an Implementation plan • Involve key stakeholders in the consultation process • Implement MoH communication strategy.	• The public is well informed of the SAL process and criteria • Midland has systems and process put in place to meet the demand • Standardised processes are regionalised • The workforce is well prepared for the SAL 1 February 2018 start date.
Radiology	Development of a regional CT pipeline model with the support of HSL analytics to reconcile available capacity with growing demand	The % and quantity per DHB of Bowel screening cases that are clinically appropriate to be done with CT scanning.	Ultrasound model demonstrating the Midland region volumes, case mix and resource used across the Midland DHBs.	Ratios of Ultrasound caseload outputs at Midland DHBs.

Regional Network	2016/17 Priority Initiative	2016/17 Quantitative Measure of Success	2017/18 Priority Initiative	2017/18 Quantitative Measure of Success
Stroke	Develop early supportive discharge care pathways for mild to moderate stroke rehabilitation patients	Discharge care pathways for mild to moderate stroke rehabilitation patients are developed.	• Support and facilitate the implementation of a pathway of care for accessing thrombectomy services through ADHB • Support and facilitate the development of a pathway of care for accessing thrombectomy services through WDHB (five-year timeframe).	Pathway(s) of care available for Midland DHB use to access thrombectomy services for their patient population.
Trauma	Midland DHBs to develop action plans to reduce trauma incidence based on known patterns of trauma in collaboration with community groups and utilising the Midland Trauma Research Centre.	DHB action plans are developed, in collaboration with community groups, utilising the MTRC developed research tools, and DHB collected trauma data.	Provide adequate regional resources to achieve agreed objectives defined in the MTS Strategic Plan.	Approval of MTS Business Case 2017-2020.

A summary of the highest priority initiative that each regional clinical group is working on in the 2018-19 year is detailed in **Table 2** below. The full 2018-19 work plans for regional clinical groups are detailed in the **Appendix in Section 4**.

Table 2: Priority initiative for delivery by July 2019 for each regional clinical network/action group

Regional Network	2018/19 Priority Initiative	2018/19 Quantitative Measure of Success
Cancer	• Support Midland DHBs to implementation of the national tumour standards of service provision and sustain equitable achievement of the FCT Health Target and wait time indicator • Support Lakes DHB with NBSP implementation and achievement of equitable participation rates • Support Midland DHBs to achieve the colonoscopy wait time indicators • Support DHBs to implement the national Early Detection of Lung Cancer Guidance to improve lung cancer outcomes	90% of Midland DHB patients referred with a high suspicion of cancer and need to be seen within 2 weeks have their first treatment (or other management) within 62 days. 85% of Midland DHB patients with a confirmed diagnosis of cancer receive their first treatment (or other management) within 31 days of decision-to-treat. 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days. 70% of people accepted for an non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days), 100% within 90 days. 70% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days), 100% within 120 days. Lakes bowel screening participation rates achieve 62% (73% for Māori)
Cardiac	STEMI - develop Pathways of Care across the continuum for STEMI	Pathways completed by June 2019
Child Health	The Child Health Action Group (CHAG) is planning a multi-pronged approach to improving oral health and reducing sugar-sweetened beverages through: • further analysis of data related to primary care enrolment and oral health ASH • supporting a new initiative to improve school oral health • working with DHBs to agree a regionally consistent contributory measure • identifying risk factors for poor oral health to support targeting on equity basis.	A regional measure is identified and agreed to.

Regional Network	2018/19 Priority Initiative	2018/19 Quantitative Measure of Success
Elective Services	The vascular initiative will support the improvement of vascular services for the population of the Midland region. The focus areas are: • optimise prevention and detection • reduce clinical variation • enhance the intervention pathway • integrate services effectively.	• Pathways are developed, endorsed and implemented in participating DHBs • Regional audit process is implemented across all Midland DHBs • Regional multi-disciplinary meeting process is implemented in participating DHBs.
Health of Older People	The Health of Older People (HOP) Action Group is planning a regional collaboration on identifying initiatives and best practice for managing acute demand and patient flow across the continuum for HOP. A new Action Group will be identified based on this particular initiative. The group will share successful initiatives and lessons learned and then agree a regional approach. The group will also agree regional measures, including rates for Maori, Pacifica and Non-Maori.	Regional measures are identified and agreed to.
Hepatitis C	Continue to support implementation of the Midland Hepatitis C Community Service across the region Support DHB regions with eradication campaigns using awareness and education resources Provide integrated, accessible and sustainable identification testing, assessment and treatment services	• Increasing number of hepatitis C diagnosis's • Increasing number of Fibroscans (Liver Electrography) • Increasing number of people with hepatitis C receiving antiviral treatment
Mental Health & Addictions	1. Regional Eating Disorders (ED) model of care in implemented 2. Regional planning priorities are agreed 3. Quality & Health Safety Commission projects are implemented consistently across the region.	• ED Service Level Agreements are signed off by each participating DHB • Regional service planning priorities are agreed and paper sent to GMs and CEs • QH&SC project updates reflect Midland participation and progress
Radiology	Analysis of District Health Board caseloads in CT, MRI and US to provide an understanding of trends in modality usage across the DHBs as new clinical demands and priorities emerge.	Data collected across the 3 modalities over 3 years minimum and a report written

Regional Network	2018/19 Priority Initiative	2018/19 Quantitative Measure of Success
Stroke	The Midland Stroke Network is planning a Patient Experience of Care initiative in conjunction with the Midland Cardiac Clinical Network and General Manager's Maori. The networks will be exploring the potential for a hui with Maori consumers and their whanau who have been involved in either (or both) stroke or cardiac services. This process will ensure consumers and whanau are supported in telling their stories and that the learnings are utilised for service improvement where appropriate to improve services for Maori.	Patient experiences are available to inform strategies/action to improve services for Maori.
Trauma	Development and implementation of the comprehensive Trauma Quality Improvement Programme (TQIP) including identification of groups that are vulnerable to variations of care including access and equity.	• Reporting framework customised to the needs of individual DHB's • Identified trauma reporting programme with a focus on; vulnerable groups; sub optimal systems and processes • Audit programme identified.

The Midland region continues to work towards improving the health and wellbeing of its population. Over the past two years, examples of key achievements have included:

Health equity

Midland's two overarching strategic objectives:

- Improve the health of the Midland populations
- Eliminate health inequities

A joint hui was held at Lakes DHB between Nga Toka Hauora (General Managers Māori Health), health equity related DHB staff and HealthShare project managers. The group considered a common tool and approach for Health Equity Assessment, and the representation of Nga Toka Hauora on Midland Regional Clinical Networks.

Hepatitis C – Midland integrated hepatitis C service

The Midland Region Community Hepatitis C Service is coordinated from Waikato Hospital in partnership with the Hepatitis Foundation of NZ, and the service covers all patients in the Midland region. The service provides a Fibroscan, which determines liver stiffness and hepatitis C education to patients in the community.

The approach of the service involves both primary care practitioners and hospital specialists using one agreed patient pathway. The key change is that responsibility for treating patients with hepatitis C has moved to primary care, avoiding a lot of hospital clinic visits during the treatment stage. A regional working group developed the patient pathway, which has been implemented across the Midland region.

Child health services – (Child Health Action Group)

The 10 year child health road map is based on current national and international evidence, data, and clinician expertise, and has been developed as a tool to assist Midland DHBs' planning and funding units and governance groups to identify work streams in child health that should be prioritised locally.

Over the past year the CHAG has been fine-tuning a data tool which utilises publically-available results and presents in some creative ways. A series of roadshows were held across the Midland region. These were well attended - including three District Health Board Chief Executives along with over 120 staff, including psychiatrists, paediatricians, community providers, Māori health, public health analysts, planning and funding, researchers, and child and women's health clinicians. CHAG's Chair, Dr Dave Graham from Waikato DHB, supported discussions at Lakes, Bay of Plenty and Waikato DHBs. The enthusiasm across the Midland region was evident and the presentations generated some interesting discussions. The report will be distributed to interested parties on a quarterly basis and for ease of access DHBs may wish to link to their intranets in the future.

Cardiac services (Midland Cardiac Clinical Network)

Network members across the Midland DHBs work to enable equitable and timely access to the national Minimum Expected Clinical Standards of prevention, detection and intervention in cardiac disease. This includes data tracking and support for the national service gap analysis to identify targeted improvements in the three big disease categories of Arrhythmias, Heart Failure and Coronary Arteriosclerosis.

Regional integrated planning is being used to identify where unmet need exists across the region, and to find ways to increase the delivery of angioplasties.

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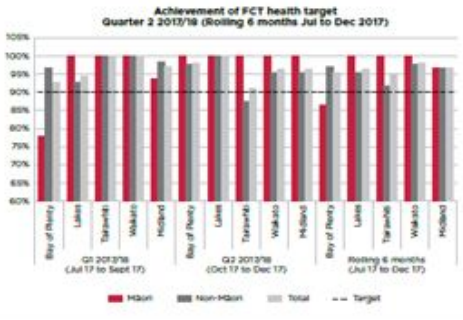
Cancer services (Midland Cancer Network)

All Midland DHBs continued to meet the Faster Cancer Treatment health target of 90% of patients triaged with a high suspicion of cancer and needing to be seen within two weeks receive treatment within 62 days.

The Midland Bowel Screening Regional Centre (BSRC) signed a three-year fixed term contract (September 2017 to June 2020) to support Midland DHBs in the National Bowel Screening Programme (NBSP) work, to provide clinical leadership and support, develop and support implementation of a regional equity plan, and undertake an overview and support of performance of Midland DHBs against quality standards and opportunities. Lakes DHB is the first Midland DHB to roll out the NBSP in September 2018, and preparations are underway between Lakes DHB and the Midland BSRC. The Midland BSRC is also assisting Midland DHBs with high-level symptomatic colonoscopy production planning. In addition, the Ministry of Health has agreed the Midland BSRC will hold the contract for the National Māori Bowel Screening Network.



Stroke services (Midland Stroke Network)

Around 9,000 people have a stroke each year in New Zealand. TeleStroke provides 24/7 assistance for emergency diagnosis and treatment of strokes in Thames and Rotorua hospitals – and provides support to smaller hospitals – using existing TeleHealth technology. This means better access and faster treatment, significantly improving outcomes and reducing the risk of permanent disability.

Trauma services (Midland Trauma System – MTS)

In October 2017, local staff and MTS members contributed to the Trauma Roadshow at Rotorua Hospital to publicise the regional trauma service, the reason for a trauma system and to show patterns of trauma and trauma care based on MTS data. This included a real-time version of the Trauma Risk Calculator developed for Fieldays, and a well-attended Grand Round presentation entitled 'Trauma in Lakes: Patterns and Progress". Roadshows are underway or planned for all Midland DHBs.

BreastFedNZ smartphone app.

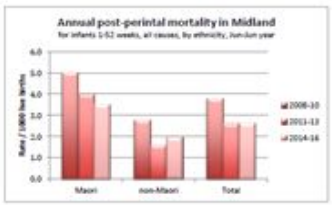
BreastFedNZ is continuing to receive positive feedback on its usefulness as a resource for breastfeeding information and help, with more than 15,000 downloads of the free app between its launch in 2015 and early 2018. New developments to the app include 'Quick Find' search, 'Free Dental Checks' information for ages 0-17 year olds, a link to MidCentral DHB's app Babble for parents with a baby in a neonatal, NICU or special care unit.

Midland Breastfeeding Framework

The Midland Breastfeeding Framework was approved in May 2017 by the Midland Maternity Action Group (MMAG) and forwarded to the Midland DHBs for implementation. The Framework offers a clear direction on how different sectors can work together to provide a suite of services and initiatives that could increase breastfeeding rates across the region.

Post-neonatal deaths

Under the National SUDI Prevention Programme, a Midland SUDI Coordinator has been working with Midland stakeholders to progress development of the Midland regional SUDI (Sudden Unexplained Death in Infancy) prevention plan, including a population analysis, stocktake of current SUDI services/activities in the region, service/activity strengths, gaps and areas for improvement, as well as SUDI prevention activities for immediate promotion and support.



Midland DHBs' Statements of Intent (SOIs)

The Midland DHBs' Statements of Intent (SOIs) outline their district trends and key outcomes –these can be viewed online, as follows:

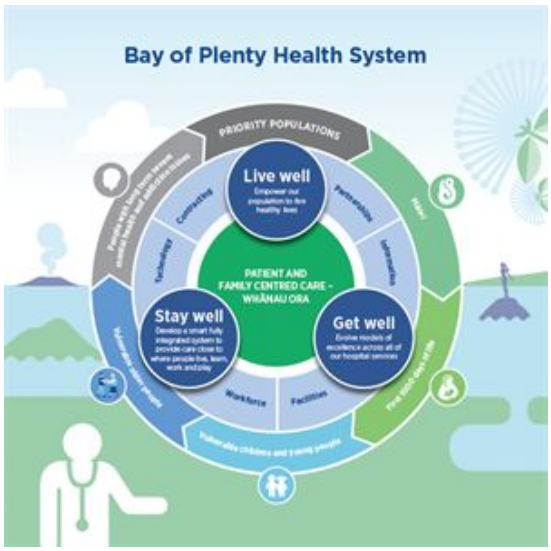
Midland DHB	Web Link
Bay of Plenty District Health Board	BOPDHB District Annual Plan 2016/17 (incorporating the Statement of Intent)
Lakes District Health Board	Lakes DHB District Annual Plan 2016/17 (incorporating the Statement of Intent)
Hauora Tairāwhiti	Hauora Tairāwhiti District Annual Plan 2016/17 (incorporating the Statement of Intent)
Taranaki DHB	Taranaki DHB District Annual Plan 2016/17 (incorporating the Statement of Intent)
Waikato DHB	Waikato DHB District Annual Plan 2016/17 (incorporating the Statement of Intent)

Table 3: Links to Midland DHBs' Statements of Intent

Midland DHBs' Strategic Intentions:

Bay of Plenty District Health Board (BOPDHB) – Strategic Direction *(TBC)*

The BOPDHB is guided by its Strategic Health Services Plan 2017-27 for the Bay of Plenty. This plan sets out how the BOPDHB intends to vision, plan, fund and provide services to improve the performance and sustainability of the health system in the Bay of Plenty over the next 10 years. The Strategic Health Services Plan has been developed in response to BOPDHB's current operating environment, the anticipated future health needs of the Bay of Plenty population, the opportunities identified to improve system performance, and local, national and international trends in models of care. This framework is supported by the Triple Aim which ensures population health, patient experience of care, and value for money perspectives are considered together in planning and decision making.



Lakes District Health Board (Lakes DHB) – Strategic Direction

(placeholder)

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Hauora Tairāwhiti – Strategic Direction

Hauora Tairāwhiti's strategic direction is the delivery on our promise inherent in our mission –"Mahia nga mahi i roto i te kotahitanga kia piki ake to oranga o te Tairāwhiti". Our way of working is one of inclusion, listening to the voice of people who require care, utilising the knowledge and skills of all those working in health, thinking holistically about the determinants and ways to better health and taking a lead from iwi Māori of te Tairāwhiti, as outline in our values and behaviours.

Taranaki District Health Board (Taranaki DHB) – Strategic Direction

(placeholder)

Waikato District Health Board (Waikato DHB) – Strategy *(TBC)*

During 2016/17 the Waikato DHB rolled out a new strategy driven by its Board which concentrated on ensuring the organisation was heading in the right direction, focusing its resources and making the most of future opportunities. It recognises that there are some fundamental challenges that must be faced along the way as the DHB continues to improve the health status of its population and works to eliminate health inequities.

(i) Outcomes framework

The outcomes

Figure 2: Outcomes framework over page) demonstrates how the region's vision, strategic outcomes, long term impacts and regional strategic objectives are aligned with national outcomes and impacts and the New Zealand Health Strategy's strategic themes. The framework provides regional and national alignment with the vision, mission, values, goals, aspirations, strategic focus and priority areas and overarching outcomes of each Midland DHB.

Figure 2: Outcomes framework

Ministry of Health's purpose and role	Improve and protect the health of New Zealanders					
Long-term success measures	Health expectancy improves over time	Life expectancy increases over time	Life expectancy by health spending per capita compares well within the OECD	Health spending growth slows over time		
Health system outcomes	New Zealanders live longer, healthier, more independent lives		The health system is cost effective and supports a productive economy			
Ministry's high-level outcomes	New Zealanders are healthier and more independent		High-quality health and disability services are delivered in a timely and accessible manner		The future sustainability of the health and disability system is assured	
Ministry's impacts	1. The public is supported to make informed decisions about their own health and independence		3. The public can access quality services that meet their needs in a timely manner where they need them		6. The health and disability system is supported by suitable infrastructure, workforce and regulatory settings	
	2. Health and disability services are closely integrated with other social services and health hazards are minimised		4. Personalised and integrated support services are provided for people who need them			
			5. Health services are clinically integrated and better coordinated		7. Quality, efficiency and value for money improvements are enhanced	
New Zealand Health Strategy – strategic themes	People-powered	Closer to home	Value and high performance	One team	Smart system	
National System Level Measures	Midland DHBs' chosen contributory measures towards System Level Measures					
	Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds	Acute hospital bed days per capita	Patient experience of care	Amenable mortality rates	Proportion of babies who live in a smoke-free household at six weeks postnatal	Youth access to and utilisation of youth appropriate health services
		^		^		^

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

^ ^ ^

Midland DHBs Performance Story						
Midland DHBs vision, mission and values		**Bay of Plenty** Vision : Kia Momoho Te Hāpori Oranga – Healthy, thriving communities	Mission : Enabling communities to achieve good health, independence and access to quality services	Values: CARE (Compassion, Attitude, Responsiveness and Excellence)		
		Lakes Vision: Healthy Communities – *Mauriora!*	Mission: Improve health for all; maximise independence for people with disabilities; with tangata whenua support a focus on health	Values: Manaakitanga; Integrity; Accountability		
		Tairāwhiti Vision: WAKA (Whakarangātira, Awhi, Kotahitanga, Aroha)	Mission: Whaia te Hauora I Roto I te Kotahitanga A healthier Tairāwhiti by working together	Values: Hauora pai rawa/ wellbeing, partnership, quality – striving for excellence, integration, choice, He Tangata/responsiveness, financial responsibility		
		Taranaki Vision: Taranaki Together, a healthy community – Taranaki Whanui He Rohe Oranga	Mission: Improving promoting, protecting and caring for the health and wellbeing of the people of Taranaki	Values: • Partnerships • Courage • Empowerment • People Matter • Safety		
		Waikato Vision: Healthy people. Excellent care	Mission: Enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative delivery	Values: People at heart Te iwi Ngakaunui Give and earn respect – Whakamana Listen to me; talk to me – Whakarongo Fair play – Mauri Pai Growing the good – Whakapakari Stronger together – Kotahitanga		
Midland DHBs goals and aspirations	Bay of Plenty	No significant increase in hospital bed capacity	Strong focus on improving health equity	Shifting care closer to home		
	Lakes	5 year plan: • Babies are born well, grow well, live well as adolescents, stay well as adults, age well and eventually die well. When needed services will help people get well	• No health disparity	• People live longer, healthier lives		
	Tairāwhiti	**Join** patient, family/ centred care	**Know** excellent Iwi/ community, family/ whānau knowledge and engagement	**Shape** working with community relationships	**Vision** building a "will do" culture	**Connect** enabling good health and wellbeing through technology
	Taranaki	To improve the health of the Taranaki DHB population	To reduce or eliminate health inequalities			

Midland DHBs strategic focus and priority areas	Bay of Plenty	1. Live well – empower our populations to live healthy lives	2. Stay well – develop a smart, fully integrated system to provide care close to where people live, learn, work and play	3. Get well – evolve models of excellence across all of our hospital services.
	Lakes	• First 2,000 days • All vulnerable children • Child, youth and maternal care	• Mental health and addictions • The frail elderly • Managing long term conditions	• Oral health
	Tairāwhiti	• Care Closer to Home • Increased patient Quality and Safety	• Health of Older People • Regional and National Cooperation	• Living within our means
	Taranaki	• Helping our people to live well, stay well and get well • Integrating our care models through a one team, one system approach	• Making best use of our primary and community resources to support hospital capacity • Using analytics to drive value	• Developing a capable, sustainable workforce matched with health needs and models of care • Improving access, efficiency and quality of care through the managed uptake of new digital technologies
	Waikato	• Health equity for high needs populations • Safe, quality health services for all • People centred services	• Effective and efficient care and services • A centre of excellence in learning, training, research, and innovation	• Productive partnerships
Midland DHBs overarching outcomes		**To improve the health of our populations**		**To reduce or eliminate health inequalities**
Midland DHBs outcomes	Bay of Plenty	**Priority 1 above:** • First 1,000 days of life • At-risk youth • Māori • Older people	**Priority 2 above:** • Extended general practice • Risk stratification and stepped care • Multidisciplinary community health and support service clusters • System-wide care coordination	**Priority 3 above:** • Management of frail elderly and people with complex conditions • Mental health and addiction services • Scope and mix of services • Step-down care
	Lakes	• Lower acute demand • Better mental health and addictions support • Fewer teenage pregnancies • More people age well in own homes	• Better oral health for children and adolescents • Less obesity • Fewer people smoke • Less diabetes • Less CVD	• Fewer rheumatic fever cases • Fewer sudden unexpected death in infancy (SUDI) cases • Healthy birth-weight • Better health for Māori
	Tairāwhiti	Prevent ill health	Reduce health inequalities between population groups	Support people to stay well in the community	Ensure people receive timely and appropriate complex care

	Taranaki	**People are supported to take greater responsibility for their health** • Fewer people smoke • Reduction in vaccine preventable diseases • Improving health behaviours	**People stay well in their homes and communities** • An improvement in childhood oral health • Long-term conditions are detected early and managed well
	Waikato	**Health equity for high needs populations**	• Radical improvement in Māori health outcomes by eliminating health inequities for Māori • Eliminate health inequities for people in rural communities • Remove barriers for people experiencing disabilities • Enable a workforce to deliver culturally appropriate services
		Safe, quality health services for all	• Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement, and innovation • Prioritise fit-for-purpose care environments • Early intervention for services in need • Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives
		People centred services	• Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services • Provide care and services that are respectful and responsive to individual and whanau needs and values • Enable a culture of professional cooperation to deliver services
		Effective and efficient care and services	• Live within our means • Achieve and maintain a sustainable workforce • Redesign services to be effective and efficient without compromising the care delivered • Enable a culture of innovation to achieve excellence in health and care services
		A centre of excellence in learning, training, research, and innovation	• Build close and enduring relationships with local, national, and international education providers • Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research • Cultivate a centre of innovation, research, learning, and training across the organisation • Foster a research environment that is responsive to the needs of our populatio
		Productive partnerships	• Incorporate te Tiriti o Waitangi in everything we do • Authentic collaboration with partner agencies and communities • Focus on effective community interventions using community development and prevention strategies • Work towards integration between health and social care services.

(ii) Population health approaches and services - Midland Regional Public Health Network

The Midland Regional Public Health Network (the Network) provides an opportunity for Public Health Units (PHUs) to work together on public health issues affecting the Midland region. As part of the DHB function PHUs provide public health advice and expertise with a general goal of protecting and improving the health of the population with a focus on eliminating health inequities [*refer to the individual PHU Annual Plans for further detail on the health approaches and services in Midland region's districts*].

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

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

In addition to providing advice and expertise to individual DHBs, the Network provides leadership for, and strengthens the performance and sustainability of, the Midland PHUs. Leadership of the Network comprises the Manager and Clinical Director from each of the four PHUs in the Midland region:

- Toi Te Ora Public Health (Bay of Plenty and Lakes DHBs)
- Population Health (Waikato DHB)
- Population Health - Hauora Tairāwhiti
- Public Health Unit (Taranaki DHB).

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

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

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

The Network's work to date has included collaborative annual planning, business continuity planning, setting up a mechanism for a regional approach to health intelligence work, standardising communicable disease control processes, adopting a single childhood obesity strategy for Midland in conjunction with the Midland Child Health Action Group, peer review, staff orientation programmes, and support of sole practitioners.

Work streams are in place for 2018 to support a consistent approach to common areas of work:

- Workforce Development
- HealthScape – Public Health Information Management system
- Public Health Intelligence
- Drinking Water

The Network will continue to liaise around areas of common interest including childhood obesity and healthy housing. As member PHUs move towards adopting a Health in All Policies approach to guide their respective DHBs' work with agencies outside of Health, an opportunity may include supporting the development of Midland position statements on key health issues

In line with *He Korowai Oranga*, the Ministry of Health's Māori Health Strategy, the Network will contribute to the overall wellbeing of the Midland population with a particular focus on improving equity of health outcomes for Māori.

(iii) Integrating services across continuums of care

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

Figure 3 (below) describes a population health continuum of care. It describes various stages in decline in health and wellbeing, from (reading left to right) being healthy and well to having end-stage (end-of-life) conditions. Keeping healthy and people proactively managing their health to prevent deterioration and complications is vital. It is important to note that everyone will not experience all stages equally. For example, the length of time spent living healthy and well may differ for individuals, as may the length of time with end-stage conditions.

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

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

Figure 3: Population health continuum of care

There is no single accepted definition of integrated healthcare[1]. However, most definitions include references to seamlessness, co-ordination, patient centeredness, and whole of system working together.

[1] The King's Fund: Lessons from experience - Making integrated care happen at scale and pace (2013)

Health and disability services are delivered by a complex network of organisations and people. Integrated healthcare is seen as essential to transforming the way that care is provided for people with long-term chronic health conditions and to enable people with complex medical and social needs to live healthy, fulfilling, independent lives[2]. People living with multiple health and social care needs often experience highly fragmented services which are complex to navigate, leading to less than optimal experiences of care and outcomes.

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

Midland DHBs are supporting integration across the continuum of care by implementing agreed care pathways using Map of Medicine and Bay Navigator. DHBs and Primary Health Organisations (PHOs) are actively working to integrate services between primary and community care, and hospital care. Regional clinical groups are reviewing systems and processes across hospitals in the region to improve the flow of information, patients and clinicians. An example of integration across continuums of care in the Midland region is the regional pathways of care – a regional enabler (Section 2.1.6 : Pathway priorities for 2018/19).

[2] A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together http://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together

2. Regional enablers and priorities

2.1 Regional enablers

2.1.1 Equitable access and outcomes (EAO)

The Midland region is required to consider and include actions in the Regional Services Plan that will help it to achieve health equity for all its populations, including Māori. Activities in this section that demonstrate Midland region's commitment to reducing and eliminating inequities between Māori and non-Māori are highlighted in red and are identified with [EAO] immediately following the activity. A list of the Equity Outcome Actions is also contained in the Appendix in Section 5.

(Note: GMs Māori Health are agreeing on activities, before discussing with the regional clinical networks/action groups – Appendix 5 is a placeholder for the collated EAO activities which are expected to be finalised for submission to the MoH on 16 July 2018)

2.1.2 Workforce priorities for 2018/19

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

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

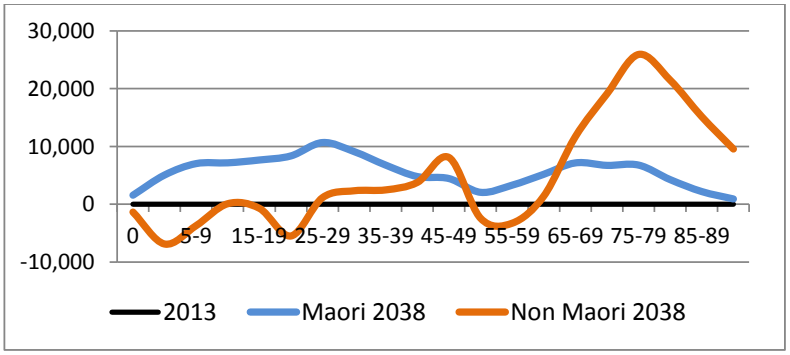
The previous 2016-19 RSP workforce development activities were over a three year horizon, including the key activities to:

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

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

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

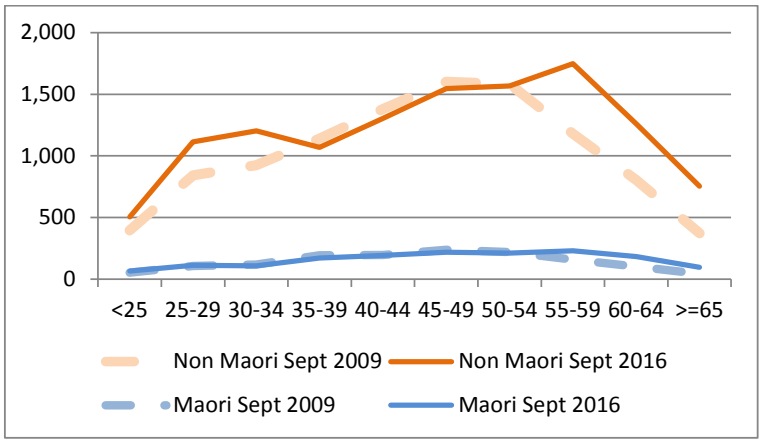
Figure 4: Midland DHBs medium population projections 2038 indexed to 2013



Data source: Statistics NZ

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

Figure 5: Midland DHB workforce 2009 and 2016



Data source: Central TAS, Health Workforce Information Programme (HWIP)

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

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

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

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

- ***enhancing capacity*** through increasing the use and span of workforce data to inform workforce planning and modeling; supporting older or retired employees to continue to use their workplace skills; reviewing the medical pipeline and deciding what can be done regionally if improvements are needed; supporting a DHB led initiative to share low fidelity simulation scenarios and establish competency assessment simulation packages, and establishing a sector wide workforce planning and development interest group
- ***enhancing diversity*** through identifying ways to increase representation of Māori in the health workforce; and supporting ways to increase the cultural competence of the healthcare workforce
- ***enhancing succession planning*** through supporting DHBs to implement the State Services Commission leadership and talent management initiatives
- ***building workforce flexibility*** by identifying how to increase competency based workplace training for care and support workforce.

Workforce priorities for 2018/19 DRAFT

Lead: Ruth Ross, Regional Director of Workforce, HealthShare (on behalf of General Managers, Human Resources, Midland DHBs)

CE Sponsor: Helen Mason (Bay of Plenty DHB)

NOTE: The following work plan is draft and subject to regional agreement and resourcing

Priority	Health Strategy Linkage	Activities / Actions	Milestone / Date	Responsibility
Workforce Diversity	One team	Work regionally and in collaboration with DHB Shared Services and the Ministry of Health to: • identify workforce data and intelligence that is collected across services and DHB areas, understanding workforce trends to inform workforce planning • understand the workforce data and intelligence requirements that best supports regions and DHB areas in order to undertake evidence-based workforce planning • support DHBs with training placements for eligible new health professional graduates within their region's DHBs (PGY1 and PGY2, CBA nurses, allied health, scientific and technical). By:		
		• regularly accessing HWIP FTE and vacancy data to identify professional groupings whose characteristics, numbers, vacancy rates, turnover rates, or age profile within the DHB, region or nationally may pose a risk to ongoing service delivery, and advise DHBs	Q2	HSL
		• utilising equity data set to identify where there is high utilisation by Māori and higher inequities and prioritise Māori health workforce distribution to those areas.	Q2-Q4	HSL
		• improving knowledge base of primary care workforce including undertake a primary care workforce survey and in the NGO sector where requested.	Q1 – Q4	HSL / DHB
		• supporting regional Kia Ora Hauora (KOH) programme to increase DHBs knowledge about KOH candidates pathway	Q1	HSL / KOH
		• supporting DHBs to collaborate about training (where required). Equity actions: • increase Māori participation and retention in the health workforce and ensure that Māori have equitable access to training opportunities as others • build cultural competence across the whole workforce	Q2 – Q4	HSL / DHB

Priority	Health Strategy Linkage	Activities / Actions	Milestone / Date	Responsibility
		• increase participation of Māori and Pacific in the health workforce • form alliances with educational institutes (including secondary and tertiary) and local iwi to identify and implement best practices to achieve the Māori health workforce that matches the proportion of Māori in the population.		
		By: • increasing access to data for communities of interest starting with DHBs about inequities in the areas of equity of outcome, access, treatment, and opportunity. Including deprivation, health utilisation etc TBC. Includes partnering with educational facilities to identify local or regional communities of interest of equity concern. Links with clinical network work below.	Q2	HSL / DHBs
		• identifying current training available to improve cultural competence/fluency and Māori best practice in DHBs and establish most useful way to share this information to other organisations.	Q2	HSL / DHBs
		• supporting DHBs to increase Māori and Pacific participation in the health workforce	Q1 – Q4	HSL / DHBs
		• supporting Kia Ora Hauora to meet the programme objectives.	Q1	HSL / KOH / DHBs
Health Literacy	One team	• supporting Midland DHBs with regional activities as required to improve health literacy.	Q1 – Q4	HSL / DHBs
Palliative Care	One team	Work regionally and in collaboration with DHB Shared Services and the Ministry of Health to develop a robust workforce plan to ensure regions are able to deliver quality, accessible palliative care across all geographical areas and settings. These plans will outline the need for palliative care across the region and projections of future demand. They will demonstrate how the region will address current and future needs for palliative care. Areas of focus include: • understanding of the vision of accessible quality palliative care for all • examples of initiatives that support implementation of the Palliative Care Action Plan 2017 • workforce resource profiles and distribution that support the needs and vision of the region including: ○ appropriate skill mix	Q1 – Q4	

Priority	Health Strategy Linkage	Activities / Actions	Milestone / Date	Responsibility
		○ full utilisation of the existing workforce ○ optimal use of expertise and skills ○ one team approach across organisations, agencies, professions and teams.		
		By: • undertaking palliative care workforce stocktake. *Refer to* ***Appendix in Section 4.1:*** **Cancer services (Midland Cancer Network)** *work plan initiative 5: Improve palliative care services.*	Q2	Midland Cancer Network / RDoW / MoH
Cardiac Services	People powered	Work regionally and in collaboration with the DHB Shared Services and Regional and National Cardiac Networks to: • clearly identify current demand for cardiac physiology services and the regional ability to meet these demands *(subject to resourcing)*. • develop and implement a workforce plan to ensure that training, recruitment, retention and other relevant workforce issues are addressed to sufficiently support all pathways to cardiac services, including to cardiac surgery. By: • Identifying demand for cardiac physiology services in Midland DHBs • Identifying accessibility of cardiac physiology services in Midland DHBs including workforce supply • Undertake gap analysis • Collaborate with DHB Shared Services and Regional and National Cardiac Networks to develop a strategic workforce plan to address gap analysis findings Support the Midland Cardiac Clinical Network in writing a revised and updated regional service plan. *Refer to* ***Appendix in Section 4.2:*** **Cardiac services (Midland Cardiac Clinical Network)** *work plan initiative 6: Service planning and workforce.*	Q1 – Q4	Regional and National Cardiac Networks/ HSL Project Manager / RDoW
Elective Services	Value and high Performance	Identify the actions that the region will undertake to maximise workforce resources. For example, completing a forecast through to 2019/20 of future workforce requirements, based on service demands and maintaining a local and regional view of specialist workforce capacity and capability. Development of long-term recruitment plan for vulnerable or hard-to-recruit roles. By: • regularly accessing HWIP FTE and vacancy data to identify professional groupings whose characteristics, numbers, vacancy rates, turnover rates, or age profile within the DHB,	Q1	HSL

Priority	Health Strategy Linkage	Activities / Actions	Milestone / Date	Responsibility
		region or nationally may pose a risk to ongoing service delivery and advise DHBs • supporting collaboration across Midland DHBs to create and access material for long term recruitment strategies. **Orthopaedics:** • complete a regional review of current orthopaedic workforce resources, factoring in subspecialty capability. *This should include an evaluation of current workforce, a view on the indicative resourcing levels required to meet acute and planned orthopaedic demand in 2018/19, and a gap analysis on how well resourcing levels can meet 2018/19 anticipated delivery levels.* develop and implement a regional orthopaedic workforce implementation plan (based on the regional review). Consider how orthopaedic workforce resources can be best used across the region to maximise delivery for patients, and identifies initiatives to support closing any gaps between demand and capacity, including use of alternative care models and workforce where appropriate. By: • undertaking orthopaedic workforce stocktake and identify issues. This activity is dependent on additional resourcing. *Refer to **Appendix in Section 4.3:** **Elective services (Elective Services Network)** 18-19 work plan note.*	Q4 Q2 – Q3	HSL HSL, dependent on additional resourcing
Mental Health	**One team**	Work regionally and in collaboration with DHB Shared Services and the Ministry of Health to implement the actions set out in the Mental Health and Addiction Workforce Action Plan 2016-2020. This work should also ensure organisations across the region are appropriately supported with a particular focus on supporting staff development and leadership. By: • working alongside the National Workforce Centres to bring more data and analysis, in order to develop our understanding of workforce issues (from MH&AWAP 2016-2020: Priority Area 1, Action 3) • trained trainer in Single Session Whānau Consultation and Five Step Whānau Intervention to support development of family support training supervision and support hubs in each (Midland) DHB (Priority Area 3, Action 3) • examine training pathways into and through L3, L4 and beyond for Support Workforce, Apprenticeships and etcetera to determine and adopt most effective training pathways for MH&A practitioners. *Refer to **Appendix in Section 4.5:** **Mental Health & Addictions (Regional Mental Health &***	Q1 – Q4	Midland MH&A / RDoW / GMs HR / MoH

Priority	Health Strategy Linkage	Activities / Actions	Milestone / Date	Responsibility
		Addictions Network) *work plan, initiative 7: Workforce capacity and capability.*		
Addiction Treatment Services	One team	Work regionally to build addiction treatment staff capability to support implementation of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SACAT). By: • work alongside the National Workforce Centres to bring more data and analysis, in order to develop our understanding of workforce issues (Priority Area 1, Action 3) • second phase of SACAT Training, focussing on integrated systems approach, whānau and service user / peer involvement. (Priority Area 2, Action 2) • trained trainer in Single Session Whānau Consultation and Five Step Whānau Intervention to support development of family support training supervision and support hubs in each (Midlands) DHB (Priority Area 3, Action 3) • examine training pathways into and through L3, L4 and beyond for Support Workforce, Apprenticeships and etcetera to determine and adopt most effective training pathways for MH&A practitioners *Refer to* ***Appendix in Section 4.5:*** **Mental Health & Addictions (Regional Mental Health & Addictions Network)** *18-19 work plan, initiative 2: Substance abuse legislation.*	Q1 – Q4	Midland MH&A / RDoW / MH&A Service Managers / MoH
Stroke Services	People powered	Work regionally and in collaboration with DHB Shared Services and Regional and National Stroke Networks to: • clearly identify current demand for acute and rehabilitation stroke services in both the hospital setting and in the community, including ambulance and radiology services and the regional ability to meet these demands • develop and implement a workforce plan to ensure that training, recruitment, retention and other relevant workforce issues are addressed and are ongoing • seek new and innovative ways of addressing service delivery in environments where health professionals work primarily in isolation or where the workforce is limited in its ability to meet recommended service delivery. By: • strengthening the regional allied health stroke network • focusing on rehabilitation and initiating a forum discussion to establish practical ways to support service delivery in isolated areas • supporting local DHBs to collaborate to recruit to hard to fill positions starting with positions that impact on retention *Refer to* ***Appendix in Section 4.6:*** **Stroke services (Midland Stroke Network)** *18-19 work plan,*	Q1	Stroke Network / national stroke network / RDoW / Directors of Allied Health / MoH /

Priority	Health Strategy Linkage	Activities / Actions	Milestone / Date	Responsibility
		initiative 4 Clinical leadership.		

2.1.3 Technology and Digital Services

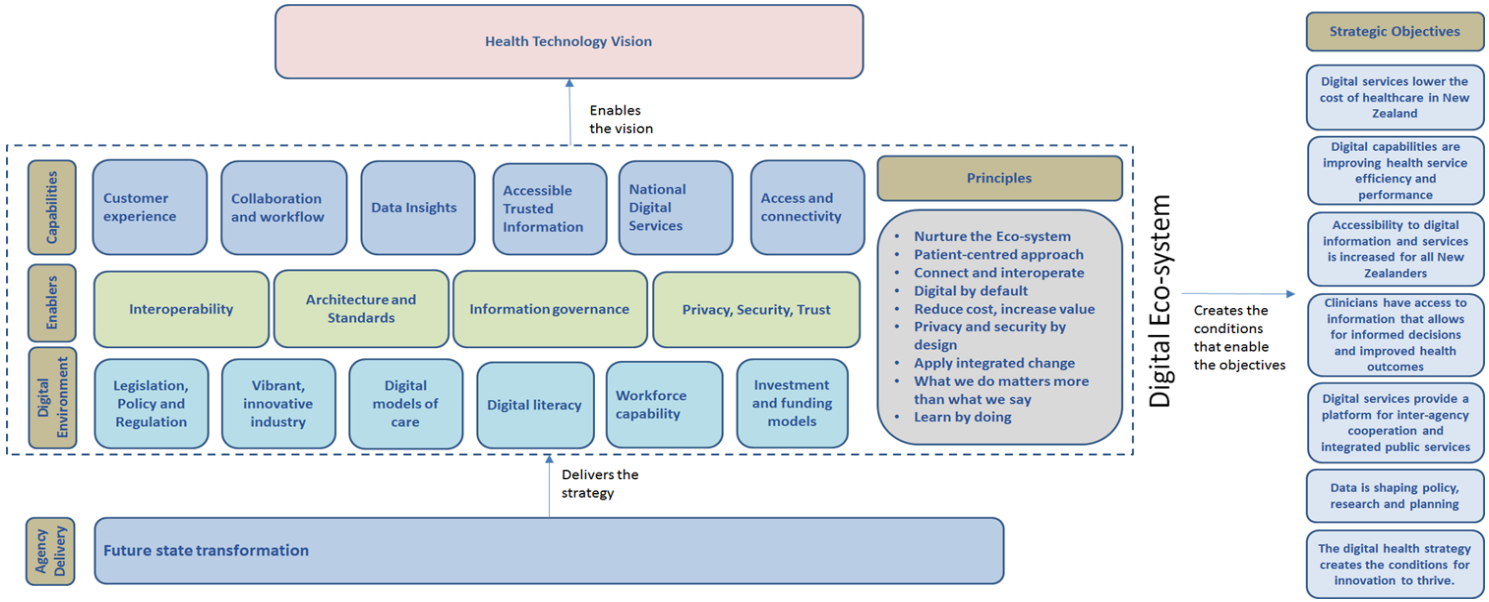
Strategic Context for Digital Health

Delivery of ICT enabled change and innovation is critical in supporting the delivery of the New Zealand Health Strategy and the Government ICT Strategy. Technology will support transformational change in the way patients and care teams access health services

New Zealand Digital Health Strategy[3]

The Digital Strategy is a living document that describes a digital eco-system creating conditions that support us to achieve the components of the New Zealand Health strategy. The following is a schema of the draft Digital Health Strategy components.

Figure 6: Digital Health Strategy Components (MoH)



[3] http://www.health.govt.nz/publication/new-zealand-health-strategy-2016

The 2018-21 Regional Plan reflects the New Zealand Health Strategy's direction, which has set a goal of a people-powered, smart health system by 2025.

Health Information Standards and Architecture[4]

The Ministry of Health is responsible for developing, maintaining and supporting the adoption of fit-for-purpose health information standards and architecture that support the effective and accelerated implementation of Digital Health capabilities. Accordingly, during 2018/19, the Ministry of Health will start focusing greater attention and dedicated resources on ensuring health ICT investments incorporate "security-by-design" within their planning, procurement, deployment, and lifecycle management phases.

Midland region projects are required to align with Health Information Standards and architecture. The region further supports this through sector architect membership and participation in national architecture working groups.

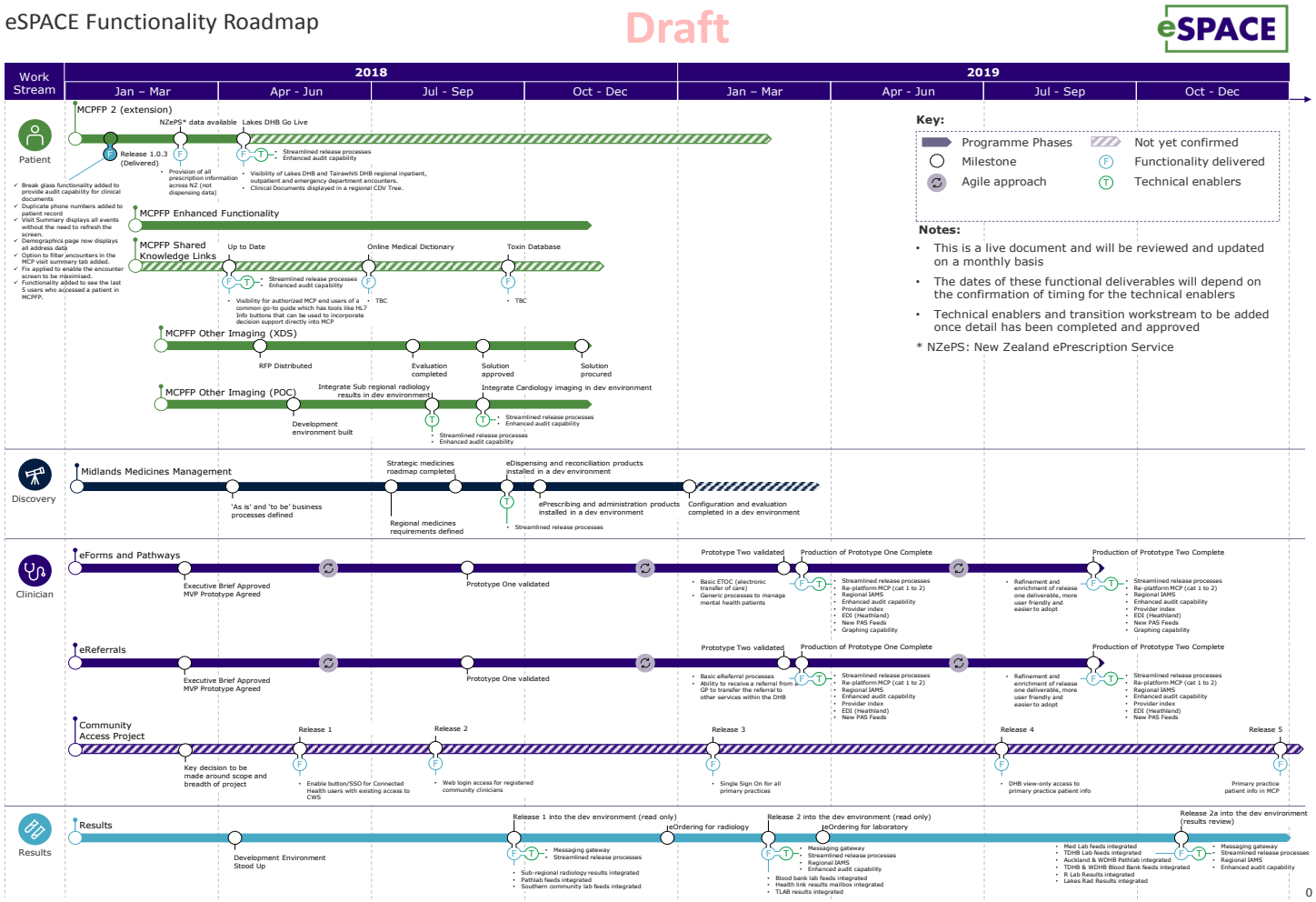
Technology and digital services priorities for 2018/19

Lead:	Debbie Manktelow, Manager – Regional Information Services (on behalf of Chief Information Officers, Midland DHBs)
CE Sponsor:	Rosemary Clements (Taranaki DHB)
eSPACE Programme Lead:	David Page, eSPACE Programme Director
eSPACE SRO:	Maureen Chrystall

The Midland region's eSPACE programme is seen as the key enabler for achieving the region's priorities in regards to integrating across continuums of care and improving clinical information systems; supports the Ministry of Health's 'smart system' strategic theme; backed-up by sound business case propositions to drive improved clinical practice, both within and between health providers across the Midland region. See over page for eSPACE Functionality Roadmap (draft).

[4] http://healthitboard.health.govt.nz/health-it-groups/health-information-standards-organisation-hiso

Figure 7: eSPACE Functionality Roadmap (draft)



Key priorities and initiatives that are expected to be implemented regionally by Midland DHBs are stated in the below table.

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

The major risks to the ICT enablement of the Regional Services Plan (RSP) are:

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

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

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
Single Electronic Health Record	**Smart system**	National programme led by Ministry of Health	Development of Detailed Business Case.	All	• DHB engagement in business case development process.
Digital Health Strategy	**Smart system**	National programme led by Ministry of Health	Publishing the Digital Health Strategy.	All	• DHB engagement and alignment with the Digital Health Strategy.
Digital Hospital	**Smart system**	Identify gaps using EMRAM assessment and work towards closing these gaps by the timelines set by the Ministry of Health, using regionally aligned solutions where possible (NB: Links to Regional IT Foundations via use of eSPACE)	Review of PACS/RIS and development of full regional solution	All	• Solution is current & enhanced functionality delivered across the region • 3rd party partner care provider access to radiology images enabled for patients in shared care
			Investigate the feasibility and develop an agreed approach to deliver electronic nursing notes	All	• Agreed approach identified
			eSPACE: Medications Management Discovery Workstream • Obtain Regional Detailed Business Requirements to inform an RFI. • Audit Evaluation of Orion med Man and Med Chart for regional implementation. • Gap Analysis between requirements and Med Man and Med Chart. • Midland Medicines Management RFI • Decision request on the recommended approach to implement a Midland Medicines Solution	All	• Regional Business Requirements approved. • Audit evaluation completed. • Gap Analysis completed. • RFI process completed. • Decision request approved by eSPACE Programme Board.

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
			eSPACE: Regional Results Workstream (EMRAM 3 & 4): • Install a regional Orion results repository • Stand up a Results Proof of Concept at Tairāwhiti i DHB. • Integrate radiology and laboratory results from Tairawhtiti DHB. • Provide visibility to Midland Clinical Portal authorised end users to "read" Tairawhtiti Radiology and Laboratory results • Provide capability to manage/acknowledge Tairawhtiti Radiology / Laboratory results using the Orion results repository.	All	• Proof of Concept results environment developed • Acceptance from the eSPACE Clinical Authority Orion results Proof of Concept. . • Radiology eOrdering PID • Laboratory eOrdering PID
Shared Clinical Information	**Smart system**	Working with the Midland United Regional Integration Leadership (MURIAL) group and other primary and community partners to create an integrated view of patient information.	Investigate options to enable bi lateral primary/secondary/community access to patient information to increase clinical visibility of patient data, developing a consistent method to enable integration into Midland Clinical Portal	All	• Agreed approach and next steps identified
			eSPACE: Development and implementation of Community Access into Midland Clinical Portal	All	• PID approved
		Midland Clinical Portal Implementation of solutions to support the regional objective of "one patient,	eSPACE: Patient Workstream: • Midland Clinical Portal Foundation, providing visibility of regional patient information in a read only view • MCPFP integration to NZePS. • Provide capability for Tairāwhiti DHB to send	All	• MCPFP 2 project closed. • MCPFP Enhanced functionality implemented in patient context. • MCPFP Enhanced functionality project closed. MCPFP Imaging Operability project closed.

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
		one record" Phased implementation of regional clinical portal functionality to replace legacy systems	documents to the Midland Clinical Portal CDV Tree. • MCPFP Enhanced functionality PID approved. • MCPFP Enhanced functionality implemented. • MCPFP Imaging Operability PID approved. • MCPFP Imaging Operability implemented.		• Acceptance of the Midland Clinical Portal integrated to Starship Proof of Concept by the eSPACE Clinical Authority. • Visibility of NZePS to authorised MCP end users.
			eSPACE Clinician Workstream: • Development environment developed to prototype eForms and Pathways, including Mental Health and, eReferrals	All	• PID approved • Development environment built • Clinical acceptance of eForms, Pathways and eReferrals
			eSPACE Transition Workstream: • Phased implementation of regional clinical portal functionality to replace transition off legacy systems		• PID approved • Clinical acceptance of enhanced functionality to support the MCP foundation and allow clinicians to search within the Midland Clinical Portal.
IT Security maturity enhancement	**Smart system**	Collaborating with the Ministry and across wider sector to drive increased IT Security maturity	Constructively engage with the Ministry and other health sector members in the establishment of projected programme of IT Security maturity activities	All	• The successful introduction, and implementation, of a suite of sector-wide IT Security maturity initiatives.
National Screening Solution	**Smart system**	National Screening Solution led by the Ministry.	Engagement with the Ministry in bowel screening planning and implementation. Rollout of National Bowel Screening Programme in accordance to Ministry of Health requirements and time lines. *Refer to* ***Appendix in Section 4.1:*** **Cancer services (Midland Cancer Network)** *work plan initiatives*	All	• Midland DHBs to engage in development of implementation plans. • Lakes NBSP live • Midland DHBs will operate on the same version of the clinical endoscopy system.

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
			2, 3 and 4. When required, engagement with the Ministry in cervical screening project planning to support HPV testing.		
Integration Services	**Smart system**	Strategic programme led by the Ministry.	National Screening Solution to be the first tranche on the Integration Service.	All	• DHB and sector to engage in integration services planning and implementation.
Telehealth	**Smart system**	Work with clinical services and specialties to build awareness and use of Telehealth across the Midland region	Continue to progress the Midland Telehealth Work Plan *Note: This initiative also improves Equitable Access and Outcomes.*	All	• National Video conference (VC) Directory implemented. • All DHBs are using the mode of delivery field (NNPAC) to record the use of VC to deliver health services.
Maternity	**Smart system**	Nationally led programme with local Maternity Providers and DHBs. This programme includes Newborn Hearing Screening.	2018/19 will focus on giving women access to their maternity notes, updating HISO standards for sharing clinical information, working with the privacy commissioner and updating privacy impact assessments, and continuing to work with DHBs to implement the National Maternity Record (regionally where feasible) .	All	• By the end of the 2018/19 financial year, all DHBs have a plan in place to implement the National Maternity Record by 2020.
Newborn Hearing Screening	**Smart system**	Ministry led programme engaging with DHBs for national implementation of the Maternity systems including the Newborn Hearing Information	Collaborate with the Maternity programme to progress a regional approach to implementing NHIMS along with the maternity systems, at all DHBs	All	• By the end of 2018/19 financial year, all DHBs have a plan in place to implement the NHIMS module by 2020

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
		Management System (NHIMS)			
Nationally consistent Electronic Oral Health Record (EOHR)	**Smart system**	National programme led by Ministry of Health in collaboration with DHBs	Work with DHBs and the current provider to address issues and risks by making improvements where possible that incrementally move towards a nationally consistent and integrated EOHR.	All	• DHB engagement with Programme to continue with the development and implementation of the Future Operating Model
National Digital Services	**Smart system**	Engagement when required for national services led by the Ministry	Adoption and operation of national digital services Enhancement of national digital services	All	• Engagement with NHI extension work • Alignment with HPI development • Data contributions to National Collections
Medicines Management Digital Services	**Smart system**	Engagement in national programme led by Ministry, with DHB governance and co-design	All regions to action their approved medicines management strategic plans. Achieve national consistency through the adoption of HISO standards for medicines management. Focus on appropriate prescribing, including using existing pharmaceutical data (eg, epharms, NZePS) for the betterment of the person/patient. *Refer also to above Digital Hospital priority, eSPACE Medications Management Discovery Workstream.*	All	• All providers to adopt the NZF/NZULM. • All regions to have an action plan for the adoption of NZePS across general practices and ePA for hospital pharmacies in a way that protects and ensures a person's safety, security and privacy.
National Patient Flow	**Value and high**	Regional collaboration to	Implement regional information governance	All	• Information Governance is established across the Midland region

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
(NPF)	Performance	support improved data quality	structure across the Midland region Align information standard across the Midland region for key datasets (including NPF)		• Key datasets, including NPF, can be accessed across the Midland region enabling better information analysis
		Support the Midland Cardiac Clinical Network (MCCN) to develop and extend the collection of data	Any agreed Midland regional outpatient modules required to be implemented as part of the National Patient Flow Out Patient data collection are implemented across agreed Midland DHBs	All	• Any agreed modules are implemented and service planning is enabled
Cancer Information Strategy	Smart system	Regional coordination by Midland Cancer Network (MCN) and support for the delivery of nationally consistent systems across Midland DHBs to inform quality improvements that ensure health gain for Māori and equitable and timely access to cancer services.	Regional co-ordination and support for DHBs' alignment of their digital systems to collect and report consistent, accessible and accurate cancer data. *Refer to* ***Appendix in Section 4.1:*** **Cancer services (Midland Cancer Network)** *work plan initiative 1: equity of access, timely diagnosis and treatment for all patients on the Faster Cancer Treatment pathway.*	All / Midland Cancer Network	• Progress the implementation of the Cancer Health Information Strategy as advised in quarterly reports. • Progress to address unwanted variation in radiation oncology treatment as advised in quarterly reports.
		Working with Midland Cancer Network (MCN) to support and progress national initiatives	Implementation of a regional clinical quality audit tool and database solution to support lung and colorectal pathways of care Investigate other opportunities for the use of the regional system across other services *Refer to* ***Appendix in Section 4.1:*** **Cancer services (Midland Cancer Network)** *work plan initiatives 2*	All	• Electronic colorectal and lung cancer pathway tool in use across the Midland region • Staging information is being captured • Data collected is able to be utilised for research studies • Feasibility completed and any next steps agreed

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
			and 6.		
			Develop a business case for Multi-Disciplinary Meeting (MDM) toolset in line with national requirements and timelines *Refer to* ***Appendix in Section 4.1:*** **Cancer services (Midland Cancer Network)** *work plan initiative 6.*	All	• Business case is developed
Mental Health	**Smart system**	DHBs accountable for delivery	All regions implement integrated systems for sharing clinical and mental health information. All regions have the ability to create electronic Mental Health Patient Care Plans that can be shared regionally. All regions can record Mental Health activity data according to PRIMHD standards by: • Ensuring Clinical Governance remains engaged with eSPACE • The development of the mental health and addiction platform being undertaking by the eSPACE Programme is undertaken in partnership with Clinical Governance • Regional Stakeholder Networks to identify data sets for analysis • Ensure that analysis of data is undertaken and informs all projects undertaken in 2018-19 • Further analyse of current data sets to ascertain effectiveness of information provided. *Refer to* ***Appendix in Section 4.5:*** **Mental Health**	All / MH&A Network	• All DHBs have implemented electronic Mental Health Patient Care Plans. • All DHBs and NGOs meet PRIMHD standards and can record Mental Health activity data.

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
			& Addictions (Regional Mental Health & Addictions Network) *work plan, initiative 4: MH&A clinical workstation.*		
Stroke Services	**Smart system**	Support the delivery of regionally (nationally where realistic) consistent systems across DHBs to deliver telestroke services for acute stoke service intervention in a safe and timely manner, and support participation in the thrombolysis register.	*Refer to **Appendix in Section 4.6:** **Stroke services (Midland Stroke Network)** 18-19 work plan, initiative 3: Acute stroke.*	All / Midland Stroke Network	• All DHBs will provide a safe and sustainable thrombolysis service 24/7
National Major Trauma data collection	**Smart system**	Nationally consistent data collection and reporting supports improved service delivery for major trauma patients.	All DHBs report the elements of the National Major Trauma Minimum Dataset to the New Zealand Major Trauma Registry. Refer to *the **Appendix in Section** Error! Reference source not found.Error! Reference source not found.*	All / Midland Trauma System	• Quarterly regional reporting of the NZ Major Trauma Minimum Dataset to the National Major Trauma Registry no more than 30 days after patient discharge.
Pathways of Care	**Smart system**	Support the Midland United Regional Integration Leadership (MURIAL) group to transition and implement a replacement care pathway tool	Transition to agreed interim care pathway tool across the Midland region Implement regionally agreed integrated service care pathway tool		• Interim Solution is in place and supported • Care pathway system and information is accessible to all required services across primary and secondary care

Priority	Health Strategy Linkage	Guidance			Measures
		Approach	Description of 18/19 activity	DHBs involved	
Cardiac Care	Smart system	Support the Midland Cardiac Care Network (MCCN) to develop and extend the collection of data	Work with the MCCN team to identify feasibility and implementation of a regional Cardiac Cath lab toolset *Refer to **Appendix in Section 4.2:** Cardiac services (Midland Cardiac Clinical Network) work plan initiative 1: Ischemic heart disease.*	All	• Business case developed based on outcomes of feasibility • Toolset is implemented and Cardiac Care Network have the ability to manage demand cross the region

2.1.4 Quality

A 'quality' focus must be on a 'whole of the system' approach to deliver the NZ Health Strategy 2017 Goals – the central black circle!! The five themes are enablers in terms of the activities to achieve the New Zealand Health Strategy (NZHS) Goals.

Figure 6: NZ Health Strategy 2016 – five strategic themes

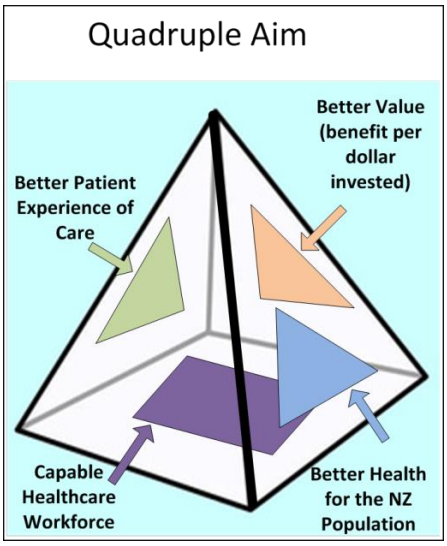
Goals for Midland DHBs in terms of Quality –

1. Best outcomes for our population and users / providers of our services:
   - to continually reduce the burden of illness, injury and disability in our populations
   - to continually improve the health & functions of all of our people particularly Māori
   - to do this as efficiently as possible.
2. Eliminate inequities in population quality outcomes.

Midland DHBs are committed to working collaboratively in our regional services planning as we develop, implement and deliver these services for the Midland population.

Midland DHBs are also working with the Health Quality & Safety Commission (HQSC) to develop, implement and deliver their range of Programmes and to support the work of the National Mortality Review Committees.

To support Quality of care throughout our system requires us to address the 'Quadruple Aim' for our Regional System Collaboration:



- ✓ Better patient experience of care
- ✓ Better health for our population
- ✓ Better value (benefit per $ invested)
- ✓ A skilled, capable healthcare workforce.

Work has continued over the past 12 months to maximise actions that take a regional approach to core services—evidence-guided initiatives in particular.

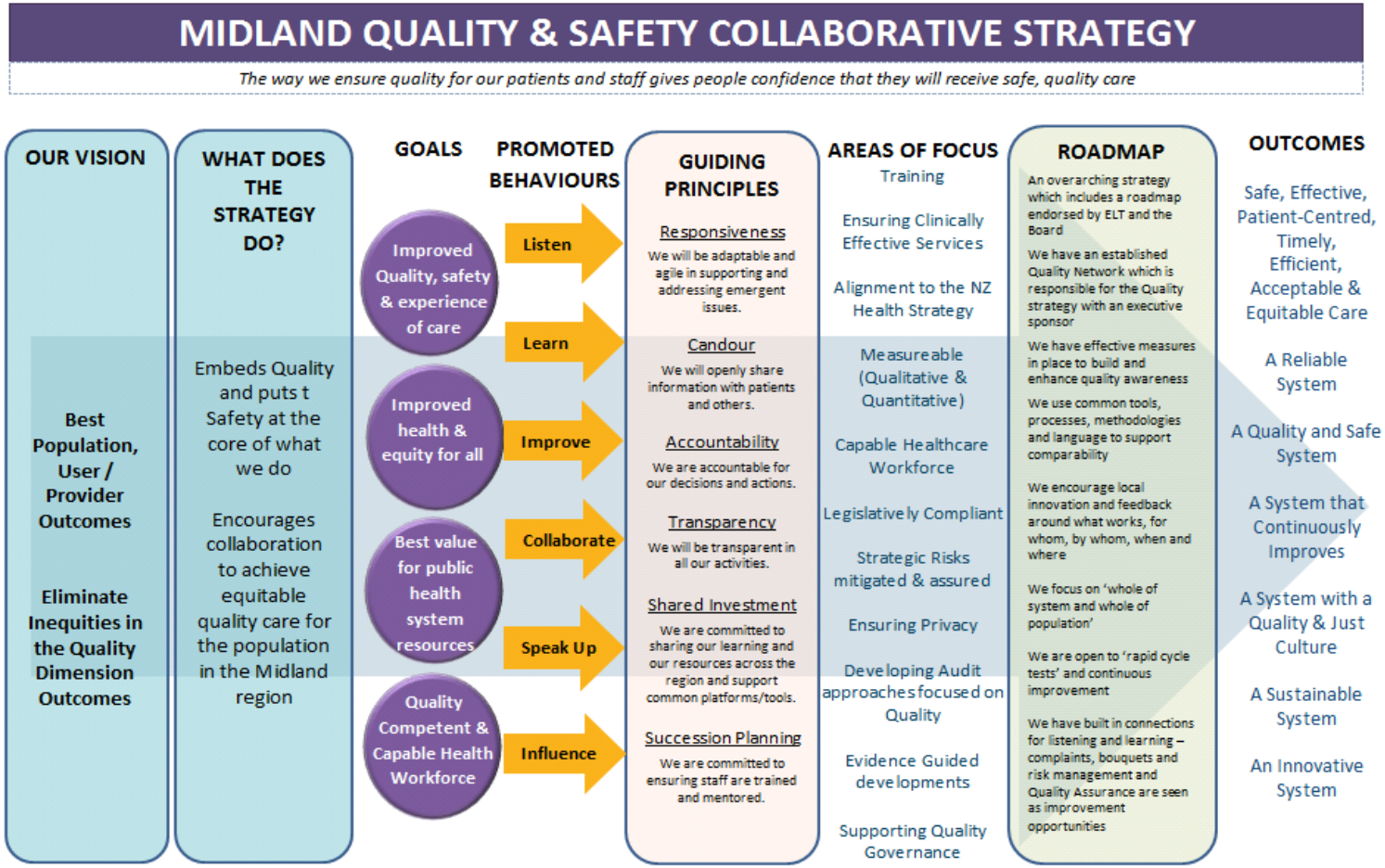
The Midland Quality & Safety Strategy:

- ✓ Embeds the dimensions of quality and puts safety at the core of what we do
- ✓ Encourages collaboration to achieve equitable quality care for the population of the Midland region.

Listening, learning, improving, collaborating, speaking-up for safety and influencing are behaviours that the Strategy promotes to achieve the 'quadruple aim'.

The picture below demonstrates the critical elements of the Collaborative Strategy:

Figure 7: Midland Quality & Safety Collaborative Strategy



We are developing a matrix that enables us to measure our success in terms of each of the dimensions of quality for each of the regional services to inform our areas of focus and outcomes.

The Midland region continues to train and support a number of Improvement Advisors (IA) within DHBs and primary care, with support from DHBs and the HQSC Programmes. This year we are implementing the Advance Care Planning 'Serious Illness Conversation Guide Training and education along with Midland Region Chief Nursing Officers and Chief Medical Officers. Eight positions have been allocated to the Midland region under the coordination of the Midland Region Quality & Risk Group. While positions will be allocated to each DHB it is intended that collaborative training occur within the region. The eight trainers will then be able to organise a programme to undertake 'in DHB' training – community, primary and hospital. This programme of work is likely to be implemented towards the end of the 2018/2019 financial year.

Other key pieces of work for 2018/19 include:

- Supporting the national mental health quality improvement collaborative
- Maintain regional collaboration with improvement work streams – deteriorating patient, Advance Care Planning (ACP), patient safety programmes such as Sepsis, venous thromboembolism (VTE)
- Developing systems to support quality and patient safety within the regional clinical service networks
- Sharing evidence-guided approaches to building staff capability for quality improvement
- Sharing best practice in developing risk management and board assurance frameworks and the systems across the region, making best due of the risk management system – Datix
- Developing the next 'Datix' evolution programme of investment in terms of Datix Cloud IQ which provides five toolkits (Capture, Evaluate, Strategy, Implement, and Assess) that take collaborating DHB organisations through a continuous improvement process. There is also a comprehensive analytics feature, allowing DHBs to look at trends as they occur and even predict where instances may arise in the future.

Quality priorities for 2018/19 DRAFT

Lead: Dr Sharon Kletchko (Lakes DHB), Chair, Midland Quality Group

CE Sponsor: Rosemary Clements (Taranaki DHB)

NOTE: The following work plan is draft and subject to regional agreement and resourcing

Priority	Health Strategy Linkage	Guidance	Measures	Milestone / Dates	Responsibility
Regional Quality and Safety	Value and high Performance	Demonstrate actions to maintain and participate in regional quality and safety improvement by applying the HQSC's four strategic priorities: 1) improving consumer/whānau experience 2) improving health equity 3) reducing harm and mortality 4) reducing unwarranted variation in patterns of care in: • implementing the Knowledge To Action framework for building quality and safety capability • working regionally to implement the HQSC's patient deterioration programme in your DHBs.	Regional progress reporting on the requirements and key actions to be provided via quarterly RSP reports.	Q1 – Q4	Midland Quality Managers
Healthy Ageing	Closer to home	Demonstrate regional support in the 2018/19 year for DHB delivery of actions identified in the Healthy Ageing Strategy 2016, in particular continued progress in supporting the development of interRAI quality indicators and using these to improve outcomes for older people. Refer to ***Appendix in Section*** *Error! Reference source not found.Error! Reference source not found. 18/19 work plan, initiative 4: Advance Care Planning (ACP).*	Regional progress reporting on the requirements and key actions to be provided via quarterly RSP reports.	Q1 – Q4	Midland Health of Older People Action Group
Elective Services	Value and high Performance	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 should be a clear	Link to quality standards and actions including key actions and updates are to be provided via	Q1 – Q4	Elective Services Network

Priority	Health Strategy Linkage	Guidance	Measures	Milestone / Dates	Responsibility
		link to quality improvements and standards, particularly in relation to unwarranted variation in patterns of care and improving health equity. *Refer to* ***Appendix in Section 4.3:*** **Elective services (Elective Services Network)** *18-19 work plan initiative 1: Vascular services.*	quarterly RSP reports.		
Cancer Services	Value and high Performance	Regional co-ordination and support of quality improvement initiatives that align with national cancer strategies to achieve health gain for Māori and equitable and timely access to cancer services. Demonstrate regional activity to co-ordinate and support DHBs to achieve service improvements as outlined in their 2018/19 Annual Plans that: • enable equity of access to timely diagnosis and treatment services for all patients on the FCT pathway (eg system/service improvements to minimise breaches of the 62 day FCT for patient or clinical consideration reasons) • ensure the application and integration of the prostate cancer decision support tool as business as usual for all general practitioners in the region and co-ordinate activity to make improvements in the quality of referral pathway into specialist services, including the quality of information provided with referrals • support and co-ordinate DHB activity to improve the quality of life for people who have completed cancer treatment to live well, through for example: - end of treatment meeting or clinic - development of follow-up care plans for both secondary and primary health care. Referrals to appropriate service providers for self-care supports such as nutrition, physical therapy and psycho social support. Progress against deliverables agreed between RCNs and the Ministry in the RCNs Annual Work Plan for 2018/19. *Refer to* ***Appendix in Section 4.1:*** **Cancer services (Midland Cancer Network)** *work plan initiative 1.*	Progress against deliverables agreed between RCNs and the Ministry in the RCNs Annual Work Plan for 2018/19.	Q1 – Q4	Midland Cancer Network
Mental Health	Value and high performance	Demonstrate the specific regional quality improvement activities undertaken in conjunction with the HQSC.	Regional progress reporting on the requirements and key actions to be	Q1 – Q4	Midland Mental Health & Addictions

Priority	Health Strategy Linkage	Guidance	Measures	Milestone / Dates	Responsibility
		By: 1. Support the Quality Health Safety Commission project work: a. Towards Zero Seclusion b. Transition Projects are identified and implemented. *Refer to* ***Appendix in Section 4.5:*** **Mental Health & Addictions (Regional Mental Health & Addictions Network)** *18-19 work plan, initiative 2: Substance abuse legislation.*	provided via quarterly RSP reports.		Network
Stroke Services	**Value and high performance**	Work regionally and collaboratively to support DHBs to ensure stroke patients are admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway. *Refer to* ***Appendix in Section 4.6:*** **Stroke services (Midland Stroke Network)** *18-19 work plan, initiative 3: Acute services.*	Regional progress reporting on the requirements and key actions to be provided via quarterly RSP reports.	Q1 – Q4	Midland Stroke Network
Major Trauma	**Value and high performance**	When fully implemented, the National Major Trauma Registry will collect nationally consistent, complete and accurate data to support service improvements for people with major trauma. Refer to ***Appendix in Section*** *Error! Reference source not found.****:*** *Error! Reference source not found., initiative 2: Develop, implement and maintain regional Trauma system infrastructure including information systems.* When implemented, appropriate staging and transfer to hospitals best able to meet the treatment needs of major trauma patients will support improved clinical outcomes. Refer to ***Appendix in Section*** *Error! Reference source not found.****:*** *Error! Reference source not found., initiative 4: Establish a Trauma Quality Improvement Program (TQIP) to enable evidence-based change.*	Quarterly regional reporting of the NZ Major Trauma Minimum Dataset to the National Major Trauma Registry no more than 30 days after patient discharge. A 6-monthly (minimum) regional review process of the alignment of actual service delivery for major trauma patients with regional destination policies, inter-hospital transfers and staging guidelines.	Q1 – Q4	Midland Trauma System

2.1.5 Clinical Leadership

(i) Promoting strong clinical governance

Effective clinical engagement and leadership supports better decision-making with more efficient implementation, resulting in integrated care, improvements to quality and safety of patient care, better health outcomes and value for money. Regional clinical networks and action groups are chaired by clinicians, and membership is representative from across the Midland region's health professions and management to support the delivery of annually agreed work plan initiatives and activities.

The Chairs of regional clinical networks provide reporting to the joint meetings of the Midland DHBs' CEs and Board Chairs, as part of the Midland governance groups' annually agreed work plan. This enables close engagement between regional governors and the region's clinical leaders involved in the priorities they and their groups have determined for the year, and beyond.

Table 4: Membership in a regional clinical action group - demonstrating clinical leadership across the continuum of care

Midland Child Health Action Group	
Member	Midland DHB / Organisation
Dr David Graham (Chair)	Waikato DHB
Dr Stephen Bradley (Deputy Chair)	Lakes DHB
Dr John Doran	Taranaki DHB
Dr Margot McLean	Hauora Tairāwhiti
Dr Justin Wilde	Bay of Plenty DHB
Ron Dunham	Midland CEO representative (Lakes DHB)
Michelle Sutherland	Midland COO representative (Waikato DHB)
Gary Lees	Midland DoN representative (Lakes DHB)
Becky Jenkins	Midland GMs P+F representative (Taranaki DHB)
Marnie Reinfelds	Child Health Portfolio Manager (Taranaki DHB)
Karen Smith	Management representative (BOP DHB)
Dr Nina Scott	Midland Māori Health representative (Waikato DHB)
Lindsay Lowe	Public Health representative (Toi Te Ora)
Dr Richard Vipond	Public Health (Waikato DHB)
Mollie Wilson/Karyn Sanson	Paediatric Society; NZ Child & Youth Clinical Network Programme
Dr Jo Scott-Jones, Tracy Jackson	Primary Sector – Pinnacle PHO
Debi Whitham	Primary Sector – Hauraki PHO
Dr Neil Poskitt / Dr Sharon Lovegrove	Primary Sector – RAPHS
Arish Naresh	Allied Health (Hauora Tairāwhiti)
Viv Edwards	Plunket
Dr Pat Tuohy	Ministry of Health
Anna-Maree Harris	Project Manager (HealthShare)
Honor Lymburn	(HealthShare)

(ii) Midland DHBs regional clinical networks and action groups

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

Regional clinical initiatives are reviewed by the Midland DHB executives and agreed by the Midland DHB CEs. Much of what occurs is supported with national guidance as part of the annual DHB planning process and aligns with activity each DHB is also undertaking. Each regional initiative is assessed against:

- Midland's six strategic objectives, to show how these contribute to the region's strategic outcomes and vision
- The NZ Health Strategy five strategic themes
- National System Level Measures, and the
- Regional enablers, as determined by the Ministry of Health (see 2018/19 Regional Services Plan Guidelines).

Midland's regional clinical networks and action groups are chaired by clinicians (current as at June 2018):

Table 7: Clinical chairs of regional clinical networks and action groups - demonstrating clinical leadership across the Midland region

Midland Regional Clinical Networks / Action Group	Clinical Chairs
Midland Cancer Network	Dr Humphrey Pullon (Waikato DHB)
Midland Cardiac Clinical Network	Dr Jonathan Tisch (Bay of Plenty DHB)
Child Health Action Group	Dr David Graham (Waikato DHB)
Elective Services Network	Dr Martin Thomas (Lakes DHB)
Health of Older People Action Group	TBC
Hepatitis C Service	Dr Frank Weilert (Waikato DHB)
Mental Health & Addictions Network	Dr Sharat Shetty (Taranaki DHB)
Midland Radiology Action Group	Dr Roy Buchanan (Bay of Plenty DHB)
Midland Stroke Network	Dr Peter Wright (Waikato DHB)
Midland Trauma Services	Dr Grant Christey (Waikato DHB)

Clinical leadership priorities for 2018/19 DRAFT

NOTE: The following work plan is draft and subject to regional agreement and resourcing

Priority	Health Strategy Linkage	Guidance	Measures	Milestone/ Dates	Responsibility
Regional Clinical Leadership and Capacity	One team	Identify: • the role of clinical leaders within the regional governance structure, their level of authority and accountability, and the extent to which leadership teams are multi-disciplinary • examples of where clinical leaders have been engaged with early in the development of regional priorities and decisions on expenditure • how the region is developing clinical leadership capabilities and ensuring clinical leadership reflects the multi-disciplinary team • how existing clinical networks are being used to support quality and sustainability of services • services within the region that may benefit from the development of a regional clinical network and how outcomes from the network will be measured.	Regional progress reporting on the requirements and key actions to be provided via quarterly RSP reports.	Q1 – Q4	HealthShare on behalf of the Midland DHBs
Healthy Ageing	One team	Demonstrate regional support in the 2018/19 year for DHB delivery of actions identified in the Healthy Ageing Strategy 2016, in particular key actions to expand the identification, interventions, information, and prioritisation of advice and support for carers following diagnosis of dementia (eg, behavioural training, daycare, etc) in line with the implementation of the New Zealand Dementia Framework, and the actions specified in *Improving the Lives of People with Dementia* (Ministry of Health 2014). Refer to ***Appendix in Section*** *Error! Reference source not found.**:** Error! Reference source not found. 18/19 work plan, initiative 2: Dementia.*	NA		Midland Health of Older People Action Group
Cardiac Services	Value and high Performance	• Continue to work with regional cardiac clinical networks, cardiothoracic surgical units, the New Zealand Cardiac Network, and the New Zealand Cardiac Surgery Clinical Network to implement actions to improve outcomes for people.	Attendance and participation within regional cardiac networks, and communication of key actions undertaken to be provided via quarterly RSP reports.		Midland Cardiac Clinical Network

Priority	Health Strategy Linkage	Guidance	Measures	Milestone/ Dates	Responsibility
		• Provide quarterly reporting at regional and DHB level utilising the ANZACS-QI and Cardiac Surgery registers. • Review and audit the Accelerated Chest Pain Pathways (ACPPs) in Emergency Departments. *Refer to **Appendix in Section 4.2:** Cardiac services (Midland Cardiac Clinical Network) work plan initiatives 1, 4, 5 and 6 (Equitable Access & Outcomes)*			
Elective Services	**Value and high Performance**	Regional clinical leadership is appointed to support effective decision making in the development, implementation and standardisation of practice, and regional collaboration on regional and national models, particularly for: • Ophthalmology (Age-Related Macular Degeneration (AMD) and Glaucoma • Vascular • Breast Reconstruction. Regional clinical leadership will support spread of improvement and innovation in the region. *Refer to **Appendix in Section 4.3:** Elective services (Elective Services Network) 18-19 work plan.*	Clear regional clinical leadership is in place and key actions demonstrating the role of clinical leadership to be provided via quarterly RSP reports.		Elective Services Network
Cancer Services	**Value and high Performance**	Regions will ensure there is strong clinical leadership at a regional level for cancer services to support service improvements, including those referred to within the quality section (this could include ensuring clinical director positions at the regional cancer networks are filled). *Refer to **Appendix in Section 4.1:** Cancer services (Midland Cancer Network) work plan.*	Progress against deliverables agreed between RCNs and the Ministry in the RCNs Annual Work Plan for 2018/19.		Midland Cancer Network
Mental Health & Addiction Treatment Service	**One team**	• outline how clinical leadership is supporting quality improvement within the region with a particular focus on the HQSC mental health improvement initiative. • outline how clinical leadership is supporting SACAT implementation. By:	Regional progress reporting		Midland Mental Health & Addictions Network

Priority	Health Strategy Linkage	Guidance	Measures	Milestone/ Dates	Responsibility
		2. Support the Quality Health Safety Commission project work: a. Towards Zero Seclusion b. Transition 3. Projects are identified and implemented. *Refer to **Appendix in Section 4.5:** Mental Health & Addictions (Regional Mental Health & Addictions Network) work plan, initiative 7: Workforce capacity and capability.*			
Stroke Services	One team	• actively support nursing and medical stroke leadership roles in regional DHBs • identify the importance of the non-clinical hours required • identify the importance of allied health stroke service activity • work with stroke clinical leaders to support and provide regular regional stroke education programmes and encourage participation. *Refer to **Appendix in Section 4.6:** Stroke services (Midland Stroke Network) 18-19 work plan, initiative 4 Clinical leadership.*	Regional progress reporting on the requirements with the identification of nursing and clinical stroke leaders, their contribution to the regional stroke network and regional representation in the national stroke network, and key actions to be provided via quarterly RSP reports.		Midland Stroke Network
Major Trauma	Value and high performance	Provide clinical leadership of the National Major Trauma Registry to support service improvements for people with major trauma. Refer to ***Appendix in Section*** *Error! Reference source not found.**:** Error! Reference source not found. 18/19 work plan, initiative 2: Develop, implement and maintain regional Trauma system infrastructure including information systems.*	Quarterly regional reporting of the NZ Major Trauma Minimum Dataset to the National Major Trauma Registry no more than 30 days after patient discharge. A 6-monthly (minimum) regional review process of the alignment of actual service delivery for major trauma patients with regional destination policies, inter-hospital transfers and staging guidelines.	Q1 – Q4 Q2 / Q4	Midland Trauma System

2.1.6 Pathway priorities for 2018/19

Pathways, as an enabler, encompass regional development and implementation processes, guidelines and models of care that:

- make best use of regional resources and capacity
- streamline the 'journey' for clients
- clarify the flow to, and between, regional centres
- reduce variability in delivery
- optimise patient outcomes
- identify disparities in current pathways, and the actions to address these.

Midland Region Community HealthPathways will connect our region with a large collaborative community throughout New Zealand, Australia and the UK, where we can collaborate, share knowledge, service configurations, and transform pathways of care for the people of the Midland region. This collaborative community has been growing over the past 10 years and the HealthPathways tool is being increasingly enhanced and improved.

Health and disability services are delivered by a complex network of organisations and people. Integrated healthcare is seen as essential to transforming the way that care is provided for people with long-term chronic health conditions and to enable people with complex medical and social needs to live healthy, fulfilling, independent lives[5]. People living with multiple health and social care needs often experience highly fragmented services which are complex to navigate, leading to less than optimal experiences of care and outcomes.

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

Transitioning to Midland Region Community HealthPathways

The withdrawal of the Map of Medicine product has required the Midland DHB CEs, with the Midland United Regional Integrated Alliance Leadership Team's support, to consider other pathway tool options. It was agreed that the Midland region move to the Community HealthPathways tool.

The HealthPathways tool will connect the Midland region with a large collaborative community throughout New Zealand, Australia and the UK, where we can collaborate, share knowledge, service configurations, and transform pathways of care for the people of the Midland region. This collaborative community has been growing over the past 10 years and the pathways tool is being increasingly enhanced and improved. Feedback from the Midland region's PHOs has been very positive regarding the change in tool. The pathways of care team are excited to move into a new phase in the Regional Pathways of Care Programme.

Midland DHBs and Primary Health Organisations (PHOs) are actively working to integrate services between primary and community care, and hospital care. Regional clinical groups are reviewing systems and processes across hospitals in the region to improve the flow of information, patients and clinicians.

[5] A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together http://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together

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

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

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

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

These dedicated pieces of work enhance the communication between clinicians as they work together across organisations and care settings to support a smooth transition for their patient between health providers and a mutual understanding of the pathway of care in a shared care environment. The interface between general practices and hospital services was recognised as a major area requiring redesign and key to the development of an integrated health system[6].

Building on this best practice guidance, the pathway development process incorporates national, regional and local guidance. The publishing of a pathway of care allows all health providers in the Midland region to have visibility of the regionally agreed pathway of care. A feedback mechanism is used by clinicians to continually improve the pathways.

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

[6] NZMJ, January 2015, vol, 128, Number 1408, Consensus pathways: evidence into practice,

Pathway priorities for 2018/19 DRAFT

Lead: Dr Damian Tomic

Project Manager: Christine Scott

Sponsor: Midland United Regional Integration Alliance Leadership Team (MURIAL Team)

NOTE: The following work plan is draft and subject to regional agreement and resourcing

Priority	Health Strategy Linkage	Guidance	Measures	Milestone / Dates	Responsibility
Cardiac Services	**Closer to home**	Work regionally and in collaboration with the DHB Shared Services and Regional and National Cardiac Networks to improve cardiac pathways, across primary and secondary service, for patients with: • Acute Coronary Syndrome • Heart Failure • Atrial Fibrillation • Ischaemic Heart Disease. *Refer to **Appendix in Section 4.2:** Cardiac services (Midland Cardiac Clinical Network) work plan initiatives 1, 2, 3 and 7.*	**Cardiology Services** • coronary angiography SIR of at least 34.7 per 10,000 population • percutaneous revascularisation SIR of at least 12.5 per 10,000 population **Cardiac-Thoracic Services** Cardiac Surgery SIR of 6.5 per 10,000 population	Q1 – Q4	Midland Pathways of Care Team / Midland Cardiac Clinical Network
	Value and high Performance	These pathways will support improved access cardiac services including: • improved and more timely access to cardiac services, including to cardiac surgery • patients with a similar level of need receive comparable access to services, regardless of where they live.			
Elective Services	**Value and high Performance**	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:	Clear regional work programme developed and regional progress reporting on the requirements and key actions to be provided via quarterly RSP reports.	Q1 – Q4	Midland Pathways of Care Team / Elective Services Network

Priority	Health Strategy Linkage	Guidance	Measures	Milestone / Dates	Responsibility
		• Vascular • Breast Reconstruction. Ophthalmology: Regional evaluation of models of care being implemented as part of the national Ophthalmology Service Improvement Initiative, including local development of best practice Ophthalmology (Age-Related Macular Degeneration (AMD) and Glaucoma pathways. Regional development of a plan to spread the most effective initiatives more widely across regional DHBs. *Refer to **Appendix in Section 4.3:** Elective services (Elective Services Network) 18-19 work plan.*	<u>Ophthalmology:</u> Regional evaluation of ophthalmology models of care (Q1) Development of regional implementation plan (Q2) Progress against identified implementation plan milestones (Q4)	Q1 Q2 Q4	
	Closer to home	Regions to explore the option of adopting early intervention programmes to support patients in the community prior to their being a need for surgical intervention, for example Mobility Action Programme (MAP). These are patient-focused services to support improved patient outcomes and quality of life for those who do not require surgery but would benefit from early support.	A regional discussion is undertaken around the opportunity to adopt early intervention programmes. Updates to be provided via quarterly RSP reports.	Q1 – Q4	Midland Pathways of Care Team
Cancer Services	Value and high Performance	Regional co-ordination and support of actions to improve cancer systems and services to ensure health gain for Māori and equitable and timely access to cancer services. *Refer to **Appendix in Section 4.1:** Cancer services (Midland Cancer Network) work plan initiative1.*	Progress against deliverables agreed between RCNs and the Ministry in the RCNs Annual Work Plan for 2018/19.	Q1 – Q4	Midland Pathways of Care Team / Midland Cancer Network
Mental Health & Addiction Treatment Services	One team	Outline how: • primary, secondary, and tertiary pathways are being improved • forensic and maternal mental health pathways are being improved • the care of complex clients requiring medium secure rehabilitation is being improved. By: 1. Develop Infant Perinatal Pathways of Care 2. Develop Eating Disorders Pathways of Care 3. Develop Addiction Pathways of Care that includes	Regional progress reporting	Q1 – Q4	Midland Pathways of Care Team / Midland Mental Health & Addictions Network

Priority	Health Strategy Linkage	Guidance	Measures	Milestone / Dates	Responsibility
		SACAT 4. Regional planning workshop to review regional contracts, complex care and primary partnerships. *Refer to **Appendix in Section 4.5:** Mental Health & Addictions (Regional Mental Health & Addictions Network) work plan, initiatives 1, 2, 6.*			
		Outline how the addiction treatment model of care being implemented, particularly with reference to work under the SACAT Act. *Refer to **Appendix in Section 4.5:** Mental Health & Addictions (Regional Mental Health & Addictions Network) work plan, initiative 2: Substance abuse legislation.*			
Stroke Services	Closer to home	Work regionally and in collaboration with the DHB Shared Services and Regional and National Stroke Networks to improve acute and rehabilitation stroke pathways, across primary community and secondary service, for patients with: • Ischaemic Stroke • TIA. *Refer to **Appendix in Section 4.6:** Stroke services (Midland Stroke Network) 18-19 work plan, initiative 2: Reduce incidence of stroke (TIA).*	Regional progress reporting on the requirements and key actions to be provided via quarterly RSP reports	Q1 – Q4	Midland Pathways of Care Team / Midland Stroke Network
Major Trauma transfer and destination processes	Value and high performance	Continue to implement regional destination policies, inter-hospital transfer processes and staging guidelines to transport major trauma patients to hospitals designated to best meet their treatment needs (in collaboration with DHBs, ambulance providers and National Major Trauma Clinical Network). Refer to ***Appendix in Section** Error! Reference source not found.**:** Error! Reference source not found. 18/19 work plan, initiative 1: Improve the delivery of high quality clinical care to trauma patients.*	A 6-monthly (minimum) regional review process of the alignment of actual service delivery for major trauma patients with regional destination policies, inter-hospital transfers and staging guidelines.	Q2 / Q4	Midland Trauma System / Midland Pathways of Care Team

2.2 Regional priorities

Table 5: Alignment of regional priorities with NZ Health Strategy, National SLMs, Midland DHB six regional objectives.

	NZ Health Strategy five strategic themes					National System Level Measures						Midland DHBs six regional objectives					
	People-powered	Closer to home	Value and high performance	One team	Smart system	Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds	Acute hospital bed days per capita	Patient experience of care	Amenable mortality rates	Proportion of babies who live in a smoke-free household at 6wk postnatal	Youth access to and utilisation of youth appropriate health services	Health equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Build the workforce	Improve clinical information systems	Efficiently allocate public health system resources
Hepatitis C – Midland integrated hepatitis C service	Y	Y	Y	Y	Y						Y	Y					
Child health services – Child Health Action Group (CHAG)																	
1: Childhood obesity											Y	Y					
2: Oral health		Y	Y			Y					Y	Y					
3: Regional approach to Child Health System Level Measures			Y	Y		Y				Y		Y		Y			
4: Implementation of a child health assessment tool – Harti Hauora or similar	Y			Y		y		Y		Y		Y	Y	Y			
Radiology services (Midland Radiology Action Group)																	
1: Modality trend analysis of case-mix and volumes for future planning of resource requirements to meet demand			Y		Y			Y							Y		
2: Did Not Arrive (DNA) and Was Not Brought (WNB)	Y	Y	Y			Y			Y			Y	Y	Y			Y
3: 'Image Once, Image Right' – Clinical Access Criteria, Integrated Pathways of Care, Service Delivery Planning, Results Availability	Y	Y	Y	Y	Y			Y	Y			Y	Y	Y		Y	Y
4: National initiatives			Y	Y	Y			Y	Y			Y	Y	Y		Y	Y

2.2.1 Hepatitis C – Midland integrated hepatitis C service

Clinical Chair:	Dr Frank Weilert, Waikato DHB
Project Manager:	Jo de Lisle

The Ministry of Health is working in collaboration with PHARMAC and the regional Hepatitis C coordinators to support the increased uptake of new funded hepatitis C treatments and:

- to increase diagnosis rates, find people lost to follow up, improve patient-related outcomes, and reduce liver-related and extra hepatic morbidity and mortality
- to implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region
- to increase hepatitis C treatment uptake and primary care prescribing

Background:

In 2015/16, DHB regions began implementation of a revised approach to the delivery of hepatitis C services across New Zealand. In 2016-17 a Midland regional project working group was established to develop a regional integrated, primary and secondary clinical pathway of care for people with hepatitis C, and developed a regional mobile service delivery model.

Over the past two years, education and awareness for health professionals and the community about hepatitis C services and treatment has been provided. The focus has been on promoting primary care prescribing and diagnosing those undiagnosed or lost to follow up. A gold standard re-issue of historic laboratory results electronically has occurred within two of the Midland DHB regions to support the lost to follow up group.

In July 2016 PHARMAC commenced funding of direct acting antiviral (DAA) therapy for hepatitis C. Access to these DAAs provided for the first time a treatment that offers a 95 percent cure for the eligible population. From October 2016 all prescribers, including general practitioners, have been able to prescribe new treatments allowing the majority of patients with hepatitis C to be managed in the community.

A Midland region community hepatitis C mobile service based on a regional developed clinical pathway has been implemented across the Midland region. The pathway is being reviewed and transitioned from the Map of Medicine tool into the HealthPathways tool.

As from July 2018 the community mobile service ie Fibroscan and patient education service, for the region is provided by Waikato DHB.

There is a BPAC electronic referral for all GPs to refer into the community mobile service where they will receive an electronic response from the service including Fibroscan result and a suggested management plan.

Actions in 2018-19 are a continuation of activities to support the successful implementation of an integrated hepatitis C assessment and treatment service in Midland. The Midland region will report in Q2 and Q4 on the following key actions, broken down by ethnicity and age bands (by decade) on the following measures.

Actions to support the regional hepatitis C objectives	Milestone/Date	Responsibility
• prioritising hepatitis C as a contributory measure within the System Level Measures Framework • provide quality identification, through testing and diagnosis; assessment; triage;	Q2 / Q4	HealthShare, on behalf of the Midland DHBs

and management, including monitoring, support and education to people with hepatitis C • primarily direct identification towards targeted testing for people who are at increased risk • regularly review and implement the Midland region hepatitis C pathway • extend primary and secondary health care services to provide improved assessment and follow up services for people with hepatitis C, including community based Liver Elastography Scanning • deliver integrated services across primary and secondary care to meet the needs of the Midland Region's population • implement a national and/or regional approach to using lab data to identify people who have been previously diagnosed with possible and active hepatitis C infection but may have been lost to follow up • Regularly update the regional hepatitis C education and awareness plan and ensure activities across DHBs are coordinated with the plan In delivering hepatitis C education and awareness services the Midland Region will: • provide information and support to PHO's to enable general practice teams to provide optimal hepatitis C care and support for the delivery of accessible PHARMAC funded DAA hepatitis C treatment for eligible patients • raise the awareness of, and education on, the hepatitis C virus and risk factors for infection both in high risk groups and general practice teams • promote nationally and locally developed hepatitis C resources and activities within the region • ensure a focus on supporting primary care prescribing of hepatitis C treatment to promote an increase in uptake of treatments in the community • ensure a focus on diagnosing those undiagnosed and at risk of hepatitis C • tailor patient information to the needs of the local populations • provide PHO based GP and nursing training sessions on prescribing and support needed for the new funded hepatitis C treatments • engage with staff working in key stakeholder organisations such as Prisons, Needle Exchange Services and Community Alcohol and Drug Services, Opioid Substitution Treatment providing information and / or on the ground training and education • liaise and share information with secondary care staff on the clinical hepatitis C pathway, appropriate treatment pathways for patients and strengthening links with primary care. Further actions to increase identification/diagnosis in each DHB region will include: • engage with local Māori and Pacific Island communities • engage with immigrants from South East Asia, Eastern Europe, Indian subcontinent and Middle East, at-risk and hard to reach groups including people who inject drugs and prisoners • opportunistic targeted testing at general practice and within the community.		

Measures	Data Collection Process and Source	Milestone/Date
1. Number of people diagnosed with hepatitis C per annum (by age bands and genotype)	Total number of people with a positive HCV PCR test in the DHB region (data from five reference labs provided to DHB regions)	Q2 / Q4
2. Number of HCV patients who have had a Liver Elastography Scan in the last year: (a) new patients (b) follow up.	Total number of hepatitis C Liver Elastography Scans performed annually (data from the delivery of Liver Elastography Scans in primary and secondary care). Note: all Liver Elastography Scans are to be counted irrespective of the device used.	Q2 / Q4
3. Number of people receiving PHARMAC funded antiviral treatment per annum	Total number of people prescribed antiviral treatment who have hepatitis C (data from PHARMAC provided to regional DHBs). Ministry of Health to obtain data (by age, ethnicity and medication type) and provide this to DHB regions via annual reporting in the Regional Services Plans.	Q2 / Q4
4. Monitor and report on progress implementing integrated regional hepatitis C services and education and awareness activities including narrative updates on:	• supporting DHBs to implement integrated services • providing information and support to PHO's to enable general practice teams to provide optimal hepatitis C care • raising community and general practice team awareness of and education on the hepatitis C virus and risk factors for infection • promoting nationally and regionally developed resources and activities • extending primary and secondary care services to provide improved assessment and follow up services for people with hepatitis C, including community based Liver Elastography Scanning • progress on secondary health care support of hepatitis C assessment and increasing treatment and follow up in primary health care	Q1-Q4
Line of sight	Midland DHB Annual Plans	
Work plan key: Refer to Table 5 for regional and national alignments.		

2.2.2 Child health services – Child Health Action Group (CHAG)

Chair:	Dr David Graham (Waikato DHB)
Project Manager:	Anna-Maree Harris
Lead Chief Executive:	Ron Dunham (Lakes DHB)

Context:

Children who receive the right supports from an early age go on to have better health outcomes, better educational achievements, and lifelong learning[7]. Child health in the Midland region has been chosen as a focus area because it has different challenges to the rest of New Zealand in terms of the constitution of the population and the highest levels of poverty and rurality in the country. The Child Health Action Group (CHAG) work plan provides an opportunity to invest in the long term health of our children and future adult population by working together regionally to maximise health gains in a cost effective way and to provide improved equitable outcomes.

A number of the risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression that arise in childhood. Child health, development and wellbeing also have broader effects on educational achievement, violence, crime and unemployment.

CHAG will focus on activities that have a wellness and disease prevention focus for children in the Midland District Health Board (DHB) region. This focus will also include decreasing the acute and chronic burden of disease for children / tamariki.

Planned Outcomes for 18/19:

- Implementation of a childhood assessment tool such as Harti Hauora or similar
- Regional initiatives to support a reduction in childhood obesity and improved oral health
- Targeted approach to reducing inequalities and Ambulatory Sensitive Hospitalisation (ASH) rates
- Regional approach to System Level Measures (SLMs).

Key Objectives:

- Recommend regional options to meet child health care needs in the primary, community and secondary sectors and implement solutions
- Co-ordinate and promote organised systems of care such as childhood assessment tools and processes
- Take a multi pronged approach to improving oral health and reducing sugar-sweetened beverages through supporting the Midland DHBs to utilise the quarterly CHAG data report to monitor and review oral health data and its relationship to ASH and inequalities, supporting a new initiative to improve school oral health, coordinating further analysis of data relating to primary care enrolment and oral health ASH and identifying risk factors for poor oral health to support targeting on an equity basis

[7] Ministry of Health. 2017. *Delivering Better Public Services* Wellington: Ministry of Health.

- Co-ordinate a focus on a common group of SLMs and their contributory measures, for alignment across Midland DHBs
- Raise the profile of regionally-led child health improvement initiatives.

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

- Reduced ASH rates – early enrolment to primary care, immunisations
- Improved oral health engagement and outcomes
- Increased development and utilisation of water/milk only policies
- Co-ordinated regional performance against SLMs.

Line of Sight

- Midland DHB Annual Plans: Section 2 – Delivering on priorities and targets

Work plan key:

Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives.

Refer to **Table 5** for regional and national alignments.

Initiative 1: Childhood obesity		Milestone/Date	Responsibility
1.1	Organise and facilitate opportunities for information sharing on childhood obesity initiatives across the Midland District Health Boards (DHBs), including Public Health Units and relevant stakeholders with alignment to Toi Te Ora's Childhood Obesity Prevention Strategy	Q1	Midland Child Health Action Group
1.2	Identify a regional initiative which may link with oral health and sugar-sweetened beverages	Q2	
1.3	Develop an implementation plan for the agreed regional initiative	Q3	
1.4	Continue to support the development and utilisation of water/milk only policies in Early Childhood Education centres and schools, in conjunction with the DHB Public Health Units and stakeholders. Investigate opportunities for collaboration with the Ministry of Education.	Q1-Q4	
Initiative 2: Oral health *(Equitable Access & Outcomes)*		**Milestone/Date**	**Responsibility**
1.1	Review available oral health quarterly data to identify existing oral health groups across the region, linkages between primary care enrolment and oral health ASH, risk factors for poor oral health and facilitate an opportunity for information sharing to review available oral health data. Initiatives 1 and 2 are closely linked with sugar-sweetened beverages *(equitable access and outcomes)*	Q1	Midland Child Health Action Group
1.2	Identify areas to reduce inequalities by prioritising and aligning with Midland DHBs' Oral Health Services and alignment with System Level Measures *(equitable access and outcomes)*	Q2	
1.3	Provide recommendations for priorities that would improve oral population health across the region to General Managers (GMs) Planning and Funding *(equitable access and outcomes)*	Q2	
1.4	Develop an implementation plan based on agreed priorities between GMs Planning and Funding and CHAG *(equitable access and outcomes)*	Q2-Q3	
1.5	Begin implementation *(equitable access and outcomes)*	Q4	
Initiative 3: Regional approach to Child Health System Level Measures *(Equitable Access & Outcomes)*		**Milestone/Date**	**Responsibility**

1.1	Review all contributory measures and select common measures for an in-depth analysis – e.g. smoking in pregnancy, oral health, Primary Health Organisation enrolment and delayed immunisation. Utilise available data to have a targeted approach to inequalities *(equitable access and outcomes)*	Q1	Midland Child Health Action Group
1.2	Identify existing groups and develop a mechanism for the sharing of information on the selected contributory measures with a focus on a reduction of inequalities *(equitable access and outcomes)*	Q1-Q2	
1.3	Develop a plan for a collaborative approach to achieving SLMs across Midland DHBs *(equitable access and outcomes)*	Q3	
1.4	Implement a plan and begin data monitoring systems in collaboration with Midland DHBs to continue to monitor progress for child health *(equitable access and outcomes).*	Q4	
Initiative 4: Implementation of a child health assessment tool – Harti Hauora, or similar		**Milestone/Date**	**Responsibility**
1.1	Review the 2017/18 stocktake of Harti Hauora or similar tools, currently being used in secondary care	Q1	Midland Child Health Action Group
1.2	Provide a report and summary of commonalities and opportunities for standardisation, for a tool such as Harti Hauora or similar, to be introduced across the Midland region and aligning with similar initiatives in primary care	Q2	
1.3	Agree a regional approach and develop an implementation plan	Q3	
1.4	Begin implementation.	Q4	

2.2.3 Radiology services (Midland Radiology Action Group)

Chair and Clinical Lead:	Dr Roy Buchanan (Bay of Plenty DHB)
Project Manager:	Philippa Edwards
Lead Chief Executive:	Derek Wright (Waikato DHB)

Context:

The Midland Radiology Departments work together through the Midland Radiology Action Group (MRAG) to information share, to implement consistent imaging protocols regional, and to work on service improvement initiatives. Their focus includes equitable and clinically effective access criteria to publically funded imaging, demand-capacity analysis, and horizon scanning. They work to provide high quality, clinically appropriate, timely and culturally safe services. MRAG is also a regional resource for pathways and service change proposals.

MRAG links with the National Radiology Advisory Group (NRAG) which works alongside the Ministry of Health (MOH) and other health agencies including Pharmac, ACC, Health Workforce NZ, and the professional colleges.

New Zealand's District Health Boards (NZ DHBs) face the challenge of new and increasing volumes of work, workforce shortages, and to provide sustainable and affordable services within a financially constrained landscape. As a support service, radiology needs to be able to respond nimbly to these demands, particularly in support of the national priorities and targets. This can be enhanced by radiology being included at the earliest stages of development of clinical pathways and service delivery models. These currently include proposals for:

- Primary Access to Computerised Tomography (CT)for Dementia patients
- Rapid and advanced scanning techniques for stroke patient's
- CT Colonography (CTC) as an alternative to Colonoscopy for some patients
- CT Coronary Angiography (CTCA) as an alternative to a catheterisation laboratory (Cath Lab) procedure

Planned Outcomes for 18/19:

1. Modality trend analysis of case-mix and volumes for future planning of resource requirements
2. Did Not Arrives (DNA) and Was Not Brought (WNB) analysis
3. "Image Once, Image Right" - Clinical Access Criteria, Integrated Pathways of Care, Service Delivery Planning, Results Availability - work with Choosing Wisely, Midland eSPACE, Pathways of Care, and with private radiology practices to create the ideal regional imaging construct
4. Primary Access Criteria Biannual Update – these are a driver for equitable and clinically informed access
5. Reporting on District Health Board (DHB) CT and Magnetic Resonance Imaging (MRI) key performance indicators (KPIs)
6. Providing collaborative advice to clinical services.

Key Objectives
Guided by the NZ Health Strategy Framework and Midland Quality Framework the focus is on wellness of the population, reduced service vulnerability, and improved value to the population through: *People powered* • Cancer Streams/Pathways – improve the value proposition and performance by working closely with the Midland Cancer Network and other services on their referral criteria, required timeframes and pathway development • Work with regional clinical networks and the National Radiology Advisory Group *Closer to Home* • Equitable access criteria, clinically and financially sustainable and delivered close to home • Meet MoH targets and performance objectives *Value and high performance* • Capacity stock takes across the region will identify where current and potential capacity and bottlenecks exist, enabling a regional approach to capital investment • Modality modeling to give visibility to the demand and capacity flows across the Midland region. This information will provide a regional view of potential capacity and bottlenecks, enabling a data informed regional approach to capital investment *One Team* • Clinical best practice will be enabled with the implementation of national access criteria based on clinical need. • Work with Regional Workforce identifying intelligence on current and future workforce requirements for the region • Work with Pathways of Care team *Smart System* • A resource for the regional Information Systems (IS) and Supporting Patients and Clinicians Electronically (e-SPACE) teams on the development of eReferrals, data repositories and links to other radiology provider studies.

Measures: (by ethnicity, locality and deprivation where possible)
1. CT- 95% of accepted referrals from primary care or outpatients for CT scans will receive their scan within six weeks (42 days) 2. CT Colonoscopy (a subset of the CT KPI above) – 95% of accepted referrals from primary care or outpatients for CT Colonoscopy scans will receive their scan within six weeks (42 days) 3. MRI - 90% of accepted referrals from primary care or outpatients for MRI scans will receive their scan within six weeks (42 days) 4. Agreed National Patient Flow system changes are implemented 5. Percentage of patients attending their imaging appointments 6. Trends in Radiology workforce analysis by ethnicity.

Line of Sight
Midland DHB Annual Plans: Section 2 -Delivering on Priorities and Targets: • Waikato- • BOP- • Taranaki- • Lakes Section 5: Performance measures: • All DHBs – PP29 Improved wait times for elective diagnostic services – CT and MRI KPIs • Linkages : NRAG, MOH, Pharmac, HWFNZ, Primary Care providers, Midland Cancer Services.
Work plan key: Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives. Refer to Table 5 for regional and national alignments.

Initiative 1: Modality trend analysis of case-mix and volumes for future planning of resource requirements to meet demand *(Workforce)*	Milestone/Date	Responsibility
The driver for tracking modality usage into the future is to inform future planning through the understanding of trends in volumes and case mix as new clinical demands and priorities emerge. The volumes, case mix and machine time trends will be tracked annually for all modalities to inform resource requirements to respond to national and local for future requirements from emerging clinical models of care and services i.e. Bowel Screening, Coronary CT Scanning etc.		MRAG
1. 1 Collect annual data per modality	Q1 - Q4	
1. 2 Trend modeling per modality	Q3 / Q4	
1. 3 Analysis of DHB caseloads and understanding the variances across the DHBs.	Q3 / Q4	
Initiative 2: Did Not Arrive (DNA) and Was Not Brought (WNB) *(Equitable Access & Outcomes)*	**Milestone/Date**	**Responsibility**
DNAs and WNBs are a problem shared by the Midland DHB Radiology departments and anecdotally appear to have different levels of severity and impact across the different modalities and DHBs. This work will provide an understanding as to what is behind these differences, and create an opportunity to develop and share solutions across the region. Reducing DNAs and WNBs will reduce resource waste and potentially improve population health outcomes. For the radiology department delivering the service there will be an increase in resource 71 utilisation. For patients and referrers there will be an improvement in the imaging turn around times by utilizing more appointments.		MRAG, DHB project teams for past and current DNA pieces of work
Actions:		
2.1 Collect DNA rates by multiple factors including ethnicity, deprivation location to services, availability by phone for appointment text, transport option, wait times to see where problem areas are problem	Q1, Q2, Q3	
2.2 Survey patients who DNA or WNB	Q1, Q2	
2.3 Review of available literature on Radiology DNA from NZ DHBs	Q2	
2.4 Document and implement recommendations.	Q4	
Initiative 3: National Initiatives and Regional Projects and Enablers - Health Literacy and Health Promotion; Pathways of Care; Information Systems and Technology Projects	**Milestone/Date**	**Responsibility**

(Equitable Access & Outcomes, Quality, Clinical leadership, Pathways)		
A. Work with the National Radiology Advisory Group (NRAG) to receive information on emerging services and to provide advice on the impacts and front line requirements of radiology services to achieve implementation of initiatives: 1. Respond to requests from NRAG for front line information and advice 2. Equity of Positron Emission Tomography – Computerised Tomography (PET-CT) 3. Implementation of Oncology Protocols 4. Implement Australasian Emergency Department protocols 5. Adopt the NRAG data portfolio	Q1 / Q3 / Q4	MRAG **Healthshare** eSPACE PoC team
B. Pathways of Care (PoC) **1.** Review of Cardiac pathways in their transition from Map of Medicine to Health Pathways **2.** Assess the PoC and the current practice within DHBs against the Choosing Wisely methodology **3.** Bi-annual update of the Midland Primary Access Criteria to inform up to date equitable, clinically informed minimum levels of access **4.** Provide radiology representation for the implementation of service initiatives and PoC including cancer stream pathways, DHB PoC and Bowel Screening program	Q1-Q4	
C. Regional ICT Projects "Image Once, Image Right" – Work with eSPACE on functionality for areas that impact on radiology or where radiology provide information of services i.e. Clinical Access Criteria, Integrated Pathways of Care, Service Delivery Planning, Results Availability	Q1-Q4	

3. Regional governance, leadership, and decision making

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

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

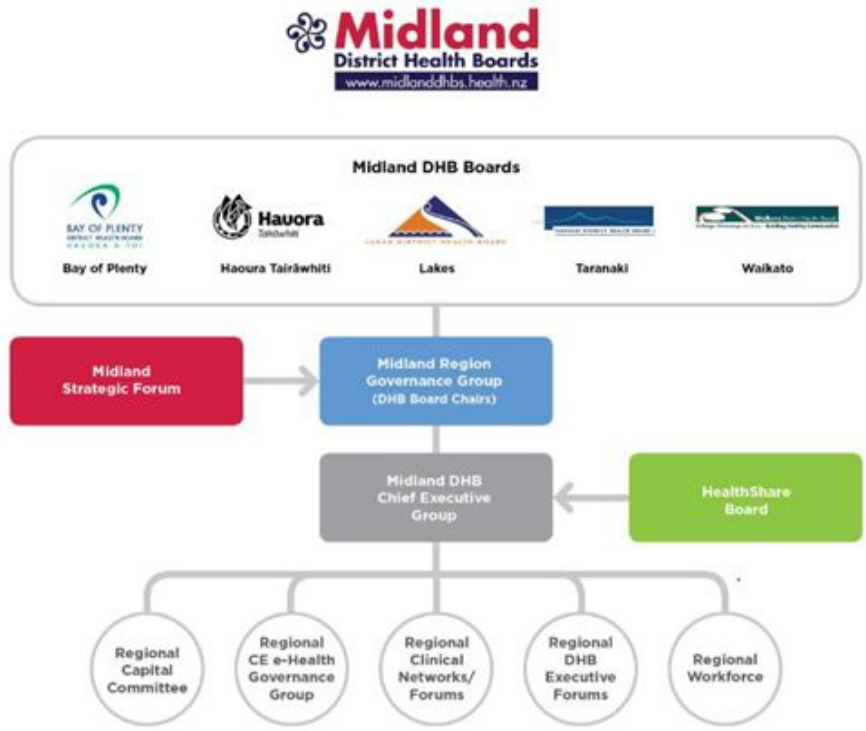
3.1 Regional governance structure

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

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

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

Figure 8: Midland region's governance structure



HealthShare is the Midland DHBs shared services agency and is a limited liability company with the five Midland DHBs holding equal shares. An outline of HealthShare's services can be found on pages 82-86, which includes support for the regional clinical networks/action groups and regional enablers to complete annual work plans. HealthShare submits an annual budget, which includes costs related to the support for regional clinical networks/action groups and Midland's regional enablers. The formal budget approval process requires the agreement of the Midland DHB Chief Financial Officers, and the Midland DHB CEs.

Midland DHBs also support the agreed work plans by releasing staff from their organisations, ie medical, nursing, allied health, public health, management, to attend regional meetings - either face-to-face, or by using teleconferencing and videoconferencing technology. In addition to this 'in kind' resourcing, where there are significant individual DHB contributions and/or lead DHB roles then these are identified in the specific work plans. Where substantial additional financial investment is required, a formal business case process is developed.

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

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

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

(i) Decision making principles for MRGG, MCEG and MSF

The purpose of these principles is to facilitate greater levels of regional co-operation and integration across the Midland DHBs and regional health system. The principles apply to any significant and substantive decision of a Midland DHB that impacts another Midland DHB. The principles apply to the Midland Region Governance Group; Midland DHB CE Group; and Midland Strategic Forum. Any significant decision taken shall:

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

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

(ii) Decision making criteria

The following criteria shall be applied to any decision:

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

(iii) Decision making processes

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

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

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

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

(iv) Code of ethics

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

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

(v) Formation of a regional group

The need for a formal regional group may arise from:

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

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

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

(vi) Regional IS governance

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

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

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

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

(vii)eSPACE governance arrangements

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

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

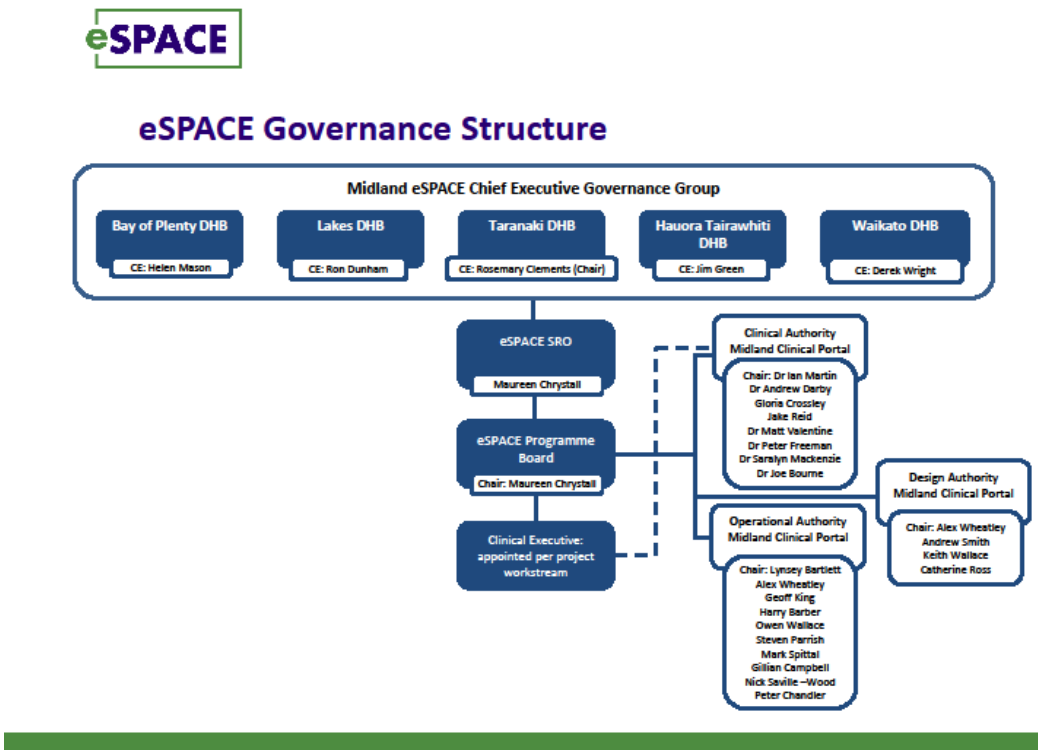
The Senior Responsible Owner (SRO) is accountable for delivery of the programme as delegated by the Midland DHB CEs on the basis of approved business cases. It is the SRO's responsibility to ensure the delivery of all activities within the Programme and realise the projected benefits.

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

The Programme Board is supported by a Clinical Authority, a Design Authority and an Operational Authority. These authorities own and oversee the implementation of the Programme's business and service transformation activities and ensure alignment with national and regional strategies. Programme artefacts pass through these three authorities in accordance with the approved eSPACE Programme RACI.

The Programme management hierarchy is led by the Programme SRO, supported by the Programme Director, the Programme Operations, the Programme Manager, the Technology Director, the Benefits Lead, the Change Manager, the Financial Director and the Programme Board.

Figure 9: Midland eSPACE CEO Governance Group (CEOGG)



(viii) Midland Region ICT Investment portfolio

The Midland region has developed a Midland ICT Investment Portfolio view to support decision making and to maximise the value of sector ICT investment.

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

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

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

(ix) Efficiently allocating public health system resources

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

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

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

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

3.2 Examples of regional collaboration in Midland

(i) Midland District Health Boards – cross appointed board members

District Health Boards have a mixture of appointed and elected board members under the New Zealand Public Health and Disability Act 2000. Cross-appointed Chairs and board members, provide an enhanced regional governance and leadership approach in the Midland region (see **Table 6** below).

Table 6: Midland District Health Boards' cross-appointed board members

Midland DHB	Name / Role	Cross appointment: Position / Board / Committee	Cross appointed to:
Bay of Plenty DHB	**Sally Webb** (Board Chair)	• Acting Chair, Waikato DHB • Member, Hospitals Advisory Committee • Member, Community & Public Health Advisory Committee • Member, Audit & Corporate Risk Management Committee • Member, Sustainability Advisory Committee	Waikato DHB
	Ron Scott (Board Member)	• Member, Hospitals Advisory Committee	Waikato DHB
	Bev Edlin (Committee Chair, Bay of Plenty DHB CPHAC/DSAC)	• Member, Disability Support Advisory Committee • Member, Community & Public Health Advisory Committee	Lakes DHB
	Marion Guy (Board Member)	• Member, Hospital Advisory Committee	Lakes DHB
	Mark Arundel (Committee Chair, BOP DHB Strategic Health Committee)	• Member, Community & Public Health Advisory Committee	Waikato DHB
Lakes DHB	**Lyall Thurston** (Board Member)	• Member, Hospital Advisory Committee	Bay of Plenty DHB
	Janine Horton (Board Member)	• Member, CPHAC/DSAC	Bay of Plenty DHB
Waikato DHB	**Dr Clyde Wade** (Board Member)	• Member, Hospital Advisory Committee	Bay of Plenty DHB
	Mary-Anne Gill (Board Member)	• Member, Strategic Health Committee • Member, CPHAC/DSAC	Bay of Plenty DHB
	Martin Gallagher (Board Member)	• Member, Hospital Advisory Committee	Lakes DHB
	Pippa Mahood (Board Member)	• Member, Disability Support Advisory Committee • Member, Community & Public Health Advisory Committee	Lakes DHB

(ii) Health Partnership Limited

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

(iii) Midland United Regional Integration Alliance Leadership Team (MURIAL Team)

The Midland United Regional Integration Alliance Leadership Team (MURIAL Team) is a regional Alliance Leadership Team (ALT) and is made up of the five DHB CEOs, GMs Planning & Funding (GMs P&F), clinical leaders (as determined), a Population Health and Māori Health Representative, the eight PHO CEOs and PHO clinical leaders (as determined) and the HealthShare CEO. The MURIAL Team's primary objective is:

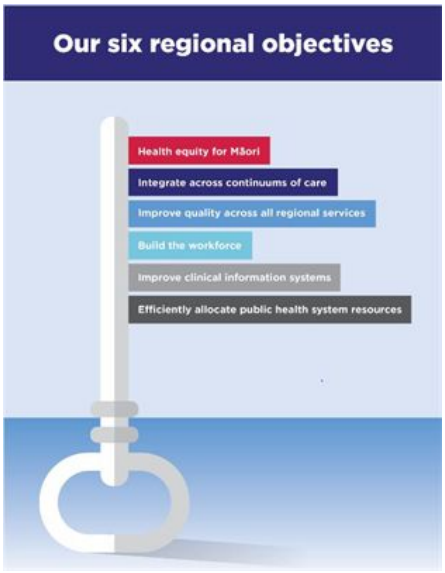
> '*to develop and lead a regional strategic 'whole of system' approach that will contribute to the delivery of better health outcomes through more integrated health services*'.

The specific work streams are defined through an agreed annual work plan. The MURIAL Team have agreed to consistently recognise and align its planning priorities with those identified by national strategic policy directions and the strategic and/or annual plans of its partners. The MURIAL partners have agreed to consistently recognise and actively progress regional activities and initiatives that reflect the New Zealand Health Strategy's Future Direction themes, i.e.:

- People-powered
- Closer to home
- Value and high performance
- One team
- Smart system.

(iv) Midland DHBs' regional groups

There are a variety of Midland DHB groups that meet to collaborate as a region on a regular basis including Nga Toka Hauora (the Midland GMs Māori Health) (regional objective 1), the Regional Quality Managers (regional objective 3), GMs Human Resources (regional objective 4), and the Chief Information Officers (Midland IS Leadership Team) (regional objective 5).



Other important regional DHB leadership groups include:

- Midland Region Governance Group (MRGG)
- Regional GMs Planning and Funding
- Chief Operating Officers forum
- Chief Financial Officers forum
- Midland Region Public Health Network
- Midland Chief Executives Group (MCEG)
- Chief Medical Advisors
- Directors of Nursing
- Directors of Allied Health
- eSPACE Programme Board
- Midland Writers Group

(v) HealthShare Limited

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

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

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

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

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

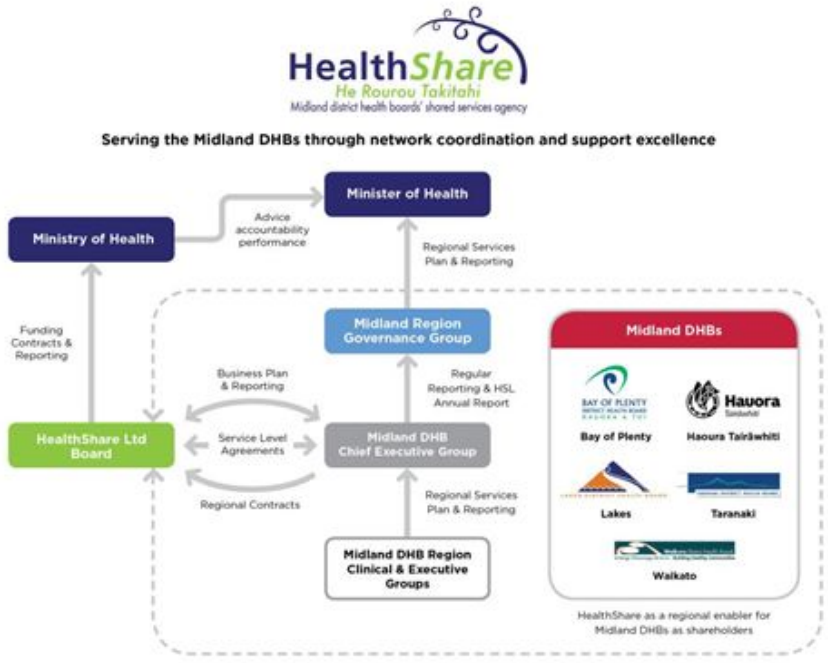
Categories of possible regional service delivery include:

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

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

HSL has multiple planning and reporting relationships within the Midland region and to national agencies as depicted in Figure 10 over page.

Figure 10: Overview of HealthShare Ltd (Midland DHBs' shared services agency)



Refreshed HealthShare vision, mission and values

Vision: *Hei oranga he hapori, kia oranga te whānau*

When communities are well, whānau will thrive

Mission: To support Midland DHBs by working in collaborative partnerships, leading and facilitating change, building a future focused organisation.

Values:

Focus on people	Kia haangai te iwi
Do the right thing well	Whaia te mea tika
Act with integrity	Mana tangata, ngaakau pono
Be courageous	Kia maia, kia manawanui

Regional clinical service development initiatives

Regional clinical service development initiatives are expected to be provided from HSL in 2018-19 through the following groups:

- Regional clinical networks and action groups:
  - Midland Cancer Network
  - Midland Cardiac Clinical Network
  - Child Health Action Group
  - Elective Services Network
  - Health of Older People Action Group
  - Midland Mental Health & Addictions Network
  - Midland Radiology Action Group
  - Midland Stroke Network
  - Midland Trauma System[8]

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

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

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

(vi) Third Party Provider Audit & Assurance Service

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

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

- Personal health
- Mental health services
- Health of older people
- Disability support services
- Māori and Pacific health services.

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

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

Audit & Assurance Service activities for 2018/19

Lead: Ajit Arulambalam, Manager, Audit & Assurance, Director DAA

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

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

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

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

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

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

- compliance and assurance
- corporate and social responsibility
- ethics and business conduct
- fraud
- information technology effectiveness
- operational /clinical effectiveness
- project risk
- quality and performance improvement
- security and technology.

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

Regional Internal Audit Service activities for 2018/19

Lead: Ian Cowley, Regional Internal Audit Manager

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

4. Appendix: Initiatives and activities of regional clinical networks and action groups

Table 7: Initiatives and activities of regional clinical networks and action groups - alignment with NZ Health Strategy, National SLMs, Midland DHB six regional objectives

	NZ Health Strategy five strategic themes					National System Level Measures						Midland DHBs six regional objectives					
	People-powered	Closer to home	Value and high performance	One team	Smart system	Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds	Acute hospital bed days per capita	Patient experience of care	Amenable mortality rates	Proportion of babies who live in a smoke-free household at 6wk postnatal	Youth access to and utilisation of youth appropriate health services	Health equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Build the workforce	Improve clinical information systems	Efficiently allocate public health system resources
Initiatives and activities of regional clinical networks and action groups																	
Cancer services (Midland Cancer Network)																	
1: Equity of access, timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway			Y	Y	Y		Y		Y			Y	Y	Y	Y	Y	
2: Improved access to colonoscopy/endoscopy services			Y						Y				Y	Y			
3: Midland bowel screening regional centre (BSRC)			Y	Y	Y				Y			Y	Y	Y	Y	Y	
4: National lead for the Māori bowel screening network			Y	Y					Y			Y		Y			
5: Improve palliative care services			Y	Y					Y			Y		Y			
6: National lead for the lung cancer work programme			Y	Y	Y				Y			Y	Y				Y
Cardiac services (Midland Cardiac Clinical Network)																	
1: Ischaemic heart disease	Y	Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y	Y	Y
2: Heart failure (HF)	Y	Y	Y	Y			Y	Y	Y			Y	Y	Y	Y	Y	Y
3: Atrial fibrillation (AF)	Y	Y		Y			Y		Y			Y	Y	Y			Y
4: Cardiac Surgery Patient Access	Y		Y	Y			Y		y			Y	Y	Y			Y
5: Maori health equity: Cultural assessment audit of cardiology and cardiac surgery services	Y	Y	Y	Y				Y	Y			Y	Y	Y	Y		
6: Service planning and workforce	Y		Y	Y				Y	Y			Y	Y	Y			Y
7: National initiatives and regional projects	Y	Y	Y	Y	Y			Y				Y	Y	Y		Y	Y
Elective services (Elective Services Network)																	
1: Vascular services																	
2: Breast reconstruction services																	
3: Ophthalmology																	

	NZ Health Strategy five strategic themes					National System Level Measures						Midland DHBs six regional objectives					
	People-powered	Closer to home	Value and high performance	One team	Smart system	Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds	Acute hospital bed days per capita	Patient experience of care	Amenable mortality rates	Proportion of babies who live in a smoke-free household at 6wk postnatal	Youth access to and utilisation of youth appropriate health services	Health equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Build the workforce	Improve clinical information systems	Efficiently allocate public health system resources
Healthy ageing (Health of Older People Working Group)																	
1: Managing acute demand and patient flow across the continuum		Y	Y	Y			Y					Y	Y	Y			
2: Dementia	Y			Y			Y	Y					Y				
3: InterRAI			Y		Y		Y		Y			Y		Y		Y	Y
4: Advance Care Planning (ACP)	Y	Y		Y	Y		Y	Y					Y	Y			
Mental Health & Addictions (Regional Mental Health & Addictions Network)																	
1: Midland eating disorders model of care		Y							Y		Y		Y		Y		
2: Substance abuse legislation		Y		Y				Y				Y	Y		Y		Y
3: National mental health & addiction inquiry	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
4: MH&A clinical workstation			Y		Y			Y					Y			Y	Y
5: Health equity for Māori	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	
6: Midland Infant Perinatal Clinical Network		Y		Y		Y		Y	Y			Y	Y		Y		
7: Workforce capacity and capability	Y		Y	Y	Y			Y				Y	Y	Y	Y	Y	Y
8: Data management			Y	Y	Y							Y	Y	Y		Y	Y
Stroke service (Midland Stroke Network)																	
1: Rehabilitation		Y		Y			Y	Y				Y	Y	Y			Y
2: Reducing incidence of stroke – Transient Ischemic Attack (TIA)		Y	Y				Y		Y				Y	Y			
3: Acute services		Y	Y	Y	Y		Y	Y				Y		Y			Y
4: Clinical leadership				Y			Y						Y		Y		Y
5: Patient experience of care				Y				Y				Y	Y	Y			
Trauma services (Midland Trauma System – MTS)																	
1: Improve the delivery of high quality clinical care to trauma patients		Y	Y				Y	Y	Y				Y	Y			
2: Develop, implement and maintain regional trauma system infrastructure including information systems			Y		Y							Y				Y	Y
3: Support injury prevention and awareness	Y			Y					Y		Y	Y					
4: Establish a Trauma Quality Improvement Program (TQIP) to enable evidence-based change	Y		Y					Y	Y					Y			

4.1 Cancer services (Midland Cancer Network)

Midland Cancer Network Executive Group Chair:	Dr Humphrey Pullon (Waikato DHB)
Programme Manager:	Jan Smith
Lead Chief Executive:	Derek Wright (Waikato DHB)

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

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

- the New Zealand Cancer Plan better, faster cancer care 2015-2018 to improve: equity of access to cancer services; timeliness of services across the whole cancer pathway; and the quality of cancer services delivered
- National Cancer Health Information Strategy
- National Bowel, Breast and Cervical Screening Programmes
- National Adult Palliative Care Service Review and Action Plan (2017).

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

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

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

The Midland strategic framework for action takes a total continuum of care approach for the Midland population from prevention and early detection – screening – diagnosis and treatment – follow-up and surveillance – survivorship – palliative care and last days of life. 2018/19 plan aims to build and strengthen the alignment and linkages of the various Midland health services related to the cancer continuum. This is demonstrated in the Line of Sight Section (refer over page).

Planned outcomes for 2018/19

Midland DHBs as partners of the Midland Cancer Network will continue to implement the Midland Cancer Strategy Plan 2015-2020 for the following key work programmes:

- Implement the Faster Cancer Treatment (FCT) work programme
- Improve the access and timeliness to colonoscopy/endoscopy services
- Support implementation of the National Bowel Screening Programme (NBSP) through the Midland Bowel Screening Regional Centre (BSRC)
- Facilitate the National Bowel Screening Māori Network
- Improve Midland palliative care services, including development of a regional workforce plan
- Facilitate the National Lung Cancer Working Group and work programme.

Measures: (by ethnicity, locality and deprivation where possible)
Faster Cancer Treatment (FCT) Health Target and indicator: 90% of Midland DHB patients referred with a high suspicion of cancer and a need to be seen within two weeks have their first treatment (or other management) within 62 days (Cancer Health Target). 85% of Midland DHB patients with a confirmed diagnosis of cancer receive their first treatment (or other management) within 31 days of decision-to-treat (policy priority 30). Colonoscopy (policy priority 29): • 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days • 70% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days • Surveillance colonoscopy – 70% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days. Note: ( ) demonstrate alignment with regional enablers.

Line of Sight		
• DHB Annual Plans: Please see BOP, Lakes, Waikato, Tairāwhiti sections for faster cancer treatment, all five DHBs for bowel screening • RSP: Please see section improving 2.7 radiology services wait times for diagnostic CT & MRI and Radiology Oncology Stream Pathways, Map of Medicine pathways of care, and objective 2 regional hepatitis C service		
Work plan key: Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives. Refer to **Table 7** for regional and national alignments.		
Initiative 1: Equity of access, timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway *(Equitable Access & Outcomes; Pathways; Workforce; Clinical Leadership)*	**Milestone/Date**	**Responsibility**
Enable equity of access and timely diagnosis and treatment services for all patients on the FCT pathway (e.g. system/service improvements to minimise breaches of the 62 day FCT for patient or clinical consideration reasons): 1. 1 Coordinate the MCN Executive Group and tumour service work groups – Midland lung, breast supra-regional gynae-oncology *(clinical leadership)* 1. 2 Support DHBs to sustain the FCT Health Target reporting by DHB, by ethnicity, equity, tumour, first treatment, breach reason *(equitable access & outcomes)* 1. 3 Support Waikato (August 2018) and Tairāwhiti DHBs (tbc) with Ministry cancer team FCT visits 1. 4 Support DHBs to implement the Midland FCT breach/delay code guidance and reporting template to drive service improvement 1. 5 Implement roll out of the Lakes FCT KPI report to all other Midland DHBs 1. 6 Continue to develop web-based reports (registrations, mortality, service purchase units, PET-CT) 1. 7 Continue development of the Midland DHB lung and colorectal cancer dashboard reports 1. 8 Continue to support Midland and Auckland DHBs/Starship to improve the pathway and formalise a service change to the AYA Acute Lymphoblastic	Achievement of the FCT Health Target and indicator Quarterly progress reporting against the MCN Annual Work Plan 2018/19 deliverables agreed with Ministry	Midland Cancer Network Midland DHBs Midland Pathways of Care Team Regional Workforce

	Leukaemia (ALL) pathway *(equitable access & outcomes)*		
1. 9	Continue to support DHBs to implement the Midland MDM Action Plan 2018 *(equitable access & outcomes)*		
1. 10	Continue to support Midland DHBs with the regional psychological and social support initiative		
1. 11	Support Midland to transition the Cancer Nurse Coordinator Initiative (CNCI) to business as usual *(equitable access and outcomes)*		
1. 12	Support the Lakes/Waikato medical oncology, chemotherapy, haematology model of service improvement		
1. 13	Support the Health Pathways transition and development for lung cancer, bowel screening, colorectal, gynae-oncology, and prostate cancer pathways and e-referrals *(pathways)*		
1. 14	Facilitate regional sarcoma MDM improvement project in partnership with NCN DHBs		
1. 15	Participate in 2018 HWNZ Fund initiative through submission of regional/local ROI's and implement as required (refer to workforce priorities)		
1. 16	Facilitate the Midland breaking bad news improvement project *(workforce)*		
1. 17	Support the Ministry as required with the development of a Cancer Strategy Plan and work programme.		
Regional coordination and support of quality improvement initiatives to achieve health gain for Māori and equitable and timely access to cancer services:			Midland Cancer Network Midland DHBs Midland Cancer Society's Māori Health Providers
1. 18	Coordinate the Midland Hei pa Harakeke Work Group (Māori cancer leadership group)		
1. 19	Support the delivery of one Kia Ora E Te Iwi community health literacy programme per DHB		
1. 20	Continue development of Midland cancer KPI dashboards and FCT equity based reporting		
1. 21	Support the Midland Reducing Delay and Increasing Access to Early Diagnosis for Colorectal Cancer HRC three year research initiative *(equitable access & outcomes)*		
1. 22	Support the Midland Improving Early Access to Lung Cancer Diagnosis for Māori and Rural Communities HRC three year research initiative *(equitable access & outcomes)*		
1. 23	Facilitate the regional implementation of the National Early Detection of Lung Cancer Guidance (2017) to improve outcomes for Māori and Midland population *(equitable access & outcomes)*		
1. 24	Support Waikato DHB Early Detection of Lung Cancer proof of concept project (alignment to Midland routes to cancer diagnosis and treatment project recommendations *(equitable access & outcomes)*		
Promote and facilitate to build health literacy practice among health workforce:			
1. 25	Facilitate a Midland cancer health literacy symposium		
1. 26	Implementation of the Midland health literacy tool for earlier detection - Midland Cancer Korero booklet		
1. 27	Support the region to investigate causes of radiation oncology variation in treatment and assist providers to reduce unwarranted variation when required (as set out in the *Radiation Oncology National Plan 2017-2021*) *(equitable access & outcomes)*	Progress to address unwanted variation in radiation oncology treatment as advised in quarterly reports	Ministry / ROAG Midland DHBs / radiation oncology providers
Ensure the application and integration of the prostate cancer decision support tool as business as usual for all general practitioners in the region and coordinate activity to			

make improvements in the quality of referral pathway into specialist services, including the quality of information provided with referrals: 1. 28 Ensure all Midland stakeholders are aware and have access to the national tool 1. 29 Consult with regional stakeholders to understand what is required to support quality referrals – note resource dependant 1. 30 Explore the feasibility of developing a Midland e-referral and pathway – note resource dependant *(pathways)*		
Support and coordinate DHB activity to improve the quality of life for people who have completed cancer treatment to live well: 1. 31 Support Midland DHBs to implement the National Lung Cancer Follow-up and Supportive Care Guidance 1. 32 Support Midland DHBs to implement the Midland Colorectal Cancer booklet on follow-up after treatment		
Regional coordination and support for the delivery of nationally consistent systems across DHBs to inform quality improvements that ensure health gain for Māori and equitable and timely access to cancer services: 1. 33 Regional coordination and support for DHBs alignment of their digital systems to collect and report consistent, accessible and accurate cancer data (IT) 1. 34 Continue development of the Midland Regional Multi-Specialty Clinical Pathway System business case (IT). If approved implement as required for Midland lung and colorectal cancer 1. 35 Continue development of the Midland MDM Management Solution business case (IT) with options and partnering with regional IS and eSPACE roadmap to ensure alignment in outcomes 1. 36 Commence scoping of regional chemotherapy prescribing requirements and alignment with eSPACE and/or regional IS work programmes (note resource dependant) (IT) 1. 37 Implement roll out of the Lakes FCT KPI report to all other Midland DHBs 1. 38 Continue to develop regional web-based reports (registrations, mortality, service purchase units, PET-CT) 1. 39 Continue development of the Midland DHB lung and colorectal cancer dashboard reports 1. 40 Support Midland DHBs with local ProVation reporting requirements (with regional consistency) to support the National Bowel Screening Programme (NBSP) quality and equity standards 1. 41 Support Midland DHBs with ProVation version updates as required to support the NBSP 1. 42 Support Midland DHBs with the NBSP implementation of the National Screening Solution when available, including transition of Lakes DHB	Progress the implementation of the Cancer Health Information Strategy and NBSP and as advised in quarterly reports	Midland Cancer Network, BSRC Midland DHBs Regional IS, eSPACE Midland CIOs Ministry CHIS team
Initiative 2: Improved access to colonoscopy /endoscopy services *(Equitable Access & Outcomes; Technology & Digital Services)*	**Milestone/Date**	**Responsibility**
2. 1 Support Midland DHBs to achieve the colonoscopy wait time indicators (by DHB, ethnicity, equity) by 31 Dec 2018 2. 2 Continue to develop and refine Midland colonoscopy demand & capacity production plan 2. 3 Continue to develop the Midland colonoscopy/colorectal cancer indicator dashboard	Progress on Midland DHBs achievement of the colonoscopy wait time indicators as advised in quarterly progress reporting	BSRC / Midland DHBs

Initiative 3: Midland bowel screening regional centre (BSRC) *(Equitable Access & Outcomes ; Technology & Digital Services; Clinical Leadership; Workforce)*		Milestone/Date	Responsibility
3. 1	Support DHBs to plan and get ready for bowel screening rollout	Lakes go live Sept 2018 Establishment day - Aug 2018 Tairāwhiti phase 1 - Feb 2019 Tairāwhiti phase 2 – June 2020	Midland BSRC / NBSP Lakes DHB NBSP /Midland BSRC / TDHB Tairāwhiti DHB
3. 2	Provide clinical leadership and support *(clinical leadership)*		
3. 3	Support Lakes DHB to go live and implement their local bowel screening programme		
3. 4	Coordinate Ministry and Tairāwhiti bowel screening establishment workshop		
3. 5	Support Tairāwhiti DHB to meet phase 1 requirements for go live in 2019/20		
3. 6	Support Tairāwhiti i to meet phase 2 requirements for go live in 2019/20 (TBC)		
3. 7	Coordinate the Midland BSRC governance groups *(clinical leadership)*	Quarterly progress reporting Midland BSRC Equity Plan Midland BSRC Quality Plan Identified DHBs to implement NBSP Solution and supply resources for each go-live All Midland DHBs will operate on the same version of the clinical endoscopy system (ProVation)	Midland BSRC Midland DHBs
3. 8	Midland BSRC equity plan continues development during NBSP roll out to assist, support and provide guidance to each Midland DHB when they are developing local DHB bowel screening equity plans.		
3. 9	Facilitate overview of performance of the Midland DHBs against the NBSP quality standards and provide support where there are opportunities of improvement.		
3. 10	Collaboratively develop Midland bowel screening colonoscopy e-referral, commencing with Lakes DHB (Pathways) and support its local implementation		
3. 11	Pilot and evaluate Midland bowel screening navigator role *(workforce)*		
3. 12	Facilitate ProVation version updates as required to support the National Bowel Screening Programme		
3. 13	Support Midland DHBs with local ProVation reporting requirements (with regional consistency) to support the National Bowel Screening Programme (NBSP) quality and equity standards		
3. 14	Support Midland DHBs with the NBSP implementation of the National Screening IT Solution when available, including transition of Lakes DHB		
Initiative 4: National lead for the Māori bowel screening network *(Technology & Digital Services)*		**Milestone/Date**	**Responsibility**
4. 1	Facilitate an annual hui and quarterly teleconferences to facilitate and promote engagement of those working for Māori equity in the NBSP	Annual bowel screening Māori hui held Six monthly progress reports to NBSP	Midland BSRC
4. 2	Facilitate quarterly teleconferences with each regional BSRC		
4. 3	Provide feedback to the Ministry about quality improvements to increase participation in the programme for Māori communities to increase equity in the NBSP		
4. 4	Participate in the National Pacifica bowel screening network.		
Initiative 5: Improve palliative care services *(Equitable Access & Outcomes; Clinical Leadership; Pathways TBC; Workforce)*		**Milestone/Date**	**Responsibility**
5. 1	Coordinate the Midland Palliative Care Work Group and support local DHB work groups as required *(clinical leadership)*	Progress reporting on the requirements and key actions via quarterly RSP reports	Midland palliative care work group Midland DHBs Midland Hospices Midland Cancer Network Midland Health Pathways Regional workforce
5. 2	Continue development and implement Midland palliative care clinical guidelines (clinical leadership)		
5. 3	Support implementation of Te Ara Whakapiri *(clinical leadership)*		
5. 4	Continue to support implementation of the *Midland Medical Advanced Palliative Care Trainee Model of Service 2015-2018 (clinical leadership)*		
5. 5	Continue to support implementation of *Waikato Palliative Care Strategy Plan 2016-2021*		
5. 6	Continue development of the Lakes Palliative Care Strategy Plan		

5. 7 Support implementation of BOP Palliative Care services review recommendations (tbc) 5. 8 Facilitate development of Health Pathways *(Pathways to be confirmed)* 5. 9 To facilitate the development of a Midland palliative care workforce plan (workforce) note: dependant on resourcing yet to be confirmed 5. 10 Participate in 2018 HWNZ Fund initiative through submission of regional/local ROI's and implement as required *(refer to workforce priorities).*		
Initiative 6: National lead for the lung cancer work programme *(Clinical Leadership; Technology & Digital Services)*	**Milestone/Date**	**Responsibility**
Midland Cancer Network is working in partnership with the Ministry of Health Cancer team to finalise the national lung cancer work programme for 2018/19 on initiatives to: 6.1 Coordinate the National Lung Cancer Working Group and sub group meetings *(clinical leadership)* 6.2 Continue to implement and evaluate the national Early Detection of Lung Cancer Guidance	National EDLC resources developed and made available	National Lung Cancer Working Group Ministry of Health Cancer & CHIS teams Midland Cancer Network
6.3 Facilitate guidance for implementation of the national lung cancer follow-up and supportive care guidance	National lung cancer follow-up and supportive care guidance finalised	
6.4 Review and update the national lung cancer quality performance indicators *(IT)* 6.5 Develop nationally consistent information to be collated at lung cancer multidisciplinary meetings (MDM) aligning with National CHIS *(IT)*	National lung cancer quality performance indicators developed, including minimum MDM lung cancer dataset.	

4.2 Cardiac services (Midland Cardiac Clinical Network)

Chair:	Dr Jonathan Tisch (Bay of Plenty DHB)
Project Manager:	Philippa Edwards
Lead Chief Executive:	Derek Wright (Waikato DHB)

Context:

The Midland Cardiac Clinical Network (MCCN) works with a regionally collective clinically informed approach that is service improvement focused. Representation includes the five District Health Boards (DHBs) Cardiology Services and Waikato DHBs Cardio-thoracic Surgical Service.

MCCN's vision is a population with well managed risk factors and timely access to appropriate prevention and intervention leading to improved health outcomes with no inequality by ethnicity or residential location.

Cardiovascular disease (CVD) is a leading cause of death in New Zealand. The three significant categories of cardiovascular disease are arrhythmia, heart failure and coronary artery disease with arrhythmia being the leading cause of cardiac admissions, followed by heart failure then ischemic heart disease.

The key foci detailed in the work programme are:

- Ischeamic Heart Disease (IHD)
- Heart Failure (HF)
- Atrial Fibrillation (AF)
- Cardiac Surgery
- Māori Health Equity
- Regional projects and enablers.

Planned Outcomes for 18/19:

1. **Quarterly communication of key actions and Key Performance Indicators (KPIs) at regional and DHB level** utilising the ANZACS-QI and Cardiac Surgery registers to streamline reporting and prevent duplication of effort; the local DHB actions can be reported quarterly by way of consolidated regional report, submitted on behalf of the DHBs if all regional parties have agreed to this, by way of the quarterly reporting template.
2. Achieve the Ministry of Health Acute Coronary Syndrome (ACS) and Elective Services Performance Indicators (**ESPI), Standarised Intervention Rates (SIR) and target Key Performance Indicators (KPIs)**
3. **Achieve or exceed equity for Māori** in SIR rates for Cardiac Surgery, Angiography and Revascularisation
4. Identify gaps in the Midland Cardiac Services against the **NZ National Expected Clinical Standards**
5. Embed the region wide catheter lab **(Cath lab) production planning** process for integrated acute and elective planning
6. **Pathways of Care review and transition** to Health Pathways from Map of Medicine for cardiac conditions i.e. STEMI, ACS Accelerated Chest Pain Pathway (ACPP), HF, AF
7. **Review the Accelerated Chest Pain Pathways (ACPPs)** in Emergency Departments
8. Inform and support regional **Information System e-SPACE** initiatives
9. Clearly identify current demand for **cardiac physiology services** and the regional ability to meet these
10. Support the development and implementation of **a workforce plan** to ensure that training, recruitment, retention and other relevant workforce issues are addressed to sufficiently support all pathways to cardiac services, including to cardiac surgery.

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

RSP Measures that will be reported quarterly:

The regional measures for cardiac services are also national indicators for DHBs. Measures will be monitored for the Māori population comparative to the non-Māori population, and by rurality where possible.

Cardiology Services

1. Acute- 70% of high risk patients receive an angiogram within three days of admission
2. Acute - >= 85% of ACS patients who undergo coronary angiogram will have pre-discharge assessment of Left Ventricular Ejection Fraction (LVEF)
3. Acute – Composite Post ACS Secondary Prevention Medication Indicator – in the absence of a contraindication all ACS patients who undergo and angiogram should be prescribed at discharge aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5-classes)
4. Acute – over 95% of patients presenting with ACS who undergo coronary angiography to have completion of ANZACSQI ACS and Cath/PCI Registry data collection within 30 days and 99% within 3 months
5. Elective + Acute -SIR coronary angiography of at least 34.7 per 10,000 population
6. Elective + Acute - SIR percutaneous revascularization of at least 12.5 per 10,000 population

Cardiac-Thoracic Surgical Services

7. Elective + Acute - SIR of 6.5 per 10,000 populations.

Primary Health Organisation (PHO) and DHB measures that will be tracked and benchmarked by DHBs regionally:

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

8. Monitor the % of patients identified as having CVDRA risk >15% who are on recall/ follow up by General Practitioner and have management as per clinical guidelines
9. % of eligible population having CVDRA
   Indicator 1: 90% of the eligible population will have had their cardiovascular risk assessed in the last five years
   Indicator 2: 90% of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the last 5 years.

Cardiology Services (DHBs report these measures to the MoH)

10. Elective - Patients to wait no longer than four months for a Cardiology FSA for Māori and non Māori
11. Elective – 95% of accepted referrals for elective coronary angiography with receive their procedure within three months (90 days) Coronary Angiogram for Māori and non Māori
12. Elective - Echocardiography, halter, device implantation and exercise tests to be completed within four months of request being submitted.

Cardiac-Thoracic Services (Waikato Hospital reports these measures to the MoH via an on line portal)

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

Line of Sight		
DHB Annual Plans: Section 2.1 - Health Equity in DHB Annual Plans: Section 4.2 - Building Capability Section 4.3 - Workforce, Health Literacy and IT Section 5: 18/19 Performance measures: All DHBs – Focus areas 3, 4, PP20 Management of long term conditions and PP29 Improved wait times for elective Dx services; SI4 SIR rates for Angiogram, PCI and Cardiac Surgery; ESPI compliance. **Linkages:** New Zealand Cardiac Network (NZCN), Heart Foundation, New Zealand Cardiac Society (NZCS), MOH, Pharmac		
Work plan key: Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives. Refer to **Table 7** for regional and national alignments.		
Initiative 1: Ischaemic heart disease *(Equitable Access and Outcomes, Quality, Clinical leadership, Pathways)*	**Milestone/ Date**	**Responsibility**
Output / Deliverables 1. **National Expected Standards –** Gap analysis and recommendations against **the** National Expected Standards	Q1-Q4	Midland Cardiac Clinical Network Project Manager
2. **Acute Coronary Syndrome (ACS) -** ACS forecasting and integrated planning with elective volumes for optimum utilisation of the Midland Cath Lab capacity. Embed the regionally integrated planning as business as usual across the five Midland DHB Cardiac Services. Continue to identify and address opportunities for service improvements	Q1-Q4	
3. **STEMI -** develop Pathways of Care across the continuum for STEMI	Q1-Q4	
4. **Primary Prevention** - understand the barriers to Cardiology FSA and provide recommendations to mitigate these, develop a mechanism to count, code and track cardiac attendances to OP clinics	Q4	
5. **Secondary Prevention and Rehabilitation** – Discharge medications and adherence will be tracked with data from Pharms	Q4	
6. **Pathways of Care** 1. Review and transition from Map of Medicine to Health Pathways 2. Review the Accelerated Cardiac Patient Pathways (ACPP) that were implemented in 2016 at each DHB	Q3-Q4	
Initiative 2: Heart failure (HF) *(Equitable Access and Outcomes, Quality, Clinical leadership, Pathways)*	**Milestone/ Date**	**Responsibility**
Timely treatment for HF has been proven to be effective for health outcomes at all ages. It allows people to return to almost fully functioning in day to day life. The goal is to have patients with heart failure optimally managed across the continuum, and so reduce acute admissions and disability. This care is to be delivered closer to home where practicable. **Output / Deliverables**		Midland Cardiac Clinical Network Project Manager
1. Pathway of Care for delivery of HF care in Primary setting – consider Primary Care Options	Q2	
2. Population of the HF ANZACS- QI Register	Q3	
3. Provide a report on how heart failure services will ideally be delivered across the five Midland DHBs to improve outcomes for the worst affected groups now identified as Māori, low deprivation, male, ages 40–65.	Q4	

Initiative 3: Atrial fibrillation (AF) *(Equitable Access and Outcomes, Quality, Clinical leadership, Pathways)*	Milestone/Date	Responsibility
The goal is that patients with atrial fibrillation are optimally managed across the continuum, so reducing the occurrence of acute admissions and disability. This care is to be delivered closer to home where practicable with a focus on: • Risk assessment and prevention of stroke • Timely access to diagnosis and treatment - as per expected standards **Output / Deliverables** 1. Undertake a stock take of services and pathways to access these 2. Provide a report on how atrial fibrillation services would ideally be delivered across the five Midland DHBs Some resourcing for Atrial Fibrillation medications and increased access to echo and ablation services, and for the device data base in ANZACSQI will be required for this initiative to be successful.	 Q1 Q4	Midland Cardiac Clinical Network Project Manager
Initiative 4: Cardiac surgery patient access *(Equitable Access and Outcomes, Quality, Clinical leadership, Pathways)*	**Milestone/Date**	**Responsibility**
Explore the current access pathway and acute presentations to determine unmet need and how much demand will occur from an improved pathway. **Output / Deliverables** 1. Outreach clinics 2. Revised Pathways of Care Resourcing for increased volumes of Cardiac Surgery required to achieve SIRs.	 Q4 Q4	Midland Cardiac Clinical Network Project Manager
Initiative 5: Māori health equity : Cultural assessment audit of cardiology and cardiac surgery services *(Equitable Access and Outcomes, Quality, Clinical leadership, Workforce)*	**Milestone/Date**	**Responsibility**
Cultural awareness training for clinical staff to enhance holistic service delivery for Māori. As clinical services work to serve people with the highest health needs, the cardiac services want to understand and address any barriers that exist, to improving the health of Māori attending their services. 1. Participate in the development or service design to enhance services for Māori into mainstream cardiac services 2. Look at previous findings of assessment tools to identify areas where the regional cardiac patient journey that could be improved	 Q4 Q1-Q4	Midland Cardiac Clinical Network Project Manager
Initiative 6: Service planning and workforce *(Workforce)*	**Milestone/Date**	**Responsibility**
1. Work regionally and in collaboration with the DHB Shared Services and Regional and National Cardiac Networks to: • Identify current demand for and access to cardiac physiology services and the regional ability to meet these demands. • Support the development and implementation by Regional HR of a workforce plan to ensure that training, recruitment, retention and other relevant workforce issues are addressed to sufficiently support all pathways to cardiac services, including to cardiac surgery *Financial Resource will be required by DHBs to achieve improvement of workforce shortages.* **2.** Write an updated regional service plan for Cardiology and Cardiac Surgery that depicts forecast demand, plans for capacity and plans to address identified expected service gaps	 Q1-Q4 Q4 Q1-Q4	Midland Cardiac Clinical Network Project Manager / Regional Director of Workforce Development

Initiative 7: National initiatives and regional projects *(Equitable Access and Outcomes, Workforce, Technical and Digital Services, Quality, Pathways)*	Milestone/ Date	Responsibility
A. Pathways of Care Review of Cardiac pathways in the transition from Map of Medicine to Health Pathways	Q4	Midland Cardiac Clinical Network Project Manager / Information Services / eSPACE / Pathways of Care team
B. Regional IS/IT Projects 1. Support the National Patient Flow (NPF) data collection and regional planning by developing an outpatient coding system across the five DHBs	Q1-Q4	
2. eSPACE service transformation	Q1-Q4	
3. Design a regional ACS Whiteboard Live Management Tool.		

4.3 Elective services (Elective Services Network)

Clinical Lead:	Dr Martin Thomas (Lakes DHB) (TBC)
Project Manager:	Jocelyn Carr
COO Lead:	Gillian Campbell
Lead Chief Executive:	Rosemary Clements (Taranaki DHB)

Context

A review of the regional electives project has been undertaken to ensure both the structure supporting the project, and the process to agree regional initiatives, deliver maximum value to the region. The outcome of the review is that the governance of the project has been devolved to the Midland Chief Operating Officers Group (COO Group) with an improved robust process has been implemented, to ensure the agreed initiative(s) better reflect the objectives below.

Based on the success of other regional clinical networks involving a whole of specialty approach, agreement has been reached to use a similar methodology for initiatives aligned to the Elective Services Network. The driver for this change is the understanding that elective service delivery is a component of the whole of service delivery. If electives are viewed in isolation the opportunity to consider the inter-relationship between acute demand and electives capacity, is missed. This approach also makes clear that while a regional focus on elective services aims to support District Health Boards (DHBs), the responsibility for meeting Elective Service Performance Indicators (ESPIs) belongs with individual DHBs

During 2017, the Midland Region COO Group reviewed a short list of specialties and considered the benefits and critical success factors of each. A decision to progress a vascular services project, based on the outcomes from the Ministry of Health Vascular Services Review, has been endorsed. All attendees at a meeting held in December 2017 of Service Managers and Vascular Surgeons, agreed there is value in the initiative and wished to progress the Ministry of Health (MoH) Vascular Services Model of Care – Implementation Action Plan. A regional forum including general practice, radiology, nursing and hospital specialists was held on 20 April 2018 to ensure cross sector engagement and agreed responsibilities and timeframes.

Planned Outcomes for 18/19:

- Increased health literacy
- Lifestyle advice and changes
- Access to diagnostics
- Standardised processes to improve quality and outcomes
- Enhanced management through best practice guidelines
- Whole of system protocols that define roles and responsibilities
- Acute and elective care pathways ensure patients receive timely intervention in the most appropriate setting
- Improve the patient journey through information pack to support clinical decision making and equity of access
- Patients are able to access appropriate imaging, allied health and social services
- Effective linkages with other service providers to support patients.

Key Objectives:
• Optimise prevention and detection • Reduce clinical variation • Enhance the intervention pathway • Integrate services effectively

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

Line of Sight		
• MoH Vascular Services Model of Care: Section 2 – Implementation Action Plan • Midland DHB Annual Plans		
Work plan key: Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives. Refer to **Table 7** for regional and national alignments.		
Initiative 1: Vascular Services **Clinical Leads : Thodur Vasudevan & Mark Morgan** *(Quality; Clinical Leadership)*	**Milestone/Date**	**Responsibility**
The Vascular Network will focus on improving the delivery of vascular services for the population of the Midland region. This will include:		Regional Vascular Network
1.1 Draft health pathways developed and are ready for publishing *(quality)*	Q1	
1.2 Stocktake of DHBs access to vascular ultrasound completed and where agreed move to national guidelines *(quality)*	Q1	
1.3 Current coding practices are audited and where appropriate changed to meet service specification guidelines *(quality)*	Q2	
1.4 Assessment and confirmation of DHB service levels *(clinical leadership)*	Q1	
1.5 Regional clinical audit process is implemented to inform service and quality improvements *(quality)*	Q2	
1.6 Acute and elective pathways are agreed and formalised for nominated conditions *(quality, clinical leadership)*	Q2	
1.7 Formal vascular multidisciplinary meeting process documented and implemented *(quality)*	Q2	
1.8 Workforce benchmarking is undertaken and opportunities to develop workforce and technology solutions are identified and progressed *(clinical leadership)*	Q2	

Initiative 2: Breast Reconstruction Services Clinical Lead: TBA	Milestone/Date	Responsibility
We acknowledge that there is work anticipated in 2018/19 relating to improving, and consistency of access, to plastics and reconstructive services, including breast reconstruction. We will engage with the national service improvement programme as actions are developed and support regional implementation as required by the Midland DHBs'. *(quality, clinical leadership)*	TBA	TBA
Initiative 3: Ophthalmology Clinical Lead: Stephen Ng	**Milestone/Date**	**Responsibility**
It is acknowledged that there is work anticipated in 2018/19 relating to improving, and consistency of access, to Age-Related Macular Degeneration (AMD) and Glaucoma pathways. Engagement will be undertaken with the national service improvement programme when guidelines are completed and as actions are developed, and will support regional implementation as required by the Midland DHBs'. *(quality, clinical leadership)*	TBA	TBA

4.4 Healthy ageing (Health of Older People Action Group)

Chair:	TBC
Project Manager:	Kirstin Pereira
Lead Chief Executive:	Helen Mason (Bay of Plenty DHB)

Context:

The Healthy Ageing Strategy[9] provides a clear direction for New Zealand and the health of its older people. There is an expected increase in the number of older people and the strategy urges the health sector to plan and ensure it is prepared at national, regional and local levels. People with long term conditions, including dementia, need support and information to help manage their conditions and to stay well. Family and whanau carers often help to keep older people in their homes for longer thereby reducing dependence on the health system. In order to be able to continue in this role without impacting on their own health carers will need training and information.

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

Planned Outcomes for 18/19:

- Reduced readmissions through appropriate management of inpatient stay and transfer of care
- Informal carers and family and whanau of older people with dementia have access to standardised support and education programmes
- InterRAI data is accessed and used, by the sector, for service development or improvements
- People in the Midland region are offered the opportunity to discuss and complete an Advance Care Planning (ACP).

Key Objectives:

- Midland District Health Boards (DHBS) are sharing initiatives for managing acute demand and patient flow across the Health of Older People continuum
- Education guidelines are agreed for education programmes for informal carers and family and whanau of people with dementia, and providers of these programmes are aware of the guidelines
- Increase the use of InterRAI data across the sector
- Midland DHBs have the opportunity to make the most efficient use of resources and information for the implementation of ACP in the Midland region.

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

Measures: (by ethnicity, locality and deprivation where possible)
• The projected population growth data analysis is received and reviewed by Midland DHBs • Providers of informal carer, family and whanau education are aware of the guidelines (when completed) • Increase in the number of reports using the InterRAI Data Visualisation Tool • Midland Region ACP Facilitators' Group report increased numbers of ACP conversations and completed plans • Key principles for discharge destination planning is incorporated in the discharge planning process.

Line of Sight
• DHB Annual Plans: • Healthy Ageing Strategy, 2016 • New Zealand Framework for Dementia Care, 2013
Work plan key: Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives. Refer to **Table 7** for regional and national alignments.

Initiative 1: Managing acute demand and patient flow across the continuum	**Milestone/Date**	**Responsibility**
Regional collaboration on identifying initiatives and best practice for managing acute demand and patient flow across the continuum for Health of Older People.		HOP Project Manager
• Agree the scope of the initiative and work with DHBs to identify the most appropriate representatives for the HOP Action Group.	Q1	HOP Action Group
• Support group to agree most appropriate way to share successful initiatives, lessons learned and agree a regional approach	Q2	
• Implement agreed method and identify regional measures, including rates for Māori, Pacifica and non- Māori.	Q4	
Initiative 2: Dementia *(Pathways; Clinical Leadership)*	**Milestone/Date**	**Responsibility**
Education programmes for informal carers, family and whanau		HOP Project Manager
• Continue to support the sector to identify ways to ensure access for informal carers and whanau to the education and support programmes (continued on from Q4 2017/18).	Q2	HOP Action Group
• Continue to support the development of the Informal Carer, Family and Whanau Education Guidelines	Q2	
• Identify opportunities to promote the completed guidelines to Midland Region education programme providers	Q3	
Dementia Assessment and Management Pathways (Pathways)		
• Analysis of the survey of GP practices to determine the use of the dementia pathways and their impact on GP and Practice Nurse confidence levels	Q1	
• Provide advice, based on the results, on any recommended changes to the pathways when to HealthCare Pathways	Q2	
Advice and Support for carers, family and whanau (Clinical Leadership)		
• Determine requirements of a new working group to support this action and seek nominations from DHBs and the sector.	Q2	
• Identify advice and support that should be available to carers, family and whanau post diagnosis and methods of delivery	Q3	
• Support the group to identify appropriate recipients of the information	Q4	

Initiative 3: InterRAI *(Quality; Equitable Access & Outcomes)*	Milestone/Date	Responsibility
InterRAI Data Visualisation Tool • Continue to promote the use and application of the new visualisation tool with Midland DHBs and the sector **InterRAI Quality indicators** (Quality) • Identify and agree indicators • Create reports for HOP Action Group to monitor, including rates for Māori and non- Māori (Health Equity)	 Q1-Q2 Q3 Q4	HOP Project Manager
Initiative 4: Advance Care Planning (ACP) *(Quality)*	**Milestone/Date**	**Responsibility**
Provide support to enable the Midland region to meet the requirements of the national ACP implementation plan • Coordinate and support the Midland Regional ACP Facilitators, working to include additional Primary Health Organisations • Represent the Midland Region and contribute to the work of the National ACP Steering Group • Support the Facilitators group to collaborate on a regional approach to the Train the Trainer programme and the Serious Illness Conversation Guide Training programme.	 Q1-Q4 Q1-Q4 Q1-Q2	HOP Project Manager Midland Regional ACP Facilitators

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

Chair:	Dr Sharat Shetty (Taranaki DHB)
Regional Director:	Eseta Nonu-Reid
Lead Chief Executive:	Ron Dunham (Lakes DHB)

Context:

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

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

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

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

Planned Outcomes for 17/20:

Vision: *"Improving Mental Health and Addictions"* underpinned by:

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

Key Objectives:

a) Leading regional mental health and addiction planning

b) Leading regional service improvement

c) Supporting the achievement of health targets and policy priorities

d) Linking to national and regional governance structures and processes

e) Leading and/or supporting the development of nationally consistent approaches to mental health and addiction

f) Reducing inequalities in mental health and addiction outcomes for Māori

g) Efficiency and effectiveness to determine and inform funding prioritisation decisions.

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

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

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

Line of Sight

- DHB Annual Plans: BOP DHB, Lakes DHB, Hauora Tairāwhiti, Taranaki DHB and Waikato DHB – section 2 – delivering on priorities and targets; section 3 – service configuration; section 5 – performance measures

Work plan key:

Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives.

Refer to Table 7 for regional and national alignments.

Initiative 1: Midland eating disorders model of care *(Pathways)*	Milestone/Date	Responsibility
Continued regional development of eating disorder services • Implement the Midland Eating Disorders Model of Care as outlined in the MoH Change Management proposal: 1. Develop a Pathway of Care 2. Establish a Prioritisation Panel 3. Develop a regional hub and spoke process 4. Standardise common policies and best practice guidelines 5. Develop workforce objectives that lead to a sustainable service.	Q4 2018/19	Regional Director and Clinical Governance
Initiative 2: Substance abuse legislation *(Workforce, Clinical Leadership, Pathways)*	**Milestone/Date**	**Responsibility**
Improved addiction service capacity and capability for implementation of substance abuse legislation 1. Implement Midland proposal to the MoH if funding secured 2. Implement and monitor the objectives as identified in the proposal 3. Implement the workforce development requirements as identified in the SACAT Model of Care 4. Develop Pathway of Care for Addiction that includes SACAT.	Q1 2018/19 Q2 2017/20 Q1 2018/20 Q3 2018/19	Midland Regional Director and Midland Clinical Governance
Initiative 3: National mental health and addiction Inquiry *(Quality)*	**Milestone/Date**	**Responsibility**
Ensure Midland is fully engaged in the national Inquiry process by: 1. Disseminating information as it becomes available 2. Providing back room support to the individual DHBs 3. Bringing together stakeholder groups as needed to consult with the Inquiry 4. Provide regional, and by DHB, data as required.	Q2 2018/19	Midland Regional Director and Midland Clinical Governance
Initiative 4: MH&A clinical workstation *(Technology & Digital Services)*	**Milestone/Date**	**Responsibility**
The successful implementation of modern clinical workstations across the Midland region. 1. Clinical Governance remains engaged with eSPACE 2. eSPACE of the mental health and addiction platform is undertaken in partnership with Clinical Governance.	Q4 2018/20	Midland Clinical Governance and eSPACE
Initiative 5: Health equity for Māori *(Equitable Access & Outcomes)*	**Milestone/Date**	**Responsibility**
Improving health outcomes for Māori by: 1. Undertaking in-depth analysis of ethnicity data to identify projects for 2018-20 2. Identify exemplar services and examine what works and how lessons learned can be transferred 3. Ensure all projects undertaken have an Equity section that is ratified by Clinical Governance and Te Huinga o Nga Pou Hauora (Māori Leadership Network) 4. Working in partnership with GMs Māori Health to ensure that Mental Health and Addiction continue to develop robust equity strategies.	Q4 2018/20	Midland Regional Director and Midland Regional Stakeholder Groups
Initiative 6: Midland Infant Perinatal Clinical Network *(Pathways)*	**Milestone/Date**	**Responsibility**
The Midland Infant Perinatal Clinical Network will: 1. Complete the review of the primary care pathway (Pathways of Care) and consult with primary, maternity and mental health and addictions services 2. Develop regionally agreed policies, procedures and clinical best practice guidelines to ensure regional consistency 3. Participate in the evaluation of the e-Learning tool in partnership with the Central region.	Q1 2018/19 Q1 - Q4 2018/19 Q1 - Q4 2018/19	Midland Regional Director and Midland Infant Perinatal Clinical Network

Initiative 7: Workforce capacity and capability *(Workforce, Clinical Leadership)*	Milestone/Date	Responsibility
Building a sustainable workforce by: 1. Analysis of the Midland workforce, including the NGO sector 2. Develop initiatives that values NGOs as integrated partners 3. Develop a Workforce MH&A Strategic Plan that aligns with the National MH&A Workforce Action Plan 4. Support the Health Quality Safety Commission project work: a. Towards Zero Seclusion b. Transition 5. Projects are identified and implemented. 6. Provide workforce leadership to the sector in partnership with the Regional Training Hub.	Q4 2018/19	Midland Regional Director and Midland Workforce Network
Initiative 8: Data management	**Milestone/Date**	**Responsibility**
Improving mental health and addiction data management by: 1. Regional Stakeholder Networks to identify data sets for analysis 2. Ensure that analysis of data is undertaken and informs all projects undertaken in 2018-19 3. Further analysis of current data sets to ascertain effectiveness of information provided.	Q4 2018/19	Midland Regional Director and Midland Regional Networks

4.6 Stroke services (Midland Stroke Network)

Chair:	Peter Wright, Neurologist (Waikato DHB)
Project Manager:	Kirstin Pereira
Lead Chief Executive:	Rosemary Clements (Taranaki DHB)

Context:

Stroke is the second most common cause of death worldwide and the most common cause of long-term adult disability in high-income countries such as New Zealand (NZ) (Johnston et al, 2009). In NZ it is estimated that 50,000 people live with stroke and 8,500 have a new stroke each year with an annual cost of $750 million to the NZ health sector (Brown, P., 2009). A substantial proportion of this overall cost results from long-term disability following stroke.

Successful rehabilitation through organised stroke care can reduce mortality and the rate of discharge to institutional care. The level of dependence for those who are discharged home can also be reduced through rehabilitation (McNaughton, H et al, 2014). The minimum and 'strongly recommended' standards for DHBs are provided by the National Stroke Network in the *NZ Organised Stroke Rehabilitation Service Specifications (in-patient and community)*.

The Midland Stroke Network has a continued focus on providing timely and accessible high-quality stroke services within the hospital setting and on providing appropriate rehabilitation in the acute and post discharge periods

Planned outcomes for 18/19:

- Midland inpatient and community stroke rehabilitation services benefit from regional collaboration
- Patients who have experienced a Transient Ischemic Attack (TIA) have access to secondary stroke prevention programmes
- Eligible patients receive out of hours thrombolysis treatment from stroke experts in all Midland DHBs
- Eligible Midland District Health Board (DHB) patients have access to thrombectomy treatment delivering improved functional outcomes compared to standard care.

Key Objectives:

- Support Midland DHB rehabilitation services to collaborate on inpatient and community stroke rehabilitation initiatives
- Establish pathway for patients who have experienced a TIA
- Support establishment of a Midland region telestroke solution
- Ensure all stroke patients have access to high-quality stroke services regardless of ethnicity or DHB region.

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

- Regional Australasian Rehabilitation Outcomes Centre (AROC) reports are available for each Midland DHB
- 10 percent or more of potentially eligible stroke patients thrombolysed 24/7
- Percentage of eligible patients receiving thrombectomy treatment at Auckland Hospital.

Line of Sight		
• Midland DHB Annual Plans • National Stroke Network. A New Zealand Strategy for Endovascular Clot Retrieval.		
Work plan key: Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives. Refer to **Table 7** for regional and national alignments.		
Initiative 1: Rehabilitation *(Quality, Equitable Access & Outcomes)*	**Milestone/Date**	**Responsibility**
Inpatient Rehabilitation - Promote use of Australasian Rehabilitation Outcomes Centre (AROC) data • Contribute to the development of regional AROC reports • Organise a forum, including the Midland Allied Health Stroke group, for sharing the application of AROC data as it applies to Stroke rehabilitation **Community Rehabilitation** • Review the quarterly community rehabilitation indicator to monitor the consistency of data collection and equity of access to community rehabilitation services *(Quality, Equitable Access & Outcomes)* • Development of a plan of action if equity issues are identified.	 Q2 Q4 Q1-Q4 Q4	Midland Stroke Network (MSN) MSN Project Manager
Initiative 2: Reducing incidence of stroke – Transient Ischemic Attack (TIA) *(Equitable Access & Outcomes; Pathways)*	**Milestone/Date**	**Responsibility**
• Review and monitor quarterly regional TIA indicators for areas of non-achievement or inequities of access • Development of a plan of action if equity issues are identified (*Equitable Access & Outcomes*) • Review Midland pathway of care in conjunction with primary care *(Pathways)* • Assess potential for regional implementation of eReferrals from primary care to secondary care.	Q1-4 Q4 Q3 Q4	Midland Stroke Network (MSN) MSN Project Manager
Initiative 3: Acute services *(Quality; Equitable Access & Outcomes, Pathways, Technology & Digital Services)*	**Milestone/Date**	**Responsibility**
Admission to a stroke unit or organised stroke service *(Quality)* • Continue to monitor rates of admission of stroke patients to a stroke unit or organised stroke service, reviewing rates for Māori and non- Māori to ensure equity of access • Support DHBs to identify actions to address any inequities of access *(Equitable Access & Outcomes)* **Thrombolysis** • Continue to monitor thrombolysis rates to ensure Midland DHBs are meeting the new 10% target • Where 10% is not being achieved, collaborate to identify initiatives for improvement *(Pathways)* • Collaborate on a regional telestroke solution to support Midland DHBs to deliver 24/7 thrombolysis services *(Technology and Digital Services)* **Thrombectomy** • Continue to collaborate on developing pathways of care for accessing Thrombectomy services through Auckland DHB.	 Q1-Q2 Q3-Q4 Q1-4 Q2-3 Q2 Q3	Midland Stroke Network (MSN) MSN Project Manager

Initiative 4: Clinical leadership *(Clinical Leadership; Workforce)*	Milestone/Date	Responsibility
• Support and advocate for defined nursing and medical stroke leadership roles in the Midland region DHBs (Clinical Leadership)	Q1-Q4	Midland Stroke Network (MSN) MSN Project Manager
• Work with clinical leaders to support and provide regional stroke education programmes	Q1-Q4	
• Support the Midland Region Allied Health Stroke Network to continue to build a regional forum *(Workforce)*	Q1-Q4	
Initiative 5: Patient experience of care *(Equitable Access & Outcomes)*	**Milestone/Date**	**Responsibility**
• In conjunction with the Midland Cardiac Clinical Network and General Managers Māori, explore potential for a meeting/hui with Māori consumers and their whanau who have been involved in either (or both) stroke or cardiac services	Q1	Midland Stroke Network (MSN) MSN Project Manager
• Agree approach to running the hui to ensure consumers and their whanau are supported and learnings are available to as many of the network and service members as possible	Q2	
• Organise forum for network members to review and discuss learnings from the hui	Q3	
• Identify strategies to improve issues identified.	Q4	

4.7 Trauma services (Midland Trauma System - MTS)

Chair:	Dr Grant Christey, Clinical Director
Programme Manager:	Alaina Campbell
Lead Chief Executive:	Ron Dunham (CEO Lakes DHB)

Context:

Trauma is the leading cause of death for New Zealanders under 45 years[10,11] and continues to have a major impact on our Midland communities and health services. It is estimated that for every death following injury there are a further nine people who survive with major injuries requiring complex, multidisciplinary care[12]. For those who survive traumatic injury, recovery periods and long term disabilities result in a reduced economic contribution and/or long-term economic liability imposed on health and social systems[2]. Trauma volumes continue to rise in Midland with 6226 incidents resulting in 7269 admissions in 2016/17 and 32,492 hospital bed days[13]. The cost of this to the Midland hospitals is over $1 million per week.

Trauma is preventable and many opportunities to improve post injury care exist. MTS is committed to reducing the trauma burden on our community and health services. We realise that linkages with multiple DHB and community groups are essential to achieve this.

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

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

Planned outcomes for 2018/19:

- Updated regional trauma guidelines
- Development and implementation of Optimal Recovery After Trauma (ORAT) programme
- Development of regional trauma education nursing plan that shares and utilises skills and resources within the region and promotes access and exposure to trauma best practice
- Delivery of customised reporting programme to Midland DHBs
- Delivery of Stage 2 of TQual platform build
- Provision for trauma rehabilitation is detailed in future regional planning and funding documents and plans
- Consortium of stakeholders formed to support information translation to assist communities at risk.

[10] Gulliver PJ Simpson JC (editors) (2007) Injury as a leading cause of death and hospitalisation. Fact Sheet 38. Injury Prevention Research Unit. (Updated April 2007). http://www.otago.ac.nz/ipru/FactSheets/FactSheet38.pdf

[11] Leonard E, Curtis K. Are Australians and New Zealand trauma service resources reflective of the Australasian Trauma Verification Model Resource Criteria? ANZ J Surg. 2014 Jul-Aug; 84(7-8):523-7. doi: 10.1111/ans.12381. Epub 2014 Feb 12.

[12] Gosselin RA, Spiegal DA, Coughlin R, Zirkle LG. Injuries: the neglected burden in developing countries. Bull World Health Organ. 2009;87(4):246

[13] Midland Trauma System Database 2017 (pers comm)

Line of Sight		
• Midland DHB Annual Plans, section 2 – delivering on priorities and targets		
Work plan key: Actions are specifically aimed at achieving the New Zealand Health Strategy five strategic themes; national System Level Measures; and Midland DHBs six regional objectives. Refer to **Table 7** for regional and national alignments.		
Initiative 1: Improve the delivery of high quality clinical care to trauma patients *(Quality; Pathways; Clinical Leadership; Equitable Access & Outcomes)i*	**Milestone/Date**	**Responsibility**
1.5 Update and promote Trauma Guidelines *(Quality, Pathways)*	Q4 2018/19	MTS
1.6 Revise pre-hospital and inter-hospital Trauma matrices *(Quality, Clinical Leadership, Pathways)*	Q4 2018/19	
1.7 Participate in the development of comprehensive trauma rehabilitation services in the Midland region *(Quality, Clinical Leadership)*	Q4 – 2020	
1.8 Complete needs analysis for regional clinical trauma education *(Quality)*	Q2 2018/19	
1.9 Identify regional trauma education programme for coordination *(Quality)*	Q4 2018/19	
1.10 Evaluation and implementation of Optimal Recovery After Trauma (ORAT) programme *(Quality)*	Q3 2018/19	
1.11 Review patient and family/whānau feedback on experience of care and promote principles of co design to trauma services *(Equitable Access & Outcomes, Quality)*.	Q4 2018/19	
Initiative 2: Develop, implement and maintain regional trauma system infrastructure including information systems *(Quality; Clinical Leadership; Equitable Access & Outcomes; Technology & Digital Services)i*	**Milestone/Date**	**Responsibility**
2.1 Design and deliver sustainable regular customised reporting to Midland DHBs including volumes, costs and process indicators *(Technology and Digital Services)*	Q1-Q4 2018/19	MTS
2.2 Design and implement snapshot programme relating to ethnicity, age, gender and inequities of care – detailing groups and communities at risk of trauma in each DHB *(Equitable Access & Outcomes; Clinical Leadership; Quality)*	Q2, Q4 2018/19	
2.3 Develop regular data management training that enhances skills to retrieve, interrogate, utilise and maximise local data in an appropriate timeframe *(IT, Quality)*	Q3,Q4 2018/19	
2.4 Design standardised template that allows local trauma service teams to feedback progress towards local and regional objectives for inclusion in the RSP.*(Clinical Leadership)*	Q1-Q4 2018/19	
2.5 Ensure regional representation at regional, national and international trauma forums *(Clinical Leadership)*	Q1-Q4 2018/19	
2.6 Comply and report on Ministry of Health targets for data collection and entry *(Clinical Leadership)*	Q1-Q4 2018/19	
2.7 Develop regional communication network and processes for information dissemination *(Technology and Digital service)*	Q3 2018/19	
2.8 Improve clinical systems by completing stage 2 of TQual platform to support clinical quality improvement and prevention programs including direct data inputs (handheld project eg IPM and Costpro feeds) *(Technology and Digital Service)*	Q3 2018/19	
2.9 Maintain hosting platform for National Major Trauma Registry including training, support and reporting *(Technology and Digital Services; Clinical Leadership).*	Q1 2018/19	

Initiative 3: Support injury prevention and awareness *(Clinical Leadership; Equitable Access & Outcomes; Workforce)*	Milestone/Date	Responsibility
3.1 Participate in community events to promote information use eg Right Track schools programme, Moana Safe City Group, Safe Driving Expo	Q1-Q4 2018/19	MTS
3.2 Create a programme to promote injury awareness by presenting MTS information at targeted meetings and forums by MTS staff eg ATS, etc *(Equitable Access & Outcomes; Clinical Leadership)*	Q1-Q4 2018/19	
3.3 Complete research collaboration with NZTA related to motorbike injuries *(Clinical Leadership)*	Q3 2018/19	
3.4 Form a consortium of funding stakeholders to support information translation to assist communities at risk. (*Workforce; Clinical Leadership; Equitable Access & Outcomes)*	Q2 2018/19	
3.5 Apply for HRC funding to enable sustainable research on issues of access and inequalities (focus 18/19 on Māori trauma) *(Equitable Access & Outcomes)*	Q4 2018/19	
3.6 Create a programme for collaboration with external research partners to maximise data use.	Q2,Q4 2018/19 (ongoing)	
Initiative 4: Establish a Trauma Quality Improvement Program (TQIP) to enable evidence-based change *(Quality; Pathways; Workforce)*	**Milestone/Date**	**Responsibility**
4.1 Recruit appropriate personnel to TQIP role *(Workforce)*	Q1 2018/19	MTS
4.2 Define TQIP elements, structure and processes, ie:		
a) Assess and improve regional trauma morbidity and mortality review processes *(Quality)*	Q2 2018/19	
b) Develop loop closure process on identified variables associated with system, process and outcomes *(Quality; Pathways)*	Q2 2018/19	
c) Conduct health literacy review on trauma information *(Equitable Access & Outcomes)*	Q3 2018/19	
d) Audit programme *(Quality)*	Q2 2018/19	
e) TQIP reporting programme, eg pre hospital and inter hospital compliance reporting; paediatric reporting.*(Quality)*	Q3 2018/19	

5. Appendix – List of equity outcome actions contained in the Midland Regional Services Plan 2018-2021

This is a list of all the Equity Outcome Actions [EOA] contained throughout the sections of this plan. Those actions that are specific to improving equity outcomes for Māori as measured by national Māori Health Priority indicators are identified in this list as "MHPI".

1. DHBs active commitment to running Kia Ora e te Iwi community based health literacy programmes in partnership with MHP, NGOs and DHBs.[EOA]
2. Midland Region will develop a data dashboard disaggregated by ethnicity (Māori and non-Māori as a minimum) and by DHB, for key indicators of palliative care performance to underpin the identification of ethnic inequalities and drive performance to improve access and outcomes for Māori. [EOA]
3.
4.

[Note this Appendix is to be developed over June–16 July 2018]

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 10.5

WAIKATO DHB WORKING DRAFT ANNUAL PLAN 2018/19 – PUBLIC EXCLUDED

Purpose	For information and comment. To provide members with the most up to date version (as at 18 June) of the working draft of the Waikato DHB Annual Plan 2018/19 for review and comment.

Background

This paper follows on from the Annual Plan update presented to the Board in May 2018. The draft Waikato DHB Annual Plan 2018/19 is due to be submitted to the Ministry of Health on 16 July 2018. The Annual Plan Financial templates will be submitted separately.

Discussion

This Annual Plan has been developed in accordance with the guidelines and templates provided by the Ministry of Health. The Ministry of Health released the planning package to DHBs on 11 May 2018 2018.

The 2018/19 Planning Priorities are:

- Primary Care Access
- Mental Health
- Public Delivery of Health Services
- Child Health
- School-Based Health Services
- Healthy Ageing
- Disability Support Services
- Pharmacy Action Plan
- Improving Quality
- Climate Change
- Waste Disposal
- Fiscal Responsibility
- Budget 18 Initiatives once confirmed
- Health Targets once confirmed
- Cross-Government Targets once confirmed.

In addition to the above, Waikato DHB has included actions to deliver the Regional Service Plan (RSP) priorities.

Upon receipt of the planning package we have developed a mix of responses and performance measures to align with the Ministry's expectations. Due to the short time frame allowed for development of this document, a few areas are yet to be completed.

On-going work is being undertaken across the organisation in the following areas:

- Capital and infrastructure development
- IT (an options paper that will inform the Annual Plan content is being submitted separately to the Board for consideration)
- Financials
- Some performance measures
- SLM Improvement Plan.

Part of the ongoing work to finalise the Annual Plan will be focused on ensuring that our plan:

- Aligns with the Midland DHB Regional Service Plan 2018/19 and shows our contribution to activities in that plan
- Aligns with our Public Health Annual Plan for 2018/19.

We expect formal feedback from the Ministry of Health on the draft Annual Plan by the week beginning 3 September 2018. The date for submission of the final plan will be set by the Ministry upon provision of feedback in September.

Recommendation
THAT
The Board:

1) Receives the report.
2) Provides comment on the working draft Annual Plan 2018/19.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

Waikato District Health Board

2018-19 ANNUAL PLAN

INCORPORATING THE 2018-19 STATEMENT OF PERFORMANCE EXPECTATIONS

Waikato District Health Board

Contents

Published by Waikato District Health Board

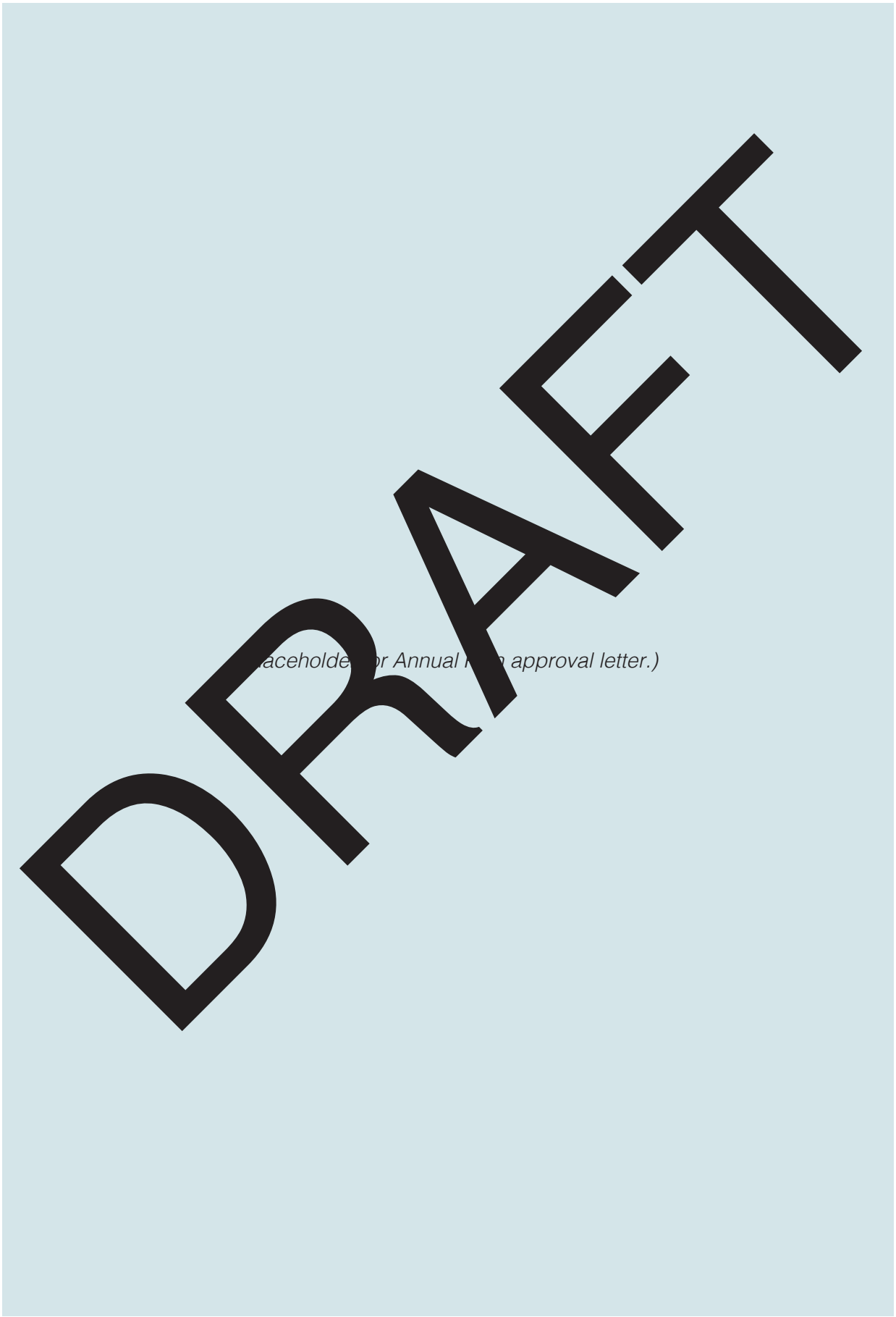
Private Bag 3200, HAMILTON 3240

This document is available on the Waikato District Health Board website **www.waikatodhb.health.nz**

Mihi

He honore, he kororia ki te Atua	All h[illegible]nd glory to [illegible]
He maungarongo ki te whenua	Peace o[illegible]
He whakaaro pai ki nga tangata katoa	[illegible]d will to all mankind
Ka tau te kei o te waka ki te Kiingi [illegible] me te whare o te Kahui ariki w[illegible]au whan[illegible]nu	I[illegible]ding Kiingi Tuheitia his family and th[illegible]val household
Paimarire.	Pai[illegible]re.
Kahuri ki te korowai aitua	We turn to acknowledge those
O ratou ko wehi ki te po	[illegible]o have passed beyond the veil
Takoto mai, moe [illegible]outou	Rest in peaceful slumber.
Haere, hae[illegible]aere atu	Haere, haere, haere atu raa
Noreira [illegible]puari te kuaha p[illegible]mu	Therefore the green stone door
Maha[illegible]a taatou katoa.	Opens wide with a very warm greeting to us all
“Mehemea [illegible]moemoeaa ahau	“If I am to dream
Ko au anake	I dream alone
Mehemea ka moe[illegible]aa [illegible]atou,	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

This Annual Plan articulates Waikato District Health Board's (DHB)'s commitment to meeting the Ministers expectations, and our continued commitment to our Board's vision – Healthy People. Excellent Care.

1. 1 Strategic Intentions/Priorities

National

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

The principles within the Treaty of partnership, protection and participation implicitly gnise important role the health sector plays in recognising the indigenous rights of Māori to achieve rad improvem n health outcomes by eliminating health inequities.

New Zealand Health Strategy
The New Zealand Health Strategy is the key source of direction for the he sector. The refreshed New Z d Health Strategy provides the sector with clear strategic direction and d map for del ery of more integrat health services for New Zealanders. The strategy has a ten-year ho , so impacts ot just immediate planning and service provision but enables and requires DHBs and t ctor to h a clear roadmap for future planning as well.

He Korowai Oranga
As New Zealand's Māori Health Strategy, He Korowai O nga sets the overarc framework that guides the Government and the health and disability sector to ac best health outco or Māori. Pae Ora (Healthy Futures) is the Government's vision and aim for the ref ed It builds on t ial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Ind uals) an Ora (Healthy nvironments). DHBs in particular should consider He Korowai Oranga in their pla ng, and i heir statutory objectives and functions for Māori health.

The Healthy Aging Strategy
The Healthy Ageing Strategy prese e str c direction change and a set of actions to improve the health of older people, into and th ghout their er years. It r shes and replaces the Health of Older People Strategy 2002, and aligns with new New Zea d Health Stra y 2016. The Healthy Ageing Strategy vision is that "older people live well well, and have l end o e in age-friendly communities". It takes a life-course approach that seeks ximise he and we g for all older people.

The UN Convention on the Rig f P ons with Disab ties
The UN Convention on the Rights o ons with Disabilities is the first United Nations human rights treaty of the 21st century. Th makes licit that member countries must ensure the full realisation of all human rights and fu mental fre s for all led people, on an equal basis with others, and without discrimination of any kin the basis of dis y. It will help to ensure that mainstream services are inclusive of disabled people delivered in non-dis inatory wa

'Ala Mo athways to Pacific lth and Wellbeing 2014–2018
To facilita delivery of high-qu y health services that meet the needs of ic peoples, 'Ala ui has been developed. This builds on the su ses of the f er plan, 'Ala Mo'ui 2010–2014. It sets out the stra direc o address health needs of Pacific peoples and new actions, to be delivered from 2014 to 2018.

Regional

See the Midland Regional Service Plan for details.

Local

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

mission

Enable us all to manage our health and
Provide excellent care through smarter, innova

OUR
strategic imperatives

OUR
priorities

Health equity for high need populations
Oranga

- Radical improve Māori health outcome liminating health inequities for Māori
- Eliminate health in ties fo rural commu
- Remove barriers fo ople exper icabilities
- Enable a workforce t liver cu e services

Safe, quality health services for all
Haumaru

- ly, high qual afe care based on a culture of accountability, respons , continuous rovement, and innovation
- Prioritise r-purpose ca vironments
- Early inte or service need
- Ensure rvices delivered to meet the needs of our populations at all st of their l

services
Manaaki

- ise the expertise of communities, providers, agencies, and specialists in the ign of health and care services
- e care and services that are respectful and responsive to individual and wh needs and values
- Enab ulture of professional cooperation to deliver services
- Promote ealth services and information to our diverse population to increase health literacy

Ef and efficient ca service
Rato

- 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

1.1.1 Population Performance

The Waikato DHB is committed to taking a life course a[pproach] [to] the heath [of the] population. Those life course groupings and an example of this approach are [outlin]ed below:

Life course group	One signific[ant action] that is to [be] [implement]ed in 2018/19
Pregnancy	Review [of] [pre]g[nancy] and parenting [edu]cation programme to increase access and coverage for [Māo]ri and [Pacif]ic women.
Early years and childhood	C[omp]rehensively rev[iew] services to im[prove] child health outcomes with respect to: • [En]rollments; • [Im]munisation ar[e] • [Oral] health.
Adolescence and young adulthood	The [Waikato DHB] [is] committed to improved [Mental] Heath outcomes for Waikato Youth. An enhanced focus [on] [self-h]arm and suicide prevention will be driven through our System Level Measure Programm[e].
Adulthood	[Increase] the [number] [of] Māori men aged 35 - 44 years who have had their cardiovascular risk [assess]ed in the [last] [5] years. This will take an outreach approach via sports clubs, workplaces, Ma[rae] and Kapa [Haka] in partnership with PHO's.
Older [adult]	STAR[T] [s]ervice expansion to reduce avoidable Emergency Department presentations and Hospi[tal] [a]dmissions.

1.2 Message from the Acting 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 is important to us that everyone receives excellent care when they or their whanau come in contact with our health system.

Our newly appointed Consumer Council will help give people who do not 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 objectives 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 10 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 by 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:

Sally Webb
Acting Chair
Waikato DHB

Date: XX XXX 2018

Vacant
Deputy Chair
Waikato DHB

Date: XX XXX 2018

Derek Wright
Interim Chief Executive
Waikato DHB

Waikato DHB

Date:

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 Zealanders have 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 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 the public health units and health promotion providers. New Zealanders have made clear that they are concerned about the increasing inequitable access to 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.

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

SECTION TWO: 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 acce and utilisation of health services more generally. We will achieve this through effective, patient centred, u sal services, as well as tailored or targeted interventions.

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

Annual activities, as well as a longer term approach within our 10 year l th System Plan, include but are n limited to:

- Promoting screening services for our priority populations to increase e det n of disease, for example, increasing the % of Māori men aged 35 – 44 years who have had their ca scular risk assessed in the last 5 years;
- Implementing services that target communities with health inequalitie
- Setting targets by ethnicity and monitoring performa
- Supporting kaupapa Māori services and 'for Pacific by cific' se
- Increasing the capability and capacity of the Māori and cific work our district;
- Applying an equity lens as part of decision-making proce s (e he Healt uity Assessment Tool);
- Engaging with our Disability Support A y Committee veloping a disability responsiveness plan
- Engaging with Iwi Māori Council t vide ce and info ecision making;
- Engaging with community healt ums and ert advisory ups to provide and receive advice (e.g. our AgeWISE advisory group an r rural health visory group).

We have included at least on ity actio used on Māori and Pacific populations across our identified planning priorities. Throughout t doc nt we have flag these with a tag "EOA" (Equitable Outcome Action). These are intended to help ader identify those actions intended to reduce equity gaps.

2.1.1 He Equity ls

Waikat B utilises the follow ealth equ ools to assess and identify disparities and outline activities for impro quitable access and o omes.

- The Healt ity Assessment T (HEAT);
- He Pikinga W Implementa Framework;
- 'Ala Mo'ui: Path to Paci ealth 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
Child Health
School-Based Health Services
Healthy Ageing
Disability Support Services
Pharmacy Action Plan
Improving Quality
Climate Change
Waste Disposal
Fiscal Responsibility
Budget 18 Initiatives once confirmed
Health Targets once confirmed
Cross-Government Targets once confirmed

In addition, Waikato DHB has identified our actions t eliver Regional Serv lan (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	roductive 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 h h other health and social services, d. Reducing inequities including reduc rate of Māori and Pasifica under community ent orders by undertaking a caseload review s of high service users for two years or longe which are subject to treatment orders – many are Māori and Pasifica To consider barriers impacting discharg work to support recovery and indep Monitoring transition process fo t group, including ethnicity inf tion clo e. Key stakeholders in the grated Saf Response to Family Vio – repres health in the inter-sector orati lative. Continued development o sentation tion to achieve tervention outcomes. ealth promo and communi agement a. The Waikat B Suicide Prev n and Postventio n has bee eloped for the ne ith stron mmunity engag as well ical input. Suicide prev and postven ovide a range of es such as menta alth literacy uicide prevention training, community-revention and postvention initiatives (ie, ement counselling, 'Lets Talk Wellbeing' h integration of mental health and addi rvices b. There is tem Level Measure group in the Waikato fo ssing 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	1a. Commence and ongoing b. Co enced, by of Q3 c. By end of Q4 d. By Q4 e. Ongoing, easing wider engagement anticipated by Q3 2a.By the end of Q4. b. By end of Q4 c. On-going	PP43: Population mental health Improving ealth status of eople with severe mental illness through improved access mproving ealth ing wellnes transition rge planning PP36: Reduce the rate of Māori under the Mental health Act: section 29 community treatment orders

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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	
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 Enquiry 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, we will be advising and encouraging our staff to attend the forums or to them to meet the Panel and the process individual or group submissions. Collat information from the Panel has yet to vided, however once we have received th mation we will be sharing this information nsumers and networks via posters, fliers, etc. 3. "Lets Talk" hui being held around the loc our district. This information is being collat will be utilised more formally to contribute fro a Mental Health an ddictions, Waikato DHB service response vernment Inquiry into Mental Health and A). 4. Support and promo portu ople who use our services, to ribute to t ent Inquiry.	1.18 June Inquiry Panel visit to WDHB 2 July Timetable for wider engagement and access to th Panel develop 2. On-going Hui completed by 4. ng	Report on activities in the Annual Plan
	Mental Health and Addictions Improvement Activities	One team	Primary partner	Waikato DHB is committed he HQ ental he and addictions improvemen ivit y: 1. zero seclusion via the National ality Safety gro aikato DHB Mental Health A tion Service is ly engaged in the collab ive work focus elimination of seclusion ti-disciplinary m including consum used on g with the HSQC p and ipating in he collaboration. 2. We lue to moni eview all seclusion across our serv tinued roll-out of the Mental health Integrated ansition Project via the Mental Health Integrated rdination Care Team. This is transitioning health patients from secondary to primary m alth services with free and extended gene ctice visits and a key worker for 12 months 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. 4. Update the current dashboard to include an equity focus in order to identify inequities with Māori and Pasifica patients. (EOA) 5. 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. On-going 3. General Practitier network to be set up by Q3 4. Completed by end of Q3 5. Scoped by end of Q2	PP26: The Mental Health and Addiction Service Development Plan
	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

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)	Access	Closer to home	Safe, quality health services for all	*TBC. Specific advice on the implementation of any new Government initiatives will be provided once decisions have been confirmed.*		Identify appropriate measure/s
	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 enhance sustainability and health outcomes 2. We will develop a work programme suppo a number of working groups to take res for System Level Measures and other development. Other sector participants bought in as required. 3. The Alliance Work Programme will be driven b evidenced based decision making 4. Our Health System Pla hich is under development will loo ation opportunities across workforces of ting sectors with a key focus on re g th for both Māori and Pasifica ulations. 5. There will be a focus on eeing on-g service development in th owing – Demand Management Gro hild outh Hea ork, Mental Hea and gration. utilisat Health Care as nts in primary health setting allow the Regi d Healthcare Practitioners ork top of scope 7. Expanded H oner roles g rolled out to increas harmacis nd nurses as well as se practi To co to increase tim wborn enrolment ary Care, we intend to roll out the onic newborn enrolment project into all birthing facilities via National Child H formation Platform (NCHIP). The Child and oordination service will follow up any unenrol ldren. There is also a proposal to integrate dland Clinical Portal with NCHIP to identify children not enrolled with Primary Care and electronically enrol.	1. By Q3 Q3 3. By Q2 4. By n-going 6. O 7. By Q2 Q2	P22: Delivery of actions to improve system integration ncluding SLM's mproving ne enrolment in Ge ractice
	System Level Measures	Value and high performance	Effective and efficient care and ser	oulk of Waikato primary care integration vity is related to improving performance and alth outcomes as reflected in meeting our SLM mprovement 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

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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) (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, kappa 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 Te Conditions (LTC) or to assist in opportunist screening of people who may potentiall a undiagnosed LTC and/or to improv literacy within the community to pr LTC.	1a. Sports Clubs & Wananga - July – Sep 2018 Kapa Haka – Oct Dec 2018 Workplace 19 – Jun b. On oui urther aces by Q4	PP20: Improved management of long-term conditions (focus CVD and diabetes)
	Pharmac l Plan	One team	Pro e partnerrshi	**Waikato DHB supports focus with macy action plan and enhance armacist se** 1. Participation in the imp ntation new national pharmacy cont gements to Integrated Pharm ices in the . The new cor g arrangements will en aikato DHB to ement the long-term visio 'Integrated P acist Services in the Cor nity' and move a system that funds ph n transact ased medicine deliver tient-cen service delivery and g, to on flexible enough t local DHB population and cons er need enhances the healthcare and medicines management expertise delivered by pharmacists ports pharmacists to work as one team her primary care services to benefit th der health care system and population health. The new contracting arrangements will provide Waikato DHB flexibility to provide our local communities with equity of access 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	1. Th urrent Community harmacy Services Agreement will expire 30 September 2018. The new national pharmacy contracting arrangements will be effective 1 October 2018 2. By the end of Q4 3. By the end of Q3	Report on activities in the Annual Plan

Government Planning Priority		Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
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. (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 continue gap analysis of new cases of a rheumatic fever to identify potential ar service improvement and improvem future patient outcomes 2. Supporting rural women and children • Roll out the Southern Rural Maternity Project increase access for rural women and children the rural maternal/baby health and social sector hubs. The hubs will tral location where women and their w ss services from a variety of ma ah providers, along with als to s providers if required.	1a. By Q2 b. By Q3 c. By Q3 d. On-going 2 uiti Hub to unched by Q3	PP27: Supporting child well-being
Child Health (both Māori and Pacific focussed equity actions are expected in this priority area) (continued)	Maternal Mental Health Services	Closer to home	Safe, quality h ervices for all	Waikato DHB is committed to ressing maternity mental health needs 1. Provi ixture of perina luding Officer) to su ommunity-sed ma mental health ces Consultation, on and advisor ction along with shared c and joint planni th other health and s s is avail o support the mental thers an ants in the commur Follow eferral direct sp perinatal mental are is available and ovided by senior al staff, nurses and allied health 4. elopment of a postpartum depression re athway from possible depression to risk of se ensuring the use of appropriate Māori and Pa oviders. (EOA)	1. On-going 2. On-going 3. On-going 4. Developed by Q4	PP39: Supporting health in schools
	Supporting Health in School	Closer to h	rvices for all	aikato DHB ommitted to supporting health in ools by: roviding Project Energize into 100% of primary chools and Kura Kaupapa Māori primary schools. EOA) General Practice (GP)services are available in all decile 4 – 6 high schools in the Waikato as well as supporting Nurse led clinics in all high schools decile 1-3, Wharekura and Teen Parent Unit Education sites. These services are well utilised by Māori. (EOA) 3. 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. 4. 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.	1. By Q1 2. On-going 3. By Q2 4. On-going	Identify appropriate measure/s
	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

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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	
Child Health (both Māori and Pacific focussed equity actions are expected in this priority area) (continued)	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 whanau: 1. Opportunistic and outreach immunisation services • 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 2. Family Start Inter sectoral Collaboration (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 t what percentage of children are immunised enrolled with a GP who are in Family Start • Facilitate ongoing management meeti h Oranga Tamariki 3. Investigate financial incentives for fa hanau who complete their child's immunisations (EOA) 4. Complete the build and roll out of the iHub within the hospital to offer opportu immunisations for all children who are inpa passing through the hospital with whanau (EO	1a. On-going b. By Q1 2. y Q3 By Q3 By Q2	HT: Increase immunisations at 8 months PP21: Immunisation coverage
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 com d t livery of health services by: 1. The DHB is currently rtaking He Planning to invest in p ntion and intervention approache keep p e well in community, while better inc lth services e system	1. L	SI16: Strengthening public delivery of health services
	Cancer Service	Value and erformance	Effective and efficie re and service	aikato DH committed to i ving cancer services part arily around Mā alth gain by: 1. Rolling ou Early Detection ng Cancer pilot with a s n Māori. will include develo t of a ated pa way with PHO for fast gnosis of l cer patients to reduce E missions and imp patient outcomes via SLM Amenable Mortality work. (EOA) engage with Te Puna Oranga across all cancer ways to minimise inequity in cancer service by ssing "Did not Attends" (DNA's) and identifying ba This will be addressed by the promotion of th al Nurse Specialist Equity and Access to ident 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

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	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) settlemt Part 2 4. InterRAI Data: • Work with Midland DHBs to ensure InterRAI assessment data is used to identify quality indicators, and service development opportunities. Agree pthways where data identifies need • Prioritise implementation of access to int data at Nation Health Index (NHI) leve ss primary and secondary Equity issue identified – editable access to Assessment and Service Coordination by Kaumatua (EOA) 5. Contribute to DHB and Ministry led development of Future Models of Ca for home and community support services 6. Support the regional s k of: • Consolidation of com ents o ntia pathway Ensure family and Whanau s have acc support and education pr mmes 7. Rollout the START service e sio revent re from primary c ute care identification an rvention plementa a frailty asse nt tool at emergency d rtment to identi tients 75 + years for on- assessment a pport ie early detec	1. By end of Q2 2. On-going 3. ongoing and awaiting furth information MoH 'F lod of Ca ject uality icators to be eveloped and utilised for service improvement by Q3 Access i impl d by Q4 5 going On-going 7. By end of Q1 8. By end of Q1	PP23: Implementing the Healthy Aging Strategy
System Settings (both Māori and Pacific focussed equity actions are expected in this priority area) (continued) – Disability Support Services	team	ductive tnerrship	Waikato DHB mmitt isability support Services h ev g e-learning (or ot training for front f and clinicians that provides advice and nation on what might be important to consider w teracting with a person with a disability. 2. Repo hat % of staff have completed the training	1. Roll out end of Q2 2. Reoprt at end of Q4.	SI14: Disabilty support services
System Settings (both Māori and Pacific focussed equity actions are expected in this priority area) (continued) – Improving Quality	Value and high performance	Effective and efficient care and ces	aikato DHB mmitted to improving patient erience by: upport the newly formed Waikato DHB consumer ouncil with the three identified work streams - ural services, Māori inequity, disability access. evelop 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 5 year strategy. 3. Work to improve equity in outcomes as measured by the Atlas of Healthcare Variation in asthma (EOA). 4. The last 1,000 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

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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	
System Settings (both Māori and Pacific focussed equity actions are expected in this priority area) (continued) – 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. Stockt… report…	PP40: Responding to climate change
System Settings (both Māori and Pacific focussed equity actions are expected in this priority area) (continued) – Waste Disposal	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to reducing pharmaceuti… waste by: 1. Undertake a stocktake to identify: a. The disposal arrangements currently i… e for both community and hospital waste… ifically including cytotoxic waste b. The DHB's understanding of the e… mental and sustainability impacts of the was… osed through these arrangements c. Any actions underway to improve the environmental and sustainability impacts of t… waste disposed. 2. Identify activity/ac… rt the environmental disposal of hospita… waste products	1. By end of Q2 … Q3	P… /aste disp…
Fiscal Responsibility	alue and high performance	Effective… ent care and …erv…	Waikato DHB is committed … eliv… t value for m… anaging our fina… e with the …ctations. …cal impl… ent activities t… pond to Government… ntions (DHBs … ed to include actions in thi… ctions will be a… d)	On-going	Report on activities in the Annual Plan

Government Planning Priority	Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Budget 18 Initiatives (those requiring DHB action in 18/19 once confirmed)	TBC.		TBC		Identify appropriate measure/s
Health Targets once confirmed (both Māori and Pacific focussed equity actions are expected in this priority area)	TBC.		TBC		Identify appropriate measure/s
Cross-Government Targets once confirmed (both Māori and Pacific focussed equity actions are expected in this priority area)	TBC.		TBC		Identify appropriate measure/s
Delivery of Regional Service Plan	One team		TBC		SI2: Delivery of regional plans

Table continues over page

Financial performance summary

(Refer to Appendix One for further detail)

Table: Prospective Statement of Financial Performance (Comprehensive Income) for three years ended 30 June 2018, 2019 and 2020

Forecast Statement of Comprehensive Income						
REVENUE						
Patient care revenue						
Other operating income						
Finance income						
TOTAL REVENUE						
EXPENSES						
Personnel costs						
Depreciation						
Amortisation						
Outsourced services						
Clinical supplies						
Infrastructure and non-clinical expenses						
Other district health boards						
Non-health board provider expenses						
Finance Costs						
Capital Charge						
TOTAL EXPENSES						
Share of profit of Associates and Joint venture						
SURPLUS/(DEFICIT)						
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve						
TOTAL COMPREHENSIVE INCOME						

Table: Prospective Financial Performance by Output Cla[illegible] four years ended 30 June 2018, 2019 and 2020

Total Cost and Revenue						
Revenue						
Costs						
Surplus/(Deficit)						
Forecast Statement of C[illegible]nd Revenue for Prevention						
Revenue						
Costs						
Surplus/(Deficit)						
Forecast S[illegible]ent o[illegible]nd Reve[illegible]r Early De[illegible]on and Mana[illegible]nt						
Reve[illegible]						
Co[illegible]						
Sur[illegible]Deficit)						
Foreca[illegible]tement of Cost and [illegible]enue for Intensive [illegible]ssment and Trea[illegible]t						
Revenue						
Costs						
Surplus/(Deficit)						
Forecast Statement o[illegible]st and Revenue for Suppo[illegible]t and Rehabilitation						
Revenue						
Costs						
Surplus/(Deficit)						

SECTION 3: Service configuration

Service coverage

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

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

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

Waikato DHB is not seeking any changes to the formal exemptions to the Service Coverage Schedule for 2018/19.

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	Benefit/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 to improve the quality of care for patients, enable a more appropriate skill mix in both gynaecology and maternity	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 • Urgent care services (primary and secondary) • Inpatient services • Community (non-hospital) services • Rural laboratory services • Service changes associated with service redesign to support development of rural health clinical services in Ruapehu, South Waikato, Coromandel, Thames and South 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 Addiction	Completing Te Pae Oriti service review commissioning plan 2018/19 and out years. Finalising capital planning and replacement of Henry Bennett. Developing strong links with primary care and others for designing 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 aim 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

Managing our business

Organisational performance management

Waikato DHB's performance is assessed on both financial and non-financial measures which are measured and reported at various level(s) of the organisation. These are reported daily, weekly, quarterly or monthly as appropriate.

Table: External reporting framework

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

Funding and financial management

Waikato DHB's key financial indicators are Revenue, Net Surplus/Deficit, Fixed Assets, Net Assets and Liabilities. These are assessed against and reported through Waikato DHB's performance management process to stakeholders on a monthly basis. Further information about Waikato DHB's planned financial position for 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.

Investment and asset management

Waikato DHBs will develop a 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.

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 NASS around support for specified service areas. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

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

Quality assurance and improvement

Waikato DHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. The DHB Board approved and published a quality governance strategy 'listen, learn, improve' in December 2016, with progress monitored by the Board of Clinical Governance.

Partnerships

Waikato DHB has a statutory responsibilities to improve, promote and protect the health of our people and communities. Therefore, Waikato DHB is committed to working in partnership with our public health unit in their work on health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and in undertaking regulatory functions.

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.

Capital and infrastructure development

Business case expecting approval in 2018/19 TBC
Business cases due for completion in 2018/19
Business cases that will be started in 2018/19
The Waikato University/Waikato DHB medical school is currently awaiting app[illegible] in concept, if appr[illegible] design work and implementation will commence in 18/19.

Information technology and communications systems

Waikato DHB's information technology and communication systems g[illegible] align with [illegible] national and regional strategic direction for IT. Further detail about Waikato DHB's current IT [illegible]tives [illegible]ontained in the 2018/19 Midland Regional Service Plan, and on page 43.

Workforce

Future workforce development - our people strategies - [illegible] se[illegible]g alignment a[illegible]tegration with the Ministry of Health's New Zealand Health Strategy: Future[illegible]ection, a[illegible]Waikato DHB Strategy. Further detail can be found in the section on local and regional enablers [illegible]thin this [illegible]cu[illegible] page 18.
However in summary the key areas are:

- Use of smart technologies has and [illegible] in innovation[illegible]hanges to the way we deliver care, and achieve sustainability, given agi[illegible]opulat[illegible]emands an[illegible]cal constraints. Virtual Health – virtual patient care – includes all of the norm[illegible]spects of p[illegible]nt care with[illegible]having in-person contact with the patient. Other technologies and innovatio[illegible]l require our v[illegible]e to adap[illegible]d change to new ways of working.
- Supporting the develop[illegible]of a culture of [illegible]vat[illegible]an inte[illegible]ional focus on the culture of our workplace; the environment our people[illegible]k in. Inv[illegible]ent is and [illegible]cur in making the workplace safer for staff, finding creative ways to addre[illegible]ui[illegible]ving and embed[illegible]ng the values staff developed, and enabling ways that staff can speak up about ma[illegible]hat concern them. A culture that encourages ideas that can result in transformati[illegible]is require

Co-ope[illegible]ve developmen[illegible]

Waika[illegible]B works and collabora[illegible] with a number of external organisation and entities, including:

- Minist[illegible]Education,
- Ministry o[illegible]tice,
- Corrections
- Police,
- Ministry of Social [illegible]o[illegible]nt,
- Local Government

Workforce

4.3.1 Healthy Ageing 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 conditions
   c. Opportunities for volunteers to supplement and enrich service models for older people living well with chronic health conditions

4.3.2 Health Literacy

Health Literacy Skills within the Workforce

Waikato DHB recognises the importance of promoting and coordinating actions to raise awareness of and to build skills in health literacy practices within 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, where errors may have occurred in the course of treatment which have caused adverse outcomes, and handling difficult/serious complaints.

Health Literacy Practices

It is acceptable 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 accessability.

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.

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 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 Practitioner midwives
- Advertising via local, national and international channels for staff
- 6-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 final 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 ACU 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 the Professional Development Unit (PDU)
- A new initiative to second four midwives into a job-share 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
- Peebles 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 experience 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 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 placements available

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

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 follow

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 2	

Performance measure	Performan e expectation			
HS: Supporting delivery of the New Zealand Health Strategy	Quarterl ghlig against the Strategy themes			
PP6: Improving the health st of people with s ntal illness through improved a t			18/19	19/20
	A 0 - 19	Māori	TBC	
		Other	TBC	
		Total	TBC	
	Age 2 64	Māori	TBC	
		Other	TBC	
		Total	TBC	
	Age 65+	Māori	TBC	
		Other	TBC	
		Total	TBC	
PP7: Im ng mental heal vices using ess and trans (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: S waits for non-urgent tal health and addiction services 9 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- M IFT 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%	

Performance measure	Performance expectation			
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	Year 1	Māori	85%	
		Other	85%	
		Total	85%	
	Year 2	Māori	85%	
		Other	85%	
		Total	85%	
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 in Living Well with Diabetes.			
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C monitor).			
Focus Area 3: Cardiovascular health	90% of eligible population have had their cardiovascular risk assessed in the last 5 years.			
	Percentage of Māori men in the PHO aged 35-44 years' who have had cardiovascular risk assessed in the past 5 years.			
Focus Area 4: Acute heart services	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 Health/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.			

Performance measure	Performance expectation		
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 c uous quality improvement in each school (or group hools) with SBHS.		
	Initiative 3: Youth Primary Mental H As reported through PP26 (see below).		
	Initiative 5: Improve the respo f primary care to youth. Report on actions to re hig formance of the youth service level allian am (SLAT) quivalent) and actions of the SLAT to mprove health of th 's youth population.		
PP26: The Mental Health and Addiction Service Development Plan	Provide reports ecified for the focus areas nary Mental Health trict Suicide Prevention and Post n, Improving Response services, improving outco s for child nd improving yment and physical health needs o le with low ience conditions.		
PP27: Supporting child well-being	Report on a es in nnual Plan.		
PP28: Reducing Rheumatic fever	Focus Area 1: the Incidence of First Episode Rheumatic Fever		
PP29: Improving waiting times for diagnostic services	95% of accepted re for elective coronary angiography ll receive their proce within 3 months (90 days).		
	cepted referral T scans, and 90% of accep als for MRI s s will receive their scan within 6 weeks (		
	0% of le ac or an urgent diagnostic lon opy will receive their procedure within two weeks (14 ar days, inclusive), 100% within 30 days.		
	of people accepted for a non-urgent diagnostic co scopy will receive their procedure within six weeks (42 da 00% within 90 days.		
	70% eople waiting for a surveillance colonoscopy will wait no lo ger than twelve weeks (84 days) beyond the planned te, 100% within 120 days.		
PP30: Faster cancer treatment	5% 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: help for smoke uit in pub pitals	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.		
PP proving the quality of eth y data collection in PHO and gisters	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).		
PP33: Im g Māori enrolment HOs	Meet and/or maintain the national average enrolment rate of 90%.		
PP36: Reduc ate of Māori r the Mental Health Act: section 29 comm treatm rders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
PP37: Improving bre g rates	60% 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.		
SI1: Ambulatory Sensitive Hospitalisations	0-4 years	As specified in the jointly agreed (by district alliances) SLM Improvement Plan	
	46 – 64 years	Total	

Performance measure	Performance expectation	
SI2: Delivery of Regional Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population.	
	Cataract procedures - a target intervention rate of 27 per 10,000 of population.	
	Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population.	
	Percutaneous revascularization procedures - a target rate of at least 12.5 per 10,000 of population.	
	Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.	
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of oral health, asthma, mental 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 agreed (by district alliances) SLM Improvement Plan.	
SI10: Improving cervical screening coverage	% coverage for all ethnic groups and overall.	
SI11: Improving breast screening rates	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 activities in the Annual Plan	
SI15: Addressing local population challenges by increasing nurse	Report activities in the Annual Plan	
SI16: Strengthening Public Delivery Health Service	Report activities in the Annual Plan	
SI17: Improving quality	Report activities in the Annual Plan	
SI18: Improving newborn enrolment in General Practice	Report activities in the Annual Plan	
OS3: Inpatient Average Length of Stay (ALOS)	Elective LOS suggested target is 1.47 days, which represents the 75th centile of national performance.	
	Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.	
OS8: Increasing 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

Performance measure	Performance expectation	
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	>= and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified ab quality audits.	
Output 1: Mental health output Delivery Against Plan	Volume delivery for speci ental and Addiction services is within 5% va e (+/-) of pl volumes for services measured b TE; 5% variance (+ clinically safe occupancy ra 5% for inpatient serv easured by available be ; actual expenditure on the ry of programmes ces is within 5% (+/-) of the yea te 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

Contents

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

This document is available on the Waikato District Health Board website **www.waikatodhb.health.nz**

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(l) of the Crown Entities Act 2004, we present the following information which forms the DRAFT Statement of Performance Expectations. This current document has been prepared in the absence of both the Minister's Letter of Expectations and Funding parameters. In addition it has not been reviewed by the Board of Waikato DHB, therefore, in signing it, my expectation is that the final copy may undergo significant change.

Sally Webb
Chair
Waikato DHB

Vacant
Deputy Chair
Waikato DHB

Date: 30 April 2018

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 performance measures chosen are not an exhaustive list of all of our activity, however 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 provide for our population and at which level. Just as fundamental is our ability to assess whether the services we are funding 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 outcomes 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 designed to measure the contribution made to an outcome by a specified set of goods and services (outputs), or actions of an organisation. 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 of our impact measures. The following impact measures will be used to evaluate the effectiveness and outcomes 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 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 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 and 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

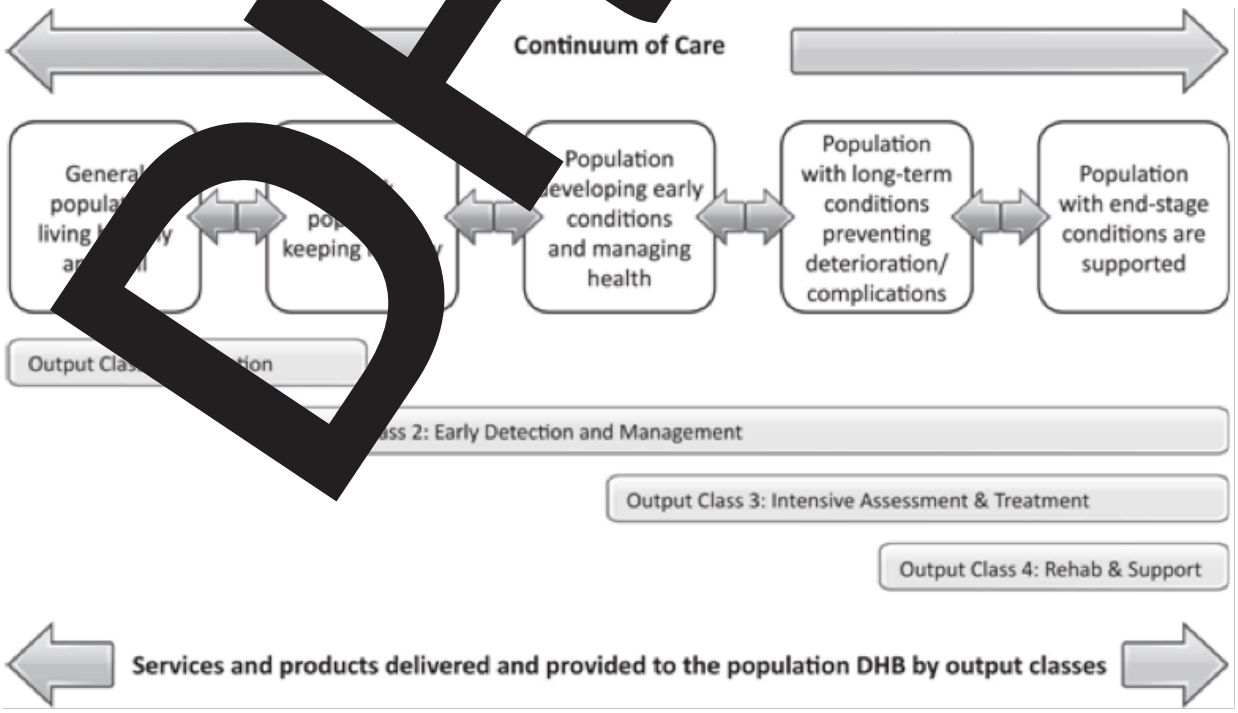
and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand by managing the flow of patients between services and moving the point of intervention to earlier in the path of illness.

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.

Long Term Impacts	People are supported to take greater responsibility for their health	People stay well in their h and communities	receive timely and app specialist care
Intermediate Impacts	• Fewer people smoke • Reduction in vaccine preventable diseases • Improving health behaviours	• An improvement dhood oral health • Long term c ons are detected d manag well • Fewer people ar o hospital for avoidable s • More people maintain the functional independence	• People receive prompt and appropriate acute and arranged care • People have appropriate access to elective services • Improve health status for those with severe mental illness and/ or addiction re people with end stage onditions are supported appropriately

OUTPUT MEASURES

In order to present a representative picture of performa ut have been grouped into four 'output classes' that are a logical fit with the stages of the continuum care and cable to all DHBs. Identifying a set of appropriate measures for each output class can lt. We do not measure 'volumes'. The number of services delivered or the number of peopl service is of s important than whether 'the right person' or 'enough' of the right people re the ser and whether t vice 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 he[illegible]le population or identifiable sub-populations comprising services designed to enhance the he[illegible]tatus [illegible]ulation as distinct from treatment services which repair/support health and disability dysfunct[illegible]
Preventative services address individual behaviours by targeting populati[illegible] wide physical and so[illegible]nments to influence health and wellbeing.
Preventative services include health promotion to ensure that illness [illegible]vented and unequal outcomes [illegible] reduced; statutorily mandated health protection services to protect the publi[illegible] toxic environmental risk and communicable diseases; and, population health protection services such as im[illegible]ation.
On a continuum of care these services are public wide prevent[illegible]services.

Early Detection and Management

Early detection and management services are delivered by a range of [illegible]d allied health professionals in various private, not-for-profit and government service settings. These include gene[illegible]e, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and [illegible] adolescent oral health and dental services.
These services are by their nature more generali[illegible]m multiple health providers and from a number of different locations within the DHB.
On a continuum of care these services are preventa[illegible]d treatme[illegible]sed on individuals and smaller groups of individuals.

Intensive Assessment and Treatment Services

Intensive assessment and treatment [illegible]e delivered b[illegible]ge of secondary and tertiary providers using public funds. These services are usually i[illegible]cilities that e[illegible]co-location of clinical expertise and specialized equipment such as a 'hospital'. [illegible]e services [illegible]generally con[illegible]nd provided by health care professionals that work closely together. They in[illegible].

- Ambulatory services (incl[illegible]outpatient, d[illegible]y services) across the range of secondary preventive, diagnostic, [illegible]eutic, and re[illegible]itative servi[illegible]
- Inpatient services (acute[illegible]ve st[illegible]s) including diagnostic, therapeutic and rehabilitative services;
- Emergency Department servi[illegible]triage, diagnostic, therapeutic and disposition services.

On a continuum of care these servic[illegible]the complex end of treatment services and focussed on individuals.

Rehabilitation [illegible]

Rehabilitation [illegible]upport se[illegible]delivered f[illegible]wing a 'needs assessment' process and coordination input by Needs A[illegible]ment and Servic[illegible]dination (NASC) Services for a range of services including palliative care services, [illegible]-based support servic[illegible]d residential care services.
On a co[illegible]um of care these services[illegible]de support for individuals.

SETTING T[illegible]

Wherever possib[illegible]ve include[illegible]seline data to support evaluation of our performance at the end of the year. All baseline data is ta[illegible]201[illegible] unless stipulated. In setting performance targets, we have considered the changing demographics [illegible]ation, increasing demand for health services and the assumption that funding growth will be limited. Our targ[illegible]eflect 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

Total Cost and Revenue	2018/19 $000 Budget	2019/20 $000 Budget	2020/21 $000 Budget	2021/22 $000 Budget
Revenue		TBC		
Costs				
Surplus/(Deficit)				
Forecast Statement of Cost and Revenue for Prevention	2018/19 $000 Budget	19/20 00	2020/21 $000 Budget	2021/22 $000 Budget
Revenue				
Costs				
Surplus/(Deficit)				
Forecast Statement of Cost and Revenue for Early Detection and Management	3/19 000 Budget	2019/20 $000 Budget	20 $000 Budget	2021/22 $000 Budget
Revenue		TBC		
Costs				
Surplus/(Deficit)				
Forecast Statement of Cost and Revenue for Intensive Assessment and Treatment	201 t	2019/20 $000 Budget	2020/21 $000 Budget	2021/22 $000 Budget
Revenue		TBC		
Costs				
Surplus/(Deficit)				
Forecast Statement of Cost and Revenue for Support and Rehabilitation	2018/19	9/20 $000 Budget	2020/21 $000 Budget	2021/22 $000 Budget
Revenue		TBC		
Costs				
Surplus/(Deficit)				

The output class financial reporting for 20 built from an a of costs by responsibility centre and an allocation of revenue by purchase unit code (purch apping to ou ss as per data dictionary version 22). The out years are based on the same cost and revenu led to total co evenue.

People are supported to take greater responsibility for their health

Long Term Impacts	People are supported to take greater responsibility for their health		
Intermediate Impacts	Fewer people smoke	Reduction in vaccine preventable diseases	roving health behaviours

Fewer people smoke

Impact Measure		ine 14	Ta 2018/	Target /20	Target 2020/21
Percentage of year 10 students who have never smoked[1]					
	Total	74%	≥ 80%	≥ 82	≥ 83%

Output Measure		Output clas	Measure type	Baseline 2014/15	Target 2018/19
Percentage of hospital patients who smoke and are seen by a health oner in a public hospital are offered brief advice and support to quit smok			Qn		
	M			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 pra the last 15 months		1	Qn		
	M			92%	90%
	Pacific			91%	90%
	Other			89%	90%
	otal			90%	90%
Percentage of pregnant women who identify as smokers upon with a DHB-employed midwife or Lead Maternity r are offered bri e and support to quit smoking		1	Qn		
	Ma			64%	90%
	Pacifi			Not available	90%
	Other			66%	90%
				95%	90%

Reduction in vaccine p tabl seases

Impac		Baseline 2014	Target 2018/19	Target 2019/20	Target 2020/21
Three year averag 00,000 of v ventable diseases in hospitalised 0-1				Reduction in admissions for vaccine preventable diseases	
	Māori	19.4	TBC		
	Pacific	0			
	Other	4.5			
	Total	8.8			

Output ure		Output class	Measure type	Baseline 2014/15	Target 2018/19
Percentage of eight m will h eir primary course of immunisations (six weeks, three 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%

[1]Reporting based on school year and based on surveying a sample of schools in New Zealand

Output Measure		Output class	Measure type	Baseline 2014/15	Target 2018/19
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 three[2]		1	Qn		
	Total			68%	75%
Seasonal influenza immunisation rates in the eligible population (65 years and over)			Qn/T		
	Total			68%	75%

Improving health behaviours

Impact Measure		Baseline 2014	Target 2018/19	20	Target 2020/21
Percentage of obese children identified in the B4 School Check programm be offered a referral to a health professional for clinical assessment and based nutrition, activity and lifestyle intervention[3]					
	M		95%	95%	95%
		%	95%	95%	95%
	Ot	%	95%	95%	95%
	Total	9%	95%	95%	95%

Output Measure			Measure type	Baseline 2014/15	Target 2018/19
The number of people participating in Green Prescript	rammes	1	Qn		
				5802	6700
Percentage of primary schools participating in Projec	ize		Qn		
Kura Kaupapa Māori	y schools			100%	100%
Total primary schools				100%	100%

People stay well in their homes and commun

Long Term Impacts	ople s well in their es and communities
Intermediate Impacts	An impro childhood ora / Lo m conditi a tected early and managed well / Fewer people are admitted to hospital for avoidable conditions / More people maintain their functional independence

An improve hood ora [4]

easure		Baseline 2014	Target 2018/19	Target 2019/20	Target 2020/21
Mean de missing and filled teet of Year 8 children					
	Māori	1.65	TBC	Decrease	TBC
	Pacific	1.40			
	Other	0.87			
	Total	1.08			

easure		Output class	Measure type	Baseline	Target 2018/19
Percentage of children (0-4) n DHB funded dental services[5]		2	Qn		
	Māori			72%	≥95%
	Pacific			72%	≥95%
	Other			72%	≥95%
	Total			72%	≥95%

[2]For 2015/16 it is the 2002 birth cohort measured at 30 June in 2016
[3]New target baseline 6 months ending September 2015
[4]Childhood oral health measures are for a calendar year
[5]2016/17 ethnicity data available

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[6]		2	Qn/T		
	Total			14%	≤10%
Percentage of adolescent utilisation of DHB funded dental services[7]		2	Qn		
	Māori			45%	TBC
	Pacific			53%	
	Other			80%	
	Total			70%	

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 assessed in the last five years		2	Qn		
	M			87%	90%
	Pa			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 5 years[8]			Qn	74%	TBC
Percentage of women aged 25-69 years who have had screening event in the past 36 months		2	Qn/T		
	M			60%	80%
	Pacific			65%	80%
	Other			80%	80%
	tal			74%	80%
Percentage of eligible women aged 50-69 who have a Breast Screen Aotearoa mammogram in the last two years		2	Qn/T		
	M			58%	70%
	Pac			60%	70%
	Other			70%	70%
	tal			68%	70%

Fewer people are admitted to hospital for avoidable conditions

Impact Measure		Baseline 2014	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[9]					
	Māori	7758	TBC	Decrease	
	Pacific	6557			
	Other	3239			
	Total	4066			

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of eligible population who 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

[6] Baseline 2014
[7] 2015/16 ethnicity data available
[8] Baseline 16/17
[9] Baseline used by Ministry is 12 months to Sep 2016

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			TBC		
	Resthome	85 years		To be allocated	
	Dementia	83 years			
	Hospital	86 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			Qn/T		
	Total			100%	100%
Percentage of people enrolled with a primary health organisation		2	Qn		
	Māori				95%
	Pacific				95%
	Other			66%	95%
	Total			95%	95%
Percentage of needs assessment and service coordination waiting ti new assessments within 20 working days					
				62%	100%

People receive timely and appropriate specialist care

Long Term Impacts	People receive timely and appropriate specialist care				
Intermediate Impacts	People receive prompt and appropriate acute and arranged care	People have appropriate access to elective services	Improve status of severe mental and/or tion	people n end stage conditions are supported appropriately	Support services

People receive prompt a e acute a anged care

ct Measure		Baseline	Target 2018/19	Target 2019/20	Target 2020/21
Percentage of patients adm discharged, o erred f ency departments within six ho					
	Māori	92%	95%	To be allocated	
	Pacific	91%	95%		
	Other	91%	95%		
	Total	94 %	95%		

easure		Output class	Measure type	Baseline	Target 2018/19
Patients t ive their first cancer tr t (or other management) within 62 days of referred with a high suspi cancer and a need to be seen within ks		3	Qn/T		
	Total			56%	90%
Arranged c elivery without c phic or severe complications as a percentage of t dary and pri deliveries		3	Qn		
	Māori			5%	<16%
	Pacific			5%	<16%
	Other			9%	<16%
	Total			10%	<16%

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:			TBC	To be allocated	
Major joint replacement procedures					
	Total	27			
Cataract procedures					
	Total	25			
Cardiac surgery					
	Total	7.3			
Percutaneous revascularisation					
	Total				
Coronary angiography services					
	Total	3.9			

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 discharges			Qn		
	Total			15,693	TBC
Did not attend percentage for outpatient services		3	Qn/T		
	Māori			21%	10%
	Pacific			18%	10%
	Other			7%	10%
				10%	10%
Elective surgical inpatient average length of stay			Qn/T		TBC
	Total			1.71 days	
Acute inpatient average length of stay		3	Qn/T		
	Total			3.89 days	

Improved health status for th[illegible] severe m[illegible] illness and/or addiction

Impact Measure		Baseline	Target 2018/19	Target 2019/20	Target 2020/21
28 day readmission rate			TBC	To be allocated	
	[illegible]	14%			
	[illegible]	8%			
	Other	12%			
	Total	12%			

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of young people referred for [illegible] mental health or addiction services seen within					
Three weeks					TBC
	Māori			82%	
	Pacific			86%	
	Other			72%	
	Total			75%	
Eight weeks					
	Māori			93%	
	Pacific			95%	
	Other			90%	
	Total			91%	
Mental health clients discharged have a transitional (discharge) plan		3	QnT		
	Māori			New measure for 2017/18 – no baseline	
	Pacific				
	Other				
	Total				

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	
Rates of post-discharge community care		3	n/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			2.8	TBC
	Pacific			Not available	
	Oth			3.07%	
	T			2.97%	
20-64 years					
	M			7.12%	
	Pacific			Not available	
	Other			4.34%	
	Total			4.33%	
65+ years					
	Māori			2.12%	
				Not available	
	Other			2.28%	
	Total			2.27%	

More people with end stage conditions are ed appropriately

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

.put Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of aged reside e facilities ut advance dire s		3	Qn		
	Total			100%	100%
Number of new patients seen by ospital palliative care services		3	Qn		
	Total			652	TBC

Support se

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

Output Measure	Output class	Measure type	Baseline	Target 2018/19
Percentage of people accepted for an **urgent** diagnostic colonoscopy will receive their procedure within[9] two weeks (14 calendar days, inclusive)	2	T		
Total			78%	TBC
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	2	T		
Total			49%	
Percentage of people waiting for a **surveillance** colonoscopy will wait no longer than 84 days beyond the planned date[10]	2	T		
Total			70%	
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt				
			00%	

[9]Baseline 15/16
[10]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						
Other operating income						
Finance income						
TOTAL REVENUE						
EXPENSES						
Personnel costs						
Depreciation						
Amortisation						
Outsourced services						
Clinical supplies						
Infrastructure and non-clinical expenses						
Other district health boards						
Non-health board provider expenses						
Finance Costs						
Capital Charge						
TOTAL EXPENSES						
Share of profit of Associates and Joint venture						
SURPLUS/(DEFICIT)						
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve						
TOTAL COMPREHENSIVE INCOME						

TBC

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						
CURRENT ASSETS:						
Bank balances, deposits and cash						
Receivables						
Inventory						
Non-current assets held for						
CURRENT LIABILITIES:						
Short Term Loans						
Payables and Accruals						
Payroll Accruals						
Net Working						
NON CUR ASSETS:						
Fixed As						
Investr						
NON CU BILITIES:						
Term Payroll L						
Term liabilities						
Trust and Special Funds						
Term Loans						
NET ASSETS						

TBC

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			TBC			
Surplus/(Deficit) for the period						
Increase in Revaluation Reserve						
Equity Injection from Crown						
Repayment to Crown						
Other movements in Equity						
Crown equity at end of period						

Note: Assumed equity injection required for a number of material capital items, such a… Adul… …alth 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 FORECAS…	…/19 …000 …LANNED	2019/2020 $000 …LANNED	2020/2… $000 PLANNED	…021/2022 $000 PLANNED
OPERATING CASHFLOWS						
Cash w as provided from Crow n Agencies and other income sources						
Cash w as disbursed to employees, suppliers and payment of finance charges						
INVESTING CASHFLOWS						
Cash w as provided from assets and investments						
Cash w as disbursed to purchase of assets and investments						
FINANCING CASHFLOWS						
Cash w as provided from proceeds of borrow ings and equity movements						
Cash w as disbursed to repayment of borrow ings and equity						
Net increase/(decrease) in cash hel…						
Add Opening cash balance						
CLOSING CASH BALANCE						
Made up from:						
Bank balances, deposits a…						

1.1 Fixed Assets

Fixed assets carrying value is reviewed ann… …ere are no material issues in valuation. We conduct annual desktop revaluations and re… …in accordan… …rnational public sector accounting standards.

- **1… …isposal of L…**

…llow the processes as … in legislation and administered by the Ministry of Health. The process for disposal of … that we follow is:

- …dentify that there is no servi… …ed for a piece of land either now or for the foreseeable future;
- …by resolution from the …, endorsement of the view that there is no service need for the land and also by …obtain approval … disposal process to be commenced;
- Adv… …he land is … disposed of and seek public comment on the proposal;
- As a res… …ceived seek either Board confirmation or amendment of the proposal to dispose of the land;
- Obtain Ministerial … …al;
- 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

New capital expenditure projects budgeted for the next three years are outlined below.

New Capital Expenditure	2017/18 $M	2018/2019 $M	2019/2020 $M	2020/2021 $M
Under $50,000				
Over $50,000				
Contingency				
Total Capital Expenditure		TBC		

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

Strategic capital spend includes:

Project Name	Business Case Start Date	Business C Comple Da	Business Case Expected Approval Date	Approx. $	rown Cap Requirement
Adult Mental Health					
Taumarunui					
Tokoroa: Te Kuiti: Rhoda Read: Matariki			C		
Education Centre Extension					
Ward Block A – Adult					

We have a working capital financing facility of no greater than 1/12th of crown r d to Provider, as part of a Shared Banking arrangement with New Zealand Health Partnerships Limited, in order to manage ou pital requirements.
The business case for the service and campus reconfiguration specified the future finan uity structure required for supporting the programme, and this Annual Plan has ed on the basis of these p financing arrangements together with additional equity injection by the Ministry of Hea

1.3 Planned financial performance by ion

Table: Prospective Financial Targets and Measures Provide

DHB Provider Forecast Statement of Financial Performance	2016/17 $000 ACTUAL	017 ST	2018/19 $000 PLANNED	2019/2020 $000 PLANNED	2020/2021 $000 PLANNED	2021/2022 $000 PLANNED
REVENUE						
Patient care revenue						
Other operating income						
Finance income						
TOTAL REVENUE						
EXPENSES						
Personnel costs						
Outsourced Services						
Clinical Supplies and Patient Costs						
Infrastructure & Non-clinical Supplies						
Internal Recharg						
TOTAL EXPE						
SURPLUS/(T)						

Table: P ective Financial Target Measures DHB Governance

DHB nce Forecast Statemen Financi nce	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 revenu						
Other operating income						
Finance income						
TOTAL REVENUE						
EXPENSES						
Personnel costs						
Outsourced Services						
Clinical Supplies and Patient Costs						
Infrastructure & Non-clinical Supplies						
Internal Recharges						
TOTAL EXPENSES						
SURPLUS/(DEFICIT)						

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						
Other operating income						
Finance income						
TOTAL REVENUE						
EXPENSES						
Governance Administration						
Personal Health						
Mental Health						
Disability Support						
Public Health						
Maori Services						
TOTAL EXPENSES						
SURPLUS/(DEFICIT)						

1.4 Significant Assumptions

The following are the key assumptions used in the build-up of next yea an 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	TBC		
Employee agreement assumptions			
Payments to NGO's (cost pressure)			
Payments to suppliers			
Capital charge			

Depreciation is charged to the statement hensive income the straight-line method. Land is not depreciated. Depreciation is set at rates that will writ fair value of t ts, less their estimated residual values, over their useful lives.

Risk	Mitigation Strategy
The employee relations envi t presents u nty in terms potential increases in emplo eration ges. Although a wage increase percentage ha the assumptions, some employee representatives may pectation of wage increases that differ from the budgeted le	Potential strategies include: • Negotiate lower than inflation or close to zero percent increases • Use sinking lid and other containment mechanisms to constrain full time equivalents where appropriate
There is risk that provider a ing of goods and ser ill exceed ed percenta creases based on th ent uncertainty o flationary pressures.	• Review contracting arrangements and negotiate more favourable terms • Participate in national procurement initiatives to take advantage of bulk purchasing
There i ial risk in terms of the inhere certainty as to the total am ding that will be appro to health beyond the current year his funding will be ted by the Population Based Funding (la. In addit F is a fixed annual funding allocation in ent w the District Health Board funds demand driven co the risk of the demand exceeding the forecast levels.	

1.5 Accounting Policies

Reporting entity

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

The group consists of Waikato DHB and its controlled entity, Waikato Health Trust. A 20% share of its jointly controlled entity, Health Share Limited, is equity accounted. Health Share Limited is incorporated and domiciled in New Zealand.

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

Basis of preparation

Financial statements and budgets are prepared on a going concern basis, and the accounting policies applied consistently throughout the periods.

Statement of compliance

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

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

Presentation currency and rounding

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

Standards issued and not yet effective and not early

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

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 – 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6-8). The new standards are effective for annual periods beginning on or after 1 January 2019 with early application permitted. These changes have no implication on the Waikato DHB group.

Financial Instruments

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

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

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

Summary of significant accounting policies

Subsidiaries

Waikato DHB is required under the Crown Entities Act 2004 to prepare consolidated financial statements in relation to the economic entity for the financial year. Consolidated financial statements 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.

Associates
Associates are those entities in which Waikato DHB has significant influence, but not control, over the financial and operating policies.

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

Joint ventures
Joint ventures are those entities over whose activities Waikato DHB has joint contr[illegible]ablished by contractual agreement.

Financial statements include Waikato DHB's interest in joint ventures, using th[illegible]uity m[illegible]m the date that joint control begins until the date that joint control ceases. When Waikato DHB's [illegible]e of losses [illegible]s interest in a joint venture, Waikato DHB's carrying amount is reduced to nil and recog[illegible]ition of further losses is [illegible]ued except to the extent that Waikato DHB has incurred legal or constructive oblig[illegible]s, or made payments on [illegible]a joint venture.

Revenue
Revenue from exchange transactions is measured at the fair v[illegible] considera[illegible]eceived or receivable, taking into account the amount of any trade discounts and volume reba[illegible]d by th[illegible]aikato DHB.

Revenue from non-exchange transactions is revenue other than reven[illegible]xchange transactions, such as donations, grants and transfers.

The specific accounting policies for significant reve[illegible]s are explained below:

Ministry of Health (MoH) population-based[illegible]enue
Waikato DHB is primarily funded through revenue re[illegible]d from Mo[illegible]ich[illegible]icted in its use for the purpose of Waikato DHB meeting the objectives specified in its fo[illegible]g legis[illegible] and the scope of the relevant appropriations of the funder. Revenue from MoH is recognised as revenue e[illegible]d. The fair value of revenue from MoH has been determined to be equivalent to the amounts due in the fun[illegible]ngements.

Ministry of Health (MoH) con[illegible]
The revenue recognition approa[illegible] MoH co[illegible]t revenue dep[illegible]on the contract terms. Those contracts where the amount of revenue is subs[illegible]ely linked to[illegible] of qu[illegible]ifiable units of service are treated as exchange contracts and revenue is re[illegible]sed as the D[illegible]vi[illegible]ces.

Other contracts are treated [illegible]xchan[illegible]nd the total funding receivable under the contract is recognised as revenue immediately, unless the[illegible]ntive conditions in the contract. If there are substantive conditions, revenue is recognised when the co[illegible] satisfied. Revenue for future periods is not recognised where the contract contains sub[illegible] termination[illegible]s for failure to comply with the service requirements of the contracts. Cond[illegible]tion provis[illegible]to be substantive, which is assessed by considering factors such as the p[illegible]actice of t[illegible] Judgeme[illegible]s often required in determining the timing of the revenue recognition[illegible]ontracts that span[illegible]nce date and multi-year funding arrangements.

ACC c[illegible]ct revenue
ACC co[illegible]enue is recognised as[illegible]enue when eligible services are provided and any contract conditions have been fulfilled.

Revenue from other [illegible]alth[illegible]ds
Inter-district patient inflow[illegible]ccurs when a patient treated by Waikato DHB is domiciled outside of Waikato DHB's district. MoH pays Wai[illegible]DHB with monthly amount based on estimated patient treatment costs for non-Waikato DHB residents. An annual revenue washup occurs at year end to reflect the actual number of non-Waikato DHB patients treated at Waikato DHB.

Interest revenue
Interest revenue is recognised using the effective interest method.

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

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

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

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

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

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

Leases
Waikato DHB as lessee
A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased term or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is uncertainty as to whether Waikato DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

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

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

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

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

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

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

Cash and cash equivalents
Cash and cash equivalents include cash on hand and bank overdrafts.

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

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

Derivative financial instruments
Derivative financial instruments are used to manage exposure to foreign exchang rising from the group's operational activities. The group does not hold or issue financial instruments f oses. The group has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative co tract is entered into an equently remeasured at their fair value at each balance date with the resulting g loss recognised in the su deficit.

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

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

Non-current assets held for sale
Non-current assets held for sale are classified as he ale if their t will be recovered principally through a sale transaction rather than through continu e. Non ent assets held for sale are measured at the lower of their carrying amount and its fair value less cost ll.

Impairment losses for write-downs o nt assets held ale are recognised in expenses. Any increases in fair value (less costs to sell) are recog evel of any im ent losses that have previously been recognised.

Non-current assets held for sa not depre tised w e they are classified as held for sale.

Property, plant and equi t
Classes of property, plant ment
The asset classes of property, p pment are:
- freehold land
- freehold buildings
- plant, equipm

Land and b gs
Land is m ed at fair value, and b s are measured at fair value less accumulated depreciation. All other asset classes easured at cost, less acc ated depreciation and impairments losses.

Revaluation
Land and buildi alued to f ue with sufficient regularity to ensure that the carrying amount does not differ materially to fair value y five years. The carrying values of revalued assets are assessed annually to ensure that they do not d y from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are rev .

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

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

in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, with the remainder then recognised as a movement in the revaluation reserve in the statement of comprehensive revenue and expense.

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

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

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

Depreciation
Depreciation is charged to the statement of comprehensive revenue and expense on a straight-line basis. Land and work in progress is not depreciated. Depreciation is set at rates that will write off the cost or valuation of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of the major classes of property, plant and equipment have been estimated as follows:

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

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

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

Intangible assets
Software acquisition and development
Acquired software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred.

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

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

Impairment of property, plant, equipment and intangible assets
Waikato DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate commercial return.

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

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

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

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

Payables
Short term payables are recorded at their face value.

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

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

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

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

A liability and expense for bonuses is recognised where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements
Employee benefits that are due to be settled beyond twelve months after the end of the period in which the employee renders the related service, such as sick leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:
- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

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

Superannuation schemes
Defined contribution schemes
Obligations for contributions to KiwiSaver, the Government Superannuation Fund, a[illegible] State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation sche[illegible]nd are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes
Employer contributions to the Defined Benefit Plan Contributors Scheme[illegible] multi-emplo[illegible]d benefit scheme managed by the Board of Trustees of the National Provident Fund. Insu[illegible]nt information is ava[illegible]se defined benefit accounting, as it is not possible to determine from the terms [illegible] scheme the extent to wh[illegible]rplus or deficit of the scheme will affect future contributions by individual [illegible]yers as there is no prescribed [illegible]is for the allocation. The scheme is therefore accounted for as a defined co[illegible]tion scheme.

Provisions
A provision is recognised for future expenditure of uncertain[illegible]r timi[illegible]en there is a present legal or constructive obligation as a result of a past event, and it is proba[illegible]tflow of future economic benefits that settlement payment will be required and a reliable estimate can be m[illegible] amount of the obligation.

ACC Partnership Programme
The liability for the ACC Partnership Programme i[illegible]ured using actuarial techn[illegible]t the present value of expected future payments to be made in respe[illegible]nd claims up to balance date. Consideration is given to anticipated future employee remunera[illegible]vels and [illegible] claims and injuries. Expected future payments are discounted using market yield[illegible]lew Zealan[illegible]ver[illegible]bonds at balance date with terms to maturity that match, as closely as possible, the estim[illegible]future [illegible]out flows.

Repairs to motor vehicles provision
A provision is provided for the cost[illegible]g motor vehi[illegible] the end of their operating lease period before return to the lessor.

Restructuring
A provision for restructurin[illegible]ecognised wh[illegible]ap[illegible]iled formal plan for the restructuring has either been announced publicly to th[illegible]ffected, or fo[illegible]ch implemen[illegible]n has already commenced.

Demolition
A provision for demolition is recogni[illegible]n an approved detailed formal plan for the demolition has either been announced publicly [illegible]which demoli[illegible]lready commenced.

Equity
Equity is m[illegible]red as the differe[illegible]ween total assets and total liabilities. Equity is disaggregated and classified into the f[illegible]ing components:
- Cro[illegible]uity
- Re[illegible]nings
- Revalua[illegible]es
- Trust funds

Revaluation reserves
These reserves relate to the r[illegible]ation of land and buildings to fair value.

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

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

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

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

Cost Allocation
Waikato DHB has determined the cost of outputs using the cost allocation s outli

Direct costs are those costs directly attributable to an output. Indirect co s are those costs that identified in an economically feasible manner with a specific output.

Direct costs are charged directly to output classes. Indirect costs a arged to output classes based on cost drivers and related activity and usage information. Depreciation i ged on the s of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Proper other prem costs, such as maintenance, are charged on the basis of floor area occupied for the productio output er indirect costs are assigned to outputs based on the proportion of direct staff costs for each out

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

Critical accounting estimates and assumptions
In preparing these financial statements, the Boa nd assumptions concerning the future. These estimates and assumptions may differ from ubsequ mates and assumptions are continually evaluated and are based on historical ex ce and oth ding expectations of future events that are believed to be reasonable under the circumsta The e ates and assumptions that have a significant risk of causing a material adjustment to the carrying amo of ts and liabilities within the next financial year are discussed below:

Land and buildings revaluations
The significant assumptions ap n determ the fair value and buildings are disclosed in note 5.

Estimating useful lives and ual values of erty, equipment
At each balance date, the lives and re l values of p erty, plant, and equipment are reviewed. Assessing the appropriateness of use resid alue estimates requires Waikato DHB to consider a number of factors such as the physical condition dvances in medical technology, expected period of use of the asset by Waikato DHB, and expected dispos ds (if any) from the future sale of the asset.

Waikato DHB ha ant chang assumptions concerning useful lives and residual values.

Retirement ities and long se ave
The notes e annual financial stat s provide an analysis of the exposure in relation to estimates and uncerta surrounding retirement a g service leave liabilities.

Critical judg in applying acc ng policies
Management ha d a critica gement in applying accounting policies for determining whether an agency relationship exists re gen s to which party bears the significant risks and rewards associated with the sale of goods or the rend ces. This judgement is based on the facts and circumstances that are evident for each contract and considering substance of the relationship.

APPENDIX B:
2018-19 System Level Measure Improvement Plan

Significant Programmes/Projects

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 11.1.1

UPDATE ON DISENGAGEMENT FROM HEALTHTAP

Purpose	For information and approval.

Introduction
At its meeting on 11 April 2018 the Board considered the report on the Next Steps in Implementation of Virtual Health Strategy and requested an update on the disengagement from HealthTap and any service impacts to patients.

This was in light of the Board decision on 28 March that the "*Board does not renew the HealthTap contract in May 2018 but continues to invest in virtual health care on a basis to be determined, recognising that this will represent a reduction in momentum"*.

The Board asked for the change of supplier/service enablement to keep disruption to a minimum and asked management to find an alternative option as quickly as possible.

This paper has been prepared in response to the request referred to above.

Steps Taken Since Last Board Meeting
Since the Board meeting in April several areas of activity have been underway to provide, where possible, continuation of service to patients. To ensure ongoing care for their patients each identified clinical service area with high utilisation of HealthTap (being Renal, Speech Language Therapy and Public Health Nursing teams) has a plan in place to manage the transition out of their virtual clinical services provided via HealthTap.

This transition will see the use of other technologies to manage patient's care and as a safeguard face to face care if no other option is possible.

Current State
The major use of HealthTap in public health nursing teams was in managing direct observation therapy. This requires a public health nurse to positively confirm adherence to a drug protocol by patients taking last line antibiotic treatments.

The HealthTap system allowed this to be done via a time date recorded video of the patient taking the drug at the prescribed time. It meant that neither the patient nor the public health nurse had to undertake travel to observe the adherence to the drug protocol.

What has now been implemented is a similar process utilising different technologies. The patient takes a time stamped video recording of the process of administering the

drug and then uploads the video into the Waikato DHB share-file service for view and confirmation by the public health nurse at a later date.

Although this is not as elegant as the HealthTap product it is working and is successfully managing work flow. However this solution is not something that would scale significantly as there is a high admin overhead to establish and manage the process. So in the medium term alternatives will be required.

The other services, Renal and Speech Language Therapy will transition to CISCO Jabber guest capability in the near future. The initial “user acceptance” testing was done in the week of the 15th June.

The administrative process work in Renal to enable the change in technology will be competed in the week of 25th June and will allow seamless integration into day to day practice.

Currently all patients, depending on clinical appropriateness, are able to followed up by telephone consult, traditional telehealth before a face-to-face consultation. The deployment of the CISCO Jabber guest capability in July of this year will provide the opportunity to reinstate many of the benefits provided by HealthTap.

Recommendations
THAT
The report be received.

DARRIN HACKETT
EXECUTIVE DIRECTOR VIRTUAL CARE AND INNOVATION

Medical School: refer agenda item 4.

Creating Our Futures: report due in July.

Papers for Information

Presentations

MEMORANDUM TO THE BOARD
27 JUNE 2018

AGENDA ITEM 13.1

MENTAL HEALTH PRESENTATION – HONOS (HEALTH OF THE NATION OUTCOMES SCALE)

Purpose	For information.

At the April Board meeting, Board members requested a presentation providing context and information in relation to the use of the HoNOS tool as a measure of acuity for Mental Health service users.

Recommendation
THAT
The Board notes the presentation.

DR REES TAPSELL
CLINICAL SERVICES DIRECTOR
MENTAL HEALTH AND ADDICTIONS SERVICES

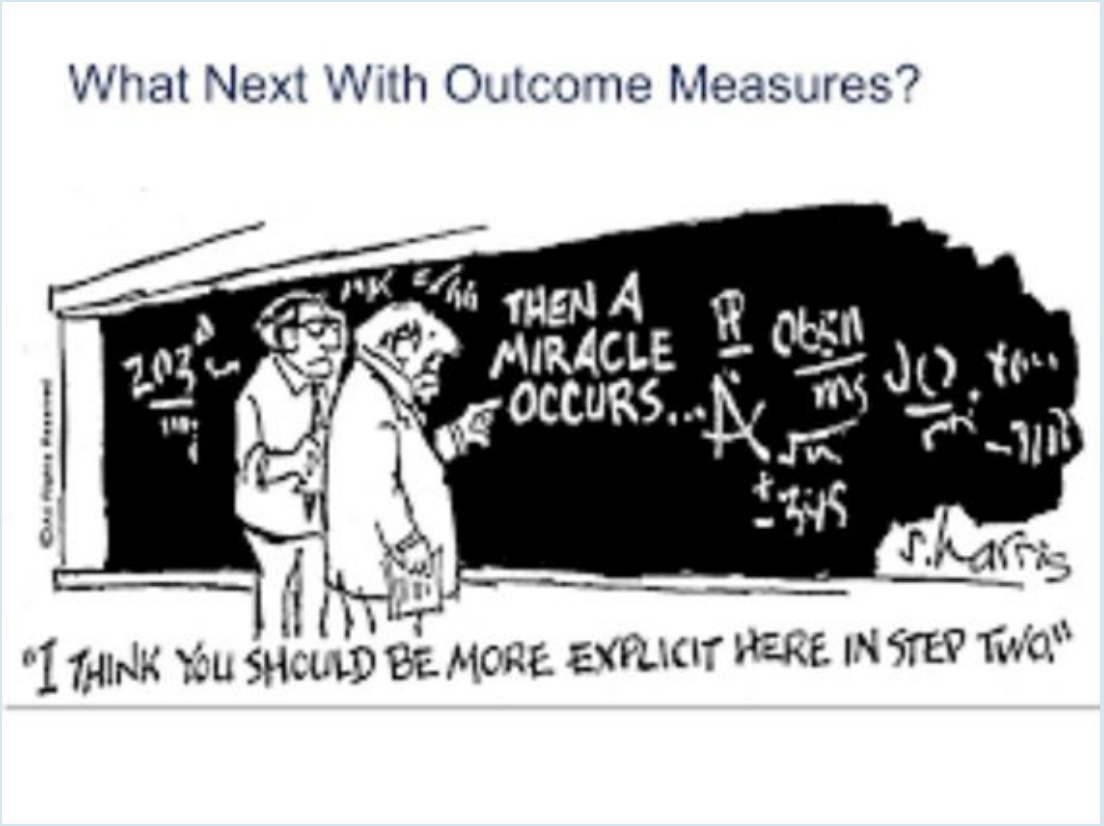
HoNOS
Health of Nation Outcomes Scale

Dr Rees Tapsell, June 2018

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – Building Healthy Communities

What Next With Outcome Measures?



HoNOS suite
Health of the Nation Outcome Scale of measures

- Clinician rated
- Health and social functioning
- Mandated for use in NZ by the MoH as part of an outcomes framework
- Suite includes: HoNOS, HoNOS65+, HoNOSCA, HoNOS_LD, HoNOS-secure

- Designed by RANZCP as a specifically broad spectrum measure
- Measure of severity and impact
- Internationally utilised
- Time efficient
- Reliable and valid
- Sensitive to change
- Diagnostically agnostic

- Rating is made using clinical judgement of the rater (using descriptors in the glossary)
- Categorical rating scale
- Variation of number of items between different HoNOS measures - regardless, each must be rated in methodical order from 1
- Each mental health/social problem is rated only once
- Problems occurring over the past two weeks are included
- Rate the most severe problem that occurred during the period

Requirements for Rating HoNOS

- be a mental health clinician
- be able to exercise clinical judgment
- have been trained in the use of the HoNOS
- have completed a comprehensive assessment – consider information from all available sources
- rate in accordance with the glossary at all times

HoNOS – 12 scale (items) adult

1. Overactivity, aggression
2. Non-accidental self-injury
3. Problem drinking or drug-taking
4. Cognitive problems
5. Physical illness or disability problems
6. Problems associated with hallucinations or delusions
7. Problems with depressed mood
8. Other mental and behavioural problem
9. Problems with relationships
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and activities

12 ITEMS, each with 5-point severity scales (0-4)

- 0 -no problem
- 1 = minor problem requiring no action
- 2 = mild problems but definitely present
- 3 = problem of moderate severity
- 4 = severe to very severe problem

Example of scale structure

Scale 1. Overactive, aggressive, disruptive or agitated behaviour

Include such behaviour due to any cause, e.g. drugs, alcohol, dementia, psychosis, depression, etc.

0 no problems of this kind during the period rated

1 occasional irritability, quarrels, restlessness etc. but generally calm

2 includes occasional aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked over-activity or agitation

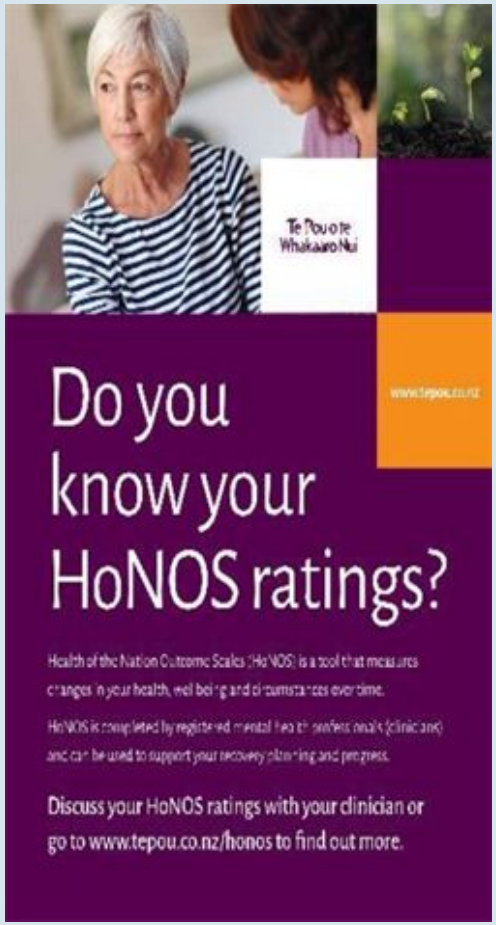
3 physically aggressive to others or animals (short of rating 4); persistently threatening manner, more serious over-activity or destruction of property

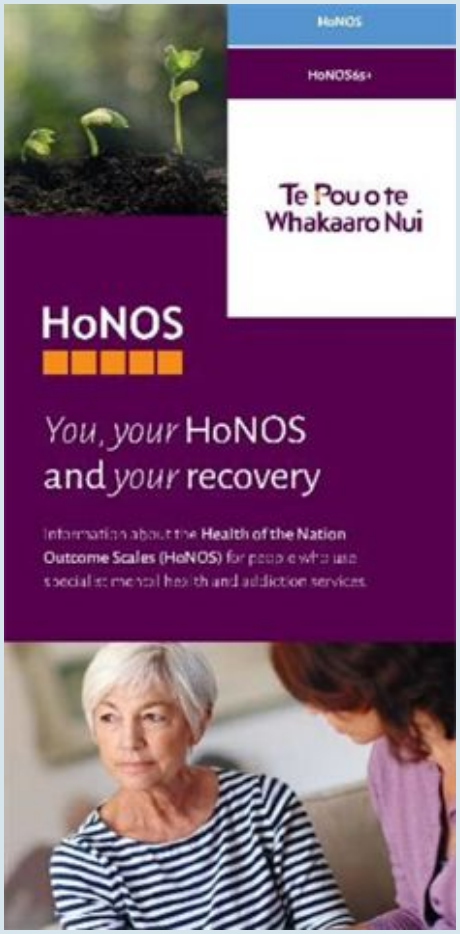
4 at least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); persistent serious intimidation or obscene behaviour.

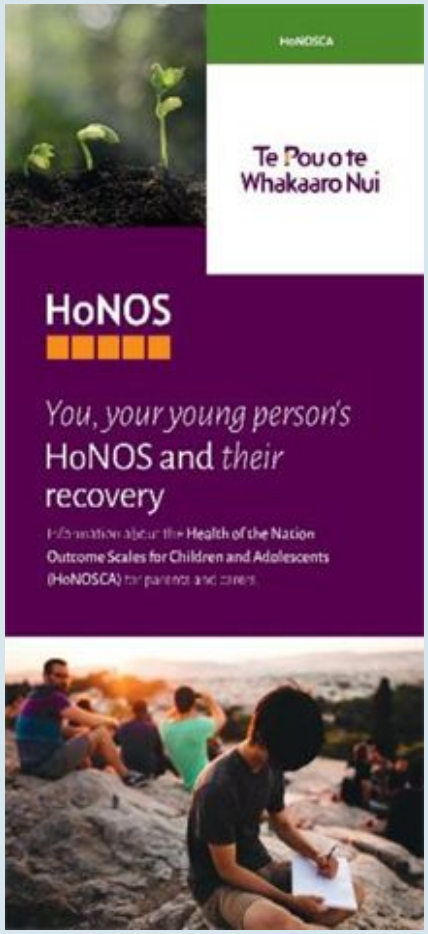
*Rating 0 or 1 - not clinically significant.

*Rating 2,3 or 4 – clinically significant

Involving tāngata whai ora







Next Board Meeting: 25 July 2018.