Board Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	27 March 2019	Time:	1pm

Board Members	Ms S Webb (Chair) Professor M Wilson (Deputy Chair) Ms S Christie Ms C Beavis Mr M Gallagher Mrs MA Gill Ms T Hodges Mr D Macpherson Mrs P Mahood Ms S Mariu Dr C Wade
In Attendance	Mr K Whelan, Crown Monitor Ms T Thompson-Evans, Chair Iwi Maori Council Mr D Wright, Interim Chief Executive and other Executives as necessary

Next Meeting Date:	24 April 2019	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680
	www.waikatodhb.health.nz	

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

Our Values:

People at heart – **Te iwi Ngakaunui**
Give and earn respect – **Whakamana**
Listen to me talk to me – **Whakarongo**

Fair play – **Mauri Pai**
Growing the good – **Whakapakari**
Stronger together – **Kotahitanga**

Board Agenda

Item

1. Apologies

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

3. MINUTES AND BOARD MATTERS
- 3.1 Board Minutes: 27 February 2019
- 3.2 Board Minutes: 13 March 2019
- 3.3 Board Minutes: 18 March 2019
- 3.4 Committees Minutes:
  - 3.4.1 Iwi Maori Council (draft): 7 March 2019
  - 3.4.2 Maori Strategic Committee (draft): 20 March 2019

4. INTERIM CHIEF EXECUTIVE REPORT

5. QUALITY AND PATIENT SAFETY
- 5.1 Patient Story (April)

6. FINANCIAL PERFORMANCE MONITORING
- 6.1 Finance Report

7. HEALTH TARGETS
- 7.1 Health Target Report

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

9. SERVICE PERFORMANCE MONITORING
- 9.1 Interim Chief Operating Officer
- 9.2 Facilities and Business (refer to item 19)
- 9.3 IS Performance Monitoring (report due in April)
- 9.4 Chief Data Officer Directorate (report due in April)
- 9.5 Strategy, Funding and Public Health (report due in April)
- 9.6 HR and Organisational Development Service (report due in May)
- 9.7 Mental Health and Addictions Service (report due in May)

10. PROFESSIONAL ADVISORY REPORTS
- 10.1 Chief Medical Officer
- 10.2 Chief Nursing & Midwifery Officer (report due in April)
- 10.3 Chief Advisor Allied Health, Scientific and Technical (report due in May)

11. DECISION REPORTS
- 11.1 Equity Focussed Reporting (report due in April)
- 11.2 Strategic Direction for Our People
- 11.3 Waikato DHB Draft Annual Plan and Statement of Intent 2019/20
- 11.4 Health System Plan – Goals, Actions and Activities

Board Agenda

12. **SIGNIFICANT PROGRAMMES/PROJECTS**

12.1 Creating our Futures
Me Koorero Taatou presentation by Ms TP Thompson-Evans and Mr G O'Brien
12.2 Mental Health and Addictions System Plan
12.3 CBD Accommodation Project (refer to items 4)
12.4 Regional eSPACE Programme (refer due in May)
12.5 Finance, Procurement and Information Management System ex NOS (report due in May)

13. **PAPERS FOR INFORMATION**

13.1 Employee Survey 2018

14. **PRESENTATIONS**

14.1 Presentation from Hauraki PHO General Practices – Dr T Mayne, Dr P Wood, Dr T Hemi and Dr A Minett to attend at 1.15pm

15. **BOARD MEMBER ITEMS**

15.1 The Living Wage

NEXT MEETING: 24 April 2019

Board Agenda

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

THAT:

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

Item 16: Minutes – Various
- (i) Waikato District Health Board for confirmation: Wednesday 27 February 2019 2019 (Items taken with the public excluded)
- (ii) Waikato District Health Board for confirmation: Wednesday 13 March 2019 2019 (Items taken with the public excluded)
- (iii) Waikato District Health Board for confirmation: Monday 18 March 2019 2019 (Items taken with the public excluded)
- (iv) Audit and Corporate Risk Management Committee to be received: Wednesday 27 February 2019 (All items)
- (v) Midland Regional Governance Group to be received: Friday 1 March 2019

Item 17: Exit of Practices from Hauraki Primary Health Organisation – Public Excluded
Item 18: Facilities and Business Service Performance Monitoring Report – Public Excluded
Item 19: Replacement of Radiology Angiography Equipment – Public Excluded
Item 20: Options for Chief Executive Recruitment – Public Excluded

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

(3) Pursuant to Clause 33 (1) of Schedule 3 of the NZ Public Health & Disability Act 2000 the general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER	SECTION OF THE ACT
Item 16 (i-v): Minutes – Public Excluded	Items to be adopted/confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 17: Exit of Practices from Hauraki PHO – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 18: Facilities and Business service report – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 19: Radiology Angiography equipment replacement – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 20: CEO recruitment – Public Excluded	Negotiation will be required	Section 9(2)(j)

Board Agenda

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

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

Board Agenda

16. MINUTES – PUBLIC EXCLUDED

16.1 Waikato District Health Board: 27 February 2019
To be confirmed: Items taken with the public excluded

16.2 Waikato District Health Board: 13 March 2019
To be confirmed: Items taken with the public excluded

16.3 Waikato District Health Board: 18 March 2019
To be confirmed: Items taken with the public excluded

16.4 Audit & Corporate Risk Management Committee: 27 February 2019
To be received: All items

16.5 Midland Regional Governance Group: 1 March 2019
To be received: All items

17. EXIT OF PRACTICES FROM HAURAKI PRIMARY HEALTH ORGANISATION – PUBLIC EXCLUDED

18. FACILITIES AND BUSINESS SERVICE PERFORMANCE MONITORING REPORT– PUBLIC EXCLUDED

19. REPLACEMENT OF RADIOLOGY ANGIOGRAPHY EQUIPMENT – PUBLIC EXCLUDED

20. OPTIONS FOR CHIEF EXECUTIVE RECRUITMENT – 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 MARCH 2019

Sally Webb

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

Crystal Beavis

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

Sally Christie

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Thames Coromandel District Council	TBA	TBA	
Partner, employee of Workwise	Pecuniary	Potential	

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

Martin Gallagher

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

Mary Anne Gill

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Life Unlimited Charitable Trust	Pecuniary	Perceived	
Member, Public Health Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Disability Support Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Health Strategic Committee, Bay of Plenty DHB	Pecuniary	Potential	

Tania Hodges

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	

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

Dave Macpherson

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Councillor, Hamilton City Council	Pecuniary	Perceived	
Deputy Chair, Waikato Regional Passenger Transport Committee	Non-Pecuniary	Potential	
Member, Waikato Regional Transport Committee	Non-pecuniary	Potential	
Member, Future Proof Joint Council Committee	Non-pecuniary	None	
Partner is an occasional contractor to Waikato DHB in "Creating our Futures"	TBA	Potential	

Pippa Mahood

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

Sharon Mariu

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

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

Interest	Nature of Interest	Type of Conflict	Mitigating Actions
Owner, Chartered Accountant in Public Practice	Pecuniary	Perceived	
Daughter is an employee of Puna Chambers Law Firm, Hamilton	Non-Pecuniary	Potential	
Daughter is an employee of Deloitte, Hamilton	Non-Pecuniary	Potential	

Clyde Wade

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Shareholder, Midland Cardiovascular Services	Pecuniary	Potential	
Trustee, Waikato Health Memorabilia Trust	Non-Pecuniary	Potential	
Trustee, Waikato Heart Trust	Non-Pecuniary	Potential	
Trustee, Waikato Cardiology Charitable Trust	Non-Pecuniary	Potential	
Patron, Zipper Club of New Zealand	Non-Pecuniary	Potential	
Emeritus Consultant Cardiologist, Waikato DHB	Non-Pecuniary	Perceived	
Cardiology Advisor, Health & Disability Commission	Pecuniary	Potential	Will not be taking any cases involving Waikato DHB
Fellow Royal Australasian College of Physicians	Non-Pecuniary	Perceived	
Occasional Cardiology consulting	Pecuniary	Potential	
Member, Hospital Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Son, employee of Waikato DHB	Non-Pecuniary	Potential	

Professor Margaret Wilson

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2

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

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

Te Pora Thompson-Evans

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

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

Conflicts related to items on the agenda.

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Board Meeting held on Wednesday 27 February 2019 at 1.00pm in the Board Room, Hockin Building at Waikato Hospital

Present:

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

In Attendance:

Ms T Thompson-Evans (Chair, Iwi Maori Council)
Mr K Whelan (Crown Monitor)
Mr D Wright (Interim Chief Executive)
Mr N Hablous (Executive Director, Chief Executive's Office)
Ms T Maloney (Executive Director, Strategy, Funding and Public Health)
Ms V Aitken (Executive Director, Mental Health and Addictions Service)
Ms S Hayward (Chief Nursing and Midwifery Officer)
Mr R Dunham (Interim Chief Operating Officer)
Ms M Neville (Director, Quality and Patient Safety)
Ms L Aydon (Executive Director Public Affairs)
Ms C Tahu (Chief Advisor Allied Health, Scientific and Technical)
Ms G Sewell (Executive Director, Human Resources and Organisational Development)
Mr M ter Beek (Chief Data Officer)
Mr A McCurdie (Chief Financial Officer)
Ms C Gardner (General Counsel)

PRESENTATION FROM MACPHERSON STEVENS FAMILY

The Board Chair welcomed the Macpherson Stevens family and their supporters to the meeting.

Mr D Macpherson and Ms J Stevens addressed the Board with their perspective of recent events relating to the Waikato DHB's decision to bring concerns about the inquest into the death of Nicky Stevens to the attention of the Solicitor General.

The Board Chair thanked the Macpherson Stevens family for their presentation.

ITEM 1: APOLOGIES FOR ABSENCE

There were no apologies.

ITEM 2: INTERESTS

2.1 Register of Interests

The Board Chair raised with Board member Mr D Macpherson his conflict of interest pertaining to the death of his son and noted that this would need to be provided in writing to the Chief Executive's office and recorded in the Board's register of interests.

There were no other changes noted for the Register of Interests.

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: 23 January 2019

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 23 January 2019 taken with the public present was confirmed as a true and accurate record.

3.2 Committee Minutes

3.2.1 Iwi Māori Council (draft): 7 February 2019

The Iwi Maori Council Chair highlighted three areas:

- Pathways to increase Maori health workforce.
- Me Koorero Taatou (Lets Talk paper) with discussion on how Iwi wish to receive ongoing information and how monitoring can be undertaken in partnership.
- Ms M Balzer had been nominated as the iwi representative on the Mental Health and Addictions clinical governance forum.

Resolved
THAT
The Board received the draft minutes of the Iwi Maori Council meeting held on 7 February 2019.

3.2.2 Hospitals Advisory Committee (draft): 12 December 2018

Resolved
THAT
The Board received the draft minutes of the Hospitals Advisory Committee meeting held on 12 December 2018.

3.2.3 Community and Public Health Advisory Committee (draft): 13 February 2019

The Committee Chair highlighted:

- A number of DHB position statements were reviewed and it was agreed that all future positions statements should include a statement on radically improving Maori health outcomes.
- A presentation on rural health and workforce issues and how this will impact on the delivery of community services.

Board member Ms C Beavis noted that the draft minutes should make reference to a request for an overview of the diabetes services as part of the Committee's work schedule and future planning for managing long term conditions, and would raise this at the next Committee meeting.

Resolved
THAT
The Board received the draft minutes of the Community and Public Health Advisory Committee meeting held on 13 February 2019, noting that an amendment would be made around future planning for the management of diabetes.

3.2.4 Maori Strategic Committee (draft): 20 February 2019

The Committee Chair highlighted:

- The March meeting would focus on this Committee's work plan and identifying priorities where traction could be made.
- Reminded Board members that they were welcome to attend the meetings of the Maori Strategic Committee.

Resolved
THAT
The Board received the draft minutes of the Maori Strategic Committee meeting held on 20 February 2019.

ITEM 4: INTERIM CHIEF EXECUTIVE REPORT

Mr D Wright presented this item. The report was taken as read.

Of note:

- The DHB and health sector is continuing through a period of industrial action. The DHB is coping but staff are becoming increasingly fatigued and stressed as a result of strike action.
- The Chief Nursing and Midwifery Officer clarified the methodology used by the DHB to report on nursing numbers (using requisitions and converting to vacancies) and advised the DHB monitors closely those wards under staffing pressure. Noted that that Waikato DHB's nursing vacancy sits at 3%.
- The Board asked Management, through Te Puna Oranga, to develop a framework that sets the criteria for statements on addressing Maori equity in all Board reports. The Board is looking for statements which are deliberate and purposeful on how a project, initiative etc will/is making positive contributions to radical improvement for Maori health. This would be discussed at a future Board meeting.

Resolved
THAT
The Board received the report.

ITEM 5: QUALITY AND PATIENT SAFETY REPORT

No report this month.

ITEM 6: FINANCIAL PERFORMANCE MONITORING

6.1 Finance Report

Mr A McCurdie presented this item.

The financial results summary for the month of January 2019 was presented to the Board. The report was taken as read.

Of note:

- An unfavourable year to date variance to budget of $4.9m.
- The DHB is waiting on a decision from the Ministry of Health with regard to equity support and will continue to follow up on this.
- The DHB is not achieving its Savings Plan targets.
- The DHB is still forecasting to be on budget for this financial year.
- Work continues on increased clinical supply costs and the drivers of this.
- The Resource Review project is investigating outsourced personnel and service costs.

Resolved
THAT
The Board received the Finance report for January 2019.

6.2 Asset Performance Indicators – December 2018 YTD Progress (Quarter 2, 2018/19)

Mr A McCurdie presented this item.

An update report on Asset Performance Indicators as at December 2018 was submitted for the Board's information.

Of note:

- Asset Performance Indicators are part of the Investor Confidence Rating process and will improve overall asset management across the organisation.
- Asset performance information covers three portfolios being Facilities, Clinical Equipment and Information Communications Technology.
- Enhancements have been made to improve the accuracy of the results being reported.
- There is work occurring with the Ministry of Health on having consistent measures for asset management.

Resolved
THAT
The Board:
1) Approved the Asset Performance Indicators December 2018 performance update.
2) Approved the updated 2018/19 targets.

ITEM 7: HEALTH TARGETS

Ms T Maloney and Mr R Dunham presented this item.

The Health Targets report was submitted for the Board's information.

Of note:

- The DHB is awaiting a new set of national performance measures from the Ministry of Health focused on population health outcomes.
- System Level Measures have been added to the report.
- It is anticipated that health targets will be presented as a trend report.

Faster Cancer Treatment
- This target continues to be met and is also a Midland-wide performance indicator.

Shorter Stays in Emergency Department
- Achieving this target remains a significant concern and is being closely monitored.
- Processes have been changed and performance has improved.
- Detailed reporting is provided to management on a daily basis covering the number of patients admitted, the number of patients who exceed the six hour target, acuity levels, urgent vs non urgent patients, referral to primary care.

Increased Immunisation
- The DHB is considering a more comprehensive approach to its immunisation strategy including a specific Maori immunisation plan.
- Engagement with Waitemata DHB is occurring to take on board their learnings (what is working for them) and with primary care.

Resolved
THAT
The Board received the report.

ITEM 8: HEALTH AND SAFETY

The Health and Safety service quarterly report to be submitted to the March board agenda.

ITEM 9: SERVICE PERFORMANCE MONITORING

9.1 Human Resources and Organisational Development Service

Ms G Sewell presented this item.

Of note:

- The Executive Director was asked to consider expanding the membership of the Strategic Recruitment Group to include additional staff from Te Puna Oranga, to ensure culture competency and Tikanga is maintained in all resourcing practices and initiatives.

Resolved
THAT
The Board received the report.

9.2 Interim Chief Operating Officer (report due in March)
9.3 People and Performance (report due March)
9.4 Facilities and Business (due in March)
9.5 IS Performance Monitoring (due in March)
9.6 Chief Data Officer Directorate (due in April)
9.7 Strategy, Funding and Public Health (due in April)
9.8 Mental Health and Addictions Service (due in May)

ITEM 10: PROFESSIONAL ADVISORY REPORTS

10.1 Chief Medical Officer

Report to be submitted to the March board agenda.

10.2 Chief Nursing and Midwifery Officer

Report to be submitted to the April board agenda.

10.3 Chief Advisor Allied Health, Scientific and Technical

Report to be submitted to the May board agenda.

ITEM 11: DECISION REPORTS

11.1 Equity Focussed Reporting

Report to be submitted to the March board agenda.

11.2 Delegations of Agreements over $10M per annum for Signing

A report seeking approval for delegated authority to be given to the Interim Chief Executive in relation to the Crown Funding Agreement – Elective and Ambulatory Initiative variation, was submitted for the Board's consideration.

Resolved
THAT
The Board:
1) Received the report.
2) Delegated authority to the Interim Chief Executive to sign the Elective and Ambulatory Initiative variation for $30,945,391.

ITEM 12: SIGNIFICANT PROGRAMMES/PROJECTS

12.1 Creating our Futures

Report to be submitted to the March board agenda.

Board member Mr D Macpherson noted that this report had been expected for the February board meeting. The Board Chair advised the report had been deferred to the March board agenda and the reasons for this. Mr Macpherson asked for Board members to be alerted if scheduled board reports were being deferred and requested this particular report be circulated as early as possible, ie outside the normal agenda circulation process. This request was declined by the Board Chair who wanted to ensure all documentation was provided (including related presentations) as a complete package and as part of the board agenda process. Mr Macpherson registered his objection this decision based on a lack of sufficient time for members to assimilate the report's content .

12.2 CBD Accommodation Project

Report to be submitted to the March board agenda.

12.3 Regional eSPACE Programme

Report to be submitted to the March board agenda.

12.4 National Oracle System

Refer agenda item 17 in the public excluded section of the February board agenda.

ITEM 13: PAPERS FOR INFORMATION

13.1 Hauora iHub

The Interim Chief Executive will pass on the Board's appreciation and thanks to the staff and volunteers who run the Hauora iHub.

Resolved
THAT
The Board noted the Hauora iHub update and its focus for the rest of the financial year.

ITEM 14: PRESENTATIONS

There were no presentations this month.

ITEM 15: BOARD MEMBER ITEMS

15.1 Living Wage

Report to be submitted to the March board agenda.

15.2 Staff Service Recognition Awards

Board member Dr C Wade circulated a display of badges given to staff in recognition of their length of service with Waikato DHB and explained why the badges had been introduced.

Of note:

- Positive feedback had been received from staff.
- Badges for staff who have worked for the DHB for 50 years and over, will be available.
- Consideration is being given to recognising the service of DHB contractors.

15.3 Future Agenda Item

Board member Mrs P Mahood raised a future agenda item being an update on the activities of the Waikato Regional Plan Leadership Group and would be available to work with the Executive Director Strategy Funding and Public Health to arrange this.

NEXT MEETING

The next meeting is to be held on Wednesday 27 March 2019 commencing at 1.00pm in the Board Room, Hockin Building, Waiora Waikato Hospital.

BOARD MINUTES OF 27 FEBRUARY 2019

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

THAT:

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

ITEM 16: MINUTES – VARIOUS:

(i) Waikato District Health Board – for confirmation: Wednesday 23 January 2019
(ii) Audit and Corporate Risk Management Committee – to be received: Wednesday 27 February 2019
(iii) Midland Regional Governance Group – to be received: Friday 1 February 2019

ITEM 17: INTERIM CHIEF EXECUTIVE REPORT (FPIM BUSINESS CASE) – PUBLIC EXCLUDED

ITEM 18: CAPITAL PLAN SUPPORT REQUEST – PUBLIC EXCLUDED

ITEM 19: EXIT OF PRACTICES FROM HAURAKI PRIMARY HEALTH ORGANISATION – PUBLIC EXCLUDED

ITEM 20: CHIEF EXECUTIVE RECRUITMENT – PUBLIC EXCLUDED

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

(3) Pursuant to Clause 33 (1) of Schedule 3 of the NZ Public Health & Disability Act 2000 the general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER	SECTION OF THE ACT
Item 16 (i-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 17:	FPIM business case – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 18:	Capital Plan support – Public Excluded	Negotiation will be required	Section 9(2)(j)

Item 19:	Exit of Practices from Hauraki PHO – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 20:	Chief Executive recruitment process – Public Excluded	Negotiation will be required	Section 9(2)(j)

(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.**

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ACTION LIST

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

Agenda Item	Action Agreed	Name of Executive Director Responsible for Action	Month action to be reported to the Board
12.5	28 November 2018 Future discussion on clinical workforce development	Gil Sewell	TBA
4	23 January 2019 Report on Drinking Water Assessment service – resourcing and accreditation	Tanya Maloney	TBA
7	23 January 2019 Report on ED performance and initial views of Waikato services	Ron Dunham	March 2019
7	23 January 2019 Report on Acute Flow and Emergency Care Review	Ron Dunham Tanya Maloney	TBA
9.2	23 January 2019 Mental Health – analysis of discharge service	Vicki Aitken	TBA
18	23 January 2019 Progress report on review of care for Thames patients	Neville Hablous	August 2019
4	27 January 2019 Draft equity statements	Loraine Elliott	TBA
15.3	27 February 2019 Future agenda item – update on the activities of the Waikato Regional Plan Leadership Group	Tanya Maloney	TBA
20	27 February 2019 CE recruitment options papers	Gil Sewell	March 2019

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 13 March 2019 at 12.30pm in the Board Room, Hockin Building at Waikato Hospital

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

In Attendance: Mr D Wright (Interim Chief Executive)
Mr N Hablous (Executive Director, Chief Executive's Office)
Mr A McCurdie (Chief Information Officer)

APOLOGIES

The apologies from Ms S Mariu and Ms T Hodges were received.

Ms T Pora Thompson-Evans was also unable to attend.

ADDITIONAL AGENDA ITEMS

Additional items were raised for discussion in the public section of the Board meeting being:

- DHB's financial position.
- Health Select Committee.
- Board Workshop on Parking and Transport.

With respect to the DHB's financial position and issues this matter will be discussed at the 27 March 2019 board meeting.

With respect to the Health Select Committee Hearing the Board Chair gave a summary of the hearing Waikato DHB attended on 6 March 2019. The topics raised at the hearing were:

- The DHB's annual plan and deficit.
- Infrastructure and Capital investment.
- Improvements in place since last year and what the DHB was proud of.
- Consumer Council.

The local MPs had acknowledged the significant progress the DHB had made under the leadership of Mr D Wright and said the community's trust in the DHB had improved.

The Board Chair clarified the status of the Health Select Committee and confirmed that Board members would be advised prior to the DHB attending future hearings.

With respect to the Board Workshop on parking and transport, this will be held at the DHB on 27 March 2019 from 10am to 11.30am. The DHB will consider involving external transport partners to provide technical and operational information. It was noted that the workshop will not be a decision making forum. It is to look at the parking and transport challenges faced by the DHB and the sharing of ideas on how to address these.

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 1: HEALTH FINANCE, PROCUREMENT AND INFORMATION MANAGEMENT SYSTEM BUSINESS CASE – PUBLIC EXCLDED

(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 OFFICIAL INFORMATION ACT
Item 1: FPIM business case – Public Excluded	Negotiations will be required	Section 9(2)(j)

(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.

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WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Monday 18 March 2019 at 4.32pm in the Board Room, Hockin Building at Waikato Hospital

Present:

Prof M Wilson (Deputy Chair)
Ms C Beavis
Ms S Christie – by phone
Mr M Gallagher
Ms M A Gill
Ms D Macpherson – by phone
Ms T Hodges – by phone
Mrs P Mahood
Dr C Wade

In Attendance:

Ms T Thompson-Evans (Chair, Iwi Maori Council)
Mr D Wright (Interim Chief Executive)
Ms L Aydon (Executive Director Public Affairs)
Ms G Sewell (Executive Director Human Resources and Organisational Development – by phone

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The Board meeting commenced with members holding a moment's silence for the victims of the Christchurch terror attack on Friday 15 March 2019.

The Deputy Chair advised that she had sent a message to the Chair of Canterbury DHB and that the Interim Chief Executive had been in contact with Canterbury DHB offering support.

ITEM 1: APOLOGIES

Apologies were received from Ms S Webb, Ms S Mariu and Ms C Beavis (for lateness).

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 2: INTERIM CHIEF EXECUTIVE – PUBLIC EXCLDED

(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 OFFICIAL INFORMATION ACT
Item 2: Appointment of Interim Chief Executive – Public Excluded	Negotiations will be required	Section 9(2)(j)

(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.

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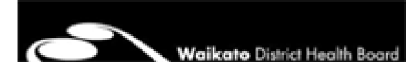

Meeting name:	Iwi Māori Council		
Location:	Board room, Level 1, Hockin Building		
Date:	07/03/2019	Time:	9:35am
Chairperson:	Ms T Thompson-Evans	Minutes by:	Ms S Greenwood
Attendees:	Ms T Moxon (Deputy Chair), Ms C Brears, Dr K McClintock, Ms K Hodge, Ms M Balzer, Ms S Turner, Ms T Te Akau, Ms P Taiaroa, Mr N Smallman		
Apologies:	Mr G Tupuhi, Mr D Astle, Mr A Chase, Mr P O'Brien, Mr T Turner, Ms T Hodges		
Others in attendance	Mr D Wright, Mr H Curtis, Ms L Elliott, Ms J Eketone, Ms J Crittenden, Ms P Mahood, Mr W Skippage		

Item No.	Details	Attachments	Assigned to
1.	**KARAKIA** Mr H Curtis		
2.	**MIHI** Mr H Curtis & Chair Acknowledged the passing of Ruruhi & Māmā of Kaunihera Kaumātua Chair Taki Turner. IMC advised that a ropu would travel to Te Awamarahi marae following hui to pay our respects.		
3.	**Apologies** Apologies noted and received		
4.	**Conflict of Interest** Noted updated Interest register. Members to declare interests at start of hui and as items arise.		
5.	**CHAIR REPORT** **Item 4.1 Mental Health building concept and design group** Venue for rebuild will be based on campus. IMC Chair noted working group formed and prehui held to confirm dates. Attended partially via teleconference and then received briefing from ED Mental & Addictions. Noted ED and CD will attend April IMC with further update. IMC encouraged to participate and to advise their attendance. Chair noted existing nomination for Dr. Kahu McClintock to Concept & Design working Group IMC noted: • Model of care yet to come to IMC • Concept needs to therapeutically reflective of Model of Care • Action: TPO to provide paper on Māori representation across WDHB for all working groups, committees Chair **MOVED** to nominate Dr Kahu McClintock to Working Group alongside Chair. **Kaituku Mōtini/Moved:** Chair **Kaitautoko Mōtini/Seconded:** Te Rūnanga o Kirikiriroa **Deferment of Item 8/Item 4.2 of Chair Report**	Agenda Item 5, Pages 5 – 8 07/03/2019	

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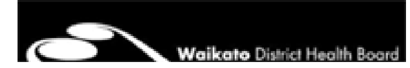

	Hapuu waananga documentary & presentation deferred as staff in Hapuu waananga and NZ on Air not yet released documentary for distribution. **Deferment of Item 4.3 of Chair Report** Tiaki Whaanau, Tiaki Ora to attend at a later date **MOVED** that the chair report was received. **Kaituku Mōtini/Moved:** Te Rūnanga o Kirikiriroa **Kaitautoko Mōtini/Seconded:** Maniapoto Māori Trust Board		
Mihi Whakatau to N. Smallman (Tuwharetoa) followed by whakawhānaungatanga. *Hui recommenced.*			
4.	**HSP WORKSHOP** • Highlighted key themes • More detail on improving Māori health and achieving equity for Māori. **Kirikiriroa** • Put kikokiko (meat/flesh) behind the words • We talk about Treaty of Waitangi but no one has known how to implement it. ○ Do we share resources to make that happen? • Bold decisions have to be made • Change needs to take place • Leadership needs to be strong • Racism called out when it happens • Cultural change needs to happen, changing mind-set. • NZ MoH hasn't made brave choices in the past and often gone with the popular vote. • Board needs to be able to push back against the Ministry if necessary. • DHB collects large quantities of data, but data has stopped once patients are referred on from Mental Health. • Who are community providers being referred to? **Raukawa** • What is the resource cost for walking the talk? • Would welcome positive change and adoption of the HSP by new Board. **Board member** • Wants to know the 'how' we are going to achieve Goal 2 of empowering whānau. • Danger that this is moved sideways and loses traction. • All Board members need to be on the same page. **Waikato-Tainui** • Community don't mind the word used, they just want services that work.	Agenda Item 7, pages 15 – 41 07/03/2019	

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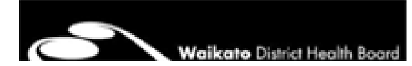

	• Both Māori and non-Māori looking after Māori need to be attuned to kaupapa Māori. • Look at the definition of Primary Care. • Need clarity around what it is that the DHB will lead and what will go in the Community. **Tūwharetoa** • Our partnership is with the Minister and the DHB are there to serve our communities. • Leadership comes from iwi Māori. • Sharing of data back to iwi and collection of Iwi/hapū data • Reports are built in as a requirement to share with iwi **TPO** • TPO have been walking alongside the HSP team providing input and feedback. It was **NOTED** that the HSP document will have a final engagement in April with a commitment to go back to all Iwi that held waananga with a proposed completion date of May.		
5.	**WORKFORCE STRATEGY FOR MĀORI EQUITY** Noted paper on Workforce Strategy. Document presented to Māori Strategic Committee previously. • A separate Māori workforce development strategy is needed for WDHB and possibly the entire Midland Region, across DHBs, primary, and community providers. • Need to incorporate articles of treaty and not just principles. • Develop KPIs for NGO sector in particular. • Feedback from MSC around supporting. • PHO Māori strategic plan – contracts have changed to require Māori equity • Where are we going with our growth and development? ○ Should we have a 'one-plan'? • An audit is needed to understand the current state • Focus on work plan around larger region wide development. • Community based groups do on-going workforce development. • In terms of kaumātua tikanga, where do they sit in terms of the HSP, where is their input, where is kaumātua input anywhere in this discussion or other project discussions?	Agenda Item 6, pages 9 -14 07/03/2019	
6.	**MINUTES AND ACTIONS** The minutes of 4th Dec 2018 are taken as a true and correct record.	Agenda Item 9, Pages 43 – 49 07/03/2019	

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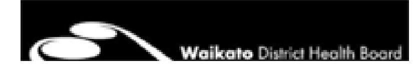

	Kaituku Mōtini/Moved: Te Rūnanga o Kirikiriroa **Kaitautoko Mōtini/Seconded:** Raukawa Charitable Trust No matters arising The minutes of 7th Feb 2019 are taken as a true and correct record. **Kaituku Mōtini/Moved:** Te Rūnanga o Kirikiriroa **Kaitautoko Mōtini/Seconded:** Te Runanga o Kirikiriroa No matters arising		
Action Item 1. & report	**IMC appointee to MH&A Clinical Governance Group** Acknowledgement of IMC appointment received via letter from Co-Chairs. Appointee has commenced attending hui. Noted: • Sense that hui are Hospital led • Discharge rate considered to be high and concern that patients are discharge still unwell only to be readmitted. • Problem focused and not solutions • Concern at rescheduling of hui • **Action:** Terms of Reference and meeting schedule to be sourced. • **Action:** Appointee to provide written report to IMC for agenda		
7.	**TE PUNA ORANGA UPDATE REPORT** Presented by Director of Strategy • Next Equity-focused report - Going to the Board in April. - Te Reo groups should be made available for all services to counter pronunciation. KPI to include Tikanga and Reo component • Workforce - Funding needs to prevent pay inequity in the Māori workforce between community and hospital workers. • Puna Waiora - convened Pūtaiao expo with 244 Rangatahi in attendance - Piopio relationship agreement signed • DNA update - TPO working with COO	Agenda Item 11, Page 50 07/03/2019	
8.	**IMC WORK PLAN** April work plan to include: ○ Hapū Wananga short film; ○ HSP to come back; ○ Mental Health and Addictions with Vicki Aitken and Rees Tapsell; ○ Planning our joint hui with Board on 29th May. June to include: • Man-Up • COF update • Annual Plan Final	Agenda Item 12, Page 51 07/03/2019	

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	• MH & A • HSP June to include: • Planning • Data Sovereignty Ideas around joint hui include: ○ Tokanui visit ○ Site visit to Whānau Ora Centre ○ Show the Board what IMC members do in their rural areas outside of their IMC role.		
9.	**GENERAL BUSINESS** **9.1 Māori Equity Fund concept** Chair updated Iwi on Māori Equity Fund concept presented by Pat Snedden Chair of ADHB and Dep. Chair CMDHB. It was **NOTED** that: • This kaupapa has not been tabled or considered by the Board yet, Chair to raise with Chair & CEO in quarterly hui. • IMC are in support of the concept & require more information • Action: Chair to source paper for concept.		Action: TPO

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Actions

Details	Who
TPO to provide paper on Māori representation across WDHB for all working groups, committees	TPO
Appointee to MH& A Clinical Governance Group to provide written report to IMC for agenda	Appointee to MH& A Clinical Governance Group
Terms of Reference & meeting schedule for MH& A Clinical Governance Group	Appointee to MH& A Clinical Governance Group
Chair to source paper for concept of Māori Equity Fund	Chair

Whakakapi: 12.35pm by Matua Hemi Curtis.
Next Meeting: Thursday 4th April 2019

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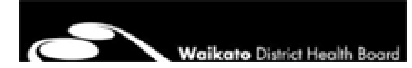

Meeting name:	Māori Strategic Committee		
Location:	Board Room, level 1, Hockin Building		
Date:	20 March 2019	**Time:**	10:00am – 11.45pm
Chairperson:	Tania Hodges	**Minutes by:**	Justine Crittenden
Attendees:	Ms T Hodges (Chair), Dr C Wade (Deputy Chair), Mr D Macpherson, Ms T Thompson-Evans, Ms M Balzer, Ms S Christie		
Apologies:	Mr A Chase, Mr H Curtis, Mr G Tupuhi, Lady T Moxon		
Others in attendance	Mr D Wright (CEO), Ms L Elliott, Ms J Eketone, Ms E Shields, Mr M Currie, Ms J Crittenden, Mr N Hablous		

Item No.	Details	Attachments	Speaker
1.	**KARAKIA/MIHI**		
	Ms J Eketone – karakia Chair – mihi and message of love to Christchurch		J Eketone T Hodges
2.	**APOLOGIES**		
	Kaituku Mōtini/Moved: Dave Macpherson **Kaitautoko Mōtini/Seconded:** Sally Christie		
3.	**PREVIOUS MSC MINUTES HELD 20 FEBRUARY 2018**		
	Corrections: • Ammend actions to add Mr Ron Dunham in place of Mr G Howard **Kaituku Mōtini/Moved:** Clyde Wade **Kaitautoko Mōtini/Seconded:** Dave Macpherson Discussion: • Add time frames in the future for actions • Imms meetings ongoing • Disability measure - no outcome yet • KPI framework ready to go to the Executives next week – included in new workforce documents (separate to the Equity-Focused Report) • Workforce Strategy to be back on the table once it is finalised. • Actions 1&9 can be aligned/combined		L Elliott

Meeting Minutes

	• Work to decrease DNAs require a formal project plan to move forward • Let's Talk paper was circulated • ITEM 5 is being actioned through the new People Strategy (e.g. Taleo PIR from Taranaki) – Tania raised the need for organisation-wide commitment not just TPO responsibility – the workforce strategy TPO has developed needs to go to the Board for formal approval (Mere raised concern about workforce hui from yesterday – equity wasn't mentioned – this was in Mental Health Clinical Governance) • Tikanga Best Practice still not over the line but orientation has been changed in alignment with this plan – Derek has requested this to come back to the Executive Leadersip Team (ELT). • Actions should go to ELT for feedback and a column added to capture feedback prior to the MSC to ensure it isn't just a verbal update. Action: • Commissioning stocktake needs to incorporate S&F plans – to be tabelled at next MSC.		
4.	**MSC WORK PLAN PRIORITIES WORKSHOP**		
	Introduction: • Goal is to be koi (sharp) – we need to narrow our focus to be effective. Scattergun approach where we jump to the loudest voices/squeaky wheels continues to not be effective. Focus should come from the letter from the Minister. CEO supported, saying we cannot do everything, we must prioritise, an approach which is supported by the Board. • PowerPoint Presentation provided a synthesis of the Minister's letter of expecations. • The identified priorities can be grouped into three catagories: 1. First 1000 Days 2. Determinents of Health (Smokefree, Violence, Healthy Eating) 3. Diseases (Cancers, CVD, Diabetes) Key points from ensuing discussion: • Both the Board and Executive learship team believe that a selection of priorities from the letter should be the priorities rather than all areas contained in the letter • The Minister's letter cover the key issues in the Waikato DHB region • Prostate cancer – is not on the list, where is it? Dr N Scott noted it is in the top 5 causes of cancer death, and is very avoidable, but screening can do more harm than good and the disease is not always fatal. • Bowel screening is an opportunity for us to have a lower age range for Māori, an approach Dr N Scott is arguing for nationally along with Te Ora. Suggestion for the Waikato DHB to write a letter of support. • First 1000 days will be hard to achieve without thriving rangitahi who are creating these pepe. First 1000 Days could be the		J Eketone N Scott R Poaneki

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	main focus rather than big killers.
	• Noted concern about Mental health issues:
	    o PTSD in older children (e.g. caused by divorce or violence in the whanau) which impacts through the lifecourse, causing substance abuse, violence, etc and we need to address this. E.g. young people in Christchurch will be under incredible stress. Mike King's work might be able to shed additional light on this topic, some evidence might come from this.
	• Key factor to consider when prioritising:
	  1. DHB capability to actually do something about an issue
	  2. Size of the impact we can make
	  3. Short vs long term impact
	  4. Effectiveness of available treatments
	• Racism conversations stemming from Christchurch shooting are going to help challenge institutional racism throughout the health system.
	• Use measures around community and whānau empowerment, helping our people to keep themselves well (eg. Smokefree 2025 across our whole region). Can also make a big difference to healthy eating and healthy weight and this impacts on all the other diseases. Need to think broader than just treating diseases at the DHB, but rather get the whole population working.
	• Annual plan should be Māori focused very explicitly.
	• A need to redirect funds to do things better. We need to take all breast screening and smokefree money and focus on Māori specifically to make a meaningful difference. We should be the best DHB on these measures, not the worst. Let's find other programmes and learn and not redesign the wheel. Eg Whakatane first 100 days programme.
	• Formal timelines and project plans requested.
	
	Outcome
	• It was general agreed that the first priority areas for the MSC to focus on would be First 1000 Days, Smokefree 2025, and Healthy Eating.
	• Given that the First 1000 days work has been initiated by S&F it would be the first of the top three to come back to MCS in April 2019
	• Other quick wins can be brought to the table quarterly by Dr N Scott to see if there are other priorities MSC should be putting pressure on to change to improve Māori equity.
	• Second group of staged priorities included screening of all kinds that are effective (Bowel, Breast, and maybe early detection of Lung?) and mental health issues.
	
	Action:
	• Amend MSC workplan accordingly		

5.	**WAIKATO DHB PRIORITISATION WORKSHOP**		
	Introduction: • Overview of the prioritisation process for the DHB was provided to MSC and noted that hui focus is on the first driver: Radical Improvement to Māori Health. There are three dimensions	Action point 9, 20th Feb 2019 minutes.	J Eketone

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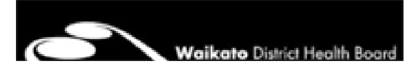

	under this strategic driver and each dimension has a five step scale: none, low, moderate, strong, or extreme. MSC feedback was requested within the next two weeks . • This is a weighting system for projects that helps inform investment and disinvestment decisions. Used by the Enterprise Programme Office to ensure the ELT are making informed choices. Key points from the ensuing discussion: • Go live 1 April • Agreement with the framework in principle. Happy to see this framework being developed and would like to see it applied to commissioning for everything the DHB pays for. • High weighting on radical improvement in Māori health. Impact statements need work though, eg numbers of patients impacted are less helpful than proportionate statements (i.e. 200 people impacted but what does this mean? How many Māori are in the cohort? Need to be clear that only projects that impact on Māori health equity would be prioritised. • The weightings seem arbitrary and it's hard to say if it will have the intended effect. The team need to workshop which types of business cases get high vs low scores and moderate the scoring through many workshops. Must be tested thoroughly. • "Ensuring appropriate demand" does not seem to be correctly named. • Current do not see a wellness focus and I think they drivers are too provider-centric.		
6.	**GENERAL BUSINESS**		
	No other business raised.		
7.	**PAPERS FOR INFORMATION**		
8.	**MEETING CLOSED:**		
	By J Eketone at 11:45am		
9.	**NEXT MEETING**		
	• Wednesday 17th April 2019, Board Room, Level 1, Hockin Building		

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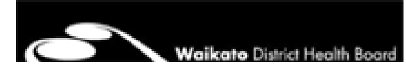
Meeting Minutes



Actions

	Details	Completed	Who	By When
1.	Māori DNAs • Report on Māori DNA actions monthly to MSC. • Draft project plan to be brought back to MSC in April 2019		Mr R Dunham Mr R Dunham with Ms L Elliott support	Monthly 17 April 2109
2.	Mr G Howard to determine whether the immunisation coordination centre updates patient contact details in iPM or if they only update the NIR.	Complete – only on NIR	Mr G Howard	
3.	Explore disability data option to measure inequities faced by Māori living with disability (Māori tāngata whaikaha).		TPO	
4.	Implement Māori equity KPIs throughout the organisation.	IP – KPIs require ELT sign-off by end of Mar-19	TPO/HR	
5.	Interview all Māori that apply for the role. Identify if there are other opportunities within the organisation that may be an appropriate fit if the candidate is unsuccessful for the initial role applied for.	IP as part of People Plan	TPO/HR	
6.	Update the measures section (wahanga tuatoru) of KTTOP to align with the first two wahanga.	In progress	TPO	
7.	Commissioning stocktake on government position on commissioning, relevant government review recommendations, literature and current WDHB position		Tanya Malony	
8.	Update workplan following MSC priorities workshop 20/3/19		TPO	

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Chief Executive Report

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

Health Select Committee

The Chair and I appeared before the Health Select Committee on 6 March 2019.

This is an annual process which occurs after the organisation completes a questionnaire sent to us on behalf of the Committee. The questionnaire had in excess of 300 questions this year and the effort involved in completing it was substantial given the need for answers before such a forum to be comprehensive and accurate.

Questions on the day did not relate to the questionnaire. The environment was relatively supportive and the only news generated was around concerns at immunisation rates.

Executive Roles

As previously advised Maureen Chrystal left the organisation on 8 March. I would like to publicly acknowledge the debt that the Waikato DHB owes Maureen both for her sterling service over 14 years and her efforts in dealing with difficult events in 2017.

I have asked Ron Dunham to extend his tenure as Interim Chief Operating Officer for a further six months beyond his previously agreed end date of 30 June. He has agreed to an extension through to 31 December 2019.

This will provide some useful stability to one of the most significant roles in the organisation.

Update on CBD Accommodation

The CBD Accommodation project remains on track in relation to cost and delivery program. An Agent has been appointed (via a competitive quotation process) to market the vacant space.

Equity Focussed Reporting

A report on this subject was due this month. A draft was discussed at the Executive Leadership Team meeting. It was concluded that further work needed to be done to ensure that the performance indicators included in the report are relevant, and aligned to the objectives for both the Board and management in driving improvement action. Further internal discussions will occur with a view to a workshop session in April (probably not separately scheduled) with the Board to obtain their input.

Staff Survey Roadshows

Last week we commenced a series of Roadshows to share with our staff the results from the staff survey that was undertaken late last year.

These roadshows are being led by myself and other Executive with sessions taking place in a number of locations around the DHB.

Support to Canterbury DHB

Following the tragic even in Christchurch on Friday 15 March, we have been in touch with our colleagues at Canterbury DHB to offer our assistance and support.

Currently they are coping well but have indicated they may seek some assistance over the coming weeks in terms of psycho-social support.

Hospital Squash and Tennis Facility

The Executive Leadership Team reviewed a proposal last year to convert the squash club building (located on the Waikato hospital campus) to a gym run by a third party and to convert the tennis courts into car parks but declined the gym due to the capital ($300k) required. We are proceeding with the extra car parking ($15k cost paid back by revenue in 10 months) while we intend to seek external investment via an RFP to develop and operate the potential gym.

Some squash club members are unhappy and have lobbied to retain their club, including requesting a paper be put on the board agenda which has been declined given this is an operational matter.

The Squash Club Inc has formally agreed via their solicitor this month to vacate the hospital campus in two stages (tennis courts in March and squash court building In May). Consultation with them commenced in May 2018 and notice was given six months ago. There has been a lot of dialogue with Club representatives and legal advisors. The Club has circa 60 members; it is a private club with only half the membership DHB staff. They have no lease and pay no rent.

Recommendation
THAT
The Board receives this report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

Quality and Patient Safety

Quality and Patient Safety: No report this month.

Finance Performance Monitoring

MEMORANDUM TO THE BOARD
27 MARCH 2019

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 the report.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Group	Year to Date			Group Budget
Result for February 2019	**Group Actual $m**	**Group Budget $m**	**Variance $m**	**Jun-19 $m**
Revenue - CFA	859.4	848.2	11.2 F	1,269.2
Revenue - other	152.0	151.1	0.9 F	229.7
Operating Expenses	(991.5)	(970.3)	(21.2) U	(1,468.2)
IDCC and Extraordinary	(57.5)	(56.4)	(1.1) U	(86.8)
DHB Surplus/(Deficit)	**(37.6)**	**(27.4)**	**(10.2) U**	**(56.1)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

Waikato DHB Group	Year to Date			Group Budget
Result for February 2019	**Group Actual $m**	**Group Budget $m**	**Variance $m**	**Jun-19 $m**
Funder	34.2	21.3	12.9 F	24.9
Governance	(1.5)	(0.9)	(0.6) U	(1.5)
Provider	(70.1)	(47.6)	(22.5) U	(79.5)
Waikato Health Trust	(0.2)	(0.2)	0.0 F	(0.0)
DHB Surplus/(Deficit)	**(37.6)**	**(27.4)**	**(10.2) U**	**(56.1)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

Episodes

Acute					
February 2019	**2019 Actuals**	**2019 Plan**	***Variance to Plan %***	**2018 Actuals**	***Variance to Prior Year %***
Surgical & CCTVS	12,480	11,711	*6.57%*	11,707	*6.60%*
Internal Medicine	12,029	12,361	*-2.69%*	11,248	*6.94%*
Regional Services	3,041	3,002	*1.32%*	2,935	*3.61%*
Child Health	3,871	3,562	*8.67%*	3,610	*7.23%*
Womens Health	6,184	6,063	*2.00%*	5,883	*5.12%*
TOTAL	**37,605**	**36,699**	***2.47%***	**35,383**	***6.28%***

Elective					
February 2019	**2019 Actuals**	**2019 Plan**	***Variance to Plan %***	**2018 Actuals**	***Variance to Prior Year %***
Surgical & CCTVS	10,131	10,146	*-0.15%*	9,751	*3.90%*
Internal Medicine	421	614	*-31.46%*	432	*-2.55%*
Regional Services	50	30	*65.89%*	28	*78.57%*
Child Health	387	489	*-20.83%*	451	*-14.19%*
Womens Health	947	772	*22.64%*	750	*26.27%*
TOTAL	**11,936**	**12,052**	***-0.96%***	**11,412**	***4.59%***
Total Episodes Acute + Elective	**49,541**	**48,750**	***1.62%***	**46,795**	***5.87%***

Case Weighted Discharges

Acute					
February 2019	**2019 Actuals**	**2019 Plan**	***Variance to Plan %***	**2018 Actuals**	***Variance to Prior Year %***
Surgical & CCTVS	20,905	20,458	*2.18%*	20,009	*4.48%*
Internal Medicine	10,573	11,062	*-4.43%*	10,231	*3.34%*
Regional Services	3,628	3,711	*-2.23%*	3,577	*1.41%*
Child Health	4,662	4,519	*3.15%*	4,644	*0.38%*
Womens Health	3,473	3,449	*0.70%*	3,302	*5.17%*
TOTAL	**43,240**	**43,199**	***0.09%***	**41,764**	***3.53%***

Elective					
February 2019	**2019 Actuals**	**2019 Plan**	***Variance to Plan %***	**2018 Actuals**	***Variance to Prior Year %***
Surgical & CCTVS	14,176	14,442	*-1.84%*	14,173	*0.03%*
Internal Medicine	302	438	*-31.06%*	318	*-5.06%*
Regional Services	88	62	*42.76%*	47	*89.37%*
Child Health	401	404	*-0.62%*	379	*5.72%*
Womens Health	848	751	*12.91%*	725	*17.08%*
TOTAL	**15,816**	**16,097**	***-1.75%***	**15,641**	***1.12%***
Total CWDs Acute + Elective	**59,056**	**59,296**	***-0.40%***	**57,405**	***2.88%***

Bed Days					
February 2019	**2019 Actuals**	**2019 Plan**	***Variance to Plan %***	**2018 Actuals**	***Variance to Prior Year %***
Waikato Inpatient Bed Days	132,872	132,336	*0.40%*	132,545	*0.25%*
Waikato Other Bed Days*	85,027	72,444	*17.37%*	72,444	*17.37%*
T-Hospital Bed Days*	20,339	20,098	*1.20%*	20,098	*1.20%*
TOTAL	**238,237**	**224,878**	***5.94%***	**225,087**	***5.84%***

February 2019	**2019 Actuals**	**2018 Actuals**	**Variance to Prior Year %**
ED Attends	78,610	78,008	*0.77%*

* - T-Hospital and Waikato other bed days plan numbers are not available and reflect prior year actual totals

MONTHLY COMMENTS

This report includes commentary on current year to date performance for the Waikato DHB Group compared to the budget to February 2019.

Delivery Plan Performance

February volumes are also impacted by RMO strike days. This led to 68 fewer elective discharges (4.4%) compared to plan; however the overall caseweights is 21.7% below plan, indicating the cases delivered are significantly lower in complexity than normal. Year to date discharges are 1% behind plan, 116 cases.
Acute volumes in February were overall 2.4% below plan. Surgical & CCTV were 4% ahead, while Internal Medicine (led by Gen Med and Respiratory services) was 200 cases or 14.5% behind plan.
Despite February being below plan for acute volumes, the year to date figures are still well ahead at 2.5% higher than plan and at 6.3% higher than last year volumes.
IDF volumes for both Jan and Feb showed a shift, presumably related to the strike action. Acute volumes trend is consistent with previous months, however acute caseweights dropped. This indicates a lower complexity of patient was treated. Elective IDFs in both volumes and caseweights were significantly lower – the caseweights for Jan and Feb being 77% and 65% of plan respectively.

The impact of the new M18 surgical assessment and short stay ward is pushing general Surgery acute volumes over plan as use of the assessment capability has moved volumes from ED to General Surgery acute admissions. These patients, assessed and not operated on, represent a lower complexity, hence lowering average CWD for general surgery.

Within the clusters, Internal Medicine is overall slightly lower than plan, with respiratory as noted previously, being significantly lower.

Two variations attributable to the planning process have been identified. We expect these to continue throughout the year.
These variations are:
1. An error in setting the volumes for a small number of ED Short Stay purchase units. These are most utilised by patients in Paediatrics and Surgical services, hence why these two are reporting ahead of plan.
2. Analysing the variation within Child Health, the Acute Paediatric Medicine figures show significant variance to plan, volumes are higher, and average caseweight is lower than anticipated – the resulting total caseweight is almost exactly at plan.

This has been attributed to a single outlier discharge (211 caseweights, next highest is 9) in the historical data which skewed the average caseweight ratio used in planning assumptions. This means the planned caseweight total is correct, while the planned volumes are lower than they should have been.

Volume analysis continues to be an area of desired improvement. The FY 19/20 volume planning process, which has already commenced, will plan day case and long stay patient volumes and caseweights separately for appropriate clinical services. This will provide an additional dimension with which to understand performance. Further enhancements to the planning and modelling are being identified and documented for FY 20/21. While current reporting makes all the detailed data on performance to plan available, it is somewhat cumbersome to analyse and the desired goal is to develop a Performance Reporting Qlik application to enable greater use and interpretation of this data.

Financial Performance Comment:

For February 2019 we have an unfavourable year to date variance to budget of $10.2m. This includes $4.3m favourable variances relating to prior year adjustments and wash-ups.

Material variances for month of February 2019

Net variances for the month of February 2019 amount to $5.3m unfavourable. This is comprised mainly of:
- $1.3m favourable revenue variance relating mainly to additional funding received;
- $1.7m unfavourable IDF revenue including impact of RMO strikes;
- $1.3m unfavourable depreciation variance in the month as a result of buildings depreciation correction;
- $1.3m Savings Plan not realised;
- $3.1m unfavourable variance relating to employed and outsourced personnel includes the impact of new acuity based staffing levels resulting in unfavourable leave movement, outsource costs and overtime, unbudgeted MECA changes, and a contract transfer. This trend further exacerbated by the RMO strike impact.
  Partly funded by favourable CFA revenue variance ($0.3m).
- $0.8m favourable - Other net favourable/unfavourable variances.

Material YTD variances as at February 2019:

Operating revenue is $12.1m favourable which includes the following variances:
- $2.6m favourable - additional funding related to NZNO MECA.
- $2.1m favourable - pay equity funding.
- $2.5m favourable - reimbursement of NOS costs.
- $2.7m favourable - prior year wash-ups and adjustments.
- other favourable variances include higher cafeteria sales, donations and research grants and reimbursement of haemophilia costs (offset in clinical supplies).

Direct cost offsets against favourable variances amount to $9.0m.

Operating expenditure is $22.3m unfavourable which includes:
- $10.5m unfavourable - nursing personnel (employed and outsourced) costs. This includes higher NZNO and MHN MECA settlements ($3.1m), new acuity based staffing levels in place earlier than budgeted and a higher level of mental health inpatient services. There is a favourable offset in CFA revenue ($2.6m).
- $4.9m unfavourable - clinical supplies. Includes mix of activity, has partial offsets in other Government revenue and in NGO payments arising from pharmaceutical savings transactional flow. Further NOS impacts are expected to be corrected in coming months, including those related to processes for receipting of goods.
- $10.0m unfavourable centrally held savings plan.
- $1.6m favourable relating to prior year wash-ups and adjustments.
- $0.8m unfavourable depreciation charge as a result of the timing of asset capitalisation.

Unfavourable variances offset by favourable variances arising from, vacancies, delayed start to building maintenance plan and timing.

Our best estimate at this stage for forecast remains budget with downside risk.

We recognise that the capital expenditure spend as per the Capital Expenditure report (YTD spend of $23,266k) doesn’t agree with the Treasury Purchase of Assets amount of $21,872k. Reconciliation of the difference is being worked through but is impacted by NOS issues.

Provider:

The Provider is unfavourable to budget $22.5m - see detail for explanations. Variances include:

1. Revenue is favourable $3.2m due mainly to favourable internal revenue ($2.9m - eliminates against Funder), reimbursement of NOS costs (offset in Outsourced personnel) and IDF income. This offset by an unfavourable side-arm contracts variance arising as revenue budgeted in Provider, received by Funder (offset in Funder).
2. Employed personnel cost is favourable to budget $0.9m mainly due to favourable variances relating to Medical, Allied and Management, Administration and Support costs (offset in outsourced services), offset by an unfavourable Nursing variance. Further analysis below.
3. Outsourced personnel cost is unfavourable to budget $13.5m - partly offset in employed personnel cost and NOS costs recovered in other government revenue.
4. Outsourced services is favourable to budget $1.3m - analysis below.
5. Clinical Supplies is unfavourable to budget $5.0m due to the increase and mix of activity, and timing.
6. Infrastructure and non clinical supplies is unfavourable to budget $8.4m - analysis below.
7. IDCC is unfavourable to budget $1.0m. This relates mainly to unfavourable depreciation arising from timing of capitalisations.

Funder and Governance:
The result for the Funder is $12.9m favourable to budget. This is mainly as a result of additional CFA funding relating to pay equity, acuity funding, NZNO MECA settlement and prior year electives ($11.1m), favourable IDF revenue variance ($0.3m), favourable NGO payments $4.3m (mainly as a result of a prior year over accrual of DSS costs) offset by unfavourable provider payment variance ($2.9m eliminated against Provider). Governance is close to budget.
Waikato Health Trust
The result for the Waikato Health Trust is close to budget.

RECOMMENDATION(S):

That this report for the period ended February 2019 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	**$12.1 F**	
CFA Revenue		
CFA revenue is favourable to budget mainly due to:		
• CFA revenue $11.1m favourable includes $2.6m favourable variance for funding received from MoH for NZNO MECA settlement (offset by nursing personnel additional cost $2.6m). A further $2.7m has been received from MoH for acuity costs related to the NZNO MECA. There is an offset in side arm revenue as the funding was expected to be received directly by the provider. Other favourable variances include a prior year under accrual of elective revenue $0.6m and additional unbudgeted funding, the largest being $2.1m pay equity funding	$11.1 F	Neutral
Crown Side-Arm Revenue		
• Crown side-arm contracts $2.7m unfavourable to budget which includes MoH funding for nursing acuity costs received as a CFA variation ($2.7m, offset in CFA revenue), with other offsets.	($2.7) U	Neutral
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) $2.5m favourable (offset in Outsourced Personnel $2.4m).	$2.8 F	Neutral
• Reimbursement of haemophilia costs $0.7m favourable in line with actual costs incurred (clinical supplies).		
• Income for an ACC contract is $0.7m unfavourable due to a variance in the optimistic budget estimate as against actual income earned.		Unfavourable
• Inter District Flow (IDF) income from other DHBs $1.1m unfavourable. Volumes by speciality and by DHB continue to fluctuate compared to budget. The unfavourable variance includes reduced volumes during the RMO strikes.		Neutral
• Inter District Flow (IDF) income relating to 2017/18 $1.3m 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 ($0.7m), which is included in NGO payments.		Favourable
Other Revenue		
• Other revenue $0.9m favourable to budget which includes favourable variances to budget for cafeteria and food sales (price review), and also donations, and research grants.	$0.9 F	Neutral

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($22.3) U**	
Personnel (employees and outsourced personnel total)	**($13.2) U**	
Employed personnel are favourable to budget mainly due to:		
Quarterly actuarial revaluation adjustments impacting across all payroll classes and relating to Long Service Leave and Retirement Gratuity liabilities have resulted in $1.1m additional expense which is included in personnel variances below.		
• Medical personnel are favourable to budget by $5.2m. This includes a higher than expected vacancy level, including delayed implementation of investment requests. This favourable variance is partly offset by the impact of the strikes, and outsourced personnel unfavourable variance of $4.9m.	$0.5 F	Neutral
• Nursing personnel are unfavourable to budget by $7.8m. This variance, along with the unfavourable outsourced personnel cost for nursing of $2.7m, includes higher final settlement compared to budget of the NZNO MECA ($2.6m, offset by CFA revenue favourable $2.6m), and the MHN MECA ($0.5m, no offset). Other variances include costs of a transferred contract of $0.8m (offset in NGO providers) and the impact of new acuity based staffing levels in place earlier than budget. In most areas we are running at full matrix for additional beds and acuity levels. This additional cost includes unfavourable annual leave movement, outsource costs, and overtime. We also have a higher level of mental health inpatient services.		Unfavourable
• Allied Health personnel are favourable to budget by $0.4m. The net unfavourable variance between employed and outsourced is $0.1m. This includes higher final settlement of the ALT MECA compared to budget of $1.2m, offset by higher than expected vacancy levels.		Neutral
• Management, Administration and Support personnel are favourable to budget by $2.7m (offset in outsourced personnel ($2.1m). Variances are spread across the DHB including clinical support, and are mainly as a result of higher than expected vacancy levels. The variance also includes higher settlement costs for DOM and ATT MECAs compared to budget, of $0.5m (no offset).		
Outsourced personnel are unfavourable to budget mainly due to:		
• Medical costs are $4.9m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $5.2m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.	($13.7) U	Neutral
• Nursing costs are $2.7m unfavourable. As for nursing personnel this is due to the impact of new acuity based staffing levels in place earlier than budget, and a higher level of mental health inpatient services.		Unfavourable
• Allied Health costs are $0.3m unfavourable to budget. The net unfavourable variance between employed and outsourced $0.1m favourable. This includes higher final settlement of the ALT MECA compared to budget of $1.2m, partly offset by higher than expected vacancy levels.		Neutral
• Management, Administration and Support costs are $5.8m unfavourable largely due to contractor costs of $2.4m for the implementation of the new NOS ERP solution (offset by $2.5m additional other government revenue), and contractor costs of $1.3m for the patient flow project. The balance of $2.1m covers management, administration and support vacancies (offset in favourable employed personnel variance of $2.7m).		

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$1.3 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced Clinical Services are $2.0m unfavourable to budget. Outsource costs for meeting ESPI compliance, including the areas of cardiology and radiology are unfavourable, partially offset by a favourable variance relating to outsourced services to meet our elective initiatives.	$1.3 F	Unfavourable
• Outsourced corporate service costs are $0.4m favourable to budget which includes delays in the implementation of Crown initiated information system changes such as IaaS.		Favourable
• Spend against allocated strategic funding is $2.7m favourable to budget to date. This includes initiatives related to health system transformation and health equity which have been deferred.		
Clinical Supplies	**($4.9) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Treatment Disposables, Instruments and Equipment - favourable to budget by $0.5m. This includes MoH coding changes of $1.4m (offset in pharmaceuticals). The adjusted variance is $0.9m unfavourable. The variance is due to mix of activity and total episodes up on budget 1.6%. This includes theatres at 105% of budget. High cost areas also include haemophilia costs over budget by $0.7m (offset by other Government revenue $0.7m).	($4.9) U	Unfavourable
• Diagnostic and Other Supplies - unfavourable to budget by $0.5m includes monthly fluctuations for volume and mix of procedures.		
• Implants and prosthesis - unfavourable to budget by $0.6m includes monthly fluctuations for volume and mix of procedures.		
• Pharmaceuticals - unfavourable to budget by $4.4m. This includes MoH coding changes of $1.4m (offset in treatment disposals). The adjusted variance is $3.0m, which includes $1.8m as a result of a change in how savings are being received from Pharmac (part offset $1.1m (timing) in payments to NGO providers). Higher PCT and retail pharmacy costs are both in line with higher levels of activity.		
Infrastructure and non-clinical supplies	**($8.7) U**	
• Favourable variances include a delayed start to building maintenance plan ($1.3m) and delayed commencement of information services projects ($0.5m), offset by unfavourable other operating expense variances.	$1.3 F	Neutral
• Savings allocation - $10.0m unfavourable variance in infrastructure costs relates to centrally held savings plan not specifically allocated.	($10.0) 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:		
● Net favourable variances amounting to $6.0m include costs not being incurred in line with CFA revenue received, MoH and accrual adjustments relating to prior year funding (includes disability support costs $2.1m), a contract transfer $0.8m (offset in nursing costs) and savings received from Pharmac of $1.1m that are budgeted under clinical supplies (pharmaceuticals offset of $1.8m). Favourable variances are partly offset by unfavourable variance to budget for pay equity of $2.6m (part offset by CFA revenue $2.1m).	$4.3 F	Favourable
● Inter District Flow (IDF) outflows to other DHBs $1.0m unfavourable. Volumes by speciality and by DHB continue to fluctuate compared to budget.		Neutral
● IDF out payments for 2017/18 are $0.7m 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 ($1.3m), which is included in Other Government and Crown Agencies Revenue.		Unfavourable
Interest, depreciation and capital charge	**($1.0) U**	
Interest charge is close to budget.	($0.1) U	Neutral
Capital charge is close to budget.	($0.1) U	Neutral
Depreciation is unfavourable to budget due mainly to:		
● timing of capitalisation of assets	($0.8) U	Neutral
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 unfavourable to budget as detailed below.

YTD Actuals Feb-18 $'000	Waikato DHB Cash flows for year to February 2019	Year to Date Actual $'000	Year to Date Budget $'000	Year to Date Variance $'000	Budget Jun-19 $'000
	Cash flow from operating activities				
895,015	Operating inflows	1,006,380	1,000,039	6,341	1,497,840
(858,828)	Operating outflows	(999,535)	(972,502)	(27,033)	(1,484,968)
36,187	**Net cash from operating activities**	**6,844**	**27,537**	**(20,693)**	**12,872**
	Cash flow from investing activities				
1,081	Interest income and proceeds on disposal of assets	732	809	(76)	1,187
(15,107)	Purchase of assets	(21,872)	(78,098)	56,226	(117,094)
(14,026)	**Net cash from investing activities**	**(21,140)**	**(77,289)**	**56,149**	**(115,907)**
	Cash flow from financing activities				
0	Equity repayment	0	0	0	(2,194)
(5,379)	Interest Paid	(653)	(548)	(105)	(826)
(142)	Net change in borrowings	(225)	37,339	(37,564)	116,821
(5,521)	**Net cash from financing activities**	**(878)**	**36,791**	**(37,669)**	**113,801**
16,640	**Net increase/**(decrease) in cash	**(15,174)**	**(12,961)**	**(2,213)**	**10,766**
856	Opening cash balance	(2,973)	(2,973)	0	(2,973)
17,496	**Closing cash balance**	**(18,147)**	**(15,934)**	**(2,213)**	**7,793**

Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Total Net cash flow from Operating Activities	**($20.7) U**	
Operating inflows	**$6.3 F**	
• The favourable operating inflow variance arises mainly as a result of additional unbudgeted MoH funding for the NZNO MECA settlement ($2.6m), additional pay equity funding ($2.1m), reimbursement of haemophilia costs ($0.7m), receipt of IDF income related to prior year ($1.3m) and higher cafeteria and food sales, donations, and research grants. Further favourable variances arise as a result of the difference between the timing of receipts against budget assumptions. Favourable variances offset by ACC contract income $0.7m unfavourable against an optimistic budget.	$6.3 F	Neutral
Operating outflows	**($27.0) U**	
Operating cash outflows for payroll costs are unfavourable mainly due to:		
• Personnel costs are unfavourable against budget mainly due to MECA settlement payments (NZNO and MHN), costs associated with the RMO strike and the impact of new acuity based nursing staff levels, offset by favourable variances arising from vacancies. The remaining variance arises from the actual timing of pay runs as compared to the phasing of the budget.	($8.2) U	Unfavourable

Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Operating cash outflows for non-payroll costs are unfavourable mainly due to:		
• The unfavourable operating cash flow variance arises mainly from unfavourable operating expenditure against budget (excluding payroll and IDCC costs) $21.7m, higher prepayments than budgeted $3.6m, offset by the favourable impact of the timing of supplier payment runs. The final Friday creditor payment run for February was paid on Friday 1 March 2019 ($4.0m).	($20.7) U	Neutral
• GST cash movement is favourable due to timing variances on GST transacted.	$1.9 F	Neutral
Net cash flow from Investing Activities	**$56.1 F**	
• Interest charge is close to budget.	($0.1) U	Neutral
• Purchase of assets is slower than planned for the year. This is as a result of deferred timing of spend.	$56.2 F	
Net cash flow from Financing Activities	**($37.7) U**	
• Cash flow from financing activities is unfavourable due to the deferment of planned finance leases and budgeted deficit support not received.	($37.7) 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 28-Feb-19	Feb-19 Actual	Mar-19 Forecast	Apr-19 Forecast	May-19 Forecast	Jun-19 Forecast	Jul-19 Forecast	Aug-19 Forecast	Sep-19 Forecast	Oct-19 Forecast	Nov-19 Forecast	Dec-19 Forecast	Jan-20 Forecast	Feb-20 Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	4,776	6,039	4,252	4,764	6,811	4,952	4,936	6,320	4,836	4,720	6,436	4,564	4,588
Funder inflow (MoH, IDF, etc)	139,151	135,261	137,631	132,761	136,414	139,704	139,704	139,704	139,704	139,704	139,704	139,704	139,704
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	2,516	3,020	3,780	3,260	2,780	2,940	3,081	2,963	3,081	2,963	2,961	2,963	2,729
Rents, ACC, & HealthPac (General Accou	3,910	3,481	3,440	3,775	3,433	3,698	3,736	3,549	3,702	3,639	3,521	3,694	3,503
	150,353	147,801	149,103	144,560	149,438	151,294	151,457	152,536	151,323	151,026	152,622	150,925	150,524
Cash was applied to:													
Personnel Costs (incl PAYE)	(55,582)	(50,720)	(51,100)	(57,820)	(51,575)	(60,561)	(55,128)	(52,767)	(59,166)	(54,864)	(61,355)	(53,197)	(52,706)
Other Operating Costs	(33,390)	(34,222)	(29,720)	(32,524)	(32,620)	(30,070)	(33,900)	(30,065)	(30,710)	(34,752)	(36,855)	(30,494)	(33,220)
Funder outflow	(52,749)	(54,652)	(50,364)	(51,640)	(50,240)	(52,791)	(56,180)	(52,196)	(52,039)	(51,262)	(51,555)	(55,832)	(51,207)
Interest and Finance Costs	(30)	(16)	(33)	(33)	(33)	(33)	(33)	(33)	(27)	(33)	(33)	(33)	(33)
Capital Charge	0	0	0	0	(17,430)	0	0	0	0	0	(18,711)	0	0
GST Payments	(8,150)	(7,500)	0	(15,000)	(7,500)	(7,500)	(7,500)	(7,500)	(15,110)	(7,500)	0	(15,000)	(9,000)
	(149,901)	(147,110)	(131,217)	(157,017)	(159,398)	(150,955)	(152,741)	(142,561)	(157,052)	(148,411)	(168,509)	(154,556)	(146,166)
OPERATING ACTIVITES	**452**	**691**	**17,886**	**(12,457)**	**(9,960)**	**339**	**(1,284)**	**9,975**	**(5,729)**	**2,615**	**(15,887)**	**(3,631)**	**4,358**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	88	75	75	75	75	50	50	50	50	50	50	50	50
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
	88	75	75	75	75	50	50	50	50	50	50	50	50
Cash was applied to:													
Purchase of Assets	(2,109)	(6,432)	(6,432)	(6,432)	(6,500)	(5,083)	(5,083)	(5,083)	(5,083)	(5,083)	(5,083)	(5,083)	(5,083)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(2,109)	(6,432)	(6,432)	(6,432)	(6,500)	(5,083)	(5,083)	(5,083)	(5,083)	(5,083)	(5,083)	(5,083)	(5,083)
INVESTING ACTIVITIES	**(2,021)**	**(6,357)**	**(6,357)**	**(6,357)**	**(6,425)**	**(5,033)**	**(5,033)**	**(5,033)**	**(5,033)**	**(5,033)**	**(5,033)**	**(5,033)**	**(5,033)**
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	0	0	0	0	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash was applied to:													
Capital Repayment	0	0	0	0	(2,194)	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	(15)	0	0	(15)	0	0	(15)	0	0	(15)
FINANCING ACTIVITIES	**(26)**	**0**	**0**	**(15)**	**(2,194)**	**0**	**(15)**	**0**	**0**	**(15)**	**0**	**0**	**(15)**
Opening cash balance	(24,462)	(26,057)	(31,723)	(20,194)	(39,022)	(57,600)	(62,294)	(68,626)	(63,683)	(74,446)	(76,879)	(97,799)	(106,462)
Overall increase/(decrease) in cash	(1,595)	(5,666)	11,529	(18,828)	(18,578)	(4,694)	(6,332)	4,943	(10,763)	(2,432)	(20,920)	(8,663)	(691)
CLOSING CASH BALANCE	(26,057)	(31,723)	(20,194)	(39,022)	(57,600)	(62,294)	(68,626)	(63,683)	(74,446)	(76,878)	(97,799)	(106,462)	(107,153)
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	(26,057)	(31,723)	(20,194)	(39,022)	(57,600)	(62,294)	(68,626)	(63,683)	(74,446)	(76,878)	(97,799)	(106,462)	(107,153)
Long-term Loans													
Finance Leases	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA Loan	(91)	(91)	(91)	(76)	(76)	(76)	(61)	(61)	(61)	(45)	(45)	(45)	(30)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(26,148)	(31,814)	(20,285)	(39,098)	(57,676)	(62,370)	(68,687)	(63,744)	(74,507)	(76,923)	(97,844)	(106,507)	(107,183)
Working capital facility	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)

BALANCE SHEET

Opinion on Result:

There are no material concerns on the balance sheet.

Prior Year June 2018 $'000	Waikato DHB Group Financial Position	As at February 2019 Actual $'000	Budget $'000	Variance $'000	Budget Jun-19 $'000
79,945	Total current assets	89,654	81,453	8,201 F	78,872
(197,999)	Total current liabilities	(233,146)	(237,542)	4,396 F	(208,093)
(118,054)	**Net working capital**	**(143,492)**	**(156,089)**	**12,597 F**	**(129,221)**
722,564	Term assets	710,364	767,514	(57,150) U	787,735
(22,122)	Term liabilities	(21,645)	(28,578)	6,933 F	(32,080)
700,442	**Net term assets**	**688,719**	**738,936**	**(50,217) U**	**755,655**
582,388	**Net assets employed**	**545,227**	**582,847**	**(37,620) U**	**626,434**
582,388	**Total Equity**	**545,227**	**582,847**	**(37,620) U**	**626,434**

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is favourable to budget mainly due to:		
Current Assets		
• Total accounts receivable and accrued debtors is higher than budgeted by $5.1m mainly as a result of unbudgeted NOS recovery $6.3m, and as a result off the timing of cash received compared with budget assumptions. • Prepayments are higher than budgeted by $3.6m mainly due to eSPACE payment timing assumption variances, actual against budget. • Other unfavourable variances across a number of areas $0.5m.	**$8.2 F**	Neutral
Current Liabilities		
• Overdrawn bank balance held with New Zealand Health Partnership Limited is higher than budget by $2.3m. This is due mainly to the unfavourable variance relating to operating activities ($20.7m) and financing activities ($37.7m) offset by a favourable investing variance from activities ($56.1m) as per the cash flow report. • Payroll liabilities are $5.8m favourable mainly due to the over budgeting of payroll accruals as a result of the timing of pay runs ($10.3m). February 2019 required accrual of only 4 days for the large WAI payrun and 11 days for the OUT payrun. The accrual budget is evenly phased. This offset by an unfavourable CME, superannuation contribution and PAYE variance of $4.5m arising from phasing differences between budget and actual. • Income in Advance $0.7m favourable to budget mainly due to timing of pay equity funding received not matching budget assumptions. • GST $1.9m unfavourable to budget mainly due to timing variances on GST transacted.	**$4.4 F**	Neutral

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Current Liabilities (continued • Accrued Creditors and Accounts Payable $1.1m unfavourable mainly due to timing of payments differing from budget assumptions. The final Friday creditor payment run for February was paid on Friday 1 March 2019. • Other Current Liabilities are favourable to budget $3.2m mainly due to Finance Leases being deferred.		Neutral
Net Term Assets:	**($57.2) U**	
Net Fixed Assets are under budget mainly due to slower than planned capital spend $56.2m, and unfavourable YTD depreciation $0.8m. Please see attached for latest forecast of capital spend for the year for further detail.	($57.3) U	Neutral
Investment in HealthShare has increased by $0.1m due to the share of profits for the 2017/18 year.	$0.1 F	Favourable
Non Current Liabilities:		
Non Current Liabilities are favourable mainly due to deferment of budgeted finance leases.	**$6.9 F**	Neutral
Equity:		
The unfavourable variance is mainly driven by budgeted MoH deficit support not received $27.9m and the unfavourable year to date result of $10.2m. The remaining variance relates to Waikato Health Trust partially reserved fund movement.	**($37.6) U**	Neutral

CAPITAL EXPENDITURE AT 28 February 2019 ($000s)

Capital Plan					Cash Flow Forecast					Full Project Forecast		
Activity	Total Prior year Board Approvals	New Approvals FY18/19	Transfers During 18/19	Total Board Approved Capital Plans	Prior year expenditure for active Projects	Total Expenditure Forecast FY 18/19 (Actual + Planned)	Actual Expenditure YTD from 1 Jul-18 to 28 Feb 19	Approved and Planned Expenditure 01 Mar 19 - 30 Jun 19	Approved and Planned Spend Subsequent Years	Total Planned Expenditure (Actual + Forecast to Project completion)	Total Planned Expenditure Versus Total Board Approved	Total Commitments
Under $50K Subtotal	0	6,000	0	6,000	0	4,500	2,843	1,657	1,500	6,000	0	1,775
											0	
Clinical Equipment Subtotal	23,428	39,693	0	63,120	12,305	23,730	6,902	16,828	20,968	57,003	6,117	8,606
Property & Infrastructure Subtotal	30,814	13,417	0	44,231	12,084	7,365	5,016	2,349	15,692	35,141	9,089	5,007
IS Subtotal	25,058	14,707	0	39,765	13,345	8,839	6,812	2,027	9,376	31,560	8,205	3,047
Corporate Systems & Processes Subtotal	9,819	320	0	10,139	3,788	1,455	389	1,066	4,569	9,811	328	283
Regional Subtotal	9,943	1,264	0	11,207	1,043	2,723	1,304	1,419	3,955	7,721	3,486	26
MOH Subtotal	-	-	-	-	-	-	-	-	-	-	-	-
												-
Trust Funded Subtotal	-	-	-	-	-	0.00	0.00	-	-	0.00	(0.00)	88
REPORT TOTALS	**99,061**	**75,400**	**0**	**174,461**	**42,565**	**48,612**	**23,266**	**25,346**	**56,059**	**147,237**	**27,225**	**18,830**

Waikato DHB
CAPITAL EXPENDITURE AT 28 February 2019 ($000s)

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
Under $50K Subtotal	6,000	2,843	3,157	-
Dialysis Machine - Model 5008S -17	527	-	527	-
Dialysis, Hemofiltration Unit	364	-	364	0
Computer Information Sys. - Oncology (Ecilpse & Aria) -1	250	-	250	-
Linarc Accelerator	5,000	113	4,986	(99)
Blood Culture Analyzer	250	-	250	-
Radg. Xray General Ed Room 1, MCC 5, Resus 1 & 2	1,400	19	1,383	(2)
Radg. Unit, Mobile Xray Machine -Mobile	300	-	300	-
Dual Head Gamma Camera - Hawkeye Infinia	730	-	730	-
Intellivue	364	-	364	-
Mp30 Intellivue	322	-	322	-
Monitor, Cardiac Multi-Parameter	282	-	282	-
Mammotest Breast Biopsy System	680	-	680	-
Monitor, Multi-Parameter	1,053	-	1,053	-
Datex As/3 Monitor 0E3867	320	-	320	-
Pump, Roller, Perfusion System	290	-	290	-
Scanners, Ultrasonic, Cardiac (Ie33)	250	209	46	(5)
Heart Lung Machine, Stockeret S111	303	-	303	(0)
Heart Lung Machine	315	-	315	(0)
Respiratory Function Equipment	299	-	299	-
Electophysiology Equipment	285	-	285	-
Maclab Muse & Haemodynamic System	690	-	690	0
Apex Pro Telemetry System (Including Installation	573	-	573	(0)
Toshiba Digital Image Processing (Cath Lab 2)	1,143	-	1,143	0
Toshiba Digital Image Processing (Cath Lab)	1,204	-	1,204	0
ICU Monitoring System	1,122	-	1,122	0
Monitoring System Upgrade - Network Project	625	-	625	0
S/5 Aespire 7900 Anaesthetic Machibe E11246	612	-	612	(0)
Physiologic Monitor Module, Multiparameter	456	-	456	0
Incubators, Infant	294	-	294	-
Incubator/Radiant Warming Unit, Infant, Mobile	330	-	330	-
Monitor, Bedside, Fetal	468	-	468	-
Replacement Theatre Lights OT 20-25	286	235	51	(0)
Renal Dialysis (CCD) machines x4 Prismaflex	-	-	-	-
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	1,148	166	(1)
Mobile Dental Unit Replacements - level 2	600	165	483	(48)
Digital Mobile X-Ray Project	-	-	-	-
Heart Lung Machines	-	-	-	-
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	568	-	32
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	-	825	-
L8 Menzies Surgical Assessment Unit (Acute)	1,561	1,736	34	(209)
Oncology Facility Development (Interim Facility_ Scoping	450	258	162	30
Other Clinical Items <$250K	7,644	1,078	6,660	(93)
Unplanned Clinical Items - Bucket / Growth	**9,081**	-	6,358	2,723
Projects Removed to be Capitalised	**13,216**	13,677	71	(533)
Other Clinical items - Net Funding & savings required	**2,973**	-	(1,350)	4,323
Timing adjustment based on capacity constraints			-	-
Clinical Equipment Subtotal	**69,120**	**22,051**	**40,952**	**6,117**
PROPERTY & INFRASTRUCTURE				
Mental Health Facility - Scoping -part 2	2,973	121	2,816	36
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Gallagher Building - Med Store & CSES Clinic	-	-	-	-
Gallagher Building - Converyor System	-	-	-	-
Waiora Level 1 - ED Acute Observation Unit	650	-	650	-
Waiora Level 1 - Development of MCC L1 Shell space (for other decants from Waiora L1 : atten	750	-	750	-
Waiora Level 1 - Seismic Works *** part of $2m in Capital Plan	500	-	500	-
Waiora Level 4 - Workspace open plan / decant from Waiora L3 (Includes item removed from be	650	-	650	-

Waiora Level 4 - Sleep space expansion	300	-	300	-
Waiora Level 2, 3 & 4 - Decant space development in ERB3 for Waiora L2, L3 & L4	600	-	600	-
Waiora L3 - Laboratory / Histology / Molecular Biology co location	250	-	250	-
Waiora L1, Menzies L8, OPR5 Kitchen Impact : Kitchen & Food Delivery - Refurbishment & extra	1,500	-	1,500	-
Hamilton Consolidation of CBD facilities - 9th Floor	850	859	-	(9)
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	3,308	5,884	(68)
Hamilton CBD - Collingwood Street Development - First Floor	5,584	717	5,030	(163)
Tokoroa / Te Kuiti / Taumarunui Pregnancy Support Facilities (Fitout of leased premises)	300	34	266	(0)
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	487	63	(0)
Hague road carpark - Seismic and Beam support	2,032	1,271	761	0
Urology to L8 Menzies	320	23	298	(1)
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Ward Block A & Environs	250	-	250	-
Waikato switchboard upgrades core buildings	866	471	395	0
Infrastructure Replacement Pool (17/18)	510	551	2	(43)
Infrastructure Replacement Pool (15/16)	600	745	-	(145)
Infrastructure Replacement Pool (16/17)	641	205	248	188
Infrastructure Replacement Pool (18/19)	600	129	471	(0)
Project Management Resource to deliver BAU Critical Infrastructure projects (2 FTE Equivalent)	250	-	250	-
Cooling Tower Dosing System Upgrades (2-plus)	300	86	214	(0)
Lomas Chillers	390	240	150	0
Fire Protection Upgrade to meet compliance requirements	379	-	379	0
Thames - PHO enabling works	500	-	500	-
Seismic Assessments & Remediation (all campus's not itemised elsewhere)	500	4	496	0
Waikato Distribution Boards	250	213	37	-
Electrical Systems Improvement	6,714	5,969	745	-
Carpark safety improvement (Nets / Cages)	550	29	521	0
Other P&I Projects Budgeted <$250K	4,671	1,514	3,306	(149)
Projects removed to be capitalise	276	124	3	149
Less: Proceeds on sale of property (206 Collingwood St)	(1,500)	-	(1,500)	-
Savings required	-	-	(293)	293
Timing adjustment based on capacity constraints			(9,000)	9,000
Property & Infrastructure Subtotal	**44,231**	**17,100**	**18,041**	**9,089**
Information Systems				
ISSP - Clinical and corporate Platform SQL Server consolidation	365	296	69	(0)
IMPACT Patient Flow Tool	1,769	2,037	76	(344)
SQL Server 2016 upgrades / Citrix XenApp vS VDI	500	82	218	200
ISSP - Data Warehouse Upgrade (Data Warehouse Phase 1)	387	342	58	(13)
ISSP- Clinical Photography and Image Management	397	219	202	(24)
ISSP - Communication Room Remediation Lifecyle	368	124	244	(0)
ISSP - Paging System Replacement	290	296	-	(6)
ISSP - Network Remediation Work Package 2015/2016	-	-	-	-
ISSP - WiFi Rollout	-	-	-	-
ISSP - Network Remediation Lifecycle Work Plan 16/17	282	278	4	(0)
LAN / WLAN - IMPLEMENT: Install WAPs (extend Wi-Fi coverage)	997	405	592	0
LAN / WLAN - UPGRADE: Wireless LAN Controllers (Address core capacity constraints)	263	248	15	0
LAN / WLAN - UPGRADE: Distribution Switches	750	-	750	-
LAN / WLAN - UPGRADE: Access Switches - Replacement	500	6	497	(4)
LAN / WLAN - UPGRADE: Access Switches - Network Remediation	497	2	497	(2)
LAN / WLAN - UPGRADE: Access Switches - Campus Comms	499	4	499	(4)
NIPS - IaaS Implementation	1,557	1,444	113	(0)
Disaster Recovery Solution	1,800	-	1,800	-
DeskTop WorkPlan 16/17	288	196	18	74
End User Devices (<$2k) - now capitalised	1,740	1,022	753	(35)
Rollout of devices at point of care (Investment in circa 500 tablets)	491	2	489	(0)
ISSP - Mobile office Productivity & Management	392	224	168	(0)
Tablet rollout (Year 2 of 4 year plan)	500	-	500	-
ISSP - MS Licensing True-Up	476	129	347	-
ISSP - Other Licensing True-Up	349	83	266	-
ISSP - MS Licensing True-Up -2	400	-	400	-
ISSP - Other Licensing True-Up 2	266	-	266	-
ISSP - Enterprise Business Intelligence Tool	305	305	45	(45)
Business Intelligence Data & Reporting	453	86	382	(15)
Enterprise Service Bus (ESB) Phase II	263	-	-	263
Enterprise Messaging/Communication Solution	350	-	330	20
ISSP - SharePoint Work Pan 16-17	401	491	7	(97)
ISSP - Rapid Logon	359	158	170	31

ISSP - Toolsets (IS Toolsets 15/16)	507	508	-	(1)
ISSP - Netscaler Infrastructure	301	340	-	(39)
Sharepoint 15/16	350	310	40	(0)
Win 10 Upgrade	364	269	95	0
Mobility & Mobile Apps	371	103	268	0
Patient IS capabilities - Observations Platform	361	58	315	(12)
ISL merge ANZ version with European version	500	-	500	-
EBI Tool implementation phase 2 (Qlik Sense Licences)	450	-	450	-
Archiving Tool Implementation	378	-	378	-
Office 2016 upgrade	300	5	295	(0)
Windows 2008r2 to 2016 Server upgrades	800	-	800	-
Security Defence in depth	500	70	360	70
Clinical Workflow Integration Work Plan	358	399	-	(41)
Clinical Workstation Core Component Workplan	513	605	-	(92)
Database Replacements	301	229	118	(46)
iPM upgrade to V10 - after 16/17	484	575	-	(91)
Cat1-5 In-House Developed Applications Work Plan	364	385	-	(21)
Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	259	248	9	2
Oral Health system	852	934	-	(82)
eCWB Infrastructure	254	238	16	-
eOrders	469	328	142	(0)
Anaesthesia Information System - Implementation	600	-	600	-
Observations Platform (eVitals) - implementation	700	-	700	-
Nutrition & Food Management	932	223	709	0
Phone Purchases Lifecycle Replacement	504	90	-	414
Other IS Projects Budgeted <$250K	7,757	3,145	4,833	(221)
Projects to be Capitalised	2,614	2,614	-	(0)
Savings required	-	-	-	-
Timing adjustment based on capacity constraints	(633)	-	(9,000)	8,367
IS Subtotal	39,765	20,157	11,403	8,204
Corporate				
HRIS Lifecycle Upgrade 15_16	529	51	478	-
Costpro Upgrade	313	250	65	(2)
HRIS Renewal Preparation	470	111	260	99
HRIS remediation	3,435	-	3,435	-
PeopleSoft IPS	313	290	14	9
incl Mobile printing for IOS	600	389	211	(0)
Clinical Device Platform	491	85	408	(2)
SCEP racking - hospital wide	400	-	400	-
PeopleSoft Global Remediation	478	478	-	(0)
MECA and Rule Management	289	289	-	0
PLA and Leave Rule Updates	361	361	-	0
Payroll Process Improvements	480	631	-	(151)
National Patient Flow Phase 3 16/17 & 17/18 & 18/19	482	353	142	(13)
Other Corporate Projects Budgeted <$250K	1,498	888	392	218
Savings required	-		(170)	170
Corporate Subtotal	10,139	4,176	5,635	328
MOH & Trust Funded				
HSL - eSpace Programme	6,014	1,243	3,771	1,000
National Oracle Solution - Elevate	3,929	1,104	2,066	759
PACS review	392	-	392	-
Telestroke Pilot	321	7	314	-
16/17 Trust Account	-	-	-	-
Other MOH & Trust Funded Projects Budgeted <$250K	872	-	872	-
Savings required	-		(1,727)	1,727
(Funded by MOH)	(321)	(7)	(314)	-
MOH & Trust Subtotal	11,207	2,347	5,374	3,486
Total Projects	**174,461**	**65,831**	**81,406**	**27,224**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
February 2019

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

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 February 2019	Month			Year to Date			
	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AITKEN VICKI	574.47	-	574.47	2,845.53	-	2,845.53	
AYDON LYDIA	-	-	-	35.00	-	35.00	
CARDWELL CHRIS	-	-	-	-	-	-	
CHRYSTALL MAUREEN	-	-	-	1,443.72	-	1,443.72	
ELLIOTT LORAINE	323.21	-	323.21	2,177.92	-	2,177.92	
HABLOUS NEVILLE	-	-	-	660.04	-	660.04	
HAYWARD SUE	450.02	-	450.02	1,500.77	1,559.78	3,060.55	Int Travel - Quality & Safety in Healthcare forum, Melbourne
HOPGOOD GARY	-	-	-	1,257.39	-	1,257.39	
HOWARD GRANT	-	-	-	927.18	-	927.18	
MALONEY TANIA	43.48	919.20	962.68	1,515.42	4,643.38	6,158.80	Int Travel - Learning Set - Melbourne
McCURDIE ANDREW	-	-	-	1,308.14	-	1,308.14	
NEVILLE MO	32.87	-	32.87	1,850.47	1,487.19	3,337.66	Int Travel - Health round table, Sydney
SEWELL GILL	-	-	-	955.35	-	955.35	
TAHU CLAIRE	205.60	-	205.60	946.46	-	946.46	
TAPSELL REES	-	-	-	667.27	-	667.27	
TER BEEK MARC	-	-	-	3,025.23	-	3,025.23	
WRIGHT DEREK	1,637.95	-	1,637.95	6,196.54	-	6,196.54	
Grand Total	**3,267.60**	**919.20**	**4,186.80**	**27,312.43**	**7,690.35**	**35,002.78**	

Interim CE Travel Expenditure Derek Wright

Travel costs for the period to 28 February 2019				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
21 February 2018	40.91	Late charge prior year Taxi Fare Health Commissioner	Taxi	Wellington
8 June 2018	45.12	Meet & Welcome new MoH Director General	Taxi	Wellington
June 2018	72.17	3 x meetings in Wellington with MoH in June 2018	Hamilton airport parking x3	Hamilton
18-19 June 2018	40.54	MoH - WDHB annual plan and Budget meeting, meeting Dept. Corrections	Taxi	Wellington
6 August 2018	77.13	Meeting CE and Chair of Counties Manukau DHB	Mileage and parking	Auckland
7 August 2018	70.00	Presented to APEX conference	Mileage	Auckland
9 August 2018	577.38	National DHB CE meeting	Parking, airfare , taxi	Wellington
24 September 2018	530.71	Allied Health Partnerships Meeting	Airfare, Taxi, parking	Wellington
5 October 2018	70.00	Midland Regional meeting	Travel	Tauranga
11 October 2018	514.99	National DHB CE meeting	Airfare, Taxi, parking	Wellington
16-17 October 2018	168.34	eMental Health Forum	Travel, parking	Auckland
7-8 November 2018	892.56	National DHB CE meeting & NZPHL workshop	Airfare, Taxi, Accommodation, parking	Wellington
30 November 2018	439.13	Koru Club	Membership	N/A
12-14 December 2018	973.67	National DHB meeting, Pharmac meeting, Mental health and SSC meetings	Airfare, Taxi, Accommodation, parking	Wellington
6-7 December 2018	546.00	Midland Regional meeting	Accommodation, Travel	Tauranga
17&19 December 2018	147.15	Various meetings	Travel, parking	Auckland
13-14 February 2019	990.73	National DHB CE meeting & National Chairs/CE meeting	Airfare, Taxi, Accommodation	Wellington
	6,196.54			

Health Targets

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 7.1

HEALTH TARGETS REPORT

Purpose	For information.

The Ministry of Health is currently developing a new set of national performance measures with a new focus on population health outcomes. Guidance on the measures are expected to be provided in the next few months, until that time we will continue to report on the existing health targets in the current format. The System Level Measures framework has also been added to this report to provide further information on wider indicators of health outcomes.

Most Recent Results

Quarterly data remains unchanged from the previous month's report. The "most recent result" (far right column) shows latest monthly data. Such data is not available for smoking quit targets.

Table 1- Health targets performance summary

HEALTH TARGETS		Target	2017/18 Q1 results	2017/18 Q2 results	2017/18 Q3 results	2017/18 Q4 results	2018/19 Q1 results	2018/19 Q2 results	Target achieved	Most recent result
Shorter stays in emergency departments		**95%**	82% 20th ✗	89% 20th ✗	86% 19th ✗	84% 19th ✗	80% 20th ✗	84% 17th ✗	X	83.9% Feb-19
Improved access to elective surgery		**100%**	111% 5th ★	104% 8th ●	105% 6th ★	105% 7th ★	102% 7th ★	99% 11th ●	X	97% Feb-19
Faster Cancer Treatment (FCT)	Achievement	**90%**	98% 1st ★	98% 2nd ★	97% 3rd ★	96% 3rd ★	94% 8th ●		√	95.3% Feb-19
Better Help for Smokers to quit	Primary Care	**90%**	88% 14th ●	89% 12th ●	88% 14th ●	87% 16th ✗	85% 17th ✗	85% 15th ✗	X	Not avail
	Maternity	**90%**	94% 8th ●	97% 4th ★	99% 3rd ★	87% 14th ●	90% 13th ●	87% 17th ✗	X	Not avail
Increased immunisation (8 months)		**95%**	88% 15th ✗	90% 15th ✗	89% 14th ●	88% 14th ●	87% 16th ✗	88% 14th ●	X	86% Feb19
Raising Healthy Kids		**95%**	76% 19th ✗	100% 1st ★	100% 1st ★	100% 1st ★	100% 1st ★	100% 1st ★	√	100% 6 mths Jan 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 2018/19

Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Feb 19
85.8%	83.6%	80.4%	83.9%	89%

Table 3 - Emergency Department Q1 results by site and by clinical unit

Quarterly Results – by DHB total population			
	Numerator: The number of Emergency Department presentations with a length of stay of less than six hours	Denominator: Total number of Emergency Department presentations	Percentage of patients admitted, discharged or transferred from the Emergency Department in less than six hours
DHB total:	24924	29704	83.9%
Waikato	16837	21003	80.2%
Taumarunui	1408	1450	97.1%
Thames	3686	4154	88.7%
Tokoroa	2993	3097	96.6%

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 Emergency Department presentations with a length of stay of less than six hours	Total number of Emergency Department presentations	Percentage of patients admitted, discharged or transferred from the Emergency Department in less than six hours	The number of Emergency Department presentations with a length of stay of less than six hours	Total number of Emergency Department presentations	Percentage of patients admitted, discharged or transferred from the Emergency Department in less than six hours
DHB total:	7750	9037	85.8%	634	737	86.0%
Waikato	5167	6314	81.8%	501	594	84.3%
Taumarunui	627	646	97.1%	10	11	90.9%
Thames	675	758	89.1%	43	49	87.8%
Tokoroa	1281	1319	97.1%	80	83	96.4%

January 2019 6hr target score: 86%- Waikato DHB only.
February 2019 6 hr target score (provisional): 89%- Waikato DHB only.

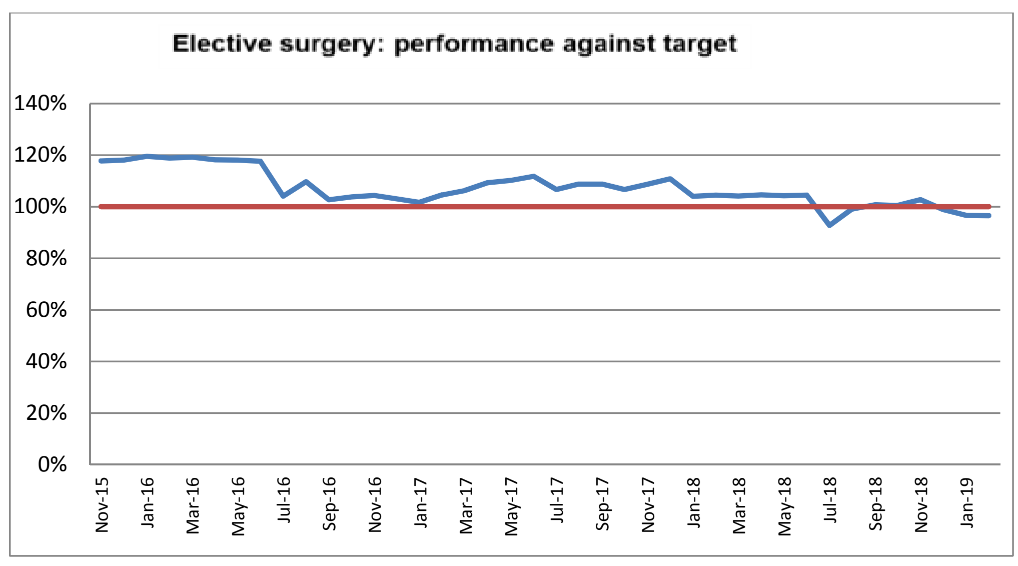
Target: Elective Surgery

Table 4 – Elective Surgery Results by Quarter

Quarter	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19
Result	104%	105%	105%	102%	99%
Ranking	8	6	7	7	11

Graph 1 below provides the most recent result of 96.5% till the end of February 2019.

Graph 1 - Waikato DHB's elective surgery performance up to Feb 2019



Target: Faster Cancer Treatment (FCT)

Table 5 - Summary of achievement against the FCT health target from October 2016 to February 2019.

FCT 62 DAY HEALTH TARGET									
DHB Current Target	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	DHB Q3 Result 17/18	DHB Q4 Result 17/18	DHB Q1 Result 18/19
90%	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 3rd equal ranking	96.6% 3rd equal ranking	99.0% 3rd ranking	95.5% 3rd ranking	95.3% 3rd ranking
FCT VOLUME TARGET									
DHB Current Target	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	DHB Q3 Result 17/18	DHB Q4 Result 17/18	DHB Q1 18/19
25%	17%	19%	19%	22%	14%	14%	14%	18%	18%

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

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

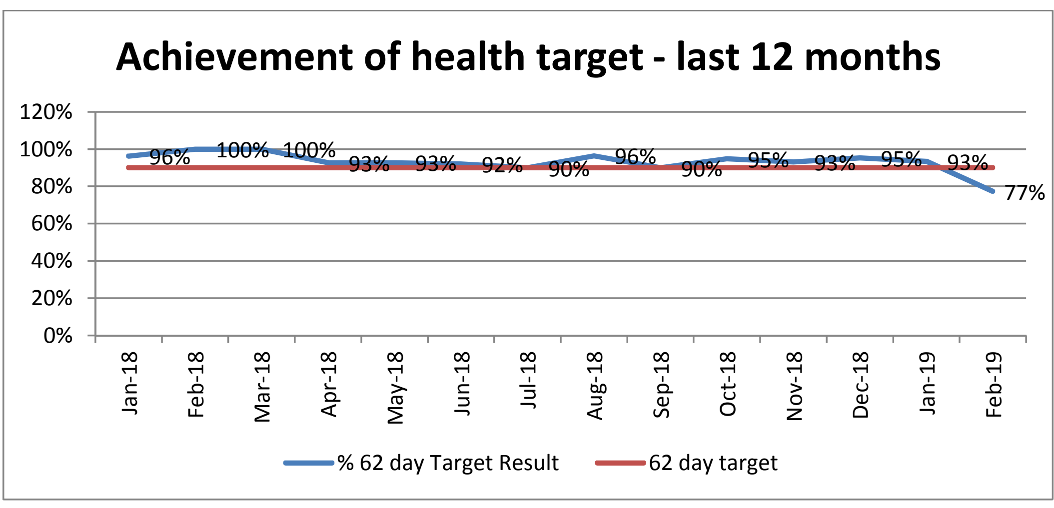


Table 6

Local FCT Database	**Dec-18**	**Jan-19**	**Feb-19**
Number reported on pathway	27	24	29
Number excluded (patient reasons/clinical considerations)	6	9	7
Number included for 62 day indicator	21	15	22
Number within 62 days	20	14	17
% 62 day Target Result	95%	93%	77%
% Volume Target Met (15%)	17%	15%	18%

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.

February 2019 has shown our overall percentage to have taken quite a drop for the first time in a couple of years. There are a number of reasons which are causing the breaches:

- Insufficient Breast surgeon capacity compared with the demand, locum commenced in October, but we know that we will have more breaches this financial year due to capacity restraints in this service.
- Shortage of Interventional Radiologists, impacting on diagnostic CT biopsies.
- Ongoing RMO strike causing cancellations of surgical procedures, which is starting to have a compounding effect.

Each of these services are putting strategies in place to manage the situation on an on-going basis, but the FCT performance target is likely to remain impacted for the next couple of months.

Target: Increase in 8 month olds fully immunised

Table 7 – Eight month Milestone Immunisation Results by Quarter

Quarter	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19
Result	**90%**	**89%**	**88%**	**89%**	**88%**
Māori	**86%**	**83%**	**82%**	**83%**	**81%**
Ranking	**15**	**14**	**14**	**16**	**14**

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

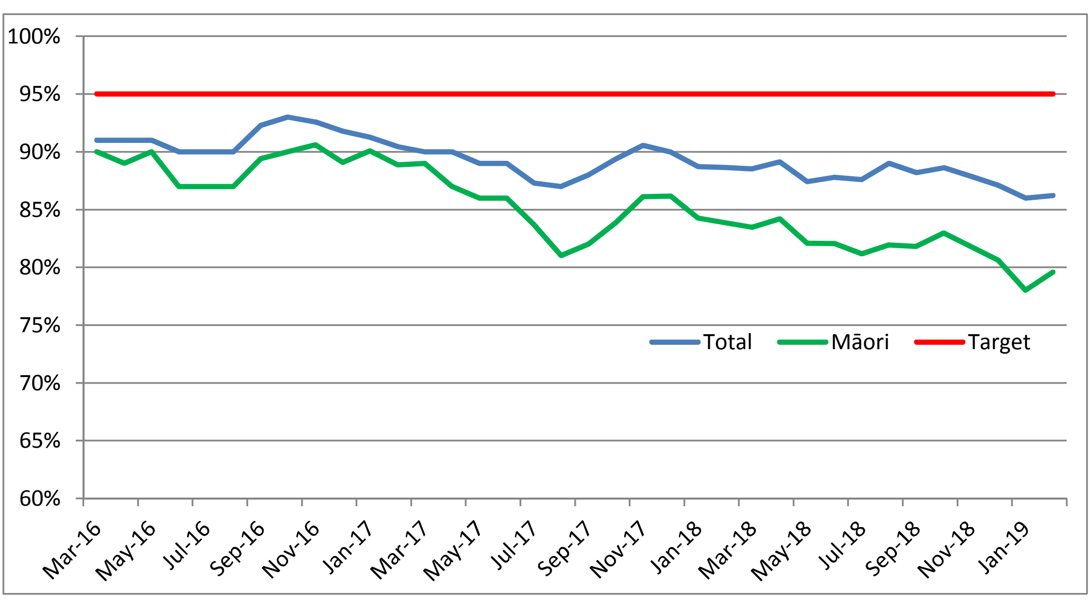


Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from Dec 2018 to Feb 2019

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	536	473	88%	37
Māori	480	382	80%	74
Pacific	62	55	89%	4
Asian	188	182	97%	0
Other	83	71	86%	8
Total across ethnicities				123
Total	1,349	1,163	86%	119

Recommendation
THAT
The Board receives this report.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

RON DUNHAM
INTERIM CHIEF OPERATING OFFICER

Health and Safety

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 8.1

HEALTH & SAFETY REPORT

Purpose	For information.

HEALTH AND SAFETY REPORT: JANUARY 2019

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

- Policy and Planning
- Monitor
- Delivery
- Review.

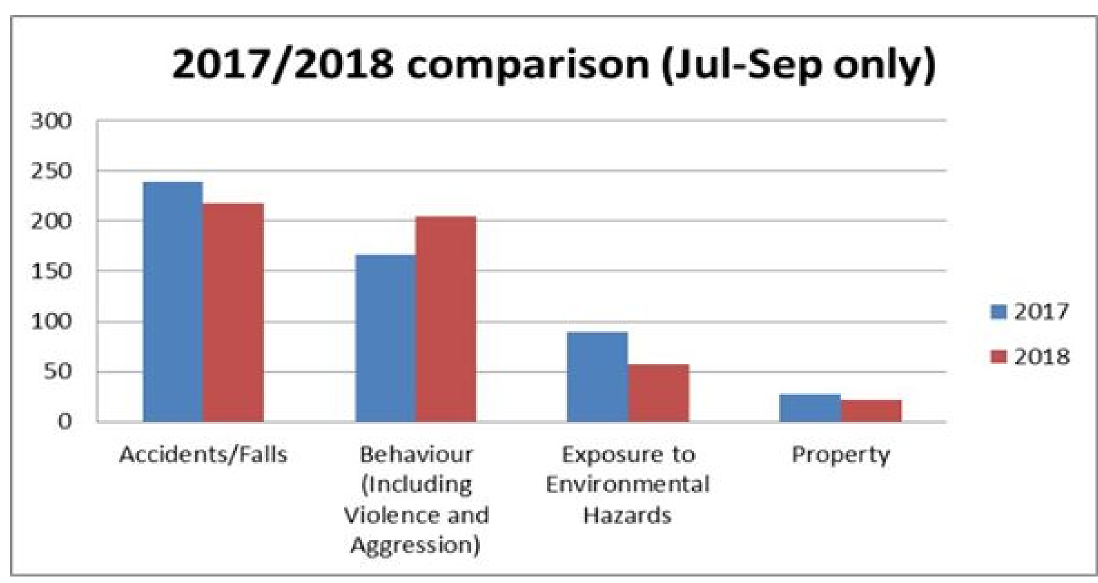
Incidents Reported to WorkSafe NZ year to date (calendar)

	Year to date
Total Incidents reported	**3**

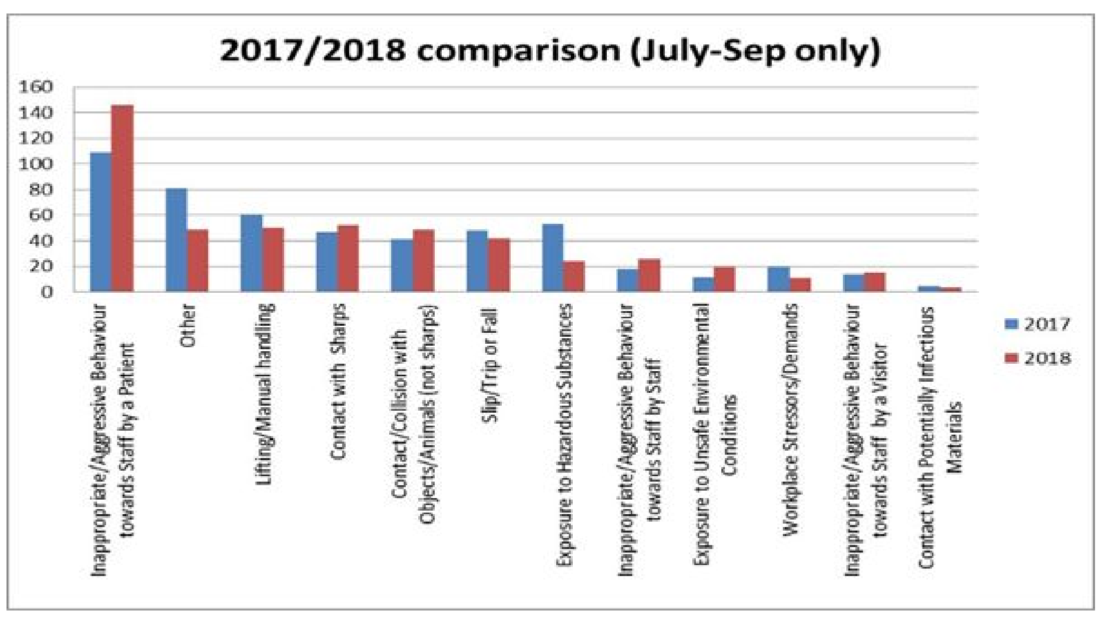
- Employee collapsed in carpark displaced fracture to right Leg –March 2018
- Employee tripped on stairs and sustained fractured right leg-May 2018
- Contractor sustained electric shock-nil injuries sustained-June 2018.

DATIX INCIDENTS (Health & Safety)

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



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



Annual Influenza Programme - 2018
Waikato DHBs Health Care Workers

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

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

Employee Assistance Programme 01 July 2018 to 30 September 2018

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

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

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

Session Data

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

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

Impact Level Assessments

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

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

Referral Source

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

Self Referral	Management Suggested	Management Formal
84	23	1

Occupational Groupings

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

Work Force	Management	Supervisory	Family Member
97	6	5	0

Total Actual Issues

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

Total Issues	Personal Issues	Workplace Issues
309	228	81

All Personal Issues

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

Personal Issues	Total	Percentage
Alcohol	3	1.32%
Anger	9	3.95%
Anxiety	34	14.91%
Children	19	8.33%
Confidence	7	3.07%
Cultural Differences	5	2.19%
Depression	12	5.26%
Domestic Violence	3	1.32%
Drugs	2	0.88%
Family	20	8.77%
Financial	3	1.32%

Gambling	1	0.44%
Grief	37	16.23%
Health/Medical	14	6.14%
Legal	2	0.88%
Low Self Esteem	1	0.44%
OCD	1	0.44%
Parenting	5	2.19%
Relationships	33	14.47%
Sleep	9	3.95%
Suicide	1	0.44%
Trauma	7	3.07%

All Workplace Issues

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

Recommendation
THAT
The Board receives this paper.

GIL SEWELL
EXECUTIVE DIRECTOR HR AND ORGANISATIONAL DEVELOPMENT

Service Performance Monitoring

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 9.1

INTERIM CHIEF OPERATING OFFICER

Purpose	For information.

This report summarises the activity in Waikato Hospital, rural hospitals and community services.

Activity during January was disrupted significantly with industrial action. In total the action included:

- Resident Doctors Association — 4 days (15 – 17 Jan, 29 – 31 Jan)
- Midwives (MERAS) — 12 hours 12 Feb (planning in Jan for 12 Feb strike action)

As well as our own staff we were impacted by St Johns withdrawal of labour for non urgent patient transfers which meant potential problems with discharging and interhospital transfers.

In addition anaesthetic technicians at Rotorua hospital are on strike which means Waikato DHB hospitals need to back up and support the Lakes DHB.

Despite all this disruption we managed to provide stable and safe services to thousands of people with no major incidents. I would like at this point to acknowledge staff, at all levels, for their support of our patients especially in an acute environment.

Acute Services

- Relevant performance indicators:
  - Emergency Department 6 hour target
  - Acute theatre access percent (80% in 24 hours, 100% in 48 hours)
  - Acute Coronary Syndrome pathway (diagnostic coronary angiography within 72 hrs of presentation to a medical facility in the Midland Region).

Emergency Department

A small working group has been working in the Emergency Department (ED). Their mandate is to achieve consistently a 90% attainment to the 6hr target. To achieve this, they have decided to focus their efforts on the following initiatives:

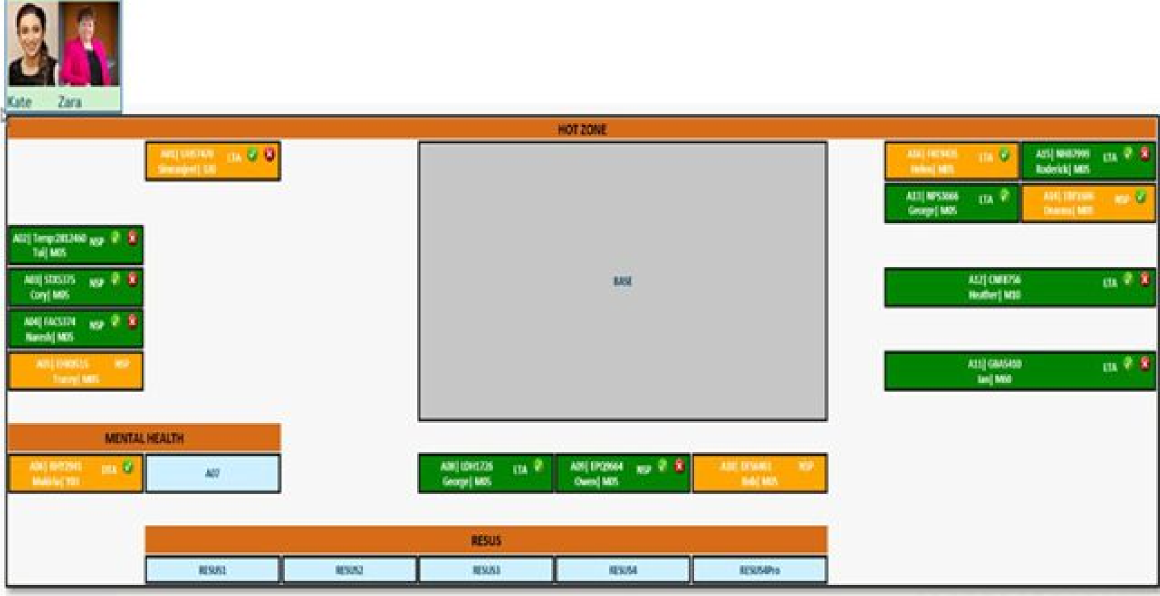
- Developing and implementing a sustainable “Model of Care” Operating Model into the Emergency Department.

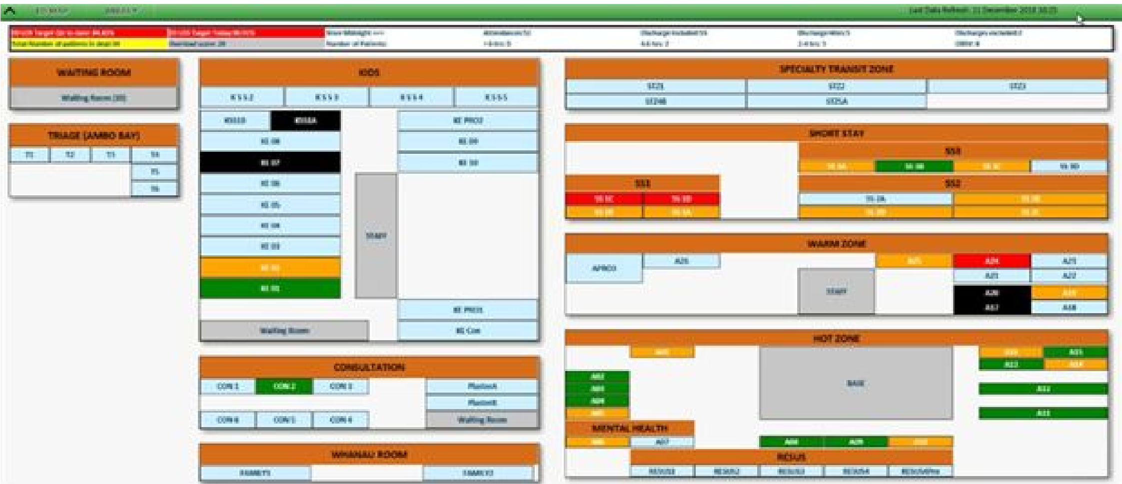
- Re-building the Emergency Department's team morale and to create a positive working environment that will reduce employee churn.
- Continuing to further develop the various zones that the Francis Group had implemented into the Emergency Department:
    - Triage
    - Consult
    - Hot Zone
    - Specialty Zone
    - Paeds
    - Resus
- Building a roster that is based around a team environment. Each zone will have a team leader that will lead the co-ordination and management of their team members and oversee the patient flow through their respective zones.
- Developing a roster (medical and nursing) that is in line with the "Model of Care" operating model. This will also matching the service's needs 24 hrs a day, 7 days a week (rather than the current Monday to Friday model).
- Reviewing and Re-writing the key roles and responsibilities in the Emergency Department to ensure alignment with the new "Model of Care" operating model.
- Continuing the patient re-direction initiative from ED to AMU/ASU and also extend this out to other suitable locations such as Plastics Hot Clinics and Women's Assessment Unit (WAU).

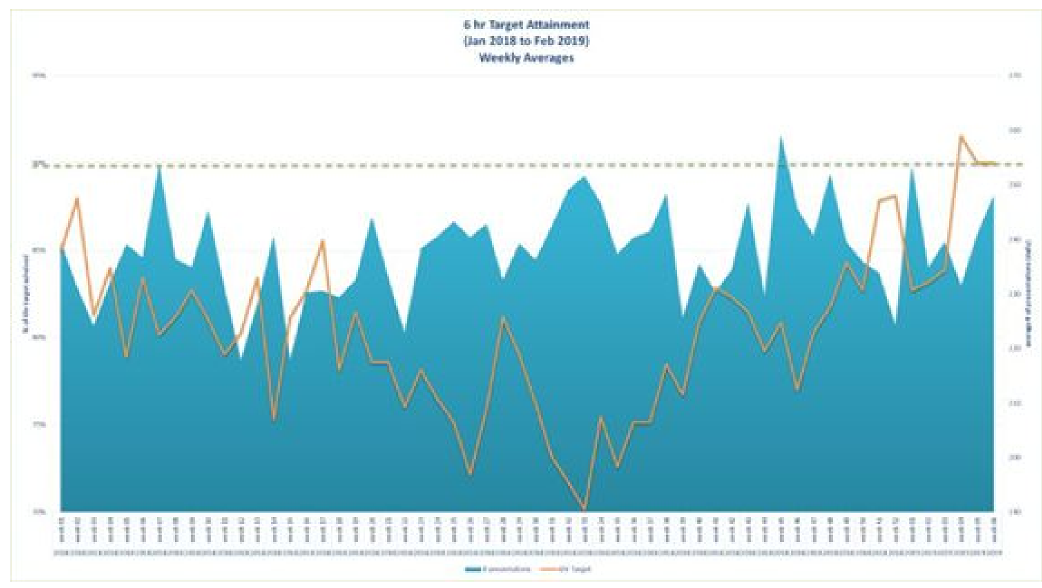
The Emergency Department has made significant progress towards achieving the 6hr target since the middle of December. As can be seen from the graph below (Chart 1), we have seen a sharp up-swing in performance from what was once an underperforming service (a weekly average of 80% between Jan 2018 to Dec 2018) to now a service that has hit an average of 90% or above for 3 consecutive weeks to date. What makes this result more impressive is that, the department has achieved this whilst still seeing the same number of daily ED presentations as before.

From an IT and Data perspective, we are developing an ED Whiteboard and ED Dashboard that will provide the department with access to LIVE critical data/information. This will allow the management team to make on the fly decisions to pro-actively manage any current and potential constraints and blockages on patient flow as and when they occur. See below for screenshots of draft designs.

Screenshot 1: (Hot Zone Detailed View)

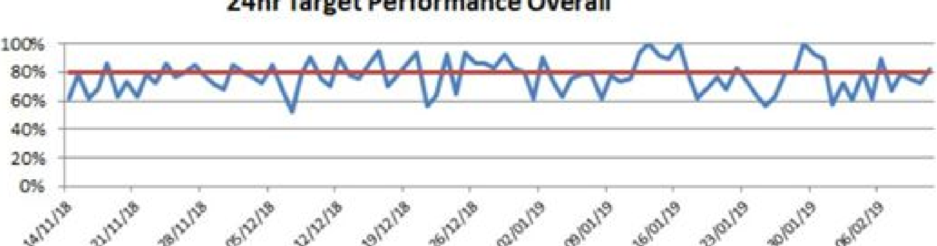




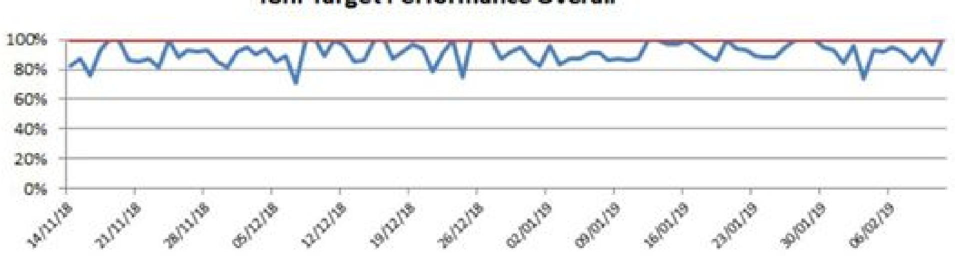


Access to Acute and Emergency Surgery

We are currently not consistently meeting our access to theatre 24 and 48 hour targets. This is in context of increasing demand for access to acute theatres over time, RDA strike action since the beginning of the year and the extended Christmas close down period. Through the Operations Centre we continue to closely manage acute demand on a daily basis by increasing the number of acute theatres in response to peaks of demand.



Target is that 80% of patients have access to acute theatres within 24 hours

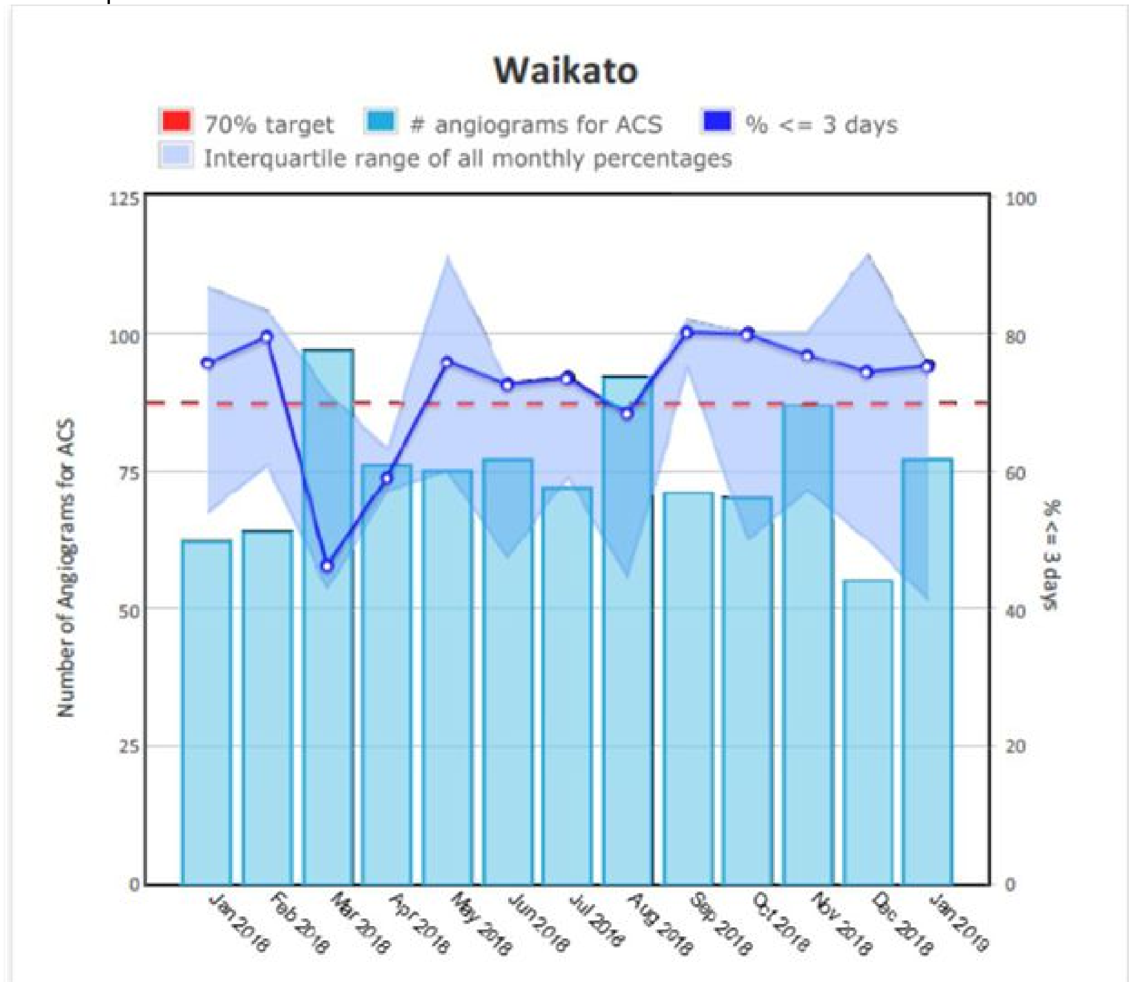


Target is that 100% of patients have access to acute theatres within 48 hours

We will continue to monitor this closely to ensure it remains a focus. As soon as we get through this industrial phase we would expect improvement here.

ACS Target

Our performance against the ACS target has been that we have met the standard since September 2018.

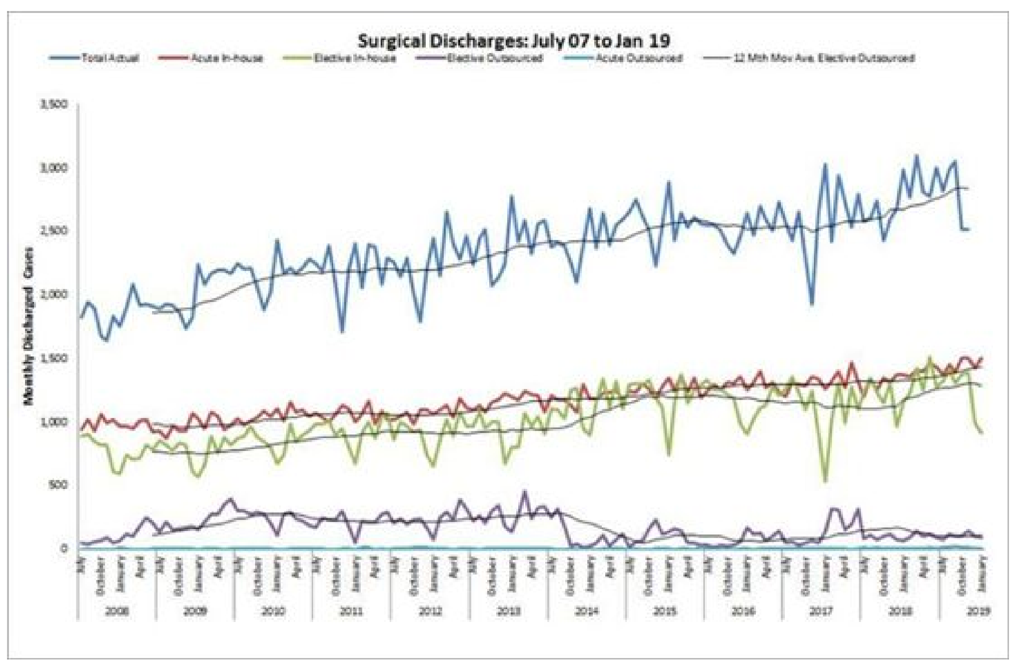


Elective Services

- Relevant performance indicators:
  - "Quantitative" – volume of patients treated
  - "Qualitative" – ESPI framework.

Quantitative

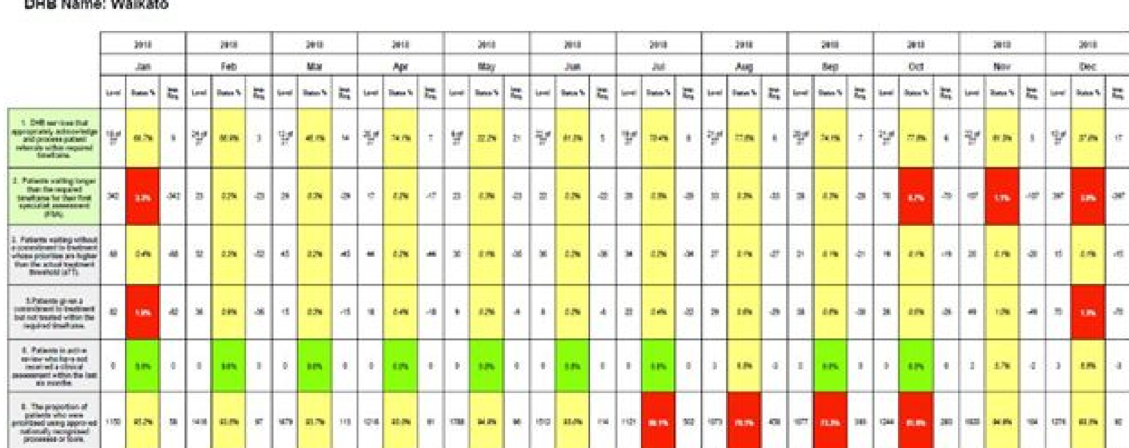
Delivery of elective volumes continues to increase over time. The drop in January is due to the annual shut down over the Christmas / New Year period.



Qualitative Measures

The DHB has been non-compliant for ESPI 2 since October 2018 and was non-compliant for ESPI 5 December 2018. A number of Services have recovery plans in place which will improve compliance in both ESPI 2 and 5.

This has been communicated to the Ministry of Health and they are supportive of our remedy plans.



Summary of Patient Flow Indicator (ESPI) results for each DHB

DHB Name: Waikato

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

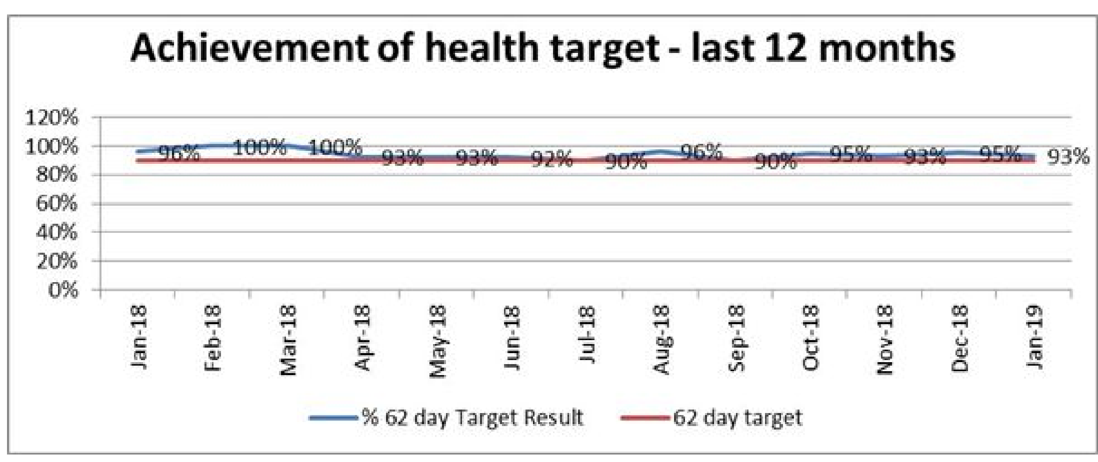
Regional and Community Based Services

Cancer services

Waikato DHB continues to meet the Faster Cancer Treatment targets with 95.3% meeting target (3rd place nationally). Activity continues to be monitored closely especially the measures for diagnostic capacity for 31 and 62 days.

The greatest risks to our future performance relate to diagnostic capacity for 31 days, whilst for 62 days it is surgical capacity to treat breast cancer patients. The FCT Business Manager works closely with both teams, but they remain the greatest current constraints.

Historical achievement against the FCT health target by month



Several members of the clinical and managerial team attended the national *"Cancer at a Crossroads"* Conference in Wellington earlier in the month. The conference attracted national media interest and was aimed at drawing together national and international experts to determine the future direction for cancer care in New Zealand. The Ministry of Health made a commitment during the conference to develop a national cancer plan by the end of the financial year, aiming to address some of the concerns raised over the lack of a plan, whether or not to create a national cancer agency, and the actions required to help address the increasing incident of cancer in Aotearoa.

Regional services

A number of P&I related issues will need to be progressed over the next couple of months. Concerns have been raised over the future use of the building that houses the Diabetic service, which has been purchased by a new landlord, with the current lease due to expire in September this year. An urgent meeting has been arranged with P&I to discuss both the short and longer term building solutions for this team.
The project to move the Oncology nurses into a new space to enable the subsequent integration of the Pain service with the Rheumatology service in the Ryburn building has been delayed due to Hamilton Council's fire assessment of the space that the nurses will move into.

The planned redevelopment of Lomas B1 (chemotherapy expansion) and M3 (Renal ambulatory care facility) have also been delayed due to Hamilton Council's requirement for a Menzies total building fire review. Both the Chemotherapy service

and the Renal dialysis service are reliant on the additional chair space that will be created.

We will continue to work closely with the P&I team on these issues.

Visit to the Oncology and Renal wards
The Executive leadership safety visit to Wards M5 (Oncology) and M3 (Renal) occurred this month. The respective Charge Nurse Managers were pleased to be able to talk through the work they have undertaken in the last year to improve leadership, team working and patient safety with the Executive leadership team. It was especially beneficial for the CNM on Ward M5 to demonstrate the significant changes that have occurred on her ward to improve things from a staff perspective, though recognising that there is a relatively junior workforce in place that will require further support to understand the complexities of care for those on cancer therapies.
Waikato Hospital campus had controlled power shutdown on Sunday 17 February between 7am and 10.30am. this was for regular testing and maintenance. The programme went smoothly with no major incidents.

Community and Clinical Support

Each of the ten services that make up the Community & Clinical Support group is making good progress against the broad range of service priorities for the 2019/19 year.

Business/Service Pressures
Plan and design the business model underpinning the Waiora facility development that is planned for 2018/19 (now 2019/20)
Slow progress, Current activity is quoting for concept design work.

Comprehensive planning for interventional radiology flow and additional capacity
The use of interventional technologies is rapidly changing and the combined pressures are significant. A business case to replace the angiography suite and to establish a schedule of angiography sessions that reflects patient demand has been completed.

Implement the rural retrieval service
This is a clinical risk project that has recently been resuscitated.

Hospital medicines in the Combined Pharmaceutical Budget (CPB)
Ongoing concerns of the 'proposed' savings with the centralisation of the community drug budget. Outcome for WDHB is a $2.6 M unfavourable variance.

Service Improvement
Implement an e-ordering link between Pathlab and Waikato
A global programme of work to establish electronic ordering of laboratory and radiology requests is progressing with a planned 'go live' in Q2 19/20.

Implement the histology digital x-ray scanner
Laboratory services are collaborating with our Breast Screening service to purchase an additional mammogram machine for the dual purposes of additional mammography capacity and histology scanning. The Business Case has been presented to Finance.

Implement a robust clinical photo archival and storage system
Slow progress to this project due to vendor delays. The system upgrade is essential to ensure that all clinical images taken on cell-phones and mobile devices will be automatically archived into the clinical record in a secure manner.

Implementation of the Southern Rural Maternity model of care
The Te Kuiti maternity centre has officially opened, 15/02/19; Tokoroa birthing unit facility upgrade commence March 2019; service delivery models for LMC support is in place for Taumarunui; ongoing negotiations for midwifery services at Tokoroa; the work to implement the rural maternity centres is continuing in Tokoroa and Taumarunui.

Patient Transfer Services
The ‘go live’ date for the above with the St John Ambulance service for PTS commences 01 April 2019. Progress is being made to centralise the service model to ensure financial viability.

Medical Staff in Rural Hospital Services
This is a project focusing on the achievement of a ‘fit for purpose’ workforce model.

KPI/Performance
Achieve national MRI & CT targets (both performance metrics increase)
Performance against the national target that 90/95% of MRI/ CTs i.e. to be reported within six weeks of referral is not being met. Waikato’s specific issues are radiologist workforce gaps coupled with upward of a 30% increase in demand for CT and MRI’s. Waikato is still performing well despite these pressures. As at the December 2019 our results were: CT at 69% - national average at 76%; MRI service at 86% - national average at 56%.

Māori health improvement results
We are experiencing improved Māori wāhine enrolment and coverage in screening (breast and cervical) and DNA rates for outpatient services.

Achievements
IANZ Assessment in November
A successful audit albeit we received three corrective actions. Of note, one corrective action relates to poor compliance of our accommodation facility.

Womens and Childrens Health Service

The Women’s Health Service hosted the RANZCOG re-accreditation team on Friday 15 February and the provisional feedback is that Waikato DHB Women’s Health Service will gain accreditation for obstetrics and gynaecology training for a period of four years.

The accreditation team acknowledged what a turnaround they have seen in the service over the last two years. The final report will need to be approved by the RANZCOG Board in the coming months.

I would like to take the opportunity to thank all staff working in the Women’s Health Service for their contribution to this great achievement.

Acute Medicine, OPR and Allied Health

The Emergency Department has been very busy throughout January and into February with the number of presentations consistently at 250 per day or more. There was one day when the service had its second highest ever number of presentations. The service has coped well with this demand. Weekly averages of 92% and 90% have been achieved for the 6-hour target, this performance has not been achieved since 2016 and our performance in January showed a 7% increase when compared with January 2018.

An acute Geriatric Team in ED is being trialled which is having a positive effect. This consists of a Geriatrician, Clinical Nurse Specialist, Occupational Therapist and Physiotherapist. This has led to our frail older clients being seen sooner with a 24% reduction in ED length of stay. The Allied Health staff and Clinical Nurse Specialist have been particularly effective in preventing unnecessary admissions. Identifying and putting in place appropriate supports so the client can return home safely direct from ED.

This demand at the front door has had a knock on effect through the hospital. Acute Medicine and Older Persons Rehabilitation and Allied Health have coped well with this with beds available every morning. Community supports have significantly contributed by ensuring there are discharge options available and also working to prevent avoidable admissions. For example:

- On a daily basis the START service is supporting at home in excess of 120 patients who would normally be in a hospital bed.
- Acute home based Supports is enabling 40-50 discharges home per week.
- Disability Support Link inpatient team are assessing and facilitation on average 25 inpatients per week who now need residential care.
- Disability Support Link community teams are assessing and reviewing in excess of 400 clients per week in the community in order to prevent unplanned presentations and admissions.

First Impressions

I have been in the position of Interim Chief Operating Officer for one month now. I have identified a number of opportunities which if addressed provide the potential for efficiencies and quality improvements. Included are:

Outsourcing

I am concerned about the volume of (in particular) surgery we outsource. Outsourcing is frequently used as a quick fix to capacity constraints. There is little strategic context to address the constraints so that we do have this as a recurring problem in the future. As we have multiple channels of commissioning there is little standardisation on volume, pricing, contracts, provider. If we could standardise this process, ensure all requests to outsource go across one ‘desk’ we have an opportunity to ensure current resources are maximised, in house and we utilise our purchasing power.

Terms of reference for an outsourcing control group are currently being established.

Campus Constraints
Many of the services based at the Waikato Campus are constrained. There are opportunities to decant some activity to T Hospitals to provide better access for local residents if we can change the medical model of delivery to adjust whilst maintaining the quality of care necessary. There are also opportunities to utilise both Tauranga (cardiology) and Rotorua (surgery, dialysis) more efficiently. We are in conversation with both District Health Boards. Constraints at Waikato must be challenged to utilise the full resources available.

Driving Improvement in the Quality of Care
Waikato DHB is data rich. There are many sources of metrics that are in some instances used well but this is not consistent across the organisation. Opportunities are missed to drive clinical quality improvement and outcomes. Data sources (internal to Waikato DHB, Ministry of Health, Health Round Table) are all reliable sources and should be triangulated to identify and drive improvement. Each service has been asked to identify data champions to drive their service forward. We will provide additional training and tools to help them do this.

Clinical Governance
Throughout the organisation there are pockets of well established medical / manager / nurse partnerships. I think it is important that we strengthen these and ensure accountability for outcomes is recognised. The overarching Clinical Governance Board is absent. The Chief Medical Officer, Director of Nursing and Chief Executive Officer / Chief Operating Officer are looking at re-establishing this to ensure standards, policy clinical practice and clinical pathways that go across services are supported. Strong clinical governance will drive quality and efficiency.

Financial situation
The provider arm services have a significant overspend. Individual clinicians find it difficult to comprehend what they can do to reduce this deficit when a unrelentless demand for their care from the patient in front of them and the one behind that continues. Addressing the overspend is like turning a supertanker, small nudges like reducing outsourcing, investing in capacity wisely, strengthening clinical accountability, providing consistent messages of restraint and improvement.

Demand is often sighted as the main driver of cost overrun and it is difficult not to see this as the reason behind costs. Demand occurs right back in our communities so must be seen as a fracture of the whole system, not just the hospital system.

For this reason the provider arm and funding planning and commissioning must operate as a closer team, a philosophy embraced by all the senior executive team.

Recommendation
THAT
The Board receives this report.

RON DUNHAM
INTERIM CHIEF OPERATING OFFICER

Facilities and Business report: refer to item 19.

Professional Advisory Reports

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 10.1

CHIEF MEDICAL OFFICER REPORT

Purpose	For information and to note.

Content of Report
This will be my first report to the Board as Chief Medical Officer and occurs some six months into my time in this position, following a complex period of interim and acting leadership. This is not a simple position with a clearly constructed and concrete description that lends itself to a report based on meaningful metrics and measures which distil nicely into matters for the Board to note or activity for the Board to direct. The following is an outline of some of the streams of activity within the CMO Office.

CMO Office Structure and Professional Governance
Previous iterations of this position have operated on a part-time basis inconsistent with the magnitude of the workload and insufficiently connected to the coalface to facilitate an understanding of shop-floor problems and institute their timely management. Moreover, a lack of structure undermined the adequacy of the medical effector arm to achieve traction in almost any cross-service endeavour. Strengthening has occurred with the appointment of two Associate CMOs in Rees Tapsell from Psychiatry and Renal and General Medicine physician – Maggie Fisher. Partly by design, the Office is now clinically connected to almost all services whilst achieving a degree of gender and ethnicity balance.

The informally established Clinical Unit Leaders (CUL) Group has in the last few weeks progressed a decision to formalise its structure, establish Terms of Reference, and align with the CMO Office. This Group comprises the Medical Directors for Medicine and Surgery in Sarah Fowler and Chris Holdaway (Chair), respectively, in addition to the Clinical Unit Leaders of all services, and the incumbent chair of the WSMSA. This sets the foundation for achieving reliable clinical advice on almost any matter to the CEO and an evolving ability to ensure signals from the services are visible at the right organisational level, and in a timely fashion. The Clinical Directors of the surgical services reporting to the Medical Director for Surgery complete an appropriately compressed pyramid in the surgical arm.

The Office now has the beginnings of a much greater profile and direct input into the greyer interface between operational management and clinical leadership. The CMO is a tangible presence where tensions between administrative management and clinicians have been historically problematic. This seems to be an effective strategy.

Next steps:
1. Consider the relationship between the remaining Clinical Directors and the CUL group
2. Continue to grow and develop the leadership capability and succession planning through an active program of mentorship

Rural Engagement
The Office has commenced activity with a view to supporting service standards across Thames Hospital and the Southern rural hospitals. These services rely heavily on a locum pool of clinicians to service a challenging population with significant social deprivation. There is a function tiered system of care based on postcode. The Office has a direct presence at Thames and Tokoroa hospitals, and is working closely with the Director of Community and Clinical Support to examine each service supplied.

Next steps:
1. We need to develop services in a sustainable fashion to predictably deliver safe and effective care. Models need to be established for each rural service that best fosters that delivery. For some services, this will best be served by standalone models which are site specific, whereas others would be better served by hub and spoke design aligned to one hospital, multiple sites approach. A sustainable workforce with agreed credentialing criteria needs to be developed with some urgency. Once those criteria are defined, we will need to balance the tensions that arise navigating decisions which must balance “no service” against a “safe service”.

CMO Office Direct reports
Restructured in early 2018, the Resident Medical Officer Support Service (RMOSS) had some challenges in the latter quarter of 2018, commencing with the resignation of the Manager, and progressing with the successive resignation of all but a single staff member. The service is now being rebuilt with a new manager in place, significant support from Human Resources, support from the Northern Regional Alliance, and ongoing recruitment. An extraordinary effort from HR has led to minimal impact on the services.

Next steps:
1. RMOSS does not naturally align to the CMO Office functions and we will review the organisational alignment of the service. It will be necessary to review the degree to which services that RMOSS supplies are centralised vs decentralised. The goal is to move Waikato DHB into a leading position with respect to priority choice for junior doctors. A wider discussion regarding organisational recruitment strategy overarches this work. We must foster and grow streamlined systems for the recruitment, on-boarding, leave planning and roster management of these doctors. There will be a need for investment in IT solutions to support this activity.

Clinical Education and Training Unit
Significant progress has been made towards shoring up the training and education environ and addressing the regulators concerns regarding accreditation for training. We anticipate a favourable response to our most recent submissions.

Next steps:

1. In this environ of resource limitation, it is imperative that the Board and organisation appreciate that education of junior doctors is prioritised in line with our responsibility as a training organisation.

Resuscitation and Simulation

Our resuscitation training obligations are a challenge to deliver across many thousands of staff. Coupled with the rapid growth in simulation as a team-based educational strategy, in addition to national programs such as NetworkZ, we have seen an explosion in demand for services and equipment in this space. Our ability to deliver is critically dependant on a single individual (Director of the Skills and Simulation Centre – Rob Sinclair), and a vast amount of donated time from a wide pool of staff. This is a "cottage" style of organisation which is vulnerable to collapse and failure at a number of points. Previous discussions involving this service have been fettered by contamination with competing interests relating to research, university roles, and significant infrastructure projects.

Next steps:

1. We have secured a small FTE increment to support the incumbent with both administration and teaching. Succession planning will form part of the recruitment process. Funding for greater technical support needs to be found for maintenance, repair, and set up of a pool of valuable equipment freeing the Director for planning, strategic work and the ongoing pursuit of external philanthropic funding.
2. An organisation view must be formed regarding our expectations of ourselves in the wider education space.

Consumer Care Facilitation

The Office receives direct contact from consumers concerned about aspects of their healthcare. The approach is to facilitate care that meets our consumers' expectations wherever possible, beginning with timely and personal response to all enquiries. These consumers often have a very complex history and needs, and frequently have resource intensive needs.

Next steps:

The Office will continue to educate around professional standards, common themes which result in dissatisfied consumers and expectations of the regulator and compliance with the Code.

Accreditation

The threat to accreditation for PGY1 and 2 doctors has largely been resolved, though a final response from the regulator is outstanding. However, we remain vulnerable in other services, as there is no unified approach to ensure consistency of compliance with accreditation standards between College accreditation visits.

Next steps:

1. Embed training needs into the resourcing requirements identified in the Clinical Services Planning process. Training needs to be prioritised as a key service output rather than seen as a drain on resources.

Staff Performance
There is a constant hum of activity as would be expected with such a large pool of highly educated, committed and passionate people. The Office operates under a number of principles. Individuals are accountable for their behaviour at all times and can expect underperformance to be identified and addressed.

We operate on a zero tolerance principle with respect to unprofessional behaviour. When managing issues which arise, we are embedding the (Air New Zealand) Just Culture approach with our Clinical Directors, aiming to support staff in difficulty and develop the mentality of Team. Activity with the Cognitive Institute and the Speak Up for Safety Programme aligns with this approach also.

Next steps:
1. It will be critical that the organisation delivers on its undertaking to release staff for the activity associated with the program.
2. We need to rebuild relationships with both the Senior and Junior Doctors Unions with a view to opening channels of communication and improving the effectiveness of performance management activity.

Service Reviews
We have reviewed the Newborn Intensive Care Services with the assistance of colleagues from around New Zealand and have embarked on a program of work to better support the service and the needs of the Waikato and Midland communities. This work is progressing well.

A review of Cardiac Surgical services is expected to be finalised shortly and we will develop a similar program of activity across Cardiology, Cardiac Surgery and Cardiac Intensive Care to maximise efficiency, safety and efficacy of these services.

Next steps:
1. We need to develop improved data around quality metrics for the services and continue to have a low threshold for external benchmarking activity.

Credentialing
Past Health & Disability Commissioner review of an orthopaedic surgeon had raised questions across the wider hospital community regarding management of recruitment and credentialing processes in the organisation. It is clear that our recruitment, on-boarding, credentialing, annual appraisal, service credentialing and HR Information Systems can be improved. Conversations have begun to establish a clearer view and strategic plan over the "cradle to grave" handling of all staff and medical staff, and their particular requirements will form part of that.

Next steps:
1. In conjunction with improved HRIS systems, and streamlined on-boarding, we need to develop a "single source of truth" model for senior medical staff from which we can confidently track career development, complaints management, regulator requirements, annual appraisal and exiting interview.
2. The CMO Office will continue to work with the Executive Director for Human Resources and Organisational Development to develop streamlined systems for senior medical staff management.
3. The annual appraisal process needs to be more embedded and actions arising understood and undertaken. Service level credentialing put into abeyance in favour of clinical services planning needs to be reconsidered, ideally in line with

national agreed activity in this domain. National expectations are near a decade old and areas of duplication and overlap in other processes such as training accreditation need to be reviewed and reconsidered. This will form part of the discussions at the next national CMO Forum.

Unacknowledged Results

Our unacknowledged result count remains stubbornly high. We have an Associate CMO dedicated to this perennial problem. Despite significant endeavour, the professional carer table remains inaccurate and confounding, and systems to reconcile and control the table continue to have some challenges. Our reliance on locums and incompletely organised exit processes for staff complicates the system. Despite a well-constructed, overarching policy, this remains a concerning area of risk.

Next steps:

1. We have established a governance group with a view to restricting and controlling access to the professional carer table, and developing consistent management of the carer table with staffing flux.
2. A definitive and agreed Midland-wide approach will need to be developed.

Industrial Activity

Industrial disruption with the NZ Resident Doctors Association (RDA) continues to affect productivity. The Office has supported incident control work and remained non-partisan in the dispute. We have been assisted by the low-level requirements for Life Preserving Services (LPS) being limited to 12.5 (c) in large part due to the flexibility of the SMO pool, as well as the very significant contributions from STONZ members, non-union members and non-striking RDA members. We have confidently provided a safe acute service and been able to facilitate a significant proportion of our elective services without undue risk.

Next steps:

1. We need to continue to monitor our staff from a pastoral perspective as the industrial activity continues, in order to mitigate the risks associated with fatigue.

Clinical Governance

While there is significant clinical governance activity throughout the DHB, there is no robust system in place. There is no overarching view of how clinical governance should be effected, how it relates to operational activity, where it is owned, and how it is ensured. It is not sufficient to operate a standalone Quality & Patient Safety service alongside leads for the professions, and consider that an integrated approach to the delivery of safe care and quality improvement will be delivered. The Board of Clinical Governance appeared to have become too large, too disconnected from the coal-face, and was broadly considered ineffective. It has been put into abeyance with its activities temporarily delivered by a streamlined group, comprising the COO and professional leads plus the Executive Director of Mental Health & Addictions Service.

Next steps:

1. Clinical Governance work needs to be fortified at the coal-face. Improved data warehousing and analytics need to be supported. Much of this activity needs to be service-based and multidisciplinary. Relevant service specific metrics for quality and patient safety need to be devised, data acquired and delivered in real time, and metrics adjusted and focused longitudinally.

2. The relationship between the Quality & Patient Safety Service and the CMO Office needs to be fortified with improved support of Serious Event Review, Mortality Review and Audit.
3. An organisational structure needs to be developed which recognises that it must integrate with work as done, rather than work as imagined.

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

The CMO Office continues to advocate for and support the operational work of others directed to the aim of equitable health outcomes for Maori.

Recommendation

THAT

The Board notes and receives the report.

DR GARY HOPGOOD
CHIEF MEDICAL OFFICER

Chief Nursing & Midwifery Officer: report due in April.

Chief Advisor Allied Health, Scientific and Technical: report due in May.

Decision Reports

Equity Focussed Reporting: report due in April.

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 11.2

STRATEGIC DIRECTION FOR OUR PEOPLE

Purpose	For approval.

This report presents the document Waikato DHB's Strategic Direction for Our People and summarises key points of note.

Please see the presentation entitled Waikato DHB's Strategic Direction for Our People.

Key points to note
Current state analysis shows:

- Deficits in systems, process and practice in how the organisation is supported to get the right people, build capability and enable performance.
- Our HR operating foundations (model, structure, capability, resourcing) are at a low level of maturity.
- Behaviours across the organisation are not aligned to values.
- Our current culture of change does not support the transformation we need.
- The organisation has a poor external brand.
- We use narrow, traditional approaches to key people functions e.g. recruitment and learning.
- HR is disconnected from the organisation.
- Business needs as not well understood.
- HR processes are inconsistent and difficult to navigate.
- People data, analytics and reporting are limited.
- Our people feel they are last on the priority list.

We can address all the above over a three to five year programme of work that tackles four priority areas under the headline "Our people at our heart – putting our people at the heart of everything we do":

- Our People – know who we need, who we want and bring them here.
- Our Development – make sure our people build the right skills, at the right time, in the right way.
- Our Culture – build an inclusive, supportive and safe place to work.
- Enable Us – create processes and information that are easy to access and use, and enable collaboration.

Next steps:
- Work up the next level of detail to understand existing streams of work and work the Strategic Direction for Our People requires so we can prioritise our

resources into the right activities and identify what we will stop, start and continue.

- Set clear KPIs and work plans against prioritised activity.
- Review the HR structure to best deliver the plan.
- Implement the Tiered HR Service Model.

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

The paper proposes the integration of Tikanga and four Treaty of Waitangi principles: Partnership, Participation, Protection and Pono (faith, belief) into HR systems, processes and practices to build a reputation, brand and promise to our Māori communities that Waikato DHB is a welcoming, supportive, inclusive and safe place to work, enabling us to recruit a Māori workforce reflective of our population. Research shows that health outcomes are improved when consumers are treated by “people like us”.

Recommendation
THAT
The Board approves Waikato DHB’s Strategic Direction for Our People.

GIL SEWELL
EXECUTIVE DIRECTOR HR AND ORGANISATIONAL DEVELOPMENT

Waikato District Health Board:
Strategic Direction for Our People
Gil Sewell, Executive Director HR & OD
February 2019
1
Waikato District Health Board

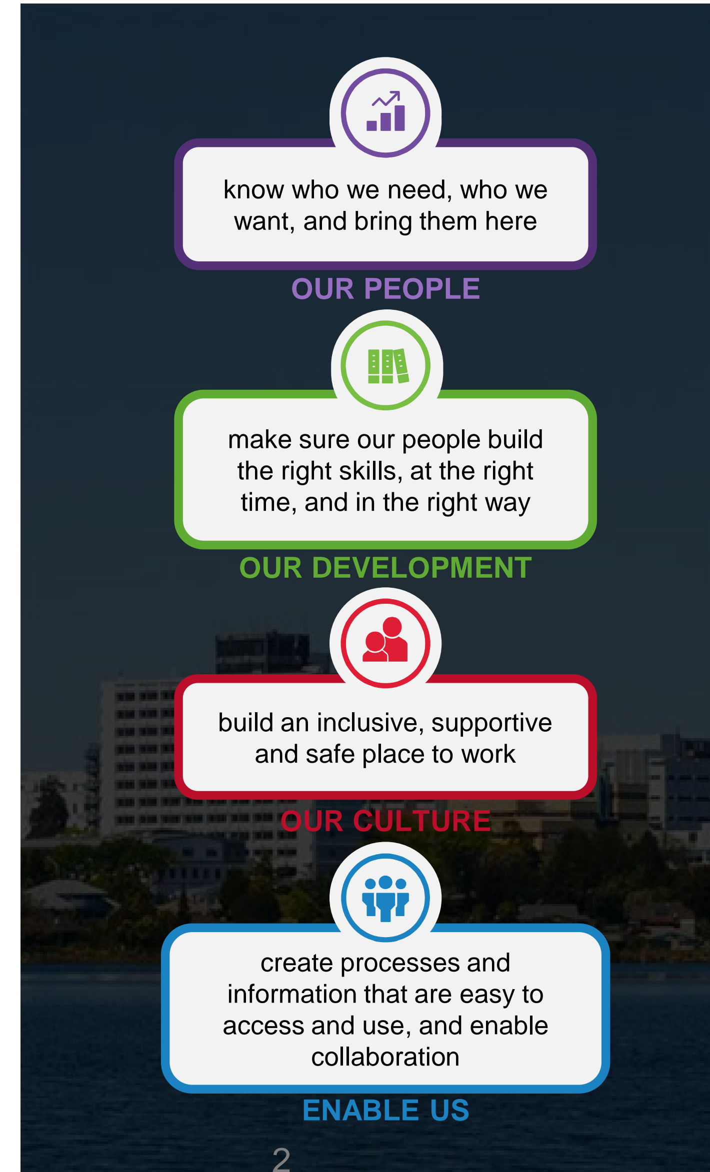
Executive summary

Our Waikato DHB Strategy sets a clear intent, indicating the changes needed in how we work and support our people to “enable us all to manage our health and wellbeing, and provide excellent care through smarter, innovative delivery.” Our people are, uniquely, compared to most sectors, also our community. The intent of the Strategic Direction for Our People is to turn the organisational strategy inwards and identify initiatives that will empower our people to achieve our vision.

It was developed through a process of co-design with organisational leaders and HR. There is much to do and this Strategic Direction for Our People outlines the pou, or key priorities (see sidebar, right) to enable targeted focus and channelling of resources.

Analysis was needed to inform us on our key areas of improvement. We conducted current state analysis on our HR operations relative to the requirements of our leaders and people, and then compared this against leading practice in other HR teams across different industries. The maturity of the current HR function was assessed and found to be at Level 1 (the lowest of four levels). Four strategic priorities were identified, which will have the greatest impact on increasing the effectiveness of the HR function and supporting achievement of the DHB Strategy. Each priority has supporting initiatives that are outlined in the body of the strategy.

We identified key barriers and risks to bring this strategy to life and make it a reality, and developed an implementation roadmap. Given the criticality of technology in modern HR operations, we have also identified a number of technology requirements. This strategy will now be shared and built on as we work together to enhance our HR function and operations to support our people as they serve our communities and patients.



Document summary

WHY AND HOW WAS THE STRATEGIC DIRECTION FOR OUR PEOPLE DEVELOPED?

We started with a wide net to determine two main areas:

1. How we develop as an organisation to best support our people
2. Where and how our HR function should focus to enable our Waikato DHB Strategy.

Approach – Page 5

A co-design approach was adopted to develop the Strategic Direction for Our People. Key stakeholders collaborated across 3 phases; Discover, Design and Develop.

WHAT WAS CONSIDERED WHEN DEVELOPING THE STRATEGIC DIRECTION FOR OUR PEOPLE ?

The Waikato DHB Strategy – Page 7

The Waikato DHB Strategy provides direction and sets intent for our Strategic Direction for Our People. It outlines workforce requirements and provides direction for our Strategic Direction for Our People.

Treaty principles – Page 8

The principles of Partnership, Participation, Protection and Pono will continue to underpin the special relationship between Waikato DHB and iwi, and are threaded throughout our strategy.

HR maturity – Page 9

The maturity of the current HR function was assessed to ensure the Strategic Direction for Our People was ambitious yet realistic for where we are now.

WHAT IS OUR STRATEGIC DIRECTION FOR OUR PEOPLE AND HOW DO WE DELIVER IT?

Our Strategic Direction for Our People – Page 10

Our Strategic Direction for Our People is about putting our own people at the heart of everything we do. To achieve this we are going to concentrate on four strategic priorities.

Strategic Direction for Our People detail – Page 13

Each priority has a number of initiatives with detail about how we will achieve them.

Implementation roadmap – Page 23

The roadmap shows all intended initiatives across the next three years and outlines key dependencies between them.

Barriers and risks– Page 26

In planning the initiatives a number of barriers were identified and will need to be addressed.

WHERE DO WE GO FROM HERE?

HRIS implications – Page 27

The Strategic Direction for Our People presents technology implications which will inform HRIS requirements and sequencing.

Next steps

With the Strategic Direction for Our People and roadmap developed, from here detailed implementation planning and prioritisation will be completed.

Purpose

Waikato DHB is on a mission to **"enable us all to manage our health and wellbeing, and provide excellent care through smarter, innovative delivery."**

The Strategic Direction for Our People was developed to determine how we develop as an organisation as well as where and how our HR function should focus to enable our workforce to achieve this mission.

Approach

A co-design approach was adopted to develop the Strategic Direction for Our People. Key stakeholders collaborated across three phases: Discover, Define and Develop.

Discover phase

Desktop research

Analysed current state existing frameworks, political and planning data to draw workforce insights.

External environment

Examined industry trends and best practice examples helped to identify gaps at Waikato DHB.

Stakeholder interviews

Conducted interviews with key representatives from the organisation including clinicians and HR to gather perspectives of current state and future requirements.

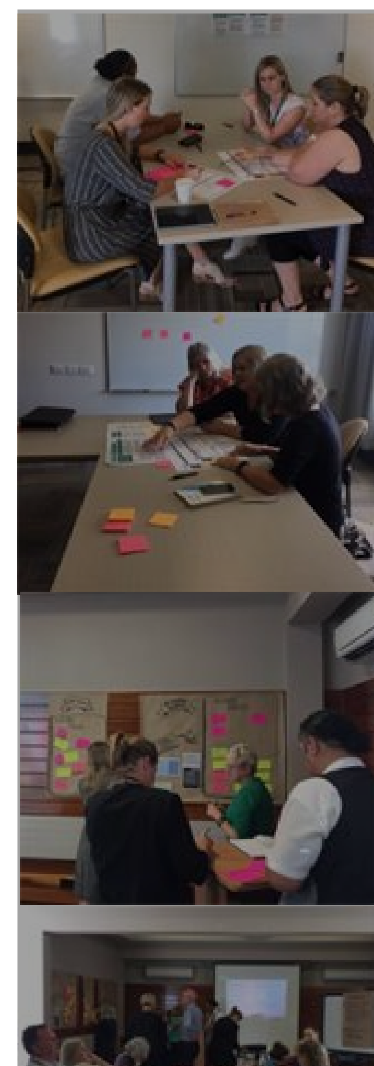
Develop phase

Strategic Direction for Our People development

Developed detail of Strategic Direction for Our People to ensure we have the initiatives in place for the workforce we need.

Strategic Direction for Our People Roadmap, HRIS implementation and sequencing planning

Developed an implementation roadmap and HRIS sequencing plan, in support of the Strategic Direction for Our People.



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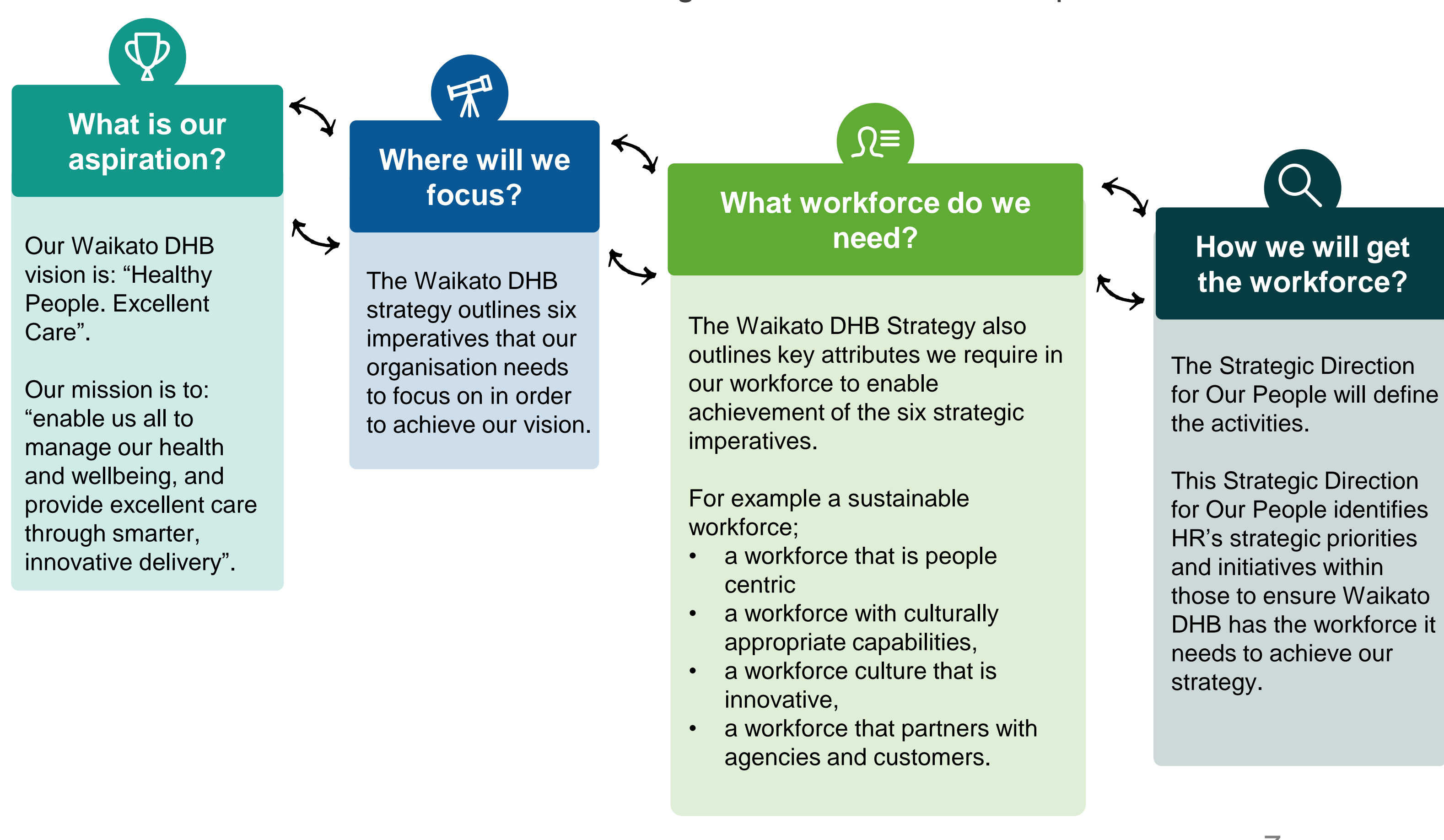
Strategy context:

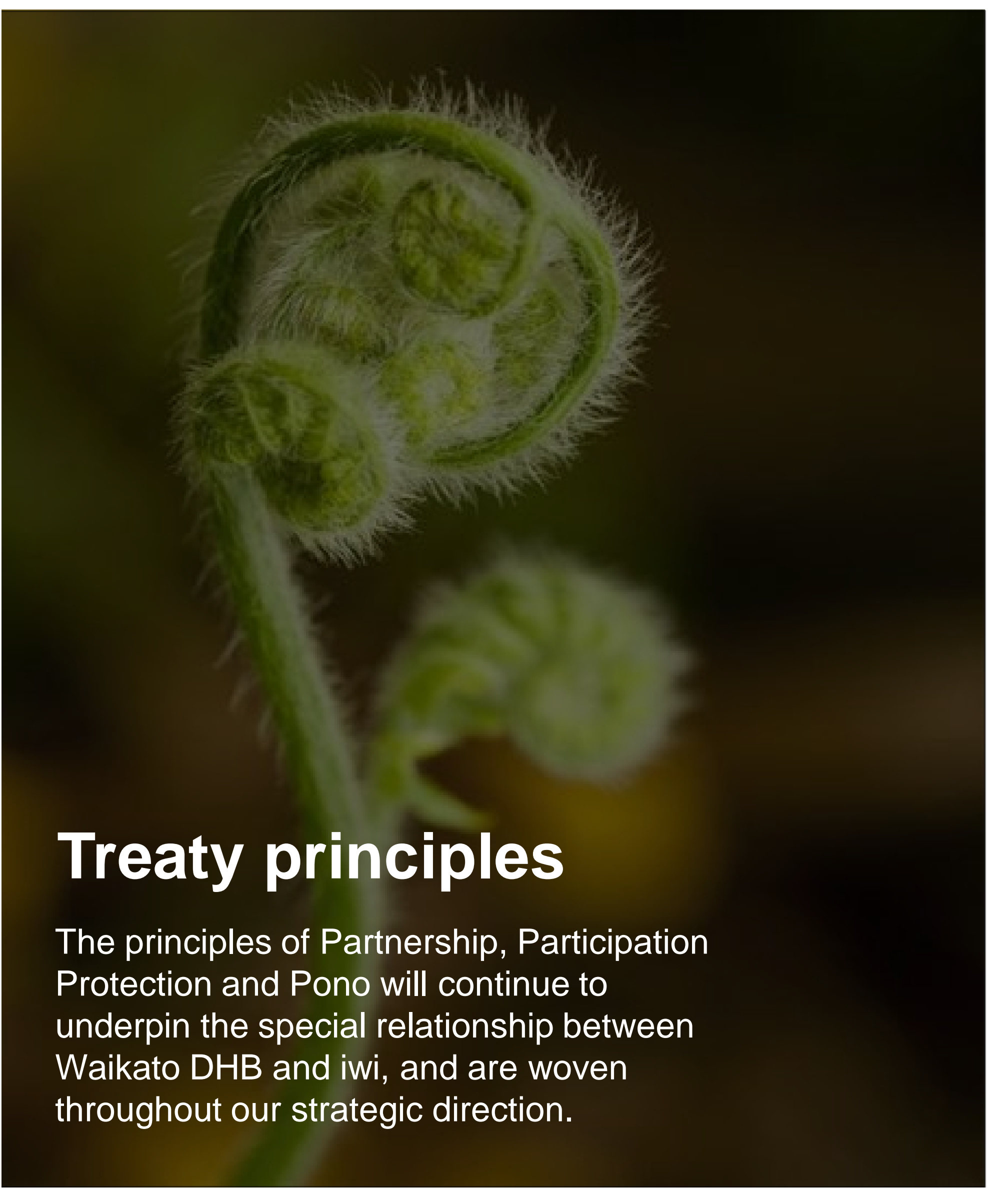
Our Strategic Direction for Our People was guided by the ambition set by the overarching Waikato DHB Strategy and understanding our current HR maturity.

6

The Waikato DHB Strategy

To achieve for our communities and patients, we must focus internally on all our employees. The Waikato DHB Strategy provides direction and sets intent for our Strategic Direction for Our People.





Treaty principles

The principles of Partnership, Participation Protection and Pono will continue to underpin the special relationship between Waikato DHB and iwi, and are woven throughout our strategic direction.

Partnership
This is about governance and decision-making involving an active and diverse Māori voice. This requires more than just a single token Māori be invited, but rather key strategic leaders who can encourage robust discussion of the topic and aren't asked to stand on their own against a group of non-Māori peers.

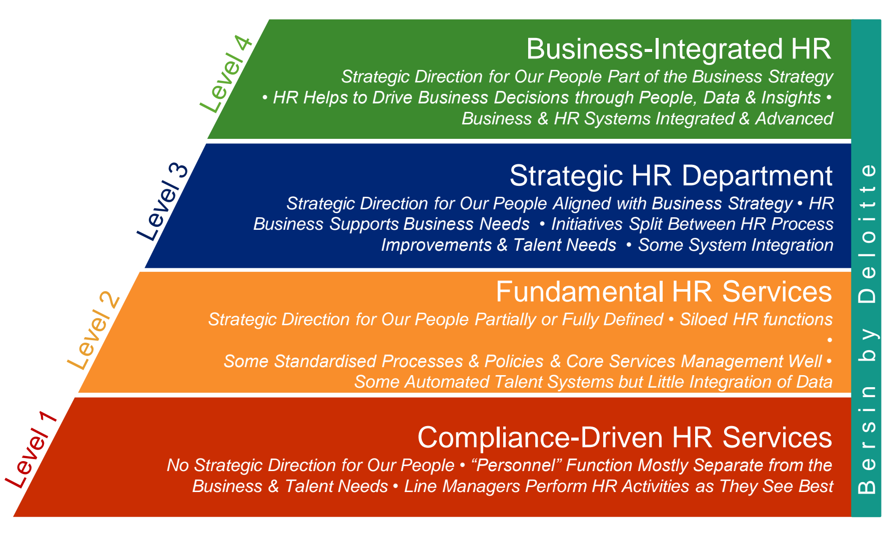
Participation
This is about both workforce and consumer voices. Our workforce must reflect our population, with 23% Māori in all role types and at all levels within our organisation to ensure Māori experiences and expertise can be found everywhere. With regard to customers, this is about the way we ask for and value whānau inclusion in the wellness journey and how we empower consumers to make choices that are best for their whānau.

Protection
This is about our (the Waikato DHB's) role in improving Māori equity for our patients and our staff through the elimination of institutional racism and through targeted approaches for Māori. It is also about acknowledging that Māori patients and staff face additional barriers to accessing the determinants of health (e.g. income, education, housing, etc.) and that we play a role in alleviating these barriers.

Pono
This means "faith" or "belief" and is about traditional Māori culture and language being upheld and valued. This means that karakia, waiata, whakawhanaungatanga, powhiri, and Te Reo Māori must be embedded into all our practices to better support Māori patients and staff.

HR maturity

The maturity of the Waikato DHB's current HR function was assessed to ensure the Strategic Direction for Our People is sufficiently ambitious yet realistic for where we are starting from.



- *Bersin by Deloitte's Human Resource Maturity Model* was used to benchmark Waikato DHB's level of sophistication in HR areas and to identify the best practices that are most relevant to improving business outcomes.
- Through the Discover and Develop Phases, the current level of maturity for Waikato DHB's HR function was recognised as predominantly sitting in Level 1.
- This Strategic Direction for Our People was developed against the current level of HR maturity and the HR function has set an aspiration to lift its level of maturity to Levels 2 and 3 within the next three years.

Indicators that the HR function currently sits at Level 1 maturity include:

Reactive – the HR function predominantly works in a reactive manner. Activities are not driven by an overarching Strategic Direction for Our People nor are they informed by data analytics.

Traditional – the HR services focus on traditional models in HR, for example a 'post and pray' approach in recruitment and classroom based training in L&D.

Disconnected – the HR function is disconnected from the organisation. Organisation leaders indicated a lack of visibility around HR activities and little to no partnering with the organisation to address their specific HR needs.

Siloed – The HR functions are siloed. There is a lack of alignment across HR managers, resulting in a minimal cross-functional collaboration between the teams.

The Strategic Direction for Our People:

Our Strategic Direction for Our People is about putting our people at the heart of everything we do.

10

Our Strategic Direction for Our People is about putting our people at the heart of everything we do.

This means putting our people at the centre of how we shape what it's like to work here, how we develop our people's capability, and build a workplace to best serve our patients and communities.

To achieve this, we are going to concentrate on four pou, or strategic priorities: Together, we will…

11

What will it look like when we accomplish these strategic priorities?

Together, we will…

know who we need, who we want, and bring them here

OUR PEOPLE

make sure our people build the right skills, at the right time, and in the right way

OUR DEVELOPMENT

build an inclusive, supportive and safe place to work

OUR CULTURE

create processes and information that are easy to access and use, and enable collaboration

ENABLE US

Our People

- We have a compelling Employee Value Proposition (EVP) that attracts the calibre of people we need to deliver the services our patients and communities need.
- HR is viewed as a valued partner in anticipating workforce requirements with the organisation.
- We acquire the best talent through targeted and dynamic approaches.

Our Development

- Our people proactively and continuously seek and complete learning.
- Our learning environment supports performance outcomes.
- Our learning environment is recognised as part of our EVP.

Our Culture

- Our leaders role model and reinforce our values.
- The Treaty of Waitangi and Tikanga principles are woven throughout our culture.
- Diversity is embraced in our organisational culture.

Enable Us

- We provide consistent, modern, easy to access HR information and advice.
- The barriers and frustrations with HR advice and information about leading and managing people are reduced or eliminated.

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20 YDS
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Strategic Direction for
Our People detail:
Why are we focusing on
these specific strategic
priorities and how will we
make them a reality?
13
Waikato District Health Board

Why is 'Our People' important?

This area is a key priority for our strategy, as we need the right workforce to achieve our Waikato DHB Strategy.

know who we need, who we want, and bring them here

OUR PEOPLE

Our Waikato DHB strategy

Ratonga a iwi – achieving and maintaining a sustainable workforce is a key priority within the strategy.

Haumaru – we have a strategic intent to ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives.

Pae taumata – the strategy recognises the importance of attracting doctors, nurses, and allied health staff to the Waikato through high quality training and research.

The Waikato DHB strategy directly states recruitment as a focus area; 'We will streamline our recruitment'.

We have a strategic intent to embed the Treaty of Waitangi principle '**Participation**': having a workforce with Māori in all role types and at all levels within our organisation to ensure Māori experiences and expertise can be found everywhere.

Our current state

Reactive working style – HR's work activity is predominantly reactive. The team's day-to-day activity is driven by on demand requests from the organisation rather than informed by a workforce plan.

Lack of workforce plan – there is no clear direction or plan for our workforce of the future. We have some workforce data about the workforce that could be utilised, but this data is currently sitting idle.

Post and pray recruitment model – Our recruiting process primarily relies on the 'post and pray' model for roles, and is not well regarded by hiring managers, with some even appointing their own recruitment resource.

Branding not leveraged for recruitment – interviewees indicated poor branding is contributing to our challenge with attracting valuable talent. The recruitment branding fails to leverage many positive aspects about working at Waikato DHB.

Examples of how leading practice in workforce planning and recruitment enables organisations to get the workforce they require to meet organisation outcomes:

- **Recruitment partners** – modern recruiters are experts in acquiring talent that partner with hiring managers in talent selection. They play strategic advisory roles that focus on true workforce planning, managing the employer brand, growing the talent pipeline, and collaborating across the organisation.
- **Digitised process** – modern technology used across key parts of recruitment e.g. chatbots for screening, video conferencing for interviewing, AI assistants to assess fit.
- **Targeted attraction** – different recruitment methods are used to attract different target workers, using a range of channels e.g. everything from social media to conversations at community events, to graduate fairs.
- **Expansion of 'worker'** – exploring alternative talent types to deliver organisational outcomes e.g. gig workers, crowdsourced and contractors.

How we will make 'Our People' a reality (p.1 of 2)

The following initiatives have been identified as activities HR will deliver to make the most impact against this strategic priority.

know who we need, who we want, and bring them here

OUR PEOPLE

FY 18/19 — STAGE 1 (first 3 months)

Goal: Understand current workforce planning activity and identify supply pain points, opportunities, and issues.

Initiatives:

1. **Explore current planning** – understand Waikato DHB's regional and national workforce planning activities.
2. **Identify supply issues and opportunities** – engage with managers to understand how workforce planning is completed and identify supply opportunities and issues internally and externally.

FY19/20 — STAGE 2 (first 3 months – 1 year)

Goal: Explore the future workforce landscape to understand demand, supply and disruption.

Initiatives:

3. **Collaborate on demand and supply** – work with organisation leaders to capture current and anticipated operational workforce demand and supply requirements.
4. **Explore workforce disruption** – explore external workforce and industry trends to inform potential workforce scenario modelling, including feasibility of alternative workforce options (e.g. talent alternatives, and automation).

FY20/21 — STAGE 3 (years 1 – 3)

Goal: Model the future workforce and build a workforce plan.

Initiatives:

5. **Workforce modelling** – model future workforce disruptors including automation, workforce type options and location.
6. **Agree workforce plan** – agree a workforce plan that shows anticipated composition (employee, alternative workforce types, and automation), size and cost of the Waikato DHB workforce across years 1 – 5.
7. **Roll out plan** – use the workforce plan to shape recruitment, learning and performance activity.

WHAT THIS WILL MEAN

- We have a forward looking view of the workforce we need.
- We proactivity identify supply challenges.
- We know where and how the future of work (automation, workforce alternatives, location alternatives) will impact the workforce we require for the future.
- Our workforce plan drives HR and organisation wide workforce activity.

Ultimately:

- HR is viewed as a valued partner in anticipating workforce requirements with the organisation.

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How we will make ‘Our People’ a reality (p.2 of 2)

The following initiatives have been identified as activities HR will deliver to make the most impact against this strategic priority.

know who we need, who we want, and bring them here

OUR PEOPLE

FY 18/19 — STAGE 1 (first 3 months)

Goal: Design and deliver an EVP.

Initiatives:

8. **Build an EVP** – understand current EVP, identify and leverage strengths to articulate the EVP story.
9. **Consolidate our recruitment strategy** – agree approach and governance where recruitment has been decentralised.

FY19/20 — STAGE 2 (first 3 months – 1 year)

Goal: Design a new recruitment model.

Initiatives:

10. **Understand requirements** - use workforce plan to identify main areas of required focus for recruitment team.
11. **Process inventory** – document existing recruitment processes, identify processes of greatest value/criticality.
12. **Redesign recruitment model** – redesign the recruitment model (including services, processes and channels) for target/critical workforce groups to eliminate, automate or streamline our work, increasing speed to value while maintaining sufficient checks and balances.
13. **Deliver the recruitment model** – introduce the new recruitment model across the organisation, starting with critical workforce groups.

FY20/21 — STAGE 3 (years 1 – 3)

Goal: Build and implement new recruitment model.

Initiatives:

14. **Review effectiveness and continuously improve** – monitor the impact of our changes and implement modifications where necessary.
15. **Recruitment is centralised across the organisation** – integrate the recruitment process within HR, collaborate with other groups within the organisation to ensure we are getting the people we need.

WHAT THIS WILL MEAN

- The majority of our recruitment activity is proactive and we partner with the organisation.
- Transactional/reactive activity has been eliminated, automated or streamlined.
- Services of the recruitment team are willingly sought by the organisation.
- Our internal and external recruitment activities are tailored to workforce groups.

Ultimately:

- We have a compelling EVP that attracts the calibre of people we need to deliver the services our patients and communities need.
- We acquire the best talent through targeted and dynamic approaches.

16

Why is 'Our Development' important?

Enhancing the way all our employees learn and develop will enable us to build the workforce we need and achieve our Strategic Direction for Our People

make sure our people build the right skills, at the right time, and in the right way

OUR DEVELOPMENT

Our Waikato DHB strategy

Manaaki – there is a clear strategic intent for Waikato DHB to provide people centred and tailored services, to move away from 'one size fits all' care models and create a person-centred approach to provision, which ensures that everyone gets the service they require, when they need it, where they need it and with their input.

Pae Taumata – we are a centre for excellence in learning. Waikato DHB have made a strategic commitment to learning and continuous organisational development.

We must provide the learning opportunities to support our people to build the capabilities to successfully embed the Treaty of Waitangi principles.

Our current state

Lack of governance – the current learning environment is disjointed. There are multiple parties providing learning services without a central body governing their direction.

Focus on technical – there are limited opportunities for our people to develop their skills aside from technical capabilities e.g. nursing techniques.

Not driven by organisational needs analysis – learning activity is not driven by organisational needs assessment to determine where the greatest needs lie relative to organisational and individual development requirements.

Reliance on traditional methods – learning is predominantly class room based learning and concentrated around milestone periods such as orientation, rather than being continuous.

Examples of what leading practice learning functions are doing to support organisation performance

- **Micro-learning** – bite-sized micro-learning allows L&D departments to launch content quickly and only provides the learning that people need in that moment.
- **Learner-led learning** – the learning environment encourages and supports learners to proactively seek the learning they need when and how suits their preferences.
- **Digital** – learning is enabled through technology platforms which enable mobile learning, provide access to just-in-time resources, connect learners, and create an engaging learning experience.
- **Continuous learning** – given the pace of change and the shelf life of learning and skills, learning is completed on a continuous rather than episodic basis.

How we will make 'Our Development' a reality

The following initiatives have been identified as activities HR will deliver to make the most impact against this strategic priority.

make sure our people build the right skills, at the right time, and in the right way

OUR DEVELOPMENT

FY 18/19 – STAGE 1 (first 3 months)

Goal: Understand learning activity happening across the organisation, main learning methods used and resources involved.

Initiatives:

16. **Learning inventory stocktake** – complete an audit of the current learning environment across the organisation (what, who, how).
17. **Establish learning governance** – create a central body of senior Waikato DHB representatives to set direction and make key decisions regarding learning and development across the organisation.

FY19/20 – STAGE 2 (first 3 months – 1 year)

Goal: Redesign cross organisational learning.

Initiatives:

18. **Identify learning requirements** – complete learning needs analysis to determine critical shared requirements of the workforce (excluding technical development that is anticipated to remain within business units under the agreed governance arrangements; see initiative 17).
19. **Design a continuous learning environment** – design a learning environment focused on;
    - targeting the right requirements,
    - providing the right channels and,
    - building a continuous learning mind-set.

FY20/21 – STAGE 3 (years 1 – 3)

Goal: Implement the learning environment we have designed.

Initiatives:

20. **Develop curriculum** – determine learning areas of focus based on the identified requirements.
21. **Design and implement the channels** – build on blended learning methods (including digital) that recognise Waikato DHB's current learning environments and technology landscape, enabling continuous learning that caters to learner preferences.
22. **Build a learning mind-set** – actively illustrate the value of learning and build awareness of the new learning opportunities established.

WHAT THIS WILL MEAN

- We understand our most important learning needs.
- Our learning resources are focused on the most important needs.

Ultimately:

- Our people proactively and continuously seek and complete learning.
- Our learning environment uses technology tools to support performance outcomes.
- Our learning environment will be recognised as part of our EVP.

18

Why is 'Our Culture' important?

The following initiatives have been identified as activities HR will deliver to positively change our workplace culture.

build an inclusive, supportive and safe place to work

OUR CULTURE

Our Waikato DHB strategy

Oranga – it is a strategic priority to enable our workforce to deliver culturally appropriate services.

Our strategic mission is to enable us all to manage our health and wellbeing.

Whakamana & Mauri Pai – Respect and Fair Play are key values for Waikato DHB, and ELT/ Te Rōpū Whakahaere need to ensure all individuals, especially those in leadership roles, are modelling these values.

We have a strategic intent to embed the Treaty of Waitangi principle **'Pono'** – this means "faith" or "belief" and is about traditional Māori culture and language being upheld and valued.

Our current state

Insufficient inclusion of diversity – the Waikato DHB's workforce is growing in diversity, however there are few examples of where diversity and equity is openly accepted, shared and encouraged. For example, blessing of food at the orientation event.

Performance management capability – it appears that poor performance is tolerated in the organisation, where leaders lack the confidence or capability to manage behaviours and performance.

Bullying behaviours – there are examples of unacceptable behaviours present in our culture. Some leaders are recognised as not embodying the Waikato DHB's values.

Examples of leading practice to build an inclusive, supportive and safe culture

- **Leader-led** – leading organisations are driving performance through focusing on leader development. Values-based leadership is a growing trend whereby leaders and teams are evaluated on metrics that are predominantly based on the organisation's set of values.
- **Regular pulse measurement** – regular simple, fast measurement and feedback on current culture in order to measure culture and judge the impact/effectiveness of initiatives.
- **Symbols and stories** – recognising the impact of intended and unintended symbols, and of the stories told is a key to cultural transformation.
- **In-the-moment and honest conversations** – true behaviour and performance change is achieved through real time feedback and coaching.

How we will make 'Our Culture' a reality

The following initiatives have been identified as activities HR will deliver to make the most impact against this strategic priority.

build an inclusive, supportive and safe place to work

FY 18/19 — STAGE 1 (first 3 months)

Goal: Understand current culture drivers and define our target inclusive, supportive and safe culture.

Initiatives:

23 **Assess culture** – understand the drivers of the current culture to identify what we need to enhance or change.

24 **Implement Speaking Up for Safety programme** – roll out this programme, requiring leaders to visibly role model the focus on wellbeing and inclusive behaviours and share examples of these with others.

FY19/20 — STAGE 2 (first 3 months – 1 year)

Goal: Build the environment that enables inclusion, support and safety.

Initiatives:

25 **Define target culture** – engage the workforce to co-design a simple and observable vision of what an inclusive and supportive culture means for them.

26 **Integrate Tikanga** – weave Tikanga principles into the key 'moments that matter' through the employee lifecycle, starting with recruitment.

27 **Conversation capability** – develop internal conversation initiative focused on building awareness of inclusion and its benefits, and capability to have focused conversations with peers and team members.

28 **Supportive employment –** develop a programme to provide the most supportive culture we can.

29 **Set expectations for leaders** – roll out a senior leadership communications campaign to share our expectations of an inclusive culture – their role as leaders in creating an inclusive culture and consequences of not doing so.

FY20/21 — STAGE 3 (years 1 – 3)

Goal: Embed and reinforce the environment.

Initiatives:

30 **Implement a programme of activities to enhance wellbeing** – complete design of targeted initiatives and implement across the organisation to increase our people's safety and wellbeing.

31 **Deliver the tools** – equip our people with simple and effective tools and capability, enabling the development to manage their own performance as well as the performance and wellbeing of others.

OUR CULTURE

WHAT THIS WILL MEAN

- We set expectations for behaviour and performance.
- Our performance environment (including tools and learning opportunities) is simple and engaging.
- We have honest and supportive conversations to enable inclusion and performance.
- We don't tolerate unacceptable behaviours.

Ultimately:

- Our leaders and our people role model and reinforce our values.
- Diversity is embraced in our organisational culture.

Why is ‘Enable Us’ important?

create processes and information that are easy to access and use, and enable collaboration

ENABLE US

Creating the foundations for our people to build upon and achieve our Strategic Direction for Our People involves creating processes and collaboration initiatives to enable

Our Waikato DHB strategy

Haumaru – prioritise fit for purpose environments. Ensure appropriate services are delivered to meet the needs of our population at all stages.

Ratonga a iwi – achieve and maintain a sustainable workforce through ensuring effective and efficient services.

Whanaketanga – authentic collaboration through productive partnerships both within each team and that team’s interaction with the wider organisation.

Kotahitanga – foster a supportive workplace and collaborate to achieve known outcomes.

Our current state

Inefficient ways of working – our services and communications are based on relationships rather than driven by a consistent process. This is disorderly, creating inefficiencies, meaning that our resources are not targeted to the greatest need. These inefficiencies flow into our processes, which are disjointed, creating re-work and increasing the workload of our people.

Disconnect between HR and the wider organisation – there is a decentralisation of some HR functions to other business functions within the organisations. Within HR, the team sits in different offices siloed from one another, making collaboration more difficult. Furthermore, exhibited capability in the team is currently weighted towards reactive, traditional HR, making it difficult to provide the services the organisation really needs.

Out-dated technology and use of data – information such as employee records are paper based, decreasing confidence in accuracy and accessibility of the data. We currently utilise some HRIS technology, however there are areas where its benefits are not implemented because our out-dated processes are incompatible.

Examples of leading practice to create processes and information that are easy to access and use, and enable collaboration

- **Customer-centric approach** - people needs remain the central focus which drives the workforce experience.
- **Digital workplace** – modern HR teams are empowered by technology to create meaningful connections between communities of experts and the wider organisation, and to capitalise on the automation of administrative tasks.
- **Workforce analytics and modelling** – on-going analysis of internal workforce requirements and external workforce trends are used as inputs to model alternative scenarios, informing workforce requirements.
- **Tiered model of HR service** – following a tiered model of HR service transforms HR from a tactical and administrative function into a strategic operation, providing direct value to the organisation’s core goal.
- **Employee centric** – leading HR teams focus on the employee experience that places the person they are serving at the centre of focus when designing processes and solutions.

How will we make ‘Enable us’ a reality?

The following initiatives have been identified as activities HR will deliver to make the most impact against this strategic priority.

create processes and information that are easy to access and use, and enable collaboration

ENABLE US

FY 18/19 — STAGE 1 (first 3 months)

Goal: Get clear on who our customers are and what they need from us

Initiatives:

32 **Identify who our customers are and what they need –** understand the customer we serve and the most effective ways we can support them through a tiered service model.

33 **HR services review** – complete our review HR's service catalogue and make deliberate choices about which services our team put effort into delivering (e.g. includes exploring new change management services within HR, and evaluate existing services).

34 **Implement our tiered service model** – introduce the model across the HR service line leveraging multiple entry channels and communicate changes to the organisation e.g. online self-service.

FY19/20 — STAGE 2 (first 3 months – 1 year)

Goals: Set the HR team up with the capability and resources needed to deliver for our customers

Initiatives:

35 **Capability needs assessment** - identify the key capabilities required to deliver HR's services. Assess current HR workforce and determine gaps in the capability we have versus what we need to deliver against requirements. Where we have gaps in our capability, build development plans and/or hire the capability required to perform our HR business functions in order to support our customer's needs.

36 **Reorganise our team** – examine the HR team structure, how the business functions divide responsibilities and the best way for HR to be structured to deliver maximum benefit to our customers.

37 **HRIS change plan** – develop and roll out a plan to support stakeholder engagement, capability uplift and adoption assessments to enable best use of the HRIS.

38 **Analysis and reporting** – implement data analysis and reporting into HR operations to ensure data is driving activity and the impact of HR service (outcomes) is being measured.

39 **Process optimisation** – evaluate our current processes against industry best practice and redesign key processes to minimise rework, and increase simplicity and transparency.

FY20/21 — STAGE 3 (years 1 – 3)

Goals: Optimise our model by leveraging simplicity and digital technology

Initiatives:

40 **Digital automation** - explore paperless and automation options and begin implementation, focusing first on highest use HR forms and those that best support our new operating model.

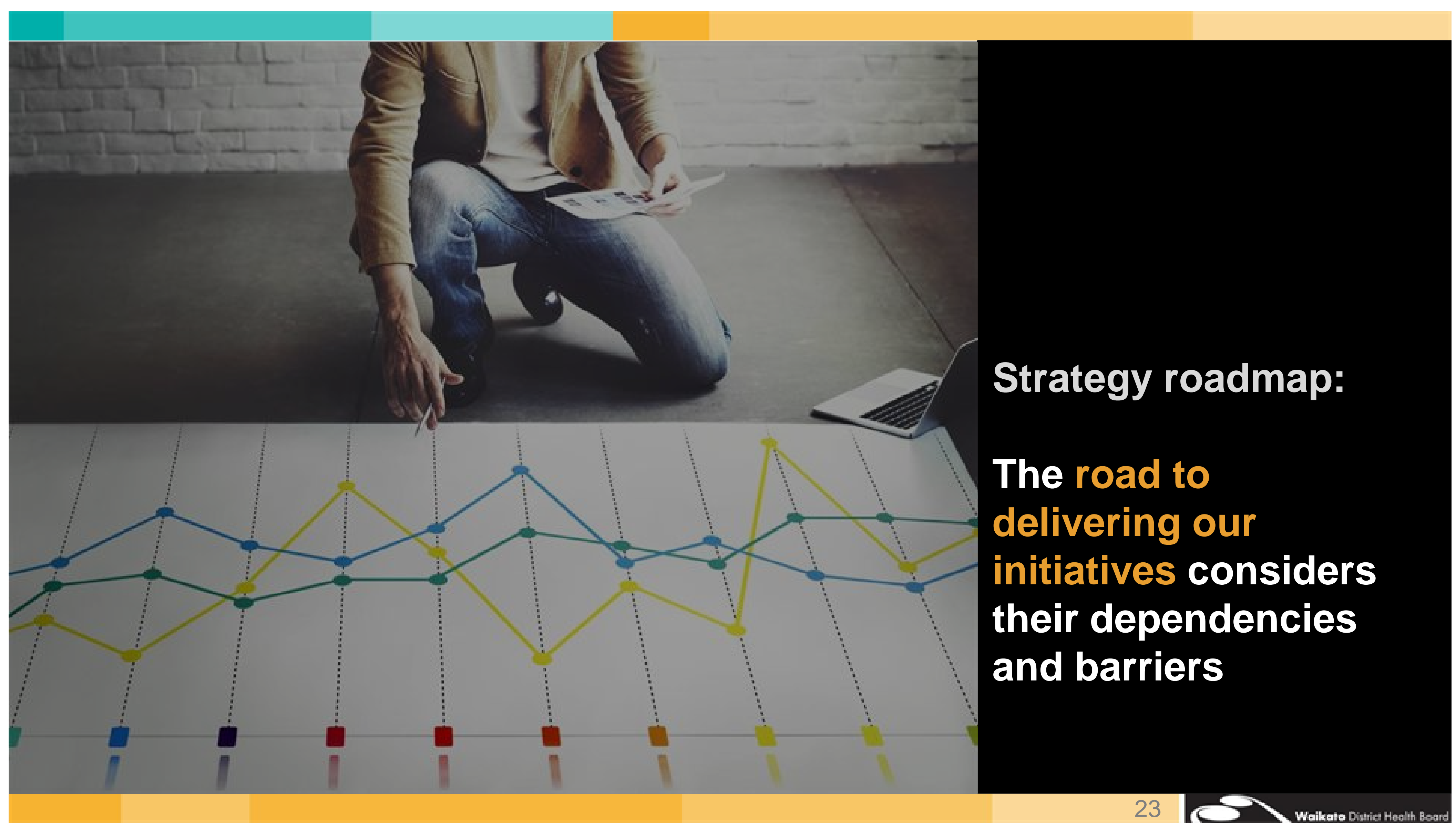
41 **Design our physical workplace** – change the physical layout of the HR space to enable collaboration across teams, and identify opportunities to better integrate within the organisation.

WHAT THIS WILL MEAN

- Our HR resource matches what the organisation needs and it will be focused on areas of greatest impact.
- People can find what they need when they need it to support their own careers and performance
- Managers can find resources and support to help them lead teams and manage performance.

Ultimately

- The barriers and frustrations with HR advice and information about leading and managing people are reduced or eliminated.
- We provide consistent, modern, easy to access HR information and advice.


Strategy roadmap:
The road to delivering our initiatives considers their dependencies and barriers
23
Waikato District Health Board

Roadmap

The following roadmap plans the initiatives across the next three years and shows key dependencies between them. Explanation of the following dependencies are given on the following page

		FY18/19 – first 3 months	FY19/20 – 3 months to 1 year	FY19/20 - FY22/23 – years 1 to 3
OUR PEOPLE	know who we need, who we want…	1 Explore current planning 2 Identify supply issues and opportunities	3 Consolidate demand and supply 4 Explore workforce disruption within industry 5 Workforce modelling	6 Agree workforce plan 7 Roll out plan
OUR PEOPLE	…and bring them here	8 Build an EVP 9 Consolidate our recruitment strategy	10 Understand requirements 11 Process Inventory 12 Redesign recruitment model	13 Recruitment is centralised across the organisation 14 Deliver the recruitment model 15 Review effectiveness and continuous improvement
OUR DEVELOPMENT	make sure our people have the right skills at the right time	16 Learning inventory stocktake	17 Establish learning governance 18 Identify learning requirements 19 Design a continuous learning environment 20 Develop curriculum 21 Design and implement the channels	22 Build a learning mind set
OUR CULTURE	build an inclusive and supportive place to work	23 Assess culture 24 Implement Speaking Up for Safety Programme 25 Define target culture	26 Integrate Tikanga 29 Set Expectations for Leaders 27 Conversation capability 28 Supportive employment	31 Deliver the tools 30 Implement a programme of activities to enhance wellbeing
ENABLE US	create an HR function that is easy to deal with and has high impact to enable our people	32 Identify who our customers are and what they need 33 HR service review 34 Implement our tiered service model	35 Capability needs assessment 36 Recognise our team 37 HRIS change plan 38 Analysis and reporting	39 Process optimisation 40 Digital automation 41 Design our physical workplace

Dependencies: D1, D2, D3, D4, D5, D6, D7

This Strategic Direction for Our People is a dynamic document. As work progresses, the Strategy and this Roadmap will be regularly reviewed to ensure the content and timing stay relevant for the organisation's needs.

Explanation of dependencies

These dependencies indicate that initiatives should be revisited and reviewed once the initiatives they are dependent on are finished. For example, identifying learning requirements (initiative 16) is dependent on the Workforce Plan (WP). This indicates that although the learning requirements initiative can start before workforce modelling begins, the learning requirements should be revised once workforce modelling is completed.

OUR PEOPLE

D1. Identify learning requirements – the assessment of learning requirements should inform workforce gaps that we should be looking for in the workforce we acquire.

D2. Design a continuous learning environment – a new continuous learning environment should be emphasised in the EVP to attract future talent who will ideally have a learning mind-set.

OUR DEVELOPMENT

D3. Agree WP – workforce requirements highlighted in the workforce plan should be used to inform which workforce capabilities we need to provide learning opportunities for our workforce.

D4. Assess culture – The cultural assessment and definition of our target culture should:

- A.) highlight diversity and culture learning gaps that we need to provide learning opportunities.
- B.) indicate gaps in our current learning culture that we need to address with modern approaches to learning.

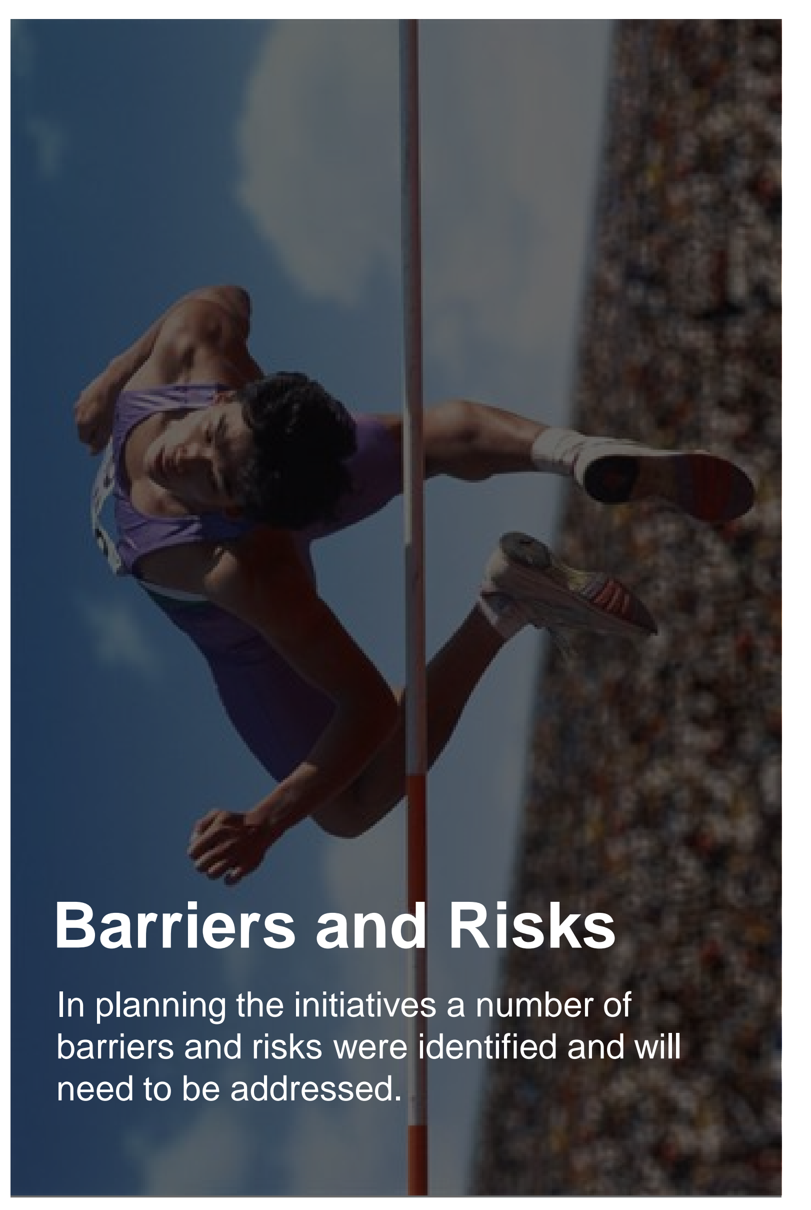
OUR CULTURE

D5. Build EVP – Understanding the current EVP should inform strengths in our organisational culture that could be considered when defining the target culture.

D6. Design a continuous learning environment – Embedding our culture will require our leaders to champion it. A new learning operating model should be used to build capability to reinforce our target culture.

ENABLE US

D7. Learning inventory stocktake – The stocktake should inform our current HR service review.



Barriers and Risks

In planning the initiatives a number of barriers and risks were identified and will need to be addressed.

Change maturity
It is recognised by HR and leaders that change management capability is not strong across the organisation. Change management will be critical to successfully embedding the Strategic Direction for Our People initiatives.

Team capability
The capability in the team is recognised to be currently weighted towards reactive and traditional HR. The strategy indicates the need for different capability within the HR team e.g. shift from reactive to be proactive and more strategic. This will require a significant skills shift within the current team.

Limited time and resources
There are other organisational priorities, and limited time and resources. Deliberate choices will need to be made about where HR effort and focus is made moving forward including which current activity can be stopped or paused to refocus effort towards the strategic initiatives.

Organisational disconnect
Other groups across the organisation complete work that the HR function also completes e.g. learning activity, recruitment activity. The HR team will need to collaborate with these groups and align our focus. This will require greater connection and communication between HR and these other groups.

Technology
Current technology is either not in place or out-dated and will require investment and ideally integration with systems outside of HR e.g. property, finance and IS.

Organisational strategy
Likely change of strategy means some initiatives must be viewed as ‘bedrock’ i.e. they will not change regardless of how the strategy is described.

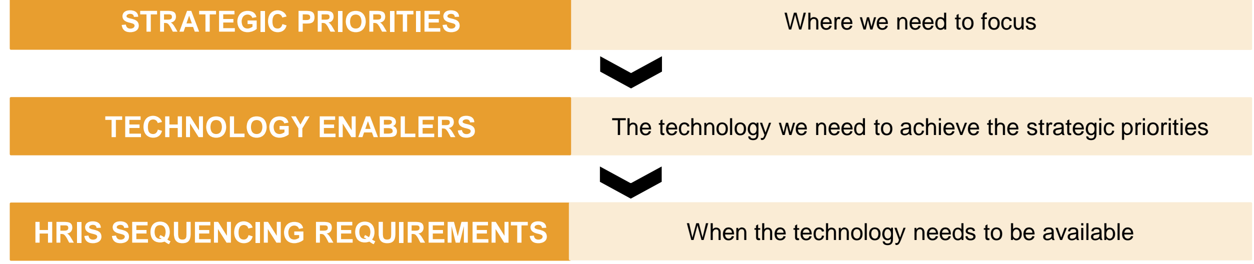
Rx
HRIS :
Technology will play a key role in enabling our Strategic Direction for Our People
27
Waikato District Health Board

Introduction to HRIS implications

The Strategic Direction for Our People creates technology implications which should inform the organisation's HRIS requirements and sequencing.

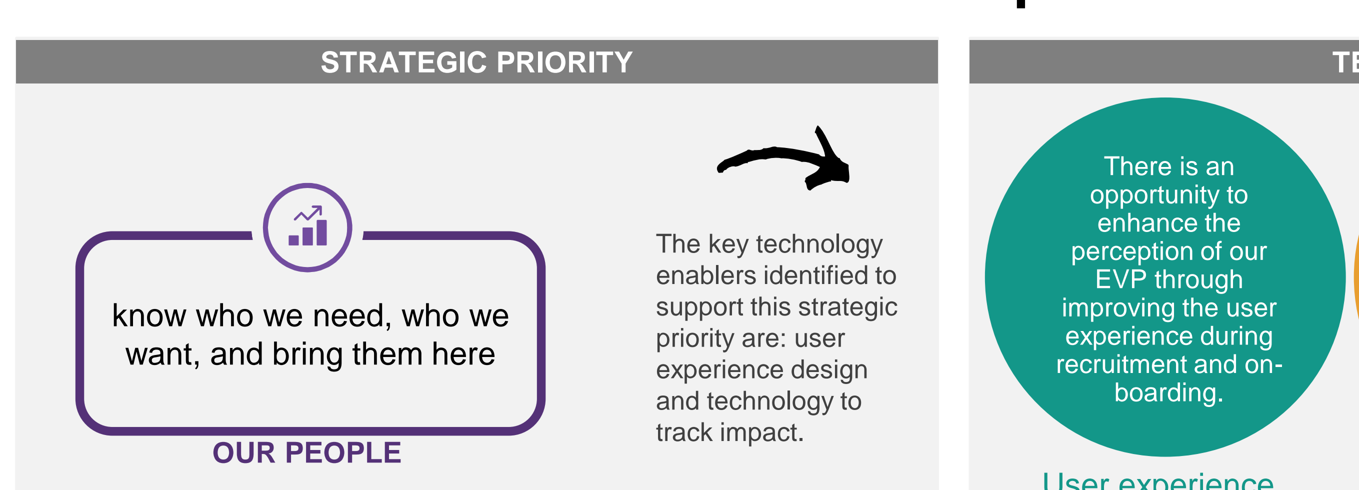
The following section presents each strategic priority within the Strategic Direction for Our People, the technology enablers identified to support this strategic priority, and the related HRIS requirements.

These HRIS requirements should be used to inform the full HRIS strategy and sequencing plan.



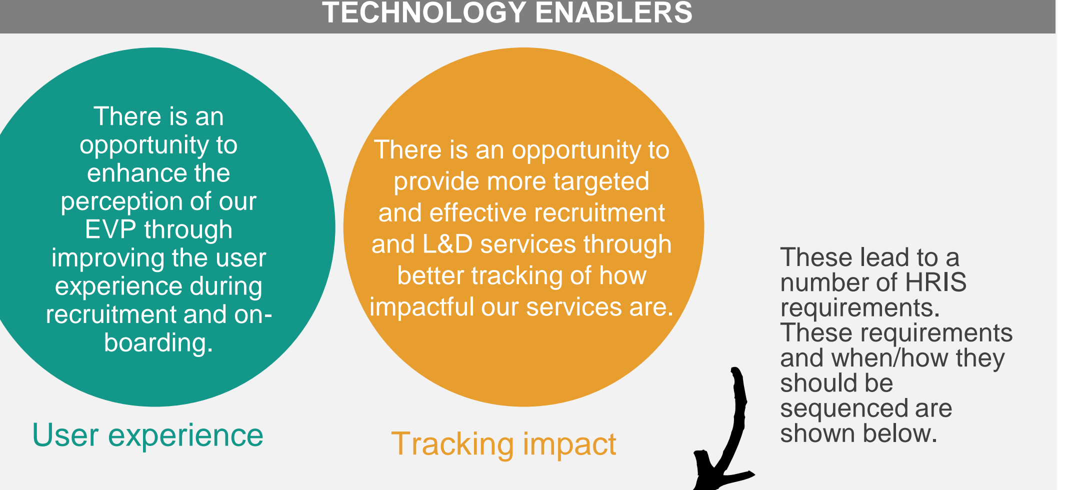
HRIS implications

STRATEGIC PRIORITY



The key technology enablers identified to support this strategic priority are: user experience design and technology to track impact.

TECHNOLOGY ENABLERS



These lead to a number of HRIS requirements. These requirements and when/how they should be sequenced are shown below.

HRIS SEQUENCING REQUIREMENTS

Our HRIS MUST have…

HRIS requirement and related enabler (●●)	This must happen before initiative:	This would ideally happen before initiative:
An ability to track and report on key recruitment timelines and milestones to continuously improve processes (e.g. time to hire by role, time to get through each stage). ●		14
An end-to-end online applicant process. ●	14	

Future functionality would ideally include…

HRIS requirement and relevant enabler (●●)	This would ideally happen before initiative:
An ability to track a pool of potential talent to speed up the recruitment process. ●	14
A configurable user interface that allows us to align to our EVP through its design and content. ●	8
An ongoing interface to support candidates through their on-boarding process, prioritising their experience e.g. access to interactive content about Waikato DHB. ●	14

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HRIS implications

STRATEGIC PRIORITY

make sure our people build the right skills, at the right time, and in the right way

OUR DEVELOPMENT

The key technology enablers identified to support this strategic priority are: technology to track impact and provide blended learning.

TECHNOLOGY ENABLERS

There is an opportunity to provide more targeted and effective recruitment and learning services through improved tracking of how impactful our products and services are on workforce needs and outcomes.

Tracking impact

There is an opportunity to build a stronger learning mind-set in our workforce through a variety of self-paced and real time learning options.

Blended learning

These lead to a number of HRIS requirements. These requirements and when/how they should be sequenced are shown below.

HRIS SEQUENCING REQUIREMENTS

Our HRIS MUST have…

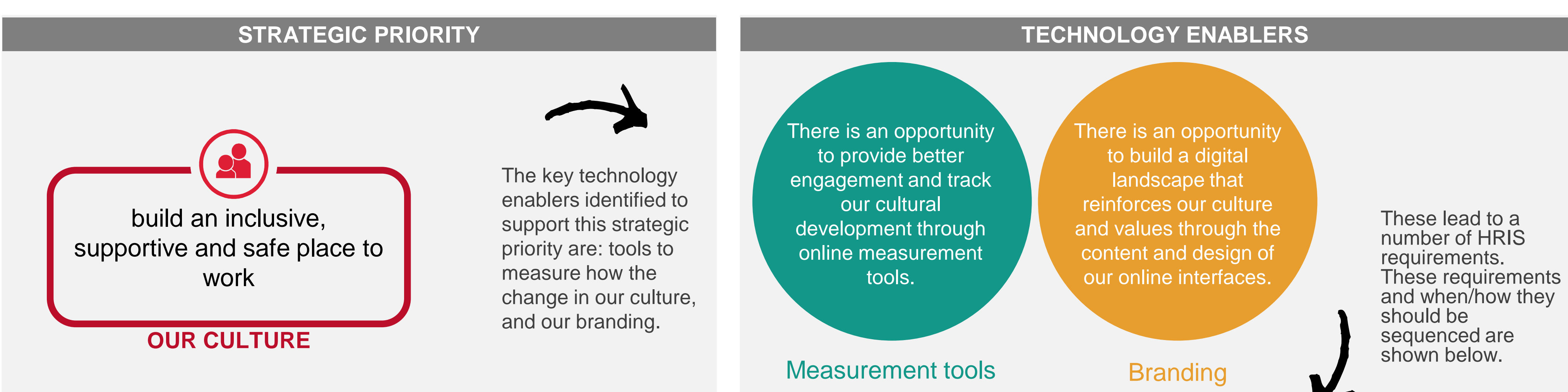
HRIS requirement and related enabler (● ●)	This should happen before initiative:	This would ideally happen before initiative:
A place to capture learning needs and the ability to continuously assess changes to learning needs. ●	18, 21	
Ability for individuals to create a development plan, where individual needs can be aggregated in a system to provide a macro view of shared learning needs. ●		19
Ability to send compulsory L&D and registration alerts to our people. ●		19

Future functionality would ideally include…

HRIS requirement and related enabler (● ●)	This would ideally happen before initiative:
An integration of learning, performance and analytics to understand correlations between learning and performance. ●	19
A search functionality to reach desired learning within 2-3 clicks. ●	22
A portal to access blended learning accommodating self-paced, formal and informal learning types to address different learning needs. ●	21
A curation platform where learners can source, share, develop and provide feedback on learning resources. ●	21
Ability to integrate with learning and registration records e.g. the National HPI.	19

30

HRIS implications



HRIS SEQUENCING REQUIREMENTS

Our HRIS MUST have…

HRIS requirement and relevant enabler (●●)	This must happen before initiative:	This would ideally happen before initiative:
An ability to administer pulse surveys online, allowing us to measure progress against our culture goals.●	23	

Future functionality would ideally include…

HRIS requirement and relevant enabler (●●)	This would ideally happen before initiative:
The ability to push content and branding about our culture to our workforce e.g. screen savers, intranet.●	26

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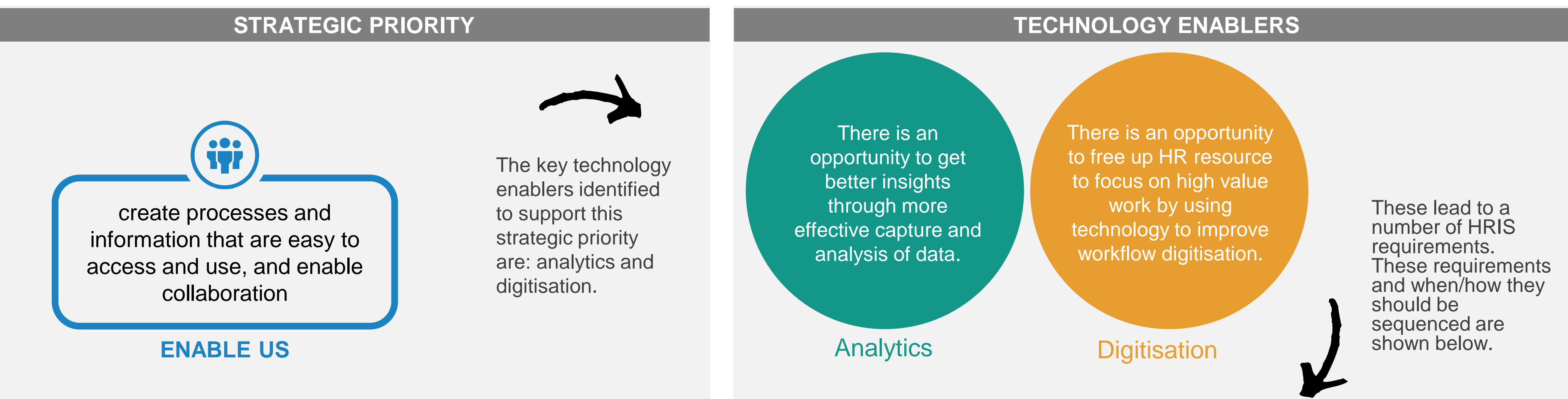
HRIS implications



HRIS SEQUENCING REQUIREMENTS

Our HRIS MUST have…

HRIS requirement and relevant opportunity (●●)	This must happen before initiative:	This would ideally happen before initiative:
Digital service desk capability to interact with the workforce through online channels. ●	5	
An ability to do correlation analysis e.g. with data and statistical analytics tools.●	5	
Dashboard functionality that visually presents metrics e.g. outputs of analytics, future forecasts. ●		7
The ability to digitise manual HR forms and processes to streamline work.●	37	
The ability to create, edit, store and access employee files electronically.●	40	32

Waikato District Health Board

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 11.3

WAIKATO DHB DRAFT ANNUAL PLAN AND STATEMENT OF INTENT 2019/20

Purpose	For information.

Background

The draft Waikato DHB Annual Plan 2019/20 is due to be submitted to the Ministry of Health on 5 April 2019. The final Waikato DHB 2019/20 - 2021/22 Statement of Intent (SOI) is due to be submitted to the Ministry of Health on 30 June 2019.

An estimate of financials should be included in the draft Annual Plan. Updated financials will be completed once the government's funding envelope for 2019/20 has been received.

The Annual Plan will include significant actions to deliver on the Regional Service Plan (RSP) priorities. Waikato DHB will work with Midland DHB partners to identify these actions upon receiving the detailed Ministry guidance.

The 2019/20 Planning Guidance requires that DHBs refresh their Statement of Intent to reflect the Ministers identified priorities. A Statement of Intent outlines a DHBs strategic intentions for the next three years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes.

Overview of the Annual Plan

This draft Annual Plan has been developed in accordance with the guidelines and templates provided by the Ministry of Health on 20 of December 2018 and the Minister's 2019 Letter of Expectations.

The 2019/20 Planning Priorities are:

- Achieving equity within the health system (overarching priority)
- Fiscal responsibility
- Strong and equitable public health system
- Mental health and addictions care (detailed guidance still to come)
- Child wellbeing (detailed guidance still to come)
- Primary health care
- Non-communicable disease prevention and management
- Public health and the environment.

Service activities and performance measures have been developed to align with the Minister of Health's expectations. We are awaiting planning guidance for several priority areas: these are indicated within the draft Annual Plan and will be updated once the guidance has been received. A copy of the draft 2019/20 Annual Plan is attached.

The draft 2019/20 - 2021/22 Waikato DHB Statement of Intent (draft SOI) is also attached. It is an update on our operative Statement of Intent and includes links to the Waikato DHB Strategy and the Health System Plan which is under development. We will update the content of the draft SOI where appropriate upon receiving further Ministry guidance.

Formal feedback is expected from the Ministry on this draft Annual Plan by 10 May 2019. While the date for submission of the final draft Annual Plan is 21 June 2019, the date for submission of the final Annual Plan will be set by the Ministry upon provision of their feedback.

As the draft Annual Plan is incomplete, the version attached is in MS Word format. Graphic design input will occur at a later date prior to the final draft plan being submitted to the Ministry in June.

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

The content of our Annual Plan reflects our commitment to improve Māori health and achieve equity, in line with our Strategic Framework and Health System Plan. The Annual Plan guidelines specified that an equity assessment be undertaken using tools such as the Health Equity Assessment Tool. A health equity assessment process will be undertaken by staff across a randomised sample of service activities to be included in the Draft Annual Plan (April -May).

Recommendation
THAT
The Board notes and provides comment on the draft Annual Plan 2019/20 and the draft 2019/20 - 2021/22 Statement of Intent.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Waikato District Health Board 2019/20 Annual Plan

INCORPORATING THE 2019/20 STATEMENT OF PERFORMANCE EXPECTATIONS

DRAFT

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

Annual Plan dated 7 March 2019
(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

DRAFT

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

Placeholder for contents page

Mihi

He honore, he kororia ki te Atua

He maungarongo ki te whenua

He whakaaro pai ki nga tāngata katoa

Ka tau te kei o te waka ki te Kiingi Tuheitia

me te whare o te Kahui ariki whānau whanui tonu

Paimarire.

Kahuri ki te korowai aitua

O ratou ko wehi ki te po

Takoto mai, moe mai koutou

Haere, haere, haere atu raa.

Noreira, ka puari te kuaha pounamu

Mahana kia taatou katoa.

“Mehemea ka moemoeaa ahau

Ko au anake

Mehemea ka moemoeaa e taatou, ka taea e taatou”

All honour and glory to God

Peace on earth

And good will to all mankind

Including Kiingi Tuheitia his family

And the royal household

Paimarire.

We turn to acknowledge those

Who have passed beyond the veil

Rest in peaceful slumber.

Haere, haere, haere atu raa

Therefore the green stone door

Opens wide with a very warm greeting to us all

“If I am to dream

I dream alone

If we all dream together

Then we will achieve”

DRAFT

Minister’s 2019/20 Letter of Expectations to Waikato DHB

Placeholder

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Dear Chair

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

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

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

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

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

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

Our approach

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

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

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

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

Strong and equitable public health and disability system

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

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

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

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

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

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

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

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

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

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

Mental health and addiction care

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

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

Child wellbeing

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

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

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

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

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

Primary health care

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

Non-communicable disease (NCD) prevention and management

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

Public health and the environment

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

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

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

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

Planning processes

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

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

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

Yours sincerely

Hon Dr David Clark
Minister of Health

Minister's 2019/20 Letter of Approval to Waikato DHB

*(*Placeholder for Annual Plan approval letter*)*

SECTION ONE: Overview of Strategic Priorities

Strategic intentions/priorities

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

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

Waikato DHB is committed to working in partnership with local iwi and Māori providers, Pacific providers as well as the other Midland Regional DHBs. This Annual Plan is aligned with national, regional and local strategies.

National

The Treaty of Waitangi

The Treaty of Waitangi (Te Tiriti o Waitangi) is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Waikato DHB values the importance of the Treaty. Central to the implementation of the Treaty principles is a shared understanding that health is a 'taonga' (treasure).
The principles within the Treaty of partnership, protection, participation and pono implicitly recognise the important role the health sector plays in recognising the indigenous rights of Māori to achieve radical improvements in health and eliminate health inequities.

New Zealand Health Strategy

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

He Korowai Oranga

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

DRAFT

DHBs in particular should consider He Korowai Oranga in their planning, and in meeting their statutory objectives and functions for Māori health.

The Healthy Aging Strategy

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

The UN Convention on the Rights of Persons with Disabilities

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

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

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

Regional

Legislation requires the DHBs to collaborate regionally and for each of the four regions of DHBs to develop a Regional Services Plan (RSP). The RSP is a companion plan to DHB Annual Plans. HealthShare Ltd, the Midland DHBs shared services agency, is tasked with developing the Midland RSP, on our behalf. This work is carried out in consultation with the Midland DHBs Annual Plan Writers Group and DHB Executive Groups to ensure collaboration and 'line of sight' (alignment) between the region and DHB planning. Specific activities that will be undertaken regionally can be found on page xx of this plan within the Delivey of Regional Service Plan priorities.

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

- 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

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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). Alignment with national and regional strategic direction is provided against each work programme's initiatives i.e. the New Zealand Health Strategy's five strategic themes; the national System Level Measures, and Midland's six regional strategic objectives. Resourcing for delivery of approved work programmes is regionally agreed, budgeted and approved.

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

Local

Waikato DHB is the Government's funder and provider of health services to an estimated 426,137 residents living in the Waikato district, covering almost nine percent of New Zealand's population, the fifth largest DHB in the country. The DHB has a larger proportion of people living in areas of high deprivation than in areas of low deprivation. The population becoming proportionally older (the 65 plus age group is projected to increase by 40 percent between 2018/19 and 2028). This will increase the prevelance of chronic and complex health conditions and informs many of the strategies being put in place to meet future health need.

23 percent of the population are Māori compared with the national average of 16 percent. The Māori population are significantly impacted by many chronic conditions such as diabetes and smoking related diseases and are disproportionally presented in adverse health statistics. These facts, combined with the acknowledgment of the status of iwi in the Waikato, provides a strong driver to include and engage Māori in health service decision making, and to deliver health information and health services in a culturally appropriate way.

The Pacific population also make up almost three percent of the DHB population and are a group that require targeted health initiatives.

Direction and Strategy

Waikato DHB Strategy

During 2016/17 Waikato DHB rolled out a new strategy 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 achieve health equity.

Our Mission - Enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative delivery.

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

Waikato DHB Health System Plan

In 2018/19 Waikato DHB developed a Health System Plan to improve our health system and futureproof it for the challenges we expect in the coming years. It translates the DHB strategy of **Healthy People. Excellent Care.** into a set of strategic goals and actions for the Waikato health system for the next ten years. The Health System Plan incorporates a roadmap of actions to guide implementation across the Waikato.

During a series of wānanga, focus groups, and workshop sessions, over 600 members of our community (including health workers from the DHB and the broader health system) took the opportunity to share their experience, knowledge and ideas. People said that they would like Waikato health services to be:

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

The community and whānau voices have been distilled into goals with underlying actions

Healthy People.

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

Excellent Care.

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

The following enablers will be critical in achieving the goals:

- Leadership and partnerships
- Commissioning
- Workforce Development
- Technology and Information
- Quality Improvement

Refer to the Health System Plan on our website www.waikatodhb.health.nz/hsp for further details.

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Health System Plan Direction

Placeholder for HSP diagram

Enhance wellbeing and prevention.
Address the social determinants of health

Whānau centred – whānau voice and experience

Improve access and choice where people live

Support whānau as active participants in their health.
Community development and whānau ora

Healthy People

Partner with Māori in the planning and delivery of health services

Empower whānau to achieve wellbeing

Support community aspirations and address determinants of health

healthy supportive communities

supporting Māori development

healthy environments

Excellent care

Improve access to services

Enhance the capacity and capability of primary and community health care

Strengthen intermediate care

equitable

culturally safe

Commissioning | Leadership + partnership | Technology | Workforce | Quality Improvement

Foreword from the Waikato DHB Chair and Chief Executive

Insert photo

Sally Webb, Chair

Over the coming year we need to start making some big changes to meet the challenges of the future and to have a health system that works for our people, particularly our large Māori community.

Our new ten year Health System Plan incoroprating the Care in the Community Plan will give us a pathway to help us do this. It will focus our work to address what is needed in communities to support people to stay well and live well with their health needs and to have better more affordable health services.

Most importantly, we want to design those changes with our communities and the people who use our services. We particularly want to partner with Māori in the planning and delivery of health services. Achieving a radical improvement to Māori health outcomes and their access to healthcare is our key priority so we can ensure equity for everyone.

Our mental health and addiction services have been working hard to engage with the community around new ways of delivering services and we are well placed to respond to the outcome of the mental health inquiry this year.

We are committed to our best endeavours to achieve the outcomes outlined in the Minister's Letter of Expectation, but like many DHBs we are struggling with a large deficit so this coming year we need to fully understand what is driving this and work hard to achieve a sustainable financial position.

In all of this we never forget that people are at the centre of all we do, both the amazing people who work for us and the people we serve in the community.

He aha te mea nui o te ao
What is it that's important in the world
He tangata, he tangata, he tangata
It is people, it is people, it is people

Insert photo
Derek Wright, Interim Chief Executive

This Annual Plan sets out the direction and priorities for the coming 2019/20 year for the Waikato DHB.

This DHB has had some financial challenges over the last year but we now have an opportunity to move forward in a number of areas. We have focused on strengthening our relationships across the Midland region and we will continue to look for new and innovative ways of working to deliver the best healthcare for the communities we serve that we can.

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

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Our Consumer Council has been in place for a little over 12 months and has assisted us in how we plan and deliver services at the DHB.

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

This is an exciting but challenging time for the DHB as we move to implement the Health System Plan and look at innovative solutions to deal with the continued demands on our services.

None of our aspirations outlined in this plan would be possible without the 7,000 dedicated and hardworking staff who are delivering more healthcare both in our hospitals and in the community and living our vision of Healthy people. Excellent care.

Signatories

Agreement for the Waikato DHB 2019/20 Annual Plan

between

Hon Dr David Clark Minister of Health Date:	Sally Webb Chair Waikato DHB Date:	Derek Wright Chief Executive Waikato DHB Date:

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SECTION 2: Delivering on Priorities

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

Health Equity

Achieveing equity within the New Zealand health system underpins all government priorities. In addition to the poor health outcomes that Māori as a population group experience, unmet need is also a barrier to health equity. In the Waikato District we will focus on activities that address the key areas of unmet need especially for Māori, Pacific, rural populations, and those who experience disability.

Health Equity Tools

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

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

Our Public Health Unit (PHU) has significant expertise in understanding population needs. Work is currently underway to strenthgen integration between the PHU and the DHB Strategy and Funding team to enhance system development and service responsiveness, particularly for Māori and other priority populations.

Māori Health

Māori as a population group experience the poorest health outcomes, we require an explicit focus on achieving equity for Māori across their life course. Activities that are specifically designed to help reduce health outcome equity gaps will be indicated as a "Equitable Outcomes Action" (EOA).

Waikato DHB wil continue to uphold our obligations as a Treaty of Waitangi partner as specified in the New Zealand Public Health and Disability Act 2000. To ensure we are staying on track with these obligations we will complete a progress report on how we are meeting these these obligations in our Annual Report.

Responding to the Guidance

Waikato DHBs 2019/20 Annual Plan is a further refinement of the 2018/19 plan, however the priorities have been updated to reflect the Ministers direction and chosen priorities. Engagement with relevant stakeholders including our primary care partners has been undertaken in developing this document.

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Public Health Plan

Waikato DHB prides itself on having an integrated public health service that prioritises its activities on promoting, improving and protecting health with a focus on achieving equity for people living in the Waikato DHB district. Good health and wellbeing is about more than healthcare. A good start in life, education, decent work and housing, and strong, supportive relationships all play their part. For this reason we are working closely with our PHU and ensuring we align our Annual Plans and work together towards achieving better health outcomes for our population. Some key focus areas we will work together on in 2019/20 are:

- Immunisations
- Healthy Food and Drink
- Transport
- Climate Change

Regional Service Planning

TBC - Guidance will be released in March/April 2019*

Government Planning Priorities

The 2019/20 Planning Priorities are:

- Strong fiscal management
- Strong and equitable public health and disability system
- Mental health and addiction care
- Child wellbeing
- Primary health care
- Public health and the environment

Connection between the whole of government priorities and the health system priorities:

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
Support healthier, safer and more connected communities	We have health equity for Māori and other groups	Stong and equitable public health and disability	Health equity for high need populations	**Engagement and obligations as a treaty partner** ***TBC***				Oversight: Loraine Elliott

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingm easure	Equity Outcom e Action (EOA)	Reporting lead & oversight
	We have improved quality of life	Stong and equitable public health and disability system	Productive partnerships	**Cross-sectoral collaboration** **Waikato DHB continues to work with all key partners to significantly improve the Districts performance, 2019/20 will see a particular focus on:** Waikato Plan The Waikato Plan is a collaborative strategic plan developed by central and local government and iwi, to address the challenges facing the region. The key areas of focus being housing affordability and mental illness. Waikato DHB will take a lead role in working with partners to scope and once agreed, implement action on mental health which will also be aligned with Te Pae Tawhiti.	Q1 and Ongoing		EOA	Oversight: Tanya Maloney Reporting: Regan Webb and Greg Moton
				Cross-sector Collaborating with other government agencies to provide digital health solutions to underserved populations and to those in difficult circumstances. For example, Waikato DHB partners with local law-enforcement agencies to provide mental health triaging facilities using FaceTime at police stations.	Q1 and Ongoing		EOA	
				The Waikato Projections Working Group The group consists of representatives from all the district councils, Hamilton City and Waikato Regional Council, the New Zealand Transport Authority and Waikato DHB. The purpose of the working group is to plan and deliver a regionally consistent set of future population and economic projections for the Waikato region, at the district and local level, providing a shared and common evidence-base for consistency in planning and decision-making.	Q1 and Ongoing			
				Smokefree Environments The Waikato DHB will work with local councils and other health system partners to strengthen their local smoke free environments policy.	Q4			
				Gateway Waikato DHB will maintain its membership of the Gateway Governance Group (Ministry of Education, Oranga Tamariki, Disability Support Link, Waikato DHB mental health Services, DHB Child Health Pediatricians). The Group is chaired by Oranga Tamariki.	Q4			
				Family Start (0-5years) Waikato DHB will lead further development of joint network activities linked to comprehensive community health workers support i.e. Family Start, Well Child Tamariki Ora and Primary Health Care Organisations.	Q4			

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We live longer in good health	Stong and		**Strategic health measures** ***TBC awaiting govt. decision***				Oversight: Tanya Maloney Reporting: Regan Webb, Rachel Poaneki, Nina Scott
	We have improved quality of life	Stong and equitable public	People centered services	**Disability** ***TBC***				Oversight: Tanya Maloney Reporting: Melinda Ch'ng, Gareth Fannin
	We live longer in good health	Stong and equitable public	Effective and efficient care and services	**Planned care** ***Awaiting guidance from the Ministry***				Oversight: Ron Dunham Reporting: David Nicholson and Gareth Fannin
		Stong and equitable public	Safe, quality health services for all	**Acute demand** ***TBC***				Oversight: Ron Dunham Reporting: Barb Garbutt and Damian Tomic

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Stong and equitable public health and disability system	Health equity for high need populations	**Rural health** **Waikato DHB is commited to improving access and reducing inequities for our rural population by:** Completing the Southern Rural Maternity Project: • Complete refurbishment of Tokoroa hospital primary birthing unit and implement new roster that is supported by midwives and LMCs working in the South Waikato. • Complete refurbishment of Taumarunui hospital primary birthing unit. • Establish Maternity Resource Centres at Taumarunui and Tokoroa. Implementing the Rural Lactation Consultant Service. Establish mother to mother support groups via the maternity resource centres. Improve equity of access for rural women to specialist support by increasing community capability that supports breast feeding. Complete the single point of entry model of care in Taumarunui and move to business as usual. This project has been in partnership with Taumarunui Community Kokiriri Trust. Whānau Ora principles and approach are central to this model of care. As a result we expect: • A reduction in low acuity presentations to Taumarunui ED • Re-engagement of people with their general practice or other primary care provider • Emergency Department being used for Emergency Care Future service design will include utilisation of a locality planning approach to enable solutions to be delivered that meet the needs of local communities.	Q4 Q1 Q3 Q4 Q1 Q1 Q4 Q4 Q1 Q3		EOA EOA EOA EOA	Oversight: Ron Dunham/Hayley McConnell Reporting: Jill Dibble
		Stong and	Productive partners	**Healthy ageing** ***TBC***				**Oversight:** Barb Garbutt **Reporting:** Graham Guy

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	**Waikato DHB Key Response Actions to Deliver Improved Performance** Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We have health equity for Māori and other groups	Stong and equitable public health and disability system	People centered services	**Improving Quality** **Waikato DHB is committed to improving quality by:** ***Atlas of Healthcare Variation activity – TBC – focus on Asthma*** Patient experience data shows work is required with regard to medication knowledge. As part of the SLM improvement plan, a quality improvement project is planned in one locality that has a rural hospital, GP, pharmacy. This includes establishing a multidisciplinary working group (primary care, pharmacy, secondary care, consumers, Māori providers) to: • Develop terms of reference and scope of an improvement project. • Review data – ethnicity/age etc. • Review international innovation best practice. • Define roles for medication safety i.e. who does what from prescribing through to taking. The DHB Antimicrobial Steering Group formed in November 2018 and has developed a work plan for 2019, which aligns activity with the New Zealand Antimicrobial Resistance Action Plan. It includes : • Centralising antimicrobial guidelines – available to all staff, reviewed and up to date. • A 'restricted' antimicrobial list agreed by the steering group. • Working with the Sepsis Working Group to optimise antimicrobial use in patients with sepsis. • Raising awareness – grand round presentation and participation in World Antimicrobial Awareness Week in November.			EOA	Oversight: Mo Neville and S&F (Atlas activity)
Support healthier, safer and more connected communities	We live longer in good health	Stong and equitable public	Safe, quality health services for all	**Cancer services** ***TBC***		Health Target: FCT		Oversight: Ron Dunham Reporting: Alex Gordon and Gareth Fannin
		Stong and	Safe, quality health services for all	**Bowel screening** ***Awaiting guidance from the Ministry***				Oversight: Ron Dunham Reporting: Lu-ana Ngatai and Gareth Fannin

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We have improved quality of life	Stong and equitable public health and	People centered services	**Healthy food and drink** Supported by the Public Health Unit, Waikato DHB will develop and implement a Healthy Food and Drink Policy. Contracts held with provider organisations will include a clause stipulating the expectation they develop a Healthy Food and Drink Policy.	Q4 Q4			Oversight: Tanya Maloney Reporting: Phil Grady and Deryl Penjueli

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We live longer in good health	Stong and equitable public health and disability system	Effective and efficient care and services	**Workforce** **Waikato DHB will support our workforce by:**				Oversight: Gil Sewell
				Exploring and identifying current workforce planning, supply issues and opportunities internally and externally.	Q4		EOA	
				Work towards having a workforce that is 23 percent Māori across all areas to be reflective of our population.	Q1 and ongoing		EOA	
				Complete workforce modelling and agree a workforce plan that shows anticipated composition (employee, alternative workforce types and automation), size and cost of the Waikato DHB workforce across 2019-2024.	Q4		EOA	
				Build Employee Value Proposition (EVP).	Q4			
				Integrate Tikanga into all Human Resource processes.	Q4		EOA	
				Redesign the recruitment model for target/critical workforce groups with the aim to eliminate, automate or streamline our work, increasing speed to value while maintaining sufficient checks and balances.	Q4			
				Create governance of learning that will set the direction and make key decisions regarding learning and development across the organisation.	Q4			
				Organisational capability needs analysis to identify the critical shared requirements of our workforce.	Q4			
				Implement "Speaking Up for Safety" programme, requiring leaders to visibly role model the focus on wellbeing and inclusive behaviours.	Q4			
				Begin the "Supportive Employment" initiative to provide the most supportive culture we can.	Q4			
				Complete a organisation wide learning inventory stocktake and review to inform our current HR service review.	Q4			
				Weave Tikanga principles into the key moments that matter through the employee lifecyle.	Q1		EOA	
				Prioritising the development of the māori workforce through partnerships with education providers and training institutions.	Q4		EOA	
				Full details see section four: Stewardship				

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We have equity for Māori and other groups	Stong and equitable public health and disability system	Health equity for high need populations	**Data and digital** **Waikato DHB will continue to support services through advancements in data and digital services, including:**				**Oversight:** Geoff King
				Continuing to provide multiple ways of contacting the DHB, including increased usage of telehealth and virtual health. These two services have proven popular with Māori patients, particularly renal services, which use Telehealth.	Ongoing		EOA	
				Accelerating the achievement of equity for Māori by focusing on responsiveness in information systems that are used by the DHB to manage Māori and other patients' health, including systems in diabetes, women's health (breast and cervical screening, smoking cessation), oral health and breastfeeding services.	Q4		EOA	
				Improving the quality of ethnicity data collected at the DHB and by primary care.	Q1 and ongoing		EOA	
				Collaborating with GPs in evaluating booking systems to move towards same-day-access and next-available-appointment for patients.	Q1 and ongoing			
				Building prompts in IT systems to ensure that patient prompts, decision support and audit tools exist and are used to support Māori health.	Q4		EOA	
				Mobility Programme has enabled clinicians with mobile devices. A number of clinical projects will be expanding the functionality and applications that are available on mobile devices.	Q4			
				FaceTime will continue to be used by Police to facilitate triage for Mental Health concerns.	Q1			
				Full details see section four: Stewardship				
	We have improve	Stong and	Productive partners	**Delivery of regional service plan prioities** ***Awaiting guidance from the Ministry***		SI2		Bay of Plenty DHB
Support healthier, safer and	We live longer and in	Mental Health	Safe, quality health	**Inquiry into mental health and addiction** ***Awaiting guidance from the Ministry***				Oversight: Vicki Aitken

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Waikato DHB Key Response Actions to Deliver Improved Performance

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Mental Health and Addictions Care	Health equity for high need populations	**Population mental health**		PP26		Oversight: Tanya Maloney Reporting: Phil Grady, Wayne Skipage, Vicki Aitken
				Waikato DHB is committed to improving our populations mental health and addictions, especially for priority populations including vulnerable children, youth, Māori and Pasifika by:				
				Engagement by Kaitakawaenga with all tāngata whaiora who are Māori to inform the provision of culturally based/appropriate services.	Q4		EOA	
				Development of a detailed business case for new acute mental health facilities	Q4			
				Partner with the Department of Corrections for the development of a proposed fit for purpose acute forensics and mental health services at Waikeria Prison.	2019-2022		EOA	
				Engagement with community and key stakeholders in co-design of future workforce requirements.	2019-2022			
				Align Mental Health and Addictions service transformation with the goals enablers and actions of the Waikato DHB Health System Plan.	Q4		EOA	
				Greater partnership and greater collaboration with NGO partners to co-design service delivery that is person centred and closer to home.	2019-2021			
				Scope and develop a range of housing alternatives for mental health and addictions tāngata whaiora.	Q4		EOA	
				Review the range of respite options across the district moulding new contracting arrangements.	Q3			
		Mental Health and	Safe, quality health services for	**Mental health and addictions improvement activities** ***TBC – Info will be available by 13 March***		PP7		Oversight: Vicki Aitken
		Mental Health	Safe, quality health	**Addiction** ***TBC – Info will be available by 13 March***		PP8		Oversight: Vicki Aitken
		Mental Health	Safe, quality health services for all	**Maternal mental health services** ***Awaiting results of stocktake to identify activities***				Oversight: Tanya Maloney Reporting: Kathryn Fromont and Adam Wardle

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
Make New Zealand the best place in the world to be a child	We have health equity for Māori and other groups	Child Wellbeing	Productive partnerships	**Immunisation** **Waikato DHB continues to proactively work with all key partners to significantly improve the Districts performance and ensure at least 95 percent of our children are immunised on time:**		Health Target: Increased Immuisation		Oversight: Tanya Maloney Reporting: Ruth Rhodes, Kathryn Hugill, Adam Wardle, Deryl Penjueli, Greg Morton
				Continue to implement the agreed immunisation action plan.	Ongoing			
				Implement the Māori immunisation action plan which will be developed in Q4 2018/19.	Starting Q1 and ongoing		EOA	
				Work with Māori providers of Well Child Tamariki Ora services to identify the reasons for lower immunisation rates within their cohort of children, and the potential solutions, support and resources required to lift on time immunisation rates for Māori.	Q1		EOA	
				Trial an expansion of outreach immunisation for high need/Māori whānau in partnership with Plunket and DHB funded Hapu Wananga pregnancy and parenting courses.	Q1		EOA	
	We have improved quality of life	Child Wellbeing	Safe, quality health services for all	**Supporting health in schools** ***Awaiting results of stocktake to identify activities***				Oversight: Tanya Maloney Reporting: Kathryn Hugill, Adam Wardle, Deryl Penjueli
		Child Wellbeing	Safe, quality health services for all	**School-based health services** ***Awaiting guidance from the Ministry***				Oversight: Tanya Maloney and Ron Dunham/Hayley McConnell Reporting: Kathryn Hugill and Adam Wardle

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Government Priority Outcomes	Health System Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Child Wellbeing	Effective and efficient care and services	**Midwifery workforce – hospital and LMC** **Waikato DHB is committed to supporting our current and future workforce by:**				**Oversight:** Sue Hayward **Reporting:** Joanne Clarke, Clinical Midwife Director
				Ensuring all applicants identifying as Māori will be offered an interview.	Q2		EOA	
				Engagement with the WINTEC Employer Partnership Group to support students in order to reduce attrition rates.	Q2			
				Supports developed to allow our Māori and Pasifika DHB employed midwives to culturally engage with Māori and Pasifika students.	Q4		EOA	
				Identifying what supports are required to allow registered midwives to work to the full breath and depth of their scope.	Q3			
				Reduce barriers to enable midwives to access and participate in ongoing relevant education.	Q4			
	We live longer in good health	Child Wellbeing	People centered services	**Waikato DHB is committed to supporting whānau and their pēpi through the First 1000 Days (conception to around two years of age) and will:**		Health Target: Raising Healthy Kids and SI18		Oversight: Ron Dunham Reporting: Michelle Sutherland and Adam Wardle/Kathryn Fromont
				Develop Tīmatanga Hauora (Healthy Start) Service. This is a wrap-around integrated Māori maternity and child First 1000 Days service consisting of Lead Maternity Carers, Kiawhina, GPs, Well Child Tamariki Ora provider, Family Start, a Family Violence Co-ordinator, Smoking Cessation Co-ordinator and Lactation Consultants working together to provide intensive support for the woman, her pēpi and whānau. During 2019/20 a pilot of the service will take place and if it is successful, will be rolled out further across the Waikato District focusing on Māori, rural and vulnerable women.	Q4		EOA	
				Develop and roll-out of the Harti Mama assessment and decision support tool focused on the First 1000 Days. This tool is for use in the Tīmatanga Hauora (Healthy Start) Service, Hapu Wanaga classes and rural maternal/baby hubs.	Q2		EOA	
				Launch the Waikato Community Breastfeeding Service into Hamilton and rural locations. This will be monitored and quality improvement methodology applied.	Q1			
				Breastfeeding clinic and support groups run in rural maternal/child hubs as the hubs launch.	Q1-Q4			
				Investigate healthy nutrition resources for the First 1000 Days.	Q2			
				Explore public health ways to respond to “First 1000 Days” mental wellbeing for hapu wahine (women), nga whaea (new mothers), and pēpi (babies).	Q1			

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Child Wellbeing	Productive partnerships	**Family violence and sexual violence** **Waikato DHB is committed to reducing family violence and sexual violence by:** Establishing a Violence Intervention Programme (VIP) advisory Group that includes senior clinicians, quality improvement, HR, Māori and Pacific staff, Oranga Tamariki, Police, Women's Refuge, and PHOs. This group will support the implementation of the VIP strategic service plan (2018/21). VIP will provide staff training on how to deal with child protection and intimate partner violence. The DHB will promote a DHB Employee Assistance Programme (EAP) or equivalent as a means for offering support to DHB employees who are victims or perpetrators of violence and abuse. Improve health pathways for women and children known to Women's Refuge. Embed the national child protection alert system enabling child protection alerts and birth plans to be generated in a timely way in collaboration with LMC's and Oranga Tamariki. Employ a Midwife Specialist for the vulnerable unborn. In cases of child sexual abuse provide faster access for children to specialist services in collaboration with Police and Oranga Tamariki.	Q1-Q4 Q1 and ongoing Q1 and ongoing Q4 Q1-Q4 Q1 Q1 and ongoing		EOA	Oversight: Tanya Maloney Reporting: Claire Tahu, Damian Tomic, Ruth Rhodes, Adam Wardle and Greg Morton

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Child Wellbeing	People centered services	**Sudden Unexplained Death in Infancy (SUDI)** **Waikato DHB is committed to reducing the rate of SUDI by:**				Oversight: Tanya Maloney Reporting: Adam Wardle, Kathryn Hugill
				Expansion of Hapu Wananga to cover a wider rural area and reach the targeted population with key risk factor messages.	Ongoing		EOA	
				Increase referrals from Hapu Wananga to the 'Once and For All' smoking cessation service.	Ongoing		EOA	
				Introduction of a smoke free coordinator in Waikato Hospital Maternity Services.	Ongoing			
				Whare Ora refresher training on hospital wards and presentations to Midwives, Kohanga, daycare and attending community events to increase knowledge and referrals.	Ongoing		EOA	
				Improved access to lactation support services in rural locations to increased breastfeeding rates.	Ongoing		EOA	
				Workshop wananga for Tamariki Ora Well Child providers to train, refresh and emphasise the SUDI risks and risk reduction techniques.	Q3			
				Development and distribution of Māori Breastfeeding resources packages.	Q3		EOA	
				Promotion of our Māori Mama who are hearty breastfeeders at five Māori events - Iwi Poukai.	Q4		EOA	
Support healthier, safer and more connected communities	We have improved quality of life	Primary Health Care	People centered services	**Primary health care integration** **Waikato DHB is committed to supporting Primary health care integration by:**				**Oversight:** Tanya Maloney **Reporting:** Ruth Rhodes, Damian Tomic, Wayne Skipage
				Implementing the Waikato DHB Health System Plan through a sector wide health system leadership group (alliance).	Q4			
				Developing a model of enhanced primary care inclusive of GPs, Pharmacy and St. John. This model will deliver better acute demand management, models of intermediate care and will re-develop our current urgent and emergency model of care.	Q3			
				Addressing equity thorugh the enhancement of the Whānau Ora approach to community care and general practice. This will help to strengthen networks and connections with other services and ensure services link effectively across the system.	Q4		EOA	

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingm easure	Equity Outcom e Action (EOA)	Reporting lead & oversight
	We have health equity for Māori nd other groups	Primary Health Care	Productive partnerships	**Pharmacy** **Waikato DHB is committed to enhanced pharmacist service by:** Piloting the pharmacy provided scheduled childhood immunisation in three pharmacies. Via the Midland Community Pharmacy Group implement a free minor ailment programme for tamariki Māori aged 0-4 to reduce ambulatory sensitive hospitalisations for skin conditions. Establishing a time limited workgroup with representation from general practitioners, pharmacists and New Zealand ePrescription Service (NZEPS) to progress NZEPS uptake in Waikato DHB general practice within primary care to support the national implementation process. Offering support and advise to the national processes to separate medicine supply and clinical advice. Working with the sector to develop a Pharmacy Action Plan aligned to the Health System Plan.	 Q2 Q3 Q4 Q4 Q3		 EOA	Oversight: Tanya Maloney Reporting: Ruth Rhodes
		Primary Health Care	Health equity for high need populations	**Smokefree 2025** **Waikato DHB is committed to smokefree 2025 and will:** Expand our Tupeka Kore programme, a stepwise, co-designed policy change management programme that has been successfully implemented in Waikato Hospital Maternity Service to support women and whānau to be smoke free. Introduce new requirements that funded services actively contribute to eliminating smoking for Māori. New reporting and monitoring systems will also be introduced to support the move to Smokefree 2025. Actively support the expansion of Tupeka Kore to include LMCs, Primary Birthing Facilities, general practices, and community organisations, particularly those with significant engagement with Māori. Linked to the above, Waikato DHB would work with all government agencies and services operating in the Waikato district to demonstrate the same active commitment to supporting Māori to be smoke free and provide support where appropriate and possible. Build on the Waikato DHB smoking cessation service directly funded by Ministry of Health by: • actively promoting the service to potential referrers. • investigate top-up funding (above that provided by the Ministry to the PHO provider) for any person who refers a Māori smoker who completes the funded smoking cessation service – particularly with the aim of promoting referrals from LMCs and whānau.	 Q4 Q4 Q1 and ongoing Q1 and ongoing	Health Target	 EOA EOA EOA EOA EOA	Oversight: Tanya Maloney Reporting: Rachel Poaneki, Rose Black and Nina Scott

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingmeasure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Primary Health Care	People centered services	**Diabetes and other long-term conditions** **Waikato DHB is commintted to addressing Diabetes and other long-term conditions by:**		PP20(1) and PP20(2)		**Oversight:** Tanya Maloney **Reporting:** Damian Tomic, Gareth Fannin, Karina Elkington, Nina Scott
				Establishing a diabetes collaborative group that brings primary and secondary care together to plan for service delivery.	Q4			
				Following the completion of the Waikato Health System Plan a road map of actions including the development of a “Long Term Conditions Plan” for the Waikato DHB district will be developed. These plans have Māori health as a focus and will address the continuum of care from prevention to specialist services.	Q3		EOA	
				Exploring a care in the community focus, specifically focusing on type 2 diabetes in the community – Mana Tu, a whānau ora approach – NZMA 9/11/2018	Q2		EOA	
				The PHOs will implement the new consensus statement on Cardiovascular Disease risk assessment and management.	Q1			
				Extend investment for the diabetes retinal screening services in Tokoroa, a high need rural area. Delivering targeted care, close to home will increase the uptake of our most at risk population groups: Māori and Pasifika. If this is successful then the service may be rolled out in other high need rural areas.	Q1		EOA	
Support healthier, safer and more connected communities	We live longer in good health	Environment sustainability and	Effective and efficient care and services	**Climate change** **Waikato DHB is committed to addressing climate change by:** Reducing hospital food wastage through the implementation of new integrated software that will help accurately forecast the amount of food to purchase and prepare based on trend information of actual patient meal orders.	Q2	PP40		**Oversight:** Chris Cardwell **Reporting:** Michael Fitzpatrick / Melinda Ch’ng
		Environment	Effective and efficient care and services	**Waste disposal** **Waikato DHB is committed to reducing waste disposal and will:**		PP41		**Oversight:** Chris Cardwell **Reporting:** Melinda Ch’ng
				Reduce the amount of landfill waste produced each year.	Q4			
				Reduce the number of single use items such as polystyrene cups which in non-clinical areas will be replaced with bio-degradable/compostable cups.	Q1 and ongoing			
				Investigate the viability of recyclable paper towels and air dryers for non-clinical bathroom facilities.	Q4			

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Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reportingm easure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Envir onm	Effectiv e and efficient	**Drinking water** ***Awaiting guidance from the Ministry***				**Oversight:** Tanya Maloney

FINANCIAL PERFORMANCE SUMMARY

Placeholder for the consolidated statement of comprehensive income (previous year's actual, current year's forecast and three years plan), and the prospective summary of revenue and expenses by ouput class for the next three years.

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

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

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

Service Change

The table below describes all known at thime of publication service reviews and service changes that have been approved or proposed for implementation in 2019/20.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Cancer **Adolescent and Young Adult Patients with Acute Lymphoblastic Leukaemia (AYA ALL)**	Working with Auckland DHB for the future referral of AYA ALL patients through to Auckland DHB for inclusion in the COG trial programs. This is considered to be best practice and to have better outcomes for patients that existed in the Midland Region prior to the proposed changes.	Midland AYA ALL patients have better outcomes, treatment path moves to current best practice	This change impacts all Midland DHB AYA ALL patients
Possible change in Hospice nursing model of care	Working with Hospice around possible changes to the mix of nursing service provided to palliative patients by both Hospice and District Nursing Services.	Hospice have requested a change as they currently provide an intensive service (Hospice at Home) to palliative patients in Hamilton, Cambridge and Ngaruawahia and a shared care service with the District Nurses in the rest of the Waikato. Hospice would like to move resource out of the Hospice at Home service and into the rural services to provide the same level of service across the Waikato. This would have major impacts on District Nursing resources in Hamilton, Cambridge and Ngaruawahia.	Local

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

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SECTION 4: Stewardship
(refer to Waikato DHBs 2019/20 Statement of Intent for more information)

Waikato DHB has a statutory responsibility to improve, promote and protect the health of our people and communities. This section will outline Waikato DHBs stewardship of its assets, workforce, IT/IS and other infrastructure needed to deliver planned services. In addition it will show our commitment 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.

Greater detail is included in Waikato DHBs three-yearly Statement of Intent, recently produced in June 2019 and is available on our website at *www.waikatodhb.health.nz*

Managing our Business

Organisational performance management

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

Table: External Reporting Framework

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

Funding and financial management

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

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Investment and asset management

Waikato DHB has recently completed a Health System Plan and a stand-alone Long Term Investment Plan (LTIP) both covering the next 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 DHBs nationally, Waikato DHB has a shared service arrangement with TAS around support for specified service areas. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

Waikato DHB has a formal risk management and reporting system, which entails incident and complaint management as well as the risk register (Datix management system) and routine reporting. 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 DHBs approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. The DHB Board approved and published a quality governance strategy 'listen, learn, improve' in December 2016 with the ongoing direction reflected in the DHB strategic imperatives. Progress is monitored by the Executive Leadership Team. The consumer council ensures a person / whanau centred approach to our planning.

Building Capability

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

Capital and infrastructure development

Placeholder Capital planning and budget process is currently underway (meeting 27 March) – update to be provided early April 2019

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Information Technology (IT) and Communications Systems

Improving equity through IT

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

Waikato DHB Information Services (IS) have met with the newly formed Waikato Consumer Council, including Māori representatives and formed a relationship with the Council to enable ongoing co-development of the IS strategy. Current activities to address inequity supported by IS can be found on *placeholder* page xx data and digital section.

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

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

Provision of health services via digital technology

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

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

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

The DHB is in the process of formulating its Health Systems Plan and whilst the plan is yet to be finalised improving access to services is seen as a goal with actions focused on supporting district wide service delivery models with technology & information (including virtual care, virtual consults, tele monitoring, and integration across the continuum of care).

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

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Alliance to access Starship patient notes is underway with a view to extend beyond paediatrics.

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

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

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

Aligning with national and regional initiatives

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

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

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

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

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

Application Portfolio Management

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

IT security maturity improvement

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

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

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

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

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Key IT Initiatives for 2019/20

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

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

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Workforce

Future workforce development - Our People Strategy – will see evolving alignment and integration with the Ministry of Health's New Zealand Health Strategy: Future Direction, and the Waikato DHB Strategy. Futher detail can be found in the section on local and regional enablers within this document, on page 18.
In summary the key areas are:

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

Leadership
Waikato DHB supports leadership developmen a number of programmes which provides learning opportunities for new or experienced managers, or those with leadership potential in the Midland DHBs.
Waikato DHB also aspires to drive future performance through focusing on leader development, building valuable team management skills. Values-based leadership is increasingly important with leaders and teams hiring, retaining, developing teams an individuals based on organisation values, for Waikato DHB this would be: Whakamana (give and earn respect), Whakarongo (listen to me, talk to me), Mauri Pai (fair play), Whakapakari (growing the good) and Kotahitanga (stronger together).

Workforce development
To achieve for our communities and patients, we must focus internally on all our employees. Our strategic direction for "Our People" is about putting our people at the heart of everything we do. This means putting our people at the centre of how we shape what it's like to work here, how we develop our people's capability, and build a workplace to best serve our patients and communities. To make this a reality HR will be developing and implementing a workforce plan which will be used to inform which workforce capabilities are required and what development/ learning opportunities we need to provide for our workforce.
Over the 2019/20 year we will be implementing a cultural component to Mental Health and Addictions service orientation for new staff. In the future all Waikato DHB staff will attend cultural training with a view to ongoing cultural compentency training through essential cultural skills based on 'the seven real skills' in "Let's Get Real Training."

Māori workforce development
Waikato DHB is commintted to attracting and retaining Māori staff and to building partnership capabilities in both Māori and non-Māori staff. Our workforce must reflect our population, this means 23 percent of our workforce should be Māori in all role types and at all levels accross our organisation, to ensure Māori experiences and expertise can be found everywhere. HR will be integrating Tikanga into all HR processes and traditional Māori culture and language will be upheld and valued. This means that karakia, waiata, whakawhānaungatanga, powhiri and Te Reo Māori will be embedded into our organisation practices to better support Māori staff. In addition, all services will need to develop a Māori health plan?, which is included in

the induction of all new staff. Training rates will also be reported by Māori and non-Māori so potential inequalities in the furture workforce can be eliminated.

Co-operative developments
Waikato DHB works and collaborates with a number of external organisation and entities, including:

- Ministry of Education,
- Corrections,
- Ministry of Justice,
- Police,
- Ministry of Social Deveopment,
- Oranga Tamariki,
- Local Government,
- Other DHBs,
- NGO health care providers.

SECTION FIVE: Performance Measures

The DHB non-financial monitoring framework aims to provide a rounded view of performance in key areas using a range of performance markers. The measures are intended to cover a specific set of markers of DHB performance in key areas, rather than all health services or DHB activity. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- Achieving Government's priority goals/objectives and targets or 'Policy priorities.'
- Meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration.'
- Providing quality services efficiently or 'Ownership.'
- Purchasing the right mix and level of services within acceptable financial performance or 'Outputs.'

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

Code	**Dimension**
HS	Health Strategy
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – Establishment of baseline (no target/performance expectation is set)

Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2019/20.

Performance measure	Performance Expectation 2019/20 **Placeholder 19/20 SPE currently out for consultation, changes indicated in this column. TBC April/May.**
HS: Supporting delivery of the New Zealand Health Strategy	Signalled for removal in 19/20
SS: Strong and equitable public health and disability system	Progress updates for actions included in Annual Plans
MH: Mental health and addiction care	Progress updates for actions included in Annual Plans
CW: Child Wellbeing	Progress updates for actions included in Annual Plans
PH: Primary Health Care	Progress updates for actions included in Annual Plans
PE: Public Health and the Environment	Progress updates for actions included in Annual Plans
PP6: Improving the health status of people with severe mental illness through improved access	(to be reviewed following decisions that are made in regard to the MH&A Inquiry)
PP7: Improving mental health services using wellness and transition (discharge) planning	
PP8: Shorter waits for non-urgent mental health and addiction services	To be reviewed as a result of the MHandA Inquiry

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PP10: Oral health: Mean DMFT score at school year 8	
PP11: Children caries free at 5 years of age	
PP12: Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	
PP13: Improving the number of children enrolled and accessing the Community Oral health service	
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	
PP21: Immunisation coverage at 2 years of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	
PP22: Delivery of actions to improve system integration and SLMs	
PP23: Delivery of actions to improve Wrap Around Services for Older People	
PP25: Youth mental health initiatives	
PP26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan	to be reviewed as a result of the MHandA Inquiry
PP27: Supporting child well-being	Updates to deliverables expected
PP28: Reducing rheumatic fever	
PP29: Improving waiting times for diagnostic services	Measure currently under review for CT, MRI and Angiography (excludes Colonoscopy) through the Planned Care refreshed Strategic approach work underway. Further information to be advised early in 2019. (Colonoscopy likely to be included as a separate measure)
PP30: Faster cancer treatment – 31 day indicator	
PP31: Better help for smokers to quit in public hospitals	
PP32: Improving the quality of ethnicity data collection in PHO and NHI registers	
PP33: Access to Care (PHO Enrolments)	
PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	
PP37: Child Health (Breastfeeding)	
PP38: Delivery of response actions agreed in annual plan	
PP39: Supporting Health in Schools	Removed - to be replaced by annual plan update reports
PP40: Responding to climate change	Removed - to be replaced by annual plan update reports
PP41: Waste disposal	Removed - to be replaced by annual plan update reports
PP43: Population mental health	Removed - to be replaced by annual plan update reports
PP44: Maternal mental health	Removed - to be replaced by annual plan update reports
PP45: Elective Surgical Discharges	Measure under review through Planned Care refreshed Strategic approach. Further information to be advised in February 2019.

SI1: Ambulatory sensitive hospitalisations (ASH)	
SI2: Ensuring delivery of Regional Service Plans	
SI3: Ensuring delivery of Service Coverage	
SI4: Elective Services Standardised Intervention Rates	Measure currently under review through the Planned Care refreshed Strategic approach work underway. Further information to be advised in early 2019.
SI5: Delivery of Whānau ora	Measure currently under review awaiting Government decision
SI7: SLM total acute hospital bed days per capita	
SI8: SLM patient experience of care	
SI9: SLM amenable mortality	
SI10: Improving cervical Screening coverage	Expectations updated
SI11: Improving breast screening coverage and rescreening	
SI12: SLM youth access to and utilisation of youth appropriate health services	
SI13: SLM number of babies who live in a smoke-free household at six weeks post natal	
SI14: Disability support services	Removed - to be replaced by annual plan update reports
SI15: Addressing local population challenges by life course and demonstrating overall progress in improving equity	Measure removed for 2019/20
SI16: Strengthening Public Delivery of Health Services	Measure removed for 2019/20
SI17: Improving Quality	Removed - to be replaced by annual plan update reports
SI18: Newborn enrolment with General Practice	
OS3: Inpatient length of stay	Elective LOS Measure currently under review through the Planned Care refreshed Strategic approach work underway. Further information to be advised in early 2019.
OS8: Acute readmissions to hospital	Measure currently under review through the Planned Care refreshed Strategic approach work underway. Further information to be advised in early 2019.
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Further updates to come
OP1: Output delivery against plan	
OP2: Engagement and obligations as a Treaty partner	New Measure 2019/20

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APPENDIX A: 2019/20 Statement of Performance Expectations including Financial Performance

Statement of Performance Expectations

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

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2019/20. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the 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, included with each measure is the past performance as baseline data.

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

National Performance Story

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

Regional Performance Story

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

Waikato DHB Performance Story

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

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Service performance

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

Stewardship

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

Impacts

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

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

Impact Measures – Measure of Performance

We seek to make a positive impact on the health and wellbeing of the Waikato population and contribute to achieving the longer-term impacts we seek. Impact measures are defined as “the contribution made to an outcome by a specified set of goods and services (outputs),

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or actions or both". While we expect our outputs will contribute to achieving the impact measures, it must be recognised that there are outputs from other organisations and groups that will also contribute to the results obtained for the impact measures. The following impact measures will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

Long-term Impact One: People are supported to take greater responsibility for their Health

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

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

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

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

Long-term Impact Two: People Stay Well in their Homes and Communities

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

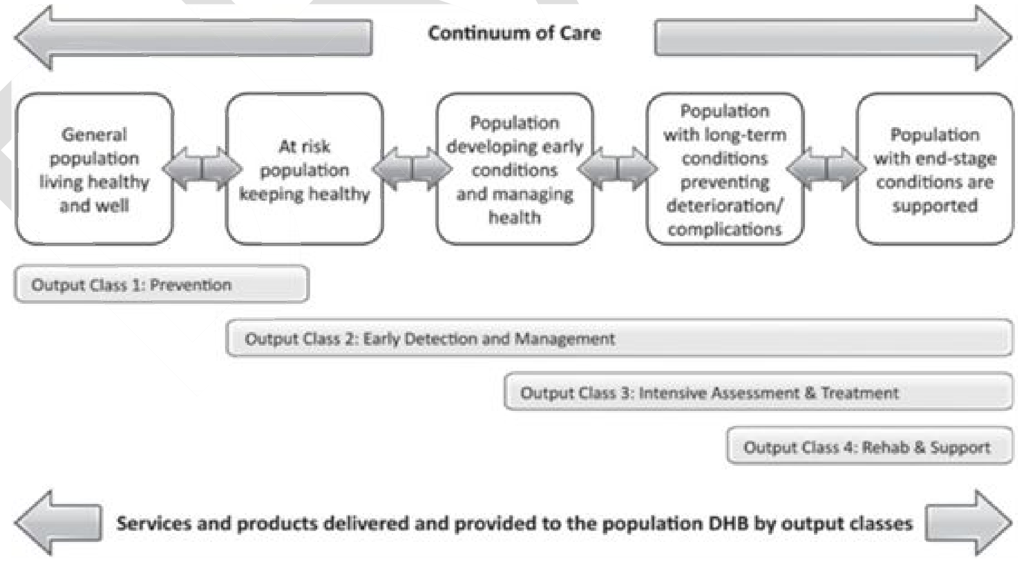
Good health begins at home and in communities so it makes sense to support people's health through services located as close to home as possible. This poses some challenges for Waikato DHB where we have communities that range from affluent urban areas to isolated rural areas, some of which experience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

Long-term Impact Three: People Receive Timely and Appropriate Specialist Care

Providing timely care can slow the progression of health conditions and improve health outcomes. Ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions, and complications that have a negative impact on the health of our population, people's experience of care, and their confidence in the health system. Ineffective or poor quality treatment and long waits also waste resources and add unnecessary cost into the system. Health care needs to be organised to meet the needs of patients in a timely manner. When people receive prompt and appropriate care it is indicative of a system that is working in a unified, coordinated, whole of system approach that improves hospital productivity and ensures health resources are used effectively and efficiently. Such a system would have timely access to acute care and elective services and effective services for those suffering from severe mental illness.
Where people have end-stage conditions it is important that they and their families are supported, so that the person can live comfortably, have their needs met and die without undue pain and suffering.

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

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



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

Output Class

Prevention

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

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

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

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

Early detection and management

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

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

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

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

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

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

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

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

Where Does The Money Go?

(placeholder for table one: "Revenue and expenditure by Output class")

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People are supported to take greater responsibility for their health

Long term impact	Intermediate impact	Impact and outputs
People are supported to take greater responsibility for their health	Fewer people smoke	Percentage of Year 10 students who have never smoked (replace with?) NEW*Percentage of babies living in smokfree homes at six weeks Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking
	Reduction in vaccine preventable diseases	Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time Percentage of two year olds are fully immunised and coverage is maintained Percentage of eligible children fully immunised at 5 years of age Percentage of eligible 12 year old girls have received HPV dose three Seasonal influenza immunisation rates in the eligible population (65 years and over)
	Improving health behaviours	95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017) The number of people participating in Green Prescription programmes

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		Percentage of Kura Kaupapa Māori primary schools participating in Project Energize Percentage of total primary schools participating in Project Energize

Fewer People Smoke

Impact Measure	Output class	Measure Type	Baseline 2014/2015	Target 2018/19	Target 2019/20
Percentage of Year 10 students who have never smoked	1	Qn	74%	≥ 80%	≥ 82%
NEW Percentage of babies living in smokefree homes at six weeks*	1	Qn	Baseline (2018) Māori 26% Pacific 42% Other 51% Total 43%	New Measure in 2019/20	Māori 60% Pacific 60% Other 60% Total 60%

Output Measure	Output class	Measure Type	Baseline 2014/2015	Target 2018/19	Target 2019/20
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	1	Qn	Māori 94% Pacific 100% Other 91% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	1	Qn	Māori 92% Pacific 91% Other 89% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of pregnant women	1	Qn	Māori 95% Pacific N/A	Māori 90% Pacific 90%	Māori 90% Pacific 90%

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who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking			Other 66% Total 95%	Other 90% Total 90%	Other 90% Total 90%

Reduction in Vaccine Preventable Diseases

Impact Measure	Output class	Measure Type	Baseline 2014/2015	Target 2018/19	Target 2019/20
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds			8.8	<8.8	

Output Measure	Output class	Measure Type	Baseline 2014/2015	Target 2018/19	Target 2019/20
Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	1	Qn	Māori 90% Pacific 95% Other 83% Total 91%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of two year olds are fully immunised and coverage is maintained	1	Qn	Māori 91% Pacific 95% Other 91% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible children fully immunised at 5 years of age	1	Qn	Māori 73% Pacific 78% Other 76% Total 73%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible 12 year old girls have received HPV dose three	1	Qn	Māori 70% Pacific 106% Other 62% Total 66%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 75% Pacific 75% Other 75% Total 75%
Seasonal	1	Qn/T	Māori 46%	Māori 75%	Māori 75%

influenza immunisation rates in the eligible population (65 years and over)			Pacific 49% Other 53% Total 52%	Pacific 75% Other 75% Total 75%	Pacific 75% Other 75% Total 75%

Improving Health Behaviours

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017)			Māori 7% Pacific 19% Other 8% Total 9%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

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

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

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		new assessment within 20 working days Percentage of people enrolled with a Primary Health Organisation Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan

An Improvement in Childhood Oral Health [i]

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Mean decayed missing and filled teeth score of Year 8 children			Māori 1.65 Pacific 1.40 Other 0.87 Total 1.08	Māori 0.69 Pacific 0.69 Other 0.69 Total 0.69	*To decrease – confirm after Q4 1819 result known* Māori 0.69 Pacific 0.69 Other 0.69 Total 0.69

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of children (0-4) enrolled in DHB funded dental services	2	Qn	Māori 72% Pacific 72% Other 72% Total 72%	Māori ≥ 95% Pacific ≥ 95% Other ≥ 95% Total ≥ 95%	Māori ≥ 95% Pacific ≥ 95% Other ≥ 95% Total ≥ 95%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	2	Qn/T	Māori 18% Pacific 20% Other 25% Total 18%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%
Percentage of adolescent utilisation of DHB funded dental services	2	Qn	Māori 45% Pacific 53% Other 80% Total 70%	Māori 85% Pacific 85% Other 85% Total 85%	*Increase?* *Māori 90%* *Pacific 90%* *Other 90%* *Total 90%*

Long-Term Conditions are Detected Early and Managed Well

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
To be developed				NA	

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Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percent of the eligible population who have had their cardiovascular risk assessed in the last five years	2	Qn	Māori 87% Pacific 88% Other 91% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	*Increase?* *Māori 95%* *Pacific 95%* *Other 95%* *Total 95%*
Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years	2	Qn	74%	90%	*Increase to 95%?*
Percentage of women aged 25 – 69 years who have had a cervical screening event in the past 36 months	2	Qn/T	Māori 60% Pacific 65% Other 80% Total 74%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 80% Pacific 80% Other 80% Total 80%
Percentage of eligible women aged 50 to 69 who have a Breast Screen Aotearoa mammogram every two years			Māori 58% Pacific 60% Other 70% Total 68%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 70% Pacific 70% Other 70% Total 70%

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Fewer People are admitted to Hospital for Avoidable Conditions

Impact Measure	Output class	Measure Type	Baseline (2017)	Target 2018/19	Target 2019/20
Ambulatory sensitive hospitalisation rate per 100,000 for the following age group: 45 – 64 year olds			Māori 9314 Pacific 6636 Other 3426	Māori 8942 Pacific 6371 Other 3357	*Māori* *Pacific* *Other*

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of eligible population who have had their B4 school checks completed	1	Qn/T	Māori 77% Pacific 83% Other 98% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	*Increase?* *Māori 95%* *Pacific 95%* *Other 95%* *Total 95%*
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)			3.9/100,000	1.2/100,000	*Decrease?*

More People Maintain their Functional Independence

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

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan	4	Qn/T	100%	100%	100%
Percentage of people enrolled with a Primary Health	2	Qn/T	Māori 91% Pacific 88% Other 66% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

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Organisation					
Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days			62%	100%	100%

Long term impact	Intermediate impact	Impact and output
People Receive Timely and Appropriate Specialist Care	People receive prompt and appropriate acute and arranged care	Percentage of patients admitted, discharged, or transferred from emergency departments within six hours 90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries
	People have appropriate access to elective services	Standardised intervention rates (per 10,000) Percentage of patients waiting longer than four months for their first specialist assessment Improved access to elective surgery, health target, agreed discharge volumes Did-not-attend percentage for outpatient services Acute inpatient average length of stay Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks Percentage of child and youth with a transition (discharge) plan Average length of acute inpatient stay Rates of post-discharge community care Improving the health status of people with severe mental illness through improved access
	More people with end stage conditions are supported appropriately	*Measure to be developed* Percentage of aged residential care facilities utilising advance directives

		Number of new patients seen by the Waikato hospital palliative care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) Percentage of accepted referrals for CT scans will receive their scan within 6 weeks (42 days) Percentage of accepted referral for MRI scans will receive their scan within 6 weeks (42 days) Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

People Have Prompt and Appropriate Acute and Arranged Care

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

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

People Have Appropriate Access to Elective Services

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

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of patients waiting longer than four months for their first specialist assessment	3	Qn/T	2.7%	0%	0%
Improved access to elective surgery, health	3	Qn/T	15,693	18,037	*To be allocated*

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target, agreed discharge volumes					
Did-not-attend percentage for outpatient services	3	Qn/T	Māori 21% Pacific 18% Other 7% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%
Elective surgical inpatient average length of stay	3	Qn/T	1.71 days	1.5 days	1.5 days
Acute inpatient average length of stay	3	Qn/T	3.89 days	2.3 days	2.3 days

Improved Health Status for those with Severe Mental Illness and/or Addiction

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

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks			**3 weeks** Māori 82% Pacific 86% Other 72% Total 75% **8 weeks** Māori 93% Pacific 95% Other 90% Total 91%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80% **8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	***3 weeks*** *Increase?* *Māori* *Pacific* *Other* *Total* **8 Weeks** Māori 95% Pacific 95% Other 95% Total 95%
Mental health clients discharged have a transitional (discharge) plan	3	Qn/T	New Measure – no baseline available	37%	95%
Average length of acute inpatient stay	3	Qn/T/QI	Māori 14.51 days Pacific 10.79 days Other 13.16 days Total 14.41 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days
Rates of post-discharge	3	Qn/T/QI	Māori 69% Pacific 73%	Māori 90% to 100%	Māori 90% to 100%

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community care			Other 72% Total 87%	Pacific 90% to 100% Other 90% to 100% Total 90% to 100%	Pacific 90% to 100% Other 90% to 100% Total 90% to 100%
Improving the health status of people with severe mental illness through improved access: 0-19 years 20-64 years 65 plus years	**3**	**Qn**	**0-19 years** Māori 2.89% Pacific 1.96% Other 3.07% Total 2.97% **20-64 years** Māori 7.12% Pacific 4.34% Other 4.34% Total 4.33% **65+ years** Māori 2.12% Pacific 2.13% Other 2.28% Total 2.27%	**0-19 years** Māori 4.73% Pacific 3.13% Other 4.23% Total 4.36% **20-64 years** Māori 8.77% Pacific 4.07% Other 3.78% Total 4.81% **65+ years** Māori 2.39% Pacific 1.69% Other 2.09% Total 2.11%	*To be allocated*

More People with End Stage Conditions are Supported Appropriately

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Measure to be developed					

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of aged residential care facilities utilising advance directives	3	Qn	100%	100%	100%
Number of new patients seen by the Waikato hospital palliative care service	3	Qn	652 original *1085 revised*	1,000	*To be allocated*

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Support services

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Measure to be developed					

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	3	Qn/T	94%	95%	95%
Percentage of accepted referrals for CT scans will receive their scan within 6 weeks (42 days)	2	T	Māori 92% Pacific 100% Other 90% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of accepted referral for MRI scans will receive their scan within 6 weeks (42 days)	2	T	Māori 55% Pacific 53% Other 52% Total 48%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	2	T	78%	90%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	2	T	49%	70%	*Increase?*
Percentage of people waiting for a **surveillance** colonoscopy will wait no longer	2	T	70%	70%	*Increase?*

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than 84 days beyond the planned date					
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	2	T	100%	100%	100%

Financial Performance

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Placeholder for financial performance*

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APPENDIX B: System Level Measures Improvement Plan

Placeholder for 2019/20 SLM Improvement Plan

APPENDIX C: 2019/20-2021/22 Statement of Intent

Placeholder for Statement of Intent

Waikato District Health Board 2019/20 – 2021/22 Statement of Intent

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

Statement of Intent dated 13 March 2019

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EXECUTIVE SUMMARY

This Statement of Intent outlines Waikato DHB's strategic intent over the coming three years (2019/20-2021/22). It identifies the organisation's strategic objectives and how these align at national, regional and district levels to strengthen the health system in its ability to improve health equity outcomes for all of the communities we serve. It is intended for use by Waikato DHB staff, its primary care partners, provider organisations, its regional partners and is public information.

Waikato DHB, like the wider New Zealand public health service continues to face challenges and pressures from factors like an ageing population, population change (both growth and decline), rapidly rising costs, increased demand and workforce shortages.

[Insert infographic]

Waikato DHB wants to achieve its community's desired health and wellbeing and equity outcomes. To do this in the face of these challenges and pressures the organisation must take a whole of health system transformational approach. It also needs to work collaboratively with other sectors that influence health and wellbeing outcomes

The burden of disease is unfairly distributed across the Waikato DHBs' population and district. This includes long term conditions and risk factors such as smoking, unhealthy weight and diabetes contribute to serious ill health and health inequities –inequities which are both avoidable and unfair.

Improving Māori health and equitable outcomes for Māori remains an area in which the organisation must do better, and more detail is to be found in our draft Waikato DHB Health System Plan, and Ki te Taumata o Pae Ora, our Māori Health Plan. Other priority population groups in the district who are not experiencing health gain or equitable health and wellbeing outcomes include rural communities and people with disabilities.

The funding environment remains constrained as health consumes an ever increasing portion of total government expenditure. Improving the Waikato DHB's financial performance continues to be a priority for the organisation. It has instituted a "sustaining a healthy future for Waikato DHB" approach which has a focus on developing quality and cost effectiveness.

Waikato DHB has identified that it wants to grow a strong and fiscally sustainable health and disability sector and implement its new strategic direction as identified in the draft Health System Plan. To do this we will focus on four key strategic objectives:

1 Implement the Health System Plan with a particular focus on community care and achievement of health equity for Māori. This includes local collective community action by seven identified localities to address issues outside the health and disability system that impact on health and wellbeing, and improving access to services.
2 Reconfigure primary health care to enhance its capacity and capability supported by the key enablers and drivers of change.
3 Implement a new model of care for mental health and addictions that has a focus on consumers/whanau and enabling wellbeing.
4 Strengthen action to demonstrate improved productivity and strong fiscal management across the organisation.

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In regard to objective 4, current and projected constraints on funding mean Waikato DHB must continue to make the most of its resources. The organisation needs to identify and make short term savings as well as work on medium and long term actions to improve the organisation's performance. This means being focused on and accountable for:

- Improved productivity
- Planning and working more co-operatively across the health system, and between the health and social service sectors
- Intentional implementation of quality improvement, and innovation actions
- Identifying and achieving savings year on year. For example, commissioning new health services that improve the organisation's performance, or de-commissioning services that that not effective or don't demonstrate fiscal responsibility.

These four strategic objectives will be enabled and underpinned by commissioning, leadership and partnership, workforce, technology, and quality improvement.

SIGNATORIES

____

Signed by Sally Webb

Chair, Waikato District Health Board

____

Professor Margaret Wilson

Deputy Chair, Waikato District Health Board

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1 Introduction and organisation overview

1.1 Introduction and purpose

This 2019/20-2022/23 Waikato District Health Board Statement of Intent (draft Statement of Intent) has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health. In accordance with sections 100 and 141 of the Crown Entities Act 2004, Waikato District Health Board (Waikato DHB) will seek the Minister of Health's consent to its investment in any shares or interest in a company, trust or partnership.

The document sets out our goals and objectives and what we intend to achieve, in terms of improving the health of our population and ensuring the sustainability of the Waikato health system over the coming three years. This Statement of Intent is extracted from the Waikato DHB's Annual Plan and presented to Parliament as a separate public accountability document.

This Statement of Intent makes clear links to national, regional and district agreed priorities including the Waikato DHB Strategy (2016) and draft Waikato DHB Health System Plan (2019). It can be read alongside the Waikato District Health Board Statement of Performance Expectations and Waikato District Health Board Annual Plan (incorporating the Waikato DHB Statement of Performance Expectations) (updated annually).

1.2 What is Waikato DHB

Waikato DHB, established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000, is one of 20 district health boards in New Zealand. District health boards were established as vehicles for public funding and provision of personal health services, public health services and disability support services in respect of specified geographically defined populations. Each district health board is a Crown Entity, owned by the Crown for the purposes of section 7 of the Crown Entities Act 2004, and is accountable to the Minister of Health,

Under the Health and Disability Act 2000, Waikato DHB has a responsibility to improve, promote and protect the health of its people and communities. Additionally, there is a responsibility to promote the reduction of adverse social and environmental effects on health of people and communities.

Waikato DHB is the Government's funder and provider of health services to an estimated 417,130 residents living in the Waikato district, covering almost nine percent of New Zealand's population, the fifth largest DHB in the country. These services are complemented by population based public health activities including communicable disease surveillance and facilitating community health improvement in key settings such as marae or workplaces.

We are responsible for health facilities located across our district – from Whitianga in the north to Taumarunui in the south, with our main hospital campus located in Hamilton (see figure x).

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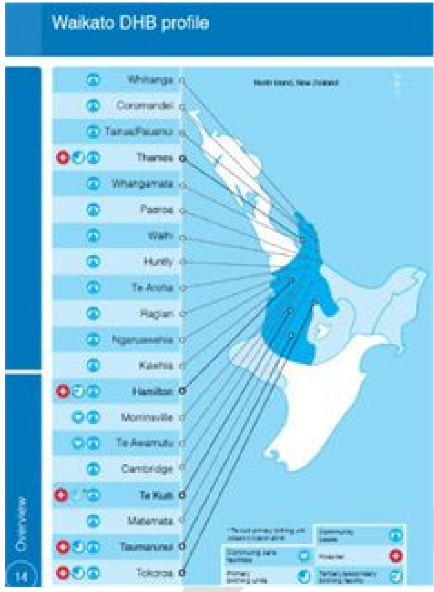

Figure x: Waikato DHB health facilities

Waikato DHB oversees funding for all levels of care including primary care such as general practitioners (GPs), nurses, pharmacists and community health services. The organisation also oversees funding for hospital services, aged care services and health services provided by non-government organisations, including Māori and Pacific providers.

The parties funded by Waikato DHB to deliver services to our population include:

- 80 dentists
- 76 pharmacies
- 75 GP practices
- 57 aged related residential care facilities
- 25 mental health and addictions non-government organisation service providers
- 18 Māori providers
- Two Pacific providers
- Three primary health alliance partners

The Waikato DHB Board is responsible to the Minister of Health and comprises 11 members. Seven of which are elected, and the Minister of Health appoints four. The aim is to ensure our Board is diverse, with two Māori members, representation for clinicians, a balance of male and female members, and members from rural communities. Sally Webb is the Chair of the Board and Derek Wright is the interim Chief Executive. The Board and executive offices are located at the Waiora Waikato Hospital campus in Hamilton.

Waikato DHB is part of a wider health and disability system which serves communities across the Waikato DHB district (see figure z).

[Enhance quality of figure]

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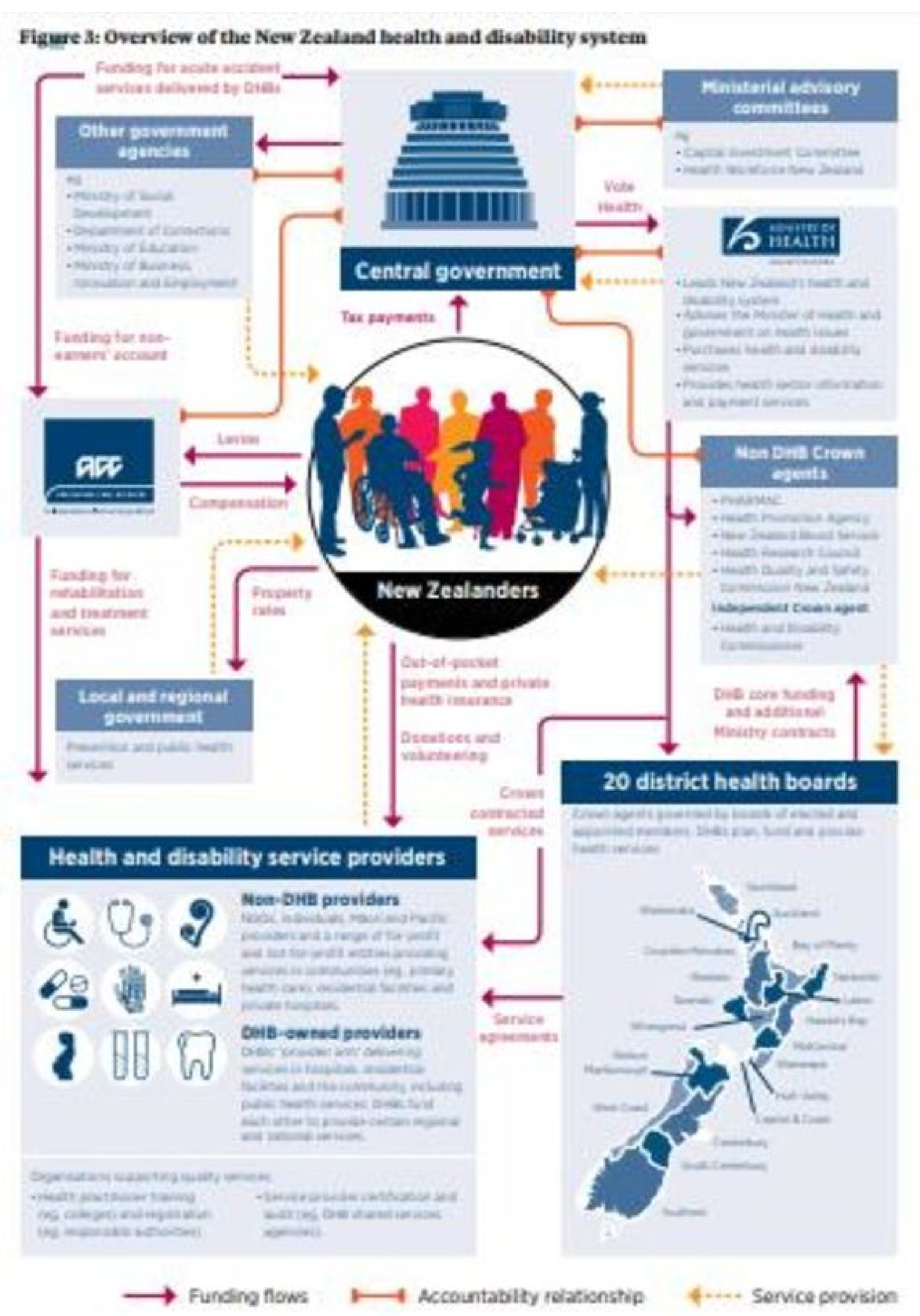

Figure z: Overview of the New Zealand Health and Disability System

1.3 The communities Waikato DHB serves

The Waikato DHB is New Zealand's largest district health board by geographical area and has a broad mix of urban and rural areas with significantly isolated communities and high proportion of rurality (60 percent are rural). The district's geographical area stretches from northern Coromandel to close to Mount Ruapehu in the south, and from Raglan on the west coast to Waihi on the east and covers more than 21,000km^2.

[Replace narrative below with an infographic figure]

There are 10 territorial local authorities within the Waikato DHB district boundary. These include: Hamilton City; Hauraki; Matamata-Piako; Otorohanga; (part of) Ruapehu; South Waikato; Thames-Coromandel; Waikato (part of); Waipa; and Waitomo with a projected combined population of 390,700 people in 2015. At this time it was projected that 35 percent of the population were aged 24 or under, 49 percent were aged between 25 and 64 and 155 were aged 65 or over.

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

[Insert infographic]

NZ Health and Disability Survey data suggests that one in five people across the district experience disability. As a result of this, and the district's ageing population profile, Waikato DHB includes and engages with people who experience disability in health service decision-making, to help ensure its services are accessible and delivered in a way that meets their needs.

[Consider replacing the narrative below with narrative or an infographic from 2013 Waikato DHB Index of Multiple Deprivation Report]

Waikato DHB has a larger proportion of people living in areas of high deprivation than in areas of low deprivation. This will increase the number of chronic and complex health conditions and informs many of the activities being put in place to meet future health and wellbeing needs.

Many of the poor outcomes for the Waikato DHB's identified priority population groups are due to social and economic factors such as poor quality or unaffordable housing, and limited access to education and employment opportunities. Support for interventions associated with these factors and help to ensure equity of access to health care services are key strategic responses for the organisation.

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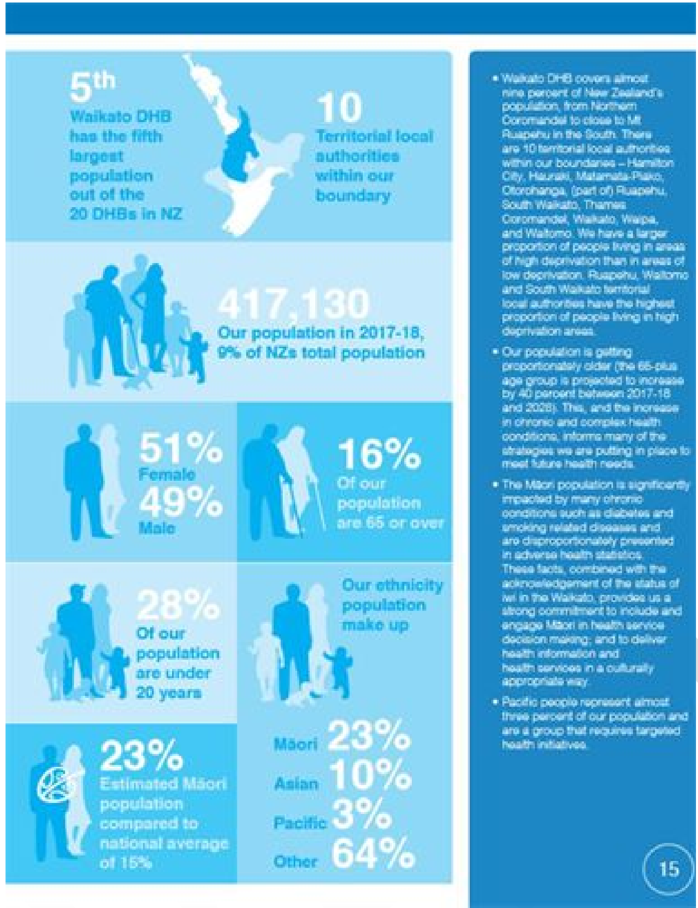

Figure Y: Waikato DHB profile summary

1.4 What Waikato DHB does

Waikato DHB provides public funding and provision of personal health services, public health services and disability support services for the district's geographically defined population. Funding is received from Government to undertake these functions. The amount of funding is determined by the size of the district's population, as well as the population's age, gender, ethnicity and socio-economic status characteristics. The organisation is both a funder and provider of health services.

The Waikato DHB provider division receives approximately 60 percent of the service funding with the remaining 40 percent being used to fund services including those provided by non-government organisations, primary care, pharmacy and laboratories.

The Ministry of Health also have a role in the planning and funding of some services. Some services are funded and contracted nationally, such as disability support services for people aged less than 65 years, public health services, and specific screening programmes.

1.5 How Waikato DHB does it

The Waikato DHB is socially responsible and upholds the ethical and quality standards commonly expected of providers of services and public sector organisations. It is responsible for monitoring and evaluating service delivery, including audits of the services it funds.

The costs of providing services to people living outside of our district are met by the DHB of the patient and are referred to as 'inter-district' services or Inter-District Flows. Likewise, where the organisation does not provide the service, it has funding arrangements in place enabling residents to travel outside the district for care. Waikato DHB also delivers against service delivery contracts with external funders, such as the Accident Compensation Corporation (ACC). The Waikato DHB closely monitors Inter-District Flows and ACC volumes to ensure its ability to provide for its own population is not adversely affected by demand from outside its district.

In 2018 Waikato DHB adopted a commissioning approach to achieve health equity outcomes (refer section 3.2.1). This entails enabling the delivery of effective and efficient health and community care services across the district. This approach begins with engagement related to identified strategic priorities, incorporates system-based co-design and joint planning, and is based upon contracting for outcomes which are monitored before a decision is taken to commission or de-commission a service(s).

This supports a move away from services designed by health for health to co-design of health services and community care to enable services to be more responsive to local community needs and health and wellbeing aspirations. This includes a shift in focus to prevention, and management of long term conditions and mental health in the community; and strong fiscal management, improved productivity and fiscal sustainability.

Waikato DHB Public Health provides service activities that help enable and support community based population health and wellbeing and equity improvement. Waikato DHB Strategy and Funding and Public Health are working together to improve integration of services to enhance community health and wellbeing outcomes.

As a large organisation within the health system, Waikato DHB has a leadership role in helping shift the system from an illness to a wellness model of care for consumers and whānau. It continues to improve how it works in partnership with Māori and other key partners within and outside of the health and disability system to deliver on agreed expectations and outcomes related to identified objectives and priorities. Waikato DHB is committed to doing this in an effective and fiscally responsible way to maximise effectiveness and health and equity outcomes for the people it serves.

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2 Te Tiriti o Waitangi

Te Tiriti o Waitangi is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. As noted previously, Waikato DHB recognises the significance of Te Tiriti o Waitangi and its impact on our approach to designing, developing and implementing health services.

The principles of kawanatanga (partnership), tino rangatirotanga (protection) and oritetanga (participation) implicitly recognise the important role the health sector plays in recognising the indigenous rights of tangata whenua to achieve radical improvements in health outcomes by eliminating health inequities.

2.1 Approach to achieving health gain and equity

Waikato DHB is committed to delivering on its strategic priority of achieving health equity for high-need populations. This is also an overarching priority for DHBs, highlighted in the Ministers 2019/20 Letter of Expectations.

Health inequalities are systematic, avoidable and unfair differences in mental or physical health between groups of people. These differences affect how long people live in good health. They are often a result of differences in people's homes, education and childhood experiences, their environments, their jobs and employment prospects, their access to good public services and their habits.

The draft Health System Plan supports this intent, and its implementation is underpinned by a commitment to health gain and equity for all communities across the district (see section 3).

2.2 Health gain and equity focus areas

There are significant opportunities for health gain and equity for Māori living in the district. Māori experience conditions that are likely to adversely impact on health at significantly greater rates than non-Māori (examples include: experiencing multiple socio-economic disadvantage , higher rates of unemployment, living in crowded conditions, and living in low income households). Life expectancy for Māori is lower than for non-Māori (by 7.5 years for females and 8.1 years for males). Amenable mortality rates are 2.6 time as high for Māori as for non-Māori.

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 as is Waikato DHB.

Ki te Taumata o Pae Ora is Waikato DHB's Māori health plan. It identifies key elements required to improve Maori health across the Waikato DHB district. The operative plan - Ki te Taumata o Pae Ora 2016-17 - is in the process of being updated and this work is being led by Te Puna Oranga. This plan will support the organisation's broader planning for Māori health gain and achieving health equity for Māori.

Work to achieve equity includes condition specific activity, but also includes actions to resolve inequities of access to and utilisation of health services across the health and disability system. We will achieve this through effective, whānau centred, universal services, as well as tailored or targeted interventions.

The high proportion of people living in rural areas is also associated with health inequities. People who live in rural areas have the highest incidence of malignancy, renal and respiratory disease, as well as the highest levels of amenable mortality. People living in rural areas are older, and have increasing health needs as they age. They also experience inequity in access to health services and care.

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

Key strategic themes have been embedded in the Statement of Intent, as well as a longer term approach within our draft Health System Plan (refer section 3). These include, but are not limited to:

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- Promoting screening services for priority populations to increase early detection of disease
- Implementing services that target communities with identified health inequalities;
- Setting targets by ethnicity and monitoring performance
- Supporting kaupapa Māori services and 'for Pacific by Pacific' services
- Increasing the capability and capacity of the Māori and Pacific workforce across the district
- Increasing cultural safety and competence, and workforce diversity to reflect the district's population profile
- Applying an equity lens as part of decision-making processes
- Engaging with community health forums, Consumer Council and expert advisory groups to provide and receive advice

Waikato DHB Public Health has significant expertise in understanding population health and wellbeing and equity. This unit is now integrated within the DHB Strategy and Funding and Public Health directorate to support the wider organisation's focus on prevention and equity improvement, particularly for Māori and other priority populations and communities.

3 National, regional and district strategic direction summary

The Waikato DHB's strategic intentions are guided by and aligned to those identified in key documents at national, regional and district levels as represented in figure y.

[Update figure y below to provide policy/plan summary]

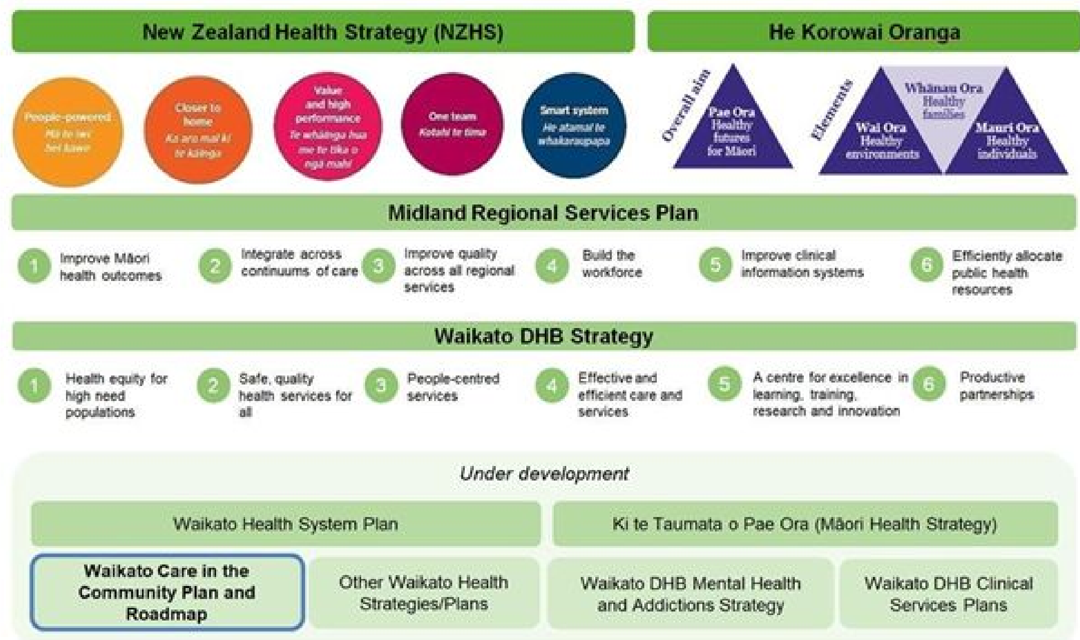

Figure z: Waikato DHB strategic direction summary

3.1 Strategic intentions

The Waikato DHB's strategic intentions and objectives for the next three years are guided by the Waikato DHB Strategy (2016) (see figure z) and draft Health System Plan (2019).

Figure z: Waikato DHB Strategy (2016) summary

3.1.1 The Health System Plan and its link to long term investment planning

Waikato DHB is developing a 10 year Waikato DHB Health System Plan to support implementation of the Waikato DHB Strategy (2016). It will identify the actions needed across the broader health and social system that will enable achievement of the outcomes described in the Waikato DHB Strategy. The draft Health System Plan encompasses a 'care in the community' focus with associated goals which align to actions needed to support Waikato DHB services and enablers. It will guide direction for future DHB services planning and implementation which will link through to hospital clinical service plans from different specialties and service strategies/plans.

The draft Health System Plan is made up of two key interdependent components which mirror our vision: 'Healthy people' and 'Excellent care' (refer figure x). This vision is in essence a high level representation of the Waikato DHBs strategic objectives. The

organisation intends to focus more effort and resource on the former as partnering with and empowering whānau to be well and stay well matters to them.

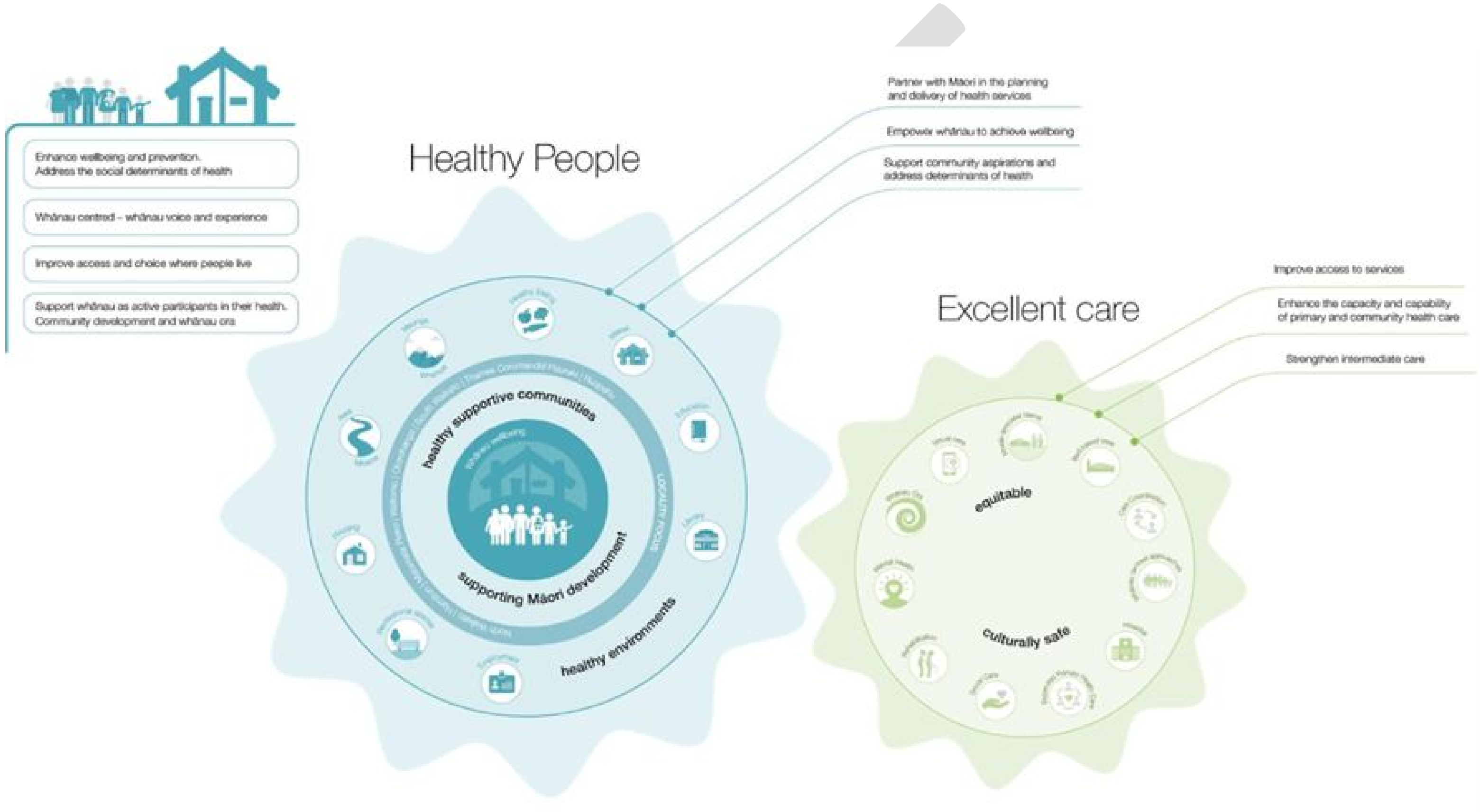

Figure X: Draft Waikato DHB Health System Plan key components and enablers: Healthy people and Excellent care

The draft Health System Plan goals under each Waikato DHB vision component include:
[Insert a figure representation of the following goals]

Draft goals –Healthy people
- Goal 1: Partner with Māori in the planning and delivery of health services
- Goal 2: Empower whānau to achieve wellbeing
- Goal 3: Support community aspirations and address determinants of health

Draft goals –Excellent care
- Goal 4: Improve access to services
- Goal 5: Enhance the capacity and capability of primary and community health care
- Goal 6: Strengthen intermediate care

We have identified the following key enablers which underpin the draft Health System Plan and are required for its successful implementation. These include:
- Commissioning
- Leadership and partnership
- Workforce development
- Technology and information; and
- Quality improvement

Work will occur over the next three years to determine what is required for each enabler in order to support delivery of the organisation's new strategic direction.

The Health System Plan will guide development of our Long Term Investment Plan (LTIP). The process to develop the 2019 and any subsequent LTIP would run in parallel to developing our hospital clinical services plans.

The next Waikato DHB LTIP is due in July 2019. Given the complexity of a LTIP and the process required to get to investment scenarios that are rational, supported by and aligned to the Health System Plan, it is proposed that the DHB takes a staged approach and focuses on a few key components for July 2019. The LTIP will include narrative the proposed phase(s) of its development.

3.1.2 Strategic objectives

The draft Health system plan goals have supported the identification of four agreed Waikato DHB strategic objectives for the draft Statement of Intent (see table x).

Objective	Associated draft Health System Plan goal(s)
1. Begin Implementation of the Health System Plan with a particular focus on community care and achievement of health equity for Māori.	All goals (Goals 1-3 in particular)
2. Reconfigure primary care across the district (linked to the draft Health System Plan).	Goals 4-5
3. Implement the new model of care for mental health and addictions services across the district.	All goals (Goals 1-4 in particular)
4. Strengthen action to demonstrate improved productivity and strong fiscal management across the organisation.	All goals

Figure x: Waikato DHB Strategic Objectives (2019/20-2021/22)

Health System Plan implementation will begin in 2019, subject to Waikato DHB Board approval of the final Health System Plan. Implementation will occur over a 10 year timeframe. To successfully achieve this new strategic direction over the short to medium term, the organisation and other health system partners will need to consider changes to how it funds services, to review the scope and nature of services provided and to shift the organisation's culture.

To support this broader implementation process, and to connect strategic intent with operational activity, Waikato DHB is developing a series of health focus area action plans during 2019/20-2020/21.

These action plans will describe how the organisation will implement each its new strategic direction (Health System Plan) by focus area and for associated priority population groups identified in the DHB Strategy. They will also identify the service development and innovation needed to support implementation of the Health System Plan. Each action plan is designed to coordinate, direct and oversee implementation of a set of related actions and activities in order to deliver on goals identified within the Health System Plan and our DHB Strategy imperatives.

Initial action plans prioritised for development and/or implementation in 2019/20 by Waikato DHB include:

- Te Pae Tawhiti/Mental Health and Wellbeing Plan,
- Tamariki Oranga/Child Health Plan, and
- A Disability Responsiveness Plan.

These plans will be delivered by locality and have a three to five year implementation timeframe although some may adopt an extended timeframe e.g. Te Pai Tawhiti (10 years).

The term 'locality' encompasses ideas of a community living within a geographic area, a physical place, or an administrative unit. Locality refers to place where people feel connected. This can be about place – a house, street, neighbourhood, the land, tūrangawaewae and a feeling of belonging and familiarity. It can be about links with history, family/whānau, communities of interest and relationships with people and involvement in different communities that make the place home. Localities are where people live, go to school, use services, are involved in community activity. People feel comfortable in and are familiar with their local areas.

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

The organisation has recognised the potential of locality as a way of thinking about health and social services design, development and delivery and as a means of supporting Health System Plan implementation. Since 2017/18, Waikato DHB has used the concept of locality as a tool to support health planning and reporting.

The Waikato DHB Board has identified and received regular reports on seven identified localities (see figure x). The decision to report by locality and consider planning by a locality lens is driven by the pragmatism of the district falling into roughly seven clusters of health services and facilities, and a concern over inequity in health outcomes between rural and urban populations.

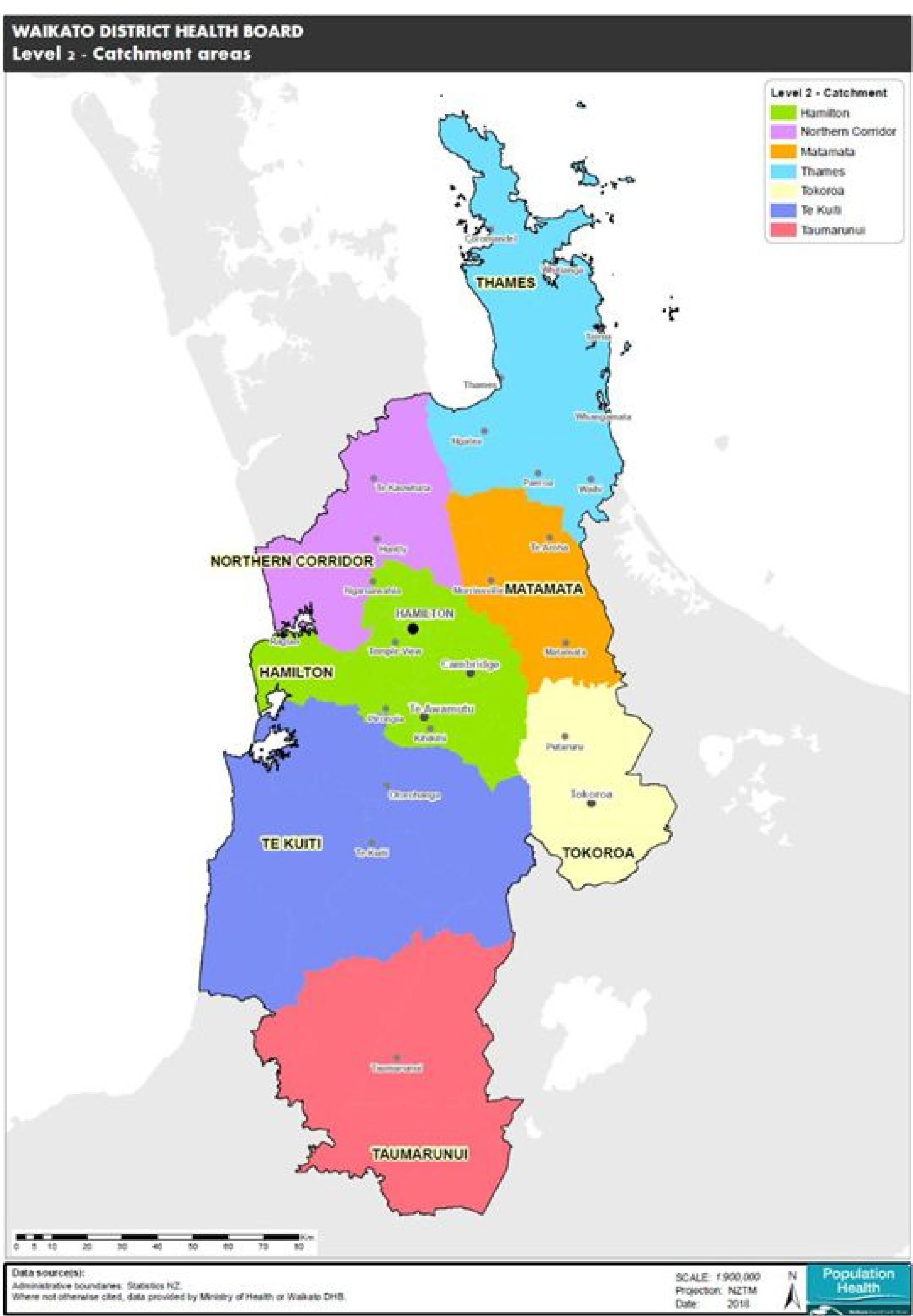

Figure x: Waikato DHB Localities (Level 2)

3.1.3 Monitoring performance against our strategic intentions

A Waikato DHB strategic outcomes framework will be developed and confirmed upon adoption of the Health System Plan in 2019. It will identify short term, medium term and long term outcomes for our organisation at district, regional and national levels. This framework

will be used by the organisation to monitor delivery of its identified strategic objectives. Progress measures will be assigned to each of the Health System Plan goals and strategy priorities, which will be reported on in Waikato DHB annual reports. The organisation will work alongside Midland DHBs to strengthen alignment of respective outcome frameworks at a regional scale to improve consistency.

3.2 Delivering on the strategic direction

As noted previously, four enablers identified in the draft Health System Plan will underpin how Waikato DHB delivers on its strategic direction. A key enabler is the move to commissioning of health and community care services.

3.2.1 Moving away from contracting towards commissioning

Despite district health boards being established with a structural purchaser/provider split, there has been recognition for some time that the adopted contracting and performance management approaches have done little to improve health outcomes, particularly for Māori and other disadvantaged communities.

Much of this can be attributed to the way services have been developed and performance managed. There has, in general, been a distinct lack of system thinking with respect to social determinants, and providers have been encouraged to deliver services strictly aligned to service contracts, which in effect, has stifled innovation. This has meant that opportunities for health improvement and service sustainability through innovation and better integration have not been exploited to the advantage of local populations.

There has been some significant learning from across New Zealand and the world in respect to effective commissioning approaches. In general the literature demonstrates that all successful models of commissioning should incorporate the following elements:

- Planning that is clearly linked to a population's health needs. This seems so simple, and yet so often the linkage between what is delivered to what is needed is tenuous. Unless a district health board fully understands what the needs (and the drivers of those needs) are, it has little chance of success in eliminating health inequalities amongst its most vulnerable communities.
- The planning and design of services should involve effective engagement of the public, service users and clinicians. From listening to communities about their particular needs through to co-designing services – a well-functioning system of commissioning should be inclusive and responsive to stakeholder perspectives.
- Services should cascade from a clear strategic direction. For Waikato DHB, this direction is best established within the Health System Plan, where health service and social service delivery intersect, and services are integrated in such a way to ensure people stay well in their community. Key priorities (such as radical Māori health improvement) are well embedded in this strategic direction setting.
- An embedded culture of collaboration and cooperation (e.g. alliancing) ensures providers from across the sector have a stake in and commitment to a future vision of sustainable and outcome focussed service delivery.
- Ensuring programmes of work are built on sound intervention logic enable robust monitoring and evaluation. In turn, this ensures the funder and the provider are working together to ensure the services provided are supported by continuous quality improvement to achieve the outcomes sought.

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- A robust commissioning approach will based on a partnership model with shared leadership and accountability, rather than a blunt and punitive contract management approach.

3.2.2 Commissioning approach

Waikato DHB's commissioning approach is founded on its commitment to working in partnership to improve population health and eliminate health inequities. Genuine partnership with consumers, communities, clinicians and providers is the goal in respect to developing services that maximise health gain.

The principles that guide our approach to commissioning are:

- *Equity for vulnerable populations:* a focus on reducing and if possible eliminating inequities in health.

- *Shared leadership:* all the actors in the local health system share leadership in achieving health gain for the population.

- *Accountability:* while each organisation has its own accountability mechanism, there will be shared accountability in Waikato for achieving health improvement.

-
- *Whole of system, end to end care:* commissioning of services will take into account the impact of any changes on the whole system of care. When commissioning new services or service changes, the principle will be to assess the improvement any service will bring to the end-to-end health experience of patients.

A number of commissioning models have been examined and as a result, Waikato DHB has developed the 'Commissioning Koru' (see figure z) in 2018 as its proposed approach for Waikato.

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Figure z: Waikato DHB Commissioning Koru –our equity-based approach to commissioning

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3.2.3 Moving beyond health care to healthy communities

The Waikato DHB's organisational intent is to shift more of its focus from health services and care, to healthy people and locality-based health care responses and action. These responses will see more collaboration with iwi and across health and social service organisations and local government to help improvement community health and wellbeing and to address barriers to achieving this.

While health care and treating ill health is important, Waikato DHB other health system partners, and the communities they serve recognise that there is a need to be proactive about factors that determine ill health, and to be enabled and empowered to take collective action on these health determinants by locality.

For example, environments that provide healthy food, enable healthy weight which supports protective behaviours for long term chronic conditions such as diabetes, cancer and heart disease. Waikato DHB will work alongside iwi and other partners including social services and Waikato Public Health to help change environments where consumers and whānau live, work, learn and play to support health and equity improvement. A further example is working on agreed actions with other sectors to support improved housing quality and affordability for better health and equity outcomes.

3.3 Organisational health and capability

Our Waikato DHB Strategy (2016) identifies the change needed in how the organisation works and supports its staff to "enable us all to manage our health and wellbeing, and provide excellent care through smarter, innovative delivery." The intent of the Waikato DHB's Our People Strategy (2019) is to turn the organisational strategy inwards and identify initiatives that will empower our staff to achieve the organisation's vision.

It was developed through a process of co-design with organisational leaders and Human Resources. It outlines the organisation's key priorities that will help strengthen our organisational health and capability (see figure z)

Figure Z: Waikato DHB People Strategy priorities summary

To achieve the aspirations of Waikato DHB communities and consumers, the organisation must focus internally on all employees. The Waikato DHB Strategy provides direction and sets intent for the Our People Strategy. This is represented in figure a.

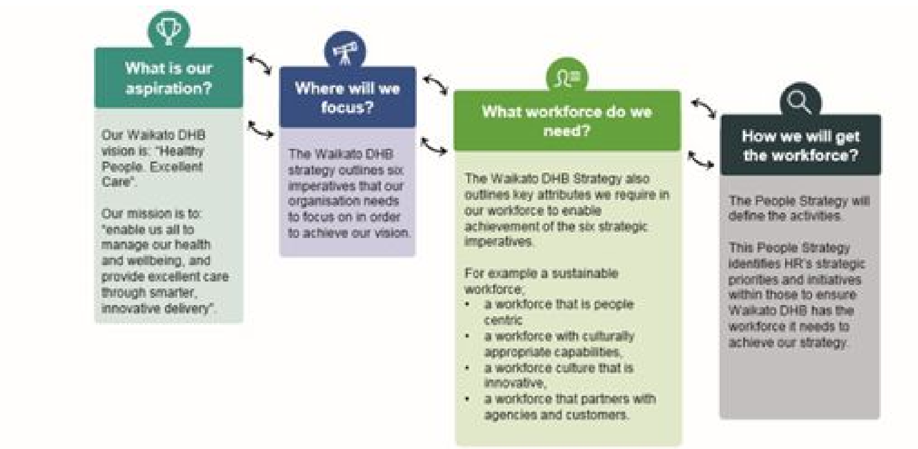

Figure a: Waikato DHB People Strategy goal, focus areas and sustainable workforce summary

The strategic direction of the Our People Strategy has been developed to support the delivery of the broader Waikato DHB Strategy. It lays out the approach that will be adopted to create a contemporary Human Resources and organisational development service for the organisation. For example, there is an identified gap in the field of organisational development which the organisation will address in part through the development of systems such as the pending introduction of the Human Resource Information System.

4 Statement of performance expectations

4.1 Introduction

Refer to Appendix A of the draft 2019/20 Annual Plan for the Waikato DHB Statement of Performance Expectations.

5 Managing assets

5.1 Introduction

[Draft narrative still to come]

6 Appendices

[Section to be updated once draft plan has been completed]

- Glossary of Terms
- Output Class Definitions
- Output Class Revenue and Expenditure
- Output Measure Rationale
- Services funded but not provided by the DHB
- Accounting Policies

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6.1 Glossary of Terms

[Draft narrative still to be updated]

Term	Description
Alliance Leadership Teams	The purpose of the Alliance Leadership Teams is to lead and guide our Alliances (with our primary care partners – Midlands Health Network, the National Hauora Coalition and Hauraki PHO) as they improve health outcomes for our population.
Catalyst Programme	This is a structured programme using lean methodologies to reduce cost through reducing waste and minimising variation. The approach is to use in-depth reviews which will include process review and benchmarking to identify opportunities and enable evidence based decision making for changes.
Crown Entity	A generic term for a diverse range of entities within 1 of the 5 categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
HealthShare	A regional shared services agency jointly owned by Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato DHBs.
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. For example, the change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989).
Impact measures	Impact measures are attributed to agency (DHBs) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can be measured after delivery, promoting timely decisions; reveal specific ways in which managers can remedy performance shortfalls.
Initiatives / activities and actions	What we do with our inputs to create outputs, impacts and other deliverables.
Input	The resources such as labour, materials, money, people, information technology used by departments to produce outputs that will achieve the stated outcomes.
Intervention	An initiative, action or activity intended to enhance outcomes or otherwise benefit an agency or group.
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes.
Map of Medicine	Is an electronic platform providing evidence-based clinical pathways to the health workforce which connect all the knowledge and services around a clinical condition.
Measure / indicator	A measure identifies the focus for measurement: it specifies what is to be measured.
NCHIP	National Child Health Information Programme – records and monitors children's health milestones from birth to 18 years
Objectives	Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve "outputs". E.g. Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving relationships; improving Governance…etc. are 'internal to the organisation and enable the achievement of 'outputs'.
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used

Term	Description
	more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. (Refer http://www.ssc.govt.nz/glossary/) A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).
Output classes	Are an aggregation of outputs. (Public Finance Act 1989). Outputs can be grouped if they are of a similar nature.
Outputs	Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).
Ownership	The Crown's core interests as 'owner' can be thought of as: Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown; Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future; Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively. (Refer http://www.ssc.govt.nz/glossary/).
Primary Health Organisation	Primary health organisations are funded by DHBs to support the provision of essential primary health care services through general practices to those people who are enrolled with the primary health organisations.
Priorities	Statements of medium term policy priorities.
Project Aroha	"Brand name" for a number of initiatives being run out through Te Puna Oranga (Māori Health Service) which focuses on smoke free whānau, breast feeding, immunisation, violence free and reducing Māori sudden unexplained death in infants rates
Project Energize	Project Energize is a project for Waikato primary schools to focus on children's physical activity and nutrition, to improve their overall health.
Regional collaboration	Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Our region is: Midland: Bay of Plenty DHB, Lakes DHB, Tairawhiti District Health, Taranaki DHB, Waikato DHB, Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network includes Taranaki DHB in addition to the Central Region DHBs.
Statement of Performance Expectations	Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. (http://www.ssc.govt.nz/glossary/)
Strategy	See Ownership. (http://www.ssc.govt.nz/glossary/)
Sub regional collaboration	Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalized with an agreement e.g. Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (centralAlliance) and Canterbury and West Coast DHBs.
Targets	Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.

6.2 Output Class Definitions

[Draft narrative still to be updated]

Prevention

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

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

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

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

Early Detection and Management

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

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Intensive Assessment and Treatment Services

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

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

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

Rehabilitation and Support

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

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

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6.3 Output Class Revenue and Expenditure

[Draft narrative still to be updated]

Total Cost and Revenue	**2015/16** **$000** **Budget**	**2016/17** **$000** **Budget**	**2017/18** **$000** **Budget**	**2018/19** **$000** **Budget**
Revenue	1,291,109	1,321,395	1,351,096	1,381,079
Costs	1,288,882	1,318,940	1,348,695	1,378,711
Surplus / (deficit)	2,227	2,455	2,401	2,368

Prevention

Forecast Statement of Cost and Revenue for Prevention	**2015/16** **$000** **Budget**	**2016/17** **$000** **Budget**	**2017/18** **$000** **Budget**	**2018/19** **$000** **Budget**
Revenue	29,289	29,976	30,650	31,330
Costs	23,253	23,795	24,332	24,873
Surplus / (deficit)	6,036	6,181	6,318	6,457

Early Detection and Management

Forecast Statement of Cost and Revenue for Early Detection and Management	**2015/16** **$000** **Budget**	**2016/17** **$000** **Budget**	**2017/18** **$000** **Budget**	**2018/19** **$000** **Budget**
Revenue	248,290	254,114	259,826	265,592
Costs	232,419	237,840	243,205	248,618
Surplus / (deficit)	15,870	16,274	16,620	16,974

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Intensive Assessment and Treatment

Forecast Statement of Cost and Revenue for Intensive Assessment and Treatment	2015/16 $000 Budget	2016/17 $000 Budget	2017/18 $000 Budget	2018/19 $000 Budget
Revenue	875,408	895,943	916,081	936,410
Costs	899,735	920,718	941,489	962,443
Surplus / (deficit)	(24,327)	(24,775)	(25,408)	(26,032)

Rehabilitation and Support

Forecast Statement of Cost and Revenue for Rehabilitation and Support	2015/16 $000 Budget	2016/17 $000 Budget	2017/18 $000 Budget	2018/19 $000 Budget
Revenue	138,122	141,362	144,539	147,747
Costs	133,474	136,587	139,668	142,777
Surplus / (deficit)	4,648	4,775	4,871	4,970

The output class financial reporting for 2015/16 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code (purchase unit code mapping to output class as per data dictionary version 20). The out years are based on the same cost and revenue ratios being applied to total cost and revenue.

6.4 Output Measure Rationale

[Draft narrative still to be updated]

Measure	Rationale	Output class / Category	Dimension of Performance
Percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt	Prevention Services / Health Promotion and Education	Quantity
Percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking	Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt	Prevention Services / Health Promotion and Education	Quantity
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice	Pregnancy is a period during which women are motivated to quit smoking, and evidence-based tobacco cessation programmes can significantly increase the likelihood of this. Reducing smoking in pregnancy would be well supported by New	Prevention Services / Health Promotion and Education	Quantity

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Measure	Rationale	Output class / Category	Dimension of Performance
and support to quit	Zealanders, is easy to understand and leads to significant positive outcomes across the whole of life span		
Percentage of eight month olds fully immunised	Immunisation can protect against harmful infections, which can cause serious complications, including death. It is one of the most effective, and cost-effective medical interventions to prevent disease	Prevention Services / Immunisation / Well Child	Quantity / Timeliness
Percentage of two year olds fully immunised			
Percentage of girls receiving the HPV dose three			
Seasonal influenza immunisation rates in the eligible population (65 years and over)		Prevention Services / Immunisation	Quantity
Percentage of infants exclusive or fully breast feed at lead maternity carer discharge and three months	Breastfeeding is the unequalled way of providing ideal food for the healthy growth and development of infants and toddlers. This measure supports the sector to get ahead of the chronic disease burden.	Prevention Services / Health Promotion and Education	Quantity / Timeliness
Percentage of infants receiving breast milk at six months			
The number of people participating in Green Prescription programmes	Research published in the New Zealand Medical Green Prescription is an inexpensive way of increasing activity. Research published in the British Medical Journal found that a Green Prescription can improve a patient's quality of life over 12 months, with no evidence of adverse effects. Research published in the British Medical Journal on the cost-effectiveness of physical activity in primary care stated that 'community walking, exercise and nutrition, and brief advice with exercise on prescription (Green Prescription) were the most cost-effective with respect to cost-utility.'	Early Detection and Management Services / Primary Healthcare	Quantity
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	Through Project Energize we can positively influence health behaviours in childhood, adolescence and adulthood. This can reduce the risk of many chronic conditions like cardiovascular disease and diabetes.	Prevention Services / Health Promotion and Education	Quantity
Percentage of total primary schools participating in Project Energize			
Percentage of children under five years of age (i.e. aged 0 – 4 years of age inclusive) who are enrolled with DHB-funded oral health services	Research shows that improving oral health in childhood and adolescence has benefits over a lifetime.	Early Detection and Management Services / Oral Health	Quantity
Percentage of pre-school and primary school children (0 – 12 years) who are overdue for their planned recall period			
Percentage of adolescents accessing DHB funded oral health services			
Percentage of people who are enrolled with a primary health organisation and have had their cardiovascular risk assessed in the last five years	By increasing the percentage of people being checked for long-term conditions ensures these are identified early and managed appropriately, and aid in the promotion and protection of good health and independence.	Early Detection and Management Services / Primary Healthcare	Quantity
Percentage of eligible women (20-69) have a cervical cancer screen every 3 years	Cervical cancer is one of the most preventable of all cancers. Having regular cervical smears can reduce a woman's risk of developing cervical cancer by 90 percent	Prevention Services / Population Based Screening	Quantity
Percentage of eligible women (50-69) have a breast screen in the last 3 years	Breast screening is a proven way for finding breast cancers early to reduce the risk of dying of breast cancer	Prevention Services / Population Based Screening	Quantity
Percentage of Rest Home residents receiving vitamin D supplement from	Vitamin D supplementation has been demonstrated to improve mineral bone density and reduce falls.	Prevention Services / Health Promotion and	Quantity

Measure	Rationale	Output class / Category	Dimension of Performance
their GP		Education	
Percentage of eligible children have their B4 School Checks completed	A nationwide programme offering a health and development check for four year olds	Prevention Services / Well Child	Quantity
Acute rheumatic fever initial hospitalisation rate and number	Rheumatic fever arises as a result of a throat infection with Group A Streptococcal bacteria. It predominantly affects children between 5 and 14 years of age. In New Zealand, evidence points to poorer housing conditions (especially overcrowding) and general social deprivation as risk factors for rheumatic fever.	Prevention Services / Well Child	Quantity
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan	More consistent and comprehensive assessment of the older person which enables determination of service capacity and service planning information	Rehabilitation and Support Services / Needs Assessment and Service Coordination	Quantity
Percentage of population enrolled with a primary health organisation	Advantages of enrolling are that your visits to the Doctor will be cheaper and you will have direct access to a range of services linked to the PHO.	Early Detection and Management Services / Primary Healthcare	Quantity
Needs assessment and service co-ordination waiting times for new assessments within 20 working days	Monitor the responsiveness and timeliness to NASC to service demand	Rehabilitation and Support Services / Age Related Residential Care Services	Quantity / Timeliness
Acute re-admission rate	Unplanned readmissions will usually present to emergency departments, and may result in admission to hospital for further treatment. This puts pressure on emergency departments and inpatient hospital capacity, efficiency and productivity. An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services.	Intensive Assessment and Treatment Services / Acute Services	Quality
Percentage of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	Specialist cancer treatment and symptom control is essential in reducing the impact of cancer	Intensive Assessment and Treatment Services / Elective Services and Acute Services	Quantity / Timeliness
Percentage of patients who require radiation or chemotherapy are treated with 4 weeks			Quantity
Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	The longer-term aim is to reduce the risks associated with an unnecessary Caesarean section, reduce the number of women at risk of a subsequent Caesarean section and reduce the number of women who experience difficulties with their second and subsequent births as a consequence of a primary Caesarean section.	Intensive Assessment and Treatment Services / Elective Services	Quantity

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Measure	Rationale	Output class / Category	Dimension of Performance
Percentage of patients waiting longer than four months for their first specialist assessment	Patients have a much better chance of recovering and getting on with their lives where they are diagnosed and treated and returned home in a timely way.	Intensive Assessment and Treatment Services / Elective Services	Quantity / Timeliness
Improved access to elective surgery, health target, agreed discharge volumes	Elective surgery reduces pain or discomfort, and improves independence and wellbeing. Increasing delivery should will improve access and reduce waiting times.	Intensive Assessment and Treatment Services / Elective Services	Quantity
Did-not-attend percentage for outpatient services	Reducing did not attends is a key objective in terms of removing waste in the system	Intensive Assessment and Treatment Services / Elective Services and Acute Services	Quantity
Inpatient Average Length of Stay (elective and acute)	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, we will positively impact hospital productivity through freeing up beds and other resources so it can provide more elective surgery, reduce waiting times in the emergency department or make savings. Supporting patients to return home sooner may, in part, be achieved by reducing the rate of patient complications and better use of the time clinical staff spend with patients. Patients will also be less at risk of contracting nosocomial infections.	Intensive Assessment and Treatment Services / Elective Services and Acute Services	Quality
Percentage of young people aged 0 - 19 referred for non-urgent mental health services are seen within three weeks or eight weeks	Access and shorter waits are very important to patients. Earlier treatment in the progression of illness links to better outcomes as evidenced in international literature. Timeliness is also a key quality indicator in calls for improvement to the health care system.	Intensive Assessment and Treatment Services / Specialist Mental Health and Addiction Services	Timeliness / Quality
Percentage of child and youth with a transition (discharge) plan	Maintaining and improving patient engagement through the use of transition/discharge plans will ensure that services are patient-centred and responsive, supporting patients' trust and confidence in services and the health and disability system. People that are better able to better manage their own health condition represent value for money because of the proven reduction in the demand for mental health services.	Intensive Assessment and Treatment Services / Specialist Mental Health and Addiction Services	Quantity / Timeliness
Rates of post-discharge community care	A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. Service users leaving hospital after an admission with a formal discharge plan involving linkages with community services and supports are less likely to need early readmission. Research indicates that service users have increased vulnerability immediately following discharge, including higher risk for suicide.	Intensive Assessment and Treatment Services / Specialist Mental Health and Addiction Services	Quality
Number of first attendances at the Waikato DHB hospital palliative care outpatient service	It is important that people who have life threatening illness, along with their family and whānau, receive appropriate care and support to cope with their situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering.	Rehabilitation and Support Services / Palliative Care Services	Quantity
Improved wait times for diagnostic services	Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of	Intensive Assessment and Treatment	Quantity / Timeliness

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Measure	Rationale	Output class / Category	Dimension of Performance
	care and improve DHB demand and capacity management.	Services / Elective Services	
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	Timely turnaround of tests support clinical diagnosis and enable early intervention and treatment.	Early Detection and Management Services / Community Testing and Diagnosis	Quantity
Total number of pharmaceutical items dispensed in the community	Pharmaceuticals are an important resource in improving health outcomes.	Early Detection and Management Services / Pharmacy Services	Quantity

6.5 Services Funded but not provided by the DHB

[Draft narrative still to be updated]

Table: DHB funded services provided by other organisations

Personal Health Services	
Pharmaceuticals	• Subsidised pharmaceuticals dispensed by 80 pharmacies across our district.
Community Laboratories	• One private laboratory located in Hamilton undertaking all the testing, 38 collection sites (12 in Hamilton two in Huntly and two in Cambridge and one in every other town).
PHOs and GP services	• Three PHOs with approximately 80 general practices.
Medical / surgical inpatient and outpatient services and primary care inpatient services	• Included within this service area are arrangements with a private provider called USL for urology services, as well as with hospitals outside our district, and a number of smaller outpatient based agreements and primary care inpatient beds in six rural facilities.
Māori health	• Includes a range of community based services including whānau ora, healthy hapu, koroua and kuia services, and mobile Māori disease state management positions delivered by Māori providers.
Other personal health	• Range of services biggest spends are in the areas of: • dental • NGO maternity facilities • Project Energize • travel and accommodation • palliative care • haemophilia

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	• primary care inpatient services • arthritis services.
Mental Health and Addiction Services	
Inpatient and residential service	• Includes 15 forensic inpatient beds purchased from Hauora Waikato and residential services funded on a fee for services basis.
Community and other service	• Included in this category are approximately 300 full time equivalent community based (mental health and/or alcohol and other drug) positions, together with residential services for mental health and addictions (including youth) funded on a capacity basis.
Health Of Older People Services	
Residential	• Included in this category is expenditure on hospital level, dementia and rest home services provided at 57 facilities ranging in size.
Other Services	• Included within this category are a range of community based and respite services including transitional care, day programmes, needs assessment and service co-ordination, home support and household management, respite and carer support services; as well as disability specific services such as orthotic services, disability information and rural stroke field worker services.

6.6 Notes to the Financial Statements

6.6.1 Significant accounting policies

[Draft narrative still to be updated]

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 in New Zealand.

Waikato DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

The group financial statements of Waikato DHB for the year ended 30 June 2013 include a controlled subsidiary, Waikato Health Trust, Waikato DHB’s interest in an associate (Urology Services Limited) and Waikato DHB’s interest in a jointly controlled entity (HealthShare Limited). Waikato DHB's interest in its associate and joint venture are equity accounted. These companies are incorporated and domiciled in New Zealand.

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Waikato DHB's activities are the purchasing and the delivering of health, disability services, and mental health services to the community within its district. Waikato DHB is a Public Benefit Entity, as defined under New Zealand International Accounting Standard (NZIAS) 1.

Statement of compliance

The financial statements have been prepared in accordance with the New Zealand Public Health and Disability Act 2000, the Crown Entities Act 2004, and Generally Accepted Accounting Practice in New Zealand (NZGAAP).

These financial statements have been prepared in accordance with, and comply with, the May 2013 iteration of the Tier 1 PBE accounting standards.

Basis of preparation

The financial statements have been presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land, buildings, and forward foreign exchange contracts at fair value.

Non-current assets held for sale are stated at the lower of carrying amount and fair value less costs to sell.

The preparation of financial statements under NZIFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets, liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Judgements made by management under NZIFRS that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 30.

Changes in accounting policies

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There have been no changes in accounting policies during the financial year.

Associates

Associates are those entities in which Waikato DHB has significant influence, but not control, over the financial and operating policies.

The 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. When Waikato DHB's share of losses exceeds its interest in an associate, Waikato DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Waikato DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Joint ventures

Joint ventures are those entities over whose activities Waikato DHB has joint control, established by contractual agreement. The financial statements include Waikato DHB's interest in joint ventures, using the equity method, from the date that joint control begins until the date that joint control ceases.

Transactions eliminated on consolidation

Unrealised gains arising from transactions with associates and joint ventures are eliminated to the extent of Waikato DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of comprehensive income.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at the foreign exchange rate ruling at the date the fair value was determined.

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Budget figures

The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable financial reporting standards as appropriate for Public Benefit Entities. Those standards are consistent with the accounting policies adopted by Waikato DHB for the preparation of these financial statements.

Financial instruments

Non-derivative financial instruments

Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest-bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments not at fair value through the statement of comprehensive income are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.

A non-derivative financial instrument is recognised if the Waikato DHB becomes a party to the contractual provisions of the instrument, and derecognised if the Waikato DHB's contractual rights to the cash flows from the financial assets expire or transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Purchases and sales of financial assets are accounted for at trade date, i.e. the date that the Waikato DHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if the Waikato DHB's obligations specified in the contract expire or are discharged or cancelled.

Cash and cash equivalents comprise cash balances and call deposits with maturity of no more than three months from the date of acquisition. Bank overdrafts repayable on demand are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Accounting for finance income and expense is explained in a separate note.

Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.

Derivative financial instruments

Derivative financial instruments comprise of foreign exchange and interest rate swap contracts to hedge exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities. Derivative financial instruments that do not qualify for hedge accounting are accounted for as trading instruments.

Derivative financial instruments are recognised initially at fair value and subsequent to initial recognition are stated at fair value. The gain or loss on remeasurement to fair value is recognised immediately in the statement of comprehensive income. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

The fair value of interest rate swaps is the estimated amount received or paid to terminate the swap at the balance date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of foreign exchange contracts is their quoted market price at the balance date, being the present value of the quoted forward price.

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Instruments at fair value through the statement of comprehensive income

An instrument is measured as at fair value through the statement of comprehensive income if it is held for trading or is designated as such upon initial recognition. Instruments are measured at fair value through the statement of comprehensive income. Upon initial recognition, attributable transaction costs are recognised in the statement of comprehensive income when incurred. Subsequent to initial recognition, changes to the fair value of financial instruments are recognised in the statement of comprehensive income.

Investments in equity securities

Investments in equity securities are classified as available-for-sale, except for investments in equity securities of subsidiaries, associates and joint ventures which are measured at cost.

The fair value of equity investments classified as available-for-sale is their quoted bid price at the balance date.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Trade and other payables

Trade and other payables are stated at amortised cost using the effective interest rate. Creditors and payables are non-interest bearing and normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their fair value.

Hedging

Cash flow hedges

Where a derivative financial instrument is designated as a hedge of the variability in cash flows of a recognised asset or liability, or a highly probable forecast transaction, the effective part of any gain or loss on the derivative financial instrument is recognised directly in equity. When the forecast transaction subsequently results in the recognition of a non-financial asset or liability, or the forecast transaction becomes a firm commitment, the associated cumulative gain or loss is removed from equity and included in the initial cost or other carrying amount of the non-financial asset or liability. If a hedge of a forecast transaction subsequently results in the recognition of a financial asset or liability, the associated gains and losses that were recognised directly in equity are reclassified into the statement of comprehensive income in the same period or periods during which the asset acquired or liability assumed affects the statement of comprehensive income (i.e. when interest income or expense is recognised). For cash flow hedges, other than those covered by the preceding two policy statements, the associated cumulative gain or loss is removed from equity and recognised in the statement of comprehensive income in the same period or periods during which the hedged forecast transaction affects the statement of comprehensive income. The ineffective part of any gain or loss is recognised immediately in the statement of comprehensive income.

When a hedging instrument expires or is sold, terminated or exercised, or the entity revokes designation of the hedge relationship but the hedged forecast transaction is still expected to occur, the cumulative gain or loss at that point remains in equity and is recognised in accordance with the above policy when the transaction occurs. If the hedged transaction is no longer expected to take place, the cumulative unrealised gain or loss recognised in equity is recognised immediately in the statement of comprehensive income.

Hedge of monetary assets and liabilities

Where a derivative financial instrument is used to hedge the foreign exchange exposure of a recognised monetary asset or liability, no hedge accounting is applied and any gain or loss on the hedging instrument is recognised in the statement of comprehensive income.

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

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- Freehold land
- Freehold buildings
- Plant, equipment and vehicles
- Work in progress.

Owned assets

Except for land and buildings and the assets vested from the Hospital and Health Service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, any costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amounts are not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive income. Any decrease in value relating to a class of land and buildings is debited directly to the revaluation reserve, to the extent that it reverses previous surpluses and is otherwise recognised as an expense in the statement of comprehensive income.

Additions to property, plant and equipment between valuations are recorded at cost.

Property that is being constructed or developed for future use as investment property is classified as property, plant and equipment and stated at cost until construction or development is complete, at which time it is reclassified as investment property.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, Plant and Equipment Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Health Waikato Limited (a Hospital and Health Service company) vested in Waikato DHB on 1 January 2001. The assets were transferred to Waikato DHB at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Waikato DHB has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of Property, Plant and Equipment

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Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive income is calculated as the difference between the net sales price and the carrying amount of the asset.

Leased assets

Leases where Waikato DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

Property, plant and equipment held under finance leases and leased out under operating leases are classified as investment property and stated at fair value. Property, plant and equipment leased under operating leases that would otherwise meet the definition of investment property may be classified as investment property on a property-by-property basis.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Waikato DHB. All other costs are recognised in the statement of comprehensive income as an expense incurred.

Depreciation

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

Class of asset	Estimated life	Depreciation rate
Buildings		
Structure	3 to 78 years	1-33percent
Fit out	2 to 71 years	1-50percent
Plant and equipment	2 to 20 years	5-50percent

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The residual value of assets is reassessed annually. Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion, and then depreciated.

Intangible assets

Research and development

Expenditure on research activities, undertaken with the prospect of gaining new scientific or technical knowledge and understanding, is recognised in the statement of comprehensive income as an expense incurred. Expenditure on development activities, whereby research findings are applied to a plan or design for the production of new or substantially improved products and processes, is capitalised if the product or process is technically and operationally feasible and Waikato DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour, and an appropriate proportion of overheads. Other development expenditure is recognised in the statement of comprehensive income as an expense incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Other intangibles

Other intangible assets acquired by Waikato DHB are stated at cost less accumulated amortisation and impairment losses.

Subsequent costs

Subsequent costs on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is recognised in the statement of comprehensive income as an expense incurred.

Amortisation

Amortisation is charged to the statement of comprehensive income on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
Software	1 to 10 years	10 – 100percent

Inventories

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Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cost is based on weighted average cost. Work in progress includes the cost of direct materials, direct labour and an appropriate share of overheads.

Inventories held for distribution

Inventories held for distribution are stated at the lower of cost and current replacement cost.

Impairment

The carrying amounts of assets other than investment property, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of comprehensive income.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance date.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive income is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of comprehensive income.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered

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significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

The estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit, value in use is based on depreciated replacement cost. For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of comprehensive income.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

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Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of comprehensive income over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive income as incurred.

Defined benefit plan

The net obligation in respect of defined benefit pension plans is calculated separately for each plan by estimating the amount of future benefit that employees have earned in return for their service in the current and prior periods; that benefit is discounted to determine its present value, and the fair value of any planned assets is deducted. The discount rate is the yield at the balance date on New Zealand government bonds that have maturity dates approximating to the terms of the obligations. The calculation is performed by a qualified actuary using the projected unit credit method. All actuarial gains and losses are recognised in the statement of comprehensive income.

Where the defined benefit scheme is a multi-employer scheme with insufficient information to use defined benefit accounting then defined contribution accounting will be used.

Long service leave, sabbatical leave and retirement gratuities

The net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance date.

Annual leave, sick leave and continuing medical education leave

Annual leave, sick leave and continuing medical education leave are short-term obligations and are calculated on an actual basis at the amount expected to pay. The obligation is accrued for paid absences when the obligation relates to employees' past services and accumulates.

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Other Liabilities

Provisions

A provision is recognised when there is a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

ACC Partnership Programme

The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of two years and up to a specified maximum amount. At the end of the two year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

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

Income tax

Waikato DHB is exempt from income tax under section CB3 of the Income Tax Act 2007.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Crown funding

The majority of revenue is via a Crown Funding Agreement between Ministry of Health (MoH) and Waikato DHB. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the revenue equally throughout the year.

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Revenue and expenses relating to service contracts

Waikato DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Waikato DHB, with the agreement of Ministry of Health, may be required to expend it on specific services in subsequent years.

Goods sold and services rendered

Revenue from goods sold is recognised when the significant risks and rewards of ownership of the goods has been transferred and where there is either no continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold. Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow and the payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied.

Rental income

Rental income from investment property is recognised in the statement of comprehensive income on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Expenses

Operating lease payments

Payments made under operating leases are recognised in the statement of comprehensive income on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of comprehensive income over the lease term as an integral part of the total lease expense.

Finance lease payments

Lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis. The interest expense component of finance lease payments is recognised in the statement of comprehensive income using the effective interest rate method.

Financing costs

Financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, and gains and losses on hedging instruments that are recognised in the statement of comprehensive income.

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Non-current assets held for sale and discontinued operations

Immediately before classification as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable NZIFRS. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

Impairment losses on initial classification as held for sale are included in the statement of comprehensive income, even when the asset was previously revalued. The same applies to gains and losses on subsequent remeasurement.

A discontinued operation is a component of the business that represents a separate major line of business or geographical area of operations.

Classification as a discontinued operation occurs upon disposal or when the operation meets the criteria to be classified as held for sale, if earlier.

Business combinations involving entities under common control

A business combination involving entities or businesses under common control is a business combination in which all of the combining entities or businesses are ultimately controlled by the same party or parties both before and after the business combination, and that control is not transitory.

The book value measurement method is applied to all common control transactions.

Standards not early adopted

The following standards have not been early adopted.

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year end 30 June 2016. However, as a new

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Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

New standards issued and not yet effective and not yet adopted

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. Waikato DHB will apply these updated standards in preparing its 30 June 2016 financial statements. Waikato DHB expects there will be minimal or no change in applying these updated accounting standards.

Cost of Service Reports

The cost of service statements represents the cost of providing the outputs less the revenue.

Cost Allocation

The net cost of service for each significant activity is arrived at using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Criteria for Direct and Indirect Costs

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

Cost Drivers for Allocation of Indirect Costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

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MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 11.4

HEALTH SYSTEM PLAN – GOALS, ACTIONS AND ACTIVITIES

Purpose	For approval.

Background

The Health System Plan (HSP) sets a direction and focus for the whole sector that will enable the strategic imperatives of the DHB's strategy *Healthy People Excellent Care* to be achieved. This direction guides specific service and planning initiatives, priorities and decisions for investment and disinvestment.

The intent of *Healthy People Excellent Care* is to shift the health system focus from specialist services to the community. Specialist services are vital and will continue to be funded to provide safe and high quality care, but we need a greater focus on preventing people becoming ill, intervening earlier when people do get ill, treating people in the community and for those with complex needs; helping them to recover, manage their illness and live independently in their communities.

The draft goals, actions and activities for the Health System Plan (HSP) have been developed through an engagement process including consumers, community members, providers and other stakeholders. The process commenced with a focus on the Care in the Community Plan, where Māori, consumers and stakeholders gave us their broad perspectives and experiences with the health system as a whole, not confining their views to community services. People do not differentiate the system in the way people within the health system do (e.g. primary, secondary, rehabilitation etc) – they see health as a single system and want it to operate as one system. Thus, we have moved our focus to the HSP, and have used the Care in the Community content to inform the HSP and to provide a vision for the whole system. The engagement process included opportunities for the Board, Iwi Māori Council (IMC) and Consumer Council to contribute.

This paper seeks Board approval of the goals, actions and activities which will form a substantive part of the (draft) HSP document.

The draft HSP goals, actions and activities are attached as Appendix 1.

Next steps

The consultation on the HSP will commence in April for four weeks. Subject to the consultation feedback, approval of the HSP will be sought from the Board in June.

Recommendation
THAT

The Board approves the goals, actions, activities and enablers for the draft Health System Plan to be consulted on from April 2019.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Appendix 1

Health System Plan – Draft Goals, Actions, Activities and Enablers

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Goal 1: Partner with Māori in the planning and delivery of health services

The DHB and providers will have collaborative partnership arrangements with Māori. This goal underpins all the actions of the Health System Plan.

This will mean:
- *Māori are partners in the planning, delivery, monitoring, evaluation and improvement of health and social services across the Waikato*
- *All planning processes in the Waikato health system will give effect to He Korowai Oranga, and its goal of Pae Ora - healthy individuals, healthy families and healthy environments*
- *Partnerships operate at multiple levels of the system as well as across organisations. Partnerships will enable Māori to participate in all the multiple levels so that the perspectives of Māori consumers and Iwi can be prioritised.*
- *Quality data will enable differences in equity for Māori to be measured, and used as improvement indicators across multiple levels of the system, and to be shared widely including with the public, providers and practitioners.*
- *Tikanga Māori is normalised in the Waikato health system, and underpins the way we work*

Goal 1 Actions

1.1. DHB takes a lead by example approach to working in partnership with Māori

Rationale:
- The DHB as a Crown agent has a responsibility to uphold and protect Te Tiriti o Waitangi, this includes working in partnership with Māori.
- The DHB as the commissioner of health services and provider of hospital services has to reflect its responsibilities through the services it provides as well as through the providers it commissions
- The DHB can lead by example with respect to partnership ways of working with Māori at all levels of the organisation to achieve equity and support Māori development.
- Equity will require the identification and elimination of institutional and individual sources of racism in the contexts and situations in which people learn, work and live.

Activities:
- DHB works with Māori to develop an ongoing programme for the whole DHB that progressively:
  - Addresses structural, policy and procedural barriers to achieving Māori equity
  - Builds knowledge and awareness, shapes beliefs, and debunks myths and stereotypes
  - Supports staff with the right behaviour
- DHB develops policies and processes that enable Māori to participate in the planning, development, delivery, quality and performance of health services it provides and commissions
  Examples of this include:
  - Evidence of Māori involvement in governance processes such as clinical governance, project steering groups, system leadership groups
  - Evidence of the involvement of Māori whānau in the design of services
  - Practice oriented around Māori models of health
- Publication of performance information including movements to achieving equity
- DHB implements a strategy to increase the proportion of Māori in its workforce across clinical, non-clinical and management areas
- DHB enables a feedback process for Māori consumers to reflect on their experience that is supported by a service improvement programme and information to address improvement priorities.

1.2. Reorient commissioning to achieve equity

Rationale:

- Providers consistently criticise that service agreements with the DHB are based on inputs and activity rather than outcomes
- A focus on inputs and activity generally does not address health inequities, rather it risks worsening them due to inverse care and bias effects
- Kaupapa Māori providers would rather focus more on whānau wellbeing than output alone
- Longer-term service agreements allow for trust-based relationships to develop between providers and the DHB, and providers to reorient their services to focus on outcomes and inequities

Activities:

- Develop an outcomes performance framework for the Waikato health system that identifies inequity and unmet need and make performance information publicly accessible. The framework includes an intervention logic that enables different parts of the sector to understand their contribution to achieving equity.
- The DHB commissioning approach involves a progressive shift from focusing on throughput to outcomes, and requires extensive engagement and co-design with providers and Māori consumers. Māori participate in the monitoring and evaluation of the outcomes.
- Equity of outcome indicators are built into service agreements, with the DHB and providers sharing responsibility for improving these and freely sharing data to support this
- Service agreement duration is extended for providers meeting defined capability and performance standards.
- DHB supports providers to understand inequities in their patient populations and lends expertise to help with strategies to address them

1.3. Build requirements for partnership with Māori into provider service agreements

Rationale:

- Consumers do not make distinctions between DHB-provided and commissioned services – they view the ‘health system’ as a single entity
- Māori consumers want to see tikanga Māori valued and operationalised in all services they interact with
- As the commissioner in the Waikato health system, the DHB can exert both soft (relationships and leadership – direction-setting) and hard (contracts and funding) influences to ensure services are fit for Māori consumers

Activities:

- DHB progressively includes requirements for partnership-based ways of working in service agreements with providers.
  Examples of this include:
  - Evidence of Māori involvement in governance
  - Māori workforce participation to reflect population proportion
  - Practice oriented around Māori models of health
  - Evidence of contribution towards achieving equity
  - Evidence of the involvement of Māori whānau in the design of services
  - Ensuring services do not worsen inequities (e.g. through application of the Health Equity Assessment Tool)
  - Publication of performance information including movements to achieving equity
- DHB supports the sector to develop partnership based ways of working through sharing its own experiences, resources, networks and relationships.
- Provider service agreements include a requirement to enable Māori consumers to provide feedback and to demonstrate how improvements for priority areas have been made through process change and performance information.

Goal 2: Empower whānau to achieve wellbeing

Whānau are supported to define and achieve their wellbeing goals and can shape the services they require.

This will mean that consumers and whānau will:

- *Have access to assessment to identify whānau wellness priorities, plans to achieve those priorities, and services are resourced to support this*
- *Be supported by health and social services to care for their own whānau*
- *Have an online portal to access their health records and shared care plans, and other reliable health-related information as part of a digital strategy*
- *Be able to control who has access to their personal health records*
- *Have access to culturally-appropriate information and tools that support wellbeing*

Goal 2 Actions

2.1. Expand resourcing for Whānau Ora in the Waikato

Rationale:

- As it is currently structured, the health system is focused on illness rather than prevention, is difficult for consumers to navigate and services are poorly coordinated
- Whānau Ora is a successful model for addressing these issues as it involves holistic assessments, targets resources to whānau aspirations and wellbeing, and coordinates an intersectoral approach to keeping whānau well
- Whānau Ora is inadequately resourced in the Waikato, with the opportunity available to expand the programme's reach to more whānau

Activities:

- The Whānau Ora approach is resourced, and embedded as the wellness model of care for the Waikato district. A workforce development strategy is devised to support this expansion
- Whānau Ora expansion is closely linked with primary health care and other government agencies to ensure availability of the required services. This will ensure that needs assessments only occur once, that information is shared between relevant providers (controlled by whānau), and that whānau needs drive service capacity and development
- Prioritise the development of Māori and Pacific Whānau Ora provider capability and capacity to enable access by the whole population
- Monitor and review Whānau Ora approaches to inform improvements

2.2. Advance initiatives to better support whānau as carers

Rationale:

- The health system relies greatly on the care performed by whānau, particularly in Māori communities. More often than not, family and whānau are the first point of care.
- Whānau want to be well supported to look after the health needs of their whānau.
- Existing support mechanisms could be further developed to provide assistance, such as improved access to and flexibility of respite, virtual access to after-hours/urgent medical advice and peer support networks

Activities:

- Develop pathways that inform whānau at a locality level of where to go for advice and services
- When planning services that avoid the need for hospitalisation or enable people to be discharged from hospital earlier, consider the needs of carers and how their needs can be incorporated
- Support the development of peer support networks in communities of need
- Develop protocols for individualised care planning that consider the need to support both carers and whānau

2.3. Support whānau to make informed decisions regarding their health and wellbeing

Rationale:

- People want to be able to obtain, process and understand health information and services to make informed choices and self-manage their health and wellbeing.
- Health workers and organisations need training and resources to enable them to communicate effectively so that community members can make informed decisions and take appropriate actions to protect and promote their health

Activities:

- DHB partners with Māori to identify specific community health literacy issues to prioritise (e.g. discharge communication, medication information)
- Workforce is upskilled in health literacy to better support whānau and communities
- Health education and health promotion material is developed in conjunction with Māori and communities to be culturally appropriate, relevant, and accessible
- Whānau and consumers can access bilingual, culturally appropriate information to support health literacy and self-management
- An interagency approach is taken to coordinate health information and ensure consistency and accessibility of health messaging

Goal 3: Support community aspirations and address determinants of health

The Waikato health system is reoriented to ensure equitable and enhanced access to the resources and environments that keep people well

This will mean:

- *Iwi, the DHB, health service providers, other government agencies and non-governmental organisations form inter-sectoral collaborations to coordinate their efforts and provide local leadership*
- *These collaborations support community development activities that enable local communities to identify and address social and environmental determinants of health that are important to them*
- *Iwi in particular are supported to develop their own health environments, communities and institutions*
- *Māori models of health are used and further developed*
- *The DHB partners with other agencies in the implementation of the Health in All Policies approach to ensure health impacts and wellbeing are considered during policy development*

Goal 3 Actions

3.1. Work with communities to design solutions that address determinants of health

Rationale:

- Often health service providers become oriented around the needs of their service, rather than the needs of the community. Increased community participation in service review and planning would improve engagement and service responsiveness
- Communities are often experts on the unhealthy environments to which they are exposed, and are best placed to address determinants that affect them. The DHB has a wealth of data that can support communities to identify whānau that have poor access to positive health determinants
- Iwi are well advanced in developing long term health plans. DHB and providers must collaborate with Iwi to ensure alignment. These relationships also act as conduits for community development and health promotion activities
- Many hospitalisations and other episodes of health care utilisation are preventable with relatively simple interventions. These episodes present opportunities to improve access to holistic healthcare for whānau and communities

Activities:

- DHB and other partners work with Māori to understand locality priorities, the resources they have, and agree on a plan to support the localities.
- DHB resources and supports communities to facilitate community development and leadership
- DHB provides additional resources for health promotion
- Where there is evidence of health benefits, the DHB directly invests in population health interventions
- The DHB actively looks for co-investors for intersectoral solutions

3.2. Expand the inter-sectorial approach to address determinants of health

Rationale:

- Factors outside the health system such as income, housing, social support and education have large effects on the health of populations
- Evidence shows that population health interventions are highly cost-effective and can be equity positive. They also address acute demand by reducing the prevalence, severity and incidence of disease
- Responsibility for addressing the determinants of health is scattered across multiple government agencies, but the health system often bears the burden of unhealthy impacts. As health affects the determinants, a collective approach is required to redress this imbalance

- A health event provides an opportunity to improve health by actively engaging whānau with housing, educational, financial, community and other health and social services in a mana enhancing and culturally safe way.

Activities:

- The DHB works in collaboration with other health and social agencies (e.g. education, local government, transport, housing, police, and social development) to form coalitions aimed at addressing determinants of health in the Waikato, and supporting the effective delivery of Whānau Ora
- Coalition activities occur at district-wide and locality levels, and focus on determinants in both human and natural environments
- The coalition in collaboration with communities develops a multiagency outcomes framework focussed on equity
- Iwi and Māori are involved as partners in both governance and operations, and Māori-based analyses and frameworks for action are employed
- Support communities in their priorities to spread information and encourage change, with health education and promotion supported by health professionals

3.3. Collaborate with local and national agencies to ensure the wellbeing of the Waikato population is considered in policy decisions

Rationale:

- The Health in All Policies approach takes into account the health implications of policy decisions by public agencies. It aims to avoid unintended harmful health impacts in order to improve health equity and population health
- The DHB is well positioned as the district's health commissioner to lead the implementation of this approach, within the DHB and across other agencies when public policy is being developed

Activities:

- The DHB works in collaboration with other health and social agencies (e.g. education, local government, transport, housing, police, and social development) to implement the Health in All Policies framework during local public policy development. This is informed by priorities identified by the local communities and builds on the coalitions formed in each locality and the district.

Goal 4: Improve access to services

Health services are configured to remove geographic, cultural, financial, timeliness and complexity barriers for consumers and whānau

This will mean:
- *Cultural competence and safety underpin the way services are planned and provided particularly for Māori*
- *Equity in access to services is achieved for Māori*
- *A model of virtual primary health care, co-designed with consumers, communities and caregivers, operates to bridge geographic barriers*
- *Innovative community care approaches to improving access for priority populations are supported and evaluated*
- *Care is delivered in a range of settings that are accessible for consumers and their whānau (e.g. marae, homes, workplaces, schools, digital)*
- *Support is provided to improve access to organised screening programmes as well as unorganised screening*
- *Where feasible, services for people with long term conditions are decentralised*
- *Health and social service providers are inter-connected, ensuring 'every door is the right door' for consumers and whānau to simplify and enhance access to multiple health and social services*
- *Urgent care and after-hours services are affordable and accessible, particularly for rural whānau*

Goal 4 Actions

4.1. Develop the Waikato health system to be culturally competent and safe for Māori

Rationale:
- Culture describes the way members of a group understand each other and communicate that understanding. Cultural safety in health is how a consumer experiences a service from their perspective. Cultural competence focuses on the capacity of the health worker to improve health by integrating culture into the clinical context. Competence is therefore more about behaviour than recognition of culture.
- Identifying and eliminating institutional and individual racism is part of addressing cultural competence and safety.
- Our workforce does not reflect the multi-cultural profile of the communities they operate in, therefore cultural competence and safety is key to maximising the gains from a health intervention. While culture is often viewed from an ethnic perspective there are other groups that have their own culture e.g. youth
- Māori consumers and whānau consistently reported that they want services (both DHB and contracted providers) that are culturally safe and where tikanga Māori is consistently integrated into service delivery

Activities:
- Develop a coordinated strategic district wide approach to improve cultural competency and safety at an organisational level
- DHB strengthens its approach to tikanga and cultural competency through changes to its own practices and services, and assists commissioned providers with this also
- DHB takes a planned approach to improving cultural safety including initiatives that address structural and policy matters that lead to prejudice and discrimination and shares its learning with other providers
- DHB leads sector Māori workforce development by enhancing its own workforce plans to increase the proportion that are Māori across clinical and non-clinical areas in proportion to the population.

4.2. Collaborate in the development of district-wide service delivery models that enhance access for Māori and other priority populations

Rationale:

- Communities want service delivery models that improve access, are more convenient, are affordable (direct and indirect costs) and achieve equity for Māori and other priority populations
- Services are provided in community settings by the DHB and a diverse range of health and social service providers. They may coordinate their services for an individual but there is less coordinated and collaborative planning in a consistent approach to improving access and using the diverse expertise in community providers. Service delivery models need to include alternative settings and providers.
- Service areas of highest need and inequity: maternity/tamariki/children, rangatahi/youth, kaumātua/older people, mental health and addictions, cancer and long term conditions
- The DHB is unable to effectively decentralise all specialist services due to geographical and staff constraints. However, there are numerous facilities already available in communities, such as pharmacies and aged residential care facilities, that are underutilised by the health system as delivery settings
- Other health activities, such as health promotion, early intervention and self-management, could be suited to being delivered in community settings to improve engagement
- Cost and transportation are barriers for many people that limit access and outcomes. Many people say the cost of medicines is a problem particularly when the sickest use the most medicines

Activities:

- Develop system wide service delivery models for priority areas aligned with locality priorities to achieve equity of outcomes
- Develop a district-wide coordination framework to guide the practical coordination initiatives that care providers at a locality level put into place
- Develop alternative approaches to face-to-face services, as settings where services can be provided
- Explore co-location and collaborative service delivery with health and intersectoral partners
- Provide greater access to specialist care and/or expertise through use of mobile teams and technology delivered in different settings e.g. schools, marae, general practice led clinics, pop-up clinics
- Develop initiatives that address cost barriers for people with high and complex needs particularly general practice services and access to subsidised medicines
- Improve transport options for areas and people of highest need to facilitate access to specialist services including those provided outside of the district

4.3. Access barriers for people with disabilities are eliminated

Rationale:

- Disabled people encounter a range of barriers when they attempt to access health services. This includes aspects such as a physical environment that is not accessible, lack of relevant assistive technology (assistive, adaptive, and rehabilitative devices), negative attitudes of people towards disability/impairment, and services, systems and policies that are either nonexistent or that hinder the involvement of all people with a health condition in all areas of life. Often there are multiple barriers that can make it extremely difficult or even impossible for disabled people to function.

Activities:

- Improve access to health services for disabled people, and progressively integrate health and disability services
- Develop appropriate systems and policies to identify disabled people

4.4. Grow the capability and capacity of the workforce to enable district wide service delivery approaches

Rationale:

- The concept of health workers practising at the top of their scope provides the potential to utilise the diverse workforce in communities and localities
- The amount of activity in rural areas may not be sufficient to sustain a local workforce. A combination of local, mobile and centralised workforce linked by technology is most likely to be used for the provision of services particularly where the health care team is broad
- There are opportunities to provide local employment and getting people into health to grow a local workforce

Activities:

- Develop workforce plans that enable the service delivery models to be delivered in a sustainable way and builds a local workforce
- Following the development of service delivery models, establish programmes that give the workforce the appropriate skills, knowledge and competencies needed to meet quality standards or expectations
- Establish mobile specialist teams and locally-based clinical staff to support the service delivery approaches in community settings where feasible

4.5. Support district-wide service delivery models with technology and information

Rationale:

- Experience to date shows an appetite for using technology in the Waikato amongst consumers and providers that is broader than video interaction
- A decision arising from the HealthTap implementation assessment was that the DHB would work with primary health care providers to implement a virtual care platform capable of supporting virtual consults (including text, telephone, video and email)
- The development and integration of technology across the system is difficult for a number of reasons therefore providers including the DHB have followed their own strategies. In a constantly evolving industry, there are significant risks with over-planning. Therefore health providers only want to align high level directions. The strategic principle is inter-operability.
- The commissioning approach needs to be informed by information that provides a population perspective of quality and performance, and the outcomes being achieved

Activities:

- The DHB and its partners agree a model of health technology for the Waikato, which has alignment between primary and secondary approaches. The planning process and detailed design of the services to be implemented involve Māori and consumers for whom the services are for.
- The technology component of services will be expanded through trialling, evaluating and scaling up well-designed pilots with defined use cases (e.g. home monitoring, observed therapy for TB etc.)
- Equitable access to health technology for Māori and priority populations is explicitly prioritised
- Collaborate across the sector to share consistent and reliable information and to develop a district wide dataset with analytical tools that can be progressively used for needs analyses and the measurement of outcomes achieved.

4.6. Further enhance district-wide patient portals and integrated health records

Rationale:

- Shared, accessible patient records and care plans will improve coordination of care across providers
- Consumers currently have very little control over their own health information, and often have difficulty even accessing it.
- Reputable information can be hard to source, including what health care options are available to whānau A portal is a mechanism that could offer health and provider information, and self-management tools

- Embracing digitally enabled care allows health to take advantage of future technologies and capabilities

Activities:

- The Waikato health system agrees an action plan that improves the shared health record and care plans, collaborating with stakeholders within the district (and Midland Region where appropriate). This record is consumer-centred and gives consumers access to their information through patient portals
- All providers involved with a consumer's care have access to appropriate information to inform their service provision
- Waikato health stakeholders collaborate and coordinate with national stakeholders on a high level digital strategy including portals to ensure a consistent approach to consumer access, content and support for agreed initiatives

4.7. Trial personalised care using whānau care budgets

Rationale:

- The increasing prevalence and complexity of long term conditions means an increasing proportion of the population is living with multiple chronic diseases and relies on ongoing care and support, which is often very difficult to access and navigate or limited in what is routinely funded or available
- In the UK, personal health budgets (PHBs) are used in different health and disability areas to give people more choice and control over money spent on meeting their health and wellbeing needs. Personalised care and support planning is an essential part of PHBs where plans and budgets are agreed. In the UK, essential services such as accident and emergency, general practice, laboratory tests and medication are excluded from PHBs and continue to be funded in their usual way
- In New Zealand, the Enabling Good Lives pilot has shown that individualised budgets and purchasing is an effective means of empowering people with disabilities and their whānau to choose the services and support that are right for them
- Personal health budgets in the Waikato would be supplementary to existing services and facilitate people accessing services that they may not otherwise have easy access to

Activities:

- Enhance awareness of what services are available and how they can be accessed
- The concept of personalised care is advanced in the Waikato, with exploration of how people living with mental health or other long-term conditions can be empowered to determine their own care using whānau care budgets
- Establish a whānau care support team that assists people with planning and advice on where to allocate their budget, to approve personal care and support plans and monitor outcomes
- Establish an evaluation and research initiative to investigate short and long term outcomes, and benefits of whanau care budgets

4.8. Improve access to services after-hours

Rationale:

- Emergency services provided by DHBs are configured as a specialist service but are often used by the public as an urgent care and/or after hours care setting for low acuity conditions.
- Providers of urgent and emergency services operate independently of each other
- Some people will be referred to a hospital by primary health care due to a lack of options they can access
- After-hours primary care is generally unaffordable for the people who need to access it most. Consumers do not pay to attend services provided by DHBs while those provided by non-DHB services are more likely to have a patient cost.
- Travel time to after-hours services and ambulance response times can be an issue

Activities:

- Establish an urgent and emergency care network that shares information, provides oversight on service quality, workforce support and development, and coordination between services
- Develop a district wide service delivery model for the provision of urgent and emergency care services to meet future demand and reduce demand where feasible.

- Develop enhanced after-hours coverage and access through locality delivery models
- Link the urgent and emergency care service delivery approaches to the development and use of intermediate care options

4.9. Develop strategic approaches to sustainable hospital services

Rationale:

- Demand for hospital services often exceeds the capacity to provide them
- Communities want specialist services provided closer to where they live. Some services cannot be provided easily in local settings and other options need to be considered e.g. use of services in neighbouring DHBs, use of emerging technologies
- Rural communities want services close to where they live. The rural hospitals have underutilised capacity, their roles need to be clarified as long term service delivery models are developed and aligned
- The DHB is operating in a significant financial deficit environment. The value of any investment needs to contribute towards achieving equity and eliminating the deficit
- A planned approach to capital investment is needed to give confidence of the potential benefit and value, and alignment with strategic approaches

Activities:

- Address the capacity constraints for elective surgery and procedures
- Develop strategic service delivery models for priority hospital services. Identify potential investment needs (high level) and align with system service delivery models
- Instigate work to address efficiency and effectiveness to enable appropriate treatment and care delivery

Goal 5: Enhance the capacity and capability of primary and community health care

Primary and community health care teams are an approach rather than a specific group of health workers. By focussing on how to work effectively together, primary and community health care service providers are able to focus on health and wellbeing in a seamless way

This will mean:
- *Primary health care providers give priority to eliminating barriers and lifting outcomes for Māori. Being responsive to Māori is embedded in primary and community health care services.*
- *An interdisciplinary team approach to community care is co-designed and implemented utilising shared care plans*
- *Patients and whānau participate in developing shared care plans when chronic and complex conditions arise, and have ongoing control over them*
- *Within the community care team, an optimised mix of regulated and non-regulated roles working to top of scope to make best use of the available professional workforce*
- *Collaborative development and implementation of a framework of minimum standards for an enhanced primary health care model*
- *Local communities shape the improvement of primary health care through co-design of services, regular feedback mechanisms, and access to provider performance result*
- *Primary health care are able to access NGO services directly rather than through referral to a specialist service*
- *Primary care clinicians have access to appropriate diagnostics (e.g. ultrasounds, cardiac investigations) through defined, resourced pathways*
- *Community care professionals have access to rapid specialist service advice (e.g. through defined locality-to-specialist relationships)*
- *Primary health care teams have access to additional initiatives to assist in managing acute hospital demand*
- *Co-design with communities of a Waikato community pharmacy model of care that incorporates wellbeing, with a one team focus*

Goal 5 Actions

5.1. Establish locality networks to encourage local collaboration and engagement in health services planning and delivery

Rationale:
- If health and social service providers would plan collaboratively to respond to needs in a local context, projected demands could be met in a more efficient and cohesive manner.
- By involving local communities in the operation and planning of local services, the health system will be more responsiveness to needs of these communities.
- As the health system leader, the DHB can act as an intermediary for locality-based collaboration in planning and service delivery
- Health systems tend to be service oriented therefore the locality voice needs leadership for operational and planning purposes

Activities:
- The DHB establishes a locality framework and appoints locality leadership roles to lead local planning and improvement of health services
- Establish locality networks with Māori, local providers and stakeholders to coordinate and improve health services and care. Locality networks are also established to address the determinants of health.
- Establish local priorities, stocktake of services and resources, and agree plans to address priorities
- Align DHB, PHO and NGO configuration to support effective locality planning and delivery of services

5.2. Develop expanded primary and community health care approaches with a focus on quality, equity and teamwork

Rationale:

- More proactive and better coordinated primary and community health care delivery carries benefits for consumer and whānau wellbeing, makes better use of the available workforce, and avoids hospital attendance and admissions.
- Within communities there is a wealth of expertise that can be used more effectively. The expertise can be used for the whole spectrum of health delivery from prevention, early intervention, assessment, treatment, reablement and palliative care of people
- General practice are a key component of expanded primary and community health care approaches. New models of enhanced general practice are spreading across the Waikato (and nationally) that can improve general practice effectiveness, efficiency and facilitate a path to achieve equity for Māori and other priority populations in collaboration with other health and social services
- There is the opportunity to bolster this innovation through effective use of care coordination functions, and an explicit commitment to achieving health equity and delivering for Māori whānau
- Expanded primary and community health care approaches include specialists and DHB provided community services as well as integrating essential services that address social needs such as whānau ora and other whānau focussed approaches
- Pharmacists are consistently identified as an underutilised professional group. Pharmacists are highly skilled clinicians, and the workforce is sustainable and generally well distributed through the Waikato

Activities:

- Realign service delivery models taking into account the desire to have care provided closer to home and work with locality networks on how those approaches can best be coordinated, resourced and delivered in their settings.
- Agree local mechanisms for care coordination to take place.
- Responsibility and accountability for Māori health access and outcome equity is built into primary care service agreements, with DHB support for the redesign of services
- Minimum standards for primary care are built into service agreements, incorporating key elements of expanded primary health care models
- Formalise the concept of individualised care plans for patients with complex clinical conditions that are developed in conjunction with the patients and whānau, and become a central function of the primary and community health care team. These plans are available to consumers via the patient portal
- In developing the service delivery models, identify where and how DHB-based specialist services provide timely general practice access to advice and diagnostics
- Develop expanded roles for community pharmacists as part of expanded service delivery approaches and identify opportunities where co-location may be beneficial particularly for pharmaceutical advice on the treatment of health conditions, self-management and early intervention.
- Enhance community health pathways to incorporate wellbeing, link to Whānau Ora and other whanau focussed approaches and encourage their use through promotion, improving systems to make them easy to use and upskilling clinicians

5.3. Develop, strengthen and embed whānau-centred approaches

Rationale:

- Māori models of health are based on a wellness or holistic health model (e.g. Te Whare Tapa Whā, Te Wheke, Te Pae Mahutonga) and are suitable for the whole population
- There are successful Kaupapa Māori whānau focussed approaches that support whānau using a holistic approach e.g. Waikato DHB has developed Hapu Wānanga, Harti Hauora Tamariki, and Whare Ora
- There is demand for whānau focussed approaches that can be accessed directly or through health providers
- Primary healthcare providers seek support from social services to address immediate social issues that they are not able to access as part of a team based approach to whānau wellness and wellbeing
- Using the “every door is the right door” concept, access to addressing immediate social issues is available to any provider including hospitals

- Urgent social needs have the potential to overload Whānau Ora providers and limit the long term support for whānau aspirations
- In addressing immediate social needs, there is the real potential for unmet need to overwhelm services. Intersectoral collaboration is essential to facilitate strategic and operational planning, and budgeting

Activities:

- Develop more whānau focussed programmes with Māori, consumers and stakeholders to address health and social issues that are aligned with district and locality priorities
- Collaborate with stakeholders on developing a workforce to enable ongoing delivery of the programmes
- Expand the primary and community health care team with a workforce who can assess and support whanau in addressing their immediate social needs
- Develop community and hospital health pathways .and optimise their use across the district
- Collaborate with stakeholders on a district wide approach to improving the knowledge and awareness service providers have of the determinants of health and how whānau can be linked into programmes and services

Goal 6: Strengthen intermediate care

The gap between primary and secondary care is bridged through accelerated development of alternative community care services and settings that avoid unnecessary travel and acute hospital utilisation

This will mean:

- *People in hospital can be discharged early with care provided to them in their home or a community facility*
- *There are community options for care as an alternative to hospital for people who do not need to be in hospital*
- *Specialist services that can be decentralised are delivered in local facilities, either in person or virtually (e.g. nurse specialists, chemotherapy delivery)*
- *Rural hospitals and selected aged residential care facilities provide accessible local sites for bedded intermediate care*
- *Services provided to people in local bed facilities have services wrapped around them tailored to their needs that are provided by appropriately skilled providers*
- *Local community involvement with these facilities is strengthened through co-design*
- *GPs' and Nurse Practitioners' admitting rights for short stays in intermediate care facilities are expanded*
- *Local intermediate care facilities are utilised for safe, supported early discharge from secondary care, and respite care as part of enhanced carer support*
- *Intermediate care services are supported by specialist expertise as identified through co-design processes*

Goal 6 Actions

6.1. Develop specialist services closer to home

Rationale:

- Technology improvements are increasing the range of services that can be safely delivered outside of tertiary hospitals
- Numerous pre-existing health facilities (e.g. rural hospitals) could be more efficiently used for specialist service delivery
- Key candidates for delivery closer to home include chemotherapy, dialysis, endoscopy, and ongoing management of long term conditions
- Referrals to specialist services and presentations to emergency departments can often be managed by primary healthcare with the support and advice of specialist expertise. Specialist advice is not limited to medical practitioners and includes all professional groups working in specialist areas
- There are DHB specialist services that are ongoing and planned and provided to people with long term conditions from a Hamilton location. There are opportunities for these to be provided closer to home or in a different way to improve access and experience

Activities:

- The Waikato health system, in conjunction with providers and regional DHB partners, determines which specialist services could be appropriately delivered in the community, with explicit aims of addressing geographic and ethnic inequities in access to care
- Using the service delivery models development process, determine which additional specialist services linked to the service delivery models can be decentralised, where the demand for these services is distributed throughout the region, how they could be provided and how specialist support for primary care can be improved
- In the interests of accessibility and patient experience, some services may be better delivered to patients near DHB borders by other DHBs

6.2. Reorient services to reduce hospital admissions

Rationale:

- There are programmes that enable people to be discharged from hospital early and to be supported by specialist services in their homes or appropriate facilities close to home. These may be able to be configured to be used for people with deteriorating conditions as an alternative to being admitted to hospital

- General practice has access to programmes to provide services in community settings as an alternative to hospital. The suite of activities should fit with clinical care models and evidence based best practice, community based services in different localities and evolving service delivery models and be directed to those who would most benefit with acute conditions.

Activities:

- Reconfigure the programmatic approaches to focus on people with acute conditions particularly Māori to enable access to a broad suite of services that avoid hospital admission
- The DHB in collaboration with stakeholders look at whether step down services could also be used for step up services to avoid hospital use, identify changes needed and a plan for how this can be implemented and maintained

6.3. Develop and extend planned early discharge and step down care services

Rationale:

- Discharge from Waikato Hospital can be delayed if services a patient requires, such as speech therapy or rehab, are not available locally, disrupting hospital flow
- Provision of these services by the DHB, and stronger links with primary and community care, could facilitate earlier discharge to home, a rural hospital, or an aged care facility
- Some programmes already exist (e.g. START (Supported Transfer Accelerated Rehabilitation Team)) which could be scaled up and broadened

Activities:

- Support early discharge/hospital flow by providing services locally to patients in appropriate settings
- Build stronger links with primary and community care that allows collaborative discharge planning, including a system for early notification of discharge and so that local providers can prepare
- Build local expertise so that the DHB can work towards commissioning from community based providers
- Integrate early discharge services provided by specialists services with primary and community care, whānau ora and whanau focussed approaches

Enablers

Enabler 1: Leadership and partnerships

What this will mean:

- Clinical governance will reflect the principles of
  - consumer/whānau centred,
  - an open and transparent culture,
  - all staff actively participate and partner in clinical governance and
  - a continuous quality improvement focus
- A district-wide framework for planning, funding, service delivery and monitoring system performance will support the delivery of the health system plan.
- The framework will have clear roles and responsibilities for prioritising resources, service development, and a continuous quality improvement approach. Measures and indicators developed by stakeholders will be linked by an intervention logic model. At the delivery level, relationships need to be fostered to translate district direction into local action
- A Waikato leadership group will provide district-level leadership to ensure a unified, system-wide approach and oversee system performance and improvement. The group will be a partnership with Māori, consumers, providers and the DHB as commissioner of services, with shared responsibility for system performance
- Providers will have individual accountability to the commissioner and collective accountability to each other in the Waikato leadership group
- Partnerships will be developed with a broad range of stakeholders including NGOs not funded by health, volunteer groups and local government
- The Waikato leadership group will strengthen existing partnerships with the wider social sector and local government to support planning and action at district and local levels to address determinants of health
- Within the DHB, structures for leadership and governance have clear roles, responsibilities and accountabilities to support organisational decision making, performance and improvement

Activities:

- Establish a district wide leadership structure (involving Māori, clinical and consumer expertise) with responsibility to monitor and lead change for quality and performance improvement
- Empower DHB clinical teams to lead and improve quality by aligning clinical governance structures to facilitate whole of DHB performance and improvement. Processes should enable different perspectives (e.g. different professional groups, Māori and consumer) and structures should clarify roles and responsibilities

Enabler 2: Commissioning

What this will mean:

- Innovative solutions that address the determinants of health will be encouraged through adopting a system perspective in commissioning of services
- New contracting models will support collaboration and focus on outcomes
- Processes for ongoing service development and planning

Activities:

- Integrate the role of the district leadership into the commissioning process and cycle
- Clarify planning and decision-making processes within the DHB and the district, identifying where authority, accountability and responsibility lie
- Develop and promote a service planning framework that includes the development of long term system views for:
  - Maternity, children (tamariki) and youth (rangatahi)
  - Older people
  - Cancer
  - Mental health & addictions
  - People with multi-morbidity and long term conditions
  - Hospital based services

- Ringfence an HSP budget to resource a portfolio of prioritised initiatives that are developed for implementation.
- Take a portfolio approach to the planning and delivery of initiatives. Benefits are viewed across the portfolio rather than by individual project so initiatives can flex around risk profiles

Enabler 3: Workforce development

What this will mean:

- Health workers operate confidently and skilfully with Māori consumers and whānau
- Workforce distribution is matched to the population need
- Increasing participation by Māori and Pasifika in the health workforce
- Leadership, co-design, community development and quality improvement capability is developed across the system; this also includes capability to work within interdisciplinary teams
- There are increasing opportunities for training of the health workforce in system-wide settings
- An increasing proportion of the workforce will come from within Waikato communities

Activities:

- Ensure training and education activities provided by organisations are underpinned by tikanga, sharing of ideas and content
- Promote health as a career (particularly in schools) and support initiatives that enable Māori and Pasifika to attain academic achievements, succeed in roles where learning is through experience (e.g. placements, internships) and choose appropriate pathways to a health career
- Establish programmes where medical, nursing and allied health workforce training can be achieved in a mix of settings e.g. hospital/primary health care, urban/rural

Enabler 4: Technology and information

[Activities / rational covered elsewhere - statement / description incorporating need to prioritise technology and information initiatives to support the broader technology needed to support the activities and other support strategies e.g. People Strategy]

Enabler 5: Quality improvement

What this will mean:

- Equity will be embedded as a key goal of quality improvement, using frameworks for improvement and implementation
- Local communities will be supported in service co-design and improvement
- Opportunities for joint research and evaluation will be pursued with inter-sectoral partners

Actions:

- Develop and integrate a whole system quality improvement framework with decision making processes, leadership and clinical governance structures, system data analytics functions and reporting.
  Focus initially will be on services needing whole system approaches, and with opportunities for large scale impacts on inequities, such as cancer, diabetes, cardiovascular disease, maternity and mental health
- Develop an outcomes intervention logic (based on the equity framework) with networks, leadership and clinical governance groups that can be used to measure and improve system performance and is shared with the public
- Prioritise the resourcing of the Waikato Research Innovation and Improvement Hub to provide district wide expertise on the planning and delivery of change, inform improvements, conduct research and advise on benefits and outcomes achieved. Resourcing allows for rapid turnaround and long term research.

Significant Programmes/Projects

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 12.1

CREATING OUR FUTURES UPDATE

Purpose	For information.

As per the Board recommendation on the 28 November 2018 discussions are underway to confirm the joined up governance between Creating Our Futures and Te Pae Tawhiti governance structure. This will essentially result in a whole of system approach to planning and governance across the mental health and addictions system of care.

The Creating our Futures programme has representation from iwi, NGOs, PHOs and other sectors. A widely representative advisory group is also well established and providing regular input and review into the programme of change. It is envisaged that these forums will be a useful starting point for a combined governance forum, chaired by Strategy and Funding. The Terms of Reference are currently being finalised.

Work has commenced to transform our centralised model of service delivery in the community to one which will provide services closer to people's homes, in an integrated model with other health and social services.

Defining the detail of where and with whom will involve comprehensive engagement with our staff and other key partners. Transforming the model in this way will bring elements of the Let's Talk Community engagement hui into action.

To support the change process a number of staff have participated in Staff Change Champion training to ensure staff are an effective part of the change implementation and able to provide support and encouragement throughout the process of change. The two day training was seen as highly valuable to the participants as it was focused on the psychology of change, particularly emotional intelligence as an essential component in leading and supporting others through change.

Planning and design is underway for transforming our community services. Currently our community MH&A services are centrally based and provide a mixed model of service based and outreach. Our communities have told us they want services to be closer to home, which are based on partnerships with tangata whaiora, whanau and key local services. The new way needs to be based on the seven key themes from the Me Koorero Taatou Report which has reducing inequity and meeting the needs of tangata whaiora and whanau at the heart.

It is clear now what needs to be different, a co-design approach will see staff and key stakeholders working together to co-design how we make this happen. It is likely that a staged approach will occur, with the first hub to be established in an area of high

need. Discussions with other sector partners are underway to look at opportunities for colocation and joint working.
Work has also been occurring with communities to develop local points of access and closer working in rural and high need communities. Discussions with Ngati Haua have now resulted in a mental health clinician, alcohol and drug worker and kaitakawaenga providing support and access at the Wahaora Hauora Clinic on a weekly basis. Some of the benefits anticipated are:

- Partner with Iwi to provide referrals and links to NGOs and community services
- Promote and enhance Whānau and iwi participation and engagement
- Potential to participate in whānau discharge planning from HRBC
- Partner and instigate local AOD and MH group sessions with local Iwi and other services
- Direct link to CADS and MH multi-disciplinary team discussions for complex presentations.
- Promote harm reduction model, safer use for Alcohol and other drugs
- Provide educations sessions in partnership with whānau and iwi
- Community and home visits in partnership with Waharoa Hauora.

The MH&A'S Facilities and Service Redevelopment indicative business case was provided to Ministry of Health and NZ Treasury for presenting to Investment Ministers at the Capital Investment Committee meeting on 14 February 2019.

Significant work went into the preparation of the documents for the committee, and confirmation has been received on the provision of funding to in preparation for Tranche 1. Further work is required with the Ministry of Health regarding capacity requirements, the impact of prison population growth and demographic changes. The other key component is more detail on the Waikato Hospital campus future requirements and any geotechnical issues related to land stability. In preparation of moving into the Detailed Business Case, a small Concept Design working group has been established to begin to engage and provide the detail of the preferred way forward. This group will have mental health, iwi, Te Puna Oranga and service user input.

Conceptual design will commence on 25 March 2019 with a series of workshops over the next six months. These workshops will include key staff, Te Puna Oranga, Iwi Maori Council, service user and whanau participation. The workshops will involve the architects experienced in acute mental health unit design, including an architect experienced in Maori health design.

Detailed design and contracting for construction will take us to build commencement in July 2020, with completion of the acute, subacute and high and complex needs components anticipated by October 2024.

In June 2018 the Corrections Minister announced that a 100 bed mental health facility would be built at Waikeria Prison by 2022. The provision of mental health care and treatment in a prison setting as not been done before in NZ. While there are a number of key issues to be worked through around this development, it does signal a strong desire by the Department of Corrections to provide a more caring, therapeutic and Kaupapa Maori approach to the significantly high proportion of people with mental health and addiction related issues in prison.

Dr Rees Tapsell and Vicki Aitken are part of the governance group overseeing the development and implementation of this initiative. A joint meeting occurred last month with both Ministers of Corrections and Health. The meeting was attended by the Deputy CE Corrections, Ministry officials, Tangata Whenua Liaison representative and Executive Director and Clinical Services Director MH&AS. This meeting was intended to provide Ministers with a briefing on the work to date and receive guidance on the preferred way forward from their perspective. During the meeting there was clarity that the unit will have a Kaupapa Maori focus and will be a therapeutic environment that supports the rehabilitation and reintegration of people from the central region who are in prison with mental health needs. The preferred option is a facility that is run by health professionals and other cultural support staff, supported by custodial staff in relation to security. The model is intended to be a hybrid model that is jointly governed by health and corrections.

The Report of the Government Inquiry into Mental Health and Addiction 'He Ara Oranga' was released in November 2018. It provides the context for improvement to the provision of mental health and addiction services in New Zealand. Implementation of the reports 9 recommendations and 40 associated actions are yet to be agreed by Government.

Waikato DHB Mental Health and Addiction Service is into a multi-year programme of service transformation to improve the delivery of services to tangata whaiora and whanau. Extensive engagement with people throughout the Waikato DHB health area has identified 7 key themes to guide service improvement.

The release of He Ara Oranga provided the opportunity to ensure that the Creating our Futures work plan actions to achieve transformative change are aligned to the recommendations within He Ara Oranga. This process involved careful consideration of the CoF vision for the delivery of person-centred care closer to home, and new partnerships with Maori, other health and social services to address the holistic needs of tangata whaiora, whānau and communities more broadly.

Attached to this report is the work undertaken to align the Creating our Future actions to the Recommendations within He Ara Oranga.

A final report has now been completed which is an analysis of the 30 iwi and community hui held between December 2017 and August 2018. The report is entitled Me Koorero Taatou. Te Pora Thompson-Evans and Grant O'Brien will provide an overview of the findings and next steps (refer attached presentation).

Recommendation
THAT
The Board receives this report for information.

VICKI AITKEN
EXECUTIVE DIRECTOR MENTAL HEALTH AND ADDICTIONS SERVICES

Proposed Creating our Futures actions to address recommendations from the Government Inquiry into Mental Health and Addictions

Note: These actions represent the Waikato DHB MH&A service proposed response to the Government Inquiry into National Mental Health and Addiction Report recommendations as part of the wider whole of system changes that are required to be addressed by the Ministry of Health and Waikato DHB Strategy & Funding

Government Inquiry Recommendations	Creating our Futures Response
Expand Access and Choice of services	
"Expand Access"	• Ensure the widest possible access leading to the provision of the most appropriate services • Implement best practice guidelines that drive service development and accountability • Commit to prioritise access to those with the greatest need. In 2016 - 2017 4.6% of the Waikato DHB adult population and 4.1% of the child and youth population accessed secondary mental health services. • Develop options for people to access services in different ways. For example: Strengthening local points of access to mental health and addiction services, both communities based and DHB based • Improve access to cultural support options for Māori and other priority population groups including; Pacifica and the LGBTIQ+ community • Establish community based hubs in partnership with community and other health and social service providers • Continue to fund FTE psychiatrists within Primary Health Organisation's (PHOs) • Ensure 24/7 support to anyone feeling in crisis, including single point of access and timely assessment, with more care and recovery at home and in the community. • Provide high quality specialist services for those with complex and intensive needs that require ongoing support close to home.

Proposed Creating our Futures actions to address recommendations from the Government Inquiry into Mental Health and Addictions

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"Increase choice of services"	• Improve access to crisis/acute points of entry and assisted referral to appropriate services • Commit to increasing the range of therapies available. For example greater access to talking therapies and specifically those appropriate to Māori • Support more options for access to kaupapa Māori /whānau ora services • Enhance service integration between primary/secondary MH&A services and MH&A and social services • Implement models of care that are person centred and evolve to address changing tāngata whaiora and whānau needs and expectations • Provide inpatient care when community based support is no longer appropriate,for the shortest time necessary, connected to community services to support recovery to living well in association with primary care and NGO services • Enhance community based assessment and service coordination (across the range of community and social services) for those in distress (cross sectoral 'front gate model')
"Facilitate co-design and implementation""	• Commit to a co-design process involving tāngata whaiora, whānau, social services and NGO stakeholders to provide person centred and coordinated care • Ensure the involvement of a broader base of tangata whaiora and whānau representation in service redesign and decision making • Commit to a service transformation approach based around the people who use the services that ensures the involvement of the right people • Continue supporting the Creating our Futures cross sector/multi stakeholder advisory group providing advice, support and oversight of transformational change

Proposed Creating our Futures actions to address recommendations from the Government Inquiry into Mental Health and Addictions

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	• Support the aspirations of Māori for more kaupapa Māori service choices and alternatives to admission • Embed co-design principals/capability as business as usual within MH&A services
"Enablers to support expanded access and choice"	• Commitment to a long term focus on workforce development incorporating: developing the workforce needed to deliver transformed services and person centred care, and taking account of workforce aging, workforce shortages and emerging wellbeing approaches, involving whole of sector integration • Commitment to peer roles and Māori workforce as priorities and a stronger focus on the health and wellbeing of the workforce to prevent burn out from increasing demand, tangata whaiora and whānau expectations and increasing acute complexities • Commit to developing an integrated workforce across DHB and NGO/primary care services • Accept the outcomes of the Me Koorero Taatou Community Engagement Hui report (experiences of people using MH&A services) and act on the key themes/outcomes • Commit to a purpose built inpatient facility providing specialist care which is integrated with the care and treatment provided by CMH&A teams, for those requiring inpatient care and treatment; including a modular speciality inpatient facility able to be utilised for the inpatient and treatment of speciality populations (e.g. head injury/adolescents/autism spectrum disorder/eating disorders) • An integrated (preferably regional or sub regional) service for the case management and service provision (including potentially an inpatient service population) for those people with high and complex needs. There are sub-populations within this group that require specific attention and these include people with mental health needs and coexisting intellectual disability; older people with mental health and age-related needs, and people with multiple health needs (long term conditions). These groups all require assistance across a range of funding boundaries, specialist and community services, other government departments and social service agencies. Services would be provided closer to home and intensive service coordination between DHBs, involvement of whānau primary care and all services necessary to

Proposed Creating our Futures actions to address recommendations from the Government Inquiry into Mental Health and Addictions

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	ensure the person's long-term care • Extended inpatient and community capacity to provide inpatient assessment for forensic patients which is fully integrated with both the correctional mental health and addictions service and the high and complex needs services • Improve recovery planning across acute inpatient and community services supporting the provision of person centred care enabling living well in the community • Ensure actions to improve the mental health care pathway for tāngata whaiora with high and complex needs and enabling them to stay well in the community
Transform primary health care	
	• DHB funded FTE psychiatrists within PHOs supporting improved diagnosis and consult liaison services supporting enhanced primary care/general practitioner management closer to home • Investigate integrated care options for MH&A services, and primary care teams / community hubs
Strengthen the NGO sector	
	• Enhance capacity and capability for support and therapy within NGO and primary care settings (new psychiatrist positions / talking therapies / service navigators and life coaches etc) for those able to be managed in a primary care setting. • Locality based community MH&A services providing specialist services integrated with other primary and NGO services (including supervised accommodation etc) for those with diagnosed mental illness requiring specialty input
Enhance wellbeing, promotion and prevention	
"Take a whole of government approach to	• Continue and enhance the current joint initiatives between MH&A services and the Ministry of Social Development (MSD) Project Seven; incorporating a person centred wellbeing assessment to determine /

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wellbeing, prevention and social determinants"	address social determinant needs to ensure improved recovery planning and tāngata whaiora outcomes in their community • Support the development of a preventative health plan to addresses the key determinants of health • Incorporate Project Seven within the community MH&A services • Continue the MH&A service stakeholder investment in the cross agency housing first initiative "The Peoples Project" to eliminate homelessness in Hamilton City • Continued involvement in the Integrated Safety Response to reduce family harm • Fully implement the Creating our Futures holistic model of care to significantly enhance the integration and coordination of health and social support services
"Facilitate mental health promotion and prevention"	• Implementation of the Creating our Futures Model of Care to achieve the goal of joining holistic care with the service users and their whānau aspirations to support recovery and achieve self-managed wellness • Increased community capacity / knowledge and support for those struggling with life's challenges (community development work) • Support individuals and communities to effectively manage their wellbeing, close to home, with a focus on prevention and resilience. • Improving community resilience both for the general population, and those at risk of developing mental ill health or of becoming more severe
Place people at the centre	
"Strengthen consumer voice and experience in	• Fully implement the Creating our Futures Model of Care that places people in the centre of their care

Proposed Creating our Futures actions to address recommendations from the Government Inquiry into Mental Health and Addictions

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mental health and addiction services"	"People at Heart" • Strengthen tangata whaiora involvement in service transformational change and the Creating our Futures multi stakeholder advisory group • Improve tangata whaiora and whānau service navigation though implementation of new integrated service pathways • Continue to strengthen the tangata whaiora voice in all aspects of MH&A service delivery, transformational change and the multi stakeholder Creating our Futures Advisory Group.
"Support the wellbeing of families and whānau"	• Commit to the recruitment of Whānau Advisor MH&A services • Accept / act on the key themes from the Me Koorero Taatou Report (Let's Talk Community Engagement Hui) – "strengthening families" and commit to the action – "whānau as equal partners in all decision-making involving their loved ones care" and "offer whānau information, training and support to recognise, monitor and act on signs of mental unwellness" • Enhance whānau involvement in the multi stakeholder Creating our Futures advisory group. • Ensure whānau as a key stakeholder / partner involvement in recovery planning
Take strong action on alcohol and other drugs	
	• Continue to use a harm minimisation and social support approach to drug use • Work with other partners, including NZ Police to improve our interagency response to Methamphetamine harm • The MH&A service will continue to support / lobby for the establishment of an Alcohol and Drug

Proposed Creating our Futures actions to address recommendations from the Government Inquiry into Mental Health and Addictions

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	Treatment Court in Hamilton • Improve provision of services to address co-existing mental health and addictions • Support the provision of residential treatment options closer to home
Prevent suicide	
	• Continue to support the Waikato DHB Suicide Prevention and Postvention action plan • Commit to ensure that services are responsive to requests from people who are suicidal • Ensure that tangata whaiora at risk of suicide on discharge have an appropriate suicide prevention plan and follow up plan including whānau input • Continue with the collaborative initiative Let's Talk Wellbeing to encourage access, support and information about mental health wellbeing.
Reform the mental health act	
	No actions
Establish a new Mental Health and Wellbeing Commission	
	No actions
Wider issues and collective commitment	
	• Continue with and expand the intersectoral whole of system collaboration as listed above
IT Solutions ***(non MH Inquiry recommendation – enablers to service improvement)***	• Implement electronic patient flow management systems to improve service user information and acute inpatient treatment • Utilise Qlik Sense service data management information systems within MH&A services to improve

Proposed Creating our Futures actions to address recommendations from the Government Inquiry into Mental Health and Addictions

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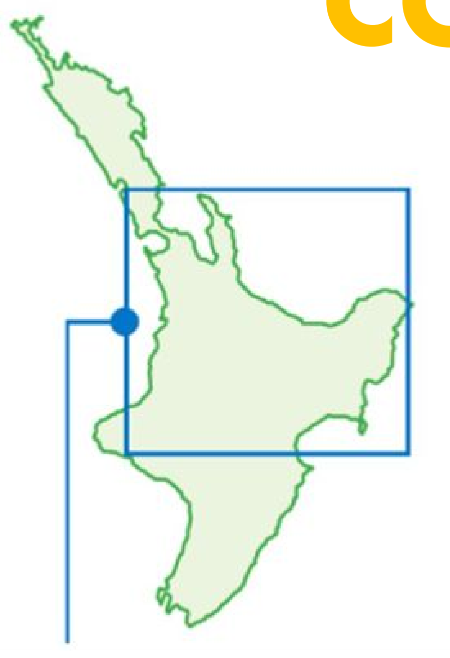
	service and resource management • Clinical Guidelines standardised to support best practice clinical decision making • Utilise Real Time Feedback to improve service user and whānau experience and ensure feedback loops to inform quality improvement • Pilot the national 'Waka App' supporting self help • Implemented the Alcohol and Addiction App 'Recovery in Hand'

ME KORERO TATOU
LETS TALK
Analysis of 30 Iwi & Community Hui



1031 people attended

44% of total attendees identified as Māori

249 electronic surveys were completed on survey monkey

30 community meetings

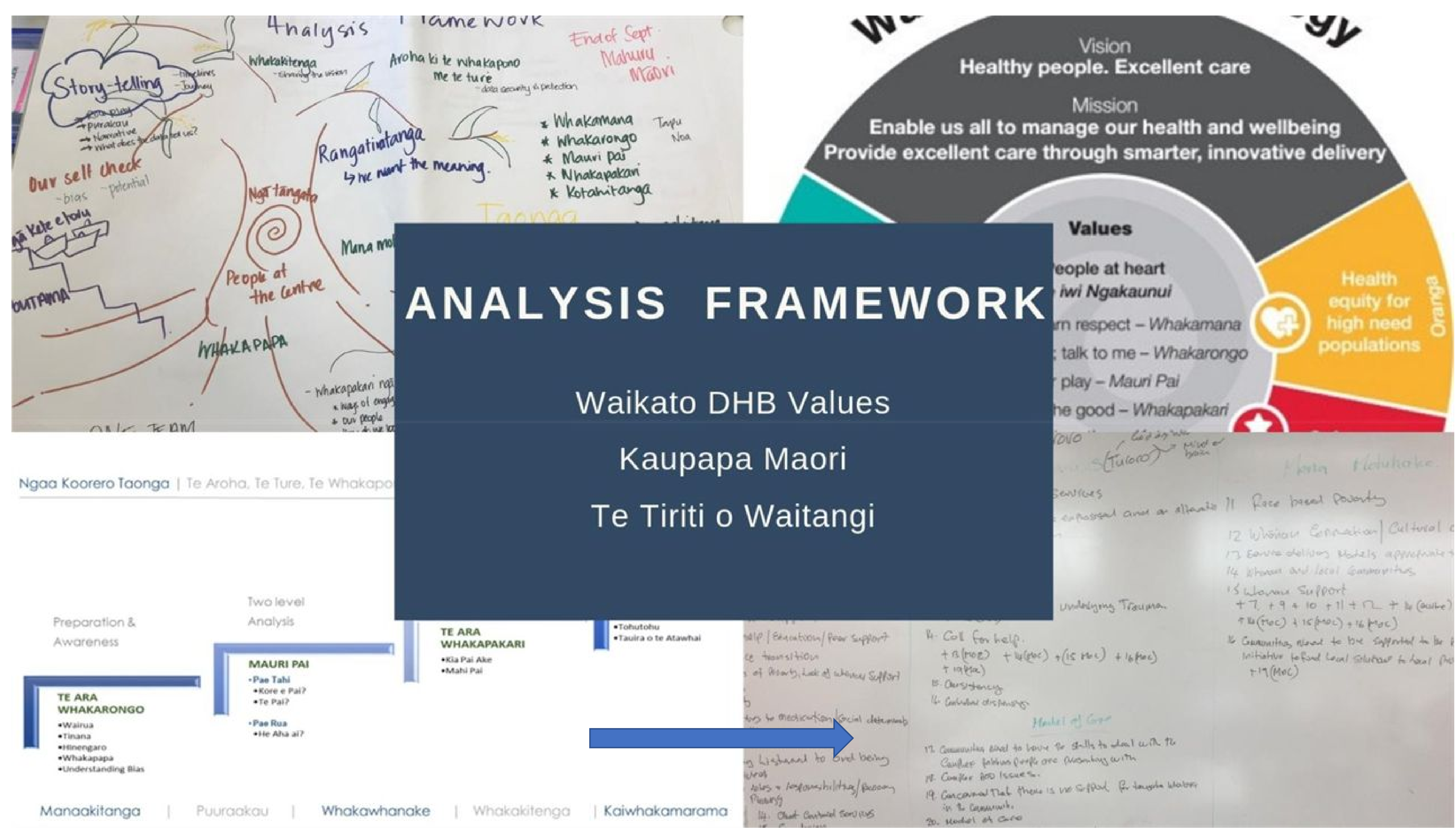
20 staff meetings

5 focus groups

PARTNERSHIP

Strategy & Funding
Mental Health & Addictions
Iwi

Te Puna Oranga
Community


ANALYSIS FRAMEWORK
Waikato DHB Values
Kaupapa Maori
Te Tiriti o Waitangi
Vision
Healthy people. Excellent care
Mission
Enable us all to manage our health and wellbeing
Provide excellent care through smarter, innovative delivery
Values
Health equity for high need populations
Ngaa Koorero Taonga | Te Aroha, Te Ture, Te Whakapo
Preparation & Awareness
Two level Analysis
TE ARA WHAKARONGO
Wairua
Tinana
Hinengaro
Whakapapa
Understanding Bias
MAURI PAI
Pae Tahi
Kore e Pai?
Te Pai?
Pae Rua
He Aha ai?
TE ARA WHAKAPAKARI
Kia Pai Ake
Mahi Pai
Tohutohu
Tauira o te Atawhai
Manaakitanga | Puuraakau | Whakawhanake | Whakakitenga | Kaiwhakamarama

THEMES

Strengthening Families

Mana Motuhake

Resilient Communities

Crisis Resolution

Stop Suicide

Workforce

Wellness Influencers

Bocanegra Baker Co. | 2020

WHĀNAU
Strengthening Families

Tautoko – Support

Mātauranga - Knowledge

Kia Manawanui - Resilience

HAPORI

RESILIENT COMMUNITIES

TUHONO – Connected

HANGA RAUKAHA – Capacity

AIWHENUA- Rural

MAHERE HAPORI – Community Mapping

KATI WHAKAMOMORI
STOP SUICIDE

RANGATAHI – Coming of Age

WHAKAKATI – Prevention

I MURI IHO – I Muri Iho

POAPOATAUNU – Stigma

NGA AWENGA

WELLNESS INFLUENCERS

RATONGA – Services

RAWAKORE – Capacity

WHAKATUTATA – Closer to Home

NGA MOREAREA
CRISIS RESOLUTION

MAHERE - Planning

WHAKAPAA – Communications

TOMURI, INAEANEI – Earlier, Timelier

MANA MOTUHAKE

HOLISTIC AUTONOMY

MAHERE - Planning

WHAKAPAA – Communications

TOMURI, INAEANEI – Earlier, Timelier

MAHIA TE MAHI
WORKFORCE

MAHERE - Planning

WHAKAPAA – Communications

TOMURI, INAEANEI – Earlier, Timelier

MEMORANDUM TO THE BOARD
27 MARCH 2109

AGENDA ITEM 12.2

MENTAL HEALTH AND ADDICTIONS SYSTEM MAP

Purpose	For information.

Background

A system map for Mental Health and Addiction services was presented to the Board in November 2018. The map depicts the natural supports, social determinants, environmental factors, agencies and health services that impact on our communities mental wellbeing and mental health care. The system map is attached for your information.

Service Planning

In order to plan for future service provision, we need to understand the spread of current services across the system map, and the gaps in service provision. The work has progressed to map current service provision across the map; this is based on Vote Health funded services and does not include services that are funded through other means.

To date this work is focused on the investment (services/initiatives) in the healthcare segment (the ‘cheese segment’) part of the system map, although many support services work with whānau and communities to enable and strengthen natural supports. Over the next two months we will complete the assessment of current service state and an assessment of gaps in service provision across the following domains:

- Service delivery setting – community vs residential/inpatient
- Type of service
- Māori and Non Māori providers
- Age Specific Services
- Service location.

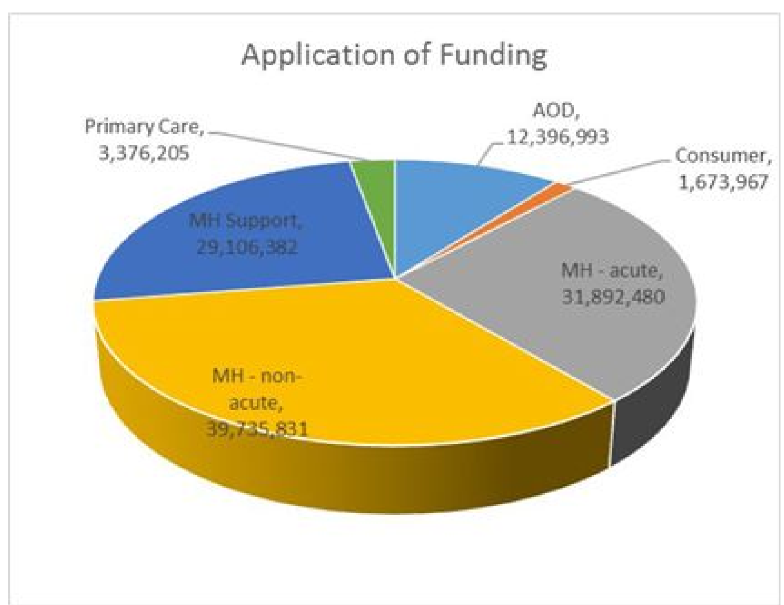
Radical Improvement in Māori Health Outcomes by Eliminating Health Inequities for Māori

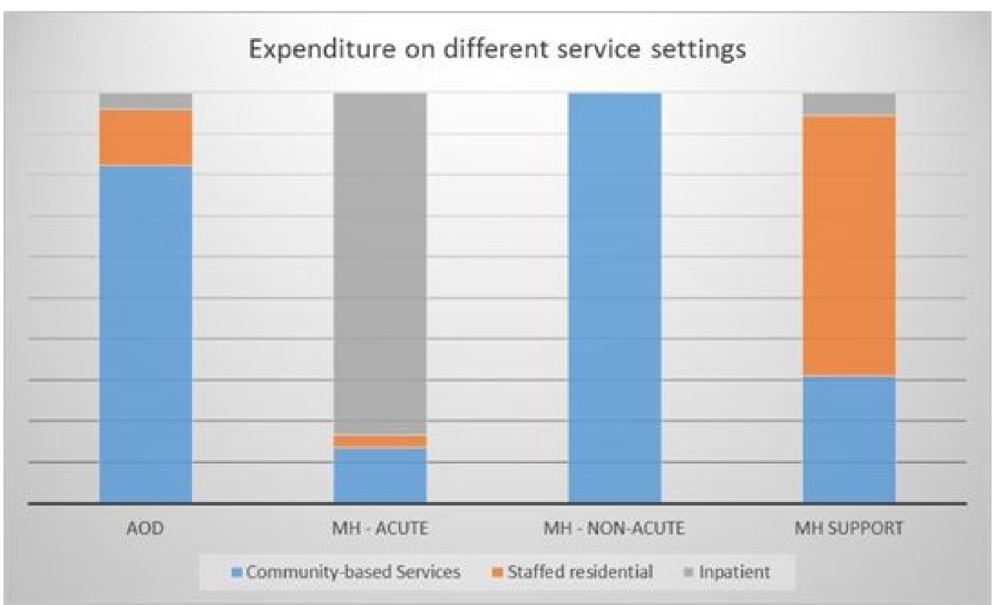
Equity for Māori is our first priority as highlighted in the system map. Our approach to Māori health equity will focus on both Māori providers with kaupapa Māori approaches, and in ensuring all services are compliant in Tikanga and are responsive to Māori.

A high level summary of the investment mapping completed to date is shown below. Please note that the figures are indicative only and yet to be fully verified.

Expenditure on Different Services and Settings

The application of funding across the different categories of service set out in the service map is shown below. "Primary Care" is funding for specific primary mental health and addictions initiatives. The total expenditure on Mental Health and Addiction Services is approximately $118M (excluding Forensic Services).

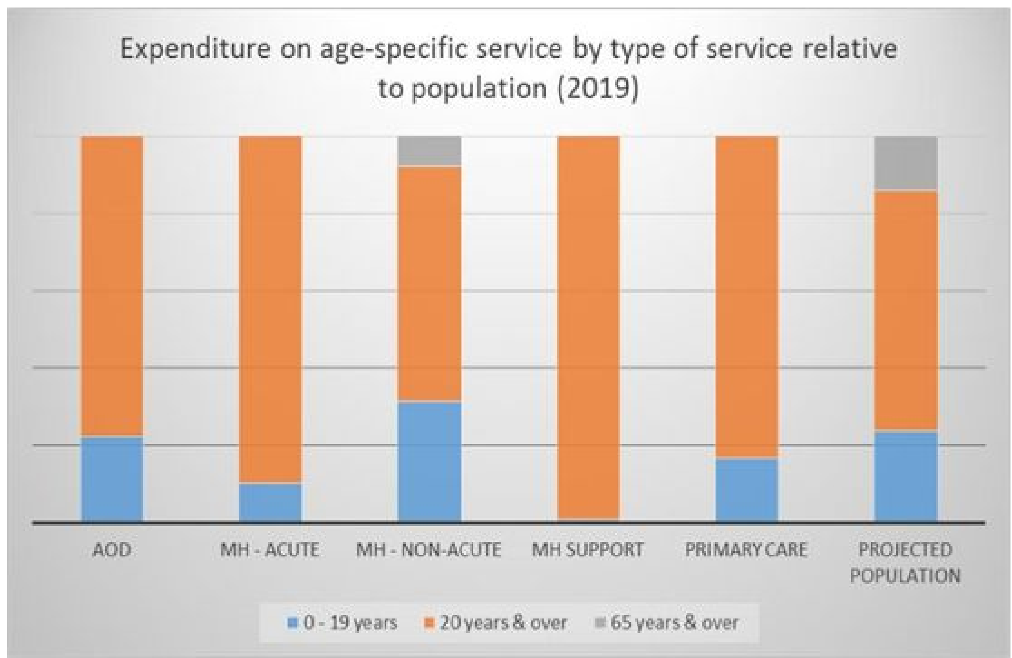




Note the different relative spending on inpatient, residential and community settings across the different service groupings. Of note is the relatively low investment in residential acute care and high investment in residential mental health support relative to community support. Benchmarking against key other DHBs may be helpful in interpreting these patterns.

Whole of Population Services

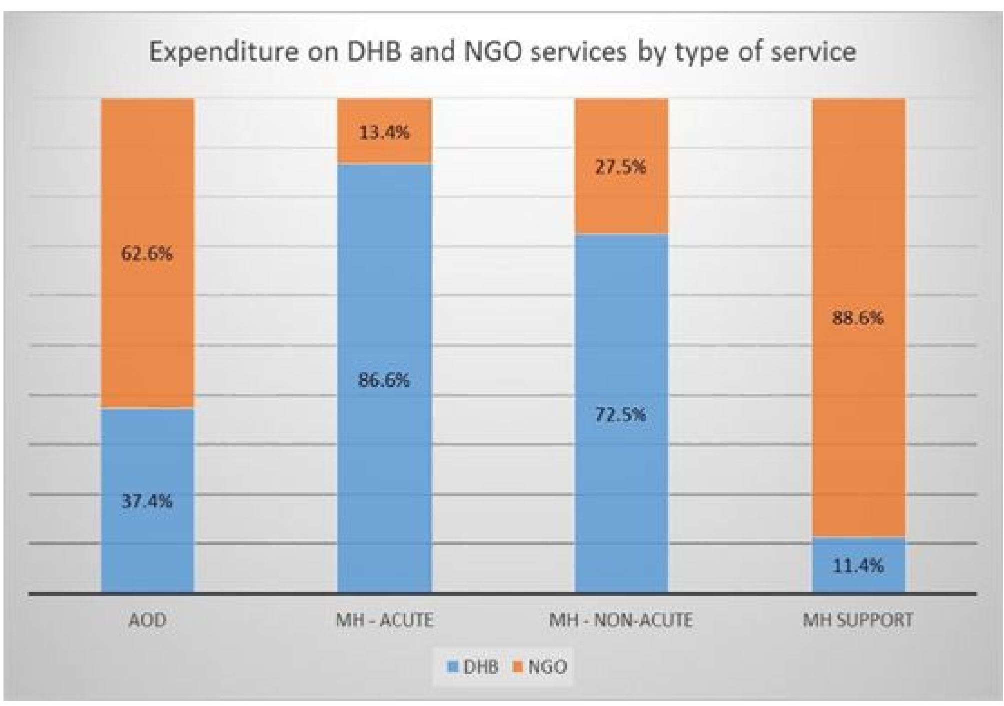
Approximately half of Mental Health and Addiction investment is allocated to services for people with an ongoing high level of need (disability), or to low volume and/or highly specialised services. It would not be possible to have these services dispersed geographically, (e.g. Eating disorders, Maternal Mental Health, Dual Disability, Acute Inpatient). The remaining community and residential services are available to people in need across the whole Waikato population. This subset of services can be tailored to the characteristics of the Waikato population: their age, ethnicity and the locations within which they live, based on their expected level of need. This "whole of population" subset of services has a value of approximately $60M and has been analysed against population characteristics below. *Note that adult mental health services also serve many of the older adults with mental illness.*



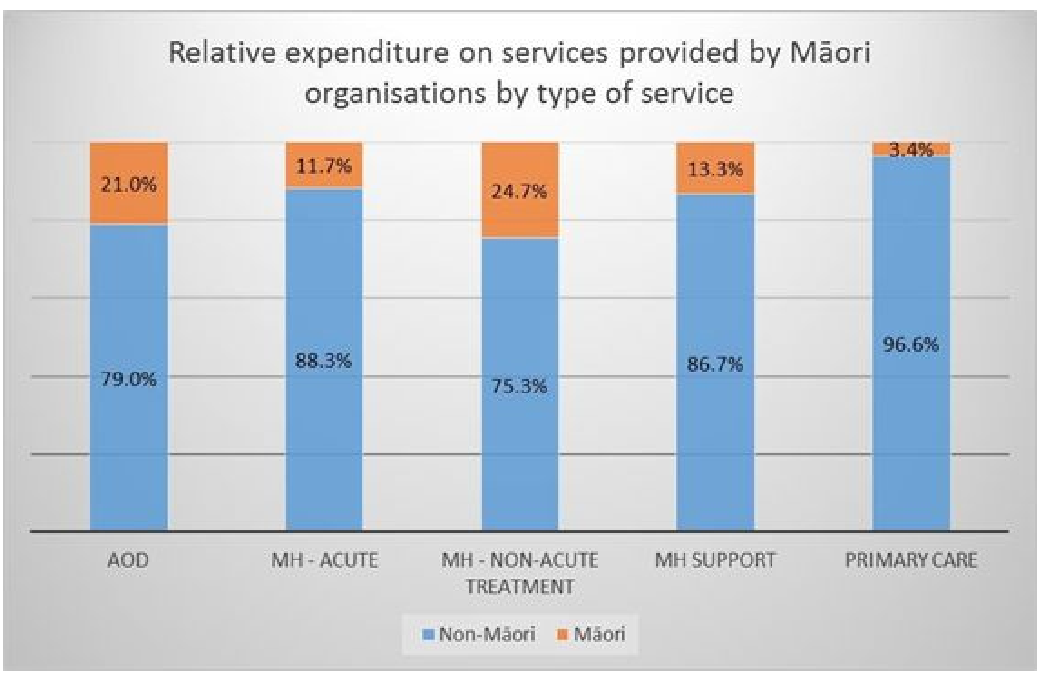
The level of expenditure on older people is low relative to their proportion of the population, however they are also served by adult-focused services and it is difficult to assess whether there is under-investment without knowing more about the number of older people accessing adult services.

The lack of investment in under twenty-year olds in the mental health support category reflects the fact that the conditions leading to high support needs commonly begin in adolescence and early adulthood, but their impact on functioning arises over time, and not in the early years.

71% of the adult mental health acute service is the crisis intervention service which covers all ages.

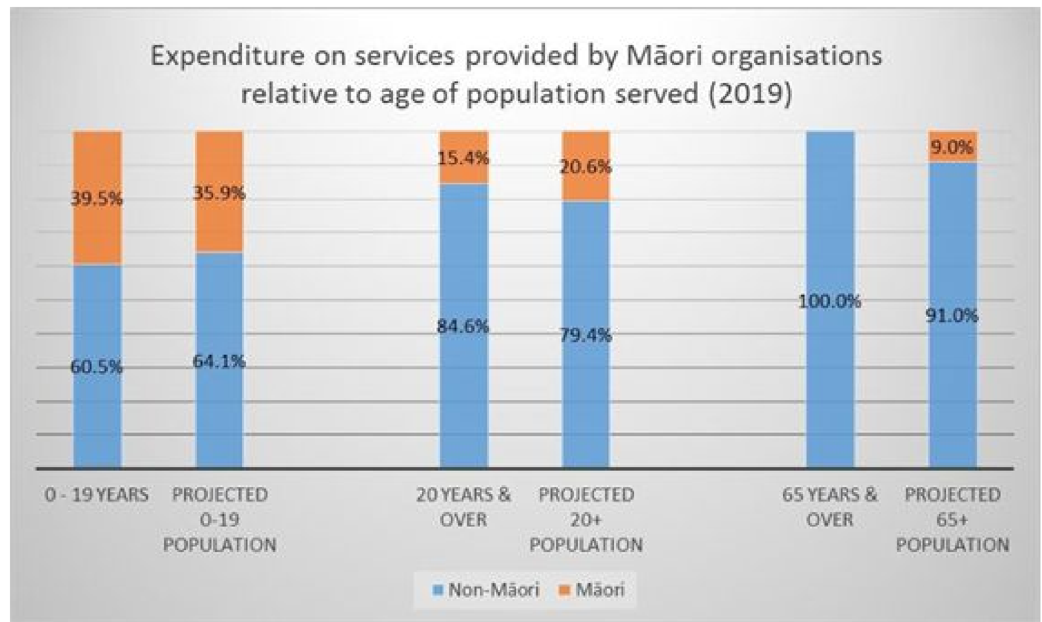


A significant proportion of the delivery of these services is by the NGO sector and this figure is highest for AOD services and mental health support services.



Expenditure on these services provided by Māori is variable across the different types of service. Based on the last census, projections are that 22.9% of the population in 2019 are Māori.

Looking at expenditure on services provided by Māori organisations analysed by age group served, there are no services provided by Māori organisations for older people. For adults, the proportion of expenditure on services that are provided by Māori organisations is lower than the percentage of Māori within population, however studies have shown that the level of need is higher among Māori than non-Māori. For children and young people a greater proportion of the overall expenditure is on Māori-provided services than the proportion of Māori within the population. Again the level of need has been shown to be higher among Māori than non-Māori.



Next Steps

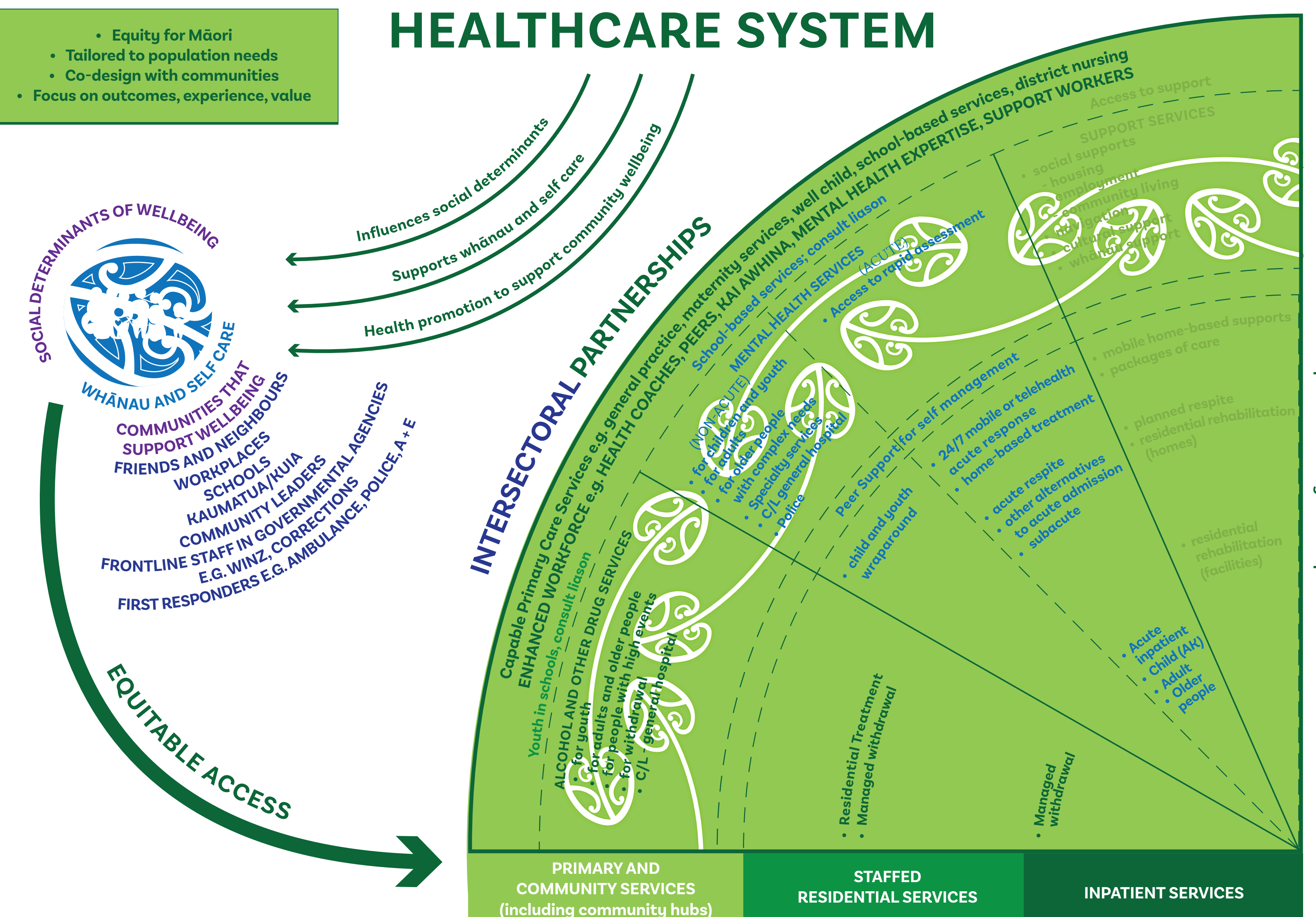
A map of current investment across all services and localities will be completed by early April. This will identify current service gaps and inform the priorities for investment. A Strategic Directions document, including investment priorities will be presented to the Board in May 2019.

Recommendation
THAT

The Board notes the report.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Attachments
1. System Map
2. Mental Health and Addictions System Map Glossary



HEALTHCARE SYSTEM
• Equity for Māori
• Tailored to population needs
• Co-design with communities
• Focus on outcomes, experience, value
Influences social determinants
Supports whānau and self care
Health promotion to support community wellbeing
SOCIAL DETERMINANTS OF WELLBEING
WHĀNAU AND SELF CARE
COMMUNITIES THAT SUPPORT WELLBEING
FRIENDS AND NEIGHBOURS
WORKPLACES
SCHOOLS
KAUMATUA/KUIA
COMMUNITY LEADERS
FRONTLINE STAFF IN GOVERNMENTAL AGENCIES E.G. WINZ, CORRECTIONS
FIRST RESPONDERS E.G. AMBULANCE, POLICE, A+E
EQUITABLE ACCESS
INTERSECTORAL PARTNERSHIPS
Capable Primary Care Services e.g. general practice, maternity services, well child, school-based services, district nursing
ENHANCED WORKFORCE e.g. HEALTH COACHES, PEERS, KAI AWHINA, MENTAL HEALTH EXPERTISE, SUPPORT WORKERS
Youth in schools, consult liason
School-based services; consult liason
ALCOHOL AND OTHER DRUG SERVICES
• for youth
• for adults and older people
• for people with high events
• for withdrawal
• C/L - general hospital
MENTAL HEALTH SERVICES
(NON-ACUTE)
• for children and youth
• for adults
• for older people
with complex needs
• Specialty services
• C/L general hospital
• Police
(ACUTE)
• Access to rapid assessment
Peer Support for self management
• 24/7 mobile or telehealth acute response
• home-based treatment
• acute respite
• other alternatives to acute admission
• subacute
• child and youth wraparound
Access to support
SUPPORT SERVICES
• social supports
- housing
- employment
• community living
• navigation
• cultural support
• whānau support
• mobile home-based supports
• packages of care
• planned respite
• residential rehabilitation (homes)
• residential rehabilitation (facilities)
• Residential Treatment
• Managed withdrawal
• Managed withdrawal
• Acute inpatient
• Child (AK)
• Adult
• Older people
PRIMARY AND COMMUNITY SERVICES (including community hubs)
STAFFED RESIDENTIAL SERVICES
INPATIENT SERVICES
INTEGRATION/COLLABORATION
KAUPAPA MĀORI SERVICES
All services competent in Tikanga and responsive to Māori

MENTAL HEALTH AND ADDICTIONS SYSTEM MAP GLOSSARY

Term	Definition
Acute mental health services	Mental health services specifically for people who are acutely unwell or in crisis and need to be seen urgently.
Addiction	Addiction is a psychological and physical inability to stop consuming a substance, drug, activity, even though it is causing psychological and physical harm.
Alcohol and Drug Treatment	Treatment is a term used to describe help, usually professional, that people get when they are experiencing alcohol and / or drug problems. Treatment includes a range of activities, such as 12 step support groups, counselling services, detoxification or residential programmes where the person stays for weeks.
24/7 mobile or telehealth acute response	Rapid access for people acutely unwell or in crisis to assessment by an experienced mental health professional, without needing to travel to them (delivered either in person or via telehealth).
Alternatives to acute admission	Staffed community-based services where people can safely stay for one or more nights when acutely unwell, with 24-hour 7-day on-site support to manage their distress and with daily access to clinical care. Home based treatment can also be an example of an alternative to acute admission.
Communities	The groups that people identify and associate with; the many places in which people live.
Consult liaison	Advice and support provided by specialist mental health or alcohol and other drug services to another service about the mental health or addiction needs of an individual /whanau e.g. consult liaison to primary care, general hospitals, or police.
Home based treatment	Access for people who are acutely unwell, living at home or in a community-based residential rehabilitation service, to mental health care delivered by an experienced mental health professional, without needing to travel to them (delivered either in person or via telehealth).
Kaupapa Māori Services	Services that are offered within a Māori cultural context, using Māori principles, knowledge, skills and values as a foundation and a framework.
Mainstream services	Health services that are responsive to Māori but are not delivered under a Māori framework.
Navigation	A service to assist people to find the social services or community resources to help them to live well within the community.
Non-acute mental health services	Mental health services that address a range of mental health needs and do not focus solely on the needs of people who are acutely unwell or in crisis.

Package of care	A range of supports specifically tailored to the needs of a particular person / whānau in order to support them to live well within the community.
Peer support	Service delivered by people who themselves have lived experience of mental health or addiction issues, who have received training to provide peer support, and who use their experience to enable recovery and wellbeing in others.
Primary care services	Generalist healthcare (to address any health issue) and that is the first level of contact with the health system. Examples include general practice teams, school-based health services, prison-based health services, maternity services, well-child services.
Primary and community services	Services that are delivered in primary care or other community settings, including generalist services (for any health issue), specialised health services (for a particular health issue such as alcohol and other drug use or mental health issues or support needs).
Recovery	The process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential.
Residential rehabilitation (homes/facilities)	A place where people live for a period of time in order to receive support from qualified staff to develop their ability to live well within the community (can be located in hospital or community settings).
Residential treatment	A place where people live temporarily in order to receive treatment from addiction treatment practitioners to enable them to address alcohol or other drug issues
Respite (planned)	A staffed home in the community where people who have complex needs can stay for a limited and prior-agreed period of time away from their family.
Respite (acute)	A staffed home in the community where people who are acutely unwell can stay for a short period of time while receiving treatment.
Self-management	Actions and decisions people take to regain, maintain and improve their own health and wellbeing.
Social supports	Services delivered by staff qualified to support people to live well within the community, including getting and keeping housing and work and forming social, cultural and spiritual connections.
Specialty services	Mental health or alcohol and other drug services for a specific sub-group of the population e.g. people with co-existing problems (mental health and addictions), people with mental health problems and intellectual disability, women in the perinatal period, etc
Staffed residential services	Services located in home-like environments in the community in which people who receive the services live for

	a period of time: services delivered in these settings include treatment services, respite services, rehabilitation services.
Subacute services	A place where people can stay following an admission to an acute inpatient unit, when they no longer need hospital care but their life circumstances prevent a move to a accommodation in the community (can be located in hospital or community settings).
Whānau support	Services that support whānau to attend to their own self-care and to support family members with mental health or addiction issues to live well in the community.

CBD Accommodation Project: refer to item 4.

Regional eSPACE Programme: report due in May.

Health Finance, Procurement and Management System ex NOS: report due in May.

Papers for Information

MEMORANDUM TO THE BOARD
27 MARCH 2019

AGENDA ITEM 13.1

EMPLOYEE SURVEY 2018

Purpose	For information.

These are the results of the 2018 Employee Survey.

Overall, there is an improvement over the 2015 Employee survey results, and there are still clear areas of focus for Waikato DHB.

Questions remain about how best to prepare for the next survey – matters that will be the subject of a future paper to the Board.

Recommendation
THAT
The Board receives this paper.

GIL SEWELL
EXECUTIVE DRECTOR HR AND ORGANISATIONAL DEVELOPMENT

Waikato DHB Employee Survey 2018

It has been three years since our previous all employee survey and the results helped us to focus on a number of initiatives including living our values and introducing workplace support people. In October 2018, we ran another all employee survey to get a snapshot of the wellbeing of our organisation and to help us decide on actions to improve.

The purpose of conducting this employee survey was to determine if the work streams since the 2015 survey had an impact on our culture and to identify what we needed to do more work on. The Health Round table survey was used

Participation

The employee survey engaged 55% of Waikato DHB staff, a total of 4,139 employees.
Data analysis has clarified that the survey questions were not completed by 144 people, so reporting is using the responses of 3995 employees, a final response rate of 53%. More detailed information on participation including department and role breakdown can be found in Appendix 1.

Findings

Overall result
The overall result for this survey was 66.3%.This is the average of all strongly positive and positive responses to all survey questions.

DHB wide findings
The top five positive and negative responses for Waikato DHB are presented below. The top five positive responses are the highlights of the survey and aspects to be celebrated. The top five negative responses identify improvements since the last survey and aspects which can be seen as opportunities for improvement.

Top 5 results (highs)

- 83.3% of people have a trusted friend or colleague in their place of work.
- 81.7% of people believe that patients are treated with respect and dignity.
- 79.5% of people feel comfortable reporting any concerns about patient safety.
- 78.2% of people believe they have had a positive influence on the culture of their workplace.
- 75.9% of people intend to continue working here for the next 12 months.

Top 5 opportunities (lows)

- 59.3% of people have witnessed bullying in their workplace in the last 12 months. This was a new question asked in 2018.
- 32.6% of people believe that staff performance problems are not corrected in a timely manner, which is an improvement on the 2015 result of 52.7%.
- 32.2% of people have been subjected to bullying behaviour in their workplace in the last 12 months. In 2015 35.9% of people had felt bullied by their team members in the last 12 months, so there is a small improvement.
- 25.8% of people do not believe that staff performance problems are identified, which is an improvement since the 44.6 % rating in 2015.
- 23.1% of people are not happy with their career development options at Waikato DHB. This was also a new question asked in 2018.

Results for all questions can be found in Appendix 2.

Waikato DHB Employee Survey 2018

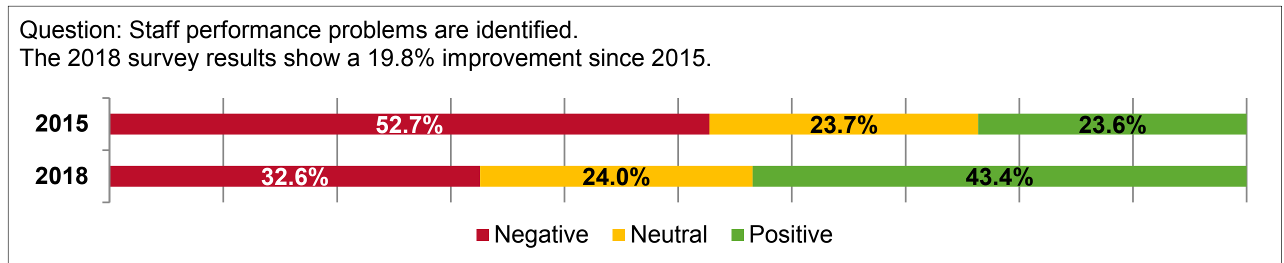
The final question of the survey asked employees "the one thing, more than anything else that needs to change to make this organisation better is".
Thematic analysis was conducted on the responses and the results are presented below.
Number of responses = 2,915

Number of ideas that fit into each cluster	0 – 50 – 100 – 150 – 200 – 250 – 300 – 350 – 400 – 450 – 500		
Leadership & management	**Listen to staff**, fewer managers, give feedback, top heavy, support & guide, on the floor	Stronger leadership, *keep CEO*, visible, lead by example, **consistency**	Take action, **accountability**, *act on feedback*, keep promises
Staffing & resourcing	**Better nurse patient ratio**, more nurses, **safe staffing levels**, address gaps in roster, *prevent turnover*, skilled / experienced staff in specialised areas, FTE, **fill vacancies faster**, burnout		
Respect & appreciation	**Appreciation, valued, understood,** understand differences in rural locations, respected, trusted	**Better pay**	*Recognised acknowledge*
Communication	Better communication **between departments & disciplines**, within teams, *transparency about changes*, honesty, **openness**		
Behaviours	Safe to speak up, looked after **kindness & compassion**	**Address bullying**	
Progress, quality, patient centered	*Training for new starters*, **clearer progression,** patient focused, funding, meaningful change		
Teamwork & collaboration	Shared goal, supportive, **collaboration across departments**		
Working environment	**Parking,** IT, enough equipment, smoke-free, office space, **clean**, *food options*		
Safety & wellbeing	Security, work life, flexibility, **workload**, self care		
Systems & processes	Organised, efficient, **red tape** *wasted funds*, simplify		
Fairness & equality	**Favouritism**, bias, bi-cultural, equity		
Improve culture	**Live values**		

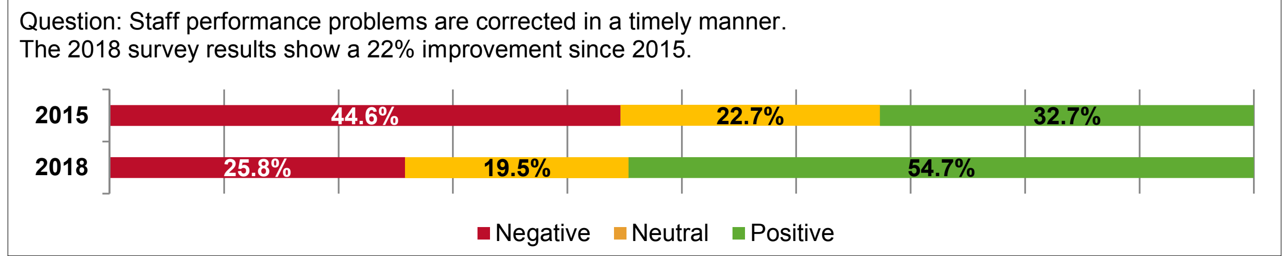
Waikato DHB Employee Survey 2018

2015 + 2018 Comparisons (Overall)
This survey allowed us to compare some question results to questions that were asked in the 2015 survey. The graphs below present the changes that have occurred since 2015.

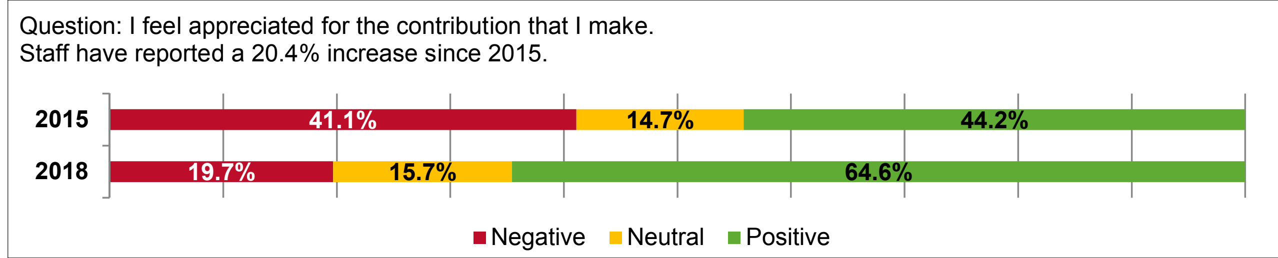
Question: Staff performance problems are identified.
The 2018 survey results show a 19.8% improvement since 2015.



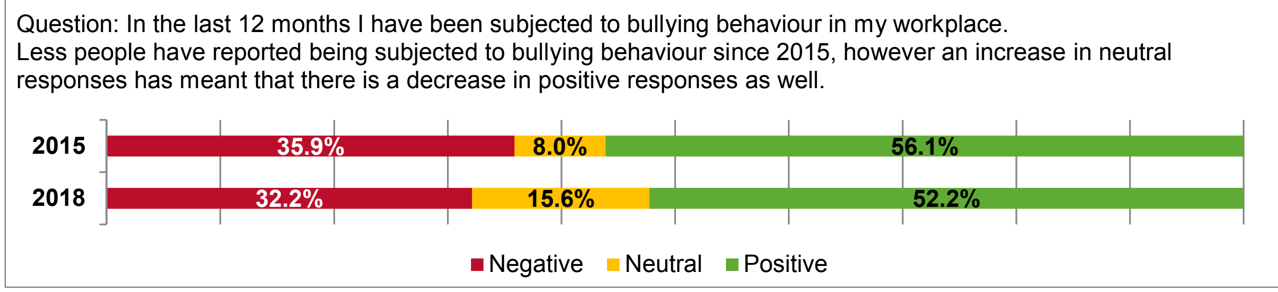
Question: Staff performance problems are corrected in a timely manner.
The 2018 survey results show a 22% improvement since 2015.



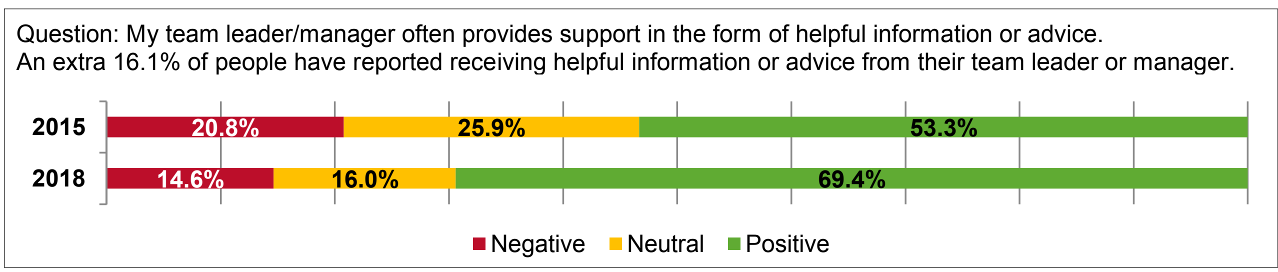
Question: I feel appreciated for the contribution that I make.
Staff have reported a 20.4% increase since 2015.



Question: In the last 12 months I have been subjected to bullying behaviour in my workplace.
Less people have reported being subjected to bullying behaviour since 2015, however an increase in neutral responses has meant that there is a decrease in positive responses as well.



Question: My team leader/manager often provides support in the form of helpful information or advice.
An extra 16.1% of people have reported receiving helpful information or advice from their team leader or manager.



Waikato DHB Employee Survey 2018

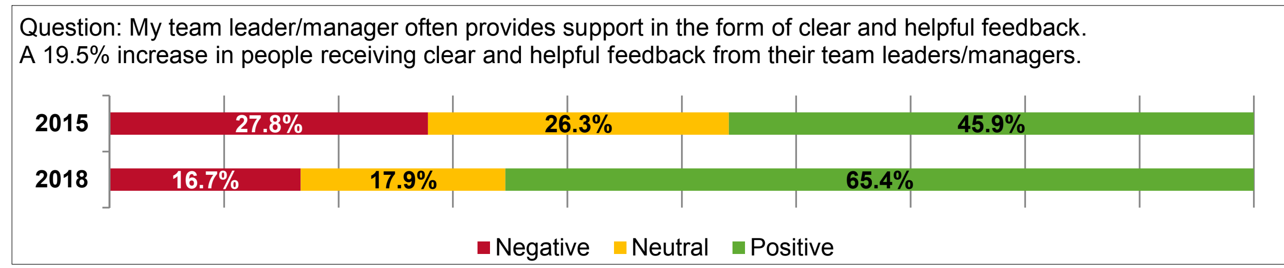
Question: My team leader/manager often provides support in the form of sympathetic understanding or concern.
There has been a 17.9% improvement in team leaders supporting people with sympathetic understanding or concern.

2015 23.1% 26.6% 50.3%

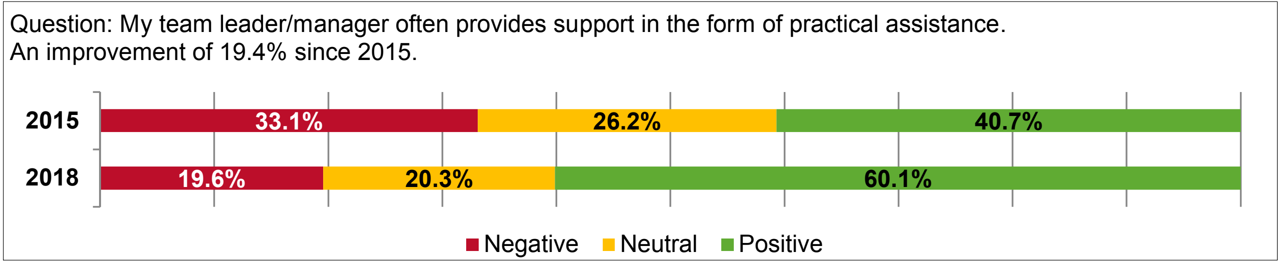
2018 15.1% 16.7% 68.2%

Negative Neutral Positive

Question: My team leader/manager often provides support in the form of clear and helpful feedback.
A 19.5% increase in people receiving clear and helpful feedback from their team leaders/managers.



Question: My team leader/manager often provides support in the form of practical assistance.
An improvement of 19.4% since 2015.



The wording of this question changed from 2015 to 2018, however the question is still comparable. We can see a small improvement between survey's.

Question: I believe I can have a positive influence on the culture of my workplace.

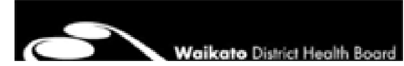
Negative Neutral Positive

2015 13.2% 9.7% 77.1%

Question: I believe I have had a positive influence on the culture of my workplace, since I joined the organisation.

2018 3.6% 18.2% 78.2%

Waikato DHB Employee Survey 2018



Recommendations DHB wide (for conformation)

Actions will be integrated with the People strategy.

A. Highlight the top five and other results with our people.

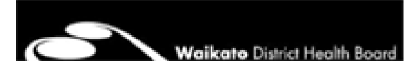
B. Continue the work on creating a positive culture, which includes addressing bullying.
   1. Create resources for staff to call behaviours that go against our values, phase three of values implementation.
   2. Continue the workplace support programme.
   3. Support the Speaking Up for Safety initiative.

C. Conduct further analysis to clarify at a facility/ divisional/ work function level the staff performance problems that are not always being identified and managed result.

D. Further analysis of the “not happy with their career development options” when delivering results to divisional and work function (professional) groups.

E. Establish and monitor actions being taken at a DHB or divisional level to address the results of the survey.

Waikato DHB Employee Survey 2018



Appendix 1: Response rate

Headcount as at 31.10.2018

Respondents self-identified department and role; therefore responses may not be accurate.

Department	Headcount	Respondents	Response rate
Chief Executive Officer	19	2	10.5%
Community and Clinical Support	1228	371	30.2%
Corporate and executive led divisions	658	262	39.8%
Facilities, business and non-clinical support	385	286	74.3%
Mental Health and Addictions	835	412	49.3%
Waikato Hospital: Medicine, Oncology, Emergency and Ambulatory Services	963	568	59.0%
Waikato Hospital: Rehabilitation and Allied Health	798	358	44.9%
Waikato Hospital: Surgical and Critical Care	1772	626	35.3%
Waikato Hospital: Women's and Children's	600	272	45.0%
Other	211	762	344.8%
Decline to say	-	76	-
Total	**7479**	**3995**	**-**

Role	Headcount	Respondents	Response rate
Administration / clerical e.g. receptionists, administrators	828	685	82.7%
Allied and scientific	1341	725	54.1%
Corporate / management	483	326	67.5%
Health care assistants / assistants	540	254	47.0%
Midwifery	138	57	41.3%
Nursing	2867	1384	48.3%
Resident Medical Officer	443	127	28.7%
Senior Medical Officer	430	204	47.4%
Support e.g. orderlies, kitchen, trades	409	99	24.2%
Decline to say	-	134	-
Total	**7479**	**3995**	**-**

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Waikato DHB Employee Survey 2018

Appendix 2: Summary of responses

Question	Positive	Neutral	Negative
All team members accept the team's performance priorities.	67.7%	17.6%	14.7%
Senior and junior members of our team work well together.	75.8%	9.2%	15.0%
Team Leader (Line Manager) is clear about what he or she expects of me.	74.6%	11.3%	14.1%
Staff performance problems are identified.	54.7%	19.5%	25.8%
Staff performance problems are corrected in a timely manner.	43.5%	24.0%	32.6%
My Team Leader (Line Manager) encourages team work and cooperation between departments.	73.5%	15.0%	11.4%
My Team Leader (Line Manager) provides useful feedback on my performance at work.	59.5%	17.7%	22.8%
My Team Leader (Line Manager) encourages the adoption of new ideas to improve the way we work.	71.4%	15.9%	12.7%
I feel accepted as a valued member of my team.	72.9%	11.7%	15.4%
I feel appreciated for the contribution that I make.	64.6%	15.7%	19.7%
I am happy with my career development options within this DHB.	53.8%	23.1%	23.1%
I am supported to develop the skills I need in my career.	62.2%	19.4%	18.5%
I have opportunities to contribute to important decisions that affect my work.	60.2%	18.8%	21.0%
I am receiving the right level of supervision for my working requirements.	73.0%	16.3%	10.7%
I intend to continue working at this DHB for at least the next 12 months.	75.9%	15.4%	8.6%
I have a trusted friend / colleague at my place of work.	83.3%	10.2%	6.5%
I have the equipment and supplies that I need to do my job properly.	74.0%	9.7%	16.3%
In the last 12 months I have witnessed bullying behaviour in my workplace.	25.7%	15.0%	59.3%
In the last 12 months I have been subjected to bullying behaviour in my workplace.	52.3%	15.6%	32.2%
I feel safe working within this DHB.	66.4%	17.8%	15.8%
I recommend this DHB as a place to work.	59.4%	23.8%	16.8%
Overall I am satisfied with my job.	71.7%	15.3%	13.0%
Patients are treated with dignity and respect.	81.7%	14.1%	4.3%
I feel comfortable reporting any concerns about patient safety.	79.5%	14.3%	6.2%
I would feel safe being treated as a patient here.	70.7%	17.2%	12.1%
My team leader/manager often provides support in the form of helpful information or advice.	69.4%	15.9%	14.6%
My team leader/manager often provides support in the form of sympathetic understanding and concern.	68.2%	16.7%	15.1%
My team leader/manager provides support in the form of clear and helpful feedback.	65.4%	17.9%	16.7%
My team leader/manager provides support in the form of practical assistance.	60.1%	20.3%	19.6%
I believe I have had a positive influence on the culture of my workplace, since I joined the organisation.	78.2%	18.2%	3.6%
Average	66.28%	16.41%	17.31%

Waikato DHB Employee Survey 2018

Presentations

Presentation from Hauraki PHO General Practices.

Board Member Items

MEMORANDUM TO THE BOARD

27 MARCH 2019

AGENDA ITEM 15.1

THE LIVING WAGE

Purpose	For consideration and approval.

What is 'Living Wage'?

The concept of a Living Wage was first introduced in 2013. It is currently set at $20.55 per hour or $42,867.30 annually for a full-time equivalent salary (2086 hours). It has been revised on an annual basis in February each year. The table below is a comparison of the Living Wage to the Minimum Wage and the respective annual movements of each. . Based on labour market statistics from June 2018 and recent collective settlements, the Living Wage can be expected to be increased to approximately $21.17 per hour in February 2019, which would equate to a full-time annual salary of $44,161 per annum.

Year	Living Wage	Percent Increase	Minimum Wage	Percent Increase
2013	$18.40		$13.75	
2014	$18.80	2.1739%	$14.25	3.6364%
2015	$19.25	2.3936%	$14.75	3.5088%
2016	$19.80	2.8571%	$15.25	3.3898%
2017	$20.20	2.0202%	$15.75	3.2787%
2018	$20.55	1.7326	$16.50	4.7619%
2019	$21.17*	3%	$17.70	7.2772%
2019	$21.17*	3%	$17.70	7.2772%

* Assumption based on recent collective settlements

The Living Wage was developed and set by the Living Wage Movement Aotearoa NZ Inc. which is a consortium comprised of faith based religious groups, unions, and secular community groups. It is noble in intent. It derived its initial calculation based on research from the Family Centre Social Policy Research Unit and increases since then have been based on the average wage movement.

It is a concept modelled on what is deemed the minimum necessary for a domestic unit of two adults and two dependent children, where the two adults work sixty hours a week between them to be able to participate in society. It does not factor in any government benefit or support that such a family would receive. It is to be noted that the family unit identifier of 2A+2C represents 11% of households in New Zealand according to Statistics NZ.

There is a complexity attached which argues for differentiating those who fit into the modelled family unit from those who don't. It is to be noted that the Human Rights Act 1993 prevents an employer offering different rates of pay based on the employee's marital status,

domestic living arrangements, and whether the employee has dependent children or not. As such, any decision to apply the Living Wage will flow on to any employee whose occupational group is covered by any such a policy directive to align pay rates with the Living Wage. The Living Wage discussion applies to fewer than 10% of our employees, but raises significant implications for relativities in pay and compression within delegations, e.g. between team member and team leader.

Current State

A number of private organisations (Vector, Bunnings, The Warehouse) and NGOs (including Wellington City Council and many of our Union partners – PSA, Unite, ETu, NZNO) have adopted the Living Wage, but few of the scale of Waikato DHB.

To date, no other DHBs have adopted a Living Wage, although two have proposed to align themselves with Living Wage – Capital & Coast and Waitemata. They have not yet, as far as we are aware, consulted with the Ministry on the proposal.

The DHB Workforce Strategy Group (WSG) has recognised the economic footprint that DHBs are responsible for, typically being one of the largest if not the largest employers in our respective regions. As part of that recognition, the significant alignment between poverty and poor health outcomes/inequalities needs to be acknowledged. Increasing the wages and incomes of our low socio-economic communities will have a positive impact through the flow on implications by contributing to reducing levels of poverty, health outcomes, and of health inequalities. The argument can be made that doing so should be a national, funded initiative, which would require a national Workforce Strategy, as yet not available.

Nevertheless, addressing our lower paid workforce remains one of the key national workforce priorities, and can be evidenced in the ETu settlement where wage rates for the lowest paid employees will increase by 8% initially and then a further three increases of approximately 6% over the three year term.

While the draft Government Expectations on Pay & Employment in the core state sector had specific reference to working to implement the Living Wage in the core state sector, the final version took out any reference to it http://www.ssc.govt.nz/govt-expectations-pay-employment.

Any movement to a Living Wage will require consultation and approval from the Ministry of Health. It should be noted that the Ministry of Health required the proposed ETu – DHB settlement to remove reference to "living-wage friendly rates" from the final document.

The national claims around Equal Pay and Pay Equity may also have an impact on closing the gap between current pay rates and the Living Wage. While there is no expectation around additional funding being available for District Health Boards who unilaterally move to a Living Wage, there is more potential for District Health Boards to obtain additional funding through authorised national processes around such initiatives.

While the Minimum Wage is unlikely to completely close the gap to the Living Wage, both recent history and the current Government's intentions to move the minimum wage to $20 per hour by April 2021, would predict that the gap will continue to close.

Some unions, such as ETu have advocated that, in a limited pool of resources, they would prefer employers prioritise the upskill of employees through formal qualifications, as the best method for lifting living standards.

Moving to Living Wage is likely to assist in recruitment and retention for the relevant workforces, and may well drive other employers in the region to adjust their rates accordingly in response.

Moving to a Living Wage will create internal relativity and band compression issues which will add to existing issues been created by the wage movements of recent MECA bargaining. Aligning with Living Wage movement is likely to receive, in the main, public support.

Some organisations have introduced their own approach, inspired by Living Wage, such as The Warehouse ('Career Retailer' pay, with tenure and service dependencies) and Auckland DHB (Supportive Employment - a package that deliberately provides additional benefits to lower paid employees but does not impact wages or government benefits).

Who are we?

Aside from the fact that adoption is riddled with challenges, it leads us into a rabbit warren and minefield of detail and calculation.

Instead, this paper elevates the discussion to a level that defines who Waikato DHB wants to be, as the largest employer in the region, and how we want to be viewed with regard to our practices and our role in the region and communities we serve.

This is an important conversation, and one that must sit above the details of implementation. At Waikato DHB we have clearly outlined and widely published our approach and intent through our Strategy and Values. It will be essential for a Living Wage to align with these. We do not yet have a published People Strategy – it is currently under development. The focus of the imminent People Strategy will be on our employees at our heart, a shift that needs to be made to emphasise the value and care we place on our people.

Strategic Alignment

A Living Wage shows a limited alignment to Waikato HB's strategic priorities. Living Wage reflects the importance of each strategic imperative thus:

Strategic Imperative	**Priorities**	**How Living Wage aligns**
Oranga Health equity for high need populations	• radical improvement in Māori health outcomes by eliminating health inequities for Māori • eliminate health inequalities for people in rural communities • remove barriers for people experiencing disabilities • enable a workforce to deliver culturally appropriate services.	• Living Wage contributes to preventing our own high need employees falling into poverty and therefore ill health • enhances our reputation as an employer committed to greater social responsibility
Haumaru	• deliver high quality,	• Drawing a rather long bow, the

Strategic Imperative	**Priorities**	**How Living Wage aligns**
Safe, quality health services for all	timely, safe care based on a culture of accountability, responsibility, continuous improvement and innovation • prioritise fit-for-purpose care environments • early intervention for services in need • ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives.	enhanced reputation of the DHB as a good employer may help us to attract appropriate staffing numbers.
Manaaki 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 whānau needs and values • Enable a culture of professional cooperation to deliver services • Promote health services and information to our diverse population to increase health literacy.	• Living Wage is an enabler of our aspiration to be renowned for our people-centred approaches, starting with our employees. It is a demonstration of how we value our people.
Ratonga a iwi Effective and efficient care 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.	• Since Living Wage has not been budgeted, its introduction can be seen to go against this priority • Living Wage supports a sustainable workforce, helping to minimise turnover from lower paid roles.
Pae taumata	• build close and enduring relationships with local,	• Taking the Living Wage on board would help build even better

Strategic Imperative	Priorities	How Living Wage aligns
A centre of excellence in learning, research and innovation	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.	relationships with our Union partners.
Whanaketanga 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.	

Organisational values are at the heart of our strategy framework. Developed by our staff and approved by the board, our values are promoted through the organisation in a variety of ways, and increasingly used by employees as a compass for individual, team and organisational attitudes and behaviour.

Value	Living Wage Alignment
People at heart / Te iwi ngakaunui	Living Wage is a clear demonstration of an organisation's focus on its people.
Give and earn respect / Whakamana	Living Wage demonstrates respect for all employees to be able to participate in society, not just survive.
Listen to me, talk to me / Whakarongo	Would indicate us listening to our Union partners.

Fair play / Mauri Pai	A Living Wage is in the spirit of fair play.
Growing the good / Whakapakari	The living wage enables individuals to have their basic needs meet, a platform from which to reach their full potential.
Stronger together / Kotahitanga	The living wage is inclusive and helps out people who in turn help us deliver on organisational strategic objectives.

Options

1. *Apply the Living Wage to Waikato DHB (not recommended)*

To move employees of Waikato DHB to a minimum pay rate formulated on the Living Wage will cost at a conservative estimate approximately $2 million per annum.

Waikato DHB has 21 current collective agreements, with another three which have either not previously been in existence or had lapsed for which bargaining has now either begun or been initiated. The majority of these agreements have salary scales that include annual salaries less than $42,900.

Waikato DHB as of October 2018 had 691 employees whose hourly rate was below the $20.55 per hour rate for the Living Wage.

Staff type	Headcount	FTE
Allied	96	85.49
Administration	192	158.87
Nursing	63	51.2
Support	340	254.73
Total	**691**	**550.29**

Most of the individuals whose current hourly rate is below the Living Wage will have the ability to move a wage rate above the Living Wage through the annual service increments and other pay increase provided in the collective agreements. After the ETu agreement is ratified, the PSA Clerical MECA (due to be renegotiated in early 2019) will be the principal outlier.

Example:

- Healthcare Assistant

Under NZNO MECA, current Y1 starting salary - $39,206, Y5 salary $46,605 (current pay rates as of 1 October 2018).

- Attendant/Kitchen Assistants

Currently, Grade 1 - $33,605.46 – Grade 6 (L3 Qualification) - $42,239

Under proposed settlement (to be backdated to June 2018)

Grade 1 - $36,296 – Grade 4 (L3 Qualification) -$44,233 (An abbreviated four step scale is being introduced rather than the current 6 step one).

Staff type (excludes casuals)	Cost to increase to Contracted FTE only	Additional Overtime Costs
Allied	200,145.44	1,589.92
Admin	263,034.55	1,239.60
Nursing	113,282.32	1,813.97
Support	1,318,810.29	26,161.11
Grand Total	**1,895,272.60**	**30,804.59**
TOTAL	**$1,926,077**	

The costs in table above exclude KiwiSaver, casuals, and ACC employer levy contributions; however, as the data set does not factor in agreed increases that have not yet been implemented, it is considered that the figure of $2 million is a conservative representation, particularly considering the ETu proposed settlement, though it is anticipated that in February 2019 that the Living Wage is likely to increase by a minimum three per cent which would equate to $21.43 per hour or $44, 703 per annum for a full FTE.

Impact

Due to abatements in the Working for Families Tax Credits as result of salary increases, the benefits of moving to a Living Wage framework will have reduced positive impact on the group to which it is most relevant i.e. those households with dependent children.

The implementation only tackles wages, and only then for a small proportion of our employs. It does not begin to address upskilling and career pathways, or the provision of any other benefits.

2. Introduce a Supportive Employment approach (recommended)

The purpose of the proposed Supportive Employment role is fourfold:

1. Focus on operationalising support mechanisms and initiatives for the following four Waikato DHB employee groups:
    - our lower income employees
    - those with disabilities
    - those with mental health needs (including measures for supporting those who develop mental health needs)
    - young people in our community who may or may not be work ready.
2. Beginning with the first group above, explore what they would like to see that would improve their situation, so we offer genuine co-design of a supportive employment solution. Create a plan to implement feasible and appropriate measures for Waikato DHB's lower paid workers, and later facilitate their extension to these employee groups as relevant and appropriate. Auckland DHB's 'To Thrive' programme is a successful

implementation of this approach, which includes developing supportive employment mechanisms such as:

- how we bring people into employment
- how we support them whilst they are here and provide opportunities and employment pathways for them to self-select and self-manage for success(by their definition of success)
- education in financial capability and improved access to benefits in partnership with MSD
- sustaining strategies for any employees who may develop mental health needs during their employment here.

3. Develop and implement a plan to achieve the above. Importantly, this work develops our push for equity by:
   - increasing the number of Māori employees
   - enabling our Māori populations see more of themselves working in the health environment, which is better for health outcomes
   - helping raise the number of opportunities for our Māori employees
   - helping prevent our own employees falling into poverty and therefore ill health
   - supporting employees dealing with mental health issues (noting that we know Māori are affected to a greater proportion by such issues)
   - enhancing our reputation as an employer committed to greater social responsibility
   - mirroring the population we serve
   - providing equitable and fulfilling employment opportunities for disabled people to have financial security and achieve their aspirations.

Supportive Employment

Health equity for high need populations	• Supportive Employment reflects the importance of this strategic imperative by: o increasing the number of Māori and Pacific employees lets our Māori and Pacific populations see more of themselves working in the health environment, which is better for health outcomes o helping raise the number of opportunities for our Māori and Pacific employees o helping prevent our own employees falling into poverty and therefore ill health o supporting employees dealing with mental health issues (noting that we know Māori are affected to a greater proportion by such issues) o enhancing our reputation as an employer committed to greater social responsibility o mirroring the population we serve.

Safe, quality health services for all	• Supportive Employment allows us to highlight where we can provide support for the safety and wellbeing of our lower income employees and otherwise challenged groups of people, to support them in their efforts to increase wellness in patients.
People centred services	• Supportive Employment is an enabler of our aspiration to be renowned for our people-centred approaches, starting with our employees. It is a demonstration of how we value our people. It offers the opportunity to provide seamless, consistent approaches across the whole organisation. Supportive employment provides evidence to drive decisions about how we provide our employment conditions and services by identifying what our people feel is important.
Effective and efficient care services	• Supportive Employment requires the collection and analysis of a wider range of employee data to support the programme. This offers the opportunity to gain a clearer picture of our employee requirements and so tailor other programmes to meet our people's needs.
A centre of excellence in learning, research and innovation	• This innovative approach moves away from a sole focus on wages and takes a wider view of the person at the centre – what do they need, want and how can we meet that. • Working with external providers and agencies to grow and develop our people.
Productive partnerships	• Supportive Employment programme is being shared across other DHBs. • Partnership with external agencies such as tertiary education providers to enhance and enable our pipelines by growing opportunities through these providers.

Recommendation
THAT
The Board receives this report and approves the Supportive Employment option to move into planning and implementation.

GIL SEWELL
EXECUTIVE DIRECTOR HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT

Next Board Meeting: 24 April 2019.