Waikato District Health Board

# 2016-17

# ANNUAL PLAN

Incorporating the Statement of Intent and Statement of Performance Expectations

*Our Annual Plan sets out the activities we plan to undertake in terms of national, regional and local priorities during the 2016/17 year. It describes to Parliament and to the New Zealand public what we intend to achieve this year, to improve the health of the Waikato DHB population and to reduce or eliminate health inequalities.*

*We are part of the Midland DHB region, and have worked together to improve the regional consistency across our plans. This collaboration is reflected throughout this plan. The Plan is broken into a number of modules to allow various sections of the document to be highlighted for different purposes and audiences. Central to understanding this Plan, is our performance story which sets out our key outcomes (what we are trying to achieve), our impacts (our shorter term contribution to an outcome), our outputs (goods and services supplied), and our inputs (resources).*

*This plan should be read in conjunction with the 2016/17 iteration of the Midland DHB Regional Services Plan, our Māori Health Plan 2016/17 and our Population Health Service Plan 2016/17.*

*The thought and creative design of the cover of this document has been intentionally aligned to the Bay of Plenty DHB 2015-16 Annual Plan Summary. Waikato DHB acknowledges the creativity of Bay of Plenty DHB and thanks them for their permission to use this approach.*



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*This document is available on the Waikato District Health Board website:*
http://www.waikatodhb.health.nz/about-us/key-publications/

# Office of Hon Dr Jonathan Coleman

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


22 DEC 2016

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

chairman@waikatodhb.health.nz

Dear Mr Simcock

**Waikato District Health Board 2016/17 Annual Plan**

This letter is to advise you I have approved and signed Waikato District Health Board's (DHB's) 2016/17 Annual Plan for three years.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and in order to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

***Living Within our Means***

In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.



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I am pleased to see that your DHB is planning a surplus for 2016/17 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2016/17.

***National Health Targets***

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

I expect delivery of your Annual Plan will improve your performance in relation to the *shorter stays in emergency departments*, and *increased immunisation* health targets, where your most recently published results indicate further work is needed.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

***System Integration including Shifting Services***

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Waikato DHB has committed to establish a regional alliance team during the year and committed to agreeing terms of reference with stakeholders by the end of quarter one. I look forward to being advised of your progress with this throughout the year.

***Cross-government Initiatives and Collaboration***

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

***Annual Plan Approval***

I am advised that you are yet to reach agreement with Midland Health Network on your Annual Plan. However, in order to ensure that appropriate accountability documents are in place for the 2016/17 year, I am approving your Annual Plan. This approval is made on the

1.2

condition that you continue to work to agree the Plan with Midland Health Network and that, while the agreement is being reached, you will collectively ensure that your population is not adversely impacted by your inability to reach agreement. In particular, I expect you to progress the establishment of the regional alliance team during the year, and expect to see a work programme developed.

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr Jonathan Coleman
**Minister of Health**

cc Dr Nigel Murray
Chief Executive
Waikato District Health Board
Private Bag 3200
Hamilton 3240

nigel.murray@waikatodhb.health.nz

# Table of Contents

# OVERVIEW

This Annual Plan provides short term (2016/17) actions and measures, as well as measures and forecast standards of performance over the medium term. The plan is intended for use by our staff, our primary care partners, our provider organisations, our regional colleagues and is public information. It is a legal requirement and the primary accountability document between the Minister of Health and Waikato District Health Board (DHB).

The burden of disease is unfairly distributed in our society; long term conditions and risk factors such as smoking, obesity and diabetes contribute to serious health disparity. The health of Māori remains an area in which we must do better, and more detail is to be found in our Māori Health Plan. Other communities who experience disparity include Pacific people, rural communities, people with disabilities and areas like the physical health of people with serious mental health and addiction problems. The life expectancy in this part of our community is 25 years less than for other New Zealanders.

The funding environment remains constrained as health consumes an ever increasing portion of total government expenditure. As ever, our financial performance will be an area of focus in 2016/17. We have instituted a “sustaining a healthy future for Waikato DHB” approach which has a focus on developing quality and cost effectiveness.

During 2015/16 we refreshed our organisational strategy because we wanted to ensure Waikato DHB is heading in the right direction, focusing its resources and making the most of future opportunities. There are fundamental challenges we identified that we must face in the short and medium term if we want to continue improving the health status of our population and our work to eliminate health inequities. We recognised we had to change to enable us to meet these challenges and make the most of the opportunities. We knew we could not deal with this by doing more of the same thing. The environment is changing, our population is changing, people’s health needs are changing and we need to be prepared. We decided we could not afford to wait until things happen before we react.

# SIGNATORIES

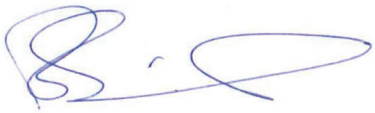
AGREEMENT DATED _____ OF 2016

Between

_____

Signed by Hon Dr Jonathan Coleman
Minister of Health

AND



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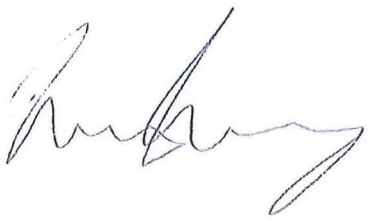
Signed by Bob Simcock
Chair, Waikato District Health Board



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Signed by Dr Nigel Murray
Chief Executive Officer, Waikato District Health Board

# KŌWAE TAHI / MODULE ONE: INTRODUCTION AND STRATEGIC INTENTIONS

## 1.1 Introduction

Waikato DHB was established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000 (NZPHD) and is one of 20 DHBs in New Zealand. DHBs were established as vehicles for the public funding and provision of personal health services, public health services and disability support services for a geographically defined population[1]. Waikato DHB is a Crown Entity and is accountable to the Minister of Health.

Our functions include both funding and planning of services, and provision of services. Like all DHBs, we receive funding from government to undertake our functions[2]. The share of funding we receive is based on:

- The size and demographic mix of our population (age, gender, ethnicity and deprivation);
- Our population's past use of health services.

We hold contracts and agreements with organisations that provide the health services required to meet the needs of our population. For example, primary health care services (such as General Practitioners and practice nurses) are funded by DHBs through primary health organisations. The services are then provided by general practices or other primary care services belonging to the primary health organisation.

In 2016/17 we will receive approximately $1,315 million in funding from the government and Crown agencies for health and disability services for our population. Our provider division will receive approximately 62 per cent of the service funding with the remaining 38 per cent being utilised to fund services including those provided by laboratories, non-government organisations, pharmacy and primary care.

We are socially responsible and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. We are responsible for monitoring and evaluating service delivery, including audits of the services we fund.

The costs of providing services to a patient are met by the DHB where they live, regardless of where those services are delivered. Where we do not provide the service, we have funding arrangements in place enabling our district residents to travel outside the district. We also deliver services for other funders such as Accident Compensation Corporation.

In order to achieve the planned outputs, impacts and outcomes as outlined in this Annual Plan, we may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or vary any current agreement for the provision or procurement of any health and disability support service. These agreements (or variations) may contain any terms or conditions acceptable to the DHB.

[1] See section 1.4.4 for a map of our district
[2] See section 1.1.2 for detail on the nature and scope of our functions

### 1.1.1 Performance Story

The diagrams presented on the following pages provide a high level summary of our performance story and demonstrate the link between our outcomes and our stewardship areas. The right hand column of the diagram indicates the relevant module of this Plan for further details.

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. | | | | | Kōwae Tahi / Module One |
| **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 | | | | | Kōwae Tahi / Module One |
| **Regional Strategic Outcomes** | To improve the health of the Midland populations | | | To eliminate health inequalities | | |
| **Regional Strategic Objectives** | Improve Māori health outcomes | Integrate across continuums of care | Improve quality across all regional services | Improve clinical information systems | Build the workforce | Efficiently allocate public health system resources |

Waikato DHB Performance Story

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

Service performance

| | | | | |
|---|---|---|---|---|
| **Long-term Impacts** | People take greater responsibility for their health | People stay well in their homes and communities | People receive timely and appropriate specialist care | Kōwae Toru / |

| | | | | |
|---|---|---|---|---|
| **Intermediate Impacts** | • Fewer people smoke<br>• Reduction in vaccine preventable diseases<br>• Improving health behaviours | • Children and adolescents have better oral health<br>• Long term conditions are detected early and managed well<br>• Fewer people are admitted to hospital for avoidable conditions<br>• People maintain functional independence | • People are seen promptly for acute care<br>• People have appropriate access to ambulatory, elective and arranged services<br>• Improved health status for people with a severe mental illness<br>• More people with end stage conditions are supported | |
| **Outputs**[3] | • 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 | Module Five |

### 1.1.2 Nature and Scope of Functions

We collaborate with other health and disability organisations (such as our primary care alliance partners), key stakeholders and our community to identify what health and disability services are needed and how best to use the funding we receive from Government. Through this collaboration, we aim to ensure that health and disability services are well coordinated and cover the full continuum of care, with the patient at the centre. We expect these collaborative partnerships to also allow the sharing of resources, reduction in duplication, variation and waste across the health system to achieve the best outcomes for our community. As a DHB we:

- Plan in partnership with key stakeholders such as our primary care alliance partners, the strategic direction for health and disability services;
- Plan regional and national work in collaboration with the Ministry of Health and other DHBs;
- Fund the provision of the majority of the public health and disability services in our district, through the agreements we have with providers;
- Provide hospital and specialist services primarily for our population and also for people referred from other DHBs;
- Promote, protect and improve our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives.

[3] Only examples of the outputs are presented here. For the full set of measures see module three

## 1.2 National Strategic Intentions

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

The New Zealand health and disability system's statutory framework is made up of over 20 pieces of legislation. The most significant are the New Zealand Public Health and Disability Act 2000, the Health Act 1956, and the Crown Entities Act 2004. Further information is available from http://www.health.govt.nz/new-zealand-health-system/overview-health-system/statutory-framework.

Health and disability services in New Zealand are delivered by a complex network of organisations and people. Each has their role in working with others across the system to achieve better, sooner, more convenient services for all New Zealanders. The network of organisations is linked through a series of funding and accountability arrangements to ensure performance and service delivery across the health and disability system.

The Ministry of Health is a funder, purchaser and regulator of national health and disability services, on behalf of the Crown. These services include:

- Public health interventions (such as immunisation or dealing with outbreaks of disease);
- Disability support services;
- Screening services (such as cervical screening);
- Maternity services;
- Child health services (such as Plunket and Child Development Centre);
- Ambulance services.

There are a large number of outcomes and priorities identified at a national level that DHBs are charged with contributing to or implementing. A number of these outcomes and priorities are presenting in the following section. Further information is available from the Ministry of Health's Statement of Intent 2015 to 2019 or on the Ministry of Health website.

### 1.2.1 New Zealand Health Strategy

The New Zealand Health Strategy is the key source of direction for the health sector and it is currently being refreshed. From late October 2015 to early December 2015 the Ministry of Health led a consultation process on a draft updated New Zealand Health Strategy. Once approved, the New Zealand Health Strategy will provide the sector with a clear strategic direction and road map for delivery of more integrated health services to New Zealanders. The strategy has a ten-year horizon so will impact not just immediate planning and service provision but will enable and require DHBs and the sector to have a clear roadmap for future planning as well. Further information on alignment with the New Zealand Health Strategy is found in section 2.1 of this document.

### 1.2.2 More Effective Social Services

In June 2014, the Productivity Commission was asked to look at ways to improve how government agencies commission and purchase social services. They produced the More Effective Social Services report which was released in mid-September 2015. The report makes several recommendations about how to make social services more responsive, client-focused, accountable and innovative. There is a strong drive for DHBs to work together with other public, private and non-profit entities to achieve improved outcomes.

### 1.2.3 Convention on the Rights of Persons with Disabilities

The 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

### 1.2.4 ‘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, which will be delivered from 2014 to 2018.

### 1.2.5 Outcomes

There are two identified health system outcomes for New Zealand. They are:

1. New Zealanders live longer, healthier, more independent lives;
2. The health system is cost effective and supports a productive economy.

These health system outcomes support the achievement of wider Government priorities and are not expected to change significantly over the medium term. The Ministry of Health has three high-level outcomes that support the achievement of the health system outcomes above:

- New Zealanders are healthier and more independent;
- High-quality health and disability services are delivered in a timely and accessible manner;
- The future sustainability of the health and disability system is assured.

### 1.2.6 The Minister of Health’s Letter of Expectations

The Minister of Health has outlined his expectations for the 2016/17 year. The expectations reinforce the Government’s ongoing commitment to protecting and growing New Zealand’s public health services. The key areas highlighted in the letter of expectations are:

- Refreshed New Zealand Health Strategy;
- Living Within our Means;
- Working Across Government;

- National Health Targets;
- Tackling Obesity;
- Shifting and Integrating Services;
- Health Information Technology Programme 2015 - 2020.

### 1.2.7 Health Targets

Improving performance across the sector is fundamental to the health system outcomes. One of the mechanisms used to monitor our performance is the nation-wide health targets. Meeting these targets makes a practical difference to individuals and families by improving access to services, reducing waiting times or preventing harmful conditions. The following table outlines our target levels for each of the six health targets.

| Health Target | National Target Goals | Waikato DHB Target for 2016/17 |
|---|---|---|
| Shorter Stays in Emergency Departments | 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours. | 95 percent |
| Improved Access to Elective Surgery | The volume of elective surgery will be increased by an average of 4,000 discharges per year. | 16,805 |
| Faster Cancer Treatment | 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 by June 2017. | 90 percent |
| Increased Immunisation | 95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. | 95 percent |
| Better Help for Smokers to Quit | 90 percent 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<br>90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking | 90 percent<br><br>90 percent |
| Raising Healthy Kids | By December 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. | 95 percent |

### 1.2.8 Better Public Service

The Government has set 10 challenging results for the public sector (which includes DHBs) to achieve over a five year period. The areas that the health sector is taking a major role in are outlined in the following table.

| Better Public Service Result Area | National Target |
|---|---|
| Result 2: Increase participation in quality early childhood education | In 2016, 98 percent of children starting school will have participated in quality early childhood education. |
| Result 3: Increase infant immunisation rates and reduce the incidence of rheumatic fever | • Increase infant immunisation rates so that 95 percent of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017<br>• Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by June 2017 |
| Result 4: Reduce the number of assaults on children | By 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5 percent. |

### 1.2.9 Social Sector Trials

The Social Sector Trials involve Education, Health, Justice and Social Development, and the New Zealand Police working together to change the way that social services are delivered. They test what happens when a local organisation or individual directs cross-agency resources, as well as local organisations and government agencies to deliver collaborative social services. There are four Social Sector Trials in our district in the following areas:

- Taumarunui;
- Waitomo District;
- South Waikato District.

### 1.2.10 Whānau Ora

Whānau Ora is an approach that supports whānau to identify and achieve their aspirations. It is a key cross-government work programme jointly implemented by a number of sectors, particularly health, education and social services. Further information about Whānau Ora in our district is provided in section 2.5.8.

## 1.3 Regional Strategic Intentions

Midland DHBs have agreed a strategic approach to assist the region to move forward in the same direction. This includes a shared vision, two strategic outcomes and six objectives. The strategic outcomes and objectives for the region are summarised below and further detail is provided in the Midland DHBs 2016-19 Regional Services Plan.

In response to the draft update of the New Zealand Health Strategy Midland DHBs have adopted the vision, refreshed guiding principles (for the system), and investment approach. Midland DHBs have also embraced Pae Ora (healthy futures), recognising that health links with the wider environment for individuals, family, whānau, and community, and the environment.

### 1.3.1 Regional Services Plan

The Midland Regional Services Plan documents the regional collaboration efforts of Midland DHBs and aligns service and capacity planning in a deliberate way. The Regional Services Plan includes national priorities and midland region priorities. It outlines how Midland DHBs intend to plan, fund and implement the identified services at a regional or sub-regional level. The plan has a specific focus on reducing service vulnerability, ensuring consistent and timely treatment and the quality of care to patients, no matter where they live in the Midland region.

The Midland DHBs Regional Services Plan 2016/19 includes a focus on a number of clinical service areas, population groups and regional objectives. There is also a continued focus on improving alignment between DHB Annual Plans and the Regional Services Plans.

Key parts of the strategic direction from the Midland DHB Regional Services Plan 2016/19 are outlined in the following section. Please see a copy of the plan for the detail and for activities planned at a regional level.

### 1.3.2 Regional Vision

The vision of our region is:

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

### 1.3.3 Regional Strategic Outcomes

Strategic Outcome 1: Improve the health of the Midland populations

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

Strategic Outcome 2: Eliminate health inequalities

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

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

### 1.3.4 Regional Objectives

The region has agreed six regional objectives, which are:

- Regional Objective 1: Improve Māori health outcomes;
- Regional Objective 2: Integrate across continuums of care;
- Regional Objective 3: Improve quality across all regional services;
- Regional Objective 4: Improve clinical information systems;
- Regional Objective 5: Build the workforce;
- Regional Objective 6: Efficiently allocate public health system resources.

## 1.4 Local Strategic Intentions

During 2015/16 Waikato DHB undertook a Strategic Refresh Project. This project was driven by our Board and focussed on ensuring the organisation is heading in the right direction, focusing its resources and making the most of future opportunities. It is recognised that there are some fundamental challenges we must face along the way if we want to continue improving the health status of our population and our work to eliminate health inequities.

### 1.4.1 Our Vision

Healthy people. Excellent Care.

### 1.4.2 Our Mission

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

### 1.4.3 Our Strategic Imperatives

1. Health equity for high needs populations - Oranga;
2. Safe, quality health services for all - Haumaru;
3. People centred services - Manaaki;
4. Effective and efficient care and services - Ratonga a iwi;
5. A centre of excellence in learning, training, research and innovation – Pae taumata;
6. Productive partnerships - Whanaketanga.

### 1.4.4 Our Priorities

We have identified a number of priorities related to each of our strategic imperatives. These priorities are outlined in the following table.

| Strategic Imperative | Priority |
|---|---|
| Health equity for high needs populations - Oranga | • Radical improvement in Māori health outcomes by eliminating health inequities for Māori<br>• Eliminate health inequities for people in rural communities<br>• Remove barriers for people experiencing disabilities<br>• 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<br>• Prioritise fit-for-purpose care environments<br>• Early intervention for services in need<br>• 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<br>• Provide care and services that are respectful and responsive to individual and whānau needs and values<br>• Enable a culture of professional cooperation to deliver services<br>• 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<br>• Achieve and maintain a sustainable workforce |

| Strategic Imperative | Priority |
|---|---|
| | • Redesign services to be effective and efficient without compromising the care delivered<br>• 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<br>• Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research<br>• Cultivate a culture of innovation, research, learning, and training across the organisation<br>• 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<br>• Authentic collaboration with partner agencies and communities<br>• Focus on effective community interventions using community development and prevention strategies<br>• Work towards integration between health and social care services |

### 1.4.5 Implementing Our Strategy

The first pre-requisite to the success of our strategy will be strong and unambiguous leadership. In order to respond to the challenges we face we must become more innovative and we must get comfortable with change. Turning this strategy into action will mean making changes; some changes will see more investment in some areas and some changes will mean disinvestment. Whatever the changes, they will be done by using robust decision-making and in partnership with others to ensure we are delivering excellent health services and care.

**Priority programme plans**

To connect strategy with day-to-day activity, priority plans will be developed during 2016/17. These will be developed for each of the priorities identified in 1.4.4. These plans will detail the transformative innovation needed to create the health system that works best for the Waikato. A priority programme plan is created to:

> *Coordinate, direct and oversee implementation of a set of related projects and activities in order to deliver outcomes and benefits related to Waikato DHB's strategic imperatives.*

A member or members of the Waikato DHB Executive Group will lead each of the priority programme plans. The plans will identify specific activity and actions that will contribute to the achievement of our strategic imperatives and vision. The plans will identify indicators of performance that will be measured and monitored to assess progress. The priority programme plans will not be individual stand-alone developments; they will need link with other priority programmes.

**Monitoring the strategy**

We will monitor delivery of the strategy by assigning performance and progress measures to each priority programme plan. Progress measures will be assigned to each of the strategic imperatives, which will be reported on publicly in our Annual Report.

### 1.4.6 Our Population

Our DHB serves a population of 400,820 and covers 21,220 square kilometres. It stretches from northern Coromandel to close to Mt Ruapehu in the south and from Raglan on the west coast to Waihi on the east.


Our district takes in the city of Hamilton and towns such as Thames, Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngaruawahia, Te Kuiti, Tokoroa and Taumarunui. Six Iwi are located within the Waikato DHB area. More detailed information on our Māori population is outlined in Ki te Taumata o Pae Ora, our Māori Health Plan.

A detailed breakdown of our population is presented in the following table.

| Age Group | Ethnicity | | | |
|---|---|---|---|---|
| | Māori | Pacific | Other | Total |
| 00 – 24 | 47,850 | 5,700 | 86,950 | 140,500 |
| 25 – 44 | 21,940 | 3,200 | 72,280 | 97,420 |
| 45 – 64 | 16,680 | 2,120 | 80,940 | 99,740 |
| 65 – 74 | 3,690 | 500 | 32,010 | 36,200 |
| 75+ | 1,640 | 280 | 25,040 | 26,960 |
| Total | 91,800 | 11,800 | 297,220 | 400,820 |

Our large rural population presents diverse challenges in service delivery and accessing health services. Significant points of interest in terms our population include:

- The population is expected to increase in Waikato but at a slower rate than the rest of New Zealand;
- We are more rural than New Zealand as a whole;
- We have a population that is getting proportionately older (the 65 plus age group is projected to increase by 52 per cent between 2011/12 and 2025/26);
- The population of children and young people is predicated to decline by 2026;
- We have a Māori population which is growing at a slightly faster rate than other population groups and is estimated to be 23.3 per cent by 2026;
- We have a population of Pacific people who make up an estimated 2.5 per cent of our population;
- A higher percentage of people in our DHB live in areas of low socio-economic status compared to the New Zealand average (24.10 per cent live in areas classified as quintile five or most deprived, compared to a national average of 20 per cent);
- Ruapehu, Waitomo and South Waikato territorial local authorities have the highest proportion of people living in areas of low socio-economic status;
- Inequalities in health tend to be highest for people living in areas identified as quintile four and five and these people are likely to experience lower life expectancy and higher rates of chronic conditions;
- High numbers of the Māori population in our district live in areas identified as quintile four and five.

### 1.4.7 Health Profile

Understanding our health profile plays an important part in our planning and decision making processes. Key points of interest in terms of the health profile of our population are[4]:

- In 2012–2014, life expectancy at birth for Māori in the Waikato Region was 76.5 years for females (7.5 years lower than for non-Māori females) and 72.2 years for males (8.1 years lower than for non-Māori);
- The all-cause mortality rate for Waikato Māori was twice as high as the non-Māori rate during 2008–2012;
- Injury mortality was 85 percent higher for Māori than for non-Māori in Waikato. Males had higher rates of death from injury than females;
- Potentially avoidable mortality and mortality amenable to health care were 2.6 times and 2.7 times as high for Māori as for non-Māori in Waikato during 2007–2011;
- The all-cause rate of hospital admissions was 16 percent higher for Māori than for non-Māori during 2011–2013;
- Almost 5,200 Māori hospital admissions per year were potentially avoidable, with the rate 38 percent higher for Māori than for non-Māori. The ambulatory sensitive hospitalisation rate was 75 percent higher;
- The rate of hospitalisation due to injury was 19 percent higher for Māori than for non-Māori. Males had higher rates of admission than females;

[4] Information in this section has been sourced from Robson B, Purdie G, Simmonds S, Waa A, Brownlee G, Rameka R. 2015. Waikato District Health Board Māori Health Profile 2015. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare

- The most common causes of injury resulting in hospitalisations among Māori were falls, exposure to mechanical forces, complications of medical and surgical care, transport accidents, and assault;
- Rates of hospital admission for injury caused by assault were over 5 times as high for Māori females as for non-Māori females and 2.4 times as high for Māori males as for non-Māori males. Males had higher rates than females;
- Compared to non-Māori, cancer incidence was almost 50 percent higher for Māori females while cancer mortality was close to twice as high. For Māori males, cancer incidence was similar to that of non-Māori, while cancer mortality was two-thirds higher;
- Breast screening coverage of Māori women aged 45–69 years was 55 percent compared to 68 percent of non-Māori women at the end of 2014;
- Cervical screening coverage of Māori women aged 25–69 years was 60 percent over 3 years and 75 percent over five years (compared to 78 percent and 91 percent of non-Māori respectively);
- The rate of lung cancer was 4 times the rate for non-Māori, as was the mortality rate. Breast cancer incidence and mortality rates were both two-thirds higher for Māori than for non-Māori;
- During 2011–2013 Māori with diabetes were nearly 4 times as likely as non-Māori to have a lower limb amputated;
- Māori adults aged 25 years were 82 percent more likely than non-Māori to be hospitalised for circulatory system diseases (including heart disease and stroke) in 2011–2013;
- Waikato Māori were 28 percent more likely than non-Māori to be admitted with acute coronary syndrome, 43 percent more likely to have angiography.
- Heart failure admission rates were 5 times as high for Māori as for non-Māori.
- Stroke admission rates were twice as high for Māori as for non-Māori, as were rates of admission for hypertensive disease;
- Chronic rheumatic heart disease admissions were almost 6 times as common for Māori as for non-Māori, while heart valve replacement rates were just over twice as high;
- By September 2014, 66 percent of Māori girls aged 17 years and 64 percent of those aged 14 years had completed all three doses of the human papilloma virus (HPV) immunisation. Coverage was higher for Māori than for non-Māori;
- Rates of hospitalisation for serious injury from self-harm were similar for Māori and non-Māori among those aged 15–24 years during 2011–2013 but over a third higher for Māori than for non-Māori at ages 25–44 years;
- Māori aged 45 years and over were 3.8 times as likely as non-Māori to be admitted to hospital for chronic obstructive pulmonary disease.
- Asthma hospitalisation rates were 2 to 3 times as high for Māori than for non-Māori in each age group;
- On average, 2,180 Māori infants were born per year during 2009–2013, 40 percent of all live births in the DHB. Seven percent of Māori and six percent of non-Māori babies had low birth weight;
- In 2013, two-thirds of Waikato Māori children aged 5 years and one-third of non-Māori children had caries;
- At Year 8 of school, almost three in five Māori children and just over two in five non-Māori children had dental caries;
- Māori children under 15 years were two-fifths more likely than non-Māori to be hospitalised for tooth and gum disease;

- Māori were four-fifths more likely as non-Māori to be admitted to hospital for a mental disorder during 2011–2013. Schizophrenia type disorders were the most common disorders, followed by mood disorders.

## 1.5 Key Risks and Opportunities

As we enter the 2016/17 planning round, we see a New Zealand Public Health System that continues to face challenges. With challenges, however, come opportunities and this plan details many of the opportunities and interventions we believe will have positive impacts on the health status of our population.

### 1.5.1 Health Inequities

Waikato DHB is committed to achieving health equity across population groups. Health inequities are described as 'differences which are unnecessary and avoidable, and are unfair and unjust'. Currently, the burden of disease is unfairly distributed in our society; long term conditions and risk factors such as smoking, obesity and diabetes contribute to serious health disparity. The health of Māori remains an area in which we must do better.

If we fail to get serious about prevention then the recent progress in healthy life expectancies will stall, the unnecessary differences will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend our budgets on reducing the impact of wholly avoidable conditions.

Targeting of vulnerable populations is essential if we are to realise more equitable health outcomes. The approach we take includes:

- Implementing our Māori Health and Public Health Plans;
- Promoting screening services too hard to reach groups to increase early detection of disease;
- Implementing services that target communities with identified health inequalities;
- Setting targets by ethnicity or by high needs and monitoring performance;
- Supporting kaupapa Māori services and 'for Pacific by Pacific' services;
- Increasing the capability of the Māori and Pacific workforce across our district;
- Using an equity lens as part of decision-making processes (e.g. the Health Equity Assessment Tool);
- Engaging with our Disability Support Advisory Committee to provide advice and inform decision making;
- Engaging with Iwi Māori Council to provide advice and inform decision making;
- Engaging with community health forums and expert advisory groups to provide and receive advice (e.g. our AgeWISE advisory group, our mental health and addictions local advisory group and our rural health advisory group).

A challenge for DHBs in the Midland Region is to configure health service delivery in a way that takes account of the complex relationships between the key social determinants of health (such as housing quality, education and employment), while recognising that a number of public and private agencies influence health outcomes.

### 1.5.2 Fiscal Discipline

The ongoing pressure of the financial environment is one of the factors driving the need for the health system to transform. This means seeking efficiency gains and improvements in purchasing, productivity and the quality of our operation and service delivery.

DHBs need to budget and operate within allocated funding. We have a long term financial model and detailed plans to improve our year on year financial performance. We continually monitor our financial performance against the national expectations of DHBs living within their means. We are continually looking for ways to increase allocative efficiency through preventative care.

### 1.5.3 Workforce Shortages

The health workforce is made up of a wide variety of occupational groups employed by a number of different organisations. Workforce shortages, particularly in rural areas, are a key threat to the health system's ability to provide a full range of accessible, high-quality health services.

Statistics from the Nursing Council and Medical Council in 2011 show, that for both nurses and doctors the largest numbers were in the 50 – 54 age group. Both professions had roughly 12 – 13 per cent of their active workforce aged over 60 and both had an average age of 45. According to the New Zealand Nurses Organisation survey, about a third of all nurses over 50 plan to retire in the next two to five years.

We cannot deliver the necessary change without investing in our current and future workforce and we must ensure our workforce is trained to work within the diverse cultural environment that exists in the Waikato. Activity is occurring at a national, regional and local level to mitigate the impact of workforce shortages. Detail on a number of the strategies in place to mitigate the impact of this challenge is set out in Kōwae Rimu / Module Five.

### 1.5.4 System Integration

We will be part of a future that no longer sees expertise locked into hospital buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. It will be a future where the system is organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. We see a future that dissolves long standing and artificial divides between:

- General Practice and hospitals;
- Physical and mental health and addiction;
- Health and social care;
- Prevention and treatment.

### 1.5.5 Regional Collaboration

There are gains to be made from working regionally in new and innovative ways, both in cost savings and better patient wellbeing. Regional services' planning[5] is a vehicle to progress regional system integration and regional service development opportunities. This must be a whole of system approach and as such, it is vital for primary care to be engaged in developments in this arena.

### 1.5.6 Changing Population Dynamics[6]

Low fertility and the ageing of the large baby boom cohort have raised the prospect of slow or no population growth in the future. The general demographic outlook for New Zealand over the coming decades is for slowing growth, a narrowing gap between births and deaths, and an ageing population. Planning and service delivery must take account of these population shifts.

As populations age, the relative risk of succumbing to an infectious disease starts to fall, while the incidence of non-communicable diseases rises. This will impact on the ability and capacity of New Zealand to provide access to health care and social services. The impact of an ageing population is felt wider than just within the health sector – in 2011 there were four people in the workforce for every person 65 years and over – by 2031 there will be just half that number, with two people in workforce for every over-65 year old. Whilst increasing numbers of people are electing to work past the age of 65 increasing numbers of people are reaching the old/old category of 85 plus – often with a high degree of frailty and high health need.

Population growth is expected to slow and end in most rural areas in New Zealand. The rural '65 plus' year old population is projected to double and the younger population are expected to move away from rural areas to seek education and job opportunities. This change will have a significant impact on health services in rural areas.

### 1.5.7 Technological Advancements

The reach of technological innovation continues to grow, changing the health sector as it evolves. Technological advancements in healthcare will contribute to services being taken out of the confines of hospital walls and integrating them with user-friendly, accessible devices.

Waikato DHB expects to be at the forefront of delivering technological innovations that enable patients to have a greater say in their own care and when and where it is delivered. It's not about technology but about transforming how health services are delivered. Waikato DHB is consciously using the disruptive opportunities created by this technology to create service change that will bring health services closer to home with greater patient convenience.

### 1.5.8 Tackling Obesity

Reducing the incidence of obesity is a key focus area[7]. There is no single solution that will fix obesity. A range of interventions across Government, the private sector, communities, schools and families have been developed and are being implemented. The Government has

[5] See section 1.3
[6] Changes in the size, structure and distribution of the population
[7] Information on activity we are planning to undertake in this area is presented in section 2.4.1.

developed a Childhood Obesity Plan which includes activities to improve public information and resources; increasing physical activities and improving nutrition.

During 2016/17 we will be pulling together work already done in this space to help inform a district wide approach to tackling obesity. This will mean activity occurring in the community setting, the primary care setting as well as the tertiary care sector. Our Population Health Service will have a lead role in this activity.

### 1.5.9 Working Across Sectors

Health determinants, and subsequently health and health equity outcomes, are often influenced by factors outside the health sector, including areas such as education, income, housing, ethnicity and gender. Working across sectors is not the sole responsibility of any part of the health system. The different levels of the system, from providers to DHBs to the Ministry of Health, need to seek out partners across a range of sectors to allow for better service integration, planning and support for improved health outcomes.

## 1.6 Key Measures of Performance

### 1.6.1 Long Term Impact - People are Supported to Take Greater Responsibility for their Health

Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. It is expected a focus on this impact will reduce the number of presentations in primary care and admissions to hospital and specialist services associated with long term conditions.

#### 1.6.1.1 Fewer People Smoke

**Why is this important?**

Smoking is a major contributor to preventable illness and long term conditions, such as cancer, respiratory disease, heart disease and strokes. Supporting our population to say “no” to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori.

**How will we know we are succeeding?**

While a number of initiatives and interventions occur in this area, we will focus on monitoring the percentage of people taking up smoking.

| Measure | Baseline 2014 | Target 2016 | Target 2017 | Target 2018 |
|---|---|---|---|---|
| Percentage of Year 10 students who have never smoked[8] | 74% | More than 75.7% | Increased percentage | |

[8] Reporting is based on school year and based on surveying a sample of schools in New Zealand

#### 1.6.1.2 Reduction in Vaccine Preventable Diseases

**Why is this important?**

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). These diseases are entirely preventable.

**How will we know we are succeeding?**

We will know we have succeeded by reducing our admissions for vaccine preventable diseases.

| Measure | Baseline | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|
| Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year old | 8.8 | Less than 8.8 | Reduction in admissions for vaccine preventable diseases | |

#### 1.6.1.3 Improving Health Behaviours

**Why is this important?**

Good nutrition is fundamental to health and to the prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in New Zealand each year.

**How will we know we are succeeding?**

By seeing a reduction in obesity, a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence people to make healthier choices.

| Measure | Baseline | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|
| 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017) | TBC | 95% | | |

### 1.6.2 Long Term Impact - People Stay Well in their Homes and Communities

For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and closer to home and prevent disease through education, screening, early detection and timely provision of treatment. Primary care is a vital point of continuity and effective coordination across the continuum of care, particularly in improving the management of care for people with long-term conditions. Activity in primary care

can lead to reductions in avoidable hospital admissions and emergency department presentations.

Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

#### 1.6.2.1 Children and Adolescents have Better Oral Health

**Why is this important?**

Good oral health demonstrates early contact with health promotion and prevention services and reduced risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights. Oral health is also an integral component of lifelong health and impacts a person's comfort in eating (and ability to maintain good nutrition in old age), self-esteem and quality of life.

**How will we know we are succeeding?**

By Year 8, children's teeth should be their permanent teeth and any damage at this stage is life long, so the lower a child's decayed missing and filled teeth score, the more likely that their teeth will last a life time.

| Measure | Baseline 2014 | Target 2016 | Target 2017 | Target 2018 |
|---|---|---|---|---|
| Mean decayed missing and filled teeth score of Year 8 children[9] | 1.08 | 1.05 | 1.03 | Decrease |

#### 1.6.2.2 Long Term Conditions are Detected Early and Managed Well

**Why is this important?**

Early detection will lead to successful treatment, or a delay / reduction the need for secondary and specialist care. This is expected to enable more people to stay well in their homes and communities for longer.

**How will we know we are succeeding?**

| Measure | Baseline | Target 2016/17 | Target 2017/18 and 2018/19 |
|---|---|---|---|
| To be confirmed during 2016/17 | tbc | tbc | tbc |

#### 1.6.2.3 Fewer people are admitted to hospital for avoidable conditions

**Why is this important?**

There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases and deliver Better, Sooner, More Convenient Healthcare for all New Zealanders.

[9] This measure covers a calendar year period to line up with the school year

**How will we know we are succeeding?**

There has been a deliberate focus in 2016/17 on addressing the inequity in rates of ambulatory sensitive hospitalisation between Māori, Pacific people and other New Zealanders. In line with this, we have set targets for ambulatory sensitive hospitalisations to reduce the equity gap in our district.

| Measure | Baseline (year ended March 2016) | Target 2016/17 | Target 2017/18 | Target 2018/19 |
|---|---|---|---|---|
| Ambulatory sensitive hospitalisation rate per 100,000 for the following age group:<br>• 45 – 64 year olds | 4,154 per 100,000 of population | 3,936 per 100,000 of population | Decrease | |

### 1.6.2.4 People Maintain Functional Independence

**Why is this important?**

We aim to support people to maintain functional independence. With a population that is ageing, there tends to be an increased demand on our constrained resources. We are looking to manage the expected growth in demand by improved models of care that support people to remain independent for as long as possible.

**How will we know we are succeeding?**

Ideally, we would like to promote a model of care that reduces the proportional length of time an older person requires Aged Residential Care. As we do not currently capture this information, our best proxy indicator is to increase the average age at which an older person enters Aged Residential Care.

| Measure | Baseline | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|
| Average Age of Entry to Aged Related Residential Care | Rest home – 85<br>Dementia – tbc<br>Hospital – 86 | More than 84<br>More than 80<br>More than 85 | Increase | |

## 1.6.3 Long Term Impact - People Receive Timely and Appropriate Specialist Care

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, people's health outcomes and quality of life can be improved.

The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter waiting lists and wait times are also indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, we are operating under increasing demand and workforce pressures. The expectations around reducing waiting times, coupled with the current fiscal situation, mean we need to develop innovative ways of treating more people and reducing

waiting times with limited resources. This reflects the importance of ensuring that hospital and specialist services are sustainable and that the Midland Region has the capacity to provide for the complex needs of its population now and into the future.

### 1.6.3.1 People Receive Prompt and Appropriate Acute Care

**Why is this important?**

Long stays in Emergency Departments are linked to overcrowding of the Emergency Department, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in an Emergency Department improves the health services DHBs are able to provide.

The duration of stay in Emergency Department is influenced by services provided in the community to reduce inappropriate Emergency Department presentations, the effectiveness of services provided in Emergency Departments and the hospital and community services provided following exit from an Emergency Department. Reduced waiting time in Emergency Departments is indicative of a coordinated 'whole of system' response to the urgent needs of the population. Improved performance against this measure will not only improve outcomes for our population, but will improve the public's confidence in being able to access services when they need to.

**How will we know we are succeeding?**

When we see an increase in the percentage of people who visit our Emergency Departments and are admitted, discharged or transferred within six hours.

| Measure | Baseline | Target 2016/17 | Target 2017/18 and 2018/19 | |
|---|---|---|---|---|
| Percentage of patients admitted, discharged or transferred from emergency departments within six hours | 94% | 95% | 95% | 95% |

### 1.6.3.2 People Have Appropriate Access to Elective Services

**Why is this important?**

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. Improved performance against this measure is also indicative of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

**How will we know we are succeeding?**

To meet the appropriate level of access, we want to ensure that our Standard Intervention Rates meet national expectations for cardiac procedures.

| Measure | Baseline | Target 2016/17 | Target 2017/18 and 2018/19 |
|---|---|---|---|
| Standardised Intervention Rates (per 10,000) | Major joint replacement: 27<br>Cataract procedures: | More than 21 | Maintain |

| Measure | Baseline | Target 2016/17 | Target 2017/18 and 2018/19 |
|---|---|---|---|
| | 25<br>Cardiac surgery:<br>7.3<br>Percutaneous revascularization:<br>11.4<br>Coronary angiography services:<br>33.9 | More than 27<br><br>More than 6.5<br><br>More than 12.54<br><br>More than 34.7 | Maintain<br><br>Maintain<br><br>Maintain<br><br>Maintain |

### 1.6.3.3 Improved Health Status for People with Severe Mental Illness

**Why is this important?**

It is estimated that at any one time, 20 percent of the New Zealand population will have a mental illness or addiction, and 3 percent are severely affected by mental illness. There is also a high prevalence of depression with the economic downturn and other pressures. The World Health Organisation predicts that depression will be the second leading cause of disability by 2020. We have an ageing population, which places increased demand from people over 65 for mental health and addiction services appropriate to their life stage.

Our goal is to build on our existing relationships, by offering programmes to individuals and groups from a broad range of ages – children and youth, adults and older people.

| Measure | Baseline | Target 2015/16 | Target 2016/17 and 2017/18 |
|---|---|---|---|
| 28 day acute re-admission rates | 12% | Less than or equal to 15% | Decrease |

**How will we know if we are succeeding?**

If we improve access, and provide services to people at the right time, and in the right place, and can expect to see a reduction in our 28 day readmission rate. This will, in turn, assist in reducing pressure on our hospital services.

### 1.8.3.4 More People with End-Stage Conditions are Appropriately Supported

**Why is this important?**

For people in our population who have end stage conditions, it is important that they, their family and whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition of end-of-life choices heavily influence the quality of life an individual experiences during the dying process. Rehabilitation and Support Services contribute to this impact. Programmes include palliative care, aged residential care, respite care and home based support services.

**How will we know we are succeeding?**

Palliative care is being accessed, but we want to target those with greatest need. The Palliative Care Council has identified inequalities of access to palliative care based on diagnosis (evidence of under-utilisation by those with non-malignant conditions), with a lack of suitable service provision for children and young people. We would like to see an increase in palliative support for this group.

A Waikato Palliative Strategy was developed in 2016/17. The strategy provides a high level 'road map' for palliative care and end of life for the Waikato district. This will take into account a significant number of national, regional and local initiatives which include increased hospice funding, palliative care health needs analysis and updated service specifications.

Now the strategy is complete, it is expected that the key measures for monitoring performance in this area will be identified. This will enable Waikato DHB to further refine our performance story for our intermediate impact of more people with end stage conditions are appropriately supported.

# KŌWAE RUA / MODULE TWO: NEW ZEALAND HEALTH STRATEGY AND DELIVERING ON PRIORITIES AND TARGETS

## 2.1 New Zealand Health Strategy

As mentioned in Kōwae Tahi / Module One the New Zealand Health Strategy was refreshed in late 2015/16. Waikato DHB acknowledges that as per the New Zealand Public Health and Disability Act (section 38) (2)(d) our 2016/17 Annual Plan must reflect the draft refreshed New Zealand Health Strategy's direction and detail our commitment to delivering appropriate actions in line with the Strategy's Roadmap.

Appropriate commitments and actions are referenced in this module to ensure that implementation of the Strategy can begin in 2016/17. They are structured around the five strategic themes identified in the strategy of:

- People-powered - Mā te iwi hei kawe;
- Closer to home - Ka aro mai ki te kāinga;
- Value and high performance - Te whāinga hua me te tika o ngā mahi;
- One team - Kotahi te tīma;
- Smart system - He atamai te whakaraupapa.

In order to reduce duplication, where there is an obvious cross over with our DHB and/or regional activities identified under existing priority areas, we have captured these in the below table that references where the detailed actions can be found elsewhere in our plan.

| **People-powered - Mā te iwi hei kawe** | **Reference** |
|---|---|
| Inform people about public and personal health services so they can be 'health smart' and have greater control over their health and wellbeing. | 1.4 |
| Make the health system more responsive to people. | 1.4, 2.7.3 |
| Engage the consumer voice by reporting progress against measures important to the public, building local responses and increasing participation of priority groups. | 1.4, 2.7.1 |
| Promote people-led service design, including for high-need priority populations. | 1.4 |
| In selected high-need communities, build on, align, clarify and simplify multiple programmes of social investment. | 1.4, 5.2.5.2 |
| **Closer to home - Ka aro mai ki te kāinga** | **Reference** |
| Ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way. | 1.4, 2.7.3 |
| Enable all people working in the health system to add the greatest value by providing the right care at the earliest time, fully utilising their skills and training. | 1.4, 2.6.2, Kōwae Rima / Module Five |
| Increase the effort on prevention, early intervention, rehabilitation and wellbeing for people with long-term conditions. This includes addressing common risk factors. | 1.4, 2.4, 2.5, 2.6.2 |
| Collaborate across government agencies, using social investment approaches, to improve the health outcomes and equity of health and social outcomes for children, young people, families and whānau, particularly those at risk. | 1.4, 2.3 |
| Involve health and other social services in developing shared care for older people with high and complex needs in residential care facilities or those needing support at home. | 1.4 |
| Support clinicians and people in developing advance care plans and advance directives. | 1.4, 2.5.4 |
| Review adult palliative care services to ensure all those who would benefit from palliative care at the end of their life are able to access high-quality care and have a seamless experience. | 1.4, 5.2.5.2 |

| Value and high performance - Te whāinga hua me te tika o ngā mahi | Reference |
|---|---|
| Enable people to be partners in the search for value by developing measures of service user experience and improving public reporting of performance. | 1.4, 2.7.1, 5.1.2, 5.5.2 |
| Implement a framework focused on health outcomes to better reflect links between people, their needs and outcomes of services. | 1.4, 2.5.6 |
| Work with the system to develop a performance management approach with reporting that makes the whole system publicly transparent. | 1.4, 2.7.1, 5.1.2, 5.5.2 |
| Maintain the direction set by the Strategy through monitoring and evaluation, and advice from a Strategy Leadership Group. | 1.4 |
| Align funding across the system to get the best value from health investment. | 1.4 |
| Continue to develop the application of the social investment approach to health investment with DHBs. Consider using this approach to improve overall outcomes for high-need priority populations, while developing and spreading better practices. | 1.4 |
| Continuously improve system quality and safety. | 1.4, 2.7.1 |
| **One team - Kotahi te tīma** | **Reference** |
| Improve governance and decision-making processes across the system in order to improve overall outcomes, by focusing on capability, innovation and best practice. | 1.4 |
| Clarify roles, responsibilities and accountabilities across the system as part of the process of putting the Strategy into action. | 1.4 |
| Create a 'one-team' approach to health in New Zealand through an annual forum for the whole system to share best practice and help build a culture of trust and partnership. | 1.4, 2.5.5 |
| Put in place a system leadership and talent management programme to enhance capacity, capability, diversity and succession planning throughout the sector. | 1.4, 5.2.7 |
| Put in place workforce development initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility. | 1.4, 2.6.2, Kōwae Rima / Module Five |
| **Smart System** | **Reference** |
| Increase New Zealand's national data quality and analytical capability to make the whole health system more transparent and provide useful information for designing and delivering effective services. | 1.4, 5.1.2, 2.6.2 |
| Establish a national electronic health record that is accessed through certified systems including patient portals, health provider portals and mobile applications. | 1.4, 2.6.2 |
| Develop capability for effectively identifying, developing, prioritising, regulating and introducing knowledge and technologies. | 1.4 |

## 2.2 Delivering on Priorities and Targets

This section presents the actions we are planning to deliver in 2016/17. Implementation of the actions outlined in this plan is expected to enable us to positively contribute to local, regional and national outcomes as well as the goal of Better, Sooner, More Convenient Health Services for all New Zealanders. The actions and measures presented in this section show:

- How we are implementing Government priorities;
- How we are contributing to the activities in the Midland Region Service Plan;
- How we plan to improve performance in terms of our local priorities.

A number of parts of this section have been developed in collaboration with key stakeholders both internal to the health sector and external. This helps us to ensure service planning is not done in silos. The methods we currently utilise include:

- An alliancing approach to service planning with our primary care partners;
- Active engagement of clinical leaders / champions;
- Working with other DHBs from the Midland region;

- A collaborative cross-sector approach to working with vulnerable children and their families;
- Working with non-government organisations;
- Utilising the expertise of community clinicians working across the service continuum with an educative and capacity building focus;
- Expanding implementation of clinical pathways via map of medicine across the region to promote regional clinical collaboration and consistency;
- Participating in the social sector trials work streams with cross agency partners.

This section is clustered into five broad categories reflecting Government planning priorities. The categories and the specific priorities are outlined in the following table. The categories and priorities are not exclusive, for example there are a number of priorities which will impact long term conditions which are not included in the long term conditions column.

| Child and Youth Health | Long Term Conditions | System Integration | Living Within Our Means | Other |
|---|---|---|---|---|
| Reducing Unintended Teenage Pregnancy | Obesity | Cancer | Living Within Our Means | Improving Quality |
| | | Stroke Services | | |
| Increased Immunisation | Living Well with Diabetes | Cardiac Services | | |
| | | Health of Older People | | |
| Supporting Vulnerable Children | Cardiovascular Disease | Service Configuration | National Entity Priority Initiatives[10] | |
| Youth Social Sector Trials | | System Level Outcome Measures | | Actions to Support Delivery of Regional Priorities[11] |
| | Tobacco | Shorter Stays in Emergency Department | | |
| Rheumatic Fever | | Whānau Ora | NZ Health Partnerships Ltd | |
| | Rising to the Challenge | Improved Access to Diagnostics | | |
| Prime Minister's Youth Mental Health Project | | Improved Access to Elective Surgery | | |

## 2.3 Child and Youth Health

A Waikato Child Health Network was established in 2015/6. This group is a cross health sector group with representatives from Māori, primary care, secondary care and population health. It provides a forum to discuss opportunities for collaborative working to improve child health outcomes. The Waikato Child Health Network will help develop a child health programme of work during early 2016/17 identifying several priority areas of focus. The initial priority areas identified are oral health and childhood obesity. We also have a Waikato Youth Health Network which has had a focus on a number of areas in the past including access to primary care, improving mental health and reducing the harm caused by alcohol and other drugs.

[10] National entities are: Health Promotion Agency, Health Quality and Safety Committee, Health Workforce New Zealand, National Health Information Technology Board
[11] Includes: Hepatitis C, Major Trauma, Workforce, Information Technology

During 2015/16 we planned to undertake a child health needs analysis and assessment. This needs analysis and assessment will be completed in 2016/17 and we expect this will inform further activity undertaken in this area. This will be a key piece work and will include an appreciation of equity challenges, workforce capacity, and the potential for service integration.

Over the years there are a number of initiatives in the Waikato DHB district focused on improving child health. Examples include (key organisations the initiatives were developed and driven by are contained in the brackets):

- School Based Health Services (Pinnacle / Midlands Health Network for General Practitioners in schools and Midland Health Network and North Waikato Primary Health Organisation for nurses in schools);
- B4 School Coordination (Pinnacle);
- National Immunisation Register co-location with Midlands Health Network (Pinnacle / Midlands Health Network);
- National Child Health Information Platform (Midlands Health Network).

Children missing out on key services will be reconnected with general practice as part of the National Child Health Information Programme which records and monitors children's health milestones from birth to 18 years. The programme will give health providers a shared view of a child's milestone achievements, while a telephone-based coordination service will monitor records and track down children missing out. We would hope to see this continue to extend nationally.

We have a child and youth health service in the DHB called Waikids. The service comprises secondary and tertiary paediatric medical and surgical inpatient services, acute and elective, and newborn intensive care, with the retrieval and transfer of sick neonates by air. Waikids is a spectrum of services including Mothercraft, Child Development Centre, Children's Clinic, Mental Health services, Emergency Department, Child Protection Service, Oral Health, and inpatients. We provide outpatient services for paediatric medicine and surgery (both secondary and tertiary) – region-wide (e.g. Tauranga, Thames etc.). Paediatric surgery includes neonatal surgery and is the tertiary service for the midland region.

Our Paediatric Service is reviewing all levels of governance through 2016, recognising the need for governance in the provider arm, linked to governance in the wider DHB, linked to governance across the Midland Region. This interwoven structure will allow a much more coordinated response to local and regional needs, equity based services, ministerial directives etc., working closely with Strategy and Funding.

The secondary/tertiary paediatric surgical services will continue to consolidate a localised paediatric surgery service across the midland region. These are services in which our surgeons provide on-site outpatient consultations, and day stay paediatric surgery, to better and locally meet the needs of these patients. Currently, localised services in addition to Waikato are occurring in Rotorua, Tauranga and Whakatane, and we are in discussions with Taranaki about further extending this work.

Waikids have recently implemented an electronic growth chart, which we anticipate will not only aid in clinical management of children's chronic health problems but assist in identifying the children who are seen through our services who are overweight, obese or underweight, for further management. This tool is also available for primary care practitioners, meaning we are

able to share data and progress. Our intention is to evaluate this as an ongoing surveillance tool for our population of children involved in secondary care services over time.

A priority for both Waikato DHB as well as regionally is childhood oral health due to the poor oral health indicator performance and high ambulatory sensitive admission to hospital rates. An intrasectoral work programme is commencing to respond to this, broadly by optimising both prevention and treatment, with a regional approach that is appropriately localised.

Harti Hauora is a tool has initially been developed through Te Puna Oranga (Māori Health Service) and Waikids, as a comprehensive screening tool for children in contact with acute service and secondary care. It is now being further developed and extended into other settings, and the intention is to implement tailored versions of this in a range of health settings, both in the Waikato and across the midland region.

### 2.3.1 Reducing Unintended Teenage Pregnancy

#### 2.3.1.1 Our Approach

Risky behaviours such as early onset of sexual activity, poor contraceptive use, alcohol and substance misuse, teenage motherhood and repeat abortions are associated with high rates of teenage conception. An unplanned teenage conception gives an indication that there was unprotected sex and high risk of sexually transmitted infections.

Waikato DHB is both a funder and provider of sexual and reproductive health services.

#### 2.3.1.2 Linkages

- 2.3.4 Youth Social Sector Trials
- 2.3.6 Prime Minister's Youth Mental Health Project

#### 2.3.1.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Workforce development: contraceptive counselling and provision | At least one professional education session in long acting reversible contraception has been offered/is available to health professionals working on identified rural towns as well as Hamilton | Confirmation and exception report | Quarter 4 |
| School based health service contracts | • The contract with Midlands Health Network for deciles one to three secondary schools for school based health services contains explicit agreements for nurses to discuss and offer contraceptive choice<br>• Waikato DHB will work with Midlands Health Network and schools to explore potential of extending services beyond the school terms | Confirmation and exception report | Quarter 4 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Access to contraceptives and termination of pregnancy | • Maintain free under 25s contraceptives sexual and reproductive services for all rural communities[12]<br>• Maintain access at no cost to emergency contraceptive pills in community pharmacy throughout Waikato<br>• Waikato DHB will continue to work proactively with our primary care partners and sexual and reproductive services including NZ Family Planning to improve access to contraceptive and reproductive health services for youth | Confirmation and exception report | Quarter 4 |
| Clinical leadership | • A youth health / sexual and reproductive health representative identified to participate in the Waikato Youth Network | Representative on network | Quarter 1 |

## 2.3.2 Increased Immunisation

### 2.3.2.1 Our Approach

We will continue our focus on increasing the number of children immunised in our district and reaching the immunisation targets. During 2015 our eight month immunisation results remained static so an Under Fives Immunisation Steering Group was established in August 2015 to provide strategic direction and drive to our 95 percent immunisation target activity. The membership of this group includes representation from our primary care alliance partners and Waikato DHB (Clinical Director Primary and Integrated Care, National Immunisation Register, Population Health Service, Strategy and Funding, Te Puna Oranga (Māori Health Service)).

Key areas of activity undertaken by members of the group include:

- Working with the national immunisation register team to extract and measure the timeliness of the six week immunisation event;
- Processes for establishing a baseline and subsequent reporting around babies not enrolled in primary care by three weeks of age;
- Review process map with our primary care alliance partners and patient management systems on new born enrolments to primary care to document the process and better understand where the gaps are occurring;
- Update the newsletters sent to general practices by Population Health Service to include message from the Chief Executive and other Immunisation Champions around the importance of improving immunisation for our population.

There is an immunisation coordination services agreement and the coordinator has links with all our primary care alliance partners as well as the National Immunisation Register. The National

[12] NZ Family Planning operates a clinic in Hamilton

Immunisation Register team send out regular reports to our primary care alliance partners regarding children who are and are not immunised.

We have worked with our primary care alliance partners and relevant outreach providers to determine how to get best value for money and improve immunisation rates in areas with comparatively low coverage from the outreach immunisation services in our district. We will continue with our hospital opportunistic immunisation service which is available for children, who for a variety of reasons, need to have vaccinations in a hospital setting. This includes inpatients, outpatients and emergency department presentations.

Children missing out on key services like immunisations will be reconnected with general practice as part of the National Child Health Information Programme which records and monitors children's health milestones from birth to 18 years. This will give health providers a shared view of a child's milestone achievements, while a telephone-based coordination service will monitor records and track down children missing out.

We have undertaken an Improving Coverage for Human Papillomavirus Vaccine Project to improve coverage of vaccination for the eligible population. A project group consisting of DHB and primary health organisation stakeholders was convened to identify the strengths of the current School Based Vaccination Programme and opportunities for improvement, especially in strengthening the role and relationships with general practice.

#### 2.3.2.2 Linkages

- Our Performance Story Impact: People take greater responsibility for their health
- Increased Immunisation Health Target;
- Ki te Taumata o Pae Ora 2016/17.

#### 2.3.2.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Increased immunisation | • Maintain our Under Fives Immunisation Steering Group | • 95 percent of eight-month-olds and two-year-olds are fully immunised. | Quarterly |
| | • Continue our hospital opportunistic immunisation service | • 95 percent of four-year-olds are fully immunised by age 5 by June 2016. | Quarterly |
| | • Work with our primary care alliance partners to agree an integrated approach to immunisation outreach service provision in the Waikato | • Use the findings from the national review and local discussions to affect change, ensuring any the new model is dynamic, equitable and provides district wide coverage | Quarterly<br>Quarterly |
| | • Work with our primary care alliance establish secure electronic reports to general practices | • All practices receive their reports via a secure website.<br>• The National Immunisation Register team provides a monthly report to our primary care alliance partners identifying the practices who are responding and those that are not. | Quarter 1<br>Quarterly |
| | • Our immunisation steering group to discuss the value of | • A reduction in Outreach Immunisation Service referrals in | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | opportunistic and regular immunisation services being delivered after hours or on weekends where the demand for outreach immunisation services is high | areas where drop-in clinics and/or after hours clinics are available | |
| | • Facilitate an evening Immunisation update for immunisers | • Immunisation update occurs | |
| | • Work with our primary care alliance partners to identify a target for the maximum number of passive referrals per practice expected in a month<br>• National Immunisation Register team provides a monthly report to our primary care alliance partners with this data | • Our primary care alliance partners, the immunisation coordinator and National Immunisation Register team work together to assist the practices that are over-referring to improve their immunisation system. | |
| | • Ensure every report produced includes an ethnicity breakdown | • Improving Māori coverage is a focus at every Immunisation Steering group meeting and strategic planning | |
| | • Implementation of the Harti Hauora Tamariki Assessment tool with a specific immunisation for pēpi referral pathway to increase whānau enrolment with primary care that may have been missed in other settings (Waikato and Midland Region) | • Harti Hauora Tamariki Assessment Tool is piloted in at least one setting per quarter from quarter one to quarter three | 6 Monthly<br><br>Quarter 2 and 4 |
| | • Review and implement kaitiaki and kaitakawaenga cultural assessment to include a specific immunisation for pēpi referral pathway | • Cultural assessment reviewed and implemented | Quarter 2 and 4<br><br>Quarter 2<br>Quarter 4 |
| | • Hapu Wananga classes will continue to review feedback from participants to promote discussion on immunisation for pēpi. | • Feedback reviewed and immunisation promoted | |
| | • Hapu Wananga Post Neonatal classes will measure the number of eligible pepi and whether they have been fully immunised. A referral pathway will be offered to whānau. | • First class completed<br><br>• Second class completed | |
| | Midlands Health Network<br>• All community providers of healthcare services to children will be able to access National Child Health Information Platform.<br>• All information available through multiple systems will be made available to co-ordinate immunisation services<br>• Drawing on the population level | • 95 percent of eight-month-olds and two-year-olds are fully immunised.<br>• 95 percent of four-year-olds are fully immunised by age 5 by June 2016. | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | data from the locality planning project at risk and children being left behind will be targeted.<br><br>Hauraki Primary Health Organisation<br>• Continue participation in the following forums:<br>- Weekly DHB eight month immunisation teleconferences;<br>- Monthly Immunisation Focus Group;<br>- Under Fives Immunisation Steering Group<br>• Continue supporting practices through:<br>- Practice Immunisation Nurse champions;<br>- Dedicated practice time funding to focus on health targets; and<br>- Regular practice updates on performance against targets;<br>- Strengthening relationships with other stakeholders -Plunket and Pre-school education providers<br>- Utilise the National Child Health Information Platform to monitor enrolled patients immunisation status | | |
| | • Support public health nurses, school nurses and general practice nurses to complete on-line human papillomavirus vaccine module<br>• School based vaccination programme to improve linkages and collaboration with school nurses to offer support and education resources for promotion of vaccine as required<br>• General Practices to identify human papillomavirus vaccination nurse champions to promote vaccination<br>• Refer girls who decline the school based vaccination programme but not the vaccine to general practice<br>• Set up recalls for girls who do not complete all three doses<br>• Work with cervical screening services to promote benefits of human papillomavirus vaccine vaccination | At least 70 percent of all 12-year-old girls will have completed all doses of their human papillomavirus vaccine (for 2016/17 it is the 2003 birth cohort measured at 30 June in 2017). | Quarter 4 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | • Promotion and communication plan for the vaccine – targeted messages, individual stories and shared personal experiences | | |

### 2.3.3 Supporting Vulnerable Children

#### 2.3.3.1 Our Approach

We are committed to implementing activities across our population for getting better outcomes for our most at-risk children. We intend to work in a collaborative cross sector multi agency approach to improve the health of our vulnerable children and their families.

Hamilton City was identified as a Children's Team site in 2014/15. The Hamilton Children's Team became operational in 2015/16 and it is the country's first large urban team. Waikato DHB has had a role in the development of the Hamilton Children's Team and is a participant in both the Local Governance Group and the Implementation Group.

We will continue to engage with other DHBs and the Ministry of Health around developments relating to the Children's Action Plan and Children's Teams. We expect the lessons learnt from the work being undertaken by other DHBs to impact on how we progress forward in the development of our approach in this area.

Waikato DHB has adopted a robust child protection policy, ensured every contract and funding arrangement requires all services working in whole or part delivering services to children adopt a child protection policy, will review the policy three yearly and report through the DHB Annual Report.

Waikato DHB will meet the safety checking requirements of the Vulnerable Children's' legislation. We already police vet staff. This process is well established. There is also a process to identify all staff within the provider division who are within the 'core children's workforce' under the Vulnerable Children's Act. These staff will then undergo additional safety vetting and screening processes as they are recruited, and in time retrospectively for those staff members already employed.

Because of its centralised and standardised recruitment process Waikato DHB is able to institute a series of worker safety interview questions. These questions would be asked during interviews and during reference checking.

#### 2.3.3.2 Linkages

- 5.3.4 Child Protection Policies
- 5.3.5 Children's Worker Safety Checking

#### 2.3.3.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| To support | We will review the potential for whole | Review completed | May 2017 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Vulnerable Children | of government approaches to reduce the harm arising from childhood trauma in the Waikato using the ACE score predictive methodology developed by population health services in the United States. | | |
| | Children's Teams<br>• Maintain participation on the local governance group<br>• Maintain agreement with Waikato Hospital and non-government organisations for lead professionals<br>• Work with the Ministry of Health and national directorate as required<br>• Undertake all safety and vetting requirement in an ongoing way<br>• Support health funded panellists<br>• Work with clinical unit leader on models of care for child health checks<br>• Contract for evaluation of health professionals as lead professionals<br>• Work with primary care alliance partners to ensure primary care engagement | • Update identifying progress made during the quarter against the actions to deliver improved performance | Quarterly |

### 2.3.4 Youth Social Sector Trials

#### 2.3.4.1 Our Approach

The social sector trials are a Government initiative involving a number of sectors with a high level objective of working together to change the way social services are delivered. The social sector trails developments have been led by the Ministry of Social Development.

In late 2015/16 a decision was made to draw the social sector trials to a close. This means:

- Where successful, the social sector trial will transition from a community-influenced model to a community-led model, with a less narrow focus for the delivery of services
- For the remaining locations, social sector trial activity will cease to be funded on 1 July 2016 because they are ready to be managed locally, or performance to date means exit is appropriate.

For the four trials that have been active in the Waikato DHB district, this means that for 2016/17:

- Waikato District Youth Social Sector Trial – was exited on 30 June 2016;
- South Waikato Youth Social Sector Trial – transitioned to a community-led model;
- Taumarunui Youth Social Sector Trial– transitioned to a community-led model;
- Te Kuiti Youth Social Sector Trial -– transitioned to a community-led model.

Over the previous two years the social sector trial leads in our district as well as school based health service representatives and Waikato DHB staff (Strategy and Funding, Population Health Service and Te Puna Oranga (Māori Health Service) have been part of the Waikato Youth Health Network.

#### 2.3.4.2 Linkages

- 2.3.4 Prime Minister's Youth Mental Health Project

#### 2.3.4.3 Action Plan

| Youth Social Sector Trial area | National direction | Waikato DHB commitments |
|---|---|---|
| South Waikato | To be transitioned to locally-led model from 1 July to 31 December. | • Work with your local lead and other key stakeholders to develop and agree a transition plan by 31 July 2016<br>• Support implementation of the transition plan. |
| Taumarunui | To be transitioned to locally-led model from 1 July to 31 December. | • Work with your local lead and other key stakeholders to develop and agree a transition plan by 31 July 2016<br>• Support implementation of the transition plan. |
| Te Kuiti | To be transitioned to locally-led model from 1 July to 31 December. | • Work with your local lead and other key stakeholders to develop and agree a transition plan by 31 July 2016<br>• Support implementation of the transition plan. |

### 2.3.5 Rheumatic Fever

#### 2.3.5.1 Our Approach

During 2015/16 we refreshed our rheumatic fever prevention plan. The refreshed plan includes a summary of the progress on action plan objectives outlined in the original rheumatic fever plan and includes ongoing actions to:

- Continue stakeholder commitment to prevention planning and harness collective actions including continued engagement from our primary care alliance partners and Waikato pharmacies;
- Ensure the plan continues to be a living document taking into account new learnings;
- Includes stakeholder activity for engagement and sustainability beyond programme funding.

Lessons learnt around rapid response sore throat management services and our health homes initiative informed our refreshed plan. A number of our key stakeholders were participated in the development of the refreshed plan. The refreshed plan includes actions to:

- Increase the awareness of rheumatic fever;
- Prevent the transmission of Group A streptococcal throat infections;
- Treat Group A streptococcal throat infections quickly and effectively.

#### 2.3.5.2 Linkages

- Better Public Service targets
- Māori Health Plan 2016/7

#### 2.3.5.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| To reduce the incidence and impact of rheumatic fever | • Ensure that all cases of acute and recurrent acute rheumatic fever are notified with complete case information to the Medical Officer of Health within seven days of hospital admission.<br>• Ensure patients with a history of rheumatic fever receive monthly antibiotics not more than 5 days after their due date.<br>• Undertake an annual audit of rheumatic fever secondary prophylaxis coverage for children aged 0-15 years, youth aged 15-24 years, and adults aged 25+ years.<br>• Identify and follow-up known risk factors and system failure points in cases of recurrent rheumatic fever.<br>• Follow-up on any issues identified by the 2015/16 audit of recurrent hospitalisations of acute rheumatic fever and unexpected rheumatic heart disease. | Confirmation and exception report against the actions to deliver improved performance | Annual |
| | • Whare Ora healthy homes initiative will be promoted and implemented throughout the Waikato for eligible whānau | • 400 healthy homes assessments completed during the year | Quarterly |

### 2.3.6 Prime Minister's Youth Mental Health Project

#### 2.3.6.1 Our Approach

The Prime Minister's Youth Mental Health Project continues to build a more co-ordinated web of support for young people with, or at risk of developing, mental health issues. It is a multi-agency project with the Ministry of Health taking the overall lead.

We will be working with our primary care alliance partners to make our contribution to this project. The activities we are planning are expected to mean young people will be able to access the services they require before their condition escalates to being a severe mental health disorder.

A significant piece of work in this priority area has been the Exemplar Co-existing Problems and Youth Alcohol and Drug Initiative. The development phase of this initiative has been completed and our new approach will become operational this year. The initiative is a programme of work intended to lead to better co-ordination of all youth alcohol and other drug services in the Waikato thereby:

- Increasing access to services;
- Improving outcomes for youth / rangatahi with alcohol and other drug problems, including those who also have other mental health problems.

### 2.3.5.2 Linkages

- 2.3.4 Youth Social Sector Trials

### 2.3.5.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| To build a more co-ordinated web of support for young people | School Based Health Services<br>• Maintain School Based Health Services in all decile one to three secondary schools (including composite schools), teen parent units and alternative education facilities.<br>• Implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with School Based Health Services.<br><br>Review and improve the follow-up care for those discharged from Child and Adolescent Mental Health Services and Youth Alcohol and Other Drug Services<br>• Continue to monitor quarterly child and youth transition/discharge planning date and make improvements as required to ensure targets are meet | • Provide quantitative reports on the implementation of School Based Health Services<br><br>• Provide narrative progress reports on actions undertaken<br><br>• 80 percent of youth to access Child and Adolescent Mental Health Services and Youth Alcohol and Other Drug Services within three weeks; 95 percent to access services within eight weeks. | Quarterly |
| Improve youth responsiveness of the health sector | • Review of Waikato Youth Health Network terms of reference and membership<br>• Work with refined Waikato Youth Health Network to develop workplan. Areas of focus of focus will include:<br>- Participation in the Rural Health Services Strategy work to ensure the needs of young people are considered<br>- Input into the Waikato DHB Consumer Council developments<br>- Reducing the harm caused by mental health and addictions<br>- Reducing the harm caused by alcohol and other drugs<br>- Providing direction for development of a needs assessment and analysis | • Review completed and recommend improvements undertaken<br><br>• Workplan developed | Quarter One<br>Quarter One |

## 2.4 Long Term Conditions – Prevention, Identification and Management

Long term conditions are ongoing, long term or recurring conditions. The prevalence of long term conditions is increasing, causing premature mortality and morbidity, which is directly or indirectly linked with the underlying disease. Māori and Pacific people, people living in low socioeconomic circumstances, people with disabilities and people with mental health and addiction issues are disproportionately affected by some long term conditions, with a more significant impact from ill health and earlier mortality.

Prevention and treatment services need to adapt to meet this increasing burden of long term conditions. If we fail to get serious about prevention then the recent progress in healthy life expectancies will stall, the unnecessary differences will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend our budgets on reducing the impact of wholly avoidable conditions.

We will continue to work with our primary care alliance partners to reduce the impact of long term conditions. Each of our primary care partners has invested in the development and implementation of a long term conditions programme. These programmes cover conditions such as cardiovascular disease, diabetes and in some cases chronic obstructive pulmonary disease.

The kinds of impacts expected from these programmes include:

- Improved performance against the relevant health targets;
- People better able to self-manage their conditions in the community;
- Reduction in emergency department presentations for people with long term conditions;
- Reduced hospitalisation rates and inpatient bed days for people with long term conditions;
- A reduction in demand for renal services due to better management of people with diabetes.

Midlands Health Network will:

- Continue their process of active review of their long term conditions framework;
- Continue the development of their risk-stratification framework and tools to support allocation of resources to their practices;
- Build the capacity of their workforce;
- Utilise long term care plans (year of care plans) in Health Care Home practices;
- Continue performance based funding.

The Whānau Ora models of care targeting individuals with long term conditions are delivered by Hauraki Primary Health Organisation and the National Hauora Coalition. These models of care encompass both the health and social needs of the individuals within the context of their whānau. Whānau are important because better outcomes are dependent on the individual being supported by their whānau. The approach is strength based and determined by the individual and whānau. They determine what the highest priorities are and then support is provided to work through these issues in order to improve their quality of life both socially as well as clinically. Research evidence supports the view that in order to make a difference to

whānau the social determinants have a more significant impact. Clinical interventions have been determined to have only a 30 percent impact on better outcomes for whānau.

### 2.4.1 Obesity

#### 2.4.1.1 Our Approach

To effectively address the issues in this area and explore the opportunities to ensure our communities live a healthy, active life, a comprehensive approach is required. We expect work will be undertaken across community, primary, secondary and tertiary settings utilising collaborative, responsive and evidence-based interventions.

The national childhood obesity plan has been developed. It contains a package of initiatives aims to prevent and manage obesity in children and young people up to 18 years of age. The package has three focus areas, made up of 22 initiatives, which are either new or an expansion of existing initiatives:

- Targeted interventions for those who are obese;
- Increased support for those at risk of becoming obese;
- Broad approaches to make healthier choices easier for all New Zealanders.

Our local approach will have a wider focus than just achievement of the raising healthy kids national health target. The approach we take locally will ensure the appropriate interplay occurs with our primary care alliance partners, the regional child health advisory group and with other areas of work like the Well Child Tamariki Ora Quality Improvement Project. It will essentially be a co-developed programme of work involving a number of key stakeholders (from the community, primary care and hospital care settings) focused on reducing childhood obesity.

Project Energize, which began in 2005, increases children's physical activity, and improves their nutrition and ultimately their overall health. A team of Energizers delivers the project in Waikato primary and intermediate schools and each Energizer supports a number of schools in their geographic area. Energizers are available to provide practical 'hands on' support and assistance to schools and teachers with any initiatives that will increase the quality and quantity of physical activity or improve the uptake of healthy eating.

Our Population Health Service has produced a Nutrition and Physical Activity Strategy 2015 - 2018. This sets out how Population Health can potentially respond across the various settings within our communities.

We will continue to provide a comprehensive integrated childhood obesity treatment programme through Bodywise. In addition we are developing an integrated package of tools for a childhood overweight and obesity management pathway, focussed specifically on the tasks, skill sets, and tools required. This leans heavily on the BeSmarter Tool developed through Bodywise, and the use of which is being extended through other DHBs.

One of the Midland Regional priorities is childhood obesity. Regionally we will be able to build on this Waikato work, for local implementation across the Midland Region.

Our approach to raising health kids national health target has DHB clinical leadership and buy in. Locally, the Waikato Child Health Network will be the key forum for developing the Waikato DHB approach and pathways in relation to childhood obesity.

We are committed to developing collaborative plans with our primary care alliance partners to achieve the national target by 31 December 2016. Coordination of the Before School Checks programme in our district is led by Midlands Health Network and the majority of the checks are delivered in general practice (except for approximately 150 each year undertaken by public health nurses). Collaborative arrangements to ensure consistent user friendly approaches to information for families / whānau and communities are also in progress with:

- Sport Waikato who deliver the Under 5s Energize programme in 121 early education centres;
- Bodywise (in Waikato Hospital).

#### 2.4.1.2 Linkages

- People are supported to take greater responsibility for their health
- 2.3 Child and Youth Health
- 2.5.8 Whānau Ora
- Ki te Taumata O Pae Ora 2016/17
- Regional Services Plan 2016/17
- Waikato DHB Population Health Plan

#### 2.4.1.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Childhood Obesity Plan | Work with key stakeholders to progress developments in this area. The specific activity is outlined below. | • 95 percent of obese children identified in the Before School Check programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. | Quarterly<br><br>Quarter One<br>Quarter Two<br>Quarter Two<br><br>Quarter Two |
| | • Referral process to a registered primary care professional usually child's own general practitioner developed | • Referral process agreed with primary health organisations | |
| | • Referral pathways from primary care to a paediatrician or Bodywise agreed | • Pathways agreed | |
| | • Referral pathways from public health nurses to primary care agreed | • Pathways agreed | |
| | • Explore workforce capability building initiatives | • Initiatives identified | |

### 2.4.2 Living Well with Diabetes

#### 2.4.2.1 Our Approach

Diabetes is a priority long-term condition in the Waikato. There are approximately 22,000 people with diabetes in the Waikato and more at risk of developing the condition. The rate of growth of diabetes has increased faster than expected. The high personal and social costs associated with diabetes present a serious health challenge both now and in the future. It is now internationally accepted that primary care should be the setting where the majority of routine clinical care for this group occurs.

The Ministry of Health have developed Living Well with Diabetes: A health care plan for people at high risk of or living with diabetes 2015–2020. This plan builds on activity already under way to achieve better outcomes for people with diabetes.

At a local level work has been done to develop a Collaborative Plan for Integrated Diabetes Services in Waikato. The Waikato Collaborative Diabetes Service Network composed of Pinnacle Midlands Health Network, Hauraki Primary Health Organisation, National Hauora Coalition, Midwifery and the Waikato Regional Diabetes Service has been established to coordinate and champion development of solutions to meet the medical needs of our population with diabetes. The collaborative plan describes a vision for integrated diabetes services in the Waikato and outlines the implementation activity agreed upon to achieve the vision. The achievement of good outcomes for our population is dependent on the provision of well organised and coordinated services that draw on the knowledge and skills of health and social care professionals working across primary and secondary care.
Each of our primary care partners has invested in the development and implementation of a long term conditions programme to meet the needs of their enrolled populations. Diabetes is one of the long term conditions covered by these programmes.

Our Population Health Service will be transitioning to a settings based approach to the delivery of public health service delivery for the 2016/17 year. These settings are Healthy Education, Healthy Whānau, Health Workplaces which all contribute to Health Communities and improvements in population health.

Our regional diabetes service is a centre for education, management and research of diabetes. It is a specialty within Waikato Hospital's Internal Medicine service cluster. The sub-specialist teams include:

- Diabetes and pregnancy with an emphasis on Type 1 and Type 2 management and insulin infusion pump therapy;
- Education, mentoring of the midwives by the diabetes in pregnancy team on the screening for diabetes in pregnancy and patient education of those who have or are at risk of diabetes in pregnancy;
- A multidisciplinary team weight management programme for the morbidly obese;
- Multi-disciplinary high-risk foot clinic;
- Insulin pump treatment programme;
- Hospital-based diabetes education team;
- Youth and Young Adult programme;
- Pharmaceutical trial unit and clinical research team;
- Community hospital outreach programme (monthly outreach in Thames, Te Kuiti and Tokoroa Hospitals);
- Community-based clinical nurse specialists;
- Support and mentoring of GP practices for the management of type 2 diabetes by the community-based clinical nurse specialists;

- Clinical research;
- Retinal photoscreening service.

#### 2.4.2.2 Linkages

- 2.4 Long Term Conditions – Prevention, Identification and Management
- 2.5.5 Service Configuration
- Ki te Taumata O Pae Ora 2016/17
- Waikato DHB Population Health Service Annual Plan 2016/17

#### 2.4.2.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Prevent high-risk people from developing type 2 diabetes | • Continue to implement Project Energize<br>• Work with key stakeholders to develop the approach to childhood obesity<br>• Health promotion settings based approach for stakeholder identification of key issues such as:<br>- Healthy eating and physical activity<br>- Breastfeeding<br>- Oral health<br>- Communicable disease prevention<br>- Smokefree<br>- Sun safety<br>• Continued implementation of Hapū Wānanga, Harti Hauora Assessment Tools and Kaitiaki and Kaitakawaenga Services<br>• Continued education by the diabetes in pregnancy team to lead maternity carers who counsel women who are at risk of developing gestational diabetes on healthy eating, exercise and healthy weight during pregnancy. | • See section 2.4.1 Obesity<br>• See Population Health Service Annual Plan (healthy education, healthy whānau and healthy workplaces)<br>• See Ki te Taumata o Pae Ora 2016/17<br>• An educational resource has been developed for patients for which lead maternity carers can use for patient education. The use and dispensing of this resource will be tracked. | |
| Enable effective self-management | • Continued implementation of the Midlands Health Network long term condition programme including the stratification and management of people at risk of and living with diabetes.<br>• Midlands Health Network will continue to develop multidisciplinary team for diabetes<br>• Hauraki Primary Health Organisation long term conditions whānau ora programme will provide the following in partnership with General Practice teams, long term conditions nursing and Kaiawhina teams: | • Reduction in proportion of patients with Hba1c above 64, 80 and 100 mmol/mol. | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | - Intensive short term outreach clinical support<br>- Kaiawhina support and health lifestyle education;<br>- Self-management support<br>• National Hauora long term conditions whānau ora programme to support improved outcomes for diabetic patients. | | |
| Improve quality of services | • Integration of quality standards in diabetic care - Ministry of Health | | |
| Detect diabetes early and reduce the risk of complications | • Contract with our primary care alliance partners for clinical podiatry services for people with diabetes at high risk of active foot disease | | |
| Provide integrated care | • Continue the work of the Waikato Collaborative Diabetes Service Network to improve outcomes of people with diabetes. This work includes supporting demographic and outcomes analyses to identify gaps in services, inform improvements, and develop plans to meet address the gaps.<br>• Work on information systems to be able to integrate the secondary services diabetes database so that if may be linked with primary care | | |
| Meet the needs of children and adults with type 1 diabetes | • Continuation of the Waikato Regional Diabetes Service management diabetes in people with type 1 or other insulin deficient states. | | |

## 2.4.3 Cardiovascular Disease

### 2.4.3.1 Our Approach

We will continue to work with our primary care alliance partners to reduce the impact of long term conditions like cardiovascular disease. We provide funding to our three primary care partners to enable implementation of their respective long term conditions programmes. Our primary care partners use the allocated funding to support and incentivise performance of their practices. This approach is intended to contribute to the achievement of our outcomes of improving the health status of our population and reducing or eliminating health inequalities.

During 2016/17 we expect to using our Harti Hauora Assessment tool and our Kaitiaki and Kaitakawaenga services to improve access for Māori.

### 2.4.3.2 Linkages

- Waikato DHB Māori Health Plan 2016/17

### 2.4.3.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Cardiovascular disease | Midlands Health Network<br>• Implementation of Midland Health Network long term condition programme including the stratification and management of people at risk of and living with diabetes.<br>• Continued development of the Health Care Homes model to support managing long term conditions.<br>• Range of electronic tools to support patients in self-management and providers in care support.<br>• Implement cardiovascular disease management training for general practice<br>• Multidisciplinary team for cardiovascular disease. | • 90 percent of the eligible adult population will have had their cardiovascular disease risk assessed in the last five years.<br>• 90 percent of 'eligible Māori men enrolled in a primary health organisation aged 35-44 years' who have had a cardiovascular disease risk recorded within the past five years. | Quarterly |
| | Hauraki Primary Health Organisation<br>• Hauraki Primary Health Organisation contracted with Wintec to provide scholarships for nurses to complete level 7 diabetes management and wound care papers<br>• Registered Nurse Diabetes Champion who will support upskilling of practice nurses with insulin starts<br>• Improve workforce capability and ensure consistency across General Practice teams<br>• Hauraki Primary Health Organsation utilises patient dashboard, BPI reporting and new electronic care plan tool to support improvements in cardiovascular disease risk assessment and management | | Quarter 2<br><br>December 2016<br><br>Quarter 2 and 4 |
| | • Design, develop and implement assessment tools based on the Harti Hauora Tamariki Assessment Tool specifically targeting kaumatua to include a specific cardiovascular disease risk assessment referral pathway<br>• Review and implement kaitiaki and kaitakawaenga cultural assessment to include a specific | • Tool specifically developed for kaumatua and kuia<br><br>• Cultural assessment reviewed and implemented | |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | cardiovascular disease risk assessment referral pathway.<br>• Design, develop and implement assessment tools based on the Harti Hauora Assessment Tool specifically targeting Kaumatua to include a specific cardiovascular disease risk assessment referral pathway | • Tool specifically developed for Kaumatua and Kuia by December 2016 | |

## 2.4.4 Tobacco

### 2.4.4.1 Our Approach

Making our contribution to achieve the Government's aspirational goal of a Smokefree New Zealand by 2025[13] is a significant focus for the health sector in the Waikato. Increased integration into all aspects of health is critical to achieving the Smokefree Aotearoa 2025 goal. The action table in this section focuses on the Better Help for Smokers to Quit national health target.

Following a procurement process led by the Ministry of Health, new service providers have been identified to deliver stop smoking services throughout New Zealand. The new services will provide better access to high quality and evidence based support including ongoing face-to-face follow-up and advice. The new services will also focus on delivering better outcomes for communities where a high number of people continue to smoke, particularly for Māori, Pacific people and pregnant women.

Pinnacle has been identified as the preferred provider for stop smoking services in our district. The roll out of these services will be on 1 January 2017. Pinnacle will be partnering with Iwi and K'aute Pasifika Services in the Waikato to co-develop and co-commission and new model for smoking session which will provide a pathway to achieving the Smokefree Aotearoa 2025 goal.

As a DHB we meet regularly with our primary alliance care partners and share information about the better help for smokers to quit health target as well as monitoring actual performance against planned performance. We have an established Waikato Tobacco Control Group which consists of a number of key stakeholders including our primary care alliance partners, Population Health Service, Te Puna Oranga (Māori Health Service), Midland Community Pharmacy Group, Asthma Waikato, the Cancer Society, the Heart Foundation, Strategy and Funding, Sport Waikato and Plunket. During 2016/17 we will be implementing our Tobacco Control Plan.

Our focus on smoking during pregnancy is part of our Maternity Quality and Safety Programme and the Well Child Tamariki Ora Quality Improvement Framework measure for smoking status at two weeks postpartum.

### 2.4.4.2 Linkages

[13] Less than 5 percent of the DHB's population will be a current smoker by 2025

- People are supported to take greater responsibility for their health

### 2.4.4.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Smokefree Aotearoa New Zealand 2025 | Midland Health Network<br>• Core area of focus in service and quality coverage for the networks quality framework<br>• Use of Patient Prompt and Best Practice Intelligence reporting tools<br>• Strategy in place for using text messaging<br>• Practice based smokefree champions<br>• Network based smokefree practitioners<br>• Centralised telephone catch up service<br>• Web-based tool available for third party providers to record smoking data<br>• Map of medicine pathway published for smoking cessation<br><br>Hauraki Primary Health Organisation<br>• Hauraki PHO patient dashboard in place. Practice champions identified<br>• Hauraki PHO will develop a Smoking Cessation Strategy | • 90 percent 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. | Quarterly<br><br>Quarter 4<br>Quarter 2<br><br>Quarter 2 |
| | • Train kaimahi that work with, or intend to work with hapu Māori, on how to use the newly developed Hapu Wananga Curriculum (Kaupapa Māori Pregnancy and Parenting curriculum) for the Midland region that promotes, empowers and encourages mama to be smoke free.<br><br>• Design, develop and implement assessment tools based on the Harti Hauora Tamariki Assessment Tool specifically targeting wahine to include a specific smoke free referral pathway.<br><br>• Review and implement kaitiaki and kaitakawaenga cultural assessment to include a specific smoke free referral pathway for hapu mama. | • 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered advice and support to quit smoking.<br><br>• Two training courses across the region<br><br>• Tool specifically developed for wahine<br><br>• Cultural assessment reviewed and implemented | |

## 2.4.5 Rising to the Challenge 2012-2017

### 2.4.5.1 Our Approach

We will continue to work collaboratively with other Government agencies, non-governmental organisations, primary care alliance partners and regional colleagues in the area. During 2016/17, we will implement a number of initiatives which support the vision and directions outlined in the Mental Health and Addictions Service Development Plan 2012 - 2017 produced by the Ministry of Health.

During 2016/17 we will continue to hold Local Advisory Group meetings every two months with the Mental Health and Addictions sector, which includes representatives from the non-government organisation sector, Māori, our primary care alliance partners and DHB services. The group participates in local, regional and annual planning and relevant issues impacting on the sector. We also support sub-group meetings as required such as a Consumer Advisory Group, Family and Whānau Service Provider Group and a Māori Advisory Group.

When undertaking service reviews / reconfiguration in the sector, we ensure we engage with key stakeholders. These stakeholders include our primary care alliance partners, non-government organisations and Government agencies such as the Ministry of Justice.

Specific projects currently in progress to enhance integration and bring services closer to home are:

<u>The Peoples Project</u>

The Peoples Project has been operating now since August 2014 from the base in Garden Place, Hamilton Central Business District. The project is a unique collaborative, committed to end homelessness in the city by 2016. The focus of the work is both on sustaining tenancies as well supporting new people experiencing homelessness to access housing.

Since August 2014, 132 people have been assisted into housing with a 92 percent retention rate. Our mental health and addictions service is involved with this initiative with a social worker from general adult services and input from Community Alcohol and Drug Service.

Understanding the concept of 'multiple needs' is critical to the formation of The Peoples Project. 'Multiple needs' acknowledges there are a group of people in any community who have multiple unmet and interrelated needs. These will include health, mental health, behavioural, practical, social, environmental, and addiction to name a few. It is the interaction of these needs that matters most.

Integrated Care Coordination Team – Primary Care Transition

The Integrated Care Coordination Team supports the transition of service users from secondary to primary care within the adult mental health service. The development of this service came on the back of a very successful pilot - the Primary Care Liaison Pilot. The focus is transition of service users to primary care as part of the integrated care pathway, and to ensure that there is clear pathway back in for those who require it, including advice for primary care practitioners around supporting people with mental illness in their practices.

Alongside this development has been a coming together of key stakeholders across our primary care alliance partner's and our service to provide direction and governance to this initiative. There has been real movement around clear criteria for transitional care arrangements that include a set number of extended consultations and a widened multi-disciplinary team focus. Work is also underway for simplifying the payment process for transitional care. This team is also involved in a number of other key intersectoral initiatives:

- Liaison with Te Whakaruruhau;
- The Children's Team;
- Family Safety Network;
- The Peoples Project.

### 2.4.5.2 Linkages

- 2.3.6 Prime Minister's Youth Mental Health Project

### 2.4.5.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Cement and build on gains for the most vulnerable | Needs assessment and analysis undertaken | • Methodology agreed<br>• Update reports provided | Quarter One<br>Quarterly |
| Support Parents Healthy Children Guidelines | Waikato DHB Strategy and Funding will:<br>• Undertake survey to ascertain where providers are at in the implementation of Ministry of Health guidelines<br>• Individual providers to develop implementation plans based on their survey results<br>• Midland Regional Network use survey results to develop appropriate training<br><br>Health Waikato Mental Health and Additions Service will:<br>• Continue to driving family inclusive practice. Family / whānau involvement training is ongoing to ensure all new staff is orientated to best practice and current staff has regular refreshers. | Narrative report on progress highlighting major achievements and / or issues | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Improving employment rates | Continue to contract for specific services to support the employment of people with serious mental illness and addiction issues | Exceptions report if actions are not on track | Quarterly |
| Ensure addiction services are responsive to the needs of older people | • Identify alcohol and drug champions in this area to support services as appropriate<br>• Identify and implement an appropriate screening tool to be used at initial assessment | Progress reports | Quarterly |
| Improving physical health | • Non-government organisation residential providers and community support services will continue to focus on improving physical activity, smoking cessation, health eating, and regular GP visits for service users as part of the recovery planning process.<br>• Continue peer support workshops to improve wellness and health literacy<br><br>Health Waikato Mental Health and Addictions Service will:<br>• Improve focus on physical health through its integration co-ordination team who will develop an organisation strategy in conjunction with primary health to:<br>- improving physical health;<br>- enhancing metabolic screening;<br>- led project in smoking cessation. | Progress reports | Quarterly |
| Improve access to child and adolescent mental health services and alcohol and other drug services | • Continue to review data and data quality to ensure all information is accurately collected.<br>• Continue to do pen and paper collection to ensure PRIMHD is reflecting what is really occurring.<br>• Ongoing training of staff re data collection.<br>• Discuss data outcomes with clusters and implement quality improvement projects as required. | Shorter wait times for non-urgent mental health and addiction services for 0 -19 year olds:<br>• 80 percent to access services within three weeks<br>• 95 percent to access services within eight weeks of contact | Quarterly |
| Improve crisis response services particularly relation to know clients being referred to crisis services by Police | Health Waikato Mental Health and Addictions Service will:<br>• Continue to have a mental health nurse situated at the Hamilton Police station seven days a week to provide advice, support and mental health assessments<br>• Continue the work being done with the Hamilton police to identify and develop communication strategies / joint management for individual who have mental illness and | Progress report on identified actions | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | frequent contact with the police<br>• Investigating possible national approaches i.e. police being able to link in with the mental health line service.<br>• Further explore how the police liaison position could be deployed to ensure that individuals referred via police are assessed promptly and issue resolved collaboratively. This may include the flexibility to follow the individual to the emergency department, where in general individuals are being taken (under the direction of a Duly Authorised Officers) to be assessed.<br>• Explore whether, for known service users, assessments could be undertaken at the Henry Rongomai Bennett Centre, once the police have notified that they require assessment of an individual. | | |
| Provide a preferred model of care for alcohol and other drug withdrawal management services | • Waikato DHB is working with the other Midland DHBs to ascertain whether a regional approach to achieve this requirement is possible. A formal project is expected to provide recommendations that will guide service provision in this area in 2016/2017 | Report submitted | Quarter 3 |
| Support the shift to an outcomes-focussed approach | • Waikato DHB is an active participant in development of the outcomes framework<br>• Attend any Ministry of Health training/workshops related to the commissioning framework implementation and outcome measures<br>• Socialisation of outcome measures with providers and communicating with them to ensure they are aware of this work<br><br>• Review current planning and contract processes to ensure practice is aligned to commissioning framework and Government procurement requirements (once finalised) | • Progress reports<br><br>• Planning processes reviewed | Quarterly<br><br>Quarter 3 |

## 2.5 System Integration

### 2.5.1 Cancer

#### 2.4.6.1 Our Approach

Waikato DHB is guided by the Midland Cancer Network - Midland Cancer Strategy Plan 2015-2020 with a vision of regionally working together as one, we will lift the performance of our health systems by driving quality, improve experience of care, accountability, innovation and value. Midland encompasses the Bay of Plenty, Lakes, Tairawhiti and Waikato districts, with an open invitation to Taranaki DHB. Cancer networks work across boundaries to improve outcomes for patients.

The Midland Cancer Network brings together regional stakeholders who are working across the cancer pathway including:

- DHBs;
- Non-government organisations;
- General practitioners and primary health organisations;
- Cancer service providers;
- Cancer consumers and their family/whānau;
- Hospices and research organisations.

Midland has a higher Māori population, more people living in more socio-economically deprived areas both rural and remote areas and those who live in larger cities. Māori have a higher cancer incidence (20% greater), higher cancer mortality (80% higher), and Māori are more likely than non-Māori to have their cancer detected at a later stage of disease spread. There are wide variations in survival rates between DHBs in New Zealand.

The Midland strategic framework for action takes a total continuum of care approach for the Midland population from prevention and early detection – screening – diagnosis and treatment – follow-up and surveillance – survivorship – palliative care and last days of life. The 2016/17 plan aims to build and strengthen the alignment and linkages of the various Midland health services related to the cancer continuum.

The faster cancer treatment programme is a key focus of Waikato DHB, Midland and National Cancer Programme. The programme is designed to improve access, timeliness, quality of cancer services, and standardise care pathways for all patients wherever they live. There are several main work streams to the faster cancer treatment programme such as development and review against national tumour standards, service improvement and / or equity initiatives to ensure achievement of the Health Target and / or implementation of the national tumour standards, one-off faster cancer treatment projects, improving the coverage and functionality of multidisciplinary meetings.

Activities continue to be undertaken to improve the faster cancer treatment pathway for patients with high suspicion of cancer. Work occurs to get identify and get an understanding of where delays occur. Breach reports giving a detailed analysis of the pathway are used.

### 2.5.1.2 Linkages

- Midland District Health Boards Regional Services Plan 2016/17

### 2.5.1.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Faster Cancer Treatment - Health Target | Deliver against the Midland Faster Cancer Treatment Implementation Plan<br>• Continue to improve the quality of data and data collection<br>• Continue to implement initiatives to achieve the 15 – 25 percent of cancer registration cohort within the 62 day Health Target<br>• Participate in the Midland Faster Cancer Treatment and Work Groups and regional activities to improve patient care<br>• Initiatives that support primary care and / or private provider interface with faster cancer treatment indicators are identified and implemented<br>• Identify and implement actions to improve faster cancer treatment data collection systems to identify service improvements along the cancer patient pathway. Where required, identify risks and mitigation strategies.<br>• Continue to work towards integration of faster cancer treatment data collection as business as usual across all clinical teams | • Progress against target to achieve 85 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 by July 2016 and increasing to 90 percent by June 2017<br>• Percentage of patients with a diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision-to-treat.<br>• Review faster cancer treatment data collection systems implemented actions to identify areas of improvement | Quarterly<br>Quarter 4 |
| | • Review and update the Māori Cancer Action Plan<br>• Develop and implement standardised equity focused reporting for all initiatives | Report on:<br>• Waikato DHB participation in Māori Cancer Action Plan work group | Quarter One |
| | • Work in partnership with Midland Cancer Network and participate in the Midland DHBs' stocktake of myeloma cancer services and gap analysis against national sarcoma tumour standards:<br>• Participate in Midland Work Group to review findings and develop report and action<br>• Work in partnership with Midland Cancer Network and participate in the Midland DHBs' stocktake of lung cancer services and gap analysis against national lung tumour standards:<br>• Participate in Midland Work Group | • Waikato DHB self-assessment and data analysis completed<br>• Group established<br>• Waikato DHB self-assessment and data analysis completed | Quarter Two<br>Quarter Four<br>Quarter Three<br>Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | to review findings and develop report and action plan<br><br>• Support monitoring through regional lung cancer key performance indicator report six monthly<br><br>• Work in partnership with Midland Cancer Network to Identify key activities to address issues identified as a result of completed regional tumour standards reviews for lung (2014), colorectal (2014), gynae-oncology (2015), breast (2015), sarcoma (2015), lymphoma (2016) | • Lung cancer key performance indicator report completed<br><br>• Report on progress to develop and update Improvement Plans and support monitoring and evaluation against review recommendations | |
| | • Improve the functionality and coverage of Midland multidisciplinary meetings<br>• Implement Midland multidisciplinary meetings Action Plan (2016) recommendations | • Report on progress | Quarter Four |
| | • Continue to implement Midland Cancer Network - Waikato Faster Access to Cancer Services through a Staged Tumour Approach to Treatment Project 2015-2020<br>• Continue to implement MCN-Waikato PMB and Endometrial Cancer Project 2015/16-20/16/17<br>• Continue to support development and implementation of Waikato Palliative Care Strategy Plan | • Report on progress | Quarterly |
| | • Scope the feasibility of establishing a Midland Urological Cancer Work Group to implement service improvements related to FCT, MDMs and national guidance (tbc - dependent on available resources)<br>• Implement the Standards for Service Provision for Lung Cancer Patients in New Zealand (2015 not yet published)<br>• Implement the national HSCAN lung cancer definitions (published April 2016) | • Report on progress | Quarterly |
| | • Work with Midland Cancer Network to identify actions to maintain timeliness of access to radiotherapy and chemotherapy<br>• Continue the Lakes-Waikato medical oncology, radiation oncology and haematology model of service improvement project (in progress)<br>• Participate in the review and | • Report on progress | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | update of the Midland Radiation Oncology Plan following completion of the Radiation Oncology National Linear Accelerator and Workforce Plan (due for publication June 2016)<br>• Participate in the review and update of the Midland Medical Oncology Plan 2013-2018 | | |

## 2.5.2 Stroke Services

### 2.5.2.1 Our Approach

The Combined Stroke Services within Waikato DHB sits within the Directorate of Older Persons, Rehabilitation and Allied Health. However, multiple services support the delivery of care and we continue to collaborate with colleagues in Internal Medicine, Emergency Medicine and Neurology to further improve the care of stroke patients at Waikato Hospital.

Patients with confirmed major acute strokes are now admitted directly to a hyper acute stroke unit in the Older Persons and Rehabilitation Building. Patients experiencing minor acute strokes and transient ischemic attacks are admitted to the minor acute stroke unit in the Acute Medical Building. Previously stroke patients were initially admitted to a medical ward and then transferred to a specialised stroke ward if required. However best practice is for stroke patients to be treated in an environment where staff have acute stroke knowledge. Although the two wards are in separate areas of the hospital campus, medical staff from internal medicine and neurology provide input into both units and staff training is consistent across the two areas.

Patients admitted to the hyper acute stroke unit are intensively monitored and will have a management plan spanning their first 72 hours in hospital. From there, the stroke team uses a "traffic light" system to make decisions about the best place for the patient to move to – this might be discharge home with Supported Transfer and Accelerated Rehabilitation Team or transfer to a stroke rehabilitation ward. Length of stay for both the acute and rehabilitation inpatients has reduced as a result of this approach and work is in place to continue to identify patients earlier for rehabilitation and discharge with community and Supported Transfer and Accelerated Rehabilitation Team supports.

A new stroke pathway has been developed. A joint stroke governance group, consisting of multi-disciplinary team members from across the services areas meet monthly and their function includes the review and improvement identification following the introduction of the pathway. The group's generic function is to analyse data / patient outcomes, and review / improve operational processes associated with the new stroke pathway to maximise teamwork, collaboration and smooth patient flow.

We have engaged with our primary care alliance partners and our Clinical Director Primary and Integrated Care at a clinical level about improvements across the continuum. We will continue with this approach to determine any actions the sector can take to contribute to an improvement in the care of people with stroke.

Equitable delivery of our Supported Transfer and Accelerated Rehabilitation Team service is an important consideration in terms of improving the care of stroke patients. We are a large DHB and equity for rural communities as well as ethnicity is an area of focus.

Stroke services are identified priority area in our Regional Services Plan. HealthShare through the Midland Stroke Network are leading the development and implementation of regional actions.

### 2.5.2.2 Linkages

- Midland District Health Boards Regional Services Plan 2016/17

### 2.5.2.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Organised Stroke Services | • All people with stroke have access to a quality assured thrombolysis service 24/7<br>• All eligible people with stroke receive early active rehabilitation by an interdisciplinary stroke team<br>• All eligible people with stroke have equitable access to community stroke services.<br>• All members of the interdisciplinary stroke team participate in ongoing education and training according to the Stroke Guidelines and advice provided by the national and regional clinical stroke networks.<br>• Provide services including individualised care management plans for people with, transient ischaemic attack and stroke - supported by an adequately staffed acute and rehabilitation stroke interdisciplinary service that regularly accesses ongoing education and training.<br>• Identify and support lead clinicians designated to stroke, such as physician, nurse, and allied health<br>• Support and participate in national and regional clinical stroke networks to identify and implement actions to improve stroke services | • 6 percent or more of potentially eligible stroke patients thrombolysed 24/7.<br>• 80 percent of stroke patients admitted to a stroke unit or organised stroke service.<br>• 80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission. | Quarterly |

### 2.5.3 Cardiac Services

#### 2.5.3.1 Our Approach

Cardiology is a large multidisciplinary unit which provides both secondary and tertiary outpatient and inpatient services for the Waikato and the wider the Midland region. Cardiology is part of the Cardiology, Cardiothoracic and Vascular Surgery department, which comes under Waikato Hospital's Surgical Services cluster. The main areas within Cardiology at Waikato Hospital are: Cardiac Care inpatient facilities - six acute cardiac care unit beds, 38 ward beds and four chest pain unit beds for low risk patients:

- Echocardiography;
- Electrocardiology;
- Cardiology Investigation;
- Cardiology Education and Rehabilitation;
- Heart Failure Programme including Heart Failure Nursing team.

We will work with the regional, and where appropriate, the national cardiac networks to improve outcomes for patients with heart failure. We are a part of the Midland Cardiac Clinical Network[14] whose tangible outcomes for 2016/17 are identified as:

- The trial of a regional Winter Plan for timely access to cath lab facilities for angiograms and percutaneous interventions (PCI) such as angioplasty and the insertion of arterial stents;
- Compliance with the Ministry of Health acute coronary syndrome targets for timeliness of angiogram and of the data entry into the ANZACS-QI data registry monitored by each of the five Midland DHBs and by ethnicity;
- A gap analysis and proposals across the five Midland DHBs to deliver the NZ Minimum Cardiac Standards of assessment and treatment. These include acute chest pain, STYEMI myocardial infarction, heart failure, atrial fibrillation, access to Holter and echo diagnostics, tachycardia/palpitations/syncope, structural or valvular heart disease.

The Midland Cardiac Clinical Network provides a leadership and monitoring role across the cardiac services in the region. This will be done through:

- Formation and facilitation of the shared regional vision for integrated cardiac services across the five Midland DHBs and in alignment with the five strategic themes in the NZ Health Strategy;
- Work with primary care to identify groups of high risk patients in need of increased access to primary or secondary care services or a higher level of preventative intervention; provide resource for primary care health literacy initiatives to increase the rate being risk assessed;
- Communication on a range of topics that the NZ Cardiac Network is working on to advise the Ministry of Health. Regional interest includes Health Workforce NZ, AED national working group, ambulance service and STEMI pathway, National Minimum Standards , Echo cardiography etc;

[14] For detail on activity for 2016/17 please see the Midland DHB Regional Services Plan

- Facilitation to identify gaps in and options for the region can move towards delivering the NZ Minimum Standards in line with the NZ Health Strategy themes and within limited regional resources;
- Identifying and sharing solutions for service improvement issues within individual DHBs;
- Regional IS e-space initiatives.

Locally, there is a nurse-led heart failure service belonging to Cardiology at Waikato Hospital but providing services in the community including expert care, support and education. The team works closely with secondary (hospital) and primary (community-based) health professionals.

The Accelerated Chest Pain Pathway was implemented in November 2014 and there was an initial review in February 2015. Further reviews of pathway implementation are undertaken on a regular basis.

#### 2.5.3.2 Linkages

- Midland District Health Boards Regional Services Plan 2016/17

#### 2.5.3.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Acute Cardiac Services | • Contribute data to the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of acute coronary syndrome risk stratification and time to appropriate intervention.<br>• Work with the regional, and where appropriate, the national cardiac networks to improve outcomes for acute coronary syndrome patients and for patients with heart failure.<br>• Review and audit Accelerated Chest Pain Pathways in Emergency Departments | 70 percent of patients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0') reported by ethnicity | Quarterly |
| Secondary Services | • Deliver a minimum target intervention rate for cardiac surgery, set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access.<br>• Ensure appropriate access to cardiac diagnostics to facilitate appropriate treatment referrals, including angiography, echocardiograms, exercise tolerance tests etc.<br>• Manage waiting times for cardiac services, so that patients wait no longer than four months for first specialist assessment or treatment.<br>• Undertake initiatives locally to ensure population access to cardiac services is not significantly below the agreed rates. This | • Agreement to and provision of a minimum of 274 total cardiac surgery discharges for your local population in 2016/17<br>• 95 percent of people will receive elective coronary angiograms within 90 days<br>• Patients wait no longer than four months for first specialist assessment and treatment.<br><br>Standardised Intervention Rates:<br>• Cardiac surgery: a target intervention rate of 6.5 per 10,000 of population will be achieved. .<br>• Percutaneous revascularisation: a target rate of at least 12.5 per 10,000 of population will be achieved.<br>• Coronary angiography: a target rate of at least 34.7 per 10,000 of | Quarterly<br><br>Six monthly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | includes cardiac surgery, percutaneous revascularisation and coronary angiography.<br>• Sustain performance against cardiac surgery waiting list management expectations<br>• Ensure consistency of clinical prioritisation for cardiac surgery patients, by using the national cardiac Clinical Prioritisation tool, and treating patients in accordance with assigned priority and urgency timeframe<br><br>• Increase lab capacity at start and end of week at Waikato Hospital (enables high volumes of patients to be treated on Monday and Friday to clear pre and post weekend backlog weekend)<br>• Smooth capacity across the region enabling more timely access to treatment for regional patients<br>• Increase direct to lab admission (including to Bay of Plenty DHB) to improve the timely flow of patients from regional hospitals and mitigate the risk of bed block impacting timely transfer<br>• Public Holiday weekend service to maintains flow and reduce the risk of delayed access to treatment as a result of public holidays<br>• Implement the agreed Regional Winter Plan (April – September) to improve ability to plan proactively based on data Improved centralised planning<br>• Ring fence beds for regional acute coronary syndrome flow to mitigate the risk of reduced flow from regions due to bed capacity issues<br>• Reduce referral time from regions to >12 hours to assist to transfer and treat in a timelier fashion<br>• Cath/PCI form completion Achieve >90% completion within a month post admission | population will be achieved.<br>• The waiting list for cardiac surgery remains between 5 and 7.5 percent of annual cardiac throughput, and does not exceed 10 percent of annual throughput.<br>• Cardiac surgery patients are operated on within nationally agreed urgency timeframes.<br><br>• Progress reports | |

## 2.5.4 Health of Older People

### 2.5.4.1 Our Approach

During 2016/17 Waikato DHB will continue to work with our primary care alliance partners, contracted service providers and regional DHBs to develop and refine integrated services. These services will be focused on addressing the needs of older people through:

- Early and appropriate intervention closer to home;
- Focusing on reducing the need for hospitalisation and/or readmission;
- Coordinating the increasing complexity of care needs for older people who are able to stay at home safely;
- Delaying the entry into long-term residential care where risk of institutionalisation has been identified.

We will progress current service developments commenced in 2015/16. These include collaboration with primary care and the Accident Compensation Corporation to reduce the risk of falls and fractures, and a coordinated pathway of support for people with dementia or delirium to reduce dependence on tertiary services. The community-based Alzheimer's navigator demonstration service model will continue into the 2016/17 year assisting people with an early diagnosis of dementia navigate through the system.

On an incremental basis we will develop and implement our approach to virtual care that supports the specialist health professional teams and community, primary and residential care providers working with older people to provide follow-up specialist care and advice closer to the older person. Care pathways will ensure that the older person receives support from the right person at the right time, and care is planned and based on shared health information between all the health providers.

As well as working regionally as part of the Midland Health of Older People focus groups which support development of regional clinical best practice approaches, we will continue to collaborate regionally to progress:

- Delivery of more responsive home and community support services;
- Development and implementation of regional dementia clinical pathway;
- Use of interRAI data to determine opportunities to improve clinical practice and service development.

The two main health services for older people directly provided by Waikato DHB are:

- Older People and Rehabilitation;
- Mental Health Services for Older People.

The Older Persons and Rehabilitation Service provides assessment, treatment and rehabilitation services for older people (65+ and those close in age and characteristics), and intensive rehabilitation for people under 65 years of age. Services are provided in hospital, outpatient clinics, and in the community, including in clients' homes. Older Persons and Rehabilitation services include:

- Combined stroke service;
- Orthopaedic rehabilitation;
- General assessment, treatment and rehabilitation;
- Intensive rehabilitation;
- Older Persons and Rehabilitation clinics;
- Disability Support Link;
- Supported Transfer and Accelerated Rehabilitation Team

The Mental Health Services for Older People is a service for people 65 years and over. Most referrals will be initially assessed in their place of residence by a community mental health nurse or doctor (consultant or registrar). The team also includes social workers, psychologists, and occupational therapists.

During 2015/16 a number of dementia educators were employed to work alongside primary care. These roles will continue in 2016/17.

### 2.5.4.2 Linkages

- Our Performance Story Impact: People receive timely and appropriate specialist care
- Midland District Health Boards Regional Services Plan 2016/17

### 2.5.4.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| System Integration for Older People | • Improve quality of information for resident transfers and communication between secondary care, primary care, age related residential care, pharmacy and resident/family<br>• Further development of Integration Between General Practice and Hospital Computer Systems through:<br>- Enabling access by hospital clinicians to selected general practice patient data for patients in shared care;<br>- Enabling access and information sharing with community pharmacy:<br>o Implementation of electronic transmission of clinical letters;<br>o E-referral enhancements and automation.<br>• Explore data interoperability requirements enabling primary care and DHB clinical access to interRAI assessment data at a national health index number level<br>• Link with the planned cross sector group around advanced care planning to co-ordinate related activity around health of older people and increase both the development and accessibility to advanced care planning for older people across the Waikato<br>• Service integration for people in | Progress report<br>• Progress Report | Quarterly<br>Annual<br>Quarterly<br>Quarter 2<br>Quarter 4 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | aged residential care<br><br>- Contribute a Waikato DHB perspective (through the national Health of Older People Steering Group) to the development and implementation of a national cross-sectoral action matrix that improves the integration of health care services for older people living in aged residential care<br><br>• Service integration of frail older people<br>- Utilise available data to define and understand the specific needs of frail older people in our population in relation to service integration | Progress Report<br><br>• Analysis modelled<br><br>• Information presented | |
| Integrated Falls and Fracture Prevention and Rehabilitation | • Work in conjunction with Accident Compensation Corporation, Health Quality and Safety Commission and the Ministry of Health to further develop and measure the progress of our integrated falls and fracture prevention services.<br><br>• Implement the Waikato DHB Fracture Liaison Service 4 – inclusive of osteoporosis pathways<br><br>• Progress the agreed actions of the Waikato and Accident Compensation Corporation Joint Community Falls Prevention Steering Group including:<br>o Development of a standardised approach to in home strength and balance programme incorporating the best of Otago Exercise Programme and also nutritional and lifestyle factors. | • Provide narrative on how older people are being assessed on their risk of falls.<br>• Report the number of older people referred from primary and secondary care into the fracture liaison services<br>• Report the number of older people referred to a strength and balance retaining service (denominator) and seen by a strength and balance retaining service (numerator)<br>• Report the number of older people referred to osteoporosis management programmes. | Quarterly |
| interRAI: Comprehensive Clinical Assessment in residential care and in home and community | • Older people referred for an interRAI assessment to access publicly funded care services will undergo the assessment and have a service allocated/declined in a timely manner.<br>• DHBs to use interRAI measures | • Evidence of the number of older people who received long term support services for home and community supports and percentage who have had an interRAI Home Care or a Contact assessment and completed care plan. | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| support settings | provided by the national data analysis and reporting service to benchmark and compare performance with other DHBs and DHB regions to improve outcomes for older people. | • The percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI LTCF assessment completed within 230 days of the previous assessment.<br>• The percentage of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first LTCF assessment.<br>• Show time taken from any referral from any source to complete (not triage) an interRAI assessment (i.e., Contact, MDS-HC, LTCF assessment).<br>• Use interRAI measures to progress and compare performance with other DHBs and DHB regions. | |
| Home and Community Support Services for Older People | • Understand the overall impact on Waikato DHB of the In-between travel settlement process<br>• Work with Midland Region DHBs to implement the agreed model of care changes for Home and Community Support Services arising from Phase B of the In between Travel Settlement. | Support the In-between Settlement agreement outcomes | Annually |
| Dementia Care Pathways | • Participate and contribute to regional activity to improve regional pathways and care around cognitive impairment (dementia and delirium)<br>• Dementia educators continue to work alongside general practice staff<br>• Participate in regional work regarding analytics for patients diagnosed with dementia and / or delirium to better inform clinical discussions<br>• Contribute to the regional analysis of the current state of educational programmes and support groups to support family / whānau careers in the Midland Region<br>• Review the effectiveness of the | • Progress report detailing specific improvements to support and services available following a dementia diagnosis<br>• Progress report<br>• Progress report outlining how we have participated in the Midland Region activity to:<br>- complete an analysis of the current state of educational programmes and support groups that support informal careers in operation in the region<br>- reduce variability of education and support programmes available to support family/whanau carers and people living with dementia. | Quarterly<br>6 monthly<br>Quarterly<br>June 2017 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | Alzheimers Navigator service demonstration programme in assisting people with a diagnosis of dementia in accessing community support in a timely way | • Outcome report | |

## 2.5.5 Service Configuration

### 2.5.5.1 Our Approach

In this context service configuration means working collaboratively to ensure the right mix of activities for patients are delivered in the right mix of places, so that patients can access personalised, high-quality care, conveniently and safely. We expect this will enable people with complex medical and social needs to live healthy, fulfilling, independent lives.

Currently people living with multiple health and social care needs often experience highly fragmented services, which are complex to navigate, leading to less than optimal experiences of care and outcomes. An integrated whole of system response is required which means a re-orientation towards prevention, self-care, better co-ordination, and care that addresses social determinants of health. It requires strong effective relationships between primary care providers and hospital providers that are based on respecting each other's skills and actively seeking to work together in an integrated way. During 2016/17 Waikato DHB will be working with its key stakeholders to develop an agreed Primary care strategy.

System integration is a key approach for design and delivery of services which we expect will enable achievement of the desired re-orientation. This will involve our primary care alliance partners, primary care providers, Waikato DHB and other key stakeholders. Collectively we are committed to this approach and believe it will improve the health of the district population and eliminate health inequities.

While taking this approach is not new to the health sector, we must strengthen system integration activities in the district and region. This needs to be done in partnership with our primary care alliance partners and other appropriate stakeholders.

The following paragraphs summarised the models of care being progressed by our primary care alliance partners.

**Hauraki Primary Health Organisation**

Hauraki Hauora Model of Care is a nurse led, kaiawhina supported community based integrated support service that works closely as an extension of the Hauraki Primary Health Organisation practice partner general practice team to empower people and their whānau across a range of health and social needs. The concept is to provide wrap around support for whānau by building on the relationship of trust that Hauraki Primary Health Organisation General Practice teams have established with individual members. Individuals with complex health needs are identified as requiring additional support in a whanau setting. By supporting whanau empowerment the Hauraki Hauora Model of Care provides navigation and coordination to support and encourage an improvement in health outcomes for whanau over a six month intervention.

**Midlands Health Network**

Midlands Health Network has begun the shift to a model of care that is focused on long-term health and wellness promotion. It is consumer led and looks to minimise the need for costly interventions provided in a hospital setting. This model of care is called the Health Care Home.

The Health Care Home provides a single place that connects individuals with the broader health and social system – their Health Care Home. It is a team-based health care delivery model led by a primary care clinician that provides comprehensive and ongoing health and social care with the overarching goal of supporting individuals to obtain better health outcomes.

**National Hauora Coalition**

Whānau ora system integrates social and health services to better support whānau to enjoy their lives, improve their own outcomes and move towards optimal independence. This system targets integration of health promotion with the wider social circumstances and determinants of risk and ill-health for whānau and high needs populations with a focus on engaging whānau (within a supportive cultural context) in developing their capacity to maintain healthy lifestyles and support the complex changes required to manage chronic conditions when this arises.

There is a use of comprehensive Whānau Ora planning tools and needs assessment as a means of enabling whānau and their members to manage their health needs, develop goals, plans and action. Partnerships are developed between whānau and a Whānau Ora team that will support continued engagement, continuity of care and navigation of services for whānau through the complexity of health and social service needs.

Outlined in the following section are a number of initiatives being progressed during 2016/17. It is expected that these integration activities will assist in improving the health of our population and eliminating inequities.

**Integrated Care Coordination for People with Long Term Mental Illness**

As an organisation we acknowledge the concept outlined in Equally Well that there needs to be a focus on the physical health needs of people experiencing challenges with mental health and / or drug and alcohol use. There is a commitment in our district to support people in our population who experience challenges with mental health and addiction(s) to transition back to primary care when stable. We also recognise that a portion of our population with long term mental illness have disengaged from primary care health services. We will support them to re-engage with primary care for their physical health needs.

A key initiative commencing in 2016/17 will be a formal arrangement with our primary care alliance partners for:

- People with long term serious mental illness to transition back to full care within the primary care general practice when they are stable;
- Provision of a package care around physical health needs for mental health consumers who have high physical health needs and have disengaged from primary care. These

packages of care will be available for people to have any outstanding physical health needs addressed in primary care whilst remaining in secondary mental health services.

Funding for this initiative will be managed through primary care. This initiative has been developed with engagement and support from all our primary care alliance partners and Waikato DHB Mental Health and Addiction Services.

**Improving the understanding of population needs**

During 2016/17 we will be working with our communities, cross sector agencies, our primary care alliance partners and other key stakeholder to better understanding health needs of our population. The initial focus will be a mental health and addictions health needs analysis and assessment. Whilst the work will largely be undertaken with a focus on health, we recognise the importance of the social determinates and will seek to work across sectors to ensure the knowledge, expertise and information from other parties is incorporated. We expect the resulting information to be useful across the health and social sectors.

This piece of work will feed into future locality planning across the district which is expected to have a particular focus for rural communities.

**Midland Integration Governance System**

During late 2015/16 the primary care organisations and DHBs in the Midland region explored the potential of creating a governance system for integration activity across the region. The proposal was to establish a regional alliance leadership team, tentatively titled Midland United Regional Integrated Alliance Leadership Team. It is proposed that this team is jointly chaired by a primary health organisation representative and a DHB representative with a focus on working jointly to improve the health of our population and eliminate health inequities.

**Demand Management**

A primary / secondary demand management group has been established with a focus on working jointly to identify opportunities to reduce presenting demand in emergency departments and ambulatory sensitive hospitals admissions. This group will also be the key oversight group for DHB funded primary options with an increased focus on evaluation and exploration of new services including new pathways and improved diagnostic access.

**Advance Care Planning**

A cross sector group is being established to co-ordinate activity and increase both the development and accessibility to advanced care planning across the Waikato. Additional support will be provided to our primary care alliance partners to meet the costs incurred during the transitional phase for:

- Project management where required;
- Supporting staff training costs;
- Backfilling staff on training.

**Integration Between General Practice and Hospital Computer Systems**

Waikato DHB has a number of initiatives either implemented or planned to enhance the integration between General Practice and Hospital Computer Systems. General Practitioners are now able to access hospital-based information electronically to assist in patient care. Providing General Practitioners with access to Clinical Work Station has proved to be both popular and useful. We have also implemented a solution enabling the electronic transmission of discharge summaries to General Practitioners electronically. This supports the timely sharing of information between general practice and our hospitals. There has been a focus on the quality of information inside the discharge summary as well as ensuring that a discharge summary is completed every time a patient leaves hospital.

Over the coming year further enhancements are planned, including:

- Enabling access by hospital clinicians to selected General Practice patient data for patients in shared care;
- Enabling access and information sharing with community pharmacy:
- Implementation of electronic transmission of clinical letters;
- E-Referral enhancements and automation.

**General Practitioner Education Events**

During 2015/16 Waikato DHB started to run regular General Practitioner engagement events. Engagement evenings have occurred to with:

- Emergency Department;
- Radiology Department;
- Renal and Diabetes Service.

Feedback on these sessions has been positive that these events encourage improved communications between primary and secondary clinicians. This process will develop further in 2016/17 with key topics identified jointly for an annual programme.

**Virtual Health Care**

Waikato DHB has embarked on an approach to contribute to improved health outcomes for our population using technology. In late 2015/16 we launched a virtual health service which supports the themes of the New Zealand Health Strategy.

**Child Health**

With the full establishment of the national child health information platform in our district there is the opportunity to get enhanced engagement around child health services. A primary /secondary child health group (the Waikato Child Health Network) has been established locally to provide co-ordinated advice and leadership on child health issues.

This group will provide oversight on our local approach to reduce ambulatory sensitive admissions in the children. The local work will align with regional activity and provide valuable input into other projects such as the child oral health improvement project. This group will also

be the key forum for developing the Waikato DHB approach and pathways in relation to childhood obesity.

**Community Pharmacy**

Waikato DHB supports the Pharmacy Action Plan's principle aim of making better use of pharmacists. We will implement pharmacist services in line with the national framework to meet the needs of our population. We will continue to participate in the national process to plan the commissioning of pharmacist services in the community that cost-effectively matches modern supply to community need. We will support the development and implementation of a sustainable solution to the pharmaceutical margin and other supply chain issues.

Midlands Health Network has set up a clinical pharmacy service level alliance team. This service level alliance team was established in June 2016 with a focus on creating a service model, led out of the primary care health care home initiative and has extended team roles including clinical pharmacists. Membership includes Midlands Health Network management, Strategy and Funding (Waikato DHB), Midcentral Community Pharmacy Group, community, hospital, academic and clinical pharmacists.

Members at the first meeting agreed the initial focus should be on developing a model of care with phased implementation and working groups addressing infrastructure, information technology, communications, competency frameworks, evidence of effectiveness and the funding model.

As a first step members have been asked to provide relevant reports or evaluations which will assist the service level alliance team to come up with next steps.

### 2.5.5.2 Linkages

- Ki te Taumata o Pae Ora Waikato DHB Māori Health Plan 2016-2017
- 2.3 Child Health
- 2.4.1 Obesity
- 2.4.5 Rising to the Challenge
- 2.7.3 Virtual DHB

### 2.5.5.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Working together to understand the needs of our population | • Undertake a health needs analysis and assessment in the area of mental health and addictions<br>• Approach to ongoing regular needs assessment activity developed | • Health needs information available to inform decision making<br>• Approach agreed and needs assessment governance group identified | Quarter 2<br>Quarter 2 |
| Creating an environment for regional integration | • Establishment of a regional alliance team<br>• Implement the recommendations from the map of medicine review as agreed in the regional service level alliance team | • Team established<br>• Terms of Reference agreed<br>• Report on progress | Quarter 1<br>Quarter 3<br>Quarter 4<br>Quarter 4 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | • Continue to work with Lakes DHB around Tokoroa Orthopaedic volumes | • Volume of acute and elective orthopaedic inpatient activity undertaken by Lakes DHB for Waikato DHB domiciled clients | |
| System Integration | • Integrated Care Coordination for People with Long Term Mental Illness<br>• Waikato DHB will work jointly with Midland DHBs and primary health organisations in the region to co-develop and implement an improvement plan for childhood respiratory conditions | Implementation of the packages of care<br><br>Review of implementation<br>• Co-development activities undertaken<br>• Improvement Plan produced<br><br>• Regular reporting on implementation | Quarter 1<br>Quarter 4<br>By Quarter 2<br>By Quarter 4 |
| Simplifying access | • Implementation of the Youth INtact brand for youth alcohol and drug services in our district | • Confirmation of district wide systems and processes | Quarter 2 |
| Demand management | • Identification of key areas for the workplan including enhancement of primary options<br><br>• Full implementation of the iron infusion process developed in 2015/16 | • Report on agreed workplan and progress<br><br>• Report on activity and processes | Quarter 1<br><br>Quarter 2 |
| Pharmacy Action Plan | • Implement any national developments related to the development of the pharmacy Long Term Conditions service to align with the new service model<br>• Review local provision of Medicine Therapy Assessments, Medicines Use Review services and any applications to convert services from one level to another<br><br>• Review the delivery of services that optimise specific medicines e.g. Community Pharmacy Anti-Coagulation Management Service ensuring alignment to the new service model | • Monitoring report on long term condition registration volumes<br><br>• Finalise mobile Medicines Use Review /medications oversight service with Midland Community Pharmacy Group<br>• Stocktake of number of Medicines Therapy Assessment qualified pharmacists and local provision of Medicines Therapy Assessments being undertaken<br>• Recommendations report on Medicines Therapy Assessments and conversion of Medicines Use Review services to Medicines Therapy Assessments services<br>• Monitoring report on Community Pharmacy Anticoagulation Monitoring Services | Quarterly<br><br>Quarter 1<br><br><br><br>Quarter 3<br><br>Quarterly |
| | • Implement the nationally agreed interim solution to address margins anomalies<br>• Implement the outcome of the national Request for Information of section 26 and section 29 medicines<br><br>• Ongoing development of a longer term solution to address the margins anomalies | • Monitoring of margins expenditure<br><br>• Implement nationally agreed solution from the Request for Information submissions<br><br>• Implement nationally identified options | Quarterly<br><br>Quarter 2<br><br>Quarter 4 |
| | • Development of a different service and funding model to deliver more | • Implement any new national contract (or contracts) for the | Quarter 4 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | co-ordinated patient centred services to New Zealanders.<br>• Stratification of patient-centric services in line with new national models<br>• Contribute with other DHBs to a Ministry business case for an integrated pharmacy minor ailments service | integration of pharmacists services in the community<br>• Develop a pilot model or models of new service delivery with a local pharmacy or pharmacies<br>• Common, core and divergent contracts in place in line with national contracting models, where this is applicable to Waikato based pharmacies or pharmacy services<br>• Input provided to the national business case | Quarter 3<br>Quarter 4 |

## 2.5.6 System Level Outcomes

### 2.5.6.1 Our Approach

The Ministry of Health has been working closely with the sector to co-develop a suite of System Level Measures that provide a system wide view of performance. There are four new system level measures to be implemented from 1 July 2016, they are:

- Ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds (i.e. keeping children out of the hospital);
- Acute hospital bed days per capita (i.e. using health resources effectively);
- Patient experience of care (i.e. person centred care);
- Amenable mortality rates (i.e. prevention and early detection).
-

Additionally, the following two system level measures will be developed during 2016/17 including definitions and identification of data sets:

- Number of babies who live in a smoke-free household at six weeks post-natal (i.e. healthy start);
- Youth access to and utilisation of youth appropriate health services (i.e. teens make good choices about their health and wellbeing).
-

Locally, the alliance leadership teams, Hauraki Primary Health Organisation, Midlands Health Network, National Hauora Coalition, Waikato DHB and other appropriate stakeholders will be involved in a process to develop Improvement Plans for our population. Once agreed these group will drive implementation of the activities outlined in the plans.

### 2.5.6.2 Linkages

- People are supported to take greater responsibility for their health;
- People stay well in their homes and communities;
- Māori Health Plan 2016/17.

#### 2.5.6.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| System Level Outcomes | Waikato System Level Outcomes Improvement Plan(s) developed | Mutually agreed Improvement Plan(s) presented to the Ministry of Health | Quarter 2 |
| Establishment of a regional alliance team | Work with key stakeholders to explore the potential creation of a Midland United Regional Alliance Leadership Team | See section 2.5.5 Service Configuration including Shifting Services | |

### 2.5.7 Shorter Stays in Emergency Department

#### 2.5.7.1 Our Approach

Waikato DHB provides 24 hour acute care for people with serious illness or injury at Taumarunui Hospital, Te Kuiti Hospital, Thames Hospital, Tokoroa Hospital and Waikato Hospital. There is close liaison among the emergency departments at all the Waikato DHB hospitals. The Emergency department is akin to the "front door" of a hospital where urgent cases can arrive by ambulance or self-presentation for assessment and treatment. Patients are prioritised according to their condition, not in the order of arrival.

A number of activities have been, and continue to be, undertaken to improve performance against this target. Waikato DHB recognises that the achievement of the Shorter Stays in Emergency Department health target has been a challenge for this organisation and in an effort to achieve the target; the following two groups have been formed:

- The Demand Management Advisory Group – chaired by Strategy and Funding and providing advice from a DHB perspective.
- The Acute Patient Governance Group – this group focus on the acute patient flow within the emergency department and the pathway through Waikato hospital.

Both groups were formed in late 2015/16 and initial efforts related to identifying the groups mutually agreed focus for the 2016/17 year. In addition, the local Managing Acute Demand group continues. This is an operational group comprising of representatives from the Accident and Medical Centres, DHB, primary care alliance partners and St John's as core members. This group has an operational focus and has achieved a number of actions in respect of both local and national initiatives to improve patient flow. The larger programmes are outlines below:

- Redirection – Utilising a redirection methodology for nurse assessed patients to have treatment at a local Accident and Medical Centre. This utilises the primary options contracts, accesses Accident Compensation Corporation for minor trauma injuries and includes a voucher for treatment. Redirection is currently a cost neutral process for patients. Through a combination of primary options and redirection initiatives, the Emergency Department has successfully redirected 9.9 percent of total attendances, after an initial nursing assessment.
- St John clinical hub is a national project that commenced in Auckland and has been in place locally since February 2016. It provides different levels of care and disposition for patients using agreed guidelines and pathways. Auckland data shows a decrease in attendance by St John over a 12 month period however this has not stopped continued

growth in their demand profile (results inconclusive currently). The success of this measure will be reviewed by the Managing Acute Demand group.

- St John Electronic Patient Report Form - This is part of a national rollout plan to provide clinical data using the National Health Index and reducing errors in information. The second phase to integrate the record in clinical work station is planned for quarter two of 2016/17.
- Provision for the 24 hour Accident and Medical Centre to access the hospital clinical workstation was agreed and a recent project has opened this to all primary health care practises. This has enabled clinicians to view patient results and support decision making.

Waikato DHB will continue to agree on clinical pathways utilising the map of medicine and referral documents as appropriate.

St John will continue to monitor the outcome of the clinical hub and identify the effectiveness on reducing transfers to the emergency department. A second project will be undertaken to provide an integrated patient record and provide a view of the ambulances on route to the emergency department.

During 2016/17 Waikato DHB will report on the Shorter Stays in Emergency health target by ethnicity (Māori and Pacific). We will a establish baseline and ensure appropriate processes are established to ensure good data quality. Waikato DHB is committed to participating in the national initiative to report on a common suite of measures as per the Quality Framework for Emergency Departments. We expect processes and systems to be in place by 30 June 2017 that ensure the organisation has the capability to monitor all mandatory and non-mandatory measures. The information from monitoring the measures will be used to improve the acute patient journey and experience.

### 2.5.7.2 Linkages

- 1.6.3 Long Term Impact – People Receive Timely and Appropriate Specialist Care
- 2.5.5 Service Configuration including Shifting Services
- 5.2.5 Collaboration

### 2.5.7.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Shorter Stays in Emergency Departments | • Achieve and maintain the Shorter Stays in Emergency Departments Health Target | • 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours of presentation | Quarterly |
| | • Continued measurement of the mandatory measures of the emergency department quality framework and present in a dashboard | • Dashboard to completed | Quarter One<br>Quarter Two |
| | • Expand the non-mandatory measures according to the perceived needs of the DHB, in line with the recommendations | • Expansion occurs | Quarter One |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | made by the national champion for Shorter Stays in Emergency Department, post site visit.<br><br>• Utilise the 3-2-1 model to provide an organisational response to the acute patient journey | <br><br>• Model utilised | |
| | • Peer benchmarking to be completed to identify the appropriate workforce<br>• Trial a “team allocation" method for all clinicians, in the main areas of the department<br>• Identify the outstanding items from the Quality Framework for Emergency Departments and address these during the year.<br>• Create a policy framework to ensure early utilisation of the discharge lounge<br>• Monitoring of all specialty delays, relating to breaches of the 6 hour target<br>• Determine an approach to address the current Waikato specific elements of the multi-employer collective agreement<br>• Creation of a policy framework to enable the efficient review, treatment and disposition of emergency department patients through the Acute Patient Governance Group<br>• Review the existing specialty referral guidelines and update them as appropriate<br>• Develop a policy framework that creates rules of engagement - Inter-Professional Standards - that will establish how the acute patient pathway is managed for emergency department patients needing a specialty opinion and / or admission into the hospital. This will include clear criteria for monitoring of the standards and a framework for action for non-compliant areas. | • Benchmarking completed<br>• Trial to commence<br>• Progress reports<br>• Policy framework agreed<br>• Regular Monitoring Reports<br>• Approach agreed<br>• Framework in place<br>• Framework approved<br>• Monitoring of the standards and development of remedial action plans from non-compliant areas | Quarter One<br>Quarter One<br>Quarterly<br>Quarter Two<br>Quarterly<br>Quarter Four<br>August 2016<br>Ongoing |

## 2.5.8 Whānau Ora

### 2.5.8.1 Our Approach

With the disestablishment of the Waikato Regional Leadership Group for Whānau Ora and the move towards the Commissioning Agency Te Pou Matakana the shape of Whānau Ora on our local landscape has shifted significantly. Currently the Waikato DHB district has only one Whānau Ora collective that is 'Te Ngira'.

Te Ngira comprises of membership from Waahi Whanui, Raukura Hauora, Ngā Miro and Te Kohao Health services. Formerly these providers had aligned themselves to Te Koiora our Northern Collective and to the National Urban Māori Authority.

As a way forward the Waikato DHB has committed to developing "Te Poutama o Whānau Ora" an action plan with Te Ngira to strengthen the implementation of Whānau Ora within the Waikato DHB district.

"Te Poutama o Whānau Ora Action Plan 2016" will define joint work and support from Waikato DHB towards Te Ngira and Whānau Ora as a formal programme within the Waikato DHB district.

Key areas of focus will focus on three key areas:

- Mahi tahi - to work as one in collaboration;
- Kaitiakitanga - Iwi guardianship in relation to Whānau Ora;
- Puawai - to support Whānau Ora capacity development.

Actions against the above three strategic directions is detailed in the action table in this section.

Working with the Whānau Ora Partnership group is crucial to improving the health of Māori in Waikato. The activity in the following action plan cannot be achieved without collaboration between Whānau Ora providers, Te Puna Oranga (Māori Health Service) and Waikato DHB.

In November 2015, the Whānau Ora Partnership Group agreed to a set of indicators to support Whānau Ora, including five key areas for the health sector that contribute to Whānau Ora to achieve accelerated progress towards health equity for Māori and Pacific, and Whānau Ora in the next four years. The indicators are:

- Mental health (reduced rate of Māori committed to compulsory treatment relative to non-Māori);
- Tobacco (95 percent of all pregnant Māori women smoke free at two weeks post-natal);
- Asthma (reduced asthma and wheeze admission rates for Māori children (ambulatory sensitive hospitalisations 0-4 years));
- Oral health (increase in the number of children who are caries free at age 5);
- Obesity (by December 2017, 95 percent of obese Māori children identified in B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions).

Waikato DHB is committed to a heightened focus in this area to achieve accelerated progress towards Whānau Ora and health equity. Through Te Puna Oranga (Māori Health Service) we are running a number of holistic projects / programmes[15] to achieve targeted improvements. These projects / programmes will impact on a number of different health indicators. The following table provides a summary of these holistic projects / programmes.

| Name | Description | Priorities Impacted |
|---|---|---|
| Whare Ora | The Whare Ora programme is an initiative that supports whānau to create healthier homes that are warmer, dryer and safer. | • Sudden Unexplained Death in Infants<br>• Rheumatic Fever |

[15] See the Waikato DHB Māori Health Plan 2016/17 for more information

| Name | Description | Priorities Impacted |
|---|---|---|
| Hapū Wananga | A Kaupapa Māori antenatal class targeting young Māori mother. The classes provide information around haputanga and parenting while maintaining tikanga values and understandings | • Breastfeeding<br>• Childhood immunisation<br>• Sudden Unexplained Death in Infants<br>• Oral Health<br>• Access to care<br>• Smokefree Mama |
| Harti Hauora Assessment Tools | Harti Hauora Tamariki assessment tool has been developed and piloted within Waikato Hospital. This will expand to our DHB services such as community and rural health. Other assessments tools will be developed and implemented to target specific groups. | • Breastfeeding<br>• Childhood immunisation<br>• Sudden Unexplained Death in Infants<br>• Cervical screening<br>• Breast screening<br>• Influenza immunisation<br>• Cardiovascular disease<br>• Oral Health<br>• Access to care<br>• Smokefree Mama |
| Kaitiaki and Kaitakawaenga Services | Delivery of cultural support and advocacy for Māori patients and their whānau across targeted Health Waikato service areas. These services play a vital role in ensuring whānau have access to services throughout the hospital and community. | • Rheumatic fever<br>• Breastfeeding<br>• Childhood immunisation<br>• Sudden Unexplained Death in Infants<br>• Cervical screening<br>• Breast screening<br>• Influenza immunisation<br>• Cardiovascular disease<br>• Oral Health<br>• Access to care<br>• Smokefree Mama |

### 2.5.8.2 Linkages

- Ki te Taumata o Pae Ora Waikato DHB Māori Health Plan 2016-2017
- Child and Youth Health
- Long Term Conditions

### 2.5.8.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| To support the capability and capacity of Whānau Ora within the Waikato DHB district | Waikato DHB has committed to developing "Te Poutama o Whanau Ora" an action plan with Te Ngira throughout the 2016-2017 period to strengthen the implementation of Whanau Ora within the Waikato DHB district.<br><br>Key areas of focus on each of the three key strategic directions are:<br><br><u>Mahi tahi</u><br>• Progressing integrated contracts<br>• Identification on how Waikato DHB can give support to Te Ngira collective impact project,<br>• Sharing of information and expertise to support Whānau Ora programme within the Waikato | • Quarterly report completed detailing progress against initiatives and activities in "Te Poutama o Whānau Ora Action Plan" 2016/17. | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | district<br>• Promotion as appropriate to whānau on how to access whānau direct funding/ support<br>• Formalisation of processes to ensure that the Whānau Ora collectives can participate in Waikato DHB Annual Planning and Māori Health Plan development<br><br><u>Kaitiakitanga - Iwi guardianship</u><br>• Establishment of processes that:<br>• Support Iwi Māori Council to effectively monitor Whānau Ora within the Waikato DHB district<br>• Ensure that success stories, key trends and the performance of Whānau Ora implementation in - the Waikato DHB district is presented 1 x per year by Te Pou Matakana to Iwi Māori Council.<br><br>Puawai – to support Whānau Ora capacity development<br>• Progressing integrated contracts<br>• Identification of funding shortfalls that impede Whānau Ora rollout in the Waikato inclusive of service provision gaps in Hauraki/Raukawa and Maniapoto<br>• Workforce development/ training for Whānau Ora kaimahi<br>• Exploration of the feasibility of how research can demonstrate the value added by Whānau Ora. | | |
| Strengthen the relationship that the Waikato DHB has with its local Whānau Ora collective | • Waikato DHB will actively promote Whanau Ora collectives programmes, initiatives, projects that improve the health of Māori in the Waikato. | • Annual report on activity undertaken to progress the Whānau Ora approach | Quarter 4 |
| | • Active collaboration and engagement in at least three projects throughout the Waikato region with Whānau Ora Collectives | • Progress report | Quarterly |
| | • Te Puna Oranga (Māori Health Service) will actively connect whanau and communities with services Whānau Ora Collectives offer. | • Referral pathways for assessment tools (Harti Hauora, Kaitiaki and Kaitakawaenga), and programmes such as Hapū Wananga will be reviewed and monitored | Quarter 2 and 4 |
| Mental health and addictions | • Working group to improve mental health and addiction outcomes for Māori within Health Waikato services established and indicators identified. | • Improving trend in the reduction of section 29 Community Treatment orders evidenced.<br>• Monitor the percentage of Māori who have an acute admission within 28 days for discharge from the inpatient unit as compare with other ethnicities. | Quarter 2 and 4 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | | • Percentage of Māori in adult inpatient beds placed in seclusion and the number of hours Māori are in seclusion as compared to other ethnicities<br>• Percentage of Māori who are followed up by Community Mental Health Team within seven days of discharge from inpatient unit. Measure if the contact has been telephone or face to face.<br>• Percentage of Māori with current treatment/recovery plans in place as compared with other population groups | |
| Tobacco Control | • Train kaimahi that work with, or intend to work with hapu Māori, on how to use the newly developed Hapu Wananga Curriculum (Kaupapa Māori Pregnancy and Parenting curriculum)<br>• Design, develop and implement assessment tools based on the Harti Hauora Tamariki Assessment Tool specifically targeting wahine to include a specific smoke free referral pathway<br>• Review and implement kaitiaki and kaitakawaenga cultural assessment to include a specific smoke free referral pathway for hapu mama. | • Two training sessions throughout Midland region<br>• Tool specifically developed for wahine<br>• Cultural assessment reviewed and implemented | Quarter 4<br>Quarter 2<br>Quarter 2 |
| Asthma | • Continue implementing Whare Ora a healthy homes initiatives which seek to make homes warmer drier and healthier and safer and refer onto social support services / Whānau Ora if required. | • Complete 400 Healthy Home Assessments in the Waikato DHB district | Quarter 4 |
| Oral health | • Harti Hauora Tamariki Assessment tool will include an oral health enrolment assessment and referral pathway of all children admitted and screened using the Harti Hauora tool.<br>• Harti Hauora Tamariki Assessment tool referral pathway is evaluated reviewed and implemented in Waikato Hospital, with a specific Community Oral Health Service referral pathway.<br>• Implementation of the Harti Hauora Tamariki Assessment tool with a specific Community Oral Health Service referral pathway in at least three other settings within Waikato and the wider Midland region, to increase whānau enrolment that may have been | • Increased enrolment of Māori tamariki and Pacific children with Community Oral Health Service<br>• Harti Hauora Tamariki Assessment Tool is evaluated, reviewed and implemented<br>• Assessment Tool is piloted in at least one setting per quarter | Quarter 3<br>Quarter 2<br>Quarters 1,2 and 3 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | missed in other settings | | |
| Obesity | • Harti Hauora Tamariki Assessment tool will include a body mass index assessment and referral pathway | • Tool includes a body mass index assessment and referral pathway of all children admitted and screened | Quarter 4 |
| Partnership | • Waikato DHB actively engage and collaborate with the Whānau Ora Commissioning Agencies in its priority programme planning initiatives | • Annual report on activity undertaken to progress the Whānau Ora approach. | Quarter 4 |

## 2.5.9 Improved Access to Diagnostics

### 2.5.9.1 Our Approach

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 care and improve DHB demand and capacity management.

We have a number of initiatives underway in terms of diagnostic services. It is planned that these initiatives will enable an improvement in waiting times.

### 2.5.9.2 Linkages

- Health Target: Shorter Stays in Emergency Departments
- Health Target: Improved Access to Elective Services
- Health Target: Faster Cancer Treatment
- Our Performance Story Impact: People receive timely and appropriate specialist care
- Midland District Health Boards Regional Services Plan 2016/17

### 2.5.9.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Improved Access to Diagnostics | • Achieve identified waiting time targets by more efficient use of existing resources; making improvements to referral management and patient pathways; and investing in workforce and capacity as required.<br>• Participate in activity relating to development and implementation of the National Patient Flow system, including adapting data collection and submission to allow reporting to the NPF as required.<br>• Work with regional and national clinical groups to contribute to development of improvement programmes | • Agreed National Patient Flow system changes are implemented.<br>• Representation, attendance and participation in national and regional clinical group activities.<br>• Coronary angiography - 95 percent of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).<br>• 95 percent of accepted referrals for CT scans, and 85 percent of accepted referrals for MRI scans will receive their scan within six weeks (42 days).<br>• 85 percent of people accepted for an urgent diagnostic colonoscopy | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Radiology Colonoscopy/ Endoscopy | • Further embed the quality improvement initiatives developed in our radiology services over the previous 18 months to achieve and sustain performance at, or above, the target levels.<br>• Extend the radiology quality improvement initiatives to modalities other than MRI and CT during the year.<br>• Role of CT at Thames Hospital will be evaluated in 2016/17<br>• Explore the potential for international collaboration to reduce reporting wait times.<br>• Use the Global Rating Scale as part of the National Endoscopy Quality Improvement Programme<br>• Use the National Referral Criteria for Direct Access Outpatient Colonoscopy<br>• Work regionally improve access and timeliness to colonoscopy procedures<br>• Standardise triage processes for surgical and medical colonoscopy referrals. | will receive their procedure within two weeks (14 calendar days, inclusive), 100 percent within 30 days<br>• 70 percent of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100 percent within 90 days.<br>• 70 percent of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100 percent within 120 days. | |

## 2.5.10 Improved Access to Elective Surgery

### 2.5.10.1 Our Approach

We will be closely managing the performance of services to ensure patients are treated in accordance with assigned priority and waiting time. There will be a priority focus on those services in which new national clinical prioritisation tools are available.

We are working regionally with other Midland DHBs to identify opportunities for greater integration of elective services. Purchasing appropriate regional volumes will allow for sustainable service improvement. Service improvement will be further supported by agreed regional referral pathways, functional clinical networks and consistently applied access criteria.

### 2.5.10.2 Linkages

- 2.5.9 Improved access to diagnostics
- Our Performance Story Impact: People receive timely and appropriate specialist care
- Midland District Health Boards Regional Services Plan 2016/17

### 2.5.10.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Improved | • Delivery against our agreed | • Minimum of 16,805 elective surgical | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Access to Elective Surgery | volume schedule, including elective surgical discharges, to deliver the Electives Health Target and the Budget 2015 investment for additional elective orthopaedic and general surgery discharges.<br>• Electives funding will be allocated to support increased levels of elective surgery, specialist assessment, diagnostics, and alternative models of care. | discharges in 2016/17 towards the Electives Health Target<br>• Minimum of 309 elective orthopaedic and general surgery discharges in 2016/17 as part of the Budget 2015 additional investment. | |
| | • Standardised intervention rates and/or other mechanisms will be used to assess areas of need for improved equity of access.<br>• Focus on patient flow management will continue in order to maintain reduced waiting times for electives, with patients waiting no longer than four months for first specialist assessment or treatment. | • Elective services standardised intervention rates.<br>• Inpatient Length of Stay<br>• Elective Services Patient Flow Indicators expectations are met and patients wait no longer than four months for first specialist assessment and treatment. | |
| | • Conduct and implement recommendations from an Elective Services review. The terms of reference are:<br>- Review the current process for establishment of clinical access thresholds and the current process for application (including changing) of these thresholds<br>- Review the processes used for prioritisation and the relationship of assigned priority to treatment decisions<br>- Review he current processes for monitoring waitlists – notably additions and exits<br>- Review demand forecasting and how this is currently used to plan elective services<br>- Review of capacity forecasting and how this is currently determined and used to set access threshold | • Progress reports completed | Quarterly |
| | • Improve the consistency of prioritisation of patients by:<br>- implementing national tools as they become available<br>- prioritising all patients for | • All patients are prioritised using the most recent national tool available. | Quarterly |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | treatment using national, or nationally recognised, tools<br>- treating in accordance with assigned priority and waiting time.<br>• Participate in activity relating to all phases of National Patient Flow including:<br>- business process and system change to meet collection requirements<br>- data quality activities, including validation of submitted data<br>- identification of, and engagement with, local, regional and sector-wide quality improvement opportunities. | • Patient level data is being reported into the National Patient Flow collection, in line with specified requirements. | Quarterly |
| | • Implement recommendations from 2015 Colorectal review as part of the general surgery quality improvement project<br>• Develop a plan as part of the cardiac patient quality improvement project for the development of a surgical services quality governance group | • Report on implementation progress | Six monthly |

## 2.6 Living Within Our Means

### 2.6.1 Living Within Our Means

#### 2.6.1.1 Our Approach

We need to control our costs now that we have completed the building programme. In short we need to be "sustaining a healthy future" for Waikato DHB. While the DHB's own efficiency efforts are usually more visible to our staff than are those of other providers, all providers need to constantly innovate to be able to continue to deliver quality services within the limited funding growth that Government can provide.

Every single dollar we receive we spend and it's up to us not to waste it and to spend it in areas of greatest benefit to the public. Waikato DHB faces a number of challenges:

- Costs growing faster than our revenue, notwithstanding the significant funding increases that the NZ health sector still enjoys;
- Higher health needs of our population - increasing demand for services and new technologies;
- Continuing to meet the Ministry's Health Targets and the Health and Quality Safety Commission's safety markers.

Our sustainable future is one where:

- We deliver clinical services safely
- We meet the health needs of our population
- Our costs equal our revenues
- We can invest in services and infrastructure.

We must continue to invest in our services, which are where the majority of our costs are, as well as our need to achieve change as our population grows and with it their health needs. Our services must be able to cope with that growth. They must be safe and provided in the appropriate location. That means positioning more services closer to people's homes by partnering more effectively with our primary care partners, but still providing high end, specialist care for those who need hospitalisation.

Waikato DHB's long-term financial planning always predicted that once the building programme was complete, there would be financial challenges. That is the phase we are now in, which is no different to other DHBs who have undergone significant campus redevelopment in the past. It is now time to realise the benefits resulting from the building programme by working differently across all service areas and we can only do this with the full support of staff and stakeholders. We must sustain a healthy future for the organisation, our staff and the people of the Waikato. Our staff are the biggest resource and we need them to help us sustain a healthy future.

#### 2.6.1.2 Linkages

- National Entity Priority Initiatives
- NZ Health Partnerships Limited
- Waikato DHB Annual Quality Report

#### 2.6.1.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Living Within Our Means | • Operate within agreed financial plans<br>• Continue to participate in implementation of National Entity initiatives as appropriate for Waikato DHB<br>• Proactively manage cost growth and improve use of workforce.<br>• Provide information on the production plans and explain major variations in the yearly variations in the production schedule. | • Ensuring delivery of Service Coverage.<br>• Inpatient Length of Stay.<br>• Reducing Acute Readmissions to Hospital.<br>• Output Delivery Against Plan | Quarterly |

### 2.6.2 National Entity Priority Initiatives

#### 2.6.2.1 Our Approach

We are expected to align our planning with the planning intentions of key national agencies. Initiatives, which will impact on our DHB, have been identified from each of the national agencies. The national agencies are:

- NZ Health Partnerships Limited;
- National Health Promotion Agency;
- Health Quality and Safety Commission;
- Health Workforce New Zealand;
- National Health Information Technology Board.

We are committed to engaging with the Ministry of Health on the work programme of the former National Health Committee (once the programme is confirmed).

A number of the initiatives Waikato DHB is specifically involved in are outlined in the following action table.

#### 2.6.2.2 Linkages

- Kōwae Whā / Module Four / Financial Performance
- Midland DHBs Regional Services Plan 2016/17

#### 2.6.2.3 Action Plan

| Entity | Initiative | Description | Action |
|---|---|---|---|
| NZ Health Partnerships | National Oracle Solution | • The National Oracle Solution will design and build a single financial management information system ready for DHB implementation. The designing of the processes and the system of the National Oracle Solution programme will be done through a co-creation approach with the sector, leveraging existing DHB expertise.<br>• DHBs will commit resources to the implementation of Oracle system, and will fully factor in expected budget benefit impacts. | Waikato DHB will work with NZ Health Partnerships as appropriate |
| | Food Services | NZ Health Partnerships will support the DHBs in considering the Food Services business case. If the DHB chooses to proceed with the business case, the DHB will commit the appropriate resources to implement the services. | Waikato DHB will work with NZ Health Partnerships as appropriate |
| | Linen and Laundry Services | NZ Health Partnerships will continue to work with the DHBs that are open to considering a collective arrangement for outsourced Linen and Laundry Services and will do this through the development of a collaborative strategy for the sector. | Waikato DHB will work with NZ Health Partnerships as appropriate |
| | National Infrastructure Platform | • The National Infrastructure Platform programme aims to achieve qualitative, clinical and financial benefits for DHBs through a national approach to | Waikato DHB will work with NZ Health Partnerships as appropriate |

| Entity | Initiative | Description | Action |
|---|---|---|---|
| | | IS infrastructure consumption. The national approach is driven by converging 40 infrastructure facilities into a single infrastructure platform delivered from two data centre facilities. It will also align the health sector's infrastructure services with the Government's overall Information Communications Technology goal of harnessing technology to deliver better, trusted public services.<br>• DHBs will commit to working collaboratively with NZ Health Partnerships to progress the National Infrastructure Platform. DHBs will commit resources to the decision reached in relation to the implementation of the programme. | |
| Health Promotion Agency | Campaign support for health targets | Health Promotion Agency is often requested to undertake national health promotion activities to support the achievement of Government priority areas, including health targets.<br>Immunisation is one of the most effective and cost-effective medical interventions to prevent disease. The Ministry of Health has contracted the Health Promotion Agency to promote immunisation in New Zealand, through various workstreams. | Waikato DHB will support national health promotion activities around the health targets |
| | Alcohol Pregnancy and Alcohol Screening and Brief Intervention | The Alcohol and Pregnancy work programme is to contribute towards a reduction in harms related to prenatal alcohol exposure by:<br>1. reducing the number of women consuming alcohol while they are pregnant<br>2. increasing public awareness of the risk associated with alcohol consumption during pregnancy<br>3. supporting health professionals (particularly primary care providers) to provide advice in a routine, effective and consistent way to women about alcohol and pregnancy.<br><br>Health Promotion Agency also has a programme of work to support Alcohol Screening and Brief Intervention in primary settings. This aligns with DHB work in this area. | Waikato DHB will support and participate in the developments around a national foetal alcohol spectrum disorder action plan<br><br>Waikato DHB will support the provision of routine and consistent advice to women of child bearing age about alcohol and pregnancy |
| Health | Surgical site infection | Continued DHB support for ongoing | Waikato DHB will commit to meeting |

| Entity | Initiative | Description | Action |
|---|---|---|---|
| Quality and Safety Commission | programme - National Infection Surveillance Data Warehouse | hosting costs of the national surveillance data warehouse | infection control expectations in accordance with Operational Policy Framework - Section 9.8. |
| | Surgical site infection programme - DHB Infections Management systems | DHB adoption of Infections Prevention and Control Systems investment and implementation including local integrations. Both Hospital and Community with National hosting. Costs are dependent on DHBs' decision to take up the system. | Waikato DHB will continue development of infection management systems at local DHB level. |
| | National inpatient patient experience survey and reporting system - Patient experience indicators | National in-patient survey to be used by all DHBs quarterly that can be incorporated in existing local patient experience surveys that provides a nationally consistent model of patient experience indicators | Waikato DHB commits to surveying patient experience of the care they received using the national core survey, at least quarterly. |
| | Capability and Leadership | Programmes to support improvement science and increased clinical leadership. | Waikato DHB will meet expectations in accordance with Operational Policy Framework Section 9.3 and 9.4.6. |
| | Primary Care - patient experience survey and reporting system | Similar proposal to the national in-patient experience survey to be used by primary health organisations | DHBs hold contract with primary health organisations but this initiative funded directly by Ministry of Health for three year period no DHB financial implications |
| Health Workforce NZ | Increasing the number of sonographers | Increasing the sonographer workforce will enable more timely delivery of healthcare services, meet faster cancer health targets and meet increased demand for sonography as a diagnostic tool. | The Midland region will:<br>• Continue work on the national work programme for sonographers;<br>• Produce a proposal to Chief Executives on the sonographer workforce shortage with a gap analysis and solutions to home grow sonographers as an effective option to minimise the workforce shortage within the region |
| | Expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses | Nurse practitioners can, amongst other services, assess, diagnose and prescribe medicines for specific groups.<br>Clinical nurses specialists cover a wide range of specialties including diabetes, cardiology, respite care, wound care, care of the elderly, mental health and addiction.<br>Expansion of the nurse practitioner and clinical nurse specialist role, especially the palliative care nurse role will enable medical staff to undertake more complex procedures and improve service delivery. | In the Waikato, several nurse practitioners are employed by Waikato DHB both in hospital-based and community-based roles and others are employed by primary healthcare organisations.<br><br>As part of the Midland Region ensure that our services are ready for diabetes prescribers and consider other nursing specialties suited for prescriber status and articulate these to and work with Health Workforce New Zealand to develop. |
| | Create new nurse specialist palliative care educator and support roles | Palliative care nurse specialist will provide training, mentoring and hands on support for staff across aged residential care, primary care practices and home-based support services. | The palliative care workforce has been identified as vulnerable at a regional level. Increasing the availability of nursing and allied health professionals to support patients and their families / whānau |

| Entity | Initiative | Description | Action |
|---|---|---|---|
| | | | is an identified priority for action in the Waikato DHB Palliative Care Strategic Plan 2016-2021. |
| | Expanding the role of specialist nurses to perform colonoscopies | Nurse endoscopists will make a direct contribution and an indirect contribution to service delivery, including enabling release of medical staff to undertake more complex procedures. Development of the nurse endoscopist role is critical to the delivery of bowel screening in New Zealand. | Waikato DHB supports the regional approach to expanding the role of specialist nurses to perform colonoscopies. |
| | Increasing the number of medical physicists | Radiation therapy is reliant on an adequate supply of medical physicists to plan and implement patient treatment programmes. Increasing the number of medical physicists will allow succession planning of a small workforce, vital to DHB workforce and service planning. | Waikato DHB will demonstrate its commitment to the recruitment of Medical Physics registrars to reduce the vulnerability of a small and critical workforce |
| | Increasing the number of medical community based training places and providing access to primary care/community settings for prevocational trainees | More medical trainees are exposed to quality community-based training experiences, and will have increased experience of integrated care and choose to vocationally train in general practice. An increase in the number and availability of prevocational clinical attachments across DHBs will support RMO career progression. Long term financial benefits are anticipated through early intervention and better integration between primary and secondary services | As a region we will, in conjunction with Medical Council of New Zealand, the Royal New Zealand College of General Practitioners and Health Workforce New Zealand, lead the coordination of community based clinical attachments outside General Practice settings, including hospice, urgent care, mental health and community based services. |
| National Health Information Technology Initiatives | Health IT Programme 2015-2020<br>(1) single EHR<br>(2) digital hospital blueprint<br>(3) preventative health IT platflorm<br>(4) data for health/social investment | A single longitudinal EHR and other national system platforms will enable access to high-value patient information to support (a) accurate, high quality information available at the point of care, (b) better care coordination (c) clinical decision support. This initiative supports the NZ Health Strategy, in particular, allowing people to access their own information, supporting virtual teams of clinicians, and overall enabling a smarter health system to operate. | Waikato DHB is committed to achieve the required EMRAM maturity level by 2020. The initial assessment has been completed and the DHB is currently working through planning, funding and resource requirements to implement solutions to fill the identified gaps, some of which will be regional solutions.<br><br>As confirmed within the Regional Services Plan, the Midland region will fully participate in the national EHR process as outlined in the Heath IT Programme 2015-2020 |
| | Regional CWS<br>Regional CDR<br>Regional PAS | Clinical Workstation and Clinical Data Repository allow a patient centric view of clinical information from a hospital (or community) setting. It is the basis for a regional electronic health record and is the essential platform enabling support of other high value functionality like eMR, electronic orders, results | Waikato DHB is committed to work regionally to ensure the regional implementation of the regional solution. The current focus is the implementation of the regional CWS and CDR, based on the Orion product. Waikato DHB will be the lead service provider for the solution once implemented. As outlined |

| Entity | Initiative | Description | Action |
|---|---|---|---|
| | | sign-off. It will also support a person's on-line access to their own health record.<br><br>Hospital based patient administration systems are a fundamental enabler to support other high value functionality, like Clinical Workstation and National Patient Flow. 8 DHB's need to replace their obsolete systems. | within the eSPACE 5 year roadmap and Midland DHB's forecast IS investments, both contained within the Regional Services Plan.<br><br>In tandem with the above, tactical interim solutions have either been or are in the process of being implemented to enable regional, community and primary care access to patient clinical information held by the DHB. |
| | National Patient Flow | National Patient Flow aligns with the vision of better integrating care so that patients can receive the appropriate services, in the right setting and in a timely way to improve overall health outcomes. Patients, referrers and providers need to better understand demand for services and waiting times. | Waikato DHB has a formal project in place and is actively working to ensure that we are collecting and providing the full mandate of phase three data. |
| | Electronic Prescribing and Administration | Studies have shown that there is up to a 50 percent error rate in the patient's drug chart. Electronic Prescribing and Administration reduces this rate and enhances both patient safety, the quality of clinical decision-making and the efficiency of managing the patient's drug chart. | ePharmacy has been implemented across the region. Waikato DHB is commited to work regionally to ensure ePA has been implemented. As defined within the Regional Services Plan, ePA implementation in the Midland Region is dependent on ePA working as required with the NZULM, and a need to demonstrate the working integration between ePA, ePx and the Regional CWS. Taranaki DHB will be the lead implementation for the integrated solution prior to regional rollout. The current non-integrated state, and reliance on Regional CWS, means that regional implementation will occur in the outer years. |
| | National Maternity Information System Platform | A single platform to record births across the sector, will enable<br>• the care received by a pregnant woman and her baby to be safer and of higher quality, because health professionals will have timely access to information about a woman's clinical/medical and maternity history before making care decisions.<br>• bring together relevant information collected about a woman and her baby in the community. | Waikato is committed to implement the National Maternity Information System. The local business case has been approved, however the project team has been stood down whilst we await further guidance from the Ministry of Health. We are in active engagement with the Ministry of Health with a view of recommencing the project once the Ministry is ready. |

## 2.7 Other

### 2.7.1 Improving Quality

#### 2.7.1.1 Our Approach

Waikato DHB aims to deliver the highest quality healthcare services to people, and ensure that these services are consistently person-centred, clinically effective and safe, for every person, all the time. Quality care is our stated priority and we strive to "Listen, Learn, Improve".

A quality governance strategy seeks to ensure that as an organisation we remain focused on quality. We will ensure that Health and Disability Standards for quality and safety are being met by every service across the organisation and support the implementation of the triple aim:

- Improved quality, safety and experience of care;
- Improved health and equity of all populations;
- Best value for public health system resources.

The following strategic objectives support our aims:

1. Deliver patient and whanau centred care – listen to, involve and empower our population and service users;
2. Embed continuous quality improvement;
3. Deliver more effective care – optimising the journey;
4. Deliver high quality safe patient care – reduce avoidable harm;
5. Empower our staff to continuously improve quality and safety;
6. Comply with our regulatory framework.

We have a dedicated Quality and Patient Safety team which has a crucial role in supporting quality initiatives across Waikato DHB. Priority areas for improving quality for 2016/17 are:

Priority1: Continue to keep our patients safe in our care.
Priority 2: Improve end of life care for patients and their family/whānau.
Priority 3: Reduce the number of people dying from preventable conditions.
Priority 4: Listening to our patients and community – ensuring a safe and welcome environment in DHB services.
Priority 5: Continue to improve care around deteriorating patients.

These priorities are published in our Annual Quality Account. This document looks back on the previous year's progress against priorities, and looks forward, identifying how we will improve our services and how we will measure that improvement. We will develop our process to gain feedback from population / community on key areas where the DHB needs to focus improvement.

The Quality Account for 2016/17 will be published by November 2016 in line with Health Quality and Safety Commission guidance. We will continue to report quarterly to the Board of Clinical Governance and the Audit and Risk Committee on progress against the priority areas during 2016/17.

### 2.7.1.2 Linkages

- Our Performance Story Impact: People Stay Well in their Homes and Communities
- Our Performance Story Impact: People Receive Timely and Appropriate Specialist Care

### 2.7.1.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| To reduce the number of falls | Complete an update falls reduction activity across the DHB, and reformat the Falls Committee to include wider community representation, links to Accident Compensation Corporation and fragility / fracture liaison work | 90 percent of older patients are given a falls risk assessment. | Quarter 4 |
| | • Update falls pathway on Map of Medicine.<br>• Continue to analyse the falls data including the contributory factors in falls that results in harm with serious harm (SAC2)<br>• Increase consumer engagement in the falls reduction programme | 98 percent of older patients assessed as at risk of falling receive an individualised care plan addressing the risks identified | |
| To improve hand hygiene | • Increase publicity and awareness campaign across all DHB sites<br>• Continue to reward areas where hand hygiene results are consistently above 85 percent across a number of audit periods<br>• Continue to audit all areas of the DHB including emergency departments and not just high risk areas.<br>• Set internal target at 85 percent and report monthly to Board of Clinical Governance, and through Quality and Patient Safety boards<br>• There is an agreed number of gold Hand Hygiene auditors for the DHB and the IPC committee monitor this and take action as necessary | 80 percent compliance with good hand hygiene practice. | Quarter 4 |
| Safe surgery | • Continue current phase 1 project and ensure that data is being collected prior to the 'go live' of the new Quality Safety Markers in July.<br>• We will sustain achievement at or above the old Quality Safety Markers threshold of all three parts of the World Health Organisation surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90 percent of operations<br>• We will ensure that the checklist is being used in paperless form, as a teamwork and communication tool rather than an audit tool | • All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100 percent of surgical procedures, with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale, 95 percent of the time. | Quarter 4 |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | • We will work with the Commission to continue to implement briefing and debriefing for each theatre list. | | |
| Surgical site infection | • Continue to present quarterly surgical site infection report to Board of Clinical Governance, orthopaedic and anaesthetic quality meetings<br>• Action to be taken where results are below target | 95 percent of hip and knee replacement patients receive cefazolin ≥ 2g or cefuroxime ≥ 1.5g as surgical prophylaxis. | Quarter 4 |
| | • Complete Information Services changes to enable collection and input of cardiac data electronically<br>• Develop business case for ICNet | 100 percent of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision. | Quarter 4 |
| Medication safety | • Continue discussions on feasibility of achievement of medicines reconciliation by proposed Health Quality and Safety Commission date of 2016/17<br>• Timeframe for SMT / eMR not known<br>• Define and implement a Medicine safety programme | Implementation of the electronic medicine reconciliation platform. | Quarter 4 |
| Pressure Injury prevention | • Continue to report / investigate all grade 3 and 4 pressure injuries as a serious event<br>• Continue the roll out of the pressure injuries project including ongoing weekly prevalence monitoring<br>• Undertake work with other Aged Residential Care and other providers (Ministry of Health, Accident Compensation Corporation and Health Quality and Safety Commission) to reduce community acquired pressure injuries<br>• Use Health Round Table data to drive improvement and work with coding to ensure accurate classification<br>• Continue to educate staff on reporting pressure injuries in Datix<br>• Encourage clinicians to complete ACC45 and ACC 2152 for grade 2 - 4 pressure injuries | • No hospital acquired grade 3 or 4 pressure injuries<br>• Top quartile of performance in Health Round Table data | Quarter 4 |
| To promote consumer engagement | • Continue to refine the consumer engagement framework for the DHB<br><br>• Implement the actions following review of the community health forums | • Performance updates published by the Health Quality and Safety Commission and included in DHB local quality accounts.<br>• Reporting 'Improving patient experience'<br><br>• Action Plan developed | Quarter Four<br><br>Quarterly<br>Quarter Three<br>Quarter Three<br>Quarter Two |

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| | • Establish a consumer council (or similar) to support the DHB and the quality governance framework | • Progress report on implementation activity<br>• Consumer council approach and terms of reference agreed | |
| Build quality improvement capability and clinical leadership | • Embed Quality and Patient Safety at executive level<br>• Continue to implement clinical leader / partnership model in new DHB structure<br>• Active involvement in the national patient safety week (November 2016) and patient experience week (April 2017)<br>• Implement capability / development program identified in the quality account and the quality governance strategy (Board to floor)<br>• Support the two quality improvement advisors and embed the new patient safety facilitator roles with the improvement program | Progress report | Quarter Four |

## 2.7.2 Actions to Support Delivery of Regional Priorities

### 2.7.2.1 Our Approach

During 2016/17 we will continue to participate as part of the Midland DHB Region. Within the Midland Regional Plan, we aim to develop the principles of culture, capability, capacity and change leadership. The focus for 2016/17 is on collaboration and the challenge is about behaviours, particularly how we will behave in an environment where we experience significant financial challenges and expectations of even higher performance.
Throughout this Annual Plan there are a number of activities we have planned to undertake which will support delivery of the regional priorities identified in our regional service plan. This section includes only those areas not covered elsewhere such as regional trauma, health workforce, information technology and hepatitis C. The focus on regional collaboration will continue and be a foundation of service delivery for the foreseeable future.

Major Trauma

Trauma continues to have a major impact on Midland communities, resulting in 5980 admissions in 2014 and 23,839 hospital bed days. After 5 years of sustained clinical effort, data collection, and data platform building, Midland Trauma System is now entering its output phase wherein we can use our clinical network and the information we have gathered to reduce the burden of trauma on the community, both in prevention, and in improving our responses at the point where prevention fails.

Workforce

Workforce planning and training in this sense is about ensuring that the Midland region has the right number of health professionals who are well skilled and display good collegial behaviours. Workforce planning and training is a key enabler to ensure Midland DHBs deliver quality healthcare (as defined in objective 3) and to protect and promote health and wellness. The Midland Region has over 10,000 full-time equivalents employed by the DHBs to provide healthcare to its populations. The health workforce is large and complex and requires sound strategic planning in order to maximise the contribution to health and have a workforce ready to accommodate new ways of working.

The workforce planning and training activities detailed in the Regional Services Plan illustrate initiatives to:

- Reshape the workforce to meet our current obligations
- Build and develop new workforces;
- Accommodate changes in models of care and healthcare delivery.

The regional workforce planning and training plan illustrates the collaborative work of the regional director of training and general managers of human resources building whole of health system solutions and also working alongside the clinical networks to meet some of their key deliverables that pertain to workforce and training.

Information Technology

An annual Information Services Regional Work Plan for 2016/17 financial year will be prepared with a 'line of sight' to regional and national strategic plans and directives. Specifically, with the majority of activities falling under the eSPACE Programme of Work, a model of closer, more collaborative engagement will be adopted. Each of the governance groups that have direct responsibility for the areas covered will provide the Programme with detailed guidance on requirements and aspects of design, and help to ensure that decisions are properly considered with outcomes that are realistic and deliverable. Overall, the Information Services Regional Work Plan will inform recommendations to DHBs on the Information Services funding decisions required to support local, regional and national priorities.

Development of an integrated Hepatitis C service across the Midland Region

The Midland DHBs are tasked with implementing a single clinical pathway for hepatitis C care across the region in order to provide consistent services, which maximise the wellbeing of all New Zealanders living with hepatitis C. A second objective is to implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region.

Actions in 2016-17 to support the implementation of integrated hepatitis C assessment and treatment services include:

- Raising community and General Practice awareness and education of the hepatitis C virus and the risk factors for infection;
- Providing targeted testing of individuals at risk for hepatitis C virus exposure;
- Raising patient and General Practice awareness of long term consequences of hepatitis C virus and the benefits of treatment, including lifestyle management and antiviral therapy;

- Providing community based access to hepatitis C virus testing and care that will include Fibroscan services to all regions as a means for assessment of disease severity and as a triage tool for referral to secondary care and prioritisation for antiviral therapy;
- Establishing systems to report on the delivery of Fibroscans in primary and secondary care settings;
- Providing community based ongoing education and support (including referral to and from needle exchange services, community alcohol and drug services, primary care services or social service agencies);
- Providing long term monitoring (life-long in people with cirrhosis and until cured in people without cirrhosis);
- Providing good information sharing with relevant health professionals;
- Working collaboratively with primary and secondary care to improve access to treatment.

#### 2.7.2.2 Linkages

- Section: 5.3 Workforce
- Section 5.2.2 Information Communications Technology

#### 2.7.2.3 Action Plan

| Objective | Actions to deliver improved performance | Measure | Reporting |
|---|---|---|---|
| Trauma | • Submit major trauma data to the Midland Regional Trauma Registry and the National Major Trauma Registry<br>• Case reviews of trauma cases across Waikato<br>• Attendance at Midland Trauma Symposium and International Trauma conference in 2016 | • Progress report on behalf of the region agreed by all DHBs within that region. | Six monthly |
| Workforce | • Refer to section: 5.3 Workforce | • Refer to section: 5.3 Workforce | |
| Information Technology | • Section 5.2.2 Information Communications Technology | • Section 5.2.2 Information Communications Technology | |
| Hepatitis C | Waikato DHB will work with HealthShare and our Midland DHB counterparts in this area. We will participate in the following regionally led initiatives as appropriate:<br>• Implement the clinical pathway<br>• Assess impact and plan for implementation of new pharmaceuticals<br>• Procurement of fibroscanning services and approval of transition plan<br>• Implementation of regional Hepatitis C services in Midland DHBs<br>• Support implementation of reporting and measuring requirements | • Narrative report on progress of the key actions | Quarterly |

### 2.7.3 Virtual DHB

#### 2.7.3.1 Our Approach

During 2015/16 a significant amount of developmental work has occurred to operationalise a Waikato DHB approach to virtual health care. The virtual health service was launched in May 2016. This work is set to enable Waikato DHB to be at the forefront of delivering the innovation needed to improve the health of our population and reduce health inequities. As an organisation, we have already been successfully using Telehealth to let patients consult with health professionals over a video link, but the scope of becoming a Virtual DHB is much wider. This approach is not about technology but about transforming how health services are delivered.

The Virtual DHB supports the government's recently launched New Zealand Health Strategy with its themes of people-powered healthcare, care delivered closer to home and using emerging technologies to deliver better results and revolutionise the way we work. Global trends and innovation in health care delivery show that moving to virtual healthcare is inevitable. Virtual care will be a required capability of health services globally in the next five years.

The Virtual DHB is powered by global health services provider company HealthTap. Work has occurred to ensure the Virtual DHB is customised and responsive to local needs. Patients will be able to use a smart phone app to book an appointment with their specialist, share a medical photo with them, send a direct message to their doctor like a text, and view their health record on the app. A multidisciplinary team of professionals who are caring for the patient will all have access to the shared care plan and can discuss the patient's care with each other. Patients are able to access health information, tips and the latest research to help them manage their own health effectively. Using the app, people can ask a question and receive an answer from a database of millions of responses all approved by doctors registered on the system.

We expect the Virtual DHB will deliver a number of benefits including:

- Reducing inequalities;
- Less travel time for patients and health professionals;
- Convenient and efficient for patients – fewer did not attends;
- Access to other members of the care team builds a fuller picture;
- Discuss cases and ask advice from peers in New Zealand and internationally – lessen professional isolation;
- Reduce referrals;
- Opportunities for professional development and education;
- Responsive to unique needs of our local community.

There are a number of long term goals that we expect the Virtual DHB to enable us to achieve, these include:

- By January 2017 all patients who want to use virtual health have access to system to get health information;
- By December 2017, 40 percent of all contact with patients across Waikato DHB to be by virtual health;

- By December 2017, 30 percent of outpatient activity moved from Meade Clinical Centre to the community;
- Evidence of our population taking responsibility for their own health.

# KŌWAE TORU / MODULE THREE: STATEMENT OF PERFORMANCE EXPECTATIONS

We have worked with a number of key stakeholders to develop the Statement of Performance Expectations in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2016/17. The performance measures chosen are not an exhaustive list of all of our activity, but they provide a good representation of the full range of outputs that we fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes[16]. Where possible, we have included with each measure past performance as baseline data.

Activity not mentioned in this module will continue to be planned, funded and/or provided to a high standard. We do report quarterly to the Ministry of Health and / or our Board on our performance related to this activity.

This statement of performance expectations was developed recognising an environment where:

- DHBs have responsibility for making decisions on the mix, level and quality of health and disability services, within the parameters of the NZ Health and Disability Strategies and nationwide minimum service coverage and safety standards;
- The Ministry of Health, as agent of the Minister of Health, defines nationwide service coverage, safety standards and the operating environment;
- The Minister enters into funding agreements with DHBs, containing DHB specific agreed performance targets.

## 3.1 Output Classes

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of performance expectations are also reflected in our financial measures (appendix 8.3). The four output classes that have been agreed nationally are defined in appendix 8.2.

## 3.2 Guide to Reading the Statement of Performance Expectations

The following points provided should be kept in mind when reading the rest of this module:

- Further detail of the performance story logic and rationale is contained in section1.1.1;
- Baseline and figures for the output performance measures are for the 2014/15 financial year unless otherwise stated;
- Some measures fall across more than one impact. Where this is the case they have only been included once;
- Measurement type key: Qn = Quantity T = Timeliness QI = Quality;

[16] See Kōwae Tahi and Rua

- There are some services we provide that support the rest of the health system so we have included these in a "Support Services" section of our performance story;
- Detailed information about the rationale for each output measure is provided in appendix 8.4.

## 3.3 People are supported to Take Greater Responsibility for their Health

### 3.3.1 Fewer People Smoke

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| 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 | 94% | 95% |
| Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months | 1 | Qn | 90% | 90% |
| Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking | 1 | Qn | 95% | 90% |

### 3.3.2 Reduction in Vaccine Preventable Diseases

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| 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/T | 91% | 95% |
| Percentage of two year olds are fully immunised and coverage is maintained | 1 | Qn | 90% | 95% |
| Percentage of eligible children fully immunised at 5 years of age. | 1 | Qn | 73% | 95% |
| Percentage of eligible 12 year old girls have received HPV dose three[17] | 1 | Qn | 68% | 70% |
| Seasonal influenza immunisation rates in the eligible population (65 years and over). | 1 | Qn/T | 68% | 75% |

### 3.3.3 Improving Health Behaviours

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| Exclusive or fully breastfed at lead maternity carer discharge (4-6 weeks)[18]<br><br>Exclusive or fully breastfed at 3 months<br><br>Receiving breast milk at 6 months | 1 | Qn/T | 68%<br>54%<br>61% | 75%<br>60%<br>65% |
| The number of people participating in Green Prescription programmes | 1 | Qn | 5,802 | TBC |
| Percentage of Kura Kaupapa Māori primary schools | 1 | Qn | 93.8% | 93.8% |

[17] For 2015/16 it is the 2002 birth cohort measured at 30 June in 2016
[18] Baseline for these measure is 1 January 2014 – 30 June 2014

| | | | | |
|---|---|---|---|---|
| participating in Project Energize | | | | |
| Percentage of total primary schools participating in Project Energize | 1 | Qn | 98.8% | 98.8% |

## 3.4 People Stay Well in their Homes and Communities

### 3.4.1 An Improvement in Childhood Oral Health[19]

| Outputs | Output Class | Measure Type | Baseline 2014 | Target 2016 |
|---|---|---|---|---|
| Percentage of children (0-4) enrolled in DHB funded dental services | 2 | Qn | 70% | 85% |
| Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination | 2 | Qn/T | 14% | Less than 7% |
| Percentage of adolescent utilisation of DHB funded dental services | 2 | Qn | 70% | 85% |

### 3.4.2 Long Terms Conditions are Detected Early and Managed Well

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| Percentage of the eligible population who have had their cardiovascular risk assessed in the last five years | 2 | Qn | 90% | 90% |
| Percentage of women aged 25 – 69 years who have had a cervical screening event in the past 36 months | 2 | Qn/T | 74% | 80% |
| Percentage of eligible women aged 50 to 69 who have a Breast Screen Aotearoa mammogram every two years. | 2 | Qn/T | 68% | 70% |

### 3.4.3 Fewer People are Admitted to Hospital for Avoidable Conditions

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| Percentage of eligible population who have had their B4 school checks completed | 1 | Qn/T | 90% | 90% |
| Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population) | 2 and 3 | Qn | 3.9 | 1.2 |

### 3.4.4 More People Maintain Their Functional Independence

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| 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% |
| Percentage of people enrolled with a primary health organisation | 2 | qn | 95% | 100% |
| Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days | 4 | qn | 62% | 100% |

[19] Childhood oral health measures are for a calendar year

## 3.5 People Receive Timely and Appropriate Specialist Care

### 3.5.1 People Receive Prompt and Appropriate Acute and Arranged Care

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| Acute re-admission rate[20] | 3 | QI | 10% | TBC |
| 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% |
| Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries | 3 | Qn | 10% | Less than 16% |

### 3.5.2 People Have Appropriate Access to Elective Services

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| Percentage of patients waiting longer than four months for their first specialist assessment | 3 | Qn/T | 0% | 0% |
| Improved access to elective surgery, health target, agreed discharge volumes | 3 | Qn | 15,693 | 16,805 |
| Did-not-attend percentage for outpatient services | 3 | Qn/T | 10% | 10% |
| Elective surgical inpatient average length of stay<br><br>Acute inpatient average length of stay | 3<br>3 | Qn/T | TBC | 1.65<br>2.50 |

### 3.5.3 Improved Health Status for Those with Severe Mental Illness and / or Addiction

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| 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 | Qn/T | 75%<br><br>91% | 3 weeks – 80%<br>8 weeks – 95% |
| Percentage of child and youth with a transition (discharge) plan | 3 | Qn/T | 98% | 95% |
| Average length of acute inpatient stays | 3 | Qn/T/QI | 14.41 days | Between 14 and 21 days |
| Rates of post-discharge community care | 3 | Qn/T/QI | 87% | Between 90% and 100% |
| Improving the health status of people with severe mental illness through improved access | 3 | Qn | TBC | 0-19 years old 4.00%<br>20 – 64 years old 4.66%<br>65 plus years old 2.69% |

[20] An assessment nationally suggests there is a need for review and re-development of the readmission model. It is anticipated that the acute readmissions model will be begin to be implemented with data sharing in quarters one and two of 2016/17 and with more formal reporting by DHBs for quarters three and four of 2016/7.

### 3.5.4 More People with End Stage Conditions are Supported Appropriately

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| Percentage of aged residential care facilities utilising advance directives | 3 | Qn | 100% | 100% |
| Number of new patients seen by the Waikato Hospital palliative care service | 3 | Qn | 652 | Greater than 650 |

## 3.6 Support Services

| Outputs | Output Class | Measure Type | Baseline | Target 2016/17 |
|---|---|---|---|---|
| Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)<br>Percentage of accepted referrals for CT scans, and percentage of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).<br><br>Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), and percentage within 30 days<br><br>Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 42 days, and percentage within 90 days<br><br>Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date, and percentage within 120 days | 2 | T | 94%<br><br>CT – 90%<br>MRI – 48%<br><br>Within 14 days – 78%<br>Within 30 days – 94%<br><br>Within 42 days – 49%<br>Within 90 days – 86%<br><br>Within 84 days – tbc%<br>Within 120 days – tbc% | 95%<br><br>CT – 95%<br>MRI – 85%<br><br>Within 14 days – 85%<br>Within 30 days – 100%<br><br>Within 42 days – 70%<br>Within 90 days – 100%<br><br>Within 84 days – 70%<br>Within 120 days – 100% |
| Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt | 2 | Qn/T | 100% | 99.6% |
| Pharmaceutical measure to be developed during 2016/17[21] | 2 | TBC | TBC | TBC |

[21] A national Pharmacy Action Plan 2016 to 2020 was published in June 2016. During 2016/17 we will work through this action plan to identify the key measure(s) for our performance story.

# KŌWAE WHĀ / MODULE FOUR: FINANCIAL PERFORMANCE

*Table: Statement of Prospective Comprehensive Income*

| Forecast Statement of Comprehensive Income | 2014/15 $000 ACTUAL | 2015/16 $000 FORECAST | 2016/17 $000 PLANNED | 2017/18 $000 PLANNED | 2018/19 $000 PLANNED | 2019/20 $000 PLANNED |
|---|---|---|---|---|---|---|
| **REVENUE** | | | | | | |
| Patient care revenue | 1,237,402 | 1,285,113 | 1,338,320 | 1,368,119 | 1,398,202 | 1,428,949 |
| Other operating income | 16,982 | 16,172 | 17,318 | 17,754 | 18,201 | 18,660 |
| Finance income | 2,027 | 1,914 | 1,505 | 1,558 | 1,587 | 1,617 |
| TOTAL REVENUE | 1,256,411 | 1,303,199 | 1,357,143 | 1,387,431 | 1,417,990 | 1,449,226 |
| **EXPENSES** | | | | | | |
| Personnel costs | 497,880 | 515,993 | 535,340 | 546,045 | 556,971 | 568,109 |
| Depreciation | 33,585 | 33,019 | 34,790 | 38,641 | 39,949 | 40,880 |
| Amortisation | 4,168 | 5,541 | 8,632 | 11,857 | 14,778 | 17,258 |
| Outsourced services | 51,932 | 61,715 | 59,949 | 59,938 | 61,421 | 63,400 |
| Clinical supplies | 132,377 | 129,109 | 136,527 | 140,946 | 145,131 | 149,101 |
| Infrastructure & non-clinical expenses | 79,940 | 70,404 | 80,841 | 80,420 | 79,569 | 79,196 |
| Other district health boards | 51,345 | 58,283 | 54,714 | 55,096 | 55,482 | 55,874 |
| Non-health board provider expenses | 380,359 | 398,792 | 415,209 | 425,049 | 434,972 | 445,116 |
| Finance Costs | 9,553 | 8,814 | 8,043 | 6,050 | 6,238 | 5,927 |
| Capital Charge | 17,749 | 18,124 | 18,468 | 18,836 | 19,504 | 21,474 |
| TOTAL EXPENSES | 1,258,888 | 1,299,794 | 1,352,513 | 1,382,878 | 1,414,015 | 1,446,335 |
| Share of profit of Associates and Joint venture | 62 | - | - | - | - | - |
| SURPLUS/(DEFICIT) | (2,415) | 3,405 | 4,630 | 4,553 | 3,975 | 2,891 |
| **OTHER COMPREHENSIVE INCOME** | | | | | | |
| Increase/(decrease) in revaluation reserve | - | - | - | - | - | - |
| TOTAL COMPREHENSIVE INCOME | (2,415) | 3,405 | 4,630 | 4,553 | 3,975 | 2,891 |

Waikato DHB plans to deliver a small surplus. To achieve this position an ambitious savings plan is required and so there is risk that if savings are not achieved then we will not achieve our surplus position.

*Table: Statement of Prospective Position*

| Forecast Statement of Financial Position | 2014/15 $000 ACTUAL | 2015/16 $000 FORECAST | 2016/17 $000 PLANNED | 2017/18 $000 PLANNED | 2018/19 $000 PLANNED | 2019/20 $000 PLANNED |
|---|---|---|---|---|---|---|
| CROWN EQUITY | 240,173 | 241,383 | 243,820 | 248,373 | 275,637 | 297,017 |
| CURRENT ASSETS: | | | | | | |
| Cash and Cash Equivalents | 5,483 | 6,471 | 5,762 | 5,891 | 6,022 | 6,152 |
| Receivables | 39,702 | 38,143 | 38,429 | 38,698 | 38,969 | 39,242 |
| Inventories | 9,937 | 10,344 | 10,418 | 10,491 | 10,564 | 10,638 |
| | 55,122 | 54,958 | 54,609 | 55,080 | 55,555 | 56,032 |
| CURRENT LIABILITIES: | | | | | | |
| Borrowings | 9,227 | 204 | 18,007 | 26,780 | 24,364 | 10,254 |
| Trade and Other Payables | 90,169 | 73,552 | 76,056 | 76,588 | 77,123 | 77,663 |
| Employee Entitlements | 76,237 | 81,225 | 82,812 | 83,382 | 83,956 | 84,535 |
| | 175,633 | 154,981 | 176,875 | 186,750 | 185,443 | 172,452 |
| | | | | | | |
| Net Working Capital | (120,511) | (100,023) | (122,266) | (131,670) | (129,888) | (116,420) |
| NON CURRENT ASSETS: | | | | | | |
| Fixed Assets | 587,445 | 561,164 | 585,742 | 599,609 | 625,136 | 634,987 |
| Investments | 318 | 7,254 | 7,254 | 7,255 | 7,253 | 7,253 |
| | 587,763 | 568,418 | 592,996 | 606,864 | 632,389 | 642,240 |
| NON CURRENT LIABILITIES: | | | | | | |
| Employee Entitlements | 14,744 | 14,881 | 14,983 | 15,087 | 15,190 | 15,295 |
| Borrowings | 212,335 | 212,131 | 211,927 | 211,735 | 211,674 | 213,508 |
| | 227,079 | 227,012 | 226,910 | 226,821 | 226,864 | 228,803 |
| | | | | | | |
| NET ASSETS | 240,173 | 241,383 | 243,820 | 248,373 | 275,637 | 297,017 |

## 4.1 Fixed Assets

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

### 4.1.1 Disposal of Land

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

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

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

### 4.1.2 Movements in Equity

*Table: Statement of Prospective Movements in Equity*

| Forecast Statement of Movements in Equity | 2014/15 $000 ACTUAL | 2015/16 $000 FORECAST | 2016/17 $000 PLANNED | 2017/18 $000 PLANNED | 2018/19 $000 PLANNED | 2019/20 $000 PLANNED |
|---|---|---|---|---|---|---|
| Crown equity at start of period | 244,782 | 240,173 | 241,383 | 243,820 | 248,373 | 275,637 |
| Surplus/(Deficit) for the period | (2,415) | 3,405 | 4,630 | 4,553 | 3,975 | 2,891 |
| Equity Injection from Crown | - | - | - | - | 23,289 | 18,489 |
| Distributions to Crown | (2,194) | (2,194) | (2,194) | - | - | - |
| Other movements in Equity | - | (1) | 1 | - | - | - |
| Crown equity at end of period | 240,173 | 241,383 | 243,820 | 248,373 | 275,637 | 297,017 |

Note: Assumed equity injection required for a number of material capital items, such as the Adult Mental Health Building and Ward Block A - Adult (see 4.2 Capital Expenditure/Investment)

*Table: Statement of Prospective Cashflow*

| Forecast Statement of Cashflows | 2014/15 $000 ACTUAL | 2015/16 $000 FORECAST | 2016/17 $000 PLANNED | 2017/18 $000 PLANNED | 2018/19 $000 PLANNED | 2019/20 $000 PLANNED |
|---|---|---|---|---|---|---|
| OPERATING CASHFLOWS | | | | | | |
| Cash provided from Crown Agencies and other income sources | 1,241,814 | 1,298,496 | 1,355,525 | 1,385,776 | 1,416,305 | 1,447,508 |
| Cash disbursed to employees, suppliers and payment of finance charges | (1,211,998) | (1,276,822) | (1,304,905) | (1,331,178) | (1,358,079) | (1,386,976) |
| | 29,816 | 21,674 | 50,620 | 54,598 | 58,226 | 60,532 |
| INVESTING CASHFLOWS | | | | | | |
| Cash provided from assets and equity | 1,782 | 1,817 | 1,260 | 1,313 | 1,342 | 1,372 |
| Cash disbursed to purchase of assets and investments | (21,103) | (11,083) | (68,001) | (64,366) | (80,253) | (67,989) |
| | (19,321) | (9,266) | (66,741) | (63,053) | (78,911) | (66,617) |
| FINANCING CASHFLOWS | | | | | | |
| Cash provided from proceeds of borrowings and equity movements | 5,639 | - | 15,412 | 8,584 | 20,816 | 6,215 |
| Cash disbursed to repayment of borrowings | - | 11,420 | - | - | - | - |
| | 5,639 | (11,420) | 15,412 | 8,584 | 20,816 | 6,215 |
| Net increase/(decrease) in cash held | 16,134 | 988 | (709) | 129 | 131 | 130 |
| Add Opening cash balance | (10,651) | 5,483 | 6,471 | 5,762 | 5,891 | 6,022 |
| CLOSING CASH BALANCE | 5,483 | 6,471 | 5,762 | 5,891 | 6,022 | 6,152 |
| Made up from: | | | | | | |
| Bank balances, deposits and cash | 5,483 | 6,471 | 5,762 | 5,891 | 6,022 | 6,152 |

## 4.2 Capital Expenditure / Investment

New capital expenditure projects budgeted for the next four years are outlined below.

| New Capital Expenditure | 2016/17 $M | 2017/18 $M | 2018/19 $M | 2019/20 $M |
|---|---|---|---|---|
| Under $50,000 | 2 | 2 | 2 | 2 |
| Over $50,000 | 65 | 61 | 77 | 65 |
| Contingency | 1 | 1 | 1 | 1 |
| Total Capital Expenditure | 68 | 64 | 80 | 68 |

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

Strategic capital spend includes:

| Project Name | Business Case Start Date | Business Case Completion Date | Business Case Expected Approval Date | Approx. $ | Crown Cap Requirement |
|---|---|---|---|---|---|
| Adult Mental Health | 2016/17 | 2016/17 | 2016/17 | $60.8m | $48.3m |
| Taumarunui | 2016/17 | 2016/17 | 2016/17 | $5.0m | $0 |
| Tokoroa: Te Kuiti: Rhoda Read: Matariki | 2016/17 | 2016/17 | 2016/17 | $10.0m | $0 |
| Education Centre Extension | 2016/17 | 2016/17 | 2016/17 | $12.1m | $0 |
| Multi Level Carpark | 2018/19 | 2018/19 | 2018/19 | $5.6m | $0 |
| Ward Block A - Adult | 2020/21 | 2020/21 | 2020/21 | $93.3m | $74.4m |

We have the following existing financing facilities:

- Ministry of Health ($211.8 million) which has been fully drawn down at end of June 2015. This facility includes:
  - $125 million for Service Campus Redevelopment;
  - $40 million for conversion of equity repayment to debt;
  - $6.7 million for the forensic rebuild.

We also use the following facility under the New Zealand Health Partnership Limited Shared Banking Arrangement in accordance with the Operating Policy Framework to manage our working capital requirements:

- Working capital facilities of no greater than 1/12 of crown revenue paid to the provider.

The business case for the service and campus reconfiguration specified the future financing and equity structure required supporting the programme, and this Annual Plan has been prepared on the basis of these planned financing arrangements.

## 4.3 Other Measures and Standards Necessary to Assess DHB Performance

The key financial indicators are set out in the following table.

| Treasury Covenants | 2014/15 $000 ACTUAL | 2015/16 $000 FORECAST | 2016/17 $000 PLANNED | 2017/18 $000 PLANNED | 2018/19 $000 PLANNED | 2019/20 $000 PLANNED |
|---|---|---|---|---|---|---|
| Equity to Total Assets | 37% | 39% | 38% | 38% | 40% | 43% |
| Interest covered | 4.70 | 5.76 | 6.97 | 10.10 | 10.41 | 11.30 |
| Debt to Debt + Equity | 49% | 48% | 48% | 48% | 45% | 44% |

The following tables set out the planned financial performance by division.

*Table: Prospective Financial Targets and Measures DHB Provider*

| DHB Provider Forecast Statement of Financial Performance | 2014/15 $000 ACTUAL | 2015/16 $000 FORECAST | 2016/17 $000 PLANNED | 2017/18 $000 PLANNED | 2018/19 $000 PLANNED | 2019/20 $000 PLANNED |
|---|---|---|---|---|---|---|
| REVENUE | | | | | | |
| Patient care revenue | 743,663 | 775,350 | 820,219 | 837,420 | 854,794 | 872,545 |
| Other operating income | 16,751 | 16,391 | 17,419 | 17,854 | 18,301 | 18,760 |
| Finance income | 1,782 | 1,709 | 1,260 | 1,313 | 1,342 | 1,372 |
| TOTAL REVENUE | 762,196 | 793,450 | 838,898 | 856,587 | 874,437 | 892,677 |
| EXPENSES | | | | | | |
| Personnel costs | 496,013 | 514,108 | 533,413 | 544,080 | 554,968 | 566,065 |
| Outsourced Services | 51,748 | 61,500 | 59,594 | 59,578 | 61,055 | 63,028 |
| Clinical Supplies and Patient Costs | 144,246 | 140,710 | 149,713 | 156,822 | 162,307 | 167,422 |
| Infrastructure & Non-clinical Supplies | 132,546 | 123,771 | 136,567 | 139,437 | 142,361 | 145,351 |
| Internal Recharges | (2,320) | (2,322) | (2,320) | (2,378) | (2,438) | (2,498) |
| TOTAL EXPENSES | 822,233 | 837,768 | 876,969 | 897,539 | 918,253 | 939,368 |
| SURPLUS/(DEFICIT) | (60,037) | (44,318) | (38,071) | (40,952) | (43,816) | (46,691) |

*Table: Prospective Financial Targets and Measures DHB Governance*

| DHB Governance Forecast Statement of Financial Performance | 2014/15 $000 ACTUAL | 2015/16 $000 FORECAST | 2016/17 $000 PLANNED | 2017/18 $000 PLANNED | 2018/19 $000 PLANNED | 2019/20 $000 PLANNED |
|---|---|---|---|---|---|---|
| REVENUE | | | | | | |
| Patient care revenue | 5,289 | 5,356 | 5,289 | 5,326 | 5,364 | 5,401 |
| Other operating income | - | - | - | - | - | - |
| Finance income | - | - | - | - | - | - |
| TOTAL REVENUE | 5,289 | 5,356 | 5,289 | 5,326 | 5,364 | 5,401 |
| EXPENSES | | | | | | |
| Personnel costs | 1,867 | 1,885 | 1,927 | 1,965 | 2,003 | 2,044 |
| Outsourced Services | 183 | 215 | 354 | 360 | 366 | 372 |
| Clinical Supplies and Patient Costs | - | 3 | - | - | - | - |
| Infrastructure & Non-clinical Supplies | 566 | 511 | 1,005 | 476 | 486 | 1,048 |
| Internal Recharges | 2,320 | 2,322 | 2,320 | 2,378 | 2,438 | 2,498 |
| TOTAL EXPENSES | 4,936 | 4,936 | 5,606 | 5,179 | 5,293 | 5,962 |
| SURPLUS/(DEFICIT) | 353 | 420 | (317) | 147 | 71 | (561) |

*Table: Prospective Financial Targets and Measures DHB Funding*

| DHB Funding Forecast Statement of Financial Performance | 2014/15 $000 ACTUAL | 2015/16 $000 FORECAST | 2016/17 $000 PLANNED | 2017/18 $000 PLANNED | 2018/19 $000 PLANNED | 2019/20 $000 PLANNED |
|---|---|---|---|---|---|---|
| REVENUE | | | | | | |
| Patient care revenue | 1,166,909 | 1,220,233 | 1,279,305 | 1,307,628 | 1,336,199 | 1,365,397 |
| Other operating income | - | - | - | - | - | - |
| Finance income | - | - | - | - | - | - |
| TOTAL REVENUE | 1,166,909 | 1,220,233 | 1,279,305 | 1,307,628 | 1,336,199 | 1,365,397 |
| EXPENSES | | | | | | |
| Governance Administration | 5,290 | 5,289 | 5,289 | 5,326 | 5,364 | 5,401 |
| Personal Health | 854,714 | 904,811 | 948,998 | 972,968 | 997,155 | 1,021,890 |
| Mental Health | 117,639 | 124,715 | 133,768 | 134,705 | 135,649 | 136,600 |
| Disability Support | 125,870 | 130,747 | 140,787 | 141,773 | 142,761 | 143,759 |
| Public Health | 1,166 | 2,130 | 1,907 | 1,921 | 1,934 | 1,948 |
| Maori Services | 5,485 | 5,209 | 5,667 | 5,707 | 5,746 | 5,786 |
| TOTAL EXPENSES | 1,110,164 | 1,172,901 | 1,236,416 | 1,262,400 | 1,288,609 | 1,315,384 |
| SURPLUS/(DEFICIT) | 56,745 | 47,332 | 42,889 | 45,228 | 47,590 | 50,013 |

## 4.4 Any Significant Assumptions

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

| Key Assumptions | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|
| CFA revenue growth assumptions are in line with information provided in the funding envelope and includes cost pressure and demographic growth | 4.3% | 2.1% | 2.1% | 2.1% |
| Employee agreement assumptions | 2.0% | 2.0% | 2.0% | 2.0% |
| Payments to NGO's (cost pressure) | 0.7% | 0.7% | 0.7% | 0.7% |
| Payments to suppliers | 2.1% | 2.1% | 2.1% | 2.1% |
| Capital charge | 8.0% | 8.0% | 8.0% | 8.0% |

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

| Risk | Mitigation Strategy |
|---|---|
| Savings are required in 2016/17 and the outer years. | • Develop realistic savings plans.<br>• Focus on process change to deliver enduring savings.<br>• Use proven methodologies.<br>• Monitor closely and take corrective action quickly.<br>• Be brave and tackle the hard issues. |

| Risk | Mitigation Strategy |
|---|---|
| The employee relations environment presents uncertainty in terms of potential increases in employee remuneration packages. Although a wage increase percentage has been included in the assumptions, some employee representatives may have an expectation of wage increases that differ from the budgeted levels. A one percent increase or decrease in wage rates equates to approximately $5.3 million in additional payroll costs | Potential strategies include:<br>• Negotiate lower than inflation or close to zero per cent increases.<br>• Use sinking lid and other containment mechanisms to constrain full time equivalents where appropriate. |
| There is risk that cost increases for the provider arm purchasing of goods and services will exceed the assumed percentage increases based on the inherent uncertainty of future inflationary pressures. A one per cent increase or decrease in the cost of provider arm goods and services equates to approximately $3.5 million in additional expenditure. | • Review contracting arrangements and negotiate more favourable terms.<br>• Participate in national procurement initiatives to take advantage of bulk purchasing. |
| There is financial risk in terms of the inherent uncertainty as to the total amount of funding that will be appropriated to health beyond the current year and how this funding will be allocated by the Population Based Funding (PBF) formula. In addition, PBF is a fixed annual funding allocation in an environment where the District Health Board funds demand driven contracts that have the risk of the demand exceeding the forecast levels. | |

## 4.5 Any Additional Information and Explanations to Fairly Reflect the Operations and Position of the DHB

The accounting policies used in the preparation of the financial statements can be found in appendix 8.6. There have been no significant changes in the accounting policies.

## 4.6 Subsidiaries

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

# KŌWAE RIMA / MODULE FIVE: STEWARDSHIP

To deliver on the functions required as a DHB, Waikato DHB has a broad set of responsibilities and interacts with a diverse range of individuals and groups. To be as effective as possible, Waikato DHB must have capable leadership, an engaged workforce, a healthy organisational culture, sound relationships, robust and rigorous systems and the right infrastructure and assets.

## 5.1 Managing our Business

Waikato DHB operates in a changing environment. The levels of success achieved over the next few years will depend on our ability to adapt to this changing environment as we continue to improve the health of our population and eliminate health inequities.

### 5.1.1 Our People

The central part of our capability is our people. Our ability to provide health and disability services now and into the future depends on having a workforce that is well matched to the health needs of the community and appropriately skilled and located.

### 5.1.2 Organisational Performance Management

Waikato DHBs performance is assessed on both non-financial and financial measures. The table in section 5.4.3 of this module provides an overview of the external reporting we produce which incorporates a significant amount of performance reporting. Our planned performance as a planner, funder and provider of health services is outlined in this plan and our service plans.

#### 5.1.2.1 Non-financial Performance Reporting

Non-financial performance relates to volume and performance expectations for health service provision by Waikato Hospital, our rural hospitals, our primary care alliance partners and the non-government organisations funded by Waikato DHB. This performance is monitored regularly.

As a funder, Waikato DHB monitors its agreements with providers through regular performance reports and data analysis. It also monitors the quality of services provided through reporting of adverse incidents, routine audits, service reviews and issue-based audits.

Waikato DHB reports quarterly to the Minister of Health on the indicators in the DHB Non-Financial Monitoring Framework and regularly feeds into benchmarking and quality programmes to compare our performance with other providers. We report to our Board on performance against the Annual Plan.

#### 5.1.2.2 Financial Performance Reporting

Each year Waikato DHB submits a set of financial templates to the Ministry of Health. These templates inform the tables and narrative presented in Kowae Wha. We report on our financial

performance monthly to our Board and the Ministry of Health. This report includes commentary and financials as well as actions planned to improve financial performance.

As part of our financial reporting we include full time equivalent reporting. This covers areas like:

- Accrued full time equivalent;
- Management/Administration full time equivalent cap;
- Clinical full time equivalent;
- Out-sourced services full time equivalent.

Waikato DHB uses financial performance information to identify issues and inform decision-making to improve performance.

### 5.1.3 Funding and Financial Management

We have an objective of strong financial performance and plan to manage and balance our financial position and to minimise cyclical deficits. The following table sets out our key financial indicators:

| Summary | 2014/15 $M ACTUAL | 2015/16 $M FORECAST | 2016/17 $M PLANNED | 2017/18 $M PLANNED | 2018/19 $M PLANNED | 2019/20 $M PLANNED |
|---|---|---|---|---|---|---|
| Revenue | 1,256 | 1,303 | 1,357 | 1,387 | 1,418 | 1,449 |
| Net Surplus/(Deficit) | - 2 | 3 | 5 | 5 | 4 | 3 |
| Total Fixed Assets | 587 | 561 | 586 | 600 | 625 | 635 |
| Net Assets | 240 | 241 | 244 | 248 | 276 | 297 |
| Term Borrowings and Liabilities | 227 | 227 | 227 | 227 | 227 | 229 |

| Summary | 2014/15 $M ACTUAL | 2015/16 $M FORECAST | 2016/17 $M PLANNED | 2017/18 $M PLANNED | 2018/19 $M PLANNED | 2019/20 $M PLANNED |
|---|---|---|---|---|---|---|
| Net Surplus/(Deficit) | (2) | 3 | 5 | 5 | 4 | 3 |

### 5.1.4 National Health Sector Entities

Waikato DHB is expected to align its planning with the planning intentions of key national agencies. These national agencies have initiatives that will impact on our DHB. The national agencies are:

- New Zealand Health Partnerships Limited
- Health Promotion Agency;
- Health Quality and Safety Commission;
- Health Workforce New Zealand;
- National Health Information Technology Board;
- PHARMAC.

Further information and actions that Waikato DHB are supporting in relation to these agencies are set out in section 2.6.

### 5.1.5 Risk Management

We run a top-down and bottom-up approach to risk management that aligns with the NZ Standard. Risk Plans are prepared at the service level, coordinated through the Quality and

Risk Department and then used as the basis for the Board's overarching Risk Plan which is signed off by the Audit and Risk Management Committee of the Board. Risks identified by the services tend to be more operational and those identified by the Board more environmental. The Risk Plan is used to drive the Internal Audit Plan, the Quality Plan and service improvement initiatives including the replacement of capital equipment and patient safety projects. Where appropriate, risks identified by the Board will be disseminated to the services for inclusion in relevant plans.

In early 2016 we implemented Datix, which is an electronic Integrated Quality and Risk Management system that will be used across the five Midland DHBs. The system is accessible to employees at all times for ease of reporting.

### 5.1.6 Performance and Management of Assets

We have developed a formal asset management plan in accordance with Ministry of Health requirements. Our asset management plan is informed by our long term financial model. Our long term financial model covers a 20 year period and provides a high level view on capital affordability of 'big ticket items'.

For the items identified as 'non big ticket', there is a rolling three year process. As part of this process a comprehensive annual prioritisation exercise is undertaken, which includes a quarterly review to identify any potential need for re-prioritisation.

### 5.1.7 Shared Decision-making

#### 5.1.7.1 Clinical governance

As we move forward and respond to the challenges, pressures and opportunities we face, strong clinical engagement and leadership is required. This happens on many levels across our organisation. We have an established Board of Clinical Governance which has the identified purposes of:

- Supporting the Chief Executive in ensuring high standards of clinical quality by monitoring relevant systems, standards, indicators of performance and plans and, where necessary, require the Health Waikato Executive to remedy / improve organisational performance in respect of those matters
- Clinical governance is the framework through which Waikato DHB is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. More specifically, it involves:
    - An emphasis on quality (including the use of the various techniques available to advance clinical quality), and patient-centred care.
    - Partnership, extending to joint decision-making, between the various clinical professions and managers comprising our workforce and between the executive and clinical staff generally, but without compromising individual accountability.
    - The organisation at all levels having the information it needs (including that relating to quality) to make sound decisions

#### 5.1.7.2 Māori participation

We have a governance relationship, through a memorandum of understanding, with local Iwi/Māori represented by Iwi Māori Council. Iwi Māori Council has representatives from:

- Pare Hauraki
- Ngāti Maniapoto
- Ngāti Tuwharetoa
- Te Runanga O Kirikiriroa (representing urban Māori)
- Pare Waikato
- Raukawa
- Whanganui Iwi

The memorandum of understanding underpins a "good faith" relationship between the parties by recognising the legitimacy of the Iwi and Te Runanga O Kirikiriroa to represent the interests of Māori, as well as the legitimacy of the Board as the statutory body charged with the determination, prioritisation and funding of health and disability services.

We have a number of established mechanisms to enable Māori to participate in and contribute to strategies for Māori health gain. These include:

- Ministerial appointments to the Waikato DHB Board
- Iwi Māori Council
- Kaumātua Kaunihera
- Te Puna Oranga (Māori Health Service)

#### 5.1.7.3 Primary Health Alliance Leadership Teams

Alliance Leadership Teams have been established across the Midland region with our primary care partners; the Midlands Health Network, the National Hauora Coalition and Hauraki Primary Health Organisation. The Alliance Leadership Teams are populated by clinical leaders and managers from across primary and secondary care.

The purpose of the Alliance Leadership Teams is to lead and guide our Alliances as they improve health outcomes for our population. The aim of the Alliance Leadership Teams is to provide the direction to enable the provision of increasingly integrated and co-ordinated health services through clinically-led service development and its implementation within a "best for patient, best for system" framework.

#### 5.1.7.4 Community Input

We regularly engage with a number of advisory groups, working groups, consumer groups and community health forums. Their advice and input assists in the development of DHB strategies and plans.

Community Health Forums are made up of local people representing specific geographical regions. They support and advise us about local health issues, activities and priorities for their community. They are also mechanisms for ensuring communities are kept involved in and informed of DHB activities and issues. A review the Community Health Forums was completed in 2015 and we have commenced work on the recommendations for improvement identified.

#### 5.1.7.5 Consumer Engagement

During 2016/17 we will look to build on our established consumer engagement and patient experience activity. This is likely to include developments around:

- People centred care framework for Waikato DHB;
- Establishment of a Consumer Council for Waikato DHB;
- Roll out of Consumer Engagement Framework across departments.

## 5.2 Building Capability

This section outlines the capabilities we will need in the next three to five years as well as touching on the approach in the short term to work towards developing these.

### 5.2.1 HealthShare Limited

HealthShare Limited, established in 2001, is a regional Shared Services Agency jointly owned by Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato District Health Boards. From August 2011 HealthShare Limited has taken on an expanded role as a regional provider of non-clinical service and now provides operational support in a number of areas identified as benefiting from a regional solution.

The Midland region DHBs determine the services that HealthShare Limited will provide, and the level of these services, on an annual basis. These determinations are made through the Regional Services Plan and regional business case processes. Categories of possible regional service delivery include:

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

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

### 5.2.2 Information Communications Technology

The Midland Regional IS service will implement the Midland Region Information Services Plan and advance National Health IT Board priorities, specifically the implementation of the National Health IT Plan priority areas. Work in this area is done within the context of the affordability envelope of the Midland DHBs.

The process of prioritising the Information Communications Technology work effort is done via the IS executive group with is comprised of clinical leaders and business leaders from each of

the Midland DHBs. This group reviews the programmes of work and provides recommendations to the regional capital committee for funding decisions.

Further information is available in the Midland DHBs Regional Service Plan for 2016/17.

### 5.2.3 Integrated Contracting

We have been participating in the Whānau ora integrated agreements developments across the health and social services sectors. This process is being led by the Ministry of Social Development) who has nominated the providers. This involves bringing together services across agencies (for example Ministry of Social Development, Ministry of Justice, Waikato DHB) to work with a defined population to ensure increased cohesion of service delivery.

We will look to take up integration opportunities as appropriate. When making decisions on integration, considerations we will take into account are:

- Consistent population coverage;
- Position in the continuum of health services;
- History of service / contract delivery;
- Integrating agreements will not result in service gaps.

### 5.2.4 Capital and Infrastructure Development

Capital expenditure is planned and prioritised at both a Midland regional and local level. DHBs capital intentions, which span 10 years, are consolidated to form a regional view. Large clinical investments are collaborated with the aim of achieving best fit for the region.

The Midland region capital committee meets regularly to consider and approve business cases requiring regional sign-off. Business cases are prepared and approved at a local Board level before submission to the regional capital committee for approval.

At a local level, our long term financial model covers a 20 year period and provides a high level view on capital affordability of 'big ticket items'. For the items identified as 'non big ticket', there is a rolling three year process. As part of this process a comprehensive annual prioritisation exercise is undertaken, which includes a quarterly review to identify any potential need for re-prioritisation.

During 2012/13 an exercise was undertaken to assess the seismic status of the Waikato DHB building stock. The work undertaken was similar to what hundreds of organisations have done since the 2011 Christchurch earthquake. An independent seismic evaluation of all Waikato DHB buildings, following revised national building standards, has resulted in a number of pieces of work. They include:

- Boiler House upgrade project;
- Laundry seismic upgrade;
- Hilda Ross House building demolition;
- Thames Campus – front entry and front ex ward (theatre) building had an IL3 20-30 percent DBS rating. Full design documentation has been completed. Works will be tendered which are to strengthen the shear walls. When completed the building seismic rating will be lifted to IL3 35-40 percent DBS;

- Tokoroa Campus – wards 1 and 2 had an IL3 20 percent rating. Works to the building's footings will lift the seismic rating to IL3 70 percent DBS;
- Taumarunui Campus – dining room had a rating of IL3 5 percent. Works to the building's roof structure, pile foundations and replacing the heavy tiled roof will lift the seismic rating to IL2 70 percent.

### 5.2.5 Collaboration

We collaborate with other health and disability organisations, stakeholders and our community to decide what health and disability services are needed and how to best use the funding we receive from Government. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the health system to achieve the best health outcomes for our community.

#### 5.2.5.1 Public Health Regional Collaboration

As part of the DHB function Public Health Units provide public health advice and expertise with a general goal of protecting and improving the health of the population with a focus on reducing inequalities. For Waikato DHB this is provided by our Population Health Service. Waikato DHB and Population Health Service work closely together to deliver on the five public health core functions:

- Health Promotion;
- Health Protection;
- Preventative Interventions;
- Health Assessment and Surveillance;
- Public Health Capacity Development.

In addition to providing advice and expertise to individual DHB, the Midland Regional Public Health Network (the Network) provides leadership for and strengthens the performance and sustainability of the Midland public health units.

**Midland Regional Public Health Network**

The Network provides an avenue for public health units to work together on public health issues affecting the Midland region. Leadership of the Network comprises the manager and clinical director from each of the four public health units in the Midlands region:

- Population Health (Hauora Tairawhiti);
- Population Health (Waikato District Health Board);
- Public Health Unit (Taranaki District Health Board);
- Toi Te Ora - Public Health Service (Bay of Plenty and Lakes District Health Boards).

The Network aims to further strengthen relationships with the Midland Regional Clinical Networks to ensure a public health perspective is considered within their planning. At a national level the Network is a member of the National Public Health Clinical Network, whose membership comprises clinical leader and manager from each public health unit and representatives from the Ministry of Health.

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

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

The Network's work to date has included collaborative annual planning, business continuity planning, supporting the development of Midland position statements on key health issues, setting up a mechanism for a regional approach to health intelligence work, standardising of communicable disease control processes, peer review, staff orientation programmes and support of sole practitioners.

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

- Public Health Capacity;
- Health Promotion Leadership Group;
- HealthScape – Public Health Information Management system;
- Public Health Intelligence.

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

In determining its direction for 2016/17, the Network will continue to align with the Ministry of Health's five core functions of public health (Health Assessment and Surveillance, Public Health Capacity Development, Health Promotion, Health Protection, and Preventive Interventions). The Network will also continue to focus on:

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

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

#### 5.2.5.2 Local Collaboration

It is recognised internationally that collaboration between health and social care agencies is critical to a safe and sustainable health service. The challenges communities are facing cannot be addressed with the limited tools that hospitals and doctors in the medical system have. It is through a collaborative approach that health services, social services and the broader community can share the responsibility of improving people's well-being to enable them to reach their full social potential.

We are uniquely placed to combine our clinical expertise, our roots in the community and our system leadership role to work collaboratively across the health and social care systems to achieve health equity and improve well-being. We will work to further develop an integrated health system in the Waikato. We will also be working with our social care partners to integrate

with them. We will be creating an environment that is flexible and enables us to take the opportunities where we find them.

In late 2015/16, Waikato DHB initiated an approach to "Closer Planning and Working Relationships Across the Sector". This involved stakeholders from within the health sector[22] as well as stakeholders from other sectors including:

- Education;
- Corrections;
- Police;
- Child Youth and Family;
- Local Government.

We expect this approach to mature over 2016/17 and enable targeted activity to support identified communities of need.

Current examples of intersectoral collaboration include:

- Youth Social Sector Trials;
- Hamilton City Children's Team;
- Gateways;
- Intersect Waikato;
- Integrated Safety Response;
- Pre-release from Prison Project (currently in developmental phase);
- Waikato Palliative Care Project;
- Social Sector Strategic Partners Workshops (Huntly intersectoral project currently in developmental phase);
- Ministry of Education Waikato Regional Cross Sector Forum;
- Project Energize;
- Waikato Plan;
- Strategic Planners Network;
- Accident Compensation Corporation and DHB relationship;
- Healthy Homes initiatives.

### 5.2.6 Long Term Demand Forecasting

We are experiencing an increasing mismatch of health service demand, supply and affordability. Increases in service delivery in one area can mean that less resource will available in another other areas. The health sector cannot continue to operate in the same way as it has been if we expect to be clinically and financially sustainable into the future.

Long term demand forecasting is one of the tools we must use to inform decisions around reforming health sector configurations and related models of care if we are to move forward with a sustainable, affordable and fit for purpose health sector. These reforms have already begun in the shape of:

- Programmes like the better, sooner, more convenient health care initiatives

[22] From non-government organisations, our primary care alliance partners, the Ministry of Health and Waikato DHB

- Expectations for closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals
- Regional service planning.

We will continue to participate in demand forecasting work as well as exploring the use of modelling and simulation techniques to assist in shaping services. These techniques can improve both efficiency and quality of services through a range of applications including:

- Waiting time reduction
- Scheduling
- Bed capacity management
- Workforce planning
- Commissioning

### 5.2.7 Leadership

Leadership is an important domain for Waikato DHB and there has been an intentional focus on developing leadership capability. We have also joined with other DHBs in the midland region to develop and implement leadership initiatives.

We have used the Lominger Leadership Architect library since 2010 as the competency base to implement leadership across processes and systems. Waikato DHB has not implemented Lominger; rather we have utilised Lominger research and tools that aligned with the following project and process deliverables from 2010 to 2015.

- Organisational leadership competencies were affirmed for differing delegations of authority and positions;
- Leadership capabilities and competencies are documented in position descriptions;
- The rewrite of all position descriptions incorporated values, accountabilities, and leadership competencies relevant to the position;
- The inclusion of leadership questions, along with technical and professional questions, at interview and when reference checking;
- Integrating capabilities and competencies into recognition and development processes;
- Establishing a system for reviewing key performance indicators and other performance requirements.

There are a number of specific clinical leadership programmes including the Pebbles Registered Nurse Clinical Leadership Development Programme and the Quality Leadership Programme for Midwives. During 2015/16 a Post Graduate Certificate in Management (Health Leadership and Management) was developed in partnership with the University of Waikato. The programme comprises three modules; Authentic Leadership, Relational Leadership and Health Management and Accountability.

Complementing a Midland and system wide approach to leadership development, internal short courses on leadership skills such as feedback are provided at Waikato DHB. Managerial skills can also be developed through attending workshops such as Recruitment and Selection, and Introduction to Finance. To support an agreed career and development goal and plan, individual staff may complete tertiary management or leadership papers or qualifications.

## 5.3 Workforce

The health and disability sector continues to face increased demand for services along with rising public expectations as to how services are delivered. There is also a strong requirement for simpler, more standardised ways of doing things to release resources for better use elsewhere and build a platform to develop a workforce with more generic skills that is flexible and able to work in integrated service models across hospital and community settings. We will continue to work with the Regional Director of Training and support the regional approach.

### 5.3.1 Managing Our Workforce within Fiscal Restraints

Waikato DHB has been undertaking activities to build our workforce capability and capacity since 2008. The issues now as then are similar:

- We still have an ageing workforce - our average age is 47 and it is higher in our rural and small town workforces;
- It is still not easy to attract health professionals to rural and semi-rural locations;
- If nothing changes, the demand for services will exceed the workforce's capacity.

To continue to answer the above issues in 2016/17 we think we need to focus on the following:

- Reliable workforce data;
- Recruitment to hard to fill areas;
- Pathway to health careers;
- Care assistant training;
- Leadership competencies;
- First line manager skills;
- Nurse prescribing;
- Dedicated education units;
- Vulnerable children;
- Nursing skill mix;
- Nurse Practitioners.

### 5.3.2 Strengthening Our Workforce

Much of the service based workforce development is covered in the Regional Services Plan. The Waikato DHBs workforce plan includes only those things which are specific to the organisation which aren't already covered in the Regional Services Plan. Much of the 2014/15 work needs to continue until it is completed and some has transferred to business as usual.

### 5.3.3 Safe and Competent Workforce

Waikato DHB continues to have a strong focus on safety and competence for our workforce. Waikato DHB continues to support the regional approach, utilising the Regional Director of Training, to address workforce requirements.

### 5.3.4 Child Protection Policies

The Vulnerable Children Act 2014 sets priorities for improving the wellbeing of vulnerable children and ensuring children's agencies work together to improve the wellbeing of vulnerable children. Key is the requirement of agencies working with children to adopt, report on and require child protection policies.

Waikato DHB has adopted a robust child protection policy, ensured every contract and funding arrangement requires all services working in whole or part delivering services to children adopt a child protection policy, will review the policy three yearly and report through the DHB Annual Report.

### 5.3.5 Children's Worker Safety Checking

Waikato DHB will meet the safety checking requirements of the Vulnerable Children's' legislation within prescribed legislative and / or regulatory timeframes (1 July 2015).

Waikato DHB already police vets staff. This process is well established. There is also a process to identify all staff within the provider division who are within the 'core children's workforce' under the Vulnerable Children's Act. These staff will then undergo additional safety vetting and screening processes as they are recruited, and in time retrospectively for those staff members already employed.

Because of its centralised and standardised recruitment process Waikato DHB is able to institute a series of worker safety interview questions once these have been identified nationally. These questions would be asked during interviews and during reference checking.

## 5.4 Organisational Health

We need to make sure that we have the people, relationships, and processes that will enable us to achieve our outcomes, impacts, and outputs. We cannot be successful without well-qualified and motivated staff, sound management of resources and an effective working relationship between staff and stakeholders.

### 5.4.1 Governance

We have an established governance structure based on the requirements of the NZPHD Act 2000, through which the DHB functions. Governance plays a key role in determining what we need to do to maximise the impact on our outcomes.

Our Board assumes the governance role and is responsible to the Minister of Health for the overall performance and management of the DHB. Its core responsibilities are to set the strategic direction for the DHB and to develop policy that is consistent with Government objectives and improves health outcomes for our population. The Board ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and our community. The normal composition of the board is 11 members, seven elected and four appointed by the Minister of Health. As required, the Board has two Māori members.

Three statutory (mandatory) advisory committees and three non-statutory committees have been established to assist the Board to meet its responsibilities. The membership of these committees is comprised of a mix of Board members and community representatives who meet regularly throughout the year. It includes both clinical and Māori members who contribute clinical and cultural experience and understanding to decision making.

The Board has not approved delegations to committees. All matters are recommended to the Board through the minutes of the relevant committee.

The public is welcome to attend meetings of the Board and its three statutory committees. However, for some items during a meeting the Board or committee may exclude the public. The Official Information Act states the grounds on which the public may be excluded. Such items are clearly noted on the agenda in question. Details of the meetings are publicly available on our website: http://www.waikatodhb.health.nz/board.

While responsibility for our DHB's overall performance rests with the Board, operational and management matters have been delegated to the chief executive. This delegation is made on such terms and conditions as the Board thinks fit. The chief executive is supported by his direct reports.

### 5.4.2 Providing health and disability services

We are responsible for the delivery of the majority of secondary and tertiary clinical services for the population of our district as the 'owner' of hospital and other specialist health services. The services are provided through Health Waikato (our provider division), across five hospital sites, two continuing care facilities, a mental health inpatient facility and 20 community bases. Our hospitals provide a range of inpatient and outpatient services and are located across the district:

- Waikato Hospital (Hamilton) – secondary and tertiary teaching hospital and Henry Rongomau Centre (mental health facility)
- Thames Hospital – Rural Hospital
- Tokoroa Hospital – Rural Hospital
- Te Kuiti Hospital – Rural Hospital
- Taumarunui Hospital – Rural Hospital

Health Waikato is incurring some operational costs related to our major building programme. These relate to change management, decanting and demolition and we will continue to incur these costs as well as the increased interest, depreciation and capital cost associated with capital spend over the time frame of this plan. Once our redevelopment is complete we will exit the costs associated with the redevelopment. In addition we have an improvement programme to "right-size" the provider and bring them close to break even on national prices.

Health Waikato, through Waikato Hospital, will maintain its preferred tertiary provider status to the Midland DHB region. Waikato Hospital is the base for nursing, midwifery and allied health clinical trainees as well as medical trainees at the Waikato Clinical School. This is an academic division of the Faculty of Medical and Health Sciences (Auckland University) and provides clinical teaching and research for undergraduate and postgraduate medical and allied health science students. The main purpose of the school is to provide an outstanding environment in which medical students can undergo their clinical training.

For further information about Health Waikato, including an overview of performance please see http://www.waikatodhb.health.nz/health_waikato .

### 5.4.3 Planning and Funding Health and Disability Services

The Planning and Funding Division of our DHB is responsible for planning and funding health and disability services across our district. The core responsibilities are:

- Assessing our population's current and future health needs
- Determining the best mix and range of services to be purchased
- Building partnerships with service providers, Government agencies and other DHBs
- Engaging with our stakeholders and community through participatory consultation
- Leading the development of new service plans and strategies in health priority areas
- Prioritising and implementing national health and disability policies and strategies in relation to local need
- Undertaking and managing contractual agreements with service providers
- Monitoring, auditing and evaluating service delivery

While the Planning and Funding Division contracts services from Health Waikato they also contract services from a wide range of non-government organisation providers, as well as other DHBs who often provide more specialist services.

Planning and Funding is responsible for oversight of the total funding package for our DHB and linking on this with the Ministry of Health. Planning and Funding role incorporates ensuring equitable acceptable and effective spending of health funds and ensuring that all services funded are delivered in line with expectations. It acts for the DHB in local and national technical and strategic forums working on the development of funding and pricing as well as service and purchasing frameworks.

In order to live within the available funding whilst maintaining sustainable services it is essential to ensure that services are funded at appropriate levels and that value from health expenditure is maximised in terms of both health gain and the DHBs priorities. Additional focus in these areas will be required given the fiscal constraints and the need for DHBs to make decisions based on information and analysis.

Planning is an integral part of purchasing and providing healthcare services. Planning is undertaken in partnership with key stakeholders.

## 5.5 Reporting And Consultation

### 5.5.1 Consultation with the Minister and the Ministry of Health

When making decisions, we follow an appropriate planning and consultation processes to avoid adverse financial, resource and clinical impacts on the affected population(s) and avoid unnecessary service instability. A well-managed process provides the confidence that:

- A robust process is followed;
- There are sufficient controls in place to avoid unnecessary service instability;
- The change is clinically appropriate and public confidence is managed.

There are a range of matters that we must consult / notify the Minister of Health, the National Health Board and Ministry of Health. These matters are:

- Proposed service changes;
- Acquisition of shares or other interests;
- Entry into joint ventures and / or collaborative or cooperative agreements / arrangements;
- Capital expenditure if required by policy and / or legislation;
- Otherwise as required by legislation, regulation or contract.

### 5.5.2 External Reporting

The Ministry of Health monitors our performance on behalf of the Minister. The mechanisms currently in place to achieve this are outlined in the following table.

*Table: External Reporting Framework*

| Reporting | Frequency |
|---|---|
| Information requests | Ad hoc |
| Financial reporting | Monthly |
| National data collections | 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 |

# KŌWAE ONO / MODULE SIX: SERVICE CONFIGURATION

Some health services for the Waikato population are not funded by Waikato DHB. Services not directly funded or provided by us include, but are not limited to:

- Well Child services through Plunket;
- Health camps;
- A range of national services purchased by the Ministry of Health, such as organ transplants;
- Emergency ambulance services;
- Strengthening Families;
- Family Start;
- Primary response in medical emergencies (PRIME).

We have little influence in these areas in respect of service coverage. We will, however seek to engage with the relevant funders or providers as appropriate. There are also services such as public health and disability support services for people under 65 years of age which are directly purchased by the Ministry of Health, but where the DHB may be contracted to deliver services.

In these areas the DHB will seek to engage and work collaboratively however decisions in relation to services purchased lie with the Ministry of Health. Access to disability support services for Waikato people under 65 years of age has been raised with the Ministry of Health as an area where the purchasing levels are insufficient to meet population needs.

### 6.1.2 Service Coverage Exceptions

TBC

## 6.2 Service Change

| Change | Description of Change | Benefits of Change | Change due to Local, Regional, or National Reasons |
|---|---|---|---|
| Midland Regional Clinical Services Plan | As part of the Regional Clinical Services planning process clinical action groups or networks have been established for identified areas. | • Reduce duplication of effort enabling DHBs to collectively develop sustainable solutions.<br>• Develop integrated approach to recruitment and retention within the global marketplace.<br>• Standardised planning, evaluation and procurement of new technology solutions within a clinical environment. | This work is consistent with the national expectation of an increased focus on regional approaches, and with the strong focus on regionalisation agreed across the Midland DHBs. |
| Better Sooner More Convenient Health Services - Primary Care | Continued implementation of the Better Sooner, More Convenient initiative with our primary care partners. | Support Better Sooner More Convenient Health Services | Link to national initiative |
| Rural Health Care Project | Development of a Rural Health Services Strategy to guide developments | • Reducing inequalities;<br>• Less travel time for patients and | Local |

| Change | Description of Change | Benefits of Change | Change due to Local, Regional, or National Reasons |
|---|---|---|---|
| Virtual Care | Operationalise a Waikato DHB approach to virtual health care. This approach is not about technology but about transforming how health services are delivered. | health professionals;<br>• Convenient and efficient for patients – fewer did not attends;<br>• Access to other members of the care team builds a fuller picture;<br>• Discuss cases and ask advice from peers in New Zealand and internationally – lessen professional isolation;<br>• Reduce referrals;<br>• Opportunities for professional development and education;<br>• Responsive to unique needs of our local community. | National, regional and local |

## 6.3 Service Issues

Women's Health Transformation Project

As part of its Women's Health Transformation Project which began in August 2015, Waikato DHB commissioned an external management and clinical review to recommend how it can improve its maternity, obstetric and gynaecological services to women in the Waikato. This review focused on the outstanding training recommendations from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. It also looked at identifying ways of improving our maternity, obstetric and gynaecological services, including better use of resources, building a culture of excellence, strengthening training, education and research capabilities, and continuing the good work being done in maternity quality and safety.

The review was published in December 2015. It recommends setting up a taskforce to implement an action plan that will help the DHB transform its service and regain the Royal Australian and New Zealand College of Obstetricians and Gynaecologists accreditation for junior doctor training that was removed from December 2015. We expect implementation of the action plan to occur during the 2016/17 year.

Rural Health Care Project

Waikato DHB has one of the largest rural populations in the country and like many other DHBs is facing increasing health demands from an ageing population and an increase in patients with long term conditions. Waikato DHB will complete a comprehensive review of rural health services and develop a programme of change to achieve sustainable services in rural settings during 2016/17. Significant change in the models of service delivery is anticipated as is a clear focus on utilising technological solutions to deliver services closer to home, better integrate the delivery of healthcare, and empower people to have greater control of their health care choices. The continuation of the procedural services delivered to other DHBs in the Waikato DHB's rural facilities will be assessed in conjunction with the relevant neighbouring DHBs. The Scottish and Western Australian systems of virtual emergency and urgent medical care will be assessed for their suitability for adoption in the rural setting during 2016/17, and if viable implementation will be progressed.

# KŌWAE WHETU / MODULE SEVEN: PERFORMANCE MEASURES

| Performance Measure | 2016/17 Performance Expectation / Target | | |
|---|---|---|---|
| PP6: Improving the health status of people with severe mental illness through improved access | 0 – 19 Age Group | | Total 4.00% |
| | 20 – 64 year olds | | Total 4.66% |
| | 65 plus years old | | Total 2.69%% |
| PP7: Improving mental health services using transition (discharge) planning and employment | Long term clients | | Provide report as specified |
| | Child and Youth with a Transition (discharge) plan | | At least 95% |
| PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds | Mental health provider arm | | |
| | Age | <= 3 weeks | <=8 weeks |
| | 0-19 | 80% | 95% |
| | Addictions (provider arm and non-government organisation) | | |
| | Age | <= 3 weeks | <=8 weeks |
| | 0-19 | 80% | 95% |
| PP10: Oral Health- Mean DMFT score at Year 8 | Ratio year 1 | | 1.05 |
| | Ratio year 2 | | 1.03 |
| PP11: Children caries-free at five years of age | Ratio year 1 | | 62% |
| | Ratio year 2 | | 64% |
| PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years) | Percentage year 1 | | 85%<br>85% |
| | Percentage year 2 | | |
| PP13: Improving the number of children enrolled in DHB funded dental services | 0-4 years<br>Percentage year 1 | | 95% |
| | Percentage year 2 | | 95% |
| | Children not examined 0-12 years<br>Percentage year 1 | | 7%<br>7% |
| | Percentage year 2 | | |
| PP20: improved management for long term conditions (CVD, diabetes and stroke)<br>Focus area 1: Long term conditions | Report on delivery of the actions and milestones identified in the Annual Plan. | | |
| Focus area 2: Diabetes services | Reporting on implementation of actions in the Diabetes plan “Living Well with Diabetes”<br><br>Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator). | | Narrative Report<br><br>Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control |
| Focus area 3: Cardiovascular health | Indicator 1: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. | | 90% |
| | Indicator 2: 90 percent of ‘eligible Māori men in the | | 90% |

| Performance Measure | 2016/17 Performance Expectation / Target | |
|---|---|---|
| | PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years. | |
| | Report on delivery of the actions and milestones identified in the Annual Plan | Narrative Report |
| Focus area 4: Acute Heart Service | 70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') by ethnicity | 70% |
| | Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days | 95% |
| | Over 95 percent of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge. | 95% |
| | Report on deliverables for acute heart services identified in annual plan and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI | Narrative Report |
| Focus area 5: Stroke Services | 6 percent of potentially eligible stroke patients thrombolysed | 6% |
| | 80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway | 80% |
| | 80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission | 80% |
| | Report on delivery of the actions and milestones identified in the Annual Plan. | Narrative Report |
| PP21: Immunisation coverage | Percentage of two year olds fully immunised | 95% |
| | Percentage of five year olds fully immunised | 95% |
| | Percentage of eligible girls fully immunised - HPV | 70% for dose 3 |

| Performance Measure | 2016/17 Performance Expectation / Target | |
|---|---|---|
| | vaccine | |
| PP22: Improving system integration | Report on delivery of the actions and milestones identified in the Annual Plan. | Report |
| PP23: Improving Wrap Around Services – Health of Older People | Report on delivery of the actions and milestones identified in the Annual Plan. | Report |
| | Percentage of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan<br>Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.<br><br>The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment. | |
| PP25: Prime Minister's youth mental health project | Initiative 1: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities.<br>1. Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided.<br>2. Provide quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.<br><br>Initiative 3: Youth Primary Mental Health<br>1. Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that | Report |

| Performance Measure | 2016/17 Performance Expectation / Target | |
|---|---|---|
| | quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes:<br>• early identification of mental health and/or addiction issues<br>• better access to timely and appropriate treatment and follow up<br>• equitable access for Maori, Pacific and low decile youth populations.<br>2. Provide quantitative reports using the template provided under PP26<br>Initiative 5: Improve the responsiveness of primary care to youth.<br>1. Provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements.<br>2. Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme. | |
| PP26: The Mental Health & Addiction Service Development Plan | Provide reports as specified for each focus area:<br>• Primary Mental Health<br>• District Suicide Prevention and Postvention<br>• Improving Crisis response services<br>• Improve outcomes for children | Report |

| Performance Measure | 2016/17 Performance Expectation / Target | |
|---|---|---|
| | • Improving employment and physical health needs of people with low prevalence conditions | |
| PP27: Delivery of the children's action plan | Report on delivery of the actions and milestones identified in the Annual Plan. | Report |
| PP28: Reducing Rheumatic fever | Provide a progress report against DHBs' rheumatic fever prevention plan | |
| | Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are two thirds lower than baseline (2009/10 – 2011/12) | 1.2 per 100,000 |
| | Reports on progress in following -up known risk factors and system failure points in cases of recurrent rheumatic fever | |
| PP29: Improving waiting times for diagnostic services | 1. Coronary angiography – 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) | 95% |
| | 2. CT and MRI – 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days) | MRI 85%<br>CT 95% |
| | 3. <u>Diagnostic colonoscopy</u> –<br>a. 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days) and 100% within 30 days<br><br>b. 70% of people accepted for a non urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days<br><u>Surveillance colonoscopy</u><br>c. 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days | 85%<br>100% (30 days)<br><br>70% (42 days)<br>100% (90 days)<br><br>70% (84 days)<br>100% (120 days) |
| PP30: Faster cancer treatment (details of expectations to be confirmed) | Part A: Faster cancer treatment<br>– 31 day indicator | 85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat. |

| Performance Measure | 2016/17 Performance Expectation / Target | |
|---|---|---|
| | Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy | All patients ready-for-treatment receive treatment within four weeks from decision-to-treat. |
| PP31: Better help for smokers to quit in public hospitals | 95 percent 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 | |
| SI1: Ambulatory sensitive (avoidable) hospital admissions | Age group 0 – 4 years | A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22. |
| | Age group 45 – 65 years | 3,936 per 100,000 of population |
| SI2: Delivery of Regional Service Plans | Provision of a single progress report on behalf of the region agreed by all DHBs within that region – facilitated by Bay of Plenty DHB for the Midland DHB region | |
| SI3: Ensuring delivery of Service Coverage | Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry) | |
| SI4: Standardised Intervention Rates (SIRs) | major joint replacement | 21.0 per 10,000 of population |
| | cataract procedures | 27.0 per 10,000 |
| | cardiac surgery | 6.5 per 10,000 of population |
| | percutaneous revascularization | 12.5 per 10,000 of population |
| | coronary angiography services | 34.7 per 10,000 of population |
| SI5: Delivery of Whānau Ora | Performance expectations are met across all the measures associated with the five priority areas:<br>• Mental health;<br>• Asthma;<br>• Oral health;<br>• Obesity;<br>• Tobacco.<br>and narrative reports cover all areas indicated. | |
| SI6: IPIF Healthy Adult - Cervical Screening | 80% of eligible women have received cervical screening services within the last 3 years | 80% |
| SI7: SLM total acute hospital bed days per capita | A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22. | |
| SI8: SLM patient experience of care | Hospital | Provide a report each quarter as specified in the measure definition.<br>A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22. |
| | Primary care | A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22. |
| SI9: SLM amenable mortality | A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22. | |

| Performance Measure | 2016/17 Performance Expectation / Target | |
|---|---|---|
| OS3: Inpatient Length of Stay | Elective length of stay | 1.65 days |
| | Acute length of stay | 2.50 days |
| OS8: Reducing Acute Readmissions to Hospital | tba - indicator definition under review | |
| OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections<br>Focus area 1:<br>Improving the quality of identity data | New NHI registration in error | Greater than 2% and less than or equal to 4% |
| | Recording of non-specific ethnicity | Greater than 0.5% and less than or equal to 2% |
| | Update of specific ethnicity value in existing NHI record with a non-specific value | Greater than 0.5% and less than or equal to 2% |
| | Update of specific ethnicity value in existing NHI record with a non-specific value | Greater than 0.5% and less than or equal to 2% |
| | Validated addresses unknown | Greater than 76% and less than or equal to 85% |
| | Invalid NHI data updates | No confirmed target |
| Focus area 2: Improving the quality of data submitted to National Collections | NBRS links to NNPAC and NMDS | Greater than or equal to 97% and less than 99.5% |
| | National collections file load success | Greater than or equal to 98% and less than 99.5% |
| | Standard vs edited descriptors | Greater than or equal to 75% |
| | NNPAC timeliness | Greater than or equal to 95% and less than 98% |
| Output 1: Mental Health Output Delivery Against Plan | Volume delivery for specialist Mental Health and Addiction services is within:<br>a. five percent variance (+/-) of planned volumes for services measured by FTE<br>b. five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day<br>c. actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan | |
| Developmental measure DV4: Improving patient experience | No performance target set | |
| Developmental measures DV6: SLM youth access to and utilisation of youth appropriate health services | No performance target set | |
| Developmental measures DV7: SLM number of babies who live in a smoke-free household at six weeks post natal | No performance target set | |

# KŌWAE WARU / MODULE EIGHT: APPENDICES

- Glossary of Terms
- Output Class Definitions
- Output Class Revenue and Expenditure
- Output Measure Rationale
- Services funded but not provided by the DHB
- Accounting Policies
- Ki te Taumata O Pae Ora 2016/17 Indicator Summary

## 8.1 Glossary of Terms

| 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 connects 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 |

| Term | Description |
|---|---|
| | 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 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/)<br>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:<br>Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown;<br>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;<br>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:<br>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. |

| Term | Description |
|---|---|
| **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.<br>A target can also be in the form of a standard or a benchmark. |

## 8.2 Output Class Definitions

### 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

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.

## 8.3 Output Class Revenue and Expenditure

| **Total Cost and Revenue** | 2016/17<br>$000<br>Budget | 2017/18<br>$000<br>Budget | 2018/19<br>$000<br>Budget | 2019/20<br>$000<br>Budget |
|---|---|---|---|---|
| Revenue | 1,356,998 | 1,387,286 | 1,417,845 | 1,449,081 |
| Costs | 1,352,498 | 1,382,863 | 1,414,001 | 1,446,319 |
| Surplus/(Deficit) | 4,500 | 4,423 | 3,844 | 2,762 |

Prevention

| **Forecast Statement of Cost and Revenue for Prevention** | 2016/17<br>$000<br>Budget | 2017/18<br>$000<br>Budget | 2018/19<br>$000<br>Budget | 2019/20<br>$000<br>Budget |
|---|---|---|---|---|
| Revenue | 28,148 | 28,776 | 29,410 | 30,058 |
| Costs | 25,765 | 26,343 | 26,936 | 27,552 |
| Surplus/(Deficit) | 2,383 | 2,433 | 2,474 | 2,506 |

Early Detection and Management

| **Forecast Statement of Cost and Revenue for Early Detection and Management** | 2016/17 $000 Budget | 2017/18 $000 Budget | 2018/19 $000 Budget | 2019/20 $000 Budget |
|---|---|---|---|---|
| Revenue | 297,222 | 303,856 | 310,550 | 317,391 |
| Costs | 266,437 | 272,419 | 278,553 | 284,920 |
| Surplus/(Deficit) | 30,785 | 31,437 | 31,997 | 32,471 |

Intensive Assessment and Treatment

| **Forecast Statement of Cost and Revenue for Intensive Assessment & Treatment** | 2016/17 $000 Budget | 2017/18 $000 Budget | 2018/19 $000 Budget | 2019/20 $000 Budget |
|---|---|---|---|---|
| Revenue | 886,974 | 906,771 | 926,745 | 947,162 |
| Costs | 920,298 | 940,960 | 962,148 | 984,138 |
| Surplus/(Deficit) | (33,324) | (34,189) | (35,403) | (36,976) |

Support and Rehabilitation

| **Forecast Statement of Cost and Revenue for Support & Rehabilitation** | 2016/17 $000 Budget | 2017/18 $000 Budget | 2018/19 $000 Budget | 2019/20 $000 Budget |
|---|---|---|---|---|
| Revenue | 144,654 | 147,883 | 151,140 | 154,470 |
| | - | - | - | - |
| Costs | 139,998 | 143,141 | 146,364 | 149,709 |
| Surplus/(Deficit) | 4,656 | 4,742 | 4,776 | 4,761 |

The output class financial reporting for 2016-17 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 21). The out years are based on the same cost and revenue ratios being applied to total cost and revenue.

## 8.4 Output Measure Rationale

| 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 and support to quit | 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 Zealanders, is easy to understand and leads to significant positive outcomes across the whole of life span | Prevention Services / Health Promotion and Education | Quantity |
| 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.<br>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 | By increasing the percentage of people being | Early Detection | Quantity |

| Measure | Rationale | Output class / Category | Dimension of Performance |
|---|---|---|---|
| enrolled with a primary health organisation and have had their cardiovascular risk assessed in the last five years | 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. | and Management Services / Primary Healthcare | |
| 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 their GP | Vitamin D supplementation has been demonstrated to improve mineral bone density and reduce falls. | Prevention Services / Health Promotion and Education | Quantity |
| 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.<br><br>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 | | | |

| Measure | Rationale | Output class / Category | Dimension of Performance |
|---|---|---|---|
| being referred with a high suspicion of cancer and a need to be seen within two weeks | | | |
| Percentage of patients who require radiation or chemotherapy are treated with 4 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 |
| 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 |
| 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 | | | |
| 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. | Intensive Assessment and Treatment Services / Specialist Mental Health and Addiction Services | Quality |

| Measure | Rationale | Output class / Category | Dimension of Performance |
|---|---|---|---|
| | Research indicates that service users have increased vulnerability immediately following discharge, including higher risk for suicide. | | |
| Number of first attendances at the Waikato DHB hospital palliative care outpatient service | | | 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 care and improve DHB demand and capacity management. | Intensive Assessment and Treatment Services / Elective Services | Quantity / Timeliness |
| 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 |
| Pharmaceutical measure (s) | Pharmaceuticals are an important resource in improving health outcomes. | Early Detection and Management Services / Pharmacy Services | Quantity |

## 8.5 Services Funded but not provided by the DHB

*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:<br>• dental<br>• NGO maternity facilities<br>• Project Energize<br>• travel and accommodation<br>• palliative care<br>• haemophilia<br>• primary care inpatient services<br>• 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. |

## 8.6 Notes to the Financial Statements - Statement of accounting policies

### Reporting entity

Waikato District Health Board ("Waikato DHB") is a District Health Board established by the New Zealand Public Health and Disability Act 2000 and is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

The group consists of Waikato DHB and its controlled entity, Waikato Health Trust. Its 50% share of its associate, Urology Services Limited, and 20% share of its jointly controlled entity, HealthShare Limited, is equity accounted. These entities are incorporated and domiciled in New Zealand.

Waikato DHB's activities are the purchasing and the delivering of health services, disability services, and mental health services to the community within its district. Waikato DHB does not operate to make a financial return. Waikato DHB has designated itself and its group as a Public Benefit Entity for financial reporting purposes.

### Basis of preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

### Statement of compliance

The financial statements have been prepared in accordance with the New Zealand Public Health and Disability Act 2000 and Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practices in New Zealand.

These financial statements have been prepared in accordance with, and comply with, Tier 1 Public Benefit Entity accounting standards.

### Measurement base

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.

### Functional and presentation currency

The financial statements are presented in NZ dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of Waikato DHB, its controlled entity, associate and joint venture is NZ dollars.

### Changes in accounting policies

There have been no changes in accounting policies during the financial year.

Revisions to accounting standards during the financial year have had minimal effect on Waikato DHB's financial statements.

**Subsidiaries**

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

**Associates**

Associates are those entities in which Waikato DHB has significant influence, but not control, over the financial and operating policies.

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.

**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. When Waikato DHB's share of losses exceeds its interest in a joint venture, 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 a joint venture.

**Budget figures**

The group budget figures are made up of the Waikato DHB's Annual Plan which was tabled in Parliament. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Waikato DHB in preparing these financial statements.

**Summary of significant accounting policies**

**Revenue**

Revenue from exchange transactions is measured at the fair value of consideration received or receivable, taking into account the amount of any trade discounts and volume rebates allowed by the Waikato DHB.

Revenue from non-exchange transactions is revenue other than revenue from exchange transactions, such as donations, grants and transfers.

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

Ministry of Health revenue
Waikato DHB is primarily funded through revenue received from Ministry of Health, which is restricted in its use for the purpose of Waikato DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder. Revenue from Ministry of Health is recognised as revenue when earned. The fair value of revenue from Ministry of Health has been determined to be equivalent to the amounts due in the funding arrangements.

Accident Compensation Corporation contract revenue
Accident Compensation Corporation contract revenue is recognised as exchange revenue when eligible services are provided and any contract conditions have been fulfilled.

Revenue from other DHBs
Inter-district patient inflow revenue occurs when a patient treated by Waikato DHB is domiciled outside of Waikato DHB's district. Ministry of Health pays Waikato DHB with monthly amount based on estimated patient treatment costs for non-Waikato DHB residents. An annual revenue wash-up occurs at year end to reflect the actual number of non-Waikato DHB patients treated at Waikato DHB.

Interest revenue
Interest revenue is recognised using the effective interest method.

Rental revenue
Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

Provision of services
Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

Grants received
Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Donations and bequests
Donations and bequests to Waikato DHB are recognised as non-exchange revenue when control over the asset is obtained. When expenditure is subsequently incurred in respect of these funds, it is recognised in the statement of comprehensive revenue and expense.

**Capital charge**

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

**Borrowing costs**

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

**Leases**

Waikato DHB as lessee

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased term or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether Waikato DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Waikato DHB as lessor

A lease where Waikato DHB, as lessor, has in fact all the benefits and risks of ownership is designated as an operating lease; otherwise, such agreements are recognised as finance leases. Property, plant and equipment made available to third parties by means of an operating lease is recognised in accordance with the accounting standards for property, plant and equipment.

Lease revenue from operating leases shall be recognised as revenue on a straight-line basis over the lease term, unless another systematic basis is more representative of the time pattern in which benefits derived from the leased asset is diminished.

Initial direct costs incurred by Waikato DHB in negotiating and arranging an operating lease shall be added to the carrying amount of the leased asset, and recognised as an expense over the lease term on the same basis as the lease revenue.

**Foreign currency transactions**

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

**Cash and cash equivalents**

Cash and cash equivalents include cash on hand and bank overdrafts.

**Receivables**

Short-term debtors and other receivables are recognised at their face value, less any provision for impairment. Bad debts are written off during the period in which they are identified.

A receivable is considered impaired when there is evidence that the Waikato DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

**Inventories**

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost and adjusted where applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition. Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The amount of any write-down for the loss of service potential is recognised as an expense in the period of the write-down.

**Non-current assets held for sale**

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and its fair value less costs to sell.

Impairment losses for write-downs of non-current assets held for sale are recognised in expenses. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have previously been recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

**Property, plant and equipment**

Classes of property, plant and equipment
The asset classes of property, plant and equipment are:

- Freehold land;
- Freehold buildings;
- Plant, equipment and vehicles.

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

Revaluations
Land and buildings are revalued to fair value with sufficient regularity to ensure that the carrying amount does not differ materially to fair value, and at least every five years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair

value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and buildings revaluation movements are classified on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised as a movement in the revaluation reserve in the statement of comprehensive revenue and expense, but is recognised in the expense section of the statement of comprehensive revenue and expense. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, with the remainder then recognised as a movement in the revaluation reserve in the statement of comprehensive revenue and expense.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to Waikato DHB and the cost or fair value of the item can be measured reliably. Work in progress is recognised at cost less impairment and is not depreciated. In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefit or service potential associated with the item will flow to Waikato DHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Disposal

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Depreciation

Depreciation is charged to the statement of comprehensive revenue and expense on a straight-line basis. Land and work in progress is not depreciated. Depreciation is set at rates that will write off the cost or valuation of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of the major classes of property, plant and equipment have been estimated as:

| Class of Asset | Estimated Life | Depreciation Rates |
|---|---|---|
| Buildings | 3 – 85 years | 1.2 – 33.3% |
| Plant equipment and vehicles | 2 – 35 years | 2.5% - 50.0% |

The residual value and useful life of assets is reviewed and adjusted if applicable, at balance sheet date.

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

**Intangible assets**

*Software acquisition and development*
Acquired software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred.

*Amortisation*
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.
The estimated useful lives and associated amortisation rates of the major classes of intangible assets are:

| Type of Asset | Estimated Life | Amortisation Rate |
|---|---|---|
| Computer Software | 2 – 10 years | 10 – 50% |

**Impairment of property, plant, equipment and intangible assets**

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

Non-cash generating assets
Property, plant, equipment and intangible assets held at cost that have a finite useful life are reviewed for indicators of impairment at balance date and whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. If any such indication exists, Waikato DHB shall estimate the recoverable amount of the asset. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in the movement of revaluation reserve in the statement of comprehensive revenue and expense to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised as an expense in the statement of comprehensive revenue and expense. For assets not carried at a revalued amount, the total impairment loss is recognised as an expense in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to movement in the revaluation reserve in the statement of comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised as an expense in the surplus or deficit, a reversal of the impairment loss is recognised as revenue in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised as an expense in the statement of comprehensive revenue and expense.

**Trade and other payables**

Creditors and other payables are non-interest bearing and normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their face value.

**Borrowings**

Borrowings are initially recognised at their fair value. After initial recognition all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Waikato DHB has an unconditional right to defer settlement of the liability for at least twelve months after balance date.

**Employee benefits**

Short-term employee entitlements
Employee benefits that are due to be settled within twelve months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned but not yet taken, continuing medical education leave and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements
Employee benefits that are due to be settled beyond twelve months after the end of the period in which the employee renders the related service, such as sick leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements
Sick leave, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within twelve months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

**Superannuation schemes**

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

Defined benefit schemes
Employer contributions to the Defined Benefit Plan Contributors Scheme are a multi-employer defined benefit scheme managed by the Board of Trustees of the National Provident Fund. Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus or deficit of the scheme will affect future contributions by individual employers as there is no prescribed basis for the allocation. The scheme is therefore accounted for as a defined contribution scheme.

**Provisions**

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

Provisions are reviewed at each reporting date and adjusted to reflect the current best estimate. A provision is used only for expenditures for which the provision was originally recognised.

Accident Compensation Corporation Partnership Programme
The liability for the Accident Compensation Corporation 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 New Zealand government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash out flows.

Repairs to motor vehicles provision
A provision is provided for the costs of repairing motor vehicles at the end of their operating lease period before return to the lessor.

Restructuring
A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Demolition
A provision for demolition is recognised when an approved detailed formal plan for the demolition has either been announced publicly or for which demolition has already commenced.

**Equity**

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- Crown equity;
- Retained earnings;
- Revaluation reserves; and
- Trust funds.

Revaluation reserves
These reserves relate to the revaluation of land and buildings to fair value.

Trust funds
Trust funds represent the unspent amount of restricted donations and bequests received.

**Income tax**

Waikato DHB is defined as a public authority in the Income Tax Act 2007 and consequently is exempt from the payment of income tax. Accordingly no provision has been made for income tax.

**Goods and services tax (GST)**

All items in the financial statements are presented exclusive of GST except for receivables and payables which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense. Commitments and contingencies are disclosed exclusive of GST.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position. The net GST received from, or paid to, the Inland Revenue Department, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

**Cost Allocation**

Waikato DHB has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributable to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area

occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

**Critical accounting estimates and assumptions**

In preparing these financial statements, the Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations
Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments are made to the unencumbered land value for land where there is a designation against the land or the use of the land is restricted.

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings. Depreciated replacement cost is determined using a number of significant assumptions including:

- The replacement asset is based on the replacement with modern equivalent assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For Waikato DHB's earthquake prone buildings that are expected to be strengthened, the estimated earthquake strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates are applied to reflect market value. These valuations include adjustments for estimated building strengthening costs for earthquake prone buildings and the associated lost rental during the time to undertake the strengthening work.

Estimating useful lives and residual values of property, plant, and equipment
At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates requires Waikato DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Waikato DHB, and expected disposal proceeds (if any) from the future sale of the asset.

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

Retirement gratuities and long service leave

The present value of sick leave, long service leave, and retirement gratuity obligations depends on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

**Critical judgements in applying accounting policies**

Management has exercised a critical judgement in applying accounting policies for determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sale of goods or the rendering of services. This judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.