Waikato District Health Board

2018-19 ANNUAL PLAN

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

Presented to the House of Representatives pursuant to section 149(L) of the Crown Entities Act 2004

Contents

Published by Waikato District Health Board

Private Bag 3200, HAMILTON 3240

This document is available on the Waikato District Health Board website **www.waikatodhb.health.nz**

Mihi

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

Minister's 2018/19 letter to Waikato DHB

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

28 FEB 2019

Ms Sally Webb
Chair
Waikato District Health Board
sally@sallyw.co.nz

Dear Sally

Waikato District Health Board 2018/19 Annual Plan

This letter is to advise you that it is the decision of both the Minister of Health and the Minister of Finance that Waikato District Health Board's (DHB's) 2018/19 Annual Plan will not be approved because of the size of the planned deficit.

I have been clear that my expectation for the total DHB sector financial position was that it was an improvement on 2017/18. I am concerned that this expectation is unlikely to be met. I have previously emphasised to you that it is important DHBs are doing all they can individually and collectively – both regionally and nationally to live within the funding provided.

I note your DHB has planned significant deficits for 2018/19 and the out years. Improving this position will require a concerted effort and I trust that this will be a key focus for the board for the remainder of 2018/19 and into 2019/20. I also trust that you will continue to work with the Ministry and your Crown Monitor to evaluate and improve your financial performance.

Your Production Plan is still to be confirmed, and you will work with the Ministry to resolve this.

I am aware you are planning a number of service reviews in the 2018/19 year. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Any capital business cases are also to be approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders. 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.

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

Yours sincerely

Hon Dr David Clark
Minister of Health

cc: Mr Derek Wright, Interim Chief Executive, Waikato District Health Board
derek.wright@waikatodhb.health.nz

SECTION 1: Overview of strategic priorities

1.1 Strategic intentions/priorities

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

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

1.1.1 National

The Treaty of Waitangi

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

The principles within the Treaty of partnership, protection and participation implicitly recognise the important role the health sector plays in recognising the indigenous rights of tangata whenua to achieve radical improvements in health outcomes by eliminating health inequities.

New Zealand Health Strategy

The New Zealand Health Strategy is the key source of direction for the health sector. The refreshed New Zealand Health Strategy provides the sector with clear strategic direction and a road map for delivery of more integrated health services for New Zealanders. The strategy has a ten-year horizon, so impacts on not just immediate planning and service provision but enables and requires DHBs and the sector to have a clear roadmap for future planning as well.

He Korowai Oranga

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

The Healthy Aging Strategy

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

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

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

1.1.2 Regional

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

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

1.1.3 Local

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

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

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

Direction and strategy

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

- **Equity**
  Waikato DHB has seven localities Hamilton, Matamata, the Northern Corridor, Taumarunui, Te Kuiti, Thames and Tokoroa with populations of different size, ethnicity and deprivation. As a DHB we plan to focus on tailoring services and models of care to the needs of the population in each locality with a particular focus on rural services and Māori, child health and Long Term Conditions.
- **Primary and community care**
  Moving to a focus on wellness, prevention and delivering services closer to home, we will look at innovative models of care including setting up multi-disciplinary teams co-located with primary care, increased use of nurse practitioners, and providing services in community settings. The health care homes model will be utilised, ensuring it is flexible enough to target high needs populations. Ongoing issues with GP access and workforce shortages need to be addressed.

- **Commissioning**
  The DHB will take a more strategic approach to contracting and look at different models for funding and service provision, including contracting for outcomes. Contracting models will be more flexible and able to target high-needs groups to improve equity.
- **Sustainability**
  A focus on ensuring services are sustainable (mental health and addictions, acute/elective provision, tertiary services) and there is appropriate workforce, funding and infrastructure to support the needs of the local population.
- **Patient flow**
  Working to improve patient flow through the hospital especially through Emergency Department and surgical waiting lists
- **Workforce**
  With difficulties recruiting and retaining clinical and non-clinical workforce, there are a number of long term hard to fill vacancies.

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

Waikato DHB Strategy

During 2016/17 Waikato DHB rolled out our new strategy driven by our Board which concentrated on ensuring the organisation was heading in the right direction, focusing its resources and making the most of future opportunities. It is recognised that there are some fundamental challenges we must face along the way if we want to continue improving the health status of our population and our work to eliminate health inequities.

OUR
vision

Healthy people Excellent care

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

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

Te Puea Herangi

OUR
mission

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

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

Population performance

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

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

1.2 Message from the Chair – Sally Webb

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

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

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

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

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

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

1.3 Message from the Interim Chief Executive – Derek Wright

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

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

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

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

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

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

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

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

1.4 Signatories

Agreement for the Waikato DHB 2018/19 Annual Plan

between

Hon Dr David Clark
Minister of Health

Date: 30 October 2018

Sally Webb
Chair
Waikato DHB

Date: 30 October 2018

Professor Margaret Wilson
Deputy Chair
Waikato DHB

Date: 30 October 2018

Derek Wright
Interim Chief Executive
Waikato DHB

Date: 30 October 2018

Letter of expectations for DHB

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Dear Chair

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

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

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

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

Our Approach

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

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

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

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

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SECTION 2: Delivering on priorities

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

2.1 Health Equity

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

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

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

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

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

2.1.1 Health Equity Tools

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

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

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

2.2 Responding to the guidance

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

2.3 Government Planning Priorities

The 2018/19 Planning Priorities are:

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

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

Government planning priorities

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

Table continued from previous page

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

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

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

Government Planning Priority		Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Primary Health Care (both Māori and Pacific focussed equity actions are expected in this priority area) (continue)	Pharmacy Action Plan	One team	Productive partnerrships	Waikato DHB supports the focus within the pharmacy action plan and enhanced pharmacist services by: 1. Participation in the implementation of the new Integrated Community Pharmacy Service Agreement (ICPSA). The ICPSA arrangements will enable Waikato DHB to implement the long-term vision for integrated pharmacist services in the community and move from a system that funds pharmacists on transaction-based medicine delivery with limited patient-centric service delivery and funding, to one that: • is flexible enough to meet local DHB population and consumer need • enhances the healthcare and medicines management expertise delivered by pharmacists • supports pharmacists to work as one team with other primary care services to benefit the wider health care system and population health. The ICPSA will provide Waikato DHB flexibility to provide our local communities with equity of access specifically for Māori to different types of pharmacist services, tailored to individual need while addressing the four target population groups (frail elderly, vulnerable children, mental health and chronic conditions) (EOA). 2. Develop local pharmacist services strategies which align with the Pharmacy Action Plan and the 'Integrated Pharmacist Services in the Community' vision. They will continue to develop and implement consumer-focused services and better integration with wider community-based interdisciplinary teams. 3. Currently there is limited access to the Waikato DHB clinical work station for community pharmacies, there will be work undertaken to improve this and to identify opportunities for secondary care to access community pharmacy dispensing information 4. Waikato DHB will work with Midland Community Pharmacy Group to develop a Cultural training program for Waikato Community Pharmacies based around the He Ritenga Self-assessment tool (EOA).	1. The current Community Pharmacy Services Agreement will expire 30 September 2018. The ICPSA will be effective 1 October 2018 2. By the end of Q4 3. By the end of Q3 4. By the end of Q4	Report on activities in the Annual Plan
	Support to quit smoking	One team	Productive partnerrships	Waikato DHB is committed to delivery of smoking ABC in primary care by supporting stop smoking services with a particular focus on reaching Māori, pregnant women, and mental health consummers: 1. Increase the number of hospital and primary care referrals to quit providers by 10% 2. Increase the number of tobacco control sector staff across the district by 10% who attend Stop Smoking training 3. Increase the number of LMCs/midwives trained in ABCs and Stop Smoking by 10% 4. Introduce a smoke-free coordinator in maternity services 5. Introduce a smoke free coordinator in MH&AS 6. Enhancing our SUDI approach through the hapu wananga programme	1. By end of Q4 2. By end of Q4 3. By end of Q4 4. By end of Q4 5. By end of Q4 6. By end of Q3	Better help for smokers to quit in primary care
Child Health (both Māori and Pacific focussed equity actions are expected in this priority area)	Child Wellbeing	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to improving child wellbeing, which includes maternal and youth health that realises a measurable improvement in equity for Waikato DHB by: 1. Supporting high needs populations - women and children by: • Investigating the use of a maternity coordinator to focus on family violence prevention, child protection and facilitation of health and social services for the vulnerable unborn/baby during pregnancy/postnatally. (EOA) • Planning for a more holistic process to supporting children's health needs. Pilot of the Harti Hauora tool in the children's team. The pilot will have a formal evaluation. This will identify how it is making a difference and which areas if any require refinement. (EOA) • Investigate a maternity Harti tool for the community. (EOA) • Continued focus on rheumatic fever reduction following an increase in incidences. Continue provision of rapid response clinics for sore throat management of eligible populations, and continue gap analysis of new cases of acute rheumatic fever to identify potential areas for service improvement and improvements in future patient outcomes 2. Supporting rural women and children • Roll out the Southern Rural Maternity Project to increase access for rural women and children via the rural maternal/baby health and social sector hubs. The hubs will be a central location where women and their whānau can access services from a variety of maternal and child health providers, along with referals to social sector providers if required. The Southern Rural Maternity Project will also undergo an evaluation to identify success. Measures of success are being developed. (EOA)	1a. By Q2 b. By Q3 c. By Q3 d. On-going 2. Te Kuiti Hub to be launched by Q3	PP27: Supporting child well-being

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

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

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Government Planning Priority		Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
System Settings (both Māori and Pacific focussed equity actions are expected in this priority area)	Strengthen public delivery of health services	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to public delievery of health services by: 1. The DHB is currently undertaking Health System Planning to invest in prevention and early intervention approaches to keep people well in the community, while better utilising health services across the system	1. By Q2	SI16: Strengthening public delivery of health services
	Access to Elective Service	Value and High Performance	Effective and Efficient Care and Services	Waikato DHB is committed to delivering our agreed number of Elective discharges, in a way that meets timliness and prioritisation requirements and improves equity of access to services by: 1. Implementing the elective planning tools designed under the KEEZZ project in respect of increasing the planning and booking horizon and increasing the internal delivery volumes 2. Streamlining the process to ensure a patient is fit, willing and able to receive surgery 3. Improving projections of future elective volumes through specialty based clinical service plans 4. Developing tools to monitor CPAC scoring patterns 5. Support regional vascular services work focussed on improving equity for Māori and Pacific by: • collect data by ethnicity, location and deprivation where this is available. • supporting standardised processes to improve equity, quality and outcomes • improve the patient journey through supporting the development of an information pack to support clinical decision making and equity of access (EOA)	1. By September 2018 2. By December 2018 3. By March 2018 4. By December 2018 5. By end of Q4	Number of Elective Discharges SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Elective Services Patient Flow Indicators
	Cancer Services	Value and high performance	Effective and efficient care and services	Waikato DHB is committed to improving cancer services particularily around Māori health gain by: 1. Rolling out the Early Detection of Lung Cancer pilot with a specific focus on Māori. This will include development of an integrated pathway with PHO for faster diagnosis of lung cancer patients to reduce ED admissions and improve patient outcomes via the SLM Amenable Mortality work. (EOA) 2. To engage with Te Puna Oranga across all cancer pathways to minimise inequity in cancer service by addressing "Did not Attends" (DNA's) and identifying barriers. This will be addressed by the promotion of the Clinical Nurse Specialist Equity and Access to identify DNA's, reasons for DNAing, breakdown barriers and re-engage with the services to ensure patients are seen in a timely manner (EOA) 3. Implement the prostate cancer decision support tool to improve the referral pathway across primary and secondary services. Clinical Nurse Specialist (CNS) for Urogenital cancer will continue to be involved in the development of national prostate cancer tumour stream. Our CNS for urogenital cancer will be part of a working group for improving Māori health access and treatment for Prostate cancer 4. We will provide support to people following their cancer treatment (survivorship) by • Providing a dedicated CNS for Urology, Continence, and Urotherapist and a CNS for urogenital cancer patients • Setting up an education session for prostate cancer patients • Providing preoperative education sessions and post operative education as required for specific conditions eg Radial prostatectomies, Trans Urethral Resection of Prostate (TURPs), Testicular cancer • Update patient education pamphlets for all conditions. Access to nurses via phone for support for patients who ring with queries. • Link patients with the cancer society and prostate cancer support groups	1. By the end of Q4 2. By the end of Q2 3. By the end of Q4 4. By the end of Q4	SI9: SLM amenable mortality HT: Faster Cancer Treatments PP29: Improving waiting times for diagnostic services PP30: Faster cancer treaments
	Disability Support Services	One team	Productive partnerrships	Waikato DHB is committed to Disability Support Services by: 1. Developing e-learning (or other) training for front line staff and clinicians that provides advice and information on what might be important to consider when interacting with a person with a disability. 2. Report on what percentage of staff have completed the training.	1. Roll out end of Q2 2. Report at end of Q4	SI14: Disabilty support services
	Shorter stays in Emergency Department	One team	Productive partnerrships	1. Continued improvement and development of pathways for the Surgical Assessment Unit now well established and supporting more specialities (i.e. Plastics and Ortho to go to the up to the unit once assessed by the Emergency Department and/or speciality). • Increased hours and bed spaces in the AMU (Acute Medical Unit) for medical patients, with patients able to present directly to the AMU from the GP if stable or redirected from the triage nurse. Move to 24/7 access	1. Q3	95% of patients will be admitted, discharged or transferred from an Emergency Department within six hours of presentation.

Government Planning Priority	Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
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System Settings (both Māori and Pacific focussed equity actions are expected in this priority area) (continued) – Shorter stays in Emergency Department	One team	Productive partnerrships	• Co-location of the ASU and AMU wards/services, so that they are on the same level (one level above the Emergency Department than currently split in two different areas of the organisation). • Clear guidelines and instructions for sending patients directly to units (AMU and ASU bypassing the Emergency Department if stable from GP's). 2. Embedding the process flow through the zones in the Emergency Department (Hot Zone and Warm Zone) and flow through front of house, triage and the consult areas. 3. Working with Mental Health to establish the acute Mental Health team to be based in the Emergency Department to see, treat and assess their patients more effectively - this team has a nurse practitioner, RMO, psychiatrist and a team of five nurses working towards providing an acute service in the Emergency Department 24/7. The few weeks it has been up and running has seen an improvement in outcomes for these patients with providing limited hours currently till team is trained and confident in working in department and out of hours 4. Large electronic dashboard designed with floor map of the department to show areas that have queues forming, to allow easy identification of patients and timeframes in the department and who is providing the care at a glance. Metrics measuring each zone's performance throughout the day allowing visibility of the flow through the department. • Engagement with IS around shift-by-shift live reporting so the department can see, treat and assess their patients more effectively - to have accountability shift-by-shift and understand changes in trends in real time to help manage the patient throughput and flow.	2. Q3 3. Q4 4. Q3	
			5. Increase the FTE of HCA's (health care assistants) in the department, so that we have one allocated to each major zone in the department 1 x Hot Zone, 1 x Warm Zone/SSU 1 x front of house, 1 x Resus, 1 x kids/consult, this will enable patients to move through the department more readily, be worked up alongside the team in the initial arrival into cubicles and have investigations started such as ECG, monitoring etc. • Employment of our first Emergency Department speciality nurse practitioner with the ability to see and treat/discharge patients across the age spectrum. • Increase nursing resource to have all resus rooms staffed 1-1 am and pm shift to allow for correct resourcing of this zone and restocking and increase patient care and through put of the zone with the right person being available to care of patients and the right resources to look after patients while in that area. • Recruitment of a specific service manager to manage the Emergency Department only and support the Emergency Department clinical team operationally to get changes in place to help improve the flow of patients. 6. Trial of iPads instead of computers on wheels to enable faster bedside registration of the patients for the clerical team 7. Continue engagement and working with the top three specialities (General Medicine, Respiratory and Cardiology) to look at ways the department can support them to move their patients through the department in a more timely way 8. Review of Primary Health and our redirection policy for low acuity patients to be seen in Alternative after hour clinics to the Emergency Department.	5. Q4 6. Q3 7. Q4 8. Q4	
Healthy Ageing	Closer to home	Safe, quality health services for all	**Waikato DHB is committed to delivery of priority actions identified in the Healthy Aging Strategy 2016, where we are in lead and supporting roles including:** 1. Development of a Waikato Healthy Aging Strategy and implementation plan to support the implementation of the NZ Healthy Aging Strategy into Waikato DHB. 2. Continue to work with Accident Compensation Corporation (ACC), Health Quality Safety Committee (HQSC), and the Ministry of Health, monitor and measure the progress of our integrated falls and fracture prevention services 3. Implement agreed activity from the In-between Travel (IBT) settlement Part 2 4. InterRAI Data: • Work with Midland DHBs to ensure InterRAI assessment data is used to identify quality indicators, and service development opportunities. Agree pathways where data identifies need • Prioritise implementation of access to inteRAI data at National Health Index (NHI) level across primary and secondary Equity issue identified – equitable access to Needs Assessment and Service Coordination by Waikato Kaumatua (EOA)	1. By end of Q2 2. On-going 3. ongoing and awaiting further information from the MoH 'Future Models of Care' project 4. Quality indicators to be developed and utilised for service improvement by Q3 Access is implemented by Q4	PP23: Implementing the Healthy Aging Strategy

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

Government Planning Priority	Link to NZ Health Strategy	Link to Waikato DHB Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Delivery of Regional Services Plan	One team	Productive partnerrships	Waikato DHB support our staff to meet and undertake work as members of the regional clinical network/action groups detailed in the individual 2018-21 Regional Services Plan work plans Our Waikato DHB actions to support planned elective activity within vascular services, breast reconstruction and ophthalmology includes: **Workforce enabler:** Identify the actions that the region will undertake to maximise workforce resources. And development of long-term recruitment plan for vulnerable or hard-to-recruit roles. By: • Provide vacancy data to Healthshare to identify professional groupings whose characteristics, numbers, vacancy rates, turnover rates, or age profile within the DHB, may pose a risk to ongoing service delivery • support collaboration across Midland DHBs to create and access material for long term recruitment strategies. Orthopaedics: • support the regional review of current orthopaedic workforce resources, factoring in subspecialty capability. Support the development and implementation of a regional orthopedic workforce implementation plan (based on the regional review). By: • providing data for Healthshare to undertake an orthopaedic workforce stocktake, gap analysis, and identify issues. This activity is dependent on additional resourcing. Refer to Elective services (Elective Services Network) 18-19 work plan. Note: orthopaedic workforce is not detailed and would be subject to additional resourcing. **Quality enabler:** When developing and implementing regional models of care for Vascular, and Breast Reconstruction and regional collaboration on Ophthalmology (Age-Related Macular Degeneration (AMD) and Glaucoma) service development, there will be a clear link to quality improvements and standards, particularly in relation to unwarranted variation in patterns of care and improving health equity. Refer to Elective services (Elective Services Network) 18-19 work plan initiative 1: Vascular services. Refer to notes in Elective services (Elective Services Network) 18-19 work plan initiative 2 Breast Reconstruction and initiative 3: Ophthalmology re constraints. **Clinical Leadership enabler:** *Refer to Elective services (Elective Services Network) 18-19 work plan:* Initiative 1: Vascular services – led by Thodur Vasudevan and Mark Morgan. Focus is on improving the delivery of vascular services for the population of the Midland region. Actions related to clinical leadership include: • Support the assessment and confirmation of DHB service levels • Support the development acute and elective pathways • Workforce benchmarking is undertaken and opportunities to develop workforce and technology solutions are identified and progressed. Initiative 2: Breast reconstruction services – note that the anticipated 18/19 work relating to improving access, and consistency of access, to plastics and reconstructive services. Midland Elective Services Network will engage with the national service improvement programme as actions are developed and will support regional implementation, as required by Waikato DHB. Initiative 3: Ophthalmology services – note that the anticipated 18/19 work relating to improving access, and consistency of access, to Age-Related Macular Degeneration (AMD) and Glaucoma pathways. Midland Elective Services Network will engage with the national service improvement programme when guidelines are completed and as actions are developed and will support regional implementation, as required by Waikato DHB. **Pathways enabler:** Support the development and implementation of regional models of care to support better flows between secondary and tertiary service providers and between community and secondary care. This will enable a streamlined journey for the patient in order to achieve better patient outcomes. Key areas identified for 2018/19 are: • Vascular • Breast Reconstruction • Ophthalmology		

Table continues over page

Financial performance summary

(Refer to Appendix One for further detail)

Table: Statement of Prospective Comprehensive Income

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

Table: Revenue and expenditure by Output class

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

SECTION 3: Service configuration

3.1 Service coverage

Waikato DHB is required to deliver a minimum of services, as defined in The Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually.

Responsibility for Waikato District service coverage is shared between Waikato DHB and the Ministry. We are responsible for taking appropriate action to ensure that service coverage is delivered for our population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups.

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

Waikato DHB is not seeking any changes to the formal exemptions to the Service Coverage Schedule in 2018/19.

3.2 Service change

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

Change	Description of change	Benefits of change	Change for local, regional or national reasons
Women's Health	Redevelopment of the Delivery Suite with respect to • Induction of labour rooms • Reconfiguration of women's health wards	• Separation of gynaecology and antenatal care will improve the quality of care for patients, and will enable a more appropriate skill mix in both gynaecology and maternity care	Primarily local, although also benefits the wider region
Rural services	Ongoing implementation of the Rural Health Services review which includes potential service changes in any aspect of rural service delivery, including, but not limited to, the early priority areas of: • Rural primary maternity • Child oral health (dentistry under GA) • Urgent care services (primary and secondary) • Inpatient services • Community based (non-hospital) services • Rural laboratory services • Service changes associated with service redesign to support the development of integrated rural health and social services in Ruapehu, South Waikato, King Country, Thames and Coromandel, and North Waikato • Service changes to support enhanced workforce development in rural settings	• Improved access • Earlier intervention • Better co-ordinated and integrated services	Local with some inter-DHB (sub-regional) aspects at the DHB boundaries
Mental Health and Addictions	Completing Te Pae Tawhiti service review commissioning plan in 18/19 and out years. Finalising capital planning and replacement of Henry Bennett. Developing stronger links with primary care and NGO's for design of services.	• Improved access • Earlier intervention • Better co-ordinated and integrated services	Local
Primary care integration	Development of the Care in the community Plan with the intent to improve primary care and other community services at a locality level. Review Primary Option services to ensure accurate service mix to reduce ED and ASH admissions Establish Waikato District Alliance to incorporate clinicians and managers across the system to enhance primary care services for our local population	• Increased integration between primary and secondary services • Increased clinical leadership • Enhanced sustainability of rural services	Local
Community Pharmacy and Pharmacist services	Potential change in model of service delivery using framework of new contract. Work towards different contracting arrangements for the provision of community pharmacist services by working with consumers and other stakeholders within the framework of the new contract to develop and agree local service options, including potential options for consumer-focused pharmacist service delivery, with wider community- based inter-disciplinary teams.	• More integration across the primary care team • Enhanced services for consumers • Improved access to pharmacist services by consumers • Consumer empowerment • Safe supply of medicines to the consumer • Improved support for vulnerable populations • More use of pharmacists as a first point of contact within primary care.	National and local

SECTION 4: Stewardship

This section provides an outline of the arrangements and systems that Waikato DHB has in place to manage our core functions and to deliver planned services. Greater detail is included in Waikato DHB's three-yearly Statement of Intent, which was last produced for the 2016/17 year and is available on our website at www.waikatodhb.health.nz

4.1 Managing our business

4.1.1 Organisational performance management

Waikato DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at various level(s) of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

Table: External reporting framework

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

4.1.2 Funding and financial management

Waikato DHB's key financial indicators are Revenue, Net Surplus/Deficit, Fixed Assets, Net Assets and Liabilities. These are assessed against and reported through Waikato DHB's performance management process to stakeholders on a monthly basis. Further information about Waikato DHB's planned financial position for 2018/19 and out years is contained in the Financial Performance Summary section of this document on page 25, and in Appendix A: Statement of Performance Expectations.

4.1.3 Investment and asset management

Waikato DHBs will develop a 10 year Health System Plan and a stand-alone Long Term Investment Plan (LTIP) covering 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system.

4.1.4 Shared service arrangements and ownership interests

Waikato DHB has a part ownership interest in HealthShare. In line with all DHB's nationally, Waikato DHB has a shared service arrangement with TAS around support for specified service areas. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

4.1.5 Risk management

Waikato DHB has a formal risk management and reporting system, which entails incident and complaint management as well as the risk register (Datix management system) and routine reporting to the District Health Board. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

4.1.6 Quality assurance and improvement

Waikato DHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. The DHB Board approved and published a quality governance strategy 'listen, learn, improve' in December 2016, with progress monitored by the Board of Clinical Governance.

4.2 Building capability

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

4.2.1 Capital and infrastructure development

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

4.2.2 Information technology and communications systems

Waikato DHB's information technology and communication systems goals align with the national and regional strategic direction for IT. Further detail about Waikato DHB's current IT initiatives is contained in the 2018/19 Midland Regional Service Plan, and on page 43.

4.2.3 Workforce

Future workforce development - our people strategies – will see evolving alignment and integration with the Ministry of Health's New Zealand Health Strategy: Future Direction, and the Waikato DHB Strategy.
In summary the key areas are:

- Use of smart technologies has and will result in innovation and changes to the way we deliver care, and achieve sustainability, given aging population demands and fiscal constraints. Virtual Health – virtual patient care – includes all of the normal aspects of patient care without having in-person contact with the patient. Other technologies and innovation will require our workforce to adapt and change to new ways of working.
- Supporting the development of a culture of innovation is an intentional focus on the culture of our workplace; the environment our people work in. Investment is and will occur in making the workplace safer for staff, finding creative ways to address equity, living and embedding the values staff developed, and enabling ways that staff can speak up about matters that concern them. A culture that encourages ideas that can result in transformational innovation is required.

4.2.4 Co-operative developments

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

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

4.3 Workforce

4.3.1 Healthy ageing workforce

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

This includes the following areas:

Additional work includes:

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

4.3.2 Health literacy

Health literacy skills within the workforce

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

Health literacy practices

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

The principles followed were:

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

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

4.3.3 Midwifery workforce

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

Recruitment strategies include:

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

Retention strategies include:

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

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

4.3.4 Care Capacity Demand Management

Waikato DHB is committed to implementing Care Capacity Demand Management (CCDM) by June 20121. This will be a phased approach with an establishment team already appointed. By the 1 July 2019 we will have the acuity tool rolled out along with the principles of CCDM implemented to 80% of inpatient wards, Te Kuiti, Taumarunui and Tokoroa rural hospitals and mental Health. This includes the local data council and executive CCDM council.

4.4 Information Technology (IT)

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

The Midland region, through the 2017-2021 Midland Region Information Services Plan (MRISP), has an established IS regional strategy aligned to the New Zealand Health Strategy direction, which has set a goal of a people-powered, smart health system by 2025. The MRISP underpins the Information Services work of the Midland Region and guides our priorities and approach. It is informed by, and supports, the Midland Regional Services Plan, Government ICT Strategy and Ministry of Health Strategies, specifically Digital Health 2020.

There are six key objectives of focus with the MRISP;

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

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

The indicative timelines for the implementation of major initiatives is as follows:

Initiative	Timeline
Regional PACS/RIS consolidation	Lakes: Go Live Nov-18. Taranaki: Go Live Q2 2019
Windows 10	Business Case approved by MoH. Phased implementation through to Q1 2020.
Office 2016	Business Case approved by MoH. Phased implementation through to Q1 2020.
eOrders	Business Case approved. Go Live Q3 2019
Disaster Recovery Solution	Business Case approved by DHB Board. Single Stage Business Case to be reviewed by MoH Q2/Q3 2019. 18 month project.
Theatres - Booking & Scheduling	Scoping & Implementation Planning 2019. Business Case 2019/20. 2 year project.
Observations Platform (eVitals)	Procurement Phase Business Case approved. Single Stage Business Case to be shared with MoH Q1/Q2 2019. 1 year project.
Enterprise Services Business	Regional solution. Decision to proceed Q1 2019. Single Stage Business Case to be shared with MoH Q2 2019. 18 month project.
Nutrition & Food solution	Business Case approved by Ministry Feb-18. Implementation during 2018/19, with phased delivery over 18 months.
Attendant Job Allocation solution	Business Case to be submitted Q1 2019. Targeting Q4 2019 delivery.
Telementry Monitor Replacement	Procurement Phase approved & underway. Single Stage Business Case to be shared with MoH Q2/Q3 2019. 1 year project.
WiFi rollout	4 year phased plan approved. Year 3 of 4.
Anaesthesia Information System	Procurement Phase approved & underway. Point of Entry Document to be shared with MoH Q1 2019. Targeting implementation during 2019. 1 year project.

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

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

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

SECTION 5: Performance measures

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

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

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

Code	Dimension
HS	Health Strategy
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – Establishment of baseline (no target/performance expectation is set)
Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.	

Performance measure	Performance expectation		
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes		
PP6: Improving the health status of people with severe mental illness through improved access			18/19
	Age 0 - 19	Māori	4.73%
		Other	4.15%
		Total	4.36%
	Age 20 - 64	Māori	8.77%
		Other	3.79%
		Total	4.81%
	Age 65+	Māori	2.39%
		Other	2.08%
		Total	2.11%
PP7: Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
	95% of audited files meet accepted good practice.		
	Report on activities in the Annual Plan		
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	80% of people seen within 3 weeks.		
	95% of people seen within 8 weeks.		
	Report on activities in the Annual Plan		
PP10: Oral Health- Mean DMFT score at Year 8	Year 1	Māori	0.69
		Other	0.69
		Total	0.69
	Year 2	Māori	0.69
		Other	0.69
		Total	0.69
PP11: Children caries-free at five years of age	Year 1	Māori	63%
		Other	63%
		Total	63%
	Year 2	Māori	63%
		Other	63%
		Total	63%
PP12: Utilisation of DHB-funded dental services by adolescents (school Year 9 up to and including age 17 years)	Year 1	Māori	85%
		Other	85%
		Total	85%
	Year 2	Māori	85%
		Other	85%
		Total	85%

Performance measure	Performance expectation		
PP13: Improving the number of children enrolled in DHB funded dental services (0-4 years)	Year 1	Māori	≥95%
		Other	≥95%
		Total	≥95%
	Year 2	Māori	≥95%
		Other	≥95%
		Total	≥95%
PP13: Improving the number of children enrolled in DHB funded dental services, (children not examined 0-12)	Year 1	Māori	≤10%
		Other	≤10%
		Total	≤10%
	Year 2	Māori	≤10%
		Other	≤10%
		Total	≤10%
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)			
Focus Area 1: Long term conditions	Report on activities in the Annual Plan.		
Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.		
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).		
Focus Area 3: Cardiovascular health	90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.		
	90% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years.		
Focus Area 4: Acute heart service	70% of high-risk patients receive an angiogram within 3 days of admission.		
	Door to catheter within 3 days for >70% of ACS patients undergoing coronary angiogram.		
	>95% of patients undergoing cardiac surgery at the regional cardiac centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge and ≥99% within 3 months.		
	Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin*, a second anti-platelet agent*, statin and an ACEI/ARB (4-classes), and LVEF<40% should also be on a beta-blocker (5-classes). *An anticoagulant can be substituted for one (but not both) of these two anti-platelet agents.		
Focus Area 5: Stroke services	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.		
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.		
	60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team ie RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.		
PP21: Immunisation coverage	At least 95% of two year olds fully immunised and coverage maintained		
	At least 95% of four year olds fully immunised by five years and coverage is maintained		
	75% of girls fully immunised – HPV vaccine		
	75% of 65+ year olds immunised – flu vaccine		
	Report on activities in the Annual Plan		
PP22: Delivery of actions to improve system integration including SLMs	Report on activities in the Annual Plan.		
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan.		
	Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4 – 6 for assessment urgency. Baseline to be established.		

Performance measure	Performance expectation	
PP25: Youth mental health Initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.	
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).	
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
PP26: The Mental Health and Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.	
PP27: Supporting child well-being	Report on activities in the Annual Plan.	
PP28: Reducing Rheumatic fever	≤1.2 per 100,000	
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	
	95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	
	90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.	
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.	
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.	
PP30: Faster cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
	Report on activities in the Annual Plan.	
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	
PP32:Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).	
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.	
PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
PP37: Improving breastfeeding rates	70% of infants are exclusively or fully breastfed at three months	
PP39 Supporting Health in Schools	Report on activities in the Annual Plan.	
PP40 Responding to climate change	Report on activities in the Annual Plan.	
PP41 Waste disposal	Report on activities in the Annual Plan.	
PP43 Population mental health	Report on activities in the Annual Plan.	
PP44 Maternal mental health	Report on activities in the Annual Plan.	
PP45: Elective surgical discharges	18,038 of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	
SI1: Ambulatory Sensitive Hospitalisations	0-4 years	As specified in the jointly agreed (by district alliances) SLM Improvement Plan
	46 – 64 years	Māori – a target rate of <9,159 per 100,000
		Pacific – a target rate of <5,935 per 100,000
		Other – target rate of <4,479 per 100,000
SI2: Delivery of Regional Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	

Performance measure	Performance expectation	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population.	
	Cataract procedures - a target intervention rate of 27 per 10,000 of population.	
	Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population.	
	Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population.	
	Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.	
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.	
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI10: Improving cervical screening coverage	80% coverage for all ethnic groups and overall.	
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall.	
SI12: SLM youth access to and utilisation of youth appropriate health services	As specified in the jointly agreed (by district alliances) SLM Improvement Plan	
SI13: SLM number of babies who live in a smoke-free household at six weeks post natal	As specified in the jointly agreed (by district alliances) SLM Improvement Plan	
SI14: Disability support services	Report on activities in the Annual Plan	
SI15: Addressing local population challenges by life course	Report on activities in the Annual Plan	
SI16: Strengthening Public Delivery of Health Services	Report on activities in the Annual Plan	
SI17: Improving quality	Report on activities in the Annual Plan	
SI18: Improving newborn enrolment in General Practice	55% of newborns enrolled in General Practice by 6 weeks of age	
	85% of newborns enrolled in General Practice by 3 months of age	
OS3: Inpatient Average Length of Stay (LOS)	Elective LOS suggested target is 1.47 days, which represents the 75th centile of national performance.	1.5 days
	Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.	2.3 days
OS8: Reducing Acute Readmissions to Hospital	<13%	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	Group A >2% and <= 4%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% and <= 2%
	Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and <= 2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and <= 85%
	Invalid NHI data updates	TBA
Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	>= 97% and <99.5%
	National Collections File load Success	>= 98% and <99.5%
	Assessment of data reported to NMDS	>= 75%
	Timeliness of NNPAC data	>= 95% and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified about data quality audits.	
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	

APPENDIX A:
2018-19 Statement of Performance Expectations

Waikato District Health Board

2018-19 STATEMENT OF PERFORMANCE EXPECTATIONS

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

Contents

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

This document is available on the Waikato District Health Board website **www.waikatodhb.health.nz**

Signatories

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

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

Sally Webb
Chair
Waikato DHB

Date:

Professor Margaret Wilson
Deputy Chair
Waikato DHB

Date:

Introduction

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

Our performance story

National performance story

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

Regional performance story

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

Waikato DHB performance story

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

Service performance

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

Stewardship

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

* These are only an example of the outputs.

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

IMPACTS

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

IMPACT MEASURES – MEASURES OF PERFORMANCE

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

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

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

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

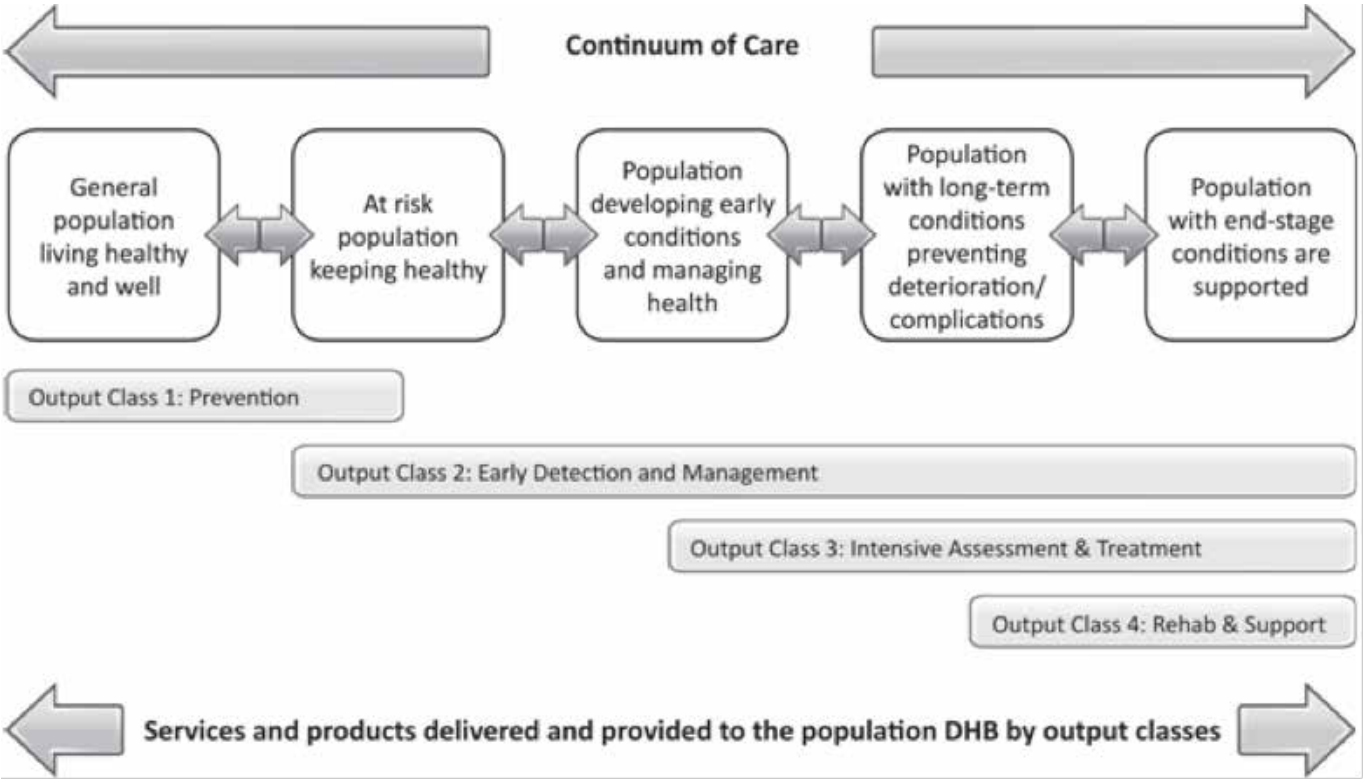
When people are supported to stay well and can access the care they need closer to home and in the community, they are less likely to need hospital-level or long-stay interventions. This is not only a better health outcome, but it reduces the pressure on our hospitals and frees up health resources. Studies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

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

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

OUTPUT MEASURES

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



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

OUTPUT CLASS

Prevention

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

Early detection and management

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

Intensive assessment and treatment services

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

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

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

Rehabilitation and support

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

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

SETTING TARGETS

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

WHERE DOES THE MONEY GO?

Table 1: Revenue and expenditure by Output class

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

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

People are supported to take greater responsibility for their health

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

Fewer people smoke

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

Output Measure	Output class	Measure type	Baseline 2014/15	Target 2018/19
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	1	Qn		
Māori			94%	95%
Pacific			100%	95%
Other			91%	95%
Total			94%	95%
Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	1	Qn		
Māori			92%	90%
Pacific			91%	90%
Other			89%	90%
Total			90%	90%
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	1	Qn		
Māori			64%	90%
Pacific			Not available	90%
Other			66%	90%
Total			95%	90%

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

Reduction in vaccine preventable diseases

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

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

Improving health behaviours

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

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

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

People stay well in their homes and communities

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

An improvement in childhood oral health[6]

Impact Measure		Baseline 2014	Target 2018/19	Target 2019/20	Target 2020/21
Mean decayed missing and filled teeth score of Year 8 children					
	Māori	1.65	0.69	Decrease	TBC
	Pacific	1.40	0.69		
	Other	0.87	0.69		
	Total	1.08	0.69		

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

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of enrolled pre-school and primary school children (0-12) overdue their scheduled dental examination[8]		2	Qn/T		
	Māori			18%	≤10%
	Pacific			20%	
	Other			25%	
	Total			18%	
Percentage of adolescent utilisation of DHB funded dental services[9]		2	Qn		
	Māori			45%	85%
	Pacific			53%	85%
	Other			80%	85%
	Total			70%	85%

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

Long-term conditions are detected early and managed well

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

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

Fewer people are admitted to hospital for avoidable conditions

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

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

People maintain their functional independence

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

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

[10]Baseline 16/17

[11]Baseline used by Ministry is 12 months to Sep 2016

People receive timely and appropriate specialist care

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

People receive prompt and appropriate acute and arranged care

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

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

People have appropriate access to elective services

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

Output Measure		Output class	Measure type	Baseline	Target 2018/19
Percentage of patients waiting longer than four months for their first specialist assessment		3	Qn/T		
	Total			2.7%	0%
Improved access to elective surgery, health target, agreed discharge volumes		3	Qn		
	Total			15,693	18,037
Did not attend percentage for outpatient services		3	Qn/T		
	Māori			21%	10%
	Pacific			18%	10%
	Other			7%	10%
	Total			10%	10%
Inpatient average length of stay (Elective)		3	Qn/T		
	Total			1.71 days	1.5 days
Inpatient average length of stay (Acute)		3	Qn/T		
	Total			3.89 days	2.3 days

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

Impact Measure		Baseline	Target 2018/19	Target 2019/20	Target 2020/21
Reducing acute readmissions to hospital					
	Māori	14%	<13%	To be allocated	
	Pacific	8%	<13%		
	Other	12%	<13%		
	Total	12%	<13%		

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

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

[12]Ethnicity data not available

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

More people with end stage conditions are supported appropriately

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

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

Support services

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

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

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

Financial performance

Table: Statement of Prospective Comprehensive Income

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

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

Table: Statement of Prospective Position

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

Table: Statement of Prospective Movements in Equity

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

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

Table: Statement of Prospective Cashflow

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

1.1 Fixed assets

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

- ### 1.1.1 Disposal of Land

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

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

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

1.2 Capital expenditure / investment

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

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

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

Strategic capital spend includes:

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

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

1.3 Planned financial performance by division

Table: Prospective Financial Targets and Measures DHB Provider

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

Table: Prospective Financial Targets and Measures DHB Governance

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

Table: Prospective Financial Targets and Measures DHB Funding

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

1.4 Significant assumptions

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

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

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

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

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

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

1.6 Subsidiaries

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

APPENDIX B:
2018-19 System Level Measure Improvement Plan

Waikato District Health Board

2018-19 SYSTEM LEVEL MEASURE IMPROVEMENT PLAN

Pinnacle Midlands Health Network

HAURAKI PHO HAURAKI PRIMARY HEALTH ORGANISATION NETWORK

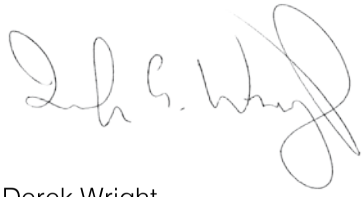
National Hauora Coalition

Contents

Introduction

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

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



Derek Wright
Interim Chief Executive Officer
Waikato DHB

David Oldershaw
Chief Executive Officer
Pinnacle Midlands Health Network

Hugh Kininmonth
Chief Executive Officer
Hauraki PHO

Simon Royal
Chief Executive Officer
National Hauora Coalition

Cath Knapton
Chief Executive Officer
Midlands Pharmacy Group

Lindsey Webber
Deputy CEO
Hauraki PHO

Background

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

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

Key lessons learned from 17/18:

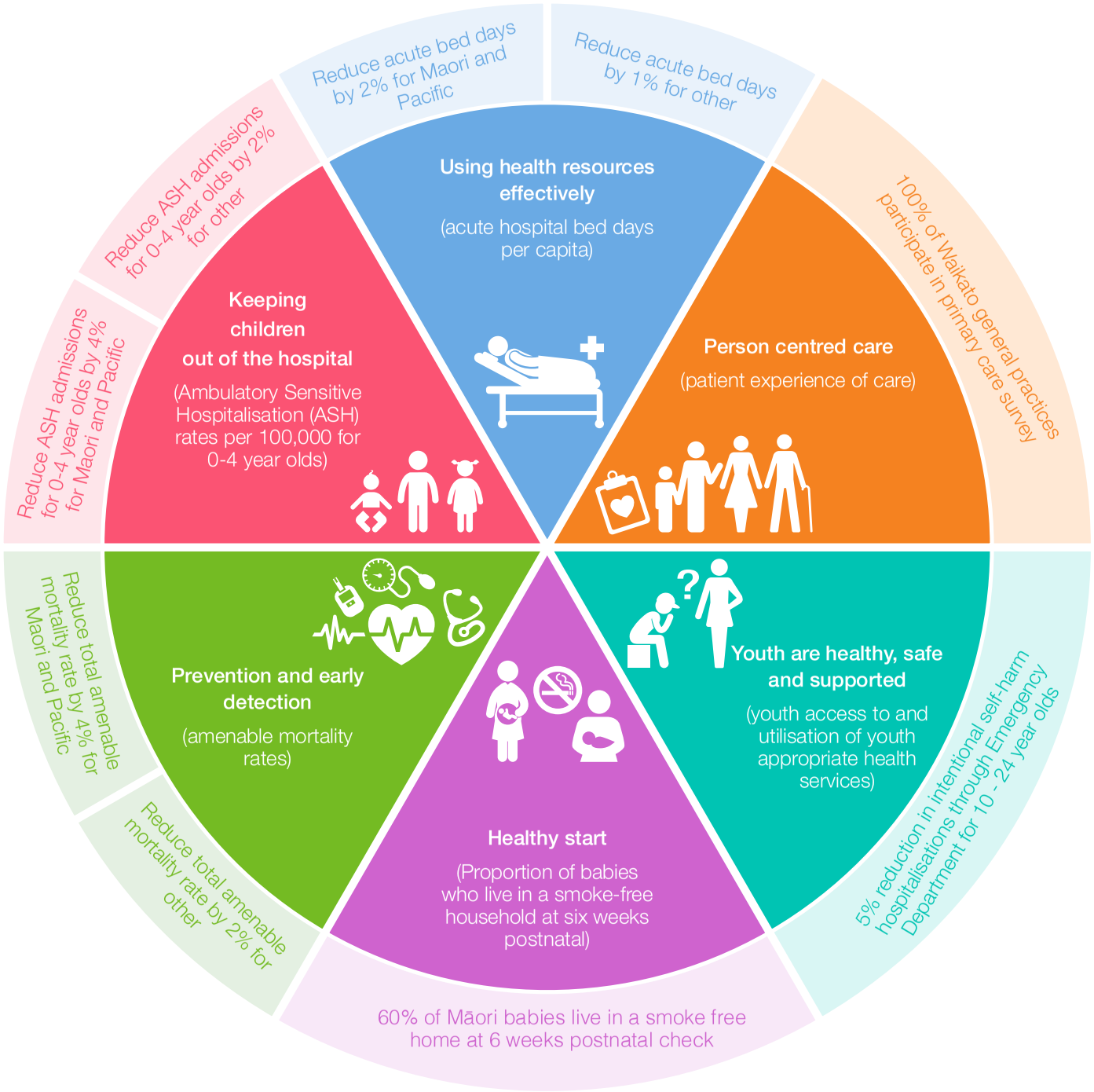
- Include a programme approach to the current SLM structure for Waikato and tighten up terms of reference around accountability and escalation
- Continue to utilise data and root cause analysis to systematically identify gaps and the areas that warrant the most attention. This has enabled us to become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

Structure

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

Communication framework

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


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

System level measure overview

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

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

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

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

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

Respiratory

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

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

System Level Measure 2:

Acute bed days: Improved management of demand for acute care

Improvement milestones:

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

Baseline data analysis:

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

Cellulitis

	Contributory measure	Rationale	Activity
1.	• Māori/Pacific cellulitis ASH rate 45-64 age group • Numbers of education and treatment packs distributed to Māori/Pacific whanau	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• Publicise the new cellulitis community pathway to all PHOs and Waikato DHB ED • All departments to use the community pathway for self-presenting patients as the primary process • Review data from Māori/Pacific patients who are assessed in ED or are admitted. Then distribute to Māori/Pacific whanau a primary care and pharmacy developed information and treatment pack containing education materials and simple creams/antiseptics within all PHOs

COPD

	Contributory measure	Rationale	Activity
2.	• Māori/Pacific COPD ASH rate 45-64 yrs • Numbers of Māori/Pacific patients referred to COPD Homebased support team	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• COPD Homebased Support Team new integrated care model initiative in the community. Implementation and evaluation of 15 month pilot. This will place respiratory nurse specialists in Waikato DHB, Hauraki PHO, and Pinnacle PHO who will work together with general practice and ambulance service to reduce COPD admissions targeting Māori/Pacific populations

Asthma

	Contributory measure	Rationale	Activity
3.	• Asthma Māori/Pacific ASH rate 45-64 yrs • Number of Māori/Pacific asthma patients with completed GASP assessment and asthma plan	Effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers	• GASP programme introduced for asthma patients targeting Māori/Pacific. This provides asthma assessment and education at the point of care and provides health care professionals with skills and knowledge to undertake structured asthma assessments. Patients are empowered through the development of an asthma care plan to enhance self-management capability though Hauraki PHO

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

System Level Measure 3:

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

Improvement milestone:

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

Baseline data analysis:

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

Increasing volumes of GP surveys			
	Contributory measures	Rationale	Activity

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

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

Pilot project for Safer Discharge Checklist for Waikato DHB Inpatient			
	Contributory measures	Rationale	Activity

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

System Level Measure 4:

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

Improvement milestones:

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

Baseline data analysis:

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

Coronary/CVD

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

Suicide

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

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

Improvement milestone:

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

Baseline data analysis:

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

Pre pregnancy and household contacts

	Contributory measures	Rationale	Activity

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

Early pregnancy			
	Contributory measures	Rationale	Activity

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

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

Lifespan			
	Contributory measures	Rationale	Activity

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

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

Improvement milestone:

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

Baseline data analysis:

- Waikato rates are generally increasing and Waikato's rate is higher than the national rates

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

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

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

Appendix

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

Purpose

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

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

Specific responsibilities

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

(Where we are now)

- Identifying improvement milestone

(Where we want to be)

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

(How will we get there?)

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

Outside of scope

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

Linkages

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

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

Formation details
The working group were established in May 2017

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

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

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

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

The Waikato Inter-alliance will have oversight for Waikato system level measures.
The working group will all report to one of the two following groups or straight to Inter-Alliance
1. Waikato Child and Youth Health Network
   - Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds;
   - Proportion of babies who live in a smoke-free household at six weeks post-natal
   - Youth access to and utilisation of youth-appropriate health services
2. Demand Management Advisory
   - Acute hospital bed days per capita;
   - Amenable mortality
3. Inter-Alliance
   - Patient Experience of Care

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

Decision making

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

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

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

Issues with recommendation to be escalated through each organisations management structure

Membership

Technical Reference Group		
Regan Webb	Jo Scott-Jones	NHC tbc
Katpaham Kasipillai/ Peter Hemming	Stephen Ayliffe	
Michelle Bayley	Reuben Kendall	

Acute hospital bed days per capita (i.e. using health resources effectively) *Reports to Demand Management Advisory Group*		
Damian Tomic (Waikato DHB) –lead	Cath Knapton (Midland Pharmacy Group)	Nina Scott (Waikato DHB)
Jo-Anne Deane (Project Manager)	Graham Guy (Waikato DHB)	Puamiria Maaka (MHN)
Andrea Coxhead (Waikato DHB)	Lorraine Hetaraka-Stevens (NHC)	Stephen Ayliffe (Hauraki)

Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (i.e., keeping children out of hospital) *Reports to Waikato Child and Youth Health Network*		
David Graham (Waikato DHB Women's and Children's) - Clinical Lead/Chair	Jo-Anne Deane (Waikato DHB Integrated Care)	Lorraine Hetaraka-Stevens (National Hauora Coalition)
Kath Yuill-Proctor (Waikato DHB Women's and Children's) – Project Manager	Karina Elkington (Waikato DHB Strategy and Funding) – Portfolio Manager	Stephen Ayliffe (Hauraki Primary Health Organisation)
Cath Knapton (Midland Community Pharmacy Group)	Katie Ayers (Oral Health Midland Clinical Advisor)	TBC (Waikato DHB ED Hospital Services)
Felicity Dumble (Waikato DHB Population Health)	Katpaham Kasipillai (Waikato DHB Strategy and Funding) – Analyst	Tracey Jackson (Pinnacle Midlands Health Network)
Geraldine Tennet (Waikato DHB Child Health GP Liaison)	Kui White (Raukura – Well Child Tamariki Ora)	

Patient experience of care (i.e., person-centered care) *Reports to Inter-Alliance*		
Mo Neville (Waikato DHB) lead	Jo-Anne Deane (Waikato DHB)	Stephen Ayliffe (Hauraki)
Cait Cresswell (Project Manager)	Lorraine Hetaraka-Stevens (NHC)	Trish Anderson (Hauraki)
Cath Knapton (Midland Pharmacy Group)	Michelle Bayley (MHN)	
Janet Ball (Waikato DHB)	Reuben Kendall (Hauraki)	

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

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

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

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

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

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

APPENDIX C:
Statement of accounting policies

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 and operates in New Zealand.

The group consists of Waikato DHB and its controlled entity, Waikato Health Trust. Its 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 (PBE) for financial reporting purposes.

Basis of preparation

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

Statement of compliance

Financial statements are 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 (NZ GAAP).

Financial Statements are prepared in accordance with, and comply with, Tier 1 PBE accounting standards.

Presentation currency and rounding

Financial statements are presented in NZ dollars and all values are rounded to the nearest thousand dollars ($000).

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective as at 30 June 2018 that have not been early adopted, and which are relevant to the Waikato DHB and group are:

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 – 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6-8). The new standards are effective for annual periods beginning on or after 1 January 2019 with early application permitted.

These changes have no implication on the Waikato DHB and group.

Financial Instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. Waikato DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The Waikato DHB and group has not yet assessed the effects of the new standard. Based on initial assessment, Waikato DHB anticipates that the standard will not have a material effect on the Waikato DHB's financial statements.

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant and equipment into the impairment accounting standards. Previously, only property, plant and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of-asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements with early adoption permitted. The timing of the Waikato DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

Service Performance Reporting

In November 2017, the XRB issued PBE FRS48, a new standard for Service Performance Reporting. PBE FRS48 is effective for periods beginning on or after 1 January 2021 with early adoption permitted.

The main components under PBE FRS48 are information to be reported, presentation, comparative information and consistency of reporting, and disclosure of judgements.

The Waikato DHB plans to apply this standard in preparing its 30 June 2022 financial statements. The Waikato DHB and group has not yet assessed the effects of the new standard.

Summary of significant accounting policies

Subsidiaries

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

Associates

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

Financial statements include Waikato DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence begins until the date that significant influence ceases.

Joint ventures

Joint ventures are those entities over whose activities Waikato DHB has joint control, established by contractual agreement.

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 Waikato DHB's budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Waikato DHB in preparing financial statements.

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 (MoH) population-based revenue

Waikato DHB is primarily funded through revenue received from MoH, 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 MoH is recognised as revenue when earned. The fair value of revenue from MoH has been determined to be equivalent to the amounts due in the funding arrangements.

Ministry of Health (MoH) contract revenue

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contracts. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of the revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Revenue from other district health boards

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of services

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

Grants received
Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the 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. Volunteer services received are not recognised as revenue or expenses.

Vested or donated assets
For assets received for no or nominal consideration, the asset is recognised at its fair value when the group obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

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

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

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.

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 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, deposits held at call with banks, other short term highly liquid investments and bank overdrafts. Bank overdrafts are presented in current liabilities in the statement of financial position.

Financial assets recognised subject to restrictions
Included in cash and cash equivalents and investments are unspent funds with restrictions that relate to the delivery of health services by the DHB.

Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions.

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 group will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Derivative financial instruments

Derivative financial instruments are used to manage exposure to foreign exchange risk arising from the group's operational activities. The group does not hold or issue financial instruments for trading purposes. The group has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently remeasured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

Forward foreign exchange derivatives are classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives is classified as non-current.

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 or from cost to net realisable value 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 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

Class of asset	Estimated life	Depreciation rate
Buildings	3- 85 years	1.2 – 33.3%
Plant, equipment and vehicles	2 - 35 years	2.5 – 50.0%

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:

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.

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.

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. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset. Costs associated with developing and maintaining the Waikato DHB's website are recognised as an expense when incurred.

Information technology shared services rights

The Waikato DHB has provided funding for the development of information technology (IT) shared

services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the Waikato DHB's capital investment.

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 intangible assets

The same approach applies to the impairment of intangible assets as to property, plant and equipment, except for intangible assets that are still under development. Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

Trade and other payables

Short term payables are recorded at their face value.

Borrowings

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

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

Finance Leases

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 item 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 over 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 the group 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.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within twelve months after the end of the period in which the employee renders the related service are measured 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

The group makes employer contributions to the DBP Contributors Scheme (the scheme), which is managed

by the board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

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.

ACC Partnership Programme

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date. Consideration is given to anticipated future employee remuneration levels and history of employee claims and injuries. Expected future payments are discounted using market yields on 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.

Investment in associate

The group's associate investment is accounted for using the equity method. Associates are those entities in which Waikato DHB has significant influence, but not control, over the financial and operating policies.

Investment in Joint Venture

Joint ventures are those entities over whose activities Waikato DHB has joint control, established by contractual agreement.

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- Crown equity;
- accumulated surpluses/(deficits);
- property 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 unrestricted 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. Other indirect costs are assigned to outputs based on responsibility centre.

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 financial statements, the Board makes 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

The significant assumptions applied in determining the fair value of land and buildings are as follows:

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the unencumbered land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensively.

Restrictions on Waikato DHB's ability to sell land would normally not impair the value of land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

Buildings:

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.

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.

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor is determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Two discount rates for retirement and long service leave are used together with a salary inflation factor.

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.