WAIKATO DISTRICT HEALTH BOARD

Agenda

Board

Date: 25 October 2017

Time: 1.30pm

Place: Conference Room
Kururau Road
TAUMARUNUI

DISTRIBUTION

Board Members (1 copy each)

- Mr B Simcock (Chair)
- Ms S Webb (Deputy Chair)
- Ms S Christie
- Ms C Beavis
- Mr M Gallagher
- Mrs MA Gill
- Ms T Hodges
- Mr D Macpherson
- Mrs P Mahood
- Ms S Mariu
- Dr C Wade

Executive Management Team

- Mr D Wright, Interim Chief Executive
- Mr N Hablous, Chief of Staff
- Mr B Paradine, Executive Director, Waikato Hospital Services
- Ms M Chrystall, Executive Director, Corporate Services
- Mr D Hackett, Executive Director, Virtual Care and Innovation
- Mrs S Hayward, Director of Nursing & Midwifery
- Ms L Elliott, Executive Director, Maori Health
- Dr T Watson, Chief Medical Advisor
- Mr I Wolstencroft, Executive Director, Strategic Projects
- Ms J Wilson, Executive Director, Strategy and Funding
- Dr D Tomic, Clinical Director, Primary and Integrated Care
- Mrs V Aitkens, Acting Executive Director, Mental Health & Addictions Service
- Mr M Spittal, Executive Director, Community & Clinical Support
- Ms M Neville, Director, Quality & Patient Safety
- Ms L Aydon, Executive Director, Public and Organisational Affairs
- Ms T Maloney, Commissioner, Women's Health Transformation Taskforce
- Prof R Lawrenson, Clinical Director, Strategy and Funding
- Mr C Cardwell, Executive Director, Facilities and Business
- Mr M ter Beek, Executive Director, Operations and Performance
- Mr P Mayes, Ministry of Health
- Minute Secretary
- Board Records

Contact Details:
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www.waikatodhb.health.nz
Next Meeting Date: 22 November 2017

Meeting of the Waikato District Health Board
to be held on Wednesday 25 October 2017
commencing at 1.30pm at Taumarunui Hospital

AGENDA

Note: Board members only session will be held at 1pm

Item

1. Apologies

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

3. **MINUTES AND BOARD MATTERS**
- 3.1 Board Minutes: 27 September 2017
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 5 October 2017
  - 3.2.2 Maori Strategic Committee: 18 October 2017
  - 3.2.3 Performance Monitoring Committee: 11 October 2017
  - 3.2.4 Health Strategy Committee: 11 October 2017

4. **INTERIM CHIEF EXECUTIVE REPORT**

5. **QUALITY AND SAFETY**
- 5.1 No report

6. **DECISION REPORTS**
- 6.1 Smokefree Policy

7. **FINANCE MONITORING**
- 7.1 Finance Report
- 7.2 Creating our Futures Programme – Indicative Business Case

8. **PRESENTATION**
No presentations this month

9. **PAPERS FOR INFORMATION**
- 9.1 Health Targets
- 9.2 Provider Arm Key Performance Dashboard
- 9.3 Prevocational Medical Training Accreditation

10. **NEXT MEETING: 23 November 2017**

RESOLUTION TO EXCLUDE THE PUBLIC

NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

THAT:

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

Item 11: Minutes – Various
- **(i) Waikato District Health Board for confirmation: Wednesday 27 September 2017 (Items taken with the public excluded)**
- **(ii) Waikato District Health Board Special Meeting for confirmation: Thursday,5 October**
- **(iii) Waikato District Health Board Special Meeting for confirmation: Friday 13 October 2017**
- **(iv) Health Strategy Committee – to be adopted: Wednesday 11 October 2017 (Item 13)**
- **(v) Performance Monitoring Committee – to be adopted: Wednesday 11 October 2017 (Items 14-15)**

Item 12: Risk Register
Item 13: Annual Financial Statements
Item 14: 2017-18 Long Term Financial Model and Capital Budget
Item 15: Nutrition and Food Management System
Item 16 Planned Caesarean Section Theatre
Item 17: Provider Concern
Item 18: Appointment to Waikato DHB Statutory Committees
Item 19: Provider Request

(2) The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 11(i-iv): Minutes		Items to be adopted / confirmed / received were taken with the public excluded
Item 12:	Risk Register	Avoid inhibiting staff advice about organisational risks
Item 13:	Annual Financial Statements	Negotiation will be required
Item 14:	2017-18 Long Term Financial Model and Capital Budget	Negotiation will be required
Item 15:	Nutrition and Food Management System – Public Excluded	Negotiation will be required
Item 16:	Planned Caesarean Section Theatre– Public Excluded	Protect the privacy of a natural person
Item 17:	Provider Concern – Public Excluded	Negotiation will be required
Item 18:	Appointment to Waikato DHB Statutory Committees	Protect the privacy of a natural person
Item 19:	Provider Request	Negotiation will be required

(3) This resolution is made in reliance on Clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official

Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public are as follows:

Item 11:	**As shown on resolution to exclude the public in minutes.**
Item 12:	**Section 9(2)(c) of the Official Information Act 1982 – To avoid prejudice to measures protecting the health or safety of members of the public.**
Item 13-16:	**Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**
Item 16:	**Section 9(2)(a) of the Official Information Act 1982 – To protect the privacy of natural persons.**
Item 17:	**Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**
Item 18:	**Section 9(2)(a) of the Official Information Act 1982 – To protect the privacy of natural persons.**
Item 19:	**Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

Item

11. MINUTES – PUBLIC EXCLUDED

- 11.1 Waikato District Health Board: 27 September 2017
  To be confirmed: Items taken with the public excluded
- 11.2 Waikato District Health Board Special Meeting: 5 October 2017
  To be confirmed: All items
- 11.3 Waikato District Health Board: 13 October 2017
  To be confirmed: All items
- 11.4 Health Strategy Committee: 11 October 2017
  To be adopted: Items taken with the public excluded
- 11.5 Performance Monitoring Committee: 11 October 2017
  To be adopted: Items taken with the public excluded

12. RISK REGISTER – PUBLIC EXCLUDED

13. ANNUAL FINANCIAL STATEMENTS— PUBLIC EXCLUDED

14. 2017/18 LONG TERM FINANCIAL MODEL AND CAPITAL BUDGET

15. NUTRITION AND FOOD MANAGEMENT SYSTEM

16. PLANNED CAESAREAN SECTION THEATRE

17. PROVIDER CONCERN

18. APPOINTMENT TO WAIKATO DHB STATUTORY COMMITTEE

19. PROVIDER REQUEST

<u>RE-ADMITTANCE OF THE PUBLIC</u>

THAT:

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

Apologies.

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO OCTOBER 2017

Bob Simcock

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Chair, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Member, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Chairman, Orchestras	TBA	TBA	
Member, Waikato Regional Council	Pecuniary	Perceived	
Director, Rotoroa LLC	TBA	TBA	
Trustee, RM & AI Simcock Family Trust	TBA	TBA	
Wife is Trustee of Child Matters, Trustee Life Unlimited which holds contracts with the DHB, Member of Governance Group for National Child Health Information Programme, Member of Waikato Child and Youth Mortality Review Group	Pecuniary	Potential	

Sally Webb

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

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

Crystal Beavis

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

Sally Christie

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Partner, employee of Workwise	Pecuniary	Potential	

Martin Gallagher

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

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

Mary Anne Gill

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Life Unlimited Charitable Trust	Pecuniary	Perceived	
Son is an employee of Hongkong and Shanghai Banking Corp Ltd (NZ)	Non-Pecuniary		
Member, Public Health Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Disability Support Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Health Strategic Committee, Bay of Plenty DHB	Pecuniary	Potential	

Tania Hodges

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	
Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None	
Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None	
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None	
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None	

Dave Macpherson

Interest	Nature of Interest (Pecuniary/Non-Pecuniary)	Type of Conflict (Actual/Potential/Perceived/None)	Mitigating Actions (Agreed approach to manage Risks)
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Councillor, Hamilton City Council	Pecuniary	Perceived	

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

Interest	Nature of Interest	Type of Conflict	Mitigating Actions
Deputy Chair, Western Community Centre, Inc	Non-pecuniary	Potential	
Partner is Chair of Ngaruawahia Community House, Inc	Non-pecuniary	Potential	
Member, Waikato Regional Transport Committee	Non-pecuniary	Potential	
Member, Waikato Water Study Governance Group	Non-pecuniary	None	
Member, Future Proof Joint Council Committee	Non-pecuniary	None	

Pippa Mahood

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

Sharon Mariu

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived	
Director/Shareholder, Asher Group Ltd	Pecuniary	Perceived	
Director, Hautu-Rangipo Whenua Ltd	Pecuniary	Perceived	
Owner, Chartered Accountant in Public Practice	Pecuniary	Perceived	
Daughter is an employee of Puna Chambers Law Firm, Hamilton	Non-Pecuniary	Potential	
Daughter is an employee of Deloitte, Hamilton	Non-Pecuniary	Potential	

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

Clyde Wade

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

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

Conflicts related to items on the agenda.

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Board Meeting
held on Wednesday 27 September 2017 commencing at 2.30pm in the Board Room, Hockin Building at Waikato Hospital

Present:

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

In Attendance:

Mr N Hablous (Acting Chief Executive)
Mr B Paradine (Executive Director, Waikato Hospital Services)
Ms M Chrystall (Executive Director, Corporate Services)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Mrs J Wilson (Executive Director, Strategy and Funding)
Ms L Elliott (Executive Director, Maori Health)
Mr D Wright (Executive Director, Mental Health and Addictions Service)
Mr M Spittal (Executive Director, Community and Clinical Support)
Mr A McCurdie (Chief Financial Officer)
Mr M ter Beek (Executive Director, Operations and Performance)
Prof R Lawrenson (Clinical Director, Strategy and Funding)

ITEM 1: APOLOGIES FOR ABSENCE

There were no apologies for absence.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

No conflicts of interest were foreshadowed in respect of items on the current agenda. There would be an opportunity at the beginning of each item for members to declare their conflicts of interest.

DRAFT

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 23 August 2017

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 23 August 2017 taken with the public present were confirmed as a true and accurate record.

3.2 Committee Meeting Minutes

3.2.1 Iwi Maori Council: 7 September 2017

Resolved
THAT
The Board noted the minutes of this meeting.

ITEM 4: CHIEF EXECUTIVE REPORT

Mr N Hablous presented this agenda item.
The report was taken as read.

Of note:

RANZCOG Visit

- The Women's Health service received a visit from RANZCOG on 11 September 2017 to assess progress made with the transformation work and to the RANZCOG accreditation standards. The feedback received from the Chair of New Zealand Training Accreditation Committee was extremely promising. An official accreditation review had been requested to have the service reaccredited.
- The Board acknowledged the progress made in Women's Health Services and passed on their congratulations to management.
- Arrangements would be made for Board members to visit the Women's Health Unit.

Nurse Entry to Practice Programme (NETP)

- The DHB aims to have at least 124 NEPT per year. This number would increase if the services were able to absorb them and extra funding was made available.
- 95% of trainees are retained in permanent roles.

DRAFT

- Waikato DHB employs nine nurse practitioners in neonatal, chronic conditions, wound care, Mental Health and Addictions Service and Aged Care.

- Six nurses are on the pathway with a focus on the "chronic conditions and lifestyle disease".

SmartHealth

The Chair reported that he had been contacted by Dr Lance O'Sullivan, a GP from Northland. Dr O'Sullivan had offered to provide a paper setting out his view of virtual healthcare. The Chair will bring that paper to the Board for discussion when he receives it.

Waikato Medical School

- The Chair had a meeting planned with Neil Quigley on 29 September 2017.

- Board members asked that if and when appropriate the NZ First Party be informed of what is being proposed by Waikato DHB and the University of Waikato to address the shortage of rural GPs.

Resolved
THAT
The Board:
Received the report.

ITEM 5: QUALITY AND SAFETY REPORT

5.1 Serious Event Reporting

Mo Neville attended for this agenda item.
This report outlined the current reporting process for serious events with the Waikato DHB. It was noted that SAC1 events would be provided to the Board on the following basis:

- Events would be reported once their rating had been confirmed.
- On publication of the final report via SER panel, an update would include root cause (if found) contributory factors, and learnings.
- Events would remain open/reported until all recommendations had been completed.
- Other ongoing processes/reviews such as HDC/Coroners would be noted.
- Any external report received by the DHB for these events would be noted and any discrepancy with findings flagged.

This reporting process would be reviewed again by the Board in 3-6 months.

Resolved
THAT
The Board:

1) Noted the content of the paper
2) Adopted the approach for reporting serious events.

ITEM 6: DECISION REPORTS

6.1 Strategy Implementation

Mr N Hablous presented this agenda item.
The implementation of the new strategy had been reviewed to:

- make the process less administratively burdensome;
- give priority to actioning the plan to address Maori inequality; and
- specifically align the process with the development of the Long Term Investment Plan (LTIP) required by Treasury in 2019

The Executive Group had given their support to this proposed.

Resolved
THAT
The approach to implementation of the strategy was adopted by the Board.

6.2 2017-18 Operating Budget

Ms M Chrystall and Mr A McCurdie attended for this agenda item.
Approval was sought for the 2017-18 budget for Waikato DHB.

The risks highlighted in the report were discussed.

The Chair commented that the DHB must operate in a financially responsible manner and within the governing legislation that applies to it:

- Crown Entities Act 2004 (section 51); and
- New Zealand Public Health and Disability Act 2000 (section 41)

Waikato DHB must not contravene those acts. The budgets set must allow the DHB to 'live within its means'.

The Ministry of Health is unlikely to accept any deficit budget or projection.

The Board approved the operating budget subject to the addition of a 4th point being added to the resolution that the DHB write to the MOH asking them to recognise the depreciation cost of approximately $10 million which cannot be absorbed within this year's budget

Resolved
THAT
1) The Board received this report.
2) Approves the operating budget with a result of a $481k deficit. Noting the risk that any worse results were unlikely to be acceptable to the Ministry.

DRAFT

3) Noted the capital budget allocation of $55.1m and that the detailed capital budget would be brought to the Board for approval in October and that specific business case approvals would be brought to the Board when required under the Delegated Authority Policy.
4) That the DHB write to the MOH asking them to recognise the depreciation cost of approximately $10 million which cannot be absorbed within this year's budget and that it presents a $10m deficit budget.

Mr D Macpherson, wished for it to be noted that he was opposed to Point 2 of the resolution.

ITEM 7: FINANCE MONITORING

Andrew McCurdie attended for this agenda item.
The Chief Financial Officer asked that his report for the month of August 2017 be taken as read highlighting the following:

- The provider was unfavourable to provisional budget mainly due to two variances:
  - Depreciation on re-valuation of land and buildings ($1.9m) and Capital charge ($1.8m – partly recovered in revenue received $1.6m)
  - Pay equity settlement for workers in aged and disability residential care and home support services ($2.4)
- Funder results were $1.7 favourable to provisional budget. Partially due to the coding catch-up and low than planned elective cases

Resolved
THAT
The financial statements of the Waikato DHB for the month to 31 August 2017 were received.

ITEM 8: PRESENTATIONS

There were no presentations this month.

ITEM 9: PAPERS FOR INFORMATION

9.1 Prevocational Medical Training Accreditation

Ms T Maloney attended for this agenda item.
The paper was taken as read

The Medical Council of New Zealand (MCNZ) conducted a review of the Waikato DHB prevocational medical training (on 1 and 2 August 2017). The review assessed the DHB against 22 sets of standards. It was noted that the following standards were not met:

- Training programme governance;
- Medical workload issues;
- Clinical task management;
- Intern welfare;

DRAFT

- Education resources.

The draft report specified 12 required actions and one recommendation. The DHB had six months to demonstrate significant progress on meeting those standards.

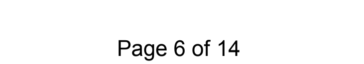
Resolved
THAT
The Board received the report.

ITEM 10: NEXT MEETING

Date of Next Meeting

The next meeting to be held on Wednesday 25 October 2017 commencing at 10.30am at Taumarunui hospital.

DRAFT



BOARD MINUTES OF 28 SEPTEMBER 2017

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

THAT:

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

Item 11: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 23 August 2017 (Items taken with the public excluded)**
- **(ii) Sustainability Advisory Committee – Wednesday 23 August 2017 – (All Items) to be adopted**
- **(iii) Audit and Corporate Risk Committee – Wednesday 23 August 2017 – (All Items) to be adopted**
- **(iv) Midland Regional Governance Group – Friday 1 September 2017 – (All items) to be received**

Item 12: Risk Register Report – Public Excluded
Item 13: Serious Event Debrief – Public Excluded
Item 14: Year End Matters including Draft Annual Report - Public Excluded
Item 15: Cleaning Services for Waikato DHB – Public Excluded
Item 16: Commercial Arrangement for Third Party Logistics Services – Public Excluded
Item 17: National Oracle Solution Change Control Report - Public Excluded

(2) The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 11 (i-iv): Minutes	Items to be adopted/ confirmed/ received were taken with the public excluded
Item 12: Risk Register Report	Negotiations will be required
Item 13: Serious Event Debrief	Negotiations will be required
Item 14: Year End Matters including Draft Annual Report	Negotiations will be required
Item 15: Cleaning Services for Waikato DHB	Negotiations will be required
Item 16: Commercial Arrangement for Third Party Logistics Services	Negotiations will be required
Item 17: National Oracle Solution Change Control Report	Negotiations will be required

(3) This resolution is made in reliance on Clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official

Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public are as follows:

Item 11:	**As shown on resolution to exclude the public in minutes.**
Item 12 - 17	**Section(9)(2)(j) of the Official Information Act 1982 – to enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

RE-ADMITTANCE OF THE PUBLIC

Resolved
THAT

1) **The Public be re-admitted.**
2) **The Executive be delegated authority after the meeting to determine which items should be made publicly available for the purposes of publicity or implementation.**

Chairperson: ________________________________

Date: ________________________________

Meeting Closed: 17:30

DRAFT

ACTION LIST

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

	ACTION	BY	WHEN
1	Update on Project Energize	Julie Wilson	ASAP
2	Organise for Board Members to visit the Women's Health Services Unit	Tanya Maloney/Donna Straiton	ASAP
3	Organise for Board Members to visit the new buildings on Gallagher Drive.	Maureen Chrystall/Donna Straiton	ASAP

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Maori Council

Held on Thursday 5th October 2017 at 9am
Venue: Board Room Hockin Building, Waikato Hospital.

Present:

Mr H Mikaere (Chair)	Hauraki Māori Trust Board
Mr T Sewell	Te Rūnanga o Kirikiriroa
Dr K McClintock	Waikato Tainui Te Whakakitenga o Waikato Inc
Ms T Thompson-Evans	Waikato Tainui Te Whakakitenga o Waikato Inc
Ms T Moxon	Te Runanga o Kirikiriroa
Mr G Tupuhi	Hauraki Māori Trust Board
Ms K Hodge	Raukawa Charitable Trust
Ms K Grosman	Tuwharetoa Māori Trust Board
Ms G Roberts	Kaumātua Kaunihera Representative

In Attendance:

Ms L Elliott	(Executive Director of Māori Health)
Matua H Curtis	(Pou Herenga Te Puna Oranga)
Mrs N Barrett	(Minute taker)

In attendance: Dr Derek Wright, Ms Virginia Endre, Ms Millie Berryman, Ms Vicki Alkington, Ms Jennifer Ashman

DRAFT

(Following items are in order of appearance)

AGENDA ITEM 1 KARAKIA: Matua Hemi Curtis

AGENDA ITEM 2 MIHI: Mr H Mikaere

AGENDA ITEM 3 APOLOGIES
Ms J Eketone
Mr B Bryan
Mr T Bell
Ms T Hodges

Action 1: Whanganui has not been attending IMC hui for a while, Ms Elliott to touch base with them to see what the relationship looks like.

Received by: Ms Hodge
Seconded by: Ms Moxon

AGENDA ITEM 4A MINUTES OF LAST MEETING
Typos on page 1.

Action 2: Ms Elliott will ensure ethnicity data presented at PMC and HSC are brought to IMC.

Minutes passed
Received by: Dr McClintock
Seconded by: Ms Moxon

AGENDA ITEM 4B MATTERS ARISING FROM LAST MEETING

- Mrs Baker would like to keep in contact with IMC

- Te Puna Oranga are bringing on board two positions that will support the strategic vision. First position is Research and second position is

Matters passed
Received by: Mr Tupuhi
Seconded by: Ms Thompson-Evans

AGENDA ITEM 5 GOVERNANCE

Māori Strategic Committee
Hui scheduled for September was cancelled and postponed until October.

There is a refresh of the Waikato DHB strategy priority plans to have the key focus on the first four priorities. The other priorities are to feed into the top four priorities.

Performance Monitoring Committee

Health Strategic Committee
Health Strategy Committee hui is next week but an agenda has not been set.

Workshop creating our future- model of care.
Dr Derek Wright, Ms Virginia Endre

Advice and guidance was sought from IMC.
Outcome- IMC can connect MH with appropriate consumer groups in the community.

Action 3: Ms L. Elliott to coordinate contact details between IMC members from representative areas- Tokoroa, Taumarunui, Thames.

Action 4: Ms L Elliott to follow up with Mental Health team that IMC would like to see the Model of Care business case before it goes to Ministry of Health and Treasury.

Hui Closed: Matua Hemi Curtis.

DRAFT

Next IMC Hui: 9.30am 2nd November 2017

Full Action List		**Completed**
1.	Whanganui has not been attending IMC hui for a while, Ms Elliott to touch base with them to see what the relationship looks like.	
2.	Ms L Elliott will ensure ethnicity data presented at PMC and HSC are brought to IMC.	
3.	Ms L. Elliott to send contact details of IMC members from representative areas- Tokoroa, Taumarunui, Thames, to Mental Health Team.	
4.	Ms L Elliott to follow up with Mental Health team that IMC would like to see the Model of Care business case before it goes to Ministry of Health and Treasury.	

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Maori Strategic Committee held on Wednesday 18 October 2017 commencing at 10:00am in the Kotahitanga Room, KPMG Building level 9

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

In Attendance:
Ms L Elliott
Mr I Tamaki-Takarei
Ms S Hayward
Mr D Hackett
Mr N Hablous
Prof R Lawrenson
Mr M Spittal
Dr N Scott
Ms J Wilson
Mr C Holdaway
Ms E Severne
Dr Jade Tamatea
Mrs R Walker (Minutes)

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Mr I Tamaki-Takarei.

Ms T Hodges welcomed all attendees.

Attendees each gave a brief whanaungatanga.

ITEM 2: APOLOGIES

Apologies were received from Ms J Eketone and Bob Simcock.

ITEM 3: WORKSHOP

3.1 If we as the Waikato DHB are serious about making radical improvements in Maori health, what's possible and how can we do it now and in 12 months?

Ms T Hodges facilitated a workshop with specific emphasis on the hospital services where attendees came up with ideas of how to make radical improvements in Maori health within the following parameters:

- Contributes to radical improvements for Maori
- Within current resources
- What we as the DHB can do, not others
- Achievable
- Measurable
- Stretching
- Maybe across hospital or in a specific area.

Three key ideas were chosen for further work up which occurred initially during the meeting, and attendees indicated whether they are available for assisting with the progression of these ideas further beyond the meeting. The three ideas are:

- Improving attendance at clinical appointments
- Maori Health Plans to be developed for every ward / service at Waikato Hospitals
- Implementation of a navigator service for Māori aged 18 years+ who are admitted to hospital more than 2 times in the last 6-12 months to reduce fragmentation of chronic disease management.

ITEM 4: FUTURE PROGRAMMES OF WORK

Deferred until next meeting.

ITEM 5: MINUTES OF PREVIOUS MEETING:

Deferred until next meeting.

ITEM 6: GENERAL BUSINESS:

No discussion held.

ITEM 7: DATES FOR 2018

- 14 February 2018
- 14 March 2018
- 18 April 2018
- 16 May 2018
- 20 June 2018
- 18 July 2018
- 15 August 2018
- 19 September 2018
- 17 October 2018
- 14 November 2018

ITEM 8: NEXT MEETING

8.1 Date of Next Meeting

Wednesday 15 November 2017

ITEM 9: KARAKIA WHAKAMUTUNA

Karakia by Mr I Tamaki-Takarei.

Chairperson: ________________________________

Date: ________________________________

Meeting closed at 11:58am

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Performance Monitoring Committee Meeting Held on Wednesday 11 October 2017 Commencing at 8:30am

Present:

Ms S Christie (Chair)
Ms C Beavis (Deputy Chair)
Mr M Gallagher
Mrs MA Gill
Dr K McClintock
Mr D Macpherson
Ms A Rolleston
Mr B Simcock
Ms S Webb

In Attendance:

Mr B Paradine (Executive Director Waikato Hospital Services)
Mr M Spittal (Executive Director Community & Clinical Services)
Mr D Wright (Executive Director Mental Health & Addictions Service
Ms B Garbutt (Director Older Persons Rehabilitation and Allied)
Ms C Coles (Service Manager, Oncology, Emergency and Ambulatory Services)
Ms C Nolan (Director, Surgery, CCTVS, Care & Theatre)
Ms M Sutherland (Director Women's and Children)
Ms M Neville (Director Quality and Patient Safety)
Mr G King (Director, Information Services)
Ms J Wilson (Executive Director Strategy and Funding)
Mr A McCurdie (Chief Financial Officer)
Ms S Hayward (Chief Nurse and Midwifery Officer)
Mr L Wilson (Manager, Allied Health)
Mr N Hablous (Chief of Staff)
Mr C Wade (Chair Health Strategy Committee)
Mr G Peploe (Director People and Performance)
Ms K Hugill (Planning Manager, Strategy and Funding)

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

ITEM 1: APOLOGIES

Ms A Morrison has tendered her resignation from the Committee which has been formally accepted.

Ms C Rankin will be put forward for nomination to the Performance Monitoring Committee at the December Board meeting.

ITEM 2: INTERESTS

2.1 Schedule of Interests
No changes.

2.2 Conflicts Related to Items on the Agenda
No conflicts of interest.

ITEM 3: MINUTES AND MATTERS ARISING

3.1 Performance Monitoring Committee Meeting: 9 August 2017

Resolved
THAT
The Performance Monitoring Committee meeting minutes on 11 August 2017 are confirmed as true and correct.

3.2 Bay of Plenty DHB – Hospital Advisory Committee: 5 July 2017
Minutes were noted.

3.3 Lakes DHB – Hospital Advisory Committee: 28 August 2017
Minutes were noted.

ITEM 4: SYSTEM LEVEL MEASURES

4.1 Developmental System Level Measures
Ms J Wilson and Ms Kathryn Hugill presented this agenda item.

Babies living in smoke free households
A smoke free household is classified as no person living in the house identifying as a smoker. The committee thoroughly discussed the issue of smoking, and emphasized the importance of smoke free households and communities. There will be more discussion when the smoking cessation report from Midland Health Network is presented at the December PMC meeting.

Self-Harm
The committee discussed the Service Level Measures (SLM) that the Ministry of Health has put forward. The Committee noted they would like more information on what other districts and DHB are focusing on, so findings and trends can be shared.

The Committee would like the reporting on smoking and self-harm to continue.

Resolved
THAT
The Committee approves the two developmental System Level Measure Plans for submission to the Ministry of Health.

ITEM 5: OPERATIONS AND PERFORMANCE

5.1 Operations and Performance Report
Mr M ter Beek presented this agenda item.

Service Development work
Implementation of the SAFER project is showing promising results and is well received by staff.

National patient flow
Struggling to recruit for a Business analyst for the National Patient Flow, this will impact the project. The Rapid Improvement Event (RIE) will be held on 25-27 October.

The Committee would like to see the “Towards a learning organisation” Strategy paper.

Resolved
THAT
The Committee received the report.

ITEM 6: SERVICES

6.1 Community and Clinical Support
Mr M Spittal presented this agenda item.

There was discussion on the areas of health which are contributing to unplanned presentations in the Emergency Department (ED).

Areas highlighted:

- ED presentations are declining in Taumarunui, and so is the population. There is more focus on planned care.
- Tokoroa and Thames are struggling with ED presentations as there is a shortage of General Practitioners.

Waikato DHB is interested in working with rural communities to address and solve these issues. Waikato DHB is currently in talks with communities and practitioners in these areas.

Smoke-free approaches
Fencing off common smoking areas has begun and there are plans to have new signs around the campus that encourage people not to smoke. Nicotine Replacement Therapy (NRT) will be readily available for patients and visitors at all times.

It was noted by the Committee that they would like:

- Further information on the health and improvement team and workflow.
- A review on the continence services.
- Early Childcare Education feedback to be provided at next meeting.

6.2 Mental Health and Addictions

Mr D Wright presented this agenda item.

Areas highlighted:

- Concerns around patient transfers from Auckland putting pressure on more rural areas. Derek is meeting with colleagues at the Auckland District Health Board to discuss transfer options.
- Waiting times over 7-8 weeks are been looked at closely including care after the initial patient assessment is taking place, including regular communication with families.
- The Addictions Comprehensive Health Enhancement Support System (ACHESS) app will be piloted in November, the feedback so far has been extremely positive.
- Relooking at how the service operates in regards to the Infant/Child/Adolescent area. In discussions with NGO's/various partners. Report to be presented on the outcomes.
- Housing – working with the Link Group around the current housing issues in the area.

It was noted that the Henry Bennett Centre proposal will be presented to the Board in October.

6.3 Waikato Hospital Overview Reports

Mr B Paradine introduced Ms C Nolan (Director Surgical and Critical Care), Ms C Coles (Service Manager, Oncology, Emergency and Ambulatory Services), Ms M Sutherland (Director of Women's and Children's Health) and Ms B Garbutt (Director Older Persons & Rehabilitation Service and Allied Health).

Medicine, Oncology, Emergency and Ambulatory Services

Ms C Coles presented this agenda item.

Surgical and Critical Care
Ms C Nolan presented this agenda item.

- The Committee noted they would like to see the paper on ICU patient transfers.

Women's and Children
Ms M Sutherland presented this agenda item.

Areas highlighted:
- The Committee would like to commend the Women's Health Service on the outstanding review from the Royal Australian and New Zealand College of Obstetricians and Gynecologists.
- In December 2017 the Waikato DHB will reach full staffing levels (12 new registrars 8 of whom are senior).
- Currently in discussions with MoH regarding having a case-load model for Maori LMCs.
- The committee noted that they would be interested in receiving a report on waiting times for patients in clinics. This could also lead to a customer survey.

Older Persons Rehabilitation and Allied Health
Ms B Garbutt presented this agenda item.

Child Development Services
Ms B Garbutt presented this agenda item.

- The Committee noted they would like to see the final report on the review of Child Development Services. A tour of the facility will be arranged at a later date.

Resolved
THAT
The Committee received the reports.

ITEM 7: QUALITY

7.1 Quality Report
Ms M Neville presented this agenda item.

Areas highlighted:
- There have been no reported falls or fractures since March, this shows that the steps to eliminate these cases are working effectively.
- The Health and Disability Commission reviews do not mean that the Waikato DHB cannot do internal reviews. Once final reviews are received the Waikato DHB is still in a position to do an internal review if needed.

The Committee noted they would like to see the complaints on a trend graph for future reports.

Resolved
THAT
The Committee received the report.

7.1 Draft Quality Account 2016/2017
Ms M Neville presented this agenda item.

Draft report presented to the Committee. The finalised version will be presented to the Committee, with the report also to be presented to the Board for sign-off before publication.

The Committee noted that this information should be available to the public/staff in a more pro-active manner as it sends a very positive message about what the DHB does.

Resolved
THAT
The Committee received the report.

ITEM 8: FINANCE REPORT

8.1 Finance Report
Mr A McCurdie presented this agenda item.

Areas highlighted:

- Discussions with the Ministry have taken place and a $10m deficit budget has been tabled and will be presented to the new government.
- Work is in process around the Clinical Supplies negative variance and pay equity.

Resolved
THAT
The Committee received the report.

ITEM 9: PEOPLE

9.1 People and Performance Report
Mr G Peploe presented this agenda item.

Areas highlighted:

- The Staff Safety Culture Working Group’s terms of reference (TOR) have been modified to focus on staff safety, wellbeing and engagement. Committee noted that there needs to be Maori representation on the executive sponsors and/or membership group.

- A staff survey will be undertaken by 10 different health boards in April/May next year.
- Electronic onboarding will go live in November, which will significantly speed up the recruitment process and onboarding experience for new starters.

Resolved
THAT
The Committee received the report.

ITEM 10: INFRASTRUCTURE

10.1 Facilities and Business Report due 13 December

ITEM 11: INFORMATION SERVICES

11.1 Information Services Plan Report
Mr G King presented on this agenda item

Areas highlighted:
- Windows 10 - Waikato DHB will be updating within two years. Discussions are currently underway with vendors.
- Disaster Recovery Plan – this will be presented to the Board at the November Board meeting.

Resolved
THAT
The Committee received the report.

ITEM 12: PERFORMANCE OF FUNDED ORGANISATIONS

12.1 No papers

ITEM 13: NEXT MEETING SCHEDULED FOR 13 DECEMBER 2017

PERFORMANCE MONITORING COMMITTEE MINUTES OF 11 OCTOBER 2017

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

THAT

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

Item 14: People and Performance – Public Excluded
Item 15: Performance of Funded Organisations – Public Excluded

(2) **The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:**

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 14: People and Performance Report	Negotiations will be required
Item 15: Performance of Funded Organisations	Negotiations will be required

(3) **This resolution is made in reliance on Clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public are as follows:-**

Item 14: **Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

Item 15: **Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Health Strategy Committee held on 11 October 2017 commencing at 1.15pm

Present:
Mr C Wade (Chair)
Ms T Hodges (Deputy Chair)
Mr B Simcock
Mr D Slone
Ms S Mariu
Mrs P Mahood
Mr F Mhlanga
Ms C Beavis
Mr J McIntosh
Mr R Vigor-Brown
Mr M Arundel
Ms S Webb

In Attendance:
Ms J Wilson, Executive Director, Strategy & Funding
Mr B Paradine, Executive Director, Waikato Hospital Services
Mr D Wright, Executive Director, Mental Health and Addictions Service
Mr M Spittal, Executive Director, Community and Clinical Services
Mr M ter Beek, Executive Director, Operations and Performance
Mr W Skipage, Strategy and Funding
Mr R Webb, Strategy and Funding
Ms D Nelson, Director Integrated Operations Centre
Ms L Aydon, Executive Director, Public and Organisational Affairs
Ms L Elliott, Executive Director, Maori Health
Mrs MA Gill, Waikato DHB Board member
Ms J Hudson, Strategy and Funding
Ms C Petch, Ministry of Health
Ms AM Ruhe, Ministry of Health
Mr M Gallagher, Waikato DHB Board member
Mr A Leaman, Waikato Times
Ms R Poaneki, Strategy and Funding
Ms B Doube, Strategy and Funding
Ms C Simcock, Waikato DHB
Ms F Dibley-Mason, Strategy and Funding
Mr K McHale, Strategy and Funding
Ms S Christie, Waikato DHB Board member
Ms V Endres, Mental Health
Ms S Baker, HealthShare
Mr C Cardwell, Executive Director, Facilities and Business

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

ITEM 1: APOLOGIES

Apologies from Ms TP Thompson-Evans were received. Apologies from Ms S Webb and Mr D Slone for leaving early at 2.45pm.

Resolved
THAT
The apologies were received.

ITEM 2: LATE ITEMS

There were no late items raised at the meeting.

ITEM 3: INTERESTS

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

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

ITEM 4: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved
THAT

1) The minutes of a meeting of the Waikato DHB Health Strategy Committee held on 9 August 2017 be confirmed as a true and correct record.
2) The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 14 August 2017 be noted.
3) The minutes of a meeting of the Bay of Plenty DHB combined Community & Public Health Advisory Committee/ Disability Advisory Service Committee held on 7 June and 6 September 2017 be noted.

ITEM 5: WORKPLAN

5.1 Support for immigrants and refugees with disabilities
Ms AM Ruhe and Ms C Petch attended for this item from the Ministry of Health.

Of note:

- There is a refugee process which is managed through the Mangere Refugee Resettlement Centre.

- The process was agreed two years ago.
- The Red Cross hold the government contract for supporting refugees upon discharge from this centre.
- A case manager is assigned to each refugee.
- Within the first six weeks of resettlement a refugees health needs are assessed. Once needs are assessed and the settlement area is known (within one of the six areas in New Zealand) the case manager makes with the local areas and paperwork is sent.

Of further interest to the Committee was how trauma is dealt with (including children).

Resolved
THAT
Further information detailing the trauma process is presented to the Committee at a future meeting.

5.2 Younger people in resthomes

Ms AM Ruhe from the Ministry of Health attended for this agenda item.

Of note:

- The Needs Assessment and Service Coordination service (NASC) do assessments of young people with disabilities, with placement in resthomes as a last resort when no other options are available in their local area. NASC will then if necessary make a referral to the Ministry for acceptance or decline.
- Patients with intellectual disabilities following drug addiction are not recognised as an identifiable ongoing trend.
- Those without a significant problem who have both disability and other health needs are being looked at between DSS and with Strategy and Funding, this will be reported back at a later date.

Resolved
THAT
Further information detailing younger people without a significant problem will be reported back to the Committee.

5.3 Interpreter Services at Waikato DHB

For Waikato DHB, the authorised interpreters are:

- I-sign for New Zealand Sign Language
- Decypher Hamilton Multicultural Services Trust Interpreter / Translation Services (HMST)
- Language Line (Departonent of Ethnic Affairs) – Mon/Fri 9am-5pm
- Approved Māori interpreters identified by the Kaumatua Kaunihera strategic group

The Interpreter services are not constrained by budget at the Waikato DHB. Consideration to safety and cultural sensitivity is always given.

Draft guidelines have been sent out for review and the Integrated Operations Centre have provided feedback on these on behalf of Waikato DHB

Resolved
THAT
The Committee received the report.

5.4 Understanding our population profile
Mr M Spittal and Mr R Webb attended for this agenda item. A working group was established with members from Population Health, Finance, and Strategy & Funding in order to develop a Locality Framework.

Resolved
THAT
1) The Committee received the report;
2) Option Two is the preferred default option

ITEM 6: STRATEGY AND FUNDING OVERVIEW REPORT

The Strategy and Funding overview report was submitted for the Committee's information.

Key areas included:

Community Health Fora
Ms B Doube attended for this item to discuss the latest round of Community Health Fora. Key issues identified throughout most of the CHFs included:
- Social isolation of older people;
- Homelessness;
- Intellectual disabilities
- Access to GPs (availability and cost)

The Foodbank in Huntly was empty however it is now overflowing following action resulting from discussions at the Huntly CHF. The issues raised were mostly community issues instead of health specific issues. In further updates an overarching statement would be valuable.

System Level Measures Plan
The two remaining measures went to the Performance Monitoring Committee today for approval.

Resolved
THAT
The Committee received the report.

ITEM 7: PAPERS FOR ACTION

7.1 Draft Suicide Prevention and Postvention Plan
Ms C Simcock, Ms J Hudson and Ms M Neville attended for this agenda item. The Suicide Prevention Postvention Coordinator role has been in place for 18 months and progress would not have happened without the role. The appointment of the correct person has been crucial.

Resolved
THAT
The Committee received the report.

ITEM 8: PAPERS FOR INFORMATION

No items for discussion.

ITEM 9: STRATEGIC PROGRAMME PLANS

9.1 eSPACE

Ms S Baker attended for this agenda item. A presentation was given with the key message "One patient, one record".

Of note:

- The roll out is going as expected, with only one issue to date relating to the performance speed
- Lakes DHB is looking to be brought on board with the Midland Clinical Portal as soon as possible however there is no date set for this to occur.

Resolved
THAT
The Committee noted the presentation.

9.2 Mental Health and Addictions Model of Care

Mr D Wright and MS V Endres attended for this agenda item. A presentation was given.

Resolved
THAT
The Committee noted the presentation.

9.3 SmartHealth

No updated at October meeting.

9.4 Rural Project

No updated at October meeting.

9.5 Women's Health Transformation

No updated at October meeting.

9.6 Elective Services Improvement

No updated at October meeting.

9.7 Patient Flow

Mr M ter Beek attended for this agenda item.

A number of initiatives have been completed and changes made to various parts of the patient flow process. Key learnings for the team have been to ensure there is appropriate support and time available in the services to progress project work quickly. A new project approach

using a 3-day workshop format will be trialled in October. This approach, based on Kaizen, has been recognized to work in other organisations where staff time is at a premium and there is difficulty coordinating multi-disciplinary input in problem solving

The current patient flow system is both a written and electronic process.

Resolved
THAT
The Committee received the paper.

9.8 Medical School
No updated at October meeting.

9.9 CBD Accommodation Project
Mr C Cardwell attended for this agenda item.

All works are on track for a hard fit out to commence in February 2018 with a staged occupancy expected from September 2018.

Of note:

- Update in December, 3D flyby/virtual tour
- Estimated carparks? Onsite over 70, 170 in knox street carpark.

Resolved
THAT
1) The Committee received the report;
2) An update with virtual tour to occur at the December Committee meeting.

9.10 Primary Care Integration
Ms J Wilson spoke to this agenda item. Two workshops were held in August 2017 with a range of health care providers. The workshops were facilitated by Mr G Scott. The summary of feedback was provided to the Waikato Inter Alliance group who agreed that a smaller working group would be established to determine the next steps.

Resolved
THAT
The Committee noted the content of the report.

ITEM 10: PRIORITY PROGRAMME PLANS

No updated at the October meeting.

ITEM 11: GENERAL BUSINESS

There were no general business items raised.

ITEM 12: DATE OF NEXT MEETING

13 December 2017

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

THAT:

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

Item 13: Interim arrangements for mental health supported accommodation

(2) **The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:**

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 13:	Interim Arrangements for Mental Health Supported Accommodation	Contract negotiations will be required

(3) **This resolution is made in reliance on Clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public are as follows:**

Item 13: **Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

Chief Executive Report

MEMORANDUM TO THE BOARD
25 OCTOBER 2017

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	1) For information

Alliance Proposal

The Board has previously supported a change to Waikato DHB alliance arrangements and consultation on proposed new arrangements has occurred.

The consultation process needs to be closed off with a formal proposal to the Board. This will occur in November.

Evaluation of HealthTap

The contract by which the Waikato DHB uses HealthTap expires in May 2018.

In order to prepare for decision-making around renewal of the contract it is necessary to undertake a review of where we have got to. We envisage the review being an independent external one.

The Executive Group will be considering draft terms of reference for this review at its meeting on Friday 27 October.

Given the importance of this matter to the Waikato DHB we would like to hold a workshop with the Board on the terms of reference in early November. The reason for doing this outside a normal meeting is that we wish to proceed with this work prior to Xmas and this would be unlikely to occur should the terms of reference not be considered until the end of November. Moreover it is likely that the conversation will be wide-ranging and therefore an informal approach seems desirable.

We envisage a couple of hours would be required.

We would like to discuss possible dates at the Board meeting.

Current financial status

For September 2017 we have a favourable YTD variance to budget of $0.4m. However this result includes $1.2m one off favourable variances so a normalised result is $0.8m unfavourable. Furthermore, the $25m savings plan which contains high risk initiatives is phased in the budget to take effect from October 2017. Thus, the year will be extremely challenging. A great deal of effort is being applied to

forecasting, variance analysis, savings plans and very close monitoring as the year progresses.

ED performance and acute flow

Shorter stays in emergency departments
For September 2017 the Shorter Stays in Emergency Department Health Target performance for Waikato Hospital remained poor at 78.2% compared to 84.4% in September 2016, despite the winter peak subsiding and presentations returning to around the same level as September last year. The reasons for this reduced performance are being investigated. There are a number of encouraging developments in the meantime:

- A new Clinical Director appointed to the Emergency Department;
- Implementation of the ED business case is almost complete, with nursing posts in place, two SMOs having commenced and two more SMOs starting shortly;
- A suite of initiatives to be trialled in the emergency department from 16 – 20 October (detailed in the Health Targets report);
- The opening of the new OPR5 ward in September;
- The SAFER discharge programme rolled out during September and reinforced at a 5 October Grand Round.

A visit and review on 13 October from Dr Peter Jones (the Ministry of Health "Shorter stays in emergency departments" champion) was encouraging regarding our approach to patient flow. A sharp improvement in this indicator should be expected over the next two months.

Theatre performance and ESPIs

In September 60 elective cases or approximately three per working day were cancelled i.e. 5.3%. The rolling target of 2.5% represents an average of one cancellation per day. The *Surgical Services Re-invention Project* is expected to favourably influence process controls and lead to an improvement in this result.

The increased day time acute capacity that has recently been scheduled is underlying a favourable change to the result in both of the theatre key performance indicators on acute surgery waiting times. The key focus for the theatre team is to maximise the use of the scheduled acute capacity to benefit of the acute and arranged patient groups. Again this is a specific area for improvement in the *Surgical Services Re-invention Project.*

The rolling target of elective and arranged day of surgery admission (DOSA) in September was 75.1% and overall performance is moving toward the desired target of approximately 80% day of surgery admissions. The performance to the Day of Surgery Admission (DOSA) measure is also an agreed area of focus with the *Surgical Re-invention Project.*

Wait list management and ESPI Compliance

ESPI results to end August have been published by the Ministry. It is pleasing to note that we were compliant in ALL ESPIs for the first time in two years. Preliminary internal results for September suggest we will be compliant in ESPI 5, but not for ESPI 2 – see comments below.

ESPI 2 (Outpatients waiting more than four months for assessment)
Due to the number of referrals accepted in May, additional clinics had to be completed by the end of September. Orthopaedics was unable to deliver the required number of clinics and will be non-compliant in September but expect to be compliant again in October. In addition, a specialist resignation in dermatology has caused a backlog that will not be cleared until the end of October.

ESPI 5 (Inpatients waiting more than four months for treatment)
As noted above, we achieved compliance in August and September (on internal results). However, orthopaedics is still the outlier in terms of the number of non-compliant patients and work will continue to reduce this number. This in turn will give the DHB a 'buffer' for unexpected events in other services.

Delivery of elective volumes

Both Ministry results (August) and internal results (September) show that we easily delivered the Health Target.

Results also show our Elective Initiative volumes are on track at a total level. The only concern at this early stage in the year is general surgery, where we must meet a specific volume target (it cannot be 'washed up' against other results). We will need to monitor this service closely.

Electives funding for 17/18
As noted above, at the global level we are delivering on the targets. It is our intention to move the counting of intraocular injections and minor skin lesion removals out of the Electives Initiative and into the Ambulatory Initiative. As long as we can confirm the process is working correctly, this will come into effect for intraocular injections from 1 November 2017. Skin lesion removals will not be affected in the current financial year. This is mainly a counting issue, but does have an effect on our Health Target volumes.

Cardiac waiting list

The cardiac surgery service reports each week to Ministry of Health (MoH) on the wait list status. Since the last week of August the service has reported the number of patient waiting a cardiac surgery or a procedure to be less than maximum waitlist target of 67. The service has worked very hard to improve patient flow and although still early in this period of stable service provision the result demonstrates that Waikato DHB can consistently meet the target.

2018 Meeting Schedule

A draft meeting schedule has been developed for 2018 and is attached for Board members to consider and provide feedback.

Recommendation	1) **THAT:** The Board notes the content of the report/proposal.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

2018 Waikato District Health Board, Committees and Iwi Maori Council Meeting Schedule

Board Monthly 1.30pm **Board only session 1pm-1.30pm**	**Audit & Risk** 3 monthly 10am – 12pm	**Iwi Maori Council** Monthly 9.30am	**Maori Strategic Committee**	**Sustainability Advisory Committee** 9am or 1pm	**Performance Monitoring Committee** 2 Monthly 8.30am – Noon	**Health Strategy Committee** 2 Monthly 12.30pm – 4pm	**Waikato Health Trust** Bi Annual 4.00pm
28 Feb	28 Feb	1 Feb	21 Feb	21 Feb	14 Feb	14 Feb	
28 Mar		1 Mar	21 Mar				
24 Apr*		5 Apr	18 Apr	18 Apr	11 Apr	11 Apr	11 Apr
23 May	23 May	3 May	16 May	16 May			
27 Jun		7 Jun	20 Jun		13 Jun	13 Jun	
25 Jul **Thames – timing TBC**		5 Jul	18 Jul	4 Jul			
22 Aug	22 Aug	2 Aug	15 Aug		8 Aug	8 Aug	
26 Sep		6 Sep	19 Sep				
24 Oct **Te Kuiti – timing TBC**		4 Oct	17 Oct		10 Oct	10 Oct	10 Oct
28 Nov	28 Nov	1 Nov	21 Nov				
		6 Dec			12 Dec	12 Dec	

Wednesday 25 April is Anzac Day so Board meeting has been moved to Tuesday 24 April.

Quality and Safety

Quality and Safety: No reports this month.

Decision Reports

MEMORANDUM TO THE BOARD
25 OCTOBER 2017

AGENDA ITEM 6.1

SMOKEFREE POLICY

Purpose	For approval

Introduction

The Waikato DHB Smoke Free policy has expired. The attached draft has been consulted on through the normal policy development process before being submitted to the Board for final consideration.

This is an updated policy based on the Hawkes Bay DHB (HB DHB) smokefree policy. Hawkes Bay developed this policy after they commissioned a research report into all New Zealand DHB smokefree policies. The report made recommendations for a best practice policy which will support the Smokefree New Zealand 2025 goal.

The policy conveys the expectation the Waikato DHB senior management will demonstrate leadership and support the roles and responsibility of staff in relation to tobacco products or electronic cigarettes. It is expected that staff will be smokefree while at work and that all campuses will be smokefree.

In support of the poliy systems to support staff, patients and visitors to achieve the goals of the policy will be refreshed. A key enabler will be the ready availability of nicotine replacement therapy for staff, patients and visitors at all DHB workplaces. All staff who smoke will have access to support to manage tobacco dependency.

Recommendation
THAT
the Smokefree / Tobacco free – Auahi Kore / Tupeka Kore policy be approved.

MARK SPITTAL
EXECUTIVE DIRECTOR – COMMUNITY & CLINICAL SUPPORT

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

Policy Responsibilities and Authorisation

Department Responsible for Policy	Community and Clinical Support
Document Facilitator Name	Kate Dallas
Document Facilitator Title	Waikato DHB Smokefree Coordinator
Document Owner Name	Mark Spittal
Document Owner Title	Executive Director Community and Clinical Support
Target Audience	All DHB staff and services
Committee Approved	Policies and Guidelines Committee
Date Approved	10 August 2017
Committee Endorsed	Executive Group
Date Endorsed	
Committee Endorsed	Waikato DHB Board
Date Endorsed	

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Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

Policy Review History

Version	Updated by	Date Updated	Summary of Changes
06	Kate Dallas		This is an updated policy based on the Hawkes Bay DHB (HB DHB) smokefree policy. HB DHB developed this policy after they commissioned a research report into all New Zealand DHB smokefree policies. The report made recommendations for a best practice policy which will support the Smokefree New Zealand 2025 goal.
			Expectation the Waikato DHB senior management shall demonstrate leadership and support the roles and responsibility of staff in relation to tobacco products or electronic cigarettes
			Expectation that staff will be smokefree while at work and systems will be developed to achieve this.
			All staff who smoke will have access to support to manage tobacco dependency

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

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Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

1. Introduction

1.1 Purpose

To improve, promote and protect present and future health and wellbeing of the Waikato District Health Board (DHB) population from the harms of tobacco consumption and exposure to second-hand smoke through demonstrating commitment and responsibilities in supporting a smokefree / tobacco free lifestyle for all.

To be a leader in health promotion in the community through advocating good health by focusing on achieving equity in reducing tobacco prevalence as smoking rates are a major contributor to inequalities in health status and outcomes in Waikato.

This policy builds on from the government's commitment to a Smokefree New Zealand/Aotearoa 2025 where smoking rates are lower than 5% and smoking will no longer be the norm.

As stated by the Ministry of Health Smokefree 2025 will be achieved by:

- Protecting children from exposure to tobacco marketing and promotion
- Reducing the supply of, and demand for tobacco
- Providing the best possible support for quitting

This Purpose aligns with the Waikato DHB Position Statement 2017, the Public Health Tobacco Strategic Plan 2017/18 and the Waikato DHB Tobacco Control Plan 2017-2020 where priority groups and issues have been identified.

1.2 Scope

This policy applies to all Waikato DHB staff and services including

- Mental Health and Addiction services Inpatient, Forensic and Community Services,
- All general Inpatient and Maternity;
- Health Delivery Services e.g. Outpatient, Community settings
- All service users, visitors, volunteers, contractors, access agreement holders and others working on or accessing Waikato DHB premises
- All contracted service providers.

2. Definitions

Smokefree	The term 'smokefree' in this policy applies to all forms of tobacco or herbal smoking products and electronic cigarettes.
A.B.C.	Clinical interventions for people who smoke; A ascertain smoke status of every patient, B brief advice to be smokefree and C cessation treatment NRT for all smokers and referral if accepted.
DHB premises	This includes all buildings; grounds owned or occupied by the DHB and all DHB vehicles.

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

EAP	Employee Assistance Program; free counselling services with councillors trained nicotine addiction and motivational therapy.
E cigarette	Electronic cigarettes – or e-cigarettes – are electrical devices that mimic real cigarettes by producing a vapour by heating a solution (e-liquid), which the user inhales or vapes. E-liquid is available with or without nicotine, and usually contains propylene glycol and flavouring agents. People who choose to use e-cigarettes (to vape), should aim to stop smoking completely to reduce the harm from smoking. Ideally, people would eventually stop vaping as well.
NRT	Products containing nicotine designed to replace the nicotine from cigarette smoke used when smoking is not permitted
Tupeka Kore	The Waikato District Health Boards Māori Health Service (Te Puna Oranga) tobacco free programme targeting whānau, communities, iwi, hapū and marae encouraging tobacco free lifestyles. See Appendix A – Tupeka Kore for more information

3. Policy Statements

The Waikato DHB smokefree policy is that:

- There will be no smoking or electronic cigarette use by staff, patients/clients, family/whanau, visitors and contractors on any campus.
- This includes all buildings, vehicles and grounds owned or occupied by the DHB.
- Staff will not smoke while on paid Waikato DHB business either onsite or in the community.

4. Background

The Waikato DHB recognises the evidence of harm caused by tobacco:

- Tobacco use is the single largest preventable cause of illness and early death. There are approximately 5,000 deaths each year linked to smoking or second-hand smoke exposure. Smoking is a major risk factor for heart attacks, strokes, chronic obstructive pulmonary disease (including emphysema and chronic bronchitis) and cancer (particularly lung, larynx, mouth and pancreatic). Second-hand smoke is the inhalation of smoke by people other than the intended 'active' smoker and causes many of the same diseases as direct smoking, e.g. cardiovascular, lung cancer and respiratory diseases and causes the death of approximately 300 New Zealand people per year
- Tobacco dependence is a chronic relapsing addictive condition
- Tobacco use is a major determinant of inequality in health in the Waikato region with 17% of adults currently smoking. In adults and youth alike, smoking rates are higher for Māori and Pacific peoples. In the 2013 Census data, 35% of Māori, 24% of Pacific, and 13% of Other adults smoked
- South Waikato, Ruapehu, Waitomo, Hauraki, Otorohanga and Waikato have significantly higher rates than the overall Waikato DHB. The highest prevalence rates

are among females in South Waikato (26%), Ruapehu (25%) and Waitomo (26%). However, in the overall Waikato DHB females have lower rates than males.

- Pregnancy, neonatal, new-born and infant health is negatively affected by exposure to first and second hand tobacco smoke and smoking in pregnancy can be associated with low birth weight, miscarriage or stillbirth. In infants there is a higher risk of Sudden Unexpected Death in Infancy (SUDI) and in children, asthma, respiratory infections and glue ear
- Maternal smoking is more common in the Waikato DHB (17.1%) than in overall NZ (12%). In the Waikato a larger proportion of Māori women smoke during pregnancy in comparison with women of other ethnicities (36.8% Māori vs. European 8.1%, Pacific 6.6%, Indian and Asian 0.29%). The prevalence has only reduced slightly between 2011-2015.The highest rates of maternal smoking are in the Ruapehu, Hauraki and South Waikato areas. However the highest numbers of women smoking during pregnancy are in Hamilton.
- In recognition of the harmful effects of tobacco use, priority groups have been targeted in the Tobacco Control Plan 2017-2020 to address the above issues. The priority groups include Māori who smoke, particularly women across all age groups, pregnant women, people with mental health and addiction issues, certain geographic areas with high deprivation.

5. Processes

5.1 Roles and Responsibilities

Waikato DHB senior management shall support the roles and responsibility of staff in relation to tobacco products or electronic cigarettes which will include:

- Increasing the number of smokefree people in Waikato community through smokefree clinical practice, health promotion and health protection activities. To support these initiatives, all Waikato DHB events will be smokefree (whether or not held on DHB grounds including events sponsored, partnered or funded by the Waikato DHB)
- Demonstrate leadership through role modelling of positive smokefree behaviours and attitudes that can be displayed to each other and to the general public. This also means privately owned vehicles whilst on Waikato DHB grounds will be smokefree
- Being mindful of ‘our boundary neighbours’ and the community that tobacco use is a health risk and is not acceptable in or near a healthcare setting. Therefore groups named in the ‘Scope’ section of this policy shall not use tobacco products or e-cigarettes on any of the Waikato DHB boundary lines
- Waikato DHB, in operating public facilities, will take steps to ensure members of the public especially service users, are not subtly encouraged to initiate smoking, or have cessation attempts undermined, by the presence of visible tobacco products or e-cigarettes or smoking related media. This will mean displaying Smokefree signs in appropriate public areas within all hospitals and all other DHB occupied buildings and ground.

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

- New employees will be screened for tobacco use during the recruitment process, informed of the Waikato DHB Smokefree Policy and provided with information about support available to staff to be smokefree at work. Screening is for the purposes of monitoring tobacco dependence in prospective staff and to ensure that the expectations of this policy are understood before employment. To support this initiative, recruitment policies shall acknowledge this policy on all communication.
- Waikato staff, contractors or volunteers are prohibited from smoking in uniform or attire worn during work (mufti clothing worn to work), or when wearing any item that might associate them with Waikato DHB, e.g. identification badge. Staff, contractors or volunteers who are not smokefree during unpaid break times are expected to change out of their uniform/mufti worn during work hours and wash their hands after tobacco use to minimise exposure of third hand smoke or signs of tobacco use
- No DHB employee will be required to escort patients off DHB grounds for the sole purpose of smoking
- Integration with local and national initiatives to support a smokefree New Zealand/Aotearoa:
  - Te Puna Oranga Tupeka Kore strategy.
  - The government supported vision of a Smokefree Aotearoa by 2025.

Breaches to this policy:

- Visitors - Waikato DHB employees are encouraged to bring this policy to the attention of people who smoke or use their electronic cigarette within the hospital or hospital grounds.
- Waikato DHB employees, security, contractors or volunteers – employees are encouraged to bring the breach to the attention of the staff member's manager or Team Leader
- Should there be significant breaches of this policy, for example continuing to visibly and obviously bring tobacco products onto Waikato DHB sites or continuing to be observed smoking in uniform or attire worn during work etc., then disciplinary action could be taken.
- Managers/Team Leaders have the obligation of ensuring employees are aware of the Smokefree Policy roles and responsibilities at annual performance reviews. In addition those staff that are not smokefree at work will have a Smokefree Health Management Plan in place to be smokefree at work within three months. These staff are offered help to access stop smoking support including Employee Assistance Programme (EAP) and free NRT products to manage their tobacco dependency whilst at work. It is the responsibility of the manager or team leader to ensure that any breaches of this policy by Waikato DHB staff are not repeated.

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

5.2 Smokefree Clinical Practice

In recognition of the chronic relapsing condition of tobacco use and harm of tobacco exposure it is expected that when accessing Waikato DHB services:

- 100% of all adult clients / patients will be screened for tobacco use
- 100% of adult clients / patients who are not smokefree will receive advice to be smokefree and strongly encouraged to utilise stop smoking support (a combination of behavioural support and stop-smoking medicine works best) and offer to help them access it.
- All inpatients that are assessed as nicotine dependent will be assisted in the management of their nicotine dependency through the provision of nicotine replacement therapy on admission and have daily monitoring of nicotine withdrawal.
- 100% of all babies / children of Waikato DHB services will be assessed for smoke exposure
- 100% of whanau / family of babies or children that are smoke exposed will receive interventions that assist families to be smokefree

5.3 Smokefree Education

All Waikato DHB staff shall receive on-going evidence based smokefree education appropriate to their role i.e.

- New staff are informed of Waikato DHB Smokefree policy at orientation
- All health professionals regulated under the Health Practitioners Competence Assurance Act 2003, Medical Students, Nursing and Midwifery Students (3rd year and above) and Allied staff shall complete the Ministry of Health “Helping People to Stop Smoking” e-learning on Ko Awatea and then annually or sooner if the e-learning tool is reviewed.
- All health professionals regulated under the Health Practitioners Competence Assurance Act 2003, Medical and Nursing Students and allied staff in particular those staff working in Mental Health and Addiction services will complete the two modules “Smokefree in Mental Health and Addictions services” on Ko Awatea
- Smokefree education is available each month and on request from the Smokefree Coordinator to ensure 100% of nursing and midwifery; medical and allied health staff receive updated and current smoking cessation and nicotine addiction clinical education

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

5.4 Smokefree / Tobacco Free Staff

- Waikato DHB staff will be able to access smokefree motivational support through EAP and through the Smokefree Coordinator or Health and Safety team, which includes:
  - free provision of monthly Nicotine Replacement Therapy products for the purpose of management of nicotine dependence short term or for long term abstinence using the Quit card system
  - emergency supply of nicotine products at their place of work
  - provision of free smokefree counselling

5.5 Stop Smoking Support

- There will be accessible, appropriate, and sufficient range and volume of community based Stop Smoking Services for the Waikato DHB community. To enable this, Waikato DHB will support the Primary Health Organisation (PHO) contracted to deliver evidenced based, best practice Stop Smoking Services to community, including all PHOs, workplaces and other non-government organisations with the overall aim to achieve Smokefree Aotearoa 2025.
- The Waikato DHB smokefree coordinator will support local and national Stop Smoking Services.
- Waikato DHB will support Smokefree health promotion, regulation and tobacco free initiatives across the district.
- Waikato DHB will work closely with District and Regional Councils to increase the number of smokefree areas; such as sport grounds, cafes, public parks, businesses.
- Waikato DHB will work with District and Regional Councils to reduce the number of tobacco outlets near secondary schools and work towards regulation/ registration of same.

5.6 Smokefree Communications

Waikato DHB will ensure that smokefree strategies are supported with communications, which will include (but not limited to) the following activities:

- adequate smokefree and tobacco free signage on all premises
- smokefree messages on appointment letters and cards
- related guidelines, procedures and standing orders are updated regularly
- stop smoking support resources are readily available
- smokefree policy will be referred to in all job adverts and Position Descriptions
- smokefree messages are integrated into other health messages, media releases and high level communications
- The week leading up to World Smoke free day, May 31st each year the Waikato DHB will further promote the smokefree message in community settings by promoting smoking cessation and outlining support available

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

- The Waikato DHB Smokefree Champions will be supported with current information and education to support clinical practice of ABC; brief advice, treatment to prevent nicotine withdrawal symptoms, offer of referral, promote smokefree lifestyle messages and where to access support to become smokefree, i.e. EAP, local Stop Smoking Services or Quit line
- All staff are encouraged to inform patients/clients and visitors of the Waikato DHB Smokefree Policy, including encouraging people not to bring tobacco products or electronic cigarettes onto the hospital grounds

5.7 Smokefree Waikato DHB Contracts and Employment Agreements

All Waikato DHB clinical contracts, recruitment policies and employment agreements shall include smokefree clauses which include statements relating to:

- This Smokefree Policy
- Clear smokefree leadership from all management and team leaders.
- ABC smokefree clinical practice delivered to all service users
- Smokefree role modelling by staff
- Smokefree education current and available on request
- 100% smokefree environments with no staff exposed to second hand smoke

With the associated indicators applying:

- Smokefree policy
- ABC smokefree tobacco screening and intervention of all service users

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

6. Smokefree Monitoring and Reporting

Waikato DHB will ensure that smokefree initiatives be monitored and reported (ensuring an ethnicity analysis is incorporated). These include (but are not limited to) the following indicators:

- ABC clinical practice
- Waikato DHB tobacco prevalence
- Waikato DHB Smokefree contract clause
- Waikato DHB Smokefree education
- Community Stop Smoking Services
- Health Promotion activities

6.1 Measurement Criteria

1. Smokefree clinical practice – 100% of clients / patients will be screened for tobacco use and those that are not smokefree will receive the appropriate intervention.
2. Waikato DHB Clinical contracts have described clauses and associated indicators in place.
3. Increase in Waikato DHB staff being smokefree.
4. Drop in prevalence of population smoking in next Census 2017/18

7. Legislative Requirements

7.1 Legislation

Meet legal obligations

a) Under the Smokefree Environments Act 1990 (and its amendments in 2003) and The Health and Safety at Work Act 2015.

b) To protect the health and safety of employees and visitors to its workplaces (includes patients/clients and visitors) from the effects of identified hazards which includes second hand smoke.

c) Actively supporting staff, contractors and volunteers to be smokefree through the Smokefree Coordinator, Health and Safety, Quitline or local Stop Smoking Services

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

8. Associated Documents

8.1 Associated Waikato DHB Documents

- The New Zealand Guidelines for Helping People Stop Smoking 2014
- Waikato DHB Smoking Cessation Intervention and Pharmacotherapy procedure (Ref. 4951)
- Waikato DHB Nicotine Replacement Therapy standing order (Ref. 2580)
- Waikato DHB Nicotine Replacement Therapy in in Outpatient Areas guideline (Ref. 1619)
- Prescribing in Smoking Cessation (T1486HWF)
- Waikato DHB Health and Safety policy (Ref. 0044)
- Waikato DHB Hazard Management policy Ref. (0051)
- Waikato DHB Code of Conduct policy (Ref. 5674)
- Waikato DHB Performance Management and Discipline policy (Ref. 5250)
- Waikato DHB Professional Image and Uniform Clothing guideline (Ref. 2723)
- Waikato DHB Vehicle Usage and Safe Driving policy (Ref. 0112)
- Waikato DHB Inter-hospital patient transfers: competencies and standards protocol (Ref. 2742)
- Position Statement: Waikato DHB's Tobacco Control 2017
- Smoke-free Workplaces: A guide to the Smoke-free Environments Act 1990
- New Zealand Health Strategy 2000
- Midlands DHB Smokefree Vision Statement 2009

8.2 References and Further Information

- Government Response to the; Report of the Māori Affairs Committee on its *Inquiry into the Tobacco Industry in Aotearoa and the Consequences of Tobacco Use for Māori* (Final Response) Presented to the House of Representatives in accordance with Standing Order 248, 2011
- New Zealand, Ministry of Health: Maori Smoking and Tobacco Use, 2011
- New Zealand, Ministry of Health: Health Targets: Better Help for Smokers to Quit 2015
- New Zealand, Ministry of Health: New Zealand Guidelines for Helping People to Stop Smoking, 2014
- New Zealand, Ministry of Health: Smoking Cessation Competencies for New Zealand, 2007
- New Zealand, Ministry of Health: Implementing the ABC Approach for Smoking Cessation: Framework and Work Programme, 2009

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

- New Zealand, Ministry of Health: 2012/13: New Zealand Health Survey – Tobacco use in New Zealand, 2014
- New Zealand, Ministry of Health: New Zealand Health Strategy Future Direction 2016
- New Zealand, Prepared by the Ministry of Health: Inquiry into the Tobacco Industry in Aotearoa and the Consequences of Tobacco Use for Maori. Presented to the House of Representatives, Maori Affairs Committee, 2010
- Smoke-free Environments Amendment Act 2003. Retrieved from http://www.legislation.govt.nz/act/public/2003/0127/latest/DLM234940.html?search=qs_act_Smoke-free%20Environments%20Amendment%20Act%202003_resel_25_h&p=1
- U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioural Basis for Smoking-Attributable Disease: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.
- U.S. Department of Health and Human Services. Clinical Practice Guideline: Treating Tobacco Use and Dependence: Public Health Service, 2008.

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

Appendix A Tupeka Kore

TUPEKA KORE
"Tobacco free whanau - a tobacco free world"

Tupeka Kore is the Waikato District Health Boards Māori Health Service (Te Puna Oranga) tobacco free programme targeting whānau, communities, iwi, hapū and marae encouraging tobacco free lifestyles. Tupeka Kore has been endorsed by the Waikato District Health Board Kaumātua Kaunihera and Iwi Māori Council to make a leadership contribution on the war against tobacco use amongst Māori.

One of the most powerful approaches to promoting Tupeka Kore is the process of making Tupeka Kore waahi / spaces. The process is to place a kawenata (covenant) through the use of karakia or prayer on an area / space or service to become Tobacco Free. Once the kawenata has been placed, No tobacco products are allowed within that designated area / space or service.

The concept of making area / spaces or services Tupeka Kore is another tool we can use to promote a smoke free environment. It is about:

1. Supporting the 2025 Smokefree Aotearoa / New Zealand vision
2. Role modelling healthy lifestyle choices
3. Supports auahi kore / smokefree initiatives
4. Aligns with the Waikato DHB Smokefree policy
5. Aligns to the national intent around quit support and smoking cessation
6. Upholds tikanga Māori as a valid and legitimate process in supporting health gain for Māori and non-Māori
7. Encourages service and community leadership
8. Workforce development

It should be noted that the creation of Tupeka Kore waahi is not limited to areas / spaces or services in the Waikato DHB but can also be extended to:

1. Early childhood centres and schools
2. Māori health provider services
3. Community health services
4. Other organisations / services who wish to role model a positive initiative

Tupeka Kore waahi becomes the responsibility of the area / space or service to promote that the covenant that has been placed is upheld and respected. General information about Tupeka Kore will be provided to visitors via signage, meeting material etc. It is not expected that staff will directly confront visitors about their smoking status or whether they are carrying tobacco products.

Should you require any further information please contact Executive Director Māori Health.

Finance Monitoring

MEMORANDUM TO THE BOARD
25 OCTOBER 2017

AGENDA ITEM 7.1

FINANCE REPORT

Purpose	For information.

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

Recommendation
THAT
The report be received.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Group Result for September 2017	Year to Date			Group Budget
	Group Actual $m	Group Budget $m	Variance $m	Jun-18 $m
Funder	2.5	0.9	1.6 F	34.0 F
Governance	0.0	0.0	0.0 F	0.2 F
Provider	(5.6)	(4.6)	(1.0) U	(44.7) U
Waikato Health Trust	(0.2)	0.0	(0.2) U	0.5 F
DHB Surplus/(Deficit)	**(3.3)**	**(3.7)**	**0.4 F**	**(10.0) U**
Note: $ F = favourable variance; ($) U = unfavourable variance				

FINANCIAL PERFORMANCE MONTHLY COMMENT:

This report includes commentary on current year to date performance for the Waikato DHB Group compared to the budget. As from the current month, the reporting is against approved budget, whilst the prior months reflected a comparison with the provisional budget. As a result, variance analysis compared month on month has in some areas changed significantly.

For September 2017 we have a favourable YTD variance to budget of $0.4m. However this result includes $1.2m one off favourable variances so a normalised result is $0.8m unfavourable. Furthermore, the $25m savings plan which contains high risk initiatives, is phased in the budget to take effect from October 2017.

Provider:

The Provider is unfavourable to budget $1.0m, variances include:

1. Revenue unfavourable to budget $0.9m due mainly to unfavourable internal revenue as a result of lower volumes.
2. Employed personnel costs favourable to budget $4.8m due mainly to vacancies and leave taken.
3. Outsourced Personnel costs unfavourable $4.4m, the dominant variances relate to medical locums ($1.7m, partly offset by savings in medical personnel costs), nursing personnel ($0.5m) and Management and Administration ($2.0m, National Oracle Solution (NOS) project portion recovered $0.6m).
4. Outsourced Services favourable $1.0m mainly due to lower utilisation for outsourcing of electives.
5. Clinical supplies unfavourable to budget $1.7m across various areas.
6. Infrastructure & Non Clinical supplies are favourable to budget $0.4m.
7. Interest, depreciation and capital charge unfavourable to budget $0.2m.

It should be noted that this is in the context of the following YTD data:

- Acute cases, excluding ED: episodes 0.4% below plan, case-weights 0.5% below plan;
- Elective cases: episodes 7.7% below plan, case-weights 8.0% below plan;
- Overall 2.3% below plan for cases, 2.6% below plan for case-weights
- ED attends: YTD ED attends are 7% higher than the same period last year.

Funder and Governance:

The results for the Funder is $1.6 favourable to budget. This as a result of higher funding received across a number of areas and a favourable provider payments variance as a result of lower provider volumes. Governance is close to budget

Waikato Health Trust

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

RECOMMENDATION(S):

That this report for September 2017 year to date be received.

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Group Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$0.9 F**	
CFA Revenue		
CFA Revenue is favourable to budget mainly due to:		
• Increase in funding across IBT, sleep over settlements and smoke cessation.	$0.4 F	Neutral
Crown Side-Arm Revenue		
Side-arm contracts revenue close to budget	($0.1) U	
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is favourable to budget mainly due to:		
• Reimbursement of costs associated with the implementation of National Oracle Solution (NOS) $0.6m favourable (offset in Outsourced Personnel) • ACC income $0.2m favourable which includes increases in income as a result of a change to a new annual contract. • Inter District Flow (IDF) income from other DHBs $0.5m unfavourable. This is due to coding being behind across DHBs as a result of year end processes. We expect this variance to reduce.	$0.4 F	Neutral
Other Revenue		
Other revenue is close to budget.	$0.2 F	Favourable

The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Operating expenditure including IDCC	**($0.5) U**	
Personnel (employees and outsourced personnel total)	**$0.4 F**	
Employed personnel are favourable to budget mainly due to:	$4.8 F	Neutral
• Medical costs are favourable to budget by $3.8m. This includes a higher than expected vacancy level (partly offset by outsourced personnel). This is partly offset by an unfavourable annual leave movement for the year to date.		
• Nursing costs are unfavourable to budget by $0.3m. This variance, along with the unfavourable outsourced personnel cost for nursing, is due to higher patient numbers entering ED, along with higher bed days. There is also an unfavourable annual leave movement for the year to date.		
• Management, Administration and Support costs are favourable to budget by $1.2m. Variances are spread across the DHB including clinical support and are mainly as a result of higher than expected vacancy levels. Partially offset in Outsourced Personnel ($0.9m).		
Outsourced personnel are unfavourable to budget mainly due to:		
• Medical personnel $1.8m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.	($4.4) U	Neutral
• Nursing personnel $0.5m unfavourable. As for employed nursing personnel this is due to higher patient numbers entering ED, along with higher bed days.		
• Management, Administration and Support costs are $2.1m unfavourable largely due to contractor costs of $1.2m for the implementation of the new NOS ERP solution (to date $0.6m of this cost is offset by additional other government revenue) and management, administration and support vacancies (offset in favourable employed personnel variance).		
Outsourced services	**$1.0 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced clinical service costs are $0.8m favourable as facility lists run through external providers did not reach full capacity. This is reflected in total elective episodes being 7.7% below plan, despite in house throughput being to plan. There is a recovery plan in place to meet the elective services target.	$1.0 F	Neutral
• Other favourable variances over a number of areas - $0.2m.		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Clinical Supplies	**($1.7) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Instruments & equipment - favourable to budget by $0.3m. These particular supplies are not volume related, and instead the variance is due to timing of ordering.	$0.3 F	Neutral
• Implants & prosthesis - favourable to budget by $0.3m. Reduced costs include high cost cardiothoracic devices for procedures that are no longer being completed on behalf of other DHB's.	$0.3 F	Favourable
• Treatment disposables - unfavourable to budget across a number of areas $1.3m. Analysis is being done to understand the drivers of the variance.	($1.3) U	Unfavourable
• Pharmaceuticals - unfavourable to budget by $1.0m. Relates mainly to $0.8m unbudgeted increase in oncology drug costs. The Pharmac forecast on which the budget was based did not include the new melanoma drugs.	($1.0) U	Neutral
• Diagnostic Supplies & Other Clinical Supplies - on budget.	$0.0 F	Neutral
Infrastructure and non-clinical supplies	**$0.4 F**	
Infrastructure and non clinical supplies - $0.4m favourable variance to budget as a result of delays in moving in to new buildings. The net variance includes ongoing additional costs due to extended leases in existing buildings.	$0.4 F	Favourable
NGO Payments	**($0.4) U**	
External Provider payments are unfavourable to budget mainly due to:		
• Provider payments for Personal Health and for Mental Health are net $1.0m unfavourable due to timing, with payments not matching CFA revenue received. The most significant of these arrangements is for PHO system level measure capability.	($0.4) U	Neutral
• IDF out payments are $0.5m favourable. As for IDF In receipts this is due to coding being behind across DHBs as a result of year end processes. We expect this variance to reduce.		
Interest, depreciation and capital charge	**($0.2) U**	
Interest charge on budget	$0.1 F	Favourable
Capital charge is close to budget	($0.1) U	Unfavourable
Depreciation is close to budget	($0.2) U	Unfavourable

TREASURY

Opinion on Group Result:

Cash flows are unfavourable to budget as detailed below.

YTD Actuals Sep-16 $'000	Waikato DHB Cash flows for year to September 2017	Year to Date Actual $'000	Year to Date Budget $'000	Year to Date Variance $'000	Budget Jun-17 $'000
	Cash flow from operating activities				
333,200	Operating inflows	350,423	356,160	(5,737)	1,438,153
(317,678)	Operating outflows	(346,237)	(340,050)	(6,187)	(1,396,156)
15,522	**Net cash from operating activities**	**4,186**	**16,110**	**(11,924)**	**41,997**
	Cash flow from investing activities				
390	Interest income and proceeds on disposal of assets	316	292	24	1,170
(6,499)	Purchase of assets	(9,330)	(13,764)	4,434	(55,056)
(6,109)	**Net cash from investing activities**	**(9,014)**	**(13,472)**	**4,458**	**(53,886)**
	Cash flow from financing activities				
0	Equity repayment	1	0	1	(2,199)
(2,162)	Interest Paid	(99)	(200)	101	(805)
77	Net change in loans	(104)	(80)	(24)	12,700
(2,085)	**Net cash from financing activities**	**(202)**	**(280)**	**78**	**9,696**
7,328	**Net increase/(decrease) in cash**	**(5,030)**	**2,358**	**(7,388)**	**(2,193)**
856	Opening cash balance	9,577	9,577	(0)	9,577
8,184	**Closing cash balance**	**4,547**	**11,935**	**(7,388)**	**7,384**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($11.9) U**	
• **Operating inflows**	**($5.7) U**	
o Revenue received unfavourable primarily as a portion of CFA revenue budgeted to be received in September was received in October.	($5.7) U	Neutral
• **Operating outflows**	**($6.2) U**	
o Personnel cost variances are favourable against budget due to higher than planned vacancies. Vacant positions are in many instances filled by outsourced personnel. Offset in unfavourable non payroll cash flows.	$3.9 F	Neutral
Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
o Operating cash outflows for non-payroll costs are unfavourable largely as a result of: - unfavourable operating costs including outsourced personnel (offset in personnel cost) and clinical supplies - the timing of vendor payments against budget assumptions	($10.8) U	Neutral
o GST cash movement is favourable due to timing variances on GST transacted.	$0.7 F	Neutral

Net cash flow from Investing Activities	**$4.4 F**	
○ Interest received is on budget.	$0.0 F	Neutral
○ Capital spend is slower than planned YTD. This is as a result of timing and send is expected to be on budget for the year.	$4.4 F	Neutral
Net cash flow from Financing Activities	**$0.1 F**	
○ Cash flow from financing activities is close to budget.	$0.1 F	Neutral

The cash flow statement budget has been calculated on the same basis as the income statement budget. The main difference to actual cash transactions is that the cash flow budget nets off GST payments to the IRD against GST inputs and outputs.

The statement of cash flow (above) is based on the cash book values derived from the general ledger. The following forecast statement of cash flows is based on bank account balances.

WAIKATO DISTRICT HEALTH BOARD - excluding Waikato Health Trust
CASHFLOW FORECAST (GST INCLUSIVE)

As at 30-Sep-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	4,137	4,448	4,452	4,116	4,340	4,116	4,340	4,116	4,564	4,228	4,594	4,708	4,366
Funder inflow (MoH, IDF, etc)	126,536	146,284	133,756	133,046	128,366	128,366	132,480	126,810	126,810	131,490	129,532	125,102	134,212
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	1,909	2,530	2,530	2,400	2,415	2,185	2,415	2,185	2,645	2,300	2,530	2,645	2,300
Rents, ACC, & Sector Services	3,585	2,608	2,695	2,584	2,592	2,504	2,681	2,514	2,761	2,651	2,733	2,816	2,641
	136,167	155,870	143,432	142,146	137,713	137,170	141,916	135,625	136,780	140,669	139,389	135,271	143,519
Cash was applied to:													
Personnel Costs (incl PAYE)	(45,377)	(42,908)	(50,934)	(43,562)	(52,926)	(46,826)	(43,592)	(43,472)	(49,034)	(45,462)	(44,506)	(57,168)	(44,310)
Other Operating Costs	(36,818)	(33,300)	(34,100)	(33,800)	(29,500)	(24,800)	(34,200)	(30,900)	(37,289)	(34,300)	(32,426)	(31,824)	(31,494)
Funder outflow	(55,504)	(46,037)	(46,354)	(45,373)	(46,027)	(45,373)	(49,659)	(45,599)	(46,617)	(45,700)	(46,808)	(50,807)	(46,148)
Interest and Finance Costs	(8)	(15)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(25)
Capital Charge	0	0	0	(18,711)	0	0	0	0	0	(18,711)	0	0	0
GST Payments	(7,198)	(7,210)	(10,210)	0	(14,510)	(9,000)	(7,325)	0	(15,210)	(7,210)	(7,210)	(7,210)	(7,210)
	(144,906)	(129,470)	(141,608)	(141,456)	(142,973)	(126,009)	(134,786)	(119,981)	(148,160)	(151,394)	(130,961)	(147,020)	(129,187)
OPERATING ACTIVITES	(8,739)	26,400	1,824	690	(5,261)	11,161	7,130	15,644	(11,380)	(10,725)	8,428	(11,749)	14,332
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	75	75	75	75	75	75	75	75	75	75	75	75	75
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
	75	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(2,974)	(3,500)	(3,500)	(3,500)	(2,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)
Investment in NZHPL (Finance project)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(2,974)	(3,500)	(3,500)	(3,500)	(2,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)
INVESTING ACTIVITIES	(2,899)	(3,425)	(3,425)	(3,425)	(1,925)	(4,925)	(4,925)	(4,925)	(4,925)	(4,925)	(4,925)	(4,925)	(4,925)
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from NZHPL	123,619	0	1,627	2,736	7,186	0	0	0	13,731	15,243	0	16,700	0
Finance Lease received	0	0	0	0	0	2,600	2,600	2,600	2,600	2,600	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	123,619	0	1,627	2,736	7,186	2,600	2,600	2,600	16,331	17,843	0	16,700	0
Cash was applied to:													
Capital Repayment	0	0	0	0	0	0	0	0	0	(2,194)	0	0	0
Transfer to NZHPL	(111,980)	(22,976)	0	0	0	(8,811)	(4,805)	(13,318)	0	0	(3,503)	0	(9,407)
Finance Lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	(111,980)	(22,976)	(26)	0	0	(8,837)	(4,805)	(13,318)	(26)	(2,194)	(3,503)	(26)	(9,407)
FINANCING ACTIVITIES	11,638	(22,976)	1,601	2,736	7,186	(6,237)	(2,205)	(10,718)	16,305	15,649	(3,503)	16,674	(9,407)
Opening cash balance	0	0	0	0	0	0	0	0	0	0	0	0	0
Overall increase/(decrease) in cash	0	(1)	0	1	0	0	0	1	0	(1)	0	1	0
CLOSING CASH BALANCE	0	0	0	0	0	0	0	0	0	0	0	0	0
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Funder Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Investment funds/(loan)													
NZ Health Partnerships Ltd (NZHPL)	(2,438)	20,537	18,910	16,174	8,988	17,799	22,604	35,923	22,192	6,948	10,451	(6,249)	3,159
Long-term Loans													
Finance Leases	0	0	0	0	0	(2,600)	(5,200)	(7,800)	(10,400)	(13,000)	(13,000)	(13,000)	(13,000)
EECA Loan	(247)	(247)	(221)	(221)	(221)	(195)	(195)	(195)	(169)	(169)	(169)	(143)	(143)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(2,685)	20,290	18,688	15,954	8,768	15,004	17,209	27,928	11,624	(6,221)	(2,718)	(19,391)	(9,984)
LOANS AVAILABLE													
Working capital facility (NZHPL)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(66,968)	(66,968)	(66,968)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(66,968)	(66,968)	(66,968)

BALANCE SHEET

Opinion on Result:

There are no material concerns on the balance sheet and performance indicators are within acceptable tolerances

Prior Year June 2017 $'000	Waikato DHB Group Financial Position	As at September 2017 Actual $'000	Budget $'000	Variance $'000	Budget Jun-18 $'000
81,105	Total current assets	89,669	89,523	146 F	65,434
(173,993)	Total current liabilities	(183,223)	(188,462)	5,239 F	(160,570)
(92,889)	**Net working capital**	**(93,554)**	**(98,939)**	**5,385 F**	**(95,136)**
736,618	Term assets	733,791	738,417	(4,626) U	739,628
(21,053)	Term liabilities	(20,892)	(20,699)	(193) U	(34,411)
715,565	**Net term assets**	**712,899**	**717,718**	**(4,819) U**	**705,217**
622,676	**Net assets employed**	**619,345**	**618,779**	**566 F**	**610,081**
622,676	**Total Equity**	**619,345**	**618,779**	**566 F**	**610,085**

Prior Year June 2017 $'000	Waikato DHB Group Ratios	As at September 2017 Actual $'000	Budget $'000	Achieved	Trend
64,198	Borrowing facilities available at month end	63,074	65,512	✓	⬄
0.0	Debt to Equity ratio	0.0	0.0	✓	⬄
0.5	Current ratio	0.5	0.5	✓	⬄
76.1%	Equity to total assets	75.2%	74.7%	✓	⇧
0.1%	Return on equity	-0.5%	-0.6%	✓	⬄

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is favourable to budget mainly due to:		
Current Assets		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $7m. The $2.4m overdraft is recorded in Current Liabilities, which resulted in a -$4.6m variance in Current Assets and -$2.4 variance in Current Liabilities.	$0.1 F	Neutral
• Total accounts receivable and accrued debtors is higher than planned by $4.9m largely due to the timing of cash received compared with budget assumptions.		
Current Liabilities		
• Payroll liabilities are $0.9m favourable mainly due to timing of pay runs.	$5.2 F	Neutral
• Income in Advance $0.2m unfavourable to budget mainly due to unbudgeted pay equity settlement funds received.		
• GST $0.8m unfavourable to budget mainly due to the timing of processing of vendor invoices.		
• Other Current Liabilities are favourable to budget $7.8m mainly due to the variances arising from the actual timing of transactions which included Pay Equity and PHO payments.		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $7m. The $2.4m overdraft is recorded in Current Liabilities, which resulted in a -$4.6m variance in Current Assets and -$2.4 variance in Current Liabilities.		
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $4.4m and unfavourable YTD depreciation $0.2m. Please see attached for latest forecast of capital spend for the year for further detail.	($4.6) U	Neutral
Non Current Liabilities:		
Close to provisional budget.	($0.2) U	Neutral
Equity:		
Driven from variance in overall results.	$0.6 F	Neutral

CAPITAL EXPENDITURE AT 30 September 2017 ($000s)

Capital Plan					Cash Flow Forecast				Full Project Forecast	
Activity	Total Prior year Board Approvals (F)	New Approvals FY17/18 (G)	Transfers During 17/18 (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 17/18 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-17 to 30 Sep 17	Planned Expenditure 01 Oct 17 - 30 Jun 18	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
Under $50K Subtotal		3,000		3,000		3000	460	2,540	3,000	0
Clinical Equipment Subtotal	9,783	14,852	104	24,725	7,918	14,852	1,834	13,017	22,770	1,956
Property & Infrastructure Subtotal	21,469	18,329	-	39,798	17,011	18,329	3,646	14,683	35,340	4,459
Strategic Projects Office Subtotal	85,410	500	0	85,910	124	500	51	449	85,912	(2)
IS Subtotal	28,328	15,941	0	44,269	9,274	15,941	4,274	11,668	25,215	19,053
Corporate Systems Subtotal	7,425	2,434	0	9,859	3,890	2,434	245	2,189	6,324	3,535
MOH Subtotal	668	-	3	671	429	22	22	-	671	0
Trust Funded Subtotal	982	0	191	1,173	797	191	191	0	989	184
REPORT TOTALS	154,065	55,056	298	209,405	39,444	55,269	10,724	44,546	180,221	29,184

CAPITAL EXPENDITURE AT 30 September 2017 ($000s)

Capital Plan					Cash Flow Forecast				Full Project Forecast	
Activity	Total Prior year Board Approvals (F)	New Approvals FY17/18 (G)	Transfers During 17/18 (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 17/18 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-17 to 30 Sep 17	Planned Expenditure 01 Oct 17 - 30 Jun 18	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
Under $50K Subtotal		**3,000**		**3,000**		**3000**	**460**	**2,540**	**3,000**	**0**
CLINICAL EQUIPMENT										
Heater Cooler units	156		-	156	159	-	-	-	159	(3)
Sorin Heater Cooler Units (funded from refund Heater cooler units above)	-		-	-	-	150	150		150	(150)
Ultrasound Replacement (Endoscope, Operating Table & EMG System)	100		-	100	83	17	-	17	100	0
Endoscopy scope replacement	604			604	604	-	-	-	604	0
Ultrasound scanner replacement	175			175	158	21	21		179	(4)
Washer Decontaminator for Thames Sterile Services	92			92	92	-	-	-	92	0
Endoscope Camera (Thames)	103			103	141	18	(18)	-	123	(20)
Gamma Camera (Nuclear Med Imaging Scanner)	1,200			1,200	880	319	3	316	1,199	1
Haematology Main Analyser (to be approved for hA negotiationing for all hospital sites)	715			715	535	180	25	155	715	0
PCA Pumps (Biomed)	500			500	421	79	-	79	500	0
Cytogenetics Digital Imaging system	800			800	28	772	295	477	800	0
Combi Diagnost Fluoroscopy Unit	619			619	186	433	417	16	619	0
Blood Gas Analyser - Critical Care	50			50	-	60	60		60	(10)
Echo Ultrasound Machine Replacement	-			-	-	599	599		599	(599)
Kay Pentax Stroboscopy System	100			100	100	-	-		100	0
BD MGIT 960 Automated TB Growth Analyser	-			-	-	104	104		104	(104)
CEP - Pool - 2016/17	200			200	-	200	-	200	200	0
Vision Hearing Truck (Moblie Ear Clinic)	200	47		247	238	-	-	-	238	9
Flow Cytometry Development				90	-	90	12	78	90	0
Oculus Pentacam	-			-	-	-	-		0	0
Older Person and Rehabilitation Ward 5 (OPR5)	-		**37**	-	-	78	78		78	(78)
Premature Anne and SimNewB Simulators	-		**67**	-	-	67	67		67	(67)
Radiation Therapy CT Scanner Replacement	-		725	725	-	725	8	717	725	0
CT Machine Replacement Waikato x3	-		3,828	3,828	-	3,828	-	3,828	3,828	0
Medrad Stellant Dual Injectors	-		122	122	-	122	-	122	122	0
Linear Accelerator (approved by BRRG Nov-15)	4,000			4,000	4,222	-	-	-	4,222	(222)
Operating Task Lighting	70			70	71	-	-	-	71	(1)
ED Short Stay Unit Expansion	99			99	-	99	3	96	99	0
Task Operating Theatre / Delivery suite Lighting		138		138		138	-	138	138	0
COO Contingency	-	1000		1,000	-	1,000	-	1000	1,000	0
Vivid Echo (portable)	-	250		250	-	250	-	250	250	0
Cardiac output machines (Critical Care) CCO Swan x2	-	60		60	-	60	-	60	60	0
Life pak 20 x3	-	51		51	-	51	-	51	51	0
Ventilators (Critical Care)	-	800		800	-	800	-	800	800	0
Linear Accelerator (Replacement)	-	4000		4,000	-	4,000	-	4000	4,000	0
CT Oncology	-	1200	-1,200	-	-	-	-	0	0	0
CT Thames		1500	-875	625		625	-	625	625	0
Haemodialysis (Incentre)	-	217		217	-	217	-	217	217	0
Home Haemo Dialysis Replacement (only requesting FY16/17 approval)	-	101		101	-	101	-	101	101	0
Telemetry	-	200		200	-	200	-	200	200	0
AISYS CARESTATION ANESTHESIA MACHINE	-	380		380	-	380	-	380	380	0
Sonosite Ultrasound Unit	-	85		85	-	85	-	85	85	0
Sonosite Ultrasound Unit	-	85		85	-	85	-	85	85	0

OPERATING THEATRE LIGHTS - OT20	-	40		40	-	40	-	40	40	0
OPERATING THEATRE LIGHTS - OT21	-	40		40	-	40	-	40	40	0
OPERATING THEATRE LIGHTS - OT22	-	40		40	-	40	-	40	40	0
OPERATING THEATRE LIGHTS - OT23	-	40		40	-	40	-	40	40	0
OPERATING THEATRE LIGHTS - OT24	-	40		40	-	40	-	40	40	0
OPERATING THEATRE LIGHTS - OT25	-	40		40	-	40	-	40	40	0
Iridex Cyclo G6 Laser	-	54		54	-	54	-	54	54	0
Accurus 800CS multifunction console with imbedded laser	-	150		150	-	150	-	150	150	0
OPMI VISU 200 Micorscope (ceiling mounted)	-	350		350	-	350	-	350	350	0
Microscope - Platics	-	300		300	-	300	-	300	300	0
Carcon dioxide Laser	-	70		70	-	70	-	70	70	0
Medtronic NIM-Neuro 3.0 Mainframe	-	60		60	-	60	-	60	60	0
M5 Microresector handpeices and console	-	55		55	-	55	-	55	55	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No:1	-	93		93	-	93	-	93	93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No:2	-	93		93	-	93	-	93	93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No:3	-	93		93	-	93	-	93	93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No:4	-	93		93	-	93	-	93	93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No:5	-	93		93	-	93	-	93	93	0
MR four section operating table	-	59		59	-	59	-	59	59	0
Eschmann 'MR Operating Table	-	100		100	-	100	-	100	100	0
Eschmann 'MR Operating Table	-	100		100	-	100	-	100	100	0
Eschmann 'MR Operating Table	-	100		100	-	100	-	100	100	0
Eschmann 'MR Operating Table	-	100		100	-	100	-	100	100	0
Eschmann 'MR Operating Table	-	100		100	-	100	-	100	100	0
Eschmann 'MR Operating Table	-	100		100	-	100	-	100	100	0
PACE 203H DUAL CHAMBER PACEMAKER E14608	-	119		119	-	119	-	119	119	0
Enscopic Tower with two scopes	-	200		200	-	200	-	200	200	0
RADIOMETER ABL 825GL BLOOD GAS ANALYSER E17193	-	83		83	-	83	-	83	83	0
Dynasil navigator 2.0 System	-	60		60	-	60	-	60	60	0
RX500 Electrohydraulic operating table 0E9484	-	52		52	-	52	-	52	52	0
Endoscopes	-	300		300	-	300	-	300	300	0
Datex Monitors X 14	-	140		140	-	140	-	140	140	0
Colposcope	-	44		44	-	44	-	44	44	0
Foetal monitor, CTG	-	100		100	-	100	-	100	100	0
Humidifier	-	36		36	-	36	-	36	36	0
Infusion Pumps (NICU)	-	24		24	-	24	-	24	24	0
Intregrated ultrasound system	-	100		100	-	100	-	100	100	0
Scanners, ultrasonic, (WOPD)	-	160		160	-	160	-	160	160	0
Cathlabs	-	1500		1,500	-	1,500	-	1500	1,500	0
CEP pool	-	200		200	-	200	11	189	200	0
Bed Replacement Programme	-	400		400	-	400	-	400	400	0
Biochemistry ICP-OES to replace A/A	-	500		500	-	500	-	500	500	0
Histology IHC stainer	-	160		160	-	160	-	160	160	0
Histology slide scanner and WSI system	-	400		400	-	400	-	400	400	0
Molecular biology integrated system	-	360		360	-	360	-	360	360	0
Rural Laboratories- AQT Analysers (X4)	-	180		180	-	180	-	180	180	0
Rural Laboratories- Biochemistry analysers (X4)	-	720		720	-	720	-	720	720	0
Analyser (TB Microbiology)	-	200		200	-	200	-	200	200	0
Mobile Dental Unit Replacements - level 2	-	600		600	-	600	-	600	600	0
Med-Dispense units	-	100		100	-	100	-	100	100	0
Healthscape	-	150		150	-	150	-	150	150	0
CT Waikato - Flash	-	2600	-2,600	-	-	-	-	0	0	0
Digital Mobile X-Ray	-	600		600	-	600	-	600	600	0
Mobile Image Intensifier - Waikato	-	300		300	-	300	-	300	300	0
Reporting Stations	-	240		240	-	240	-	240	240	0
Trauma Gantry (Radiology ED)	-	350		350	-	350	-	350	350	0
Ultrasound (Theatres)	-	100		100	-	100	-	100	100	0

Vascular & Interventional Unit Replacement	-	1750		1,750	-	1,750	-	1750	1,750	0
X-ray general (Radiology ED Room 1)	-	350		350	-	350	-	350	350	0
X-ray general (Radiology MCC Room 5)	-	350		350	-	350	-	350	350	0
X-ray mobile (Taumarunui)	-	300		300	-	300	-	300	300	0
X-ray mobile (Te kuiti)	-	300		300	-	300	-	300	300	0
X-ray mobile (Thames)	-	300		300	-	300	-	300	300	0
X-ray mobile (Tokaroa)	-	300		300	-	300	-	300	300	0
Equipment and Supply Washer	-	100		100	-	100	-	100	100	0
Endoscopes (Thames)	-	120		120	-	120	-	120	120	0
Anaesthesia Unit & Ventilators (Thames Theatre)	-	66		66	-	66	-	66	66	0
Endoscope Camera (Thames)	-	103		103	-	103	-	103	103	0
Scopes (Thames Theatre)	-	123		123	-	123	-	123	123	0
Theatre Instruments (Thames Theatre)	-	82		82	-	82	-	82	82	0
Blood gas analysers	-	400		400	-	400	-	400	400	0
Glucose meters	-	275		275	-	275	-	275	275	0
SAVINGS REQUIRED		-13662		-13,662		16,865	-	-16,865	16,865	3,203
Clinical Equipment Subtotal	**9,783**	**14,852**	**104**	**24,725**	**7,918**	**14,852**	**1,834**	**13,017**	**22,770**	**1,956**
PROPERTY & INFRASTRUCTURE - PLANT										
Property and Infrastructure	-						-			
Infrastructure Replacement Pool (15/16)	600			600	679	25	25	-	704	(104)
Infrastructure Replacement Pool (16/17)	241			241	129	38	38		167	74
Infrastructure Replacement Pool (17/18)	-	600		600	-	600	-	600	600	0
MCC - Edge roof protection	30			30	28	2	-	2	30	0
Carpark Lighting - Upgrade	50		-	50	45	5	-	5	50	0
Hockin Sewer Pumping Stations and Heating Controls	20	45		65	18	47	2	45	65	0
Waikato Distribution Boards	250		-	250	213	37	-	37	250	0
Lift car upgrades	-	150	-	150	-	150	-	150	150	0
Lift car upgrades	1,835			1,835	1,845	214	214		2,059	(224)
Kempthorne Theatre Plant room Upgrade	250			250	246	4	-	4	250	0
Extension to Current ERM Manifolds for NICU	18			18	-	18	16	2	18	(0)
OPRS - Roof access	-	30		30	-	30	-	30	30	0
Theatre - Air conditioning upgrades	250	150		400	-	400	-	400	400	0
HV System - upgrade- SCADA to BMS	-	160	-	160	-	160	-	160	160	0
Waikato Switchboards - Menzies,Kemp,Waiora & ERB	-	675	-	675	-	675	-	675	675	0
ERB window improvements (counter cold & wind)	-	150		150	-	150	-	150	150	0
Lomas Chillers	-	150		150	-	150	-	150	150	0
Urology Refurbishment - L8 Mezies		114	-114	-		-	-		0	0
ERB - Delivery Suite examination light end of life replacement	-	75		75	-	75	-	75	75	0
Tunnel lighting	-	30	-	30	-	30	-	30	30	0
ERB chilled water buffer tank installation	-	120	-	120	-	120	-	120	120	0
ERB Fire panel upgrade	-	200	-	200	-	200	-	200	200	0
Ambulance Bay - Taumarunui	-	30		30	-	30	-	30	30	0
ERB Medical Air Compressor	-	120		120	-	120	-	120	120	0
Oil Curcuit Breaker Replacements	-	350		350	-	350	-	350	350	0
Back up of medical gas bank supply to ERB	-	50		50	-	50	-	50	50	0
Energy Saving Initiatives	-	50		50	-	50	-	50	50	0
Regional Main Switchboards - Thames & Te Kuiti	-	50		50	-	50	-	50	50	0
Security	-			-	-		-		0	
Avigilon DVR's in all building x9	39	39	-36	42	32	10	-	10	42	0
Pembroke Street Car Park CCTV	87			87	13	79	79		92	(5)
Develop Web based payment for Multicash	102			102	17	85	57	28	102	0
Change Readers X 125	30		-	30	27	3	-	3	30	0
Gallagher door controllers - upgrade to 6000 model	100			100	90	10	-	10	100	0
CCTV Installations for Hockin	54	-		54	51	14	14	-	65	(11)
Ward - standard install	88			88	-	143	81	62	143	(55)
Swap out 125 readers	-	30		30	-	30	27	3	30	0
Upgrade all Gallagher controller models	-	100		100	-	100	67	33	100	0
Avigilon NVR's in all buildings	-		36	36	-	36	36		36	0
Carpark CCTV	13	50		63	-	63	-	63	63	0
Convert CCTV from analogue to IP	30	15	-	45	-	45	-	45	45	0
Virtual Video controller for Monitoring stations	-	80	-	80	-	80	-	80	80	0
Master key - Waikato buildings (2 x bldgs)	-	35	-	35	-	35	2	33	35	(0)

FACILITIES & BUSINESS	-			-	-				0	0
Site & Intra Building Site Master Planning Hamilton Campus	-			-	-		-		0	
Hilda Ross - Remediation	3,683	550		4,233	1,530	1,099	508	591	2,629	1,604
Concept Design- Oncology/Haematology Facility	201		-	201	105	196	-	196	301	(100)
Electrical Systems Improvement	6,714	-		6,714	5,956	9	9	-	5,965	749
Legacy SCR - Still Required - decanting	520	50	-	570	704	-	-		704	(134)
Seismic Remediation	1,862			1,862	1,591	270	0	270	1,861	1
Waikato Hauora iHub	200	-	-	200	18	182	7	175	200	0
Hockin - Open planning/ Modernisation of Level 3 Executive Wing	95			95	119	-	-	-	119	(24)
Gallagher Building - Med Store & CSES Clinic	-	406		406	-	406	-	406	406	0
Gallagher Building - Racking System	-	362		362	-	362	5	357	362	(0)
Gallagher Building - Converyor System	-	348		348	-	348	124	224	348	0
Gallagher Building - Rolltainers / Bollards / Racking corner - Guards		184		184		184	-	184	184	0
SCEP racking - Hospital wide (ex funds from wk0044)		400		400		400	-	400	400	0
Office Relocations	405	-		405	-	405	-	405	405	0
Multi Level carpark 3 or 4 levels - laundry site	-	250		250	-	250	-	250	250	0
Concept Design & Facility Use	-	125		125	-	125	-	125	125	0
Kitchen; Cafeteria & food Delivery	-	250		250	-	250	-	250	250	0
Hague Road Car Park - Seismic and Beam Support	-	375		375	-	375	-	375	375	0
Boiler House Upgrade	1,833	-		1,833	1,866	-	-	-	1,866	(33)
RFP Food Service System	6			6		6	6		6	0
	-			-	-		-		0	0
Major Internal Reconfigurations to Shift Services or Departments	-			-	-		-		0	0
Hamilton Consolidation of CBD facilities - 9th Floor	894		-	894	894	0	0		894	(0)
Gallagher Drive Development (Community / Rural and Supply Chain)	202	4,036	-	4,238	137	4,101	2,002	2,099	4,238	0
Internal Reconfiguration - Room Pressure	210		-	210	240	0	0		240	(30)
Combining Matariki and Princess Street Bases	140			140	141	-	-		141	(1)
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	277	2,263		2,540	277	2,262	276	1,986	2,539	0
Hamilton CBD - Collingwood Street Development - First Floor		2,263		2,263	-	2,262	50	2,212	2,262	0
Harti Hauora Hub - MCC L1	-	250		250	-	250	-	250	250	0
Menzies L3 Development	-	450		450	-	450	-	450	450	0
Urology to L8 Menzies	-	180	114	294	-	294	0	294	294	(0)
Pain Clinic - L3 Menzies	-	450	-	450	-	450	-	450	450	0
Regional Renal expansion on Campus	-	550		550	-	550	-	550	550	0
ED - Reconfiguration of entry / Front of house	-	400		400	-	400	-	400	400	0
Child Development Unit	-	200		200	-	200	-	200	200	0
	-			-	-		-		0	
Rural Hospital Build/Refurb Projects (Community Villages)	-			-	-		-		0	
Sexual Health Services building - fitout upgrade	-	40		40	-	40	-	40	40	0
Tokoroa - Primary Birthing	140	300		440	-	440	-	440	440	0
				-		-	-		0	0
Savings required				-		2,751	-	(2,751)	2,751	2,751
Property & Infrastructure Subtotal	**21,469**	**18,329**	**-**	**39,798**	**17,011**	**18,329**	**3,646**	**14,683**	**35,340**	**4,459**
Strategic Projects Office										
Education; Research and supporting amenities	25,000			25,000	18	27	27		25,000	0
Mental Health Facility - scoping	77	-		77	106	24	24		130	(53)
Adult Mental Health Project	60,333	500		60,833	-	500	-	500	60,833	0
SAVINGS REQUIRED				-		51	-	(51)	51	51
Strategic Projects Office Subtotal	**85,410**	**500**	**0**	**85,910**	**124**	**500**	**51**	**449**	**85,912**	**(2)**
INFORMATION SYSTEMS	-						-			
PLATFORM	-			-	-	-	-			
ISSP - Clinical and corporate Platform SQL Server consolidation	475		-	475	185	290	18	272	475	(0)
ISSP - Decommission Galen 15/16	315			315	115	200	-	200	315	0
ISSP - Backup Capacity Augment	200		-	200	46	-	-		46	154
ISSP - Fidge Monitoring	-	500		500	-	500	-	500	500	0
ISSP - Identity and Access Management	-	500		500	-	500	-	500	500	0
ISSP - Contingency (IS)	200	200		400	-	-	-	-	0	400
IMPACT Patient Flow Tool	-		739	739		739	22	717	739	(0)
STORAGE & REPORTING	-			-	-	-	-	-	0	0
ISSP- Clinical Photography and Image Management	397			397	7	390	7	383	397	0
ISSP - Data Warehouse Upgrade (Data Warehouse Phase 1)	400		-	400	253	147	19	128	400	0
ISSP - Data Warehouse Phase 2 15_16 (Data Warehouse Phase 1b)	200			200	13	187	4	183	200	(0)

ISSP - Enterprise Reporting 16-17	250			250	5	245	1	244	250	(0)
ISSP - SharePoint (Doc Management Pilot)	700		-	700	250	450	14	436	700	0
ISSP - Enterprise Business Intelligence Tool	350			350	92	258	10	248	350	0
ISSP - Business Intelligence Data and Reporting 16_17	207			207	5	202	1	201	207	(0)
ISSP - San Controller	-	322		322	-	322	-	322	322	0
ISSP - Data Analyst Toolset Implementation (16/17) (Business Intelligence Toolset)	-	350		350	-	350	-	350	350	0
ISSP - Lifecycle: Data Warehouse, Cubes, Master Data and Reporting Workplan	-	400		400	-	400	-	400	400	0
NETWORK & COMMUNICATIONS	-			-	-	-	-	-	0	0
ISSP - Hylafax replacement	96			96	25	70	15	55	95	0
ISSP - Comms Rooms remediation 2015/2016	230		-	230	89	141	52	89	230	0
ISSP - Communication Room Remediation Lifecyle	370	300		670	4	666	7	659	670	0
ISSP - Network Remediation Work Package 2015/2016	400			400	262	138	-	138	400	0
ISSP - Network Remediation Lifecycle Work Plan 16/17	-	350		350	243	107	8	99	350	0
ISSP - Paging System Replacement	350		-	350	88	262	84	178	350	0
ISSP - Jabber Instant Messaging and Guest	201			201	61	140	6	134	201	0
ISSP - Unified Communications Lifecycle	62			62	21	41	1	40	62	0
ISSP - Unified Comms Phase 4	147		-	147	97	50	6	44	147	(0)
ISSP - WiFi Rollout	500	500	-	1,000	381	619	25	594	1,000	(0)
ISSP - Unified Comms Phase 4 (16/17)	-	200		200	-	200	-	200	200	0
ISSP - UPS Lifecycle	-	130		130	-	130	-	130	130	0
ISSP - Communication Site Upgrades	-	429		429	-	429	-	429	429	0
IAAS	-			-	-		-		0	
NIPS - IaaS Implementation	150			150	164	179	179		343	(193)
ISSP - Disaster Recovery Solution 15_16	200		-	200	57	143	9	134	200	0
ISSP - Archiving Tool Implementation	-	300		300	-	300	-	300	300	0
ISSP - Archiving Tool Scoping	-	50		50	-	50	-	50	50	0
DEVICES	-			-	-		-		0	
ISSP - Mobile office Productivity & Management	392			392	4	388	-	388	392	0
IS Pool - clearing	-	1,234	42	1,276	5	1,271	328	943	1,276	0
ISSP - Southern Rural Outpatient Video Units	27			27	25	-	-		25	2
ISSP - Desktop environment replacement >$2k	150	700	-	850	-	850	-	850	850	0
ISSP - Mobile device management	36	90		126	-	126	-	126	126	0
SmartHealth - (iPhones, iPads, Monitors)	-	1,455		1,455	-	1,455	-	1,455	1,455	0
ISSP - Tablets to enable mobile workforce	58	500	-42	516	-	516	-	516	516	0
ISSP - Touch screens	-	350		350	-	350	-	350	350	0
ISSP - Telehealth- replacement schedule	380	200	-	580	-	580	-	580	580	0
ISSP - Hardware Solution - Medication Room	20		-	20	9	11	-	11	20	0
LICENSING	-			-	-	-	-	-	0	0
ISSP - MS Licensing True-Up	176	300		476	129	347	-	347	476	0
ISSP - Other Licensing True-Up	49	300		349	65	284	-	284	349	0
ISSP - Other True-Up Winscribe	29			29	23	6	-	6	29	0
ENTERPRISE SERVICE BUSINESS / RULES ENGINE	-			-	-	-	-	-	0	0
ISSP - Enterprise Service Bus (ESB)	100			100	5	95	-	95	100	0
ISSP - Web Applications -S_Web_Services Infra_Mess Standards	400			400	-	400	-	400	400	0
ISSP - Web Applications -Forms Development Tools Selection Implementation (eg Nintex)	-	500		500	-	500	-	500	500	0
TOOLS	-			-	-	-	-	-	0	0
ISSP - Desktop upgrade from windows 7 to windows 10	-	500		500	-	500	-	500	500	0
ISSP - Lifecycle integration Tools workplan - Rhapsody etc	160	250		410	-	410	-	410	410	0
ISSP - Mobile device management	90			90	3	87	-	87	90	0
ISSP - Archiving Tool	350		-	350	13	337	0	337	350	(0)
ISSP - PVS Citrix	39		-	39	15	24	-	24	39	0
ISSP - Lifecycle - 1-2 Communication Tools Workplan	100	100	-	200	35	165	11	154	200	0
ISSP - Lifecycle - 1-2 Security Tools Workplan	150	150		300	-	300	-	300	300	0
ISSP - Lifecycle - Desktop Workplan (Outlook, Flexplus, etc)	-	500		500	-	500	-	500	500	0
ISSP - Desktop Work Plan 16/17	299			299	11	288	30	258	299	0
ISSP - Lifecycle - Development tools (Visual studio, Kendo etc)	50	50	-	100	-	100	-	100	100	0
ISSP - Lifecycle - IS Monitoring and Support Tools WorkPlan	-	350		350	-	350	-	350	350	0
ISSP - Lifecycle - Infrastructure Application Workplan 16/17	250	250	-	500	69	431	24	407	500	(0)
ISSP - Lifecycle - IS Cherwell Workplan	-	350		350	-	350	-	350	350	0

ISSP - TQUAL Reporting	50		-	50	37	13	7	6	50	0
ISSP - Rapid Logon	500	200		700	12	688	1	687	700	0
ISSP - Toolsets (IS Toolsets 15/16)	563		-	563	473	90	9	81	563	(0)
ISSP - Toolsets (14/15)	130		-	130	114	16	3	13	130	(0)
ISSP - SharePoint Work Pan 16-17	450			450	4	446	14	432	450	(0)
ISSP - LIS Reporting Development	200		-	200	141	59	33	26	200	(0)
SECURITY	-			-	-	-	-	-	0	0
Lifecycle: Security (eg AV)	-	150		150	-	150	-	150	150	0
Perimeter Redesign	87	249		336	-	336	-	336	336	0
Perimeter Remediation Work Plan 16/17	173			173	17	156	2	154	173	(0)
Security Defence in depth	-	250		250	70	180	-	180	250	0
Security Defence in depth	-	150		150	-	150	-	150	150	0
REGIONAL	-			-	-	-	-	-	0	0
HSL - Medicines Reconciliation (phase 1 & 2)	-	365		365	-	365	-	365	365	0
HSL - Regional Netscaler Reconfiguration	34		-	34	-	34	-	34	34	0
HSL - Regional Microsoft Reporting Services	134		-	134	-	134	-	134	134	0
Federation / Directory Enablement	-	36		36	-	36	-	36	36	0
Move to TAAS	-	120		120	-	120	-	120	120	0
Regional Med Chart	-	72		72	-	72	-	72	72	0
HSL - PACS Review	-	96		96	-	96	-	96	96	0
HSL - eHealth Scoping	-	96		96	-	96	-	96	96	0
PACS/RIS Switch & Firewall	-	100		100	-	100	-	100	100	0
RISSP - HSL - Enhanced Regional Integration	-	34	-	34	-	34	-	34	34	0
HSL - eSpace Programme	2,500	8,000		10,500	-	10,500	2,149	8,351	10,500	(0)
HSL - Lifecylce Management	-	226		226	-	226	-	226	226	0
RISSP - Risk Management Solution (Regional)	369		-	369	306	63	-	63	369	0
RISSP - Clinical Workstation - Phase II (License)	1,000	**500**	-	1,500	1,000	500	500	-	1,500	0
ISSP - Netscaler Infrastructure	343			343	276	67	27	40	343	0
CLINICAL SYSTEMS	-			-	-	-	-	-	0	0
eCWB Infrastructure (Vendor $526, PC Monitor $200, IS Services $250)	611	1,420	-739	1,292	-	2,031	-	2,031	2,031	(739)
eCWB Infrastructure	437			437		437	8	429	437	(0)
Clinical Workstation Core Component Workplan	480			480	234	246	87	159	480	0
HealthViews access to Primary Encounters (GP to Workstations)	300		-	300	288	12	2	10	300	0
Access to Primary Encounters - Indici to Clinical Workstation	-	90		90	-	90	-	90	90	0
Phlebotomy Bedside Labelling Discovery	-	150		150	-	150	21	129	150	0
MCP Historical Data	-	150		150	-	150	-	150	150	0
eMails to Patients	-	30		30	-	30	-	30	30	0
HealthViews - External eReferrals	220		-	220	8	212	-	212	220	0
eTasks	100		-	100	3	97	-	97	100	0
Internal eReferrals	499			499	99	400	-	400	499	0
eOrders	350	200	-	550	3	546	17	530	549	1
eOrders - Additional Funding	-	200		200	-	200	-	200	200	0
eVitals & Nursing Notes	-	500		500	-	500	-	500	500	0
Clinical workstations - Document Tree search	179			179	5	174	1	173	179	0
Workflow eData	250		-	250	138	112	18	94	250	0
Workflow eData	1,250	650		1,900	-	1,900	-	1,900	1,900	0
Surgical Services Audit Systems	116			116	42	74	3	72	116	(0)
Procedure based Booking / Scheduling	250	750	-	1,000	-	1,000	-	1,000	1,000	0
ipm upgrade to V10 - after 16/17 refer to lifecycle capital plan items	430	20	-	450	215	235	48	187	450	0
iPM - Replacement Scoping	-	100		100	-	100	-	100	100	0
Implementation / Upgrades as required for EMRAM level 5 (on seeking approval for FY17/18)	-	700	-290	410	-	410	-	410	410	0
eOrders			290	290		290	5	285	290	0
Lab Analysers	100	150	-50	200	-	200	-	200	200	0
Histology Digital Imaging Discovery			50	50	-	50	1	49	50	0
Laboratory Information Print solution	80	80	-	160	-	160	-	160	160	0
Laboratory Information LIS June-2016 GA Upgrade	200	200		400	-	400	-	400	400	0
ISSP - LIS Drop 8	150			150	1	149	0	149	150	(0)
Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense	100	150		250	-	250	-	250	250	0
Life cycle - cat 1-2 Medical Records Workplan (eg Kofax)	150	150	-	300	-	300	-	300	300	0

Life cycle - cat 1-5 In house Apps Workplan(eg Whitboards)	-	350		350	-	350	-	350	350	0
Cat1-5 In-House Developed Applications Work Plan	350			350	128	222	57	165	350	0
Life cycle - cat 2 Clinical Apps Workplan(eg NHI Gateway)	-	150		150	-	150	-	150	150	0
Cat 2 Off-the-shelf Applications Work Plan	150			150	22	128	25	103	150	0
Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	350	350	-	700	97	603	56	547	700	(0)
Life cycle - CWS / Healthviews Workplan	-	500		500	-	500	-	500	500	0
Clinical Workflow Integration Work Plan	430			430	52	378	91	287	430	0
Maternity (CleverMed)	760		-	760	12	748	-	748	760	0
NCAMP. 3M, MKR	250			250	172	78	-	78	250	0
NCAMP 2017	-	250		250	23	227	13	214	250	0
Oral Health system	950		-	950	786	164	56	108	950	(0)
Oral Health system Phase 2	-	100		100	-	100	-	100	100	0
Order Entry	-	500		500	-	500	-	500	500	0
Radiology - PACS/RIS Upgrade 16/17	-	400		400	-	400	-	400	400	0
RIS Release 5	150			150	-	150	-	150	150	0
PACS Release 5	200			200	5	194	1	193	199	1
RIS Upgrade (Project split) (PACS Upgrade 15)	223		-	223	171	52	0	52	223	0
RIS Upgrade 2016	124		-	124	34	90	19	71	124	0
PACS Network Connectivity	-	50		50	-	46	46		46	4
Renal Electronic System	-	450		450	-	450	-	450	450	0
Rheumatology - replace access database	-	100		100	-	100	-	100	100	0
Sexual health (SHIP to Med Tech Migration)	-	350		350	-	350	-	350	350	0
Sexual Health Electronic Lab orders	-	150		150	-	150	-	150	150	0
Speech Recognition	100	500		600	3	597	14	584	600	(0)
SmartHealth - (deployment / technical integration)	-	1,260		1,260	-	1,260	-	1,260	1,260	0
Database Replacements	300		-	300	28	272	4	268	300	0
Software Upgrades (Apps Lifecycle 15/16)	250		-	250	228	21	21	-	249	1
HealthViews - e2e Clinical Documents	350		-	350	485	9	9	-	494	(144)
Clinical Workstation Metadata Scoping	50			50	9	40	2	39	49	1
Provation Host Tairawhiti	27		-	27	-	27	10	17	27	0
Other Projects	-			-	-		-		0	
	-			-	-		-		0	
ISSP - Hockin Conversion	21		-	21	16	5	-	5	21	0
ISSP - Printer Architecture Upgrade	130		-	130	28	102	12	90	130	0
ISSP - Baseline - Infrastructure Lifecycle Management	465		-	465	458	7	-	7	465	0
ISSP - Windows 10 COE (Part deduction see below for balance of deduction	45		-	45	45	-	-	-	45	0
ISSP - Cobas IT 1000	120		-	120	3	117	-	117	120	0
ISSP - Spark Consultancy Services	43			43	14	29	-	29	43	0
>$20K ISSP - Resourse Management	-			-	95	-	-		95	(95)
				-		-	-		0	0
				-		-	-		0	0
SAVINGS REQUIRED		-18,513		-18,513		38,173	-	(38,173)	38,173	19,660
IS Subtotal	**28,328**	**15,941**	**0**	**44,269**	**9,274**	**15,941**	**4,274**	**11,668**	**25,215**	**19,053**

CORPORATE SYSTEMS & PROCESSES	-			-	-	-	-	-	0	0
eTK Replacement	-	250		250	-	250	-	250	250	0
Lifecycle HRIS / Peoplesoft Workplan	-	450		450	-	450	-	450	450	0
HRIS PeopleSoft WorkPlan AWE Calculation Pay Rules	150			150	2	156	156	-	158	(8)
HRIS Lifecycle Upgrade 15_16	400		-	400	51	349	0	349	400	(0)
Lifecycle - Sharepoint Workplan (e.g. replace fileshares, online sharepoint)	-	250		250	-	250	-	250	250	0
Attendants System - enhancements or replacement	100	30	-	130	-	130	-	130	130	0
Catalyst Initiatives	426	1,000		1,426	-	1,426	-	1,426	1,426	0
Positive NPV Projects	1,000	1,000		2,000	-	2,000	-	2,000	2,000	0
Nutrition and food software	-	500		500	-	500	-	500	500	0
Costpro Upgrade	400		-	400	239	161	0	161	400	(0)
HRIS Remediation of current issues	-	150		150	-	150	-	150	150	0
HRIS Self Service implementation - payroll improvement	1,600			1,600	1,608	-	-		1,608	(8)
National Oracle Solution / Elevate	2,314	1,186		3,500	1,806	1,693	85	1,608	3,499	1
Oracle - Mop ups and Budgeting solution	500	-		500	-	500	-	500	500	0
Service & Capacity Planning Tool	98			98	-	98	-	98	98	0

BPAC eReferral Phase 2	247			247	-	247	-	247	247	0
Taleo - Transition module	30			30	24	6	-	6	30	0
Audio Visual Equipment	160			160	160	3	3	-	163	(3)
				-		-	-		0	0
SAVINGS REQUIRED		-2,382		-2,382		5,936	-	(5,936)	5,936	3,554
Corporate Systems Subtotal	**7,425**	**2,434**	**0**	**9,859**	**3,890**	**2,434**	**245**	**2,189**	**6,324**	**3,535**
National Patient Flow-Phase 2	177	-		177	177	-	-	-	177	0
National Patient Flow Phase 3	449		3	452	210	22	22		452	(0)
Telestroke Pilot	42			42	42	-	-	-	42	0
MOH Subtotal	**668**	**-**	**3**	**671**	**429**	**22**	**22**	**-**	**671**	**0**
15/16 Trust Account	476			476	476	-	-	-	476	0
16/17 Trust Account	297		191	488	112	191	191	-	303	185
15/16 Other Donated Assets	89			89	89	-	-	-	89	0
16/17 Other Donated Assets	120			120	120	-	-	-	120	(0)
Trust Funded Subtotal	**982**	**0**	**191**	**1,173**	**797**	**191**	**191**	**0**	**989**	**184**
REPORT TOTALS	**154,065**	**55,056**	**298**	**209,405**	**39,444**	**55,269**	**10,724**	**44,546**	**180,221**	**29,184**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
SEPTEMBER 2017

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

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

Travel costs - Executive Group	Month			Year to Date			
September 2017	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AYDON LYDIA HELEN MS	-	-	-	127.87	-	127.87	
CHRYSTALL MAUREEN MS	-	-	-	422.49	-	422.49	
HACKETT DARRIN MR	-	-	-	126.35	-	126.35	
HAYWARD SUSAN MRS	350.39	142.32	492.71	1,298.99	2,899.68	4,198.67	Training related $2,573
LAWRENSON ROSS PROF	-	-	-	353.63	-	353.63	
MALONEY TANYA MS	65.22	583.73	648.95	313.05	583.73	896.78	
MURRAY NIGEL MR	-	-	-	6,478.89	(499.90)	5,978.99	Detail below
PARADINE BRETT MR	167.91	-	167.91	231.39	-	231.39	
TOMIC DAMIAN MR	-	-	-	2,332.27	-	2,332.27	
WATSON TOM MR	-	-	-	426.73	-	426.73	
WILSON JULIE MS	406.79	-	406.79	1,200.13	-	1,200.13	
WOLSTENCROFT IAN MR	146.96	-	146.96	146.96	-	146.96	
WRIGHT DEREK MR	-	-	-	-	63.48	63.48	
TER BEEK MARC MR	-	-	-	551.58	-	551.58	
NEVILLE MAUREEN MS	435.96	-	435.96	435.96	-	435.96	
Taxi	-	-	-	350.63	-	350.63	Largely CE costs
TOTAL	**1,573.23**	**726.05**	**2,299.28**	**14,796.92**	**3,046.99**	**17,843.91**	

Travel charges for the year to 30 September 2017				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
8 to 12 April 2017	1,084.40	CEO activity	Accommodation 4 nights	Auckland
20 to 23 April 2017	940.12	Meetings with officials and organisations re Waikato Med School	Accommodation, 3 nights	Wellington
27 April to 1 May 2017	275.70	Cairns - Waikato Med School, Sydney - Theatres/surgical performance	Accommodation, 1 night	Sydney
7 to 9 May 2017	430.09	Waikato Medical School	Accommodation, 2 nights	Wellington
18 to 20 May 2017	330.68	Speaker - Healthcare Reform conference	Accommodation, 2 nights	Wellington
14 to 15 June 2017	744.86	Presentation Medical School to DHB Chairs/CEs	Airfare (return), accommodation, 1 night	Wellington
25 to 26 June 2017	1,433.59	Meeting with Lance O'Sullivan re Smarthealth	Airfare (return), accommodation, 3 nights	Kaitaia
2 to 4 May 2017	665.31	Meetings re Smarthealth (2/5) and Medical School (3/5)	Accommodation, 2 nights	Auckland
25 to 26 May 2017	478.05	Procurement meeting 25/5, Pharmac 26/5, returned late to Auckland	Accommodation, 2 nights	Auckland
Aug 2017	(403.81)	Corrections from Tandem Travel	Airfares - corrections to original charges Sept 16	Sydney
	5,978.99			

Acting CE Travel Expenditure Neville Hablous

Travel charges for the year to 30 September 2017				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
	-			
	-			

MEMORANDUM TO THE BOARD
25 OCTOBER 2017

AGENDA ITEM 7.2

CREATING OUR FUTURES PROGRAMME – INDICATIVE BUSINESS CASE

Purpose	For approval

Content of Report

The Mental Health and Addictions Indicative Business Case Capital Infrastructure Long List Options are presented for the Board's review.

The purpose of the Programme Indicative Business Case is to seek formal approval from the Government's Capital Investment Committee to invest in the Waikato District Health Board (DHB) Mental Health and Addictions service (MH&AS). This investment is to ensure MH&AS service provision is safe, effective and efficient without compromising outcomes for service users and their family whanau, and staff; and supports the region's growing population needs, values and aspirations, now and into the future.

This investment includes the requirements for construction of fit for purpose environments that use evidenced based design to support current and future models of care, values and needs.

The following summarises the services that are considered in scope for the purposes of the business case:

- Acute and sub-acute mental health inpatient requirements (consideration to outreach areas and speciality services).
- Repatriation of adolescent and youth inpatient services from Auckland DHB's Starship.
- Appropriate co-location of High and Complex inpatient services.
- Relocation of ECT services to medical area or community-based service.
- Potential consolidation and co-location of AoD acute inpatient services (relocation of detoxification beds; and SACAT legislative requirements).
- Increased forensic footprint to meet the NZ Corrections increased capacity programme and reconfiguration of wards.

Investment Options

Eleven possible acute mental health inpatient options were considered for future services [including three Alcohol and other Drug, and three Forensic

increased capacity options (this assessment currently excludes the High and Complex requirements as this yet to be development)].

The three highest scoring acute mental health options against the criteria were:

a) **Main Waiora Hospital Campus New Build**
   Development of a holistic, flexible and modular build on main Waikato Hospital campus Ryburn site.

b) **New Build Green Fields**
   New fit-for-purpose build on green fields site (site to be determined)

c) **Main Waiora Hospital Campus and Outreach Builds**
   Development of a holistic, flexible and modular build on Waikato Hospital campus Ryburn site, and, purpose built community facilities in main rural outreach areas (rural north and rural south locations).

The highest scoring Alcohol and other Drugs options against the criteria were:

a) **HRBC full refurbishment [rebuild] of existing adult HRBC space**

b) **Co-location in new acute mental health build**

The highest scoring Puawai [Forensic] increased capacity options against the criteria were:

a) **Increased forensic footprint on current adult HRBC site (includes reconfiguration of current ward space) [rebuild]**

It is proposed that these options are taken into consideration for the Waiora Waikato Hospital campus strategic build plan, noting that further and full assessment is required prior to taking these options to the Detailed Business Case.

RECOMMENDATION
THAT

1) The Board receives the Mental Health and Addictions Service indicative options assessment.
2) The Board considers the highest scoring possible options within the Waiora Hospital Campus strategic build plan.

VICKI AITKEN, ACTING EXECUTIVE DIRECTOR, WAIKATO DHB MENTAL HEALTH AND ADDICTIONS SERVICE

IAN WOLSTENCROFT, EXECUTIVE DIRECTOR, WAIKATO DHB STRATEGIC PROJECTS

ANNEX: Long List Options Assessment Methodology

The benefits form the *evaluation framework* against which all long list options are assessed. The benefits are those identified within the Creating Our Futures programme investment logic map.

Assessment Key:

Indicator	Explanation	
○ ○ ○	No benefit	*Each of the long-list options will be subjectively evaluated for meeting the programme benefits.*
● ○ ○	Minimum benefit	
● ● ○	Moderate benefit	
● ● ●	Significant benefit	

Benefits Key:

Benefits	Assessment Criterion Comment
Improved Access and Health Outcomes	KPI 1: improve the degree of recovery KPI 2: improve time to recovery aspirations / return to daily activites KPI 3: recovery aspirations achieved and sustained over time KPI 4: improve end-to-end recovery aspirations
Improved Experience and Engagement	KPI 1: improve communication and information sharing KPI 2: encourage and support participation and collaboration in recovery decision making KPI 3: improve co-ordination/transition of care between and across services/providers KPI 4: treat service users and whanau with dignity and respect
Therapeutic and Safe Environments	KPI 1: holistic care disutility[1] (SAC1/SAC2, accreditation, clinical audit) KPI 2: engage proactive participation in managing risk KPI 3: service user and whanau lead co-design, safety and quality KPI 4: sustainable therapeutic environments
Operational Efficiency and Effectiveness Gains	KPI 1: care is coordinated across the system (shared recovery plan) KPI 2: care is delivered at the appropriate location KPI 3: evidence based practice throughout the care trajectory
Workforce Gains	KPI 1: staff wellbeing KPI 2: increase the capability and capacity of the consumer, peer-led, family / whanau workforce KPI 3: increase the cultural competency of the workforce

[1] Disutility refers to the adverse or harmful effects associated with a particular activity or process

Table 1 Acute Inpatient Mental Health Long List Options – initial summary

Option	**1,2**	**3**	**4**	**5**	**6**	**7**	**8, 9, 10**	**11**
	Main Campus New Build	**HRBC and Outreach Builds**	**New Build Green Fields**	**NGO/Private Sector Development**	**Tokanui Rebuild**	**Retreat Centres**	**JV with Regional DHB(s)**	**HRBC Refurbishment**
Location Summary	New fit-for-purpose build/s on Waikato Hospital campus. - Development of a holistic, flexible and modular build on Waikato Hospital campus Ryburn site or other identified site. OR - Development of a step down transitional build within the least restrictive environment.	Refurbishment and repurpose HRBC adult wards and outreach community development builds. - HRBC development of 2 adult wards and 1 prison muster ward within current footprint. AND - Purpose built community facilities in main rural outreach areas (rural north and rural south location).	New build on newly purchased Waikato DHB land; and HRBC repurpose.	Procurement of new MH&AS acute service provider (e.g. NGO or other private sector agency/ies). - New fit-for-purpose build/s on newly purchased land. OR - New fit-for-purpose build/s on Waikato DHB site/s.	New fit for purpose build on Tokanui land.	Respite and therapeutic retreat centres (elimination of acute inpatient services). - Build or refurbish of community facilities (therapeutic retreat centres with specialised programmes). - Health and social sector collaboration and flexible funding models (namely, funded access to retreat centres and programmes).	Development of a new inpatient facility to meet Waikato DHB MH&A service need in co-operation with Midlands DHBs. • Development of new Midlands DHB inpatient facility on existing DHB site. OR • Development of new Midlands DHB inpatient facility on greenfields site. OR • Develop of Waikato DHB new inpatient facility and partial Midlands JV for speciality services	Refurbishment of adult HRBC facilities to meet 3 - 5 year capacity.
Key Consider-ations	- The provision of a purpose built facility that provides sufficient capacity for current and future demand is expected to positively impact on each of the problems described in the ILM. - Option assumes main campus ability to release space for development. - Limited space options on main campus due to soft fill.	- Potential rebuild required as existing HRBC facility is outdated and based on an institutional footprint, low natural light and limited outdoor space. - HRBC space constraints limits expected medium / long term demand. - Community and inpatient proximity a significant integration benefit. - Option assumes outreach land available.	- Significant capital investment. - Clinical considerations for distances and transfer. - Possible community stigma and unknown / existing issues within the community confounding MH&A problems. - Potential lack of proximity to medical and emergency care.	- Significant capital investment. - Unknown preferred supplier / provider/s. - Possible delays in identifying, procuring new site and/or provider/s. - Possible issues with quality of workforce and training. - Possible issues with compliance with the Mental Health Act.	- Possible out-dated institutional model (potential stigma). - Significant capital investment. - Possible oversized build footprint. - Possible time delays in demolishing existing Tokanui infrastructure and rebuild. - Possible lack of proximity to community for outreach areas. - Potential lack of proximity to medical and emergency care.	- Significant investment into longitudinal community / primary health care. - Possible issues on decision programme and funding disputes. - Possible challenges with provision of care across the continuum. - Significant social housing investment. - Possible issues with quality of workforce and training. - Potential lack of proximity to medical and emergency care. - Possible issues with compliance with the Mental Health Act.	- JV would combine expertise in a centre of specialty and excellence - Interface risks around competing DHB needs. - Lack of proximity to community based teams (significant disadvantage to community integration). - Requirement for service user's transfer of significant distances to/from. - No existing regional capacity therefore all require new build.	- Potential rebuild required as existing HRBC facility is outdated and based on an institutional footprint, low natural light and limited outdoor space. - Unresolved practice of locked/secure wards; and seclusion. - Unlikely to effectively address critical risk factors. - Decant costs during construction. - Inability to accommodate need for increased capacity (prison muster and SACAT).

Table 2 Initial Acute Inpatient Mental Health Long List Options – initial assessment

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
	Main Campus New Build	**Main Campus New Build**	**HRBC and Outreach Builds**	**New Build Green Fields**	**NGO/Private Sector Development**	**Tokanui Rebuild**	**Retreat Centres**	**JV with Regional DHB(s)**	**JV with Regional DHB(s)**	**JV with Regional DHB(s)**	**HRBC Refurbishment**
Options	New Acute MH&AS build and HRBC Repurpose Waikato Hospital Campus.	New Adult Acute MH&AS build and HRBC repurpose Waikato Hospital campus.	New local builds, at Waikato DHB Hospital sites, including Hamilton and outreach locations; and HRBC repurpose.	New Build on newly purchased Waikato DHB land; and HRBC repurpose.	New build on either DHB, non-Government Organisation / Private sector sites.	'Fit for purpose' new build on Tokanui land.	Respite and therapeutic retreat centres (elimination of acute inpatient services).	Joint venture options with Midlands Regional DHB, including Lakes, Bay of Plenty, Tairawhiti, Taranaki existing Hospital Campus.	Joint venture options with Midlands Regional DHB, including Lakes, Bay of Plenty, Tairawhiti, Taranaki a new site.	New builds - Waikato DHB adult inpatient and Partial joint venture with Midlands Regional DHB for specific need.	HRBC Acute Adult full refurbishment, Waikato Hospital Campus.
Improved Access and Health Outcomes	●●○	●○○	●○○	●●●	●●●	○○○	●○○	●○○	○○○	●●○	○○○
Improved Experience and Engagement	●●○	○○○	●○○	●●●	●●●	○○○	●●○	●○○	○○○	●●●	○○○
Therapeutic and Safe Environments	●○○	●○○	○○○	●●●	●●●	○○○	●●○	●●●	●●●	●●○	○○○
Operational Efficiency and Effectiveness Gains	●●○	●●○	●○○	●○○	●○○	○○○	●○○	●○○	●○○	●●○	○○○
Workforce Gains	●●●	●○○	●○○	●○○	●○○	○○○	●●○	●●○	○○○	●●○	○○○

Tables 3 & 4 Alcohol and other Drugs Long List Options – initial summary

Alcohol and other Drugs Long List Options – summary of location

	1	2	3
	Repurpose HRBC footprint	**Co-location**	**Main Campus and Outreach Builds**
Location Summary	Refurbishment of existing adult HRBC ward to meet AoD future requirements.	Main Waikato Hospital new development footprint includes capacity to meet requirements for AoD service provision.	New development on main Waikato Hospital site and outreach areas to provide full AoD services.
Key Consider-ations	- Outdated institutional footprint and space constraint. - Option assumes new acute inpatient developments.	- Assumes new acute MH development. - Additional land required. - Clinical considerations of co-location of detoxification, SACAT and psychosis service provision.	- Assumes co-location of detoxification beds, SACAT and psychosis service provision.

Alcohol and other Drugs Long List Options – initial assessment

	1	2	3
	Repurpose HRBC footprint	**Co-location**	**Main Campus and Outreach Builds**
Improved Access and Health Outcomes	●●○	●●○	●●●
Improved Experience and Engagement	○○○	●●●	●●●
Therapeutic and Safe Environments	●●○	●●●	●○○
Operational Efficiency and Effectiveness Gains	●●○	●●●	○○○
Workforce Gains	●●○	●●●	●○○

Tables 5 & 6 Pauwai Increased Capacity Long List Options – initial summary

Pauwai Long List Options – summary of location

	1 Extend Pauwai footprint	2 Repurpose adult HRBC footprint	3 Rebuild on HRBC footprint
Location Summary	Extend the Puawai footprint – additional level.	Refurbishment of existing adult HRBC ward to meet increased prison muster capacity.	New purpose built development on adult HRBC site.
Key Consider-ations	- Above ground-level wards pose risk and security / access considerations. - Additional land required for outdoor and de-escalation space.	- The existing adult HRBC building is not intended for forensic wards. - Outdated institutional footprint and space constraint. - Option assumes new acute inpatient and AoD developments.	- The provision of a purpose-built facility (and ability to reconfigure Pauwai wards) that provides sufficient capacity. - Significant investment cost.

Pauwai Long List Options – initial assessment

	1 Extend Pauwai footprint	2 Repurpose adult HRBC footprint	3 Rebuild on HRBC footprint
Improved Access and Health Outcomes	○○○	●●○	○○○
Improved Experience and Engagement	○○○	●●○	○○○
Therapeutic and Safe Environments	○○○	●●○	○○○
Operational Efficiency and Effectiveness Gains	●○○	●●○	○○○
Workforce Gains	●○○	●●○	○○○

Presentations

No presentations this month.

Papers for Information

MEMORANDUM TO THE BOARD
25 OCTOBER 2017

AGENDA ITEM 9.1

HEALTH TARGETS REPORT

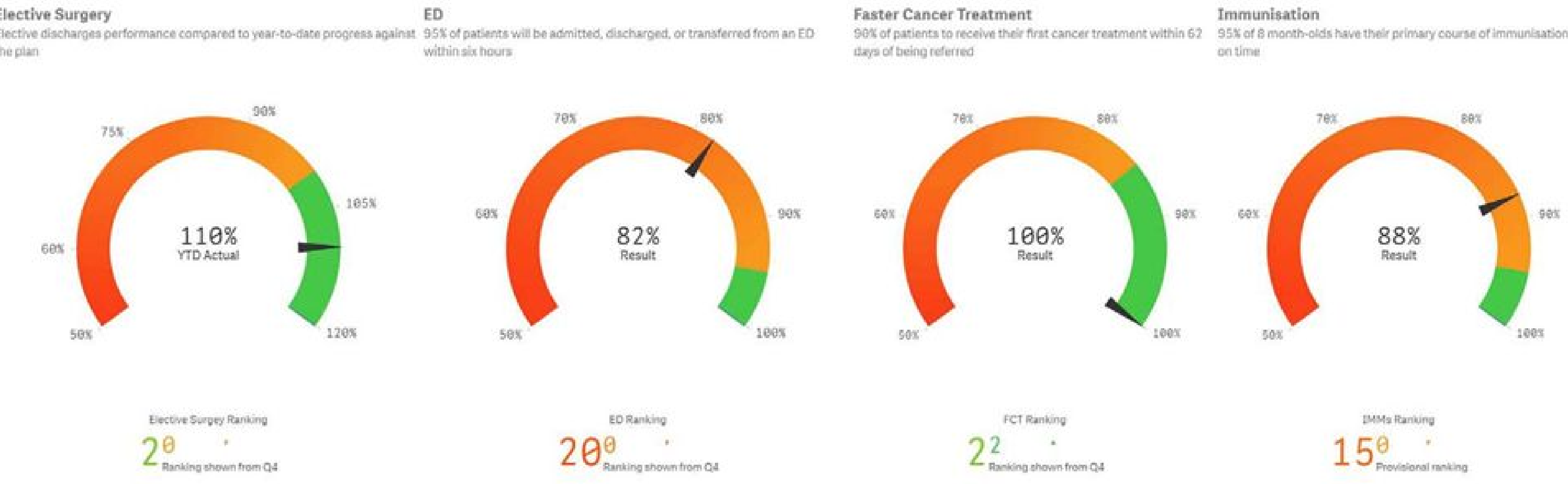
Purpose	For information.

Most recent results

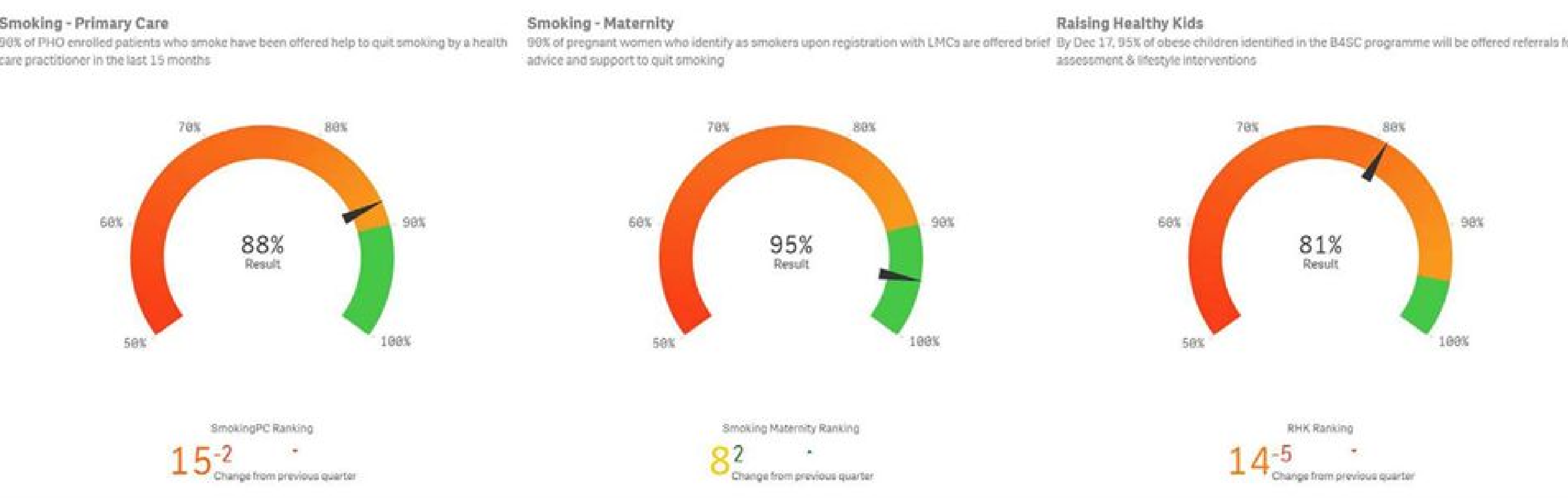
The newly designed dashboard on page 2 shows a summary of performance for Waikato DHB's health target results using the latest available monthly or quarterly data. DHB comparison rankings for 2016/17 quarter four performance are included where available as results for quarter one 17/18 were not available at time of report writing.

Pages following the dashboard give a more in depth picture of each individual health target along with performance narratives and activities underway or planned to improve results.

Latest monthly results (September 2017)



Latest quarterly results (Q4 1617)



Target: Shorter stays in Emergency Departments (ED)

Table 1 - DHB quarter results 2017

DHB Q4 result 12/13	DHB Q4 result 13/14	DHB Q4 result 14/15	DHB Target 15/16	DHB Q1 result 15/16	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
88.4% 18th ranking	93.0% 16th ranking	94.0% 16th ranking	**95%**	89.5% 18th ranking	91.9% 16th ranking	90.5% 19th ranking	**91%**	**89.3%**	**87.6%**	**88.4%**	**85.8%**	**82.1%**

Table 2 – 2017 ED results for September

	Clinical Unit	Mth Attendances	Sep'17 %	YTD Attendances	YTD %
By Specialty/Division (Waikato Hospital Only)	General & Specialty Surgery	813	66.4%	2454	71.3%
	Cardiology	349	46.1%	1005	49.8%
	Cardiothoracic Surgery	14	71.4%	46	80.4%
	Critical Care	6	100.0%	24	90.9%
	Paediatrics	569	84.0%	1956	77.4%
	Emergency Department	2993	90.7%	10025	88.6%
	Internal Medicine	1020	66.1%	3425	62.2%
	Womens Care	151	64.9%	422	65.6%
	Oncology	94	61.3%	277	67.4%
	Orthopaedics	261	72.7%	780	72.1%
	Renal	76	71.1%	227	69.9%
	Vascular Surgery	46	73.9%	133	86.5%
	Allied Health	0	0.0%	1	100.0%
	Community Services	0	0.0%	0	0.0%
	Older Persons	3	100.0%	5	100.0%
	Mental Health	101	80.6%	180	81.3%
By Site	Waikato Hospital	6496	78.2%	21030	77.3%
	Tokoroa Hospital	1061	96.3%	3527	96.8%
	Thames Hospital	1409	88.3%	4548	87.4%
	Taumarunui Hospital	468	97.2%	1495	96.7%
	Total Health Waikato	**9434**	**82.6%**	**30600**	**81.9%**

NB: From 1 July 2013 Tokoroa and Taumarunui EDs have been added to the calculation.

* By specialty for Waikato Hospital Only

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

Shorter Stays in Emergency Departments (EDs) health target
DHB name: Waikato
Quarter: 1 - 2018

Quarterly Results – by DHB total population

	Numerator: The number of ED presentations with a length of stay of less than six hours	Denominator: Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	23773	28969	82.1%
Waikato	15494	20013	77.4%
Taumarunui	1417	1464	96.8%
Thames	3675	4201	87.5%
Tokoroa	3187	3291	96.8%

Quarterly results – by ethnicity

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

	Māori Ethnicity			Pacific Ethnicity		
	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	6842	8173	83.7%	555	776	71.5%
Waikato	4309	5503	78.3%	416	625	66.6%
Taumarunui	611	630	97.0%	15	15	100.0%
Thames	627	714	87.8%	35	42	83.3%
Tokoroa	1295	1326	97.7%	89	94	94.7%

The result for the first quarter was 82.1% for Waikato DHB, which reflects the significantly high presentation number of nearly 29,000 to the emergency department this quarter.

For September 2017, the DHB has continued to struggle with performance against the six hour target, however performance has risen slightly when compared to July and August. September ED attendances have decreased to below 10,000 attendances for the first time in three months.

Thames, Tokoroa and Taumarunui Hospitals

There has been a significant increase in ED presentations at both Thames and Tokoroa compared to the same time last year (+21% or 622 cases YTD at Tokoroa, and +15% (600 cases) at Thames).

The overall context remains unchanged from that previously reported: access to primary care alternatives continues to be an issue in both locations. (The number of GPs in active practice has reduced). Access to inpatient beds at Thames has also been more constrained than usual due to overall hospital occupancy.

In response an additional medical swing shift was added at Tokoroa for July/August to address the winter peak. The trial of a SmartHealth booth has also commenced there albeit with limited uptake. A pilot of ED medical consultations via telehealth linking the EDs at both Tokoroa and Thames has occurred prior to a more through pilot in October.

Options for managing low acuity presentations in Taumarunui differently by implementing a Single Point of Entry (SPOE) model of service are under active discussion between Kokiri Trust and the DHB's Southern Rural Health service. Under a SPOE model patients are triaged to be seen in either the ED or at a general practice located onsite based on the nature of their condition. That model of service has existed at Te Kuiti for a decade or more. The flat demand curve that has been sustained over a number of years is a marked feature of Te Kuiti's performance relative to all other Emergency Departments operated by the DHB. A GP practice in Thames has formally approached the DHB seeking to lease part of the Thames Hospital facility from which to operate. The practice

understands that the DHB would require the delivery of urgent primary care services outside of normal weekday business hours if this was to occur.

Waikato Hospital

The large number of winter presentations did not carry through to September. While the overall rate for the Shorter stays in Emergency Departments target was very disappointing at 78.2%, performance for patients discharged straight home from the ED showed a small improvement from the prior month at 90.7% for September compared to the August result of 89.6%.

The reduction in presentations to the emergency department assisted and it is possible that the opening of the 26 bedded OPR5 ward, early effects of introduction of the new SAFER initiative and other pieces of work that have commenced to improve throughput contributed to this small improvement.

The medical workforce has been strengthened with a new SMO starting work in the department. Another two SMOs will be starting soon. Furthermore the Clinical Director for the Emergency Department, Dr Ian Martin, has commenced in his role and has identified a review of the medical staff rostering as one of his three priorities.

The emergency department team has been progressing a number of initiatives to make the bigger differences in performance that we seek. The team has been developing a "Better Way" of delivering health care in the emergency department using a "Plan Do Study Act" methodology. This will be trialled from 16-20 October and will simultaneously test seven changes:

1. Establish a single area of assessment by closing Acute Medicine Unit assessment area
2. Avoid duplication of medical assessment
3. Change Acute Medicine Unit registrar shift to 1pm-10pm
4. Primary on call General Medicine SMO based in the emergency department from 1pm to 6pm instead of being located in the Acute Medicine Unit
5. Patients referred to internal medicine will be physically located in the emergency department
6. Cardiology and respiratory teams on board with these changes
7. Bed management awareness of changes occurs

Work continues in Waikato Hospital emergency department with input from our change team to focus on the "see and treat" patients and front of house triaging to help refine and standardise processes so that these patients are pulled through in a timely way.

An acute medicine unit (AMU) working group is meeting weekly to also look at more effective ways of using our AMU in the future. Internal Medicine has seen an improvement from 62.2% to 66.1% and we expect to see further improvement with a number of initiatives underway.

A visit on 13 October from Dr Peter Jones (the Ministry of Health Target Champion) was encouraging regarding our approach to patient flow.

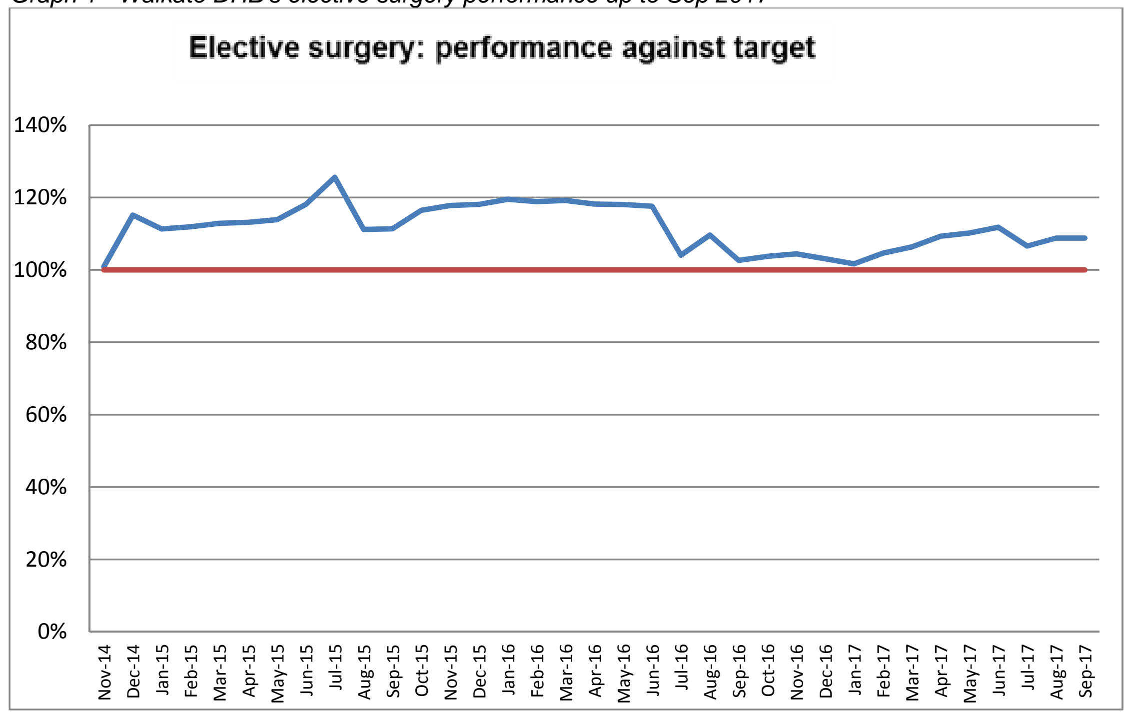
Target: Elective Surgery

Table 4 – Elective Surgery Results by Quarter

Quarter	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Result	102.6%	103.1%	106.3%	111.8%	108.8%
Ranking	**7**	**10**	**3**	**2**	**Awaiting ranking**

The 17/18 YTD target fro September was 4.578 discharges. Graph 1 below provides the most recent result of 108.8% a total of 5,025 actual discharges for the period from 1 July 2017 to 30 September 2017.

Graph 1 - Waikato DHB's elective surgery performance up to Sep 2017



Target: Faster Cancer Treatment (FCT)

Table 5 - Summary of achievement against the FCT health target from July 2015 to September 2017

FCT 62 DAY HEALTH TARGET								
DHB Current Target	DHB Q2 Result 15/16	DHB Q3 Result 15/16	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	**DHB Q1 Result 17/18**
90%	68.0% 17th ranking	76.5% 10th ranking	72.6% 14th ranking	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	**100% Provisional**
FCT VOLUME TARGET								
DHB Current Target	DHB Q2 Result 15/16	DHB Q3 Result 15/16	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	**DHB Q1 Result 17/18**
25%	16% 14th ranking	14% 15th ranking	14%	17%	19%	19%	22%	**16% Provisional**

The 2016/17 quarter 4 result of 86.4% (for the six months January to June 2017) shows that Waikato has continued to deliver sustained achievement against the 85% health target. This confirms the result that Waikato ranked second nationally for this metric for 2016/17.

This is the first quarter that we have been measured against the 2017/18 Faster Cancer Treatment Target. For this year the target has been increased from 85% to 90%, whilst at the same time amending the target so that patients who are not seen within the specified timeframe due to either patient choice or clinical considerations are not counted as breaches of the target.

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

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

Achievement of health target by month Nov 2015 to Sep 2017

% 62 day result — 62 day target

Q1 Data provisional

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

- FCT Business Manager and FCT Nurse Tracker are working very closely with cancer care coordinators and clinical nurse specialists monitoring patient pathways from initial date of referral
- Improving the timeliness of gynaecology triaging and first specialist appointment

- Weekly coordinated meeting with the gynaecology clinical nurse specialist and cancer care coordinator to discuss individual patients and tracking pathways to ensure patients are discussed at Auckland multi-disciplinary meetings in a timely manner
- Ongoing monitoring of respiratory triaging and time to FSA
- Weekly coordinated meeting with upper gastro-intestinal surgeons and upper gastro-intestinal cancer nurse coordinator to discuss and track individual patients to ensure patients proceed along the pathway in a timely manner.
- Liaising with interventional radiologists to ensure patients receive their CT biopsy in a timely manner.
- Weekly urology waitlist meeting to discuss any patients triaged onto 62 day pathway.
- Monitoring and collaborative approach between breast care and plastics for women requiring immediate breast reconstruction.
- Engagement with Te Puna Oranga to minimise inequity in FCT, including addressing DNAs and identifying barriers
- Daily reports are now being generated to highlight any DNAs for FCT patients

Graph 3 - Faster Cancer Treatment health target performance for Q1 2017-18 by month

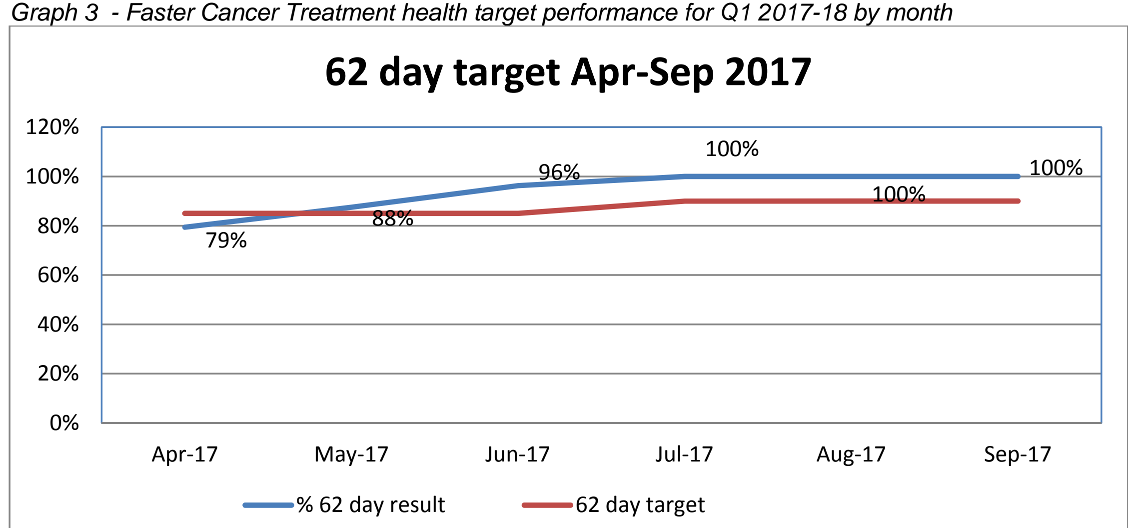


Table 6 - Faster Cancer Treatment health target performance for Q1 2017-18 by month

Local FCT Database	Jul-17	Aug-17	Sep-17	Total
Number of records submitted	21	29	29	79
Number of records within 62 days	21	29	29	79
% 62 day Target Met (90%)	100%	100%	100%	100%
% Volume Target Met (15%)	13%	16%	17%	16%

Target: Increased immunisations for 8 months

Table 7 – 8mth Milestone Immunisation Results by Quarter

Quarter	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Result	**92.3%**	**91.8%**	**90.0%**	**89.0%**	**88.0%**
Maori	**89.4%**	**89.1%**	**91.0%**	**86.0%**	**82.0%**
Ranking	**13**	**15**	**16**	**15**	**15 (provisional)**

Data for this target is reported on a three month rolling basis. Graph 4 shows our most recent result of 88% for the three month period from 1 Jul 2017 to 30 Sep 2017.

Waikato DHB has not met this target to date despite a range of well-established additional services such as outreach immunisation and the child health coordination services which have been in place for the last five years. Our Immunisation Action Plan and the associated activities undertaken by PHOs, the NIR and Outreach Immunisation Services are recognised as very useful by the MoH and the Chief Child Health Advisor the MoH are at loss to understand why we cannot meet this target.

The drop in coverage for Māori Tamariki over the last 6 months is a major concern for Waikato DHB. Our outreach providers and PHO s report the reason may be the negative impact of the Vaxxed film , transient families who are difficult to contact, higher winter illness for both whanau and PHO staff, and poor mobile phone connectivity. We are aware that there is often multiple home visits by Outreach services before vaccination events are completed.

Over recent months good communication channels have been developed to promote and support immunisation with Well Child/ Tamariki Ora providers, Plunket and LMCs through the maternity collaborative teleconferences. The PHOs are working with general practices to reduce the number of declines and delayers for both Maori and the total population and identify those families who may move from a delayer to receiving vaccination on time with additional engagement.

The MoH and Waikato DHB share concerns around structural fragmentation instead of integration of child health services. Our community paediatrician is concerned about missed opportunities for opportunistic immunization in general practice, and whether our missing events services are working effectively. There is overall concern that general practice and outreach and other arrangements in place are getting us over the line.

We are waiting for a formal letter from the Chief Child Health Advisor to inform our next action plan and have received the new action plan from the Bay of Plenty DHB to review in the Waikato context.

A workshop with primary care partners will occur in November to discussa refocus around immunisatioin.

Graph 4 - Waikato DHB's fully immunised rates for 8 month olds (rolling three month result)

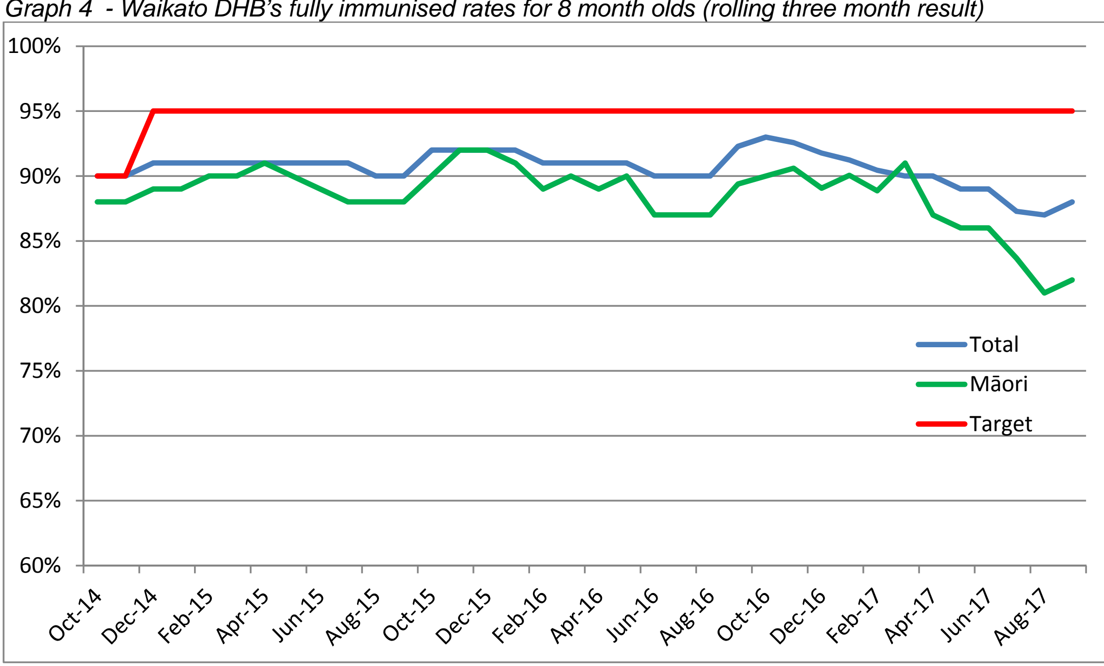


Table 8 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 108 additional children needed to be immunised to meet the 95% target.

Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from July 2017 to September 2017

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
Asian	186	186	100%	0
Māori	532	436	82%	70
NZ European	531	479	90%	26
Other	112	99	88%	8
Pacific	59	54	92%	3
Total across ethnicities				107
Total	1,420	1,254	88.31%	95

Table 9 below shows the latest immunisation rates for the eight month population for Waikato DHB by PHO and the population not fully enrolled with a Waikato based PHO.

Table 9 - Waikato DHB's PHO level results for 8 month old immunisation from Jul 2017 to Sep 2017

	Total population			Maori population		
PHO	No eligible population	No fully immunised population	Percent immunised	No eligible population	No fully immunised population	Percent immunised
Hauraki PHO	482	427	89%	207	173	84%
Midlands Health Network – Waikato	782	709	91%	244	210	86%
National Hauora Coalition	25	25	100%	16	16	100%
Enrolled with a PHO outside of Waikato	47	40	85%	21	16	76%
Unenrolled Waikato population	84	53	63%	44	21	48%
DHB Total	1,420	1,254	88%	532	436	82%

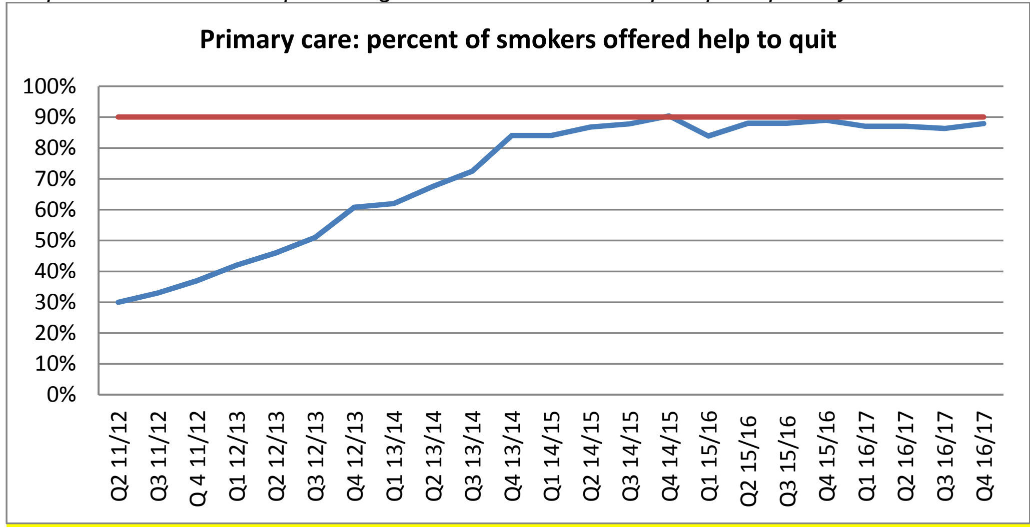
Target: Better help for smokers to quit - primary care

Table 10 – Quarterly Results

DHB Q4 result 14/15	**DHB Target 16/17**	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	DHB Q2 result 16/17	DHB Q2 result 16/17	**Most recent result Q4 16/17**
90.4% 10th ranking	**90%**	88% 7th ranking	88% 6th ranking	89% 8th ranking	87% 7th ranking	87% 12th ranking	86% 13th ranking	**88% 15th ranking**

Graph 5 of the quarter four final result of 87.9% shows Waikato DHB has increased from the previous quarter.

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



Following a recent discussion at the Waikato inter-alliance forum we are aware that approaches are occurring in relation to both improving achievement against this target and improving primary care referrals for cessation. Information for quarter 4 suggests this may have begun to impact on results particularly in NHC and Hauraki PHO practices.

Table 11 shows a breakdown of primary care smoking results by PHOs for 2016/17 quarter four.

Table 11 – 2016/17 Q4 primary care smoking results by PHOs (target 90%)

PHOs	**Tobacco Numerator**	**Tobacco Denominator**	**2016/17 Q4 result**	**2016/17 Q3 result**	**2016/17 Q2 result**	**2016/17 Q1 result**
Midlands Health Network	25,527	29,324	87%	88%	88%	88%
Hauraki PHO	20,771	23,397	89%	86%	86%	86%
National Hauora Coalition	1,258	1,345	94%	87%	86%	87%
Total	46,791	54,204	**86%**	**86%**	**87%**	**87%**

Target: Better help for smokers to quit - maternity

Table 12 – Quarterly Results

DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	DHB Q2 16/17	DHB Q3 16/17	**Most recent result Q4 16/17**	**Most recent result Q4 16/17**
89% 15th ranking	97% 8th ranking	95% 13th ranking	93% 12th Ranking	98% 4th Ranking	96% 12th Ranking	**95% 8th Ranking**	**95% 8th Ranking**

Graph 6 quarter two result of 95% shows we continue to met this target.

Graph 6 - Waikato DHB's percentage of smokers offered help to quit in maternity

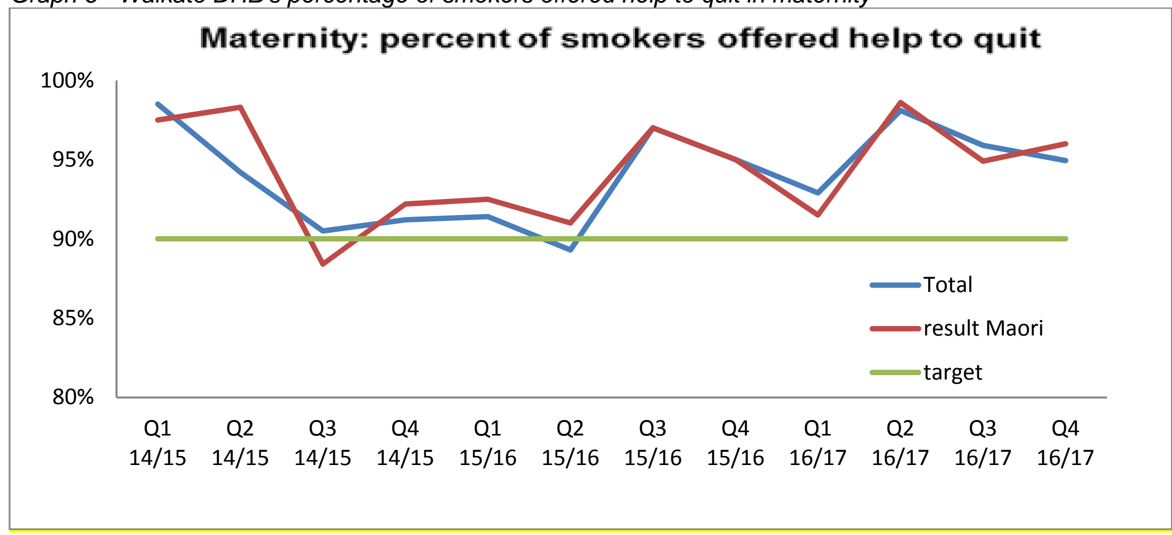


Table 13 shows our quarter three results provided by the Ministry for our total and Maori population.

Table 13 – 2016/17 Q4 maternity smoking status and advice results (target 90%)

	No. women registered *	**No. of women identified as smokers**	**No. people given advice**	**Smoking prevalence**	**Percent of smokers offered advice**
Maori	122	50	48	41%	96.00%
Total	479	79	75	16%	94.94%

**Data comes from three sources: Midwifery and Maternity Providers Organisations (MMPOs), Lead Maternity Carers Services (LMCs) and from DHB employed midwives (if available)*[1]

The information for this measure is received directly from the Ministry of Health. Concerns exist around the completeness of this information given total birth numbers for the Waikato District. Communications have occurred with the Ministry of Health in relation to increasing the completeness of this data.

[1] Note, Waikato DHB has reported to the Ministry that the data shows significantly less first registrations with a midwife than expected in Waikato. The Ministry has informed us full activity is not reflected in the data for other DHBs also and they are working through the accuracy of information but have yet to resolve the problem.

Target: Raising healthy kids

On 30 June 2016 the Ministry launched the new Raising Healthy Kids health target. The target reads that by December 2017, 95% of obese children identified in the B4 School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Target results only capture children aged four to five who have had a B4SC.

The health target is one of two targeted interventions in the Ministry's Childhood Obesity Plan. The Obesity Plan has three focus areas made up of 22 initiatives across three areas; (1) targeted interventions, (2) increased support and (3) broad population approaches. The two targeted intervention initiatives are Raising Healthy Kids target and access to nutrition and physical activity programmes for families.

Locally the introduction of the target is led out by the Waikato Child Health Network chaired by our primary care clinical lead and GP Child health liaison doctor. The health target is just one part of both a national and district wide multifaceted approach to tackle child hood obesity including amongst others health promotion, Green Prescription, Project Energize, Under-fives Energize and Bodywise. The key aim of the target is that health professionals will manage clinical risks associated with obesity, encourage and support family and whanau to take actions around nutrition, lifestyle and physical activity and importantly regularly monitor children's growth.

Our GP Liaison is working on the referral pathways for children identified as very overweight (BMI> 98 centile). Our scope has been broadened to include BMI >91% centile. As our B4SC checks are done in general practice by the child's usual practice nurse referrals will be made to the family general practitioner within 30 days of the check, recorded formally and reported to the national B4SC system. We are also ensuring that our referral pathways include a missing events service as we anticipate almost all children will be referred but not all will return for and appointment.

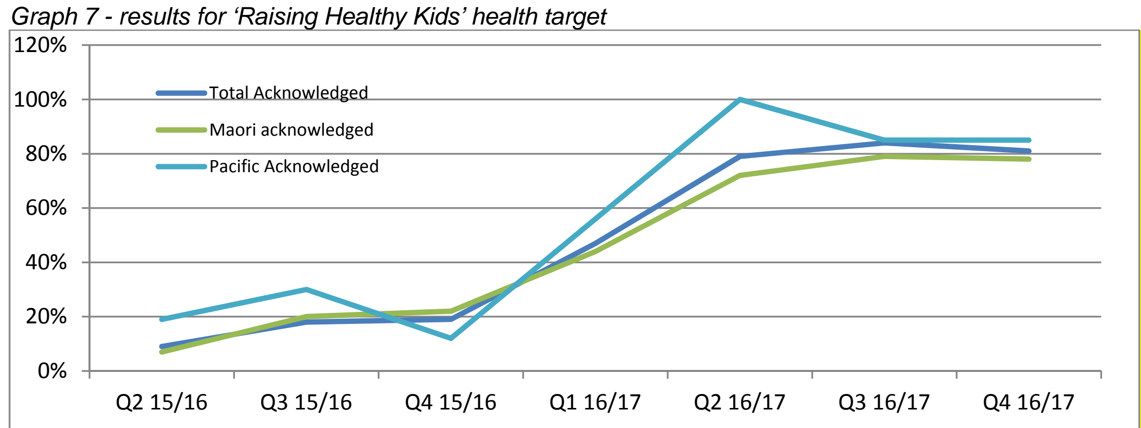
Table 14 – 2016/17 Q4 Raising Healthy Kids Results (target 95%)

		Waikato DHB						**National**
		2015/16 Q3	**2015/16 Q4**	**2016/17 Q1**	**2016/17 Q2**	**2016/17 Q3**	**2016/17 Q4**	**2016/17 Q4**
		Six mths Dec 15	**Six mths Mar 16**	**Six mths Aug 16**	**Six mths Nov 16**	**Six mths Feb 17**	**Six mths May17**	**Six mths May 17**
Total	Referral Sent	18%	23%	50%	82% (141)	86% (133)	83% (102)	94 %
	Referral Sent and Acknowledged	**18%**	**19%**	**47%**	**79% (135)**	**84% (127)**	**81% (98)**	**91%**
Maori	Referral Sent	21%	30%	49%	76% (63)	82% (65)	80% (43)	91%
	Referral Sent and Acknowledged	**20%**	**22%**	**44%**	**72% (58)**	**79% (61)**	**78% (41)**	**88%**
Pacific	Referral Sent	30%	12%	56%	100% (11)	90% (9)	88% (10)	98%
	Referral Sent and Acknowledged	**30%**	**12%**	**56%**	**100% (11)**	**85% (8)**	**75% (8)**	**95%**

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

Recent advice has been received from the Ministry of Health in relation to some additional funding that will be provided to support services for the children identified as very overweight through the B4SC process. The approach to how this funding can provide maximum benefit is currently under discussion.

Graph 7 - results for 'Raising Healthy Kids' health target



Data for a 6 month rolling period up to July 2017

Recommendation
THAT
The Board receives this report.

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

BRETT PARADINE
EXECUTIVE DIRECTOR
WAIKATO HOSPITAL SERVICES

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY AND CLINICAL SUPPORT

MEMORANDUM TO THE BOARD
25 OCTOBER 2017

AGENDA ITEM 9.2

PROVIDER ARM KEY PERFORMANCE DASHBOARD

Purpose	For information.

The high level provider arm key performance dashboards for September 2017 are attached for the Board's information. This sees three separate dashboards, which cover:

1. Community & Clinical Support
2. Mental Health
3. Waikato Hospital.

Any indicator where performance is below plan by more than 5% is marked red in the "variance" column. For any items marked red in the year to date (YTD) variance column, notes are appended to the report regarding:

- the cause(s) of less than planned performance (where known);
- the approach being taken to address it; and
- an estimate of timeframe for performance to improve.

Recommendation
THAT
The Board notes the report.

MARK SPITTAL	**DEREK WRIGHT**	**BRETT PARADINE**
EXECUTIVE DIRECTOR	**EXECUTIVE DIRECTOR**	**EXECUTIVE DIRECTOR**
COMMUNITY & CLINICAL SUPPORT	**MENTAL HEALTH**	**WAIKATO HOSPITAL SERVICES**

Key Performance Dashboard

Community & Clinical Support

September 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	92.7	95.0	(2.3)	92.4	95.0	(3)		
Number of long wait patients on outpatient waiting lists	# > 4 mths	0	0	0					
Number of long wait patients on inpatient waiting lists	# > 4 mths	0	0	0					
CTs reported within 6 weeks of referral	%	86.9	90.0	(3.1)	86.7	90.0	(3.3)		
MRIs reported within 6 weeks of referral	%	83.6	85.0	(1.4)	84.8	85.0	(0.2)		

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department - Number relative to Target growth of 4% p.a.	Numbers	Rolling 12 month measure			35,290	34,507	(783)		
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			79.8	80.2	(0.5)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			93.7	99.6	(5.9)		1
Laboratory – Histology specimens reported within 7 days of receipt	% for Aug YTD	-	80.0	(80.0)		80.0			
Pharmacy - Chart turnaround times, % within 2.5 hours	%	99.0	80.0	19.0	95.0	80.0	15.0		
Pharmacy on Meade script turnaround time in minutes	minutes	0.0	10.0	10.0	8.2	10.0	1.9		
Outpatient DNA Rate	%	10.8	10.0	(1)	11.1	10.0	(1.1)		2
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	84.2	100.0	(15.8)	86.4	100.0	(13.6)		3
Output Delivery Against Plan - Inpatient Number of Episodes	%	95.0	100.0	(5.0)	97.5	100.0	(2.5)		
Output Delivery Against Plan - Inpatient CWD Volumes	%	88.4	100.0	(11.6)	94.0	100.0	(6.0)		4
District Nurse Contacts (DHB Purchased)	Numbers	10,257	-		30,959				
District Nurse Contacts (ACC Purchased)	Numbers	1,908	-		6,078				

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Assigned EDD (SAFER)	%	86	100	(14)	78	100	(22)		5
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			3.36	3.24	(0.12)		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			1.40	1.07	(0.32)		6
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			0.31	0.32	0.00		

Health target measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	86.9	95.0	(8.1)	89.6	95.0	(5.4)		7

Quality Indicators - Patient Safety

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Breast screening Total volumes - Waikato DHB	Numbers	3,850	4,050	(200)	11,069	12,300	(1231)		8
Breast screening Maori volumes - Waikato DHB	Numbers	388	328	60	1,107	1,007	100		
Hospital Acquired MRSA (Department)	Numbers	0	0	0	0	0	0		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints resolved within 20 wd (1 month lag)	% for Aug-17	83	70	13	92	70	22		
Falls Resulting in Harm	Numbers	0	0	0	2	1	(1)		9
Pressure Injuries - Total	Numbers	0	0	0	0	0	0		
Patient Feedback	*Not yet collected - in Development*								

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	3,380	3,617	(236)	10,934	10,378	556		
Actual Expenditure vs Budget ($000s)	$000s	14,878	14,944	66	45,982	44,692	(1,290)		
Actual Contribution vs Budget ($000s)	$000s	(11,497)	(11,327)	(170)	(35,048)	(34,314)	(734)		
Actual FTEs vs Budget	FTEs	1,008.8	1,025.8	17.1	1,011.8	1,025.1	13.4		
Sick Leave	% of paid hours	3.2	3.2	0.1	4.0	3.2	(0.7)		10
Overtime $'s	$000s	179	151	(28)	541	396	(145)		11
Annual Leave Taken	% of Budget	Rolling 12 month measure			86.3	100.0	(13.7)		12

Key - MTD Measures
At or above target
Below target by less than 5%
Below target by more than 5%

Key - YTD Measures
At or above target
Below target by less than 5%
Below target by more than 5%; operational plan in place

Key - Trend Measure
Favourable Trend
Unfavourable Trend - but YTD performance has met target
Unfavourable Trend - but YTD performance is below target

Community & Clinical Support Services: KPIs

Commentary on the current KPI report (Year to September 30th 2017):

Note	Indicator	Commentary
1	Elective and Arranged Day of Surgery Admissions	Phenomenally good performance in Australasian terms.
2	Outpatient DNA rate	No concerns of note other than in Radiology where a specific project is commencing to reduce DNA rates among Māori clients.
3	Output delivery against plan – FSA/ Nurse consults etc	This reflects small variations across many service lines. Some are explainable and the causes of others is less clear. The reduction in general surgery FSA is because patients are now assessed and triaged to endoscopy via a phone call rather than a clinic visit. Plastics procedures are behind because the service cannot supply a Registrar of the right skill level for the clinics at Thames. In general referrals to home based nursing services have reduced.
4	Output delivery against plan – inpatient cwd	YTD 97.5% of planned patient events have occurred but only 94% of cwd have been earned. The differential was even more marked in September. This is largely an artefact of the new WEIS method for calculating CWD that was introduced nationally on 1 July. Essentially the change means less revenue will be earned for treating the same number and type of patients as previously. These artefacts of changes in the calculation method are not uncommon. Future production planning and volume based cost of delivery reporting both need to be cognisant of this methodological issue. Discussions to get the impact of WEIS changes better reflected in the internal PVS and production planning in 18/19 is underway.
5	Assigned EDD – Safer	This is a new measure. The SAFER project launched in mid-August and improvements in the use of EDD re already evident.
6	Inpatient length of stay –as arranged	Recent HRT benchmarks show Thames has made a significant improvement in its relative stay index and ALOS. This indicator is at odds with that positive trend. Watching brief.
7	Better help for smokers to quit	This indicator is highly susceptible to very small variations in patient numbers. A project to reinvigorate a whole of provider arm approach to smoking cessation is underway.
8	Breast screening Total volumes - Waikato DHB	Volumes are behind plan. A detailed recovery plan is in progress. While overall eligible volumes are down, Maori screening rates are on target which was not the case in 2016/17. Note that to be counted a woman must be screened within a specific time period. (If she is screened before or after that period the mammogram isn't counted in this kpi even though it is performed.)
9	Falls with harm	No concerns about the trend that are of note.
10	Sick leave	No concerns of note.
11	Overtime $'s	Overtime is being investigated as part of the sustainability programme. Current levels reflect acute winter demand and staff shortages in Radiology in particular.
12	Annual leave taken	No concerns about the trend that are of note.

Key Performance Dashboard

Mental Health

September 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	81.4	95.0	(13.6)	87.9	95.0	(7)		1

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health seclusion hours	Hours	478	736	257	1,435	2,208	772		
Mental health recovery plans	% Cases	90.9	95.0	(4.1)	89.8	95.0	(5.2)		2
Mental health HoNos matched pairs	% Cases	95.2	95.0	0.2	96.3	95.0	1.3		
Mental health inpatient bed occupancy	%	95.0	49.0	46.0	94.6	49.0	45.6		
Mental health GP methadone cases	Cases	91.0	76.0	15.0	91.3	76.0	15.3		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health post discharge follow up - % seen in 7 days	%	87.1	90.0	(2.9)	86.0	90.0	(4.0)		
Mental health follow up - numbers seen in 7 days	Number of Cases	88	91	(3)	74	77	(3)		
Mental health community contract positions filled	% FTEs	97.1	95.0	2.1	97.9	95.0	2.9		
Mental health 28 day readmission rate	%	14.4	18.0	3.6	13.4	15.0	1.6		

Health target measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	100.0	95.0	5.0	97.6	95.0	2.6		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers (All)	1	5	4	12	15	3		
Complaints resolved within 20 wd (1 month lag)	% for Aug-17	50	70	(20)	70	70	0		
Falls Resulting in Harm	Numbers	0	0	0	1	1	0		

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	204	214	(10)	597	642	(45)		3
Actual Expenditure vs Budget ($000s)	$000s	5,968	5,975	7	18,754	18,218	(536)		
Actual Contribution vs Budget ($000s)	$000s	(5,764)	(5,761)	(2)	(18,157)	(17,576)	(581)		
Actual FTEs vs Budget	FTEs	745.7	746.3	0.7	748.0	744.7	(3.3)		
Sick Leave	% of paid hours	3.1	3.2	0.1	4.1	3.4	(0.7)		4
Overtime $'s	$000s	160	77	(83)	440	229	(211)		5
Annual Leave Taken	% of Budget	Rolling 12 month measure			88.7	100.0	(11.3)		6

Key - MTD Measures
At or above target
Below target by less than 5%
Below target by more than 5%

Key - YTD Measures
At or above target
Below target by less than 5%
Below target by more than 5%; operational plan in place

Key - Trend Measure
Favourable Trend
Unfavourable Trend - but YTD performance has met target
Unfavourable Trend - but YTD performance is below target

KPI Report: Mental Health & Addictions Services September 2017

The following is a current state KPI dashboard for the directorate (Year to Sept 30 2017)

Note	Indicator	Commentary
1	Emergency Hours <6 hours	In September 138 presentations to the Emergency Department were reported. This is a significant increase from August (65) and July (79). Of the 138, 100 cases were included in the 6 hour target, with 93 of the total cases occurring after hours. MHAS management team will be meeting with the CNMs to discuss the introduction of a specific MH nurse resource in ED. This will initially be a Monday-Friday position, until such time as work on the Mental Health Acute Care Pathway is completed.
2	Recovery Plans	There has been a real service focus on improving both the quantity and quality of Recovery Plans across all areas. This has resulted in steady improvement over the past quarter and we are monitoring closely the current trend.
3	Overtime	Overtime has been an increasing issue, largely due to the combination of vacancies, high occupancy rates and acuity. As a service we are keen to ensure we have a strong focus on health and safety and the wellbeing of our staff. Discussions are commencing with our union organisers (PSA and NZNO) to advocate for a joint approach to the management and oversight of the use of overtime.
4	Seclusion	Seclusion reduction remains a core priority. Whilst there are significant environmental challenges in the current facility, September results are encouraging. Between September 19 and October 5th 2017 there were NO seclusion episodes across adult or forensic services, with the forensic service managing no seclusion events since August 2015.

Key Performance Dashboard

Waikato Hospital Services

September 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	78.2	95.0	(16.8)	77.3	95.0	(18)		1
Faster Cancer Treatment - Referral received to first treatment <= 62 days	% of patients	96.4	85.0	11.4	94.9	85.0	9.9		
Chemotherapy treatment < 4 Weeks Wait	% of patients	-	100.0	(100.0)	100.0	100.0	0.0		
Radiotherapy < 4 Weeks Wait	% of patients	-	100.0	(100.0)	100.0	100.0	0.0		
Number of long wait patients on outpatient waiting lists	# > 4 mths	121	0	(121)					
Number of long wait patients on OPRS outpatient waiting lists	Patients	2	0	(2)					
Number of long wait patients on inpatient waiting lists	# > 4 mths	41	0	(41)					

Theatre Productivity

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Theatre Utilisation - Elective Sessions	%	76.1	85	(8.9)	75.5	85.0	(9.5)		2
Hospital initiated elective theatre cancellations (< 24hrs)	numbers	60			169				
Hospital initiated elective theatre cancellations (< 24hrs)	%	5.3	2.5	(2.8)	4.8	2.5	(2.3)		3
Waiting Time for acute theatre < 24 hrs	%	72.1	80	(7.9)	74.5	80.0	(5.5)		4
Waiting Time for acute theatre < 48 hrs	%	85.7	100	(14.3)	88.7	100.0	(11.3)		5

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Elective Services Standardised Intervention Rates (SIRs)	Discharges per 10,000 pop	Rolling 12 month measure			269.3				
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			51.5	52.6	(1.1)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			75.2	81.3	(6.1)		6
Outpatient DNA Rate	%	9.4	10.0	1	9.6	10.0	0.4		
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	91.6	100.0	(8.4)	94.5	100.0	(5.5)		7
Output Delivery Against Plan - Inpatient Number of Episodes	%	99.0	100.0	(1.0)	97.7	100.0	(2.3)		
Output Delivery Against Plan - Inpatient CWD Volumes	%	94.2	100.0	(5.8)	97.6	100.0	(2.4)		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Number of long stay patients (>20 days length of stay)	Discharges	71	60	(11)	196	180	(16)		8
Number of long stay patient bed days (>20 days los)	Bed Days	2,308	2,089	(219)	6,216	6,009	(207)		
Assigned EDD (SAFER)	%	86	100	(14)	84	100	(16)		9
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			4.00	4.01	0.01		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			2.17	2.15	(0.03)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			1.01	1.00	(0.01)		

Health target measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	90.7	95.0	(4.3)	93.0	95.0	(2.0)		

Organisational Quality Safety Markers

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Patients assessed as being at risk have an individualised care plan which addresses their falls risk.	% for Aug-17	100.0	90.0	10.0	95.6	90.0	5.6		
Compliance with good hand hygiene practice (Cluster Rate)	%	82.3	85.0	(2.7)	85.0	80	5.0		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints resolved within 20 wd (1 month lag)	% for Aug-17	68	70	(2)	68	70	(2)		
Falls Resulting in Harm	Numbers	22	19	(3)	67	56	(11)		10

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	9,196	9,831	(635)	28,708	30,195	(1,488)		
Actual Expenditure vs Budget ($000s)	$000s	36,204	36,958	754	112,210	112,759	549		
Actual FTEs vs Budget	FTEs	3,221.4	3,271.6	50.2	3,198.6	3,292.0	93.4		
Sick Leave	% of paid hours	3.5	2.9	(0.6)	3.8	3.2	(0.6)		11
Overtime $'s	$000s	521	267	(254)	1,713	834	(879)		12
Annual Leave Taken	% of Budget	Rolling 12 month measure			84.2	100.0	(15.8)		13

Key - MTD Measures
At or above target
Below target by less than 5%
Below target by more than 5%

Key - YTD Measures
At or above target
Below target by less than 5%
Below target by more than 5%; operational plan in place

Key - Trend Measure
Favourable Trend
Unfavourable Trend - but YTD performance has met target
Unfavourable Trend - but YTD performance is below target

Waikato Hospital Services KPI Dashboard

Notes re Operational Plan Items – September 2017

<table>
<tr><th>Note</th><th>Indicator</th><th>Commentary</th></tr>
<tr><td>1.</td><td>Emergency Department < 6 hours</td><td>
For September 2017, the DHB has continued to struggle with performance against the six hour target, however performance has risen slightly when compared to July and August. September ED attendances have decreased to below 10,000 attendances for the first time in three months.
The result for the first quarter was 82.1% for Waikato DHB, which reflects the significantly high presentation number of nearly 29,000 to the emergency department this quarter.
The large number of winter presentations did not carry through to September. The percentage of patients admitted, discharged or transferred from a Waikato DHB emergency department in less than six hours was 90.7% for September which was an improvement on the August result (89.6%). The reduction in presentations to the emergency department assisted and it is possible that the opening of the 26 bedded OPR5 ward, early effects of introduction of the new SAFER initiative and other pieces of work that have commenced to improve throughput contributed to this small improvement.
The medical workforce has been strengthened with a new SMO starting work in the department. Another two SMOs will be starting soon. Furthermore the Clinical Director for the Emergency Department, Dr Ian Martin, has commenced in his role and has identified a review of the medical staff rostering as one of his three priorities.
The emergency department team has been progressing a number of initiatives to make the bigger differences in performance that we seek. The team has been developing a ”Better Way” of delivering health care in the emergency department using a “Plan Do Study Act” methodology. This will be trialled from 16-20 October and will simultaneously test seven changes:

Establish a single area of assessment by closing Acute Medicine Unit assessment area
Avoid duplication of medical assessment
Change Acute Medicine Unit registrar shift to 1pm-10pm
Primary on call General Medicine SMO based in the emergency department from 1pm to 6pm instead of being located in the Acute Medicine Unit
Patients referred to internal medicine will be physically located in the emergency department
Cardiology and respiratory teams on board with these changes
Bed management awareness of changes occurs

Work continues in Waikato Hospital emergency department with input from our change team to focus on the “see and treat” patients and front of house triaging to help refine and standardise processes so that these patients are pulled through in a timely way.
An acute medicine unit (AMU) working group is meeting weekly to also look at more effective ways of using our AMU in the future. Internal Medicine has seen an improvement from 62.2% to 66.1% and we expect to see further improvement with a number of initiatives underway.
A visit on 13 October from Dr Peter Jones (the Ministry of Health Target Champion) was encouraging regarding our approach to patient flow.
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<tr><th>Note</th><th>Indicator</th><th>Commentary</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th></th><th>Clinical Unit</th><th>Mth Attendances</th><th>Sep'17 %</th><th>YTD Attendances</th><th>YTD %</th></tr>
<tr><td rowspan="16">By Specialty/Division (Waikato Hospital Only)</td><td>General & Specialty Surgery</td><td>813</td><td>66.4%</td><td>2454</td><td>71.3%</td></tr>
<tr><td>Cardiology</td><td>349</td><td>46.1%</td><td>1005</td><td>49.8%</td></tr>
<tr><td>Cardiothoracic Surgery</td><td>14</td><td>71.4%</td><td>46</td><td>80.4%</td></tr>
<tr><td>Critical Care</td><td>6</td><td>100.0%</td><td>24</td><td>90.9%</td></tr>
<tr><td>Paediatrics</td><td>569</td><td>84.0%</td><td>1956</td><td>77.4%</td></tr>
<tr><td>Emergency Department</td><td>2993</td><td>90.7%</td><td>10025</td><td>88.6%</td></tr>
<tr><td>Internal Medicine</td><td>1020</td><td>66.1%</td><td>3425</td><td>62.2%</td></tr>
<tr><td>Womens Care</td><td>151</td><td>64.9%</td><td>422</td><td>65.6%</td></tr>
<tr><td>Oncology</td><td>94</td><td>61.3%</td><td>277</td><td>67.4%</td></tr>
<tr><td>Orthopaedics</td><td>261</td><td>72.7%</td><td>780</td><td>72.1%</td></tr>
<tr><td>Renal</td><td>76</td><td>71.1%</td><td>227</td><td>69.9%</td></tr>
<tr><td>Vascular Surgery</td><td>46</td><td>73.9%</td><td>133</td><td>86.5%</td></tr>
<tr><td>Allied Health</td><td>0</td><td>0.0%</td><td>1</td><td>100.0%</td></tr>
<tr><td>Community Services</td><td>0</td><td>0.0%</td><td>0</td><td>0.0%</td></tr>
<tr><td>Older Persons</td><td>3</td><td>100.0%</td><td>5</td><td>100.0%</td></tr>
<tr><td>Mental Health</td><td>101</td><td>80.6%</td><td>180</td><td>81.3%</td></tr>
<tr><td rowspan="4">By Site</td><td>Waikato Hospital</td><td>6496</td><td>78.2%</td><td>21030</td><td>77.3%</td></tr>
<tr><td>Tokoroa Hospital</td><td>1061</td><td>96.3%</td><td>3527</td><td>96.8%</td></tr>
<tr><td>Thames Hospital</td><td>1409</td><td>88.3%</td><td>4548</td><td>87.4%</td></tr>
<tr><td>Taumarunui Hospital</td><td>468</td><td>97.2%</td><td>1495</td><td>96.7%</td></tr>
<tr><td></td><td>Total Health Waikato</td><td>9434</td><td>82.6%</td><td>30600</td><td>81.9%</td></tr>
</table>
NB: From 1 July 2013 Tokoroa and Taumarunui EDs have been added to the calculation.
* By specialty for Waikato Hospital Only
As noted in the table above the performance of each of the speciality departments is variable.
In September the C4TV service cluster contribution to meeting the Emergency Department target is low at 50% and across the days of week the results fluctuate differently for each surgical department.
Further, C4TV reaches 100% in the early hours of the 24 hour day although it is the response time greater than 6 hours in the day time that is the source of the overall poor result.
The day, and hours of the day, reports will be shared with the service clusters to inform the distribution of work load for registrars and timely decision making supported by use of electronic tools such as iMPACT, the patient flow electronic whiteboard tool.
The number of children through the Emergency Department continues to be significant and has resulted in the Emergency Department target not being met. The acuity was very high with continuing trends in respiratory illnesses.
</td></tr>
<tr><td>2.</td><td>Theatre Utilisation – Elective Sessions</td><td>
Please note the KPI report includes the theatre time utilisation of the elective caesarean theatre session and Thames hospital; as such the result for September is 64.7%.
This KPI measures the utilisation of elective theatre time at Waikato Hospital minus the non-operating time. In September the surgical and C4TV result is 76.8%. There is one surgical and C4TV specialty meeting the target of 85% - cardiothoracic surgery. Of the remaining specialities most results are reported on or around 80% with three exceptions; dental, ENT and ophthalmology in the 65% range. The three specialities have a typical performance profile relative to other DHBs as the specialties have more cases per list and as such higher turnaround time i.e. more than 15% of the theatre time is used in turning around higher numbers of patents. The performance of the specialties, general surgery, orthopaedics, plastics and maxillo-facial will be the focus on improved theatre time utilisation to maximise the all-day eight hour lists.
</td></tr>
</table>

Note	Indicator	Commentary
3.	Hospital Initiated elective theatre cancellations	In September 60 elective cases or approximately three per working day were cancelled i.e. 5.3% hospital initiated elective theatre cancellations within 24 hours of the planned elective cases in September. The rolling target of 2.5% represents an average of one cancellation per day. The Surgical Services Re-invention Project is expected to favourably influence any process controls that will lead to an improvement in this result and meet target.
4.	Waiting time for acute theatre less than 24 hours	The increased day time acute capacity is underlying the favourable change to this result in both of the theatre key performance indicators on waiting for acute surgery i.e. waiting time for acute theatre up to 24 hours and 48 hours. The key focus for the theatre team is to maximise the use of the scheduled acute capacity to benefit of the acute and arranged patient groups. Again this is a specific area for improvement in the *Surgical Services Re-invention Project.*
5.	Waiting time for acute theatre less than 48 hours	
6.	Elective and arranged day of surgery admissions	The rolling target of elective and arranged day of surgery admission (DOSA) in September was 75.1% and overall performance is moving toward the desired target of approx. 80% day of surgery admissions. The performance to the Day of Surgery Admission (DOSA) measure is also an agreed area of focus with the *Surgical Re-invention Project.*
7.	Output Delivery Against Plan – Volumes for FSA, F/UP and Nurse Consults	Surgical outpatient activity for the month was 96.4% of target with orthopaedics behind in FSAs and follow ups. Catch up to plan will be a focus once the new locum specialist is employed from early 2018. C4TV was 84.4% with cardiology behind in most outpatient activity. Cardiology patient flow is now a specific area for improvement in the *Surgical Services Re-invention Project.* Below target in child health due to high sick leave of both senior medical officers and registered medical officers. This should improve with Womens Health SMOs expected to be able to end the contingency roster covering RMO vacancies shortly. <u>Physiotherapy</u> The service has 6.6 FTE vacancy in positions impact PVS outpatient volumes. 5.6FTE are in active recruitment and should be filled by the end of September. The remaining 1 FTE is currently part of a wider Thames recruitment shortfall and is being worked on with human resources and the Allied Health Management team to develop additional recruitment strategies for this part of the District. <u>Audiology</u> The service currently only has 35% of usual staffing (3.0FTE vacancy of 4.6FTE service). Externally contracted audiology staff have been undertaking weekend clinics which has helped offset this shortfall. <u>Dietician PVS versus Actual</u> This unfavourable variance is due to a lack of referrals to the primary care based group clinic volumes. Work continues with the funder to explore further options for these clinics.

Note	Indicator	Commentary
8.	Number of long stay patients (> 20 days length of stay)	C4TV in September had 20 discharges of patients who stayed longer than 20 days, compared to a target of no more than 14 such discharges. This is an ongoing challenge in the service cluster and is linked to expected date of discharge. C4TV performance is under a change in practice that commenced in July i.e. the long stay review for patient that has reached a stay of 5 days stay not 10 days as was previous practice and to be led by Charge Nurse Manager. The Clinical Nurse Director initiated this approach. Additional work on this issue across Waikato Hospital (as a part of the acute patient flow programme of work) is in the discovery phase. Recruitment of the key project staff is underway.
9.	Assigned EDD (SAFER)	This is a new KPI measure with official launch and the roll out of the SAFER programme in early September. All clinical staff now in implementation mode of the full programme, which requires an expected date of discharge for each inpatient. Generally this can be identified prior to an elective admission or as soon a clinically practical for an acute admission. It is well accepted that an accurate expected date of discharge avoids unnecessary long stays in hospital or a 'stranded patient' i.e. a longer hospital stay than clinically indicated. Medicine, Oncology, Emergency Department and Ambulatory services achieved 91%. Most days the target was achieved across the service. <u>Older Persons Rehabilitation</u> Work continues to review expected date of discharge set and work towards 100% completion and clinical ownership.
10.	Falls resulting in Harm	This indicator remains a little over target however it is very encouraging that we have not had a fall resulting in hip fracture since January 2017.
11.	Sick Leave	Sick leave is down a little for the month although still above target. It is expected to improve further with improving conditions.
12.	Overtime $'s	Child health - increased sick leave required additional cover from medical staff and additional staffing resource required for the 8 inpatient beds in E7. Women's health – acuity of the maternity ward required higher use of overtime to cover gaps in the roster. As in previous months over time is higher than budget across service clusters in September; partially offset with FTE vacancies. This is now an area of focus in the end of month result reviews each month in order to understand and look for control mechanisms as available.
13.	Annual leave taken	This result continues at a level that is favourable compared to sector norms.

MEMORANDUM TO THE BOARD
25 OCTOBER 2017

AGENDA ITEM 9.3

PREVOCATIONAL MEDICAL TRAINING ACCREDITATION

Purpose	1) For information

Background

The Medical Council of New Zealand (MCNZ) conducted a review of Waikato DHB prevocational medical training on 1 and 2 August 2017. The review assessed the training provider (the DHB) against 22 sets of standards.

The report outlining the DHB's performance against the standards was received on 27 September 2017 (attached).

The DHB has been granted a further six months accreditation through until **30 March 2018** at which time there will be another review. The MCNZ requires a report from the DHB by 20 November 2017 outlining progress on the required actions.

Summary of Accreditation Outcome

The report includes very positive feedback, and commendations, on the leadership provided by the Director of Clinical Training, the quality of supervision and support by the prevocational education supervisors and the Clinical Education and Training Unit (CETU). The DHB was also commended for its excellent progress with the development of community based training attachments.

However, the overall outcome of the review is "not met". The report indicates that the DHB has failed to meet four of 22 sets of standards and substantially met one standard as detailed below. The report has specified 12 required actions and one recommendation.

Standard 1 - Strategic priorities (not met)
The report recognises the DHB's strategic priority to develop a centre of excellence in learning, training, research and innovation. However, the report is critical of the Executive Team's commitment to prevocational medical training and of the perceived lack of understanding by the Executive Team of the workload pressures impacting on intern training.

The reviewers also reported that there was a lack of a clear governance structure for prevocational medical training.

> ***Required action 1:*** *Evidence of prevocational training as a key strategic priority must be reflected in Waikato DHB's strategic planning documents.*
>
> ***Required action 2:*** *Waikato DHB must establish a governance group for the intern training programme with appropriate intern representation. This must have the authority to effect change and facilitate support in response to identified issues. This must also include advocating, at executive level, for the role and requirements to be an effective training establishment.*

Standard 2.1 – The context of intern training (not met)
The report outlines concerns about resource issues that impact on the delivery of the intern training programme, primarily the high workload of SMOs that is believed to compromise their ability to provide adequate training and support of interns. There were also concerns about the communication between clinical supervisors and education supervisors regarding any performance problems of interns.

> ***Required action 3:*** *Waikato DHB must ensure appropriate resources for the delivery of the intern training programme, including Senior Medical Officer (SMO) staffing, to ensure the effective support and supervision of interns.*
>
> ***Required action 4:*** *Clinical supervisors must be made aware of their responsibility to escalate any concerns about intern performance to the prevocational educational supervisors.*

Standard 4.2 – Supervision (not met)
It was determined that there are insufficient prevocational education supervisors (PES) for the number of interns. There are currently six PESs for 76 interns; the Council's required ratio is one PES for up to 10 interns. Furthermore, the number of interns is projected to increase in the third quarter of 2017.

The Council also raised serious concerns about the support of interns working at night, particularly in Medicine, which has only one intern covering all medical wards at night. This is deemed by the Council to be insufficient, particularly given the geography of the hospital and the distances between wards.

> ***Required action 7:*** *Council's required ratio of prevocational educational supervisors to interns (1:10), with FTE protected time, must be met at all times.*
>
> ***Required action 8:*** *Council's serious concerns regarding medical night cover must be addressed. Interns must be appropriately supported and supervised by qualified medical staff at all times.*

Standard 6.2 – Welfare and support (not met)
The primary concerns about welfare and support relate to the workload of interns, particularly at night and in weekends. The workload is compounded by the lack of an effective task management system and the lack of consistent handover across all services, both of which would assist in the prioritisation of tasks (see standard 3.2 below).

It was also noted that the Interns have reported that the process of applying for and accessing annual leave is ineffective.

Also related to intern wellbeing, there appears to be a perception that EAP counselling may not be confidential; the report states that those using the service have been asked to waive their right to privacy. However, the DHB is firm in its position that EAP is confidential and those accessing EAP will not be asked to waive their right to privacy. Nevertheless, steps must be taken to ensure that the interns are aware of this.

The other concern mentioned in relation to welfare and support relates to harassment and bullying. The report refers to a specific allegation of bullying within General Medicine but also makes broad reference to *other 'instances of harassment and bullying'.*

> ***Required action 9:*** *The workload of interns must be consistent with the delivery of safe patient care within a safe working environment.*
>
> ***Required action 10:*** *Waikato DHB must ensure a safe working environment that is free from bullying and harassment.*
>
> ***Required action 11:*** *Access to confidential counselling services for interns must be ensured.*
>
> ***Required action 12:*** *Waikato DHB must implement an effective and transparent system for annual leave applications.*

Standard 3.2 – Programme components (substantially met)
The report outlines concerns about the lack of a consistent handover process across all services and notes instances of interns not being included in SMO and registrar handovers. This has the potential to impact on clinical quality and excludes interns from a valuable learning experience. As noted in relation to Standard 6.2 above, the lack of a clear mechanism for the prioritization of clinical tasks is also a concern.

> ***Required action 5:*** *Waikato DHB must ensure appropriate engagement between consultants and interns during handover.*
>
> ***Required action 6:*** *Mechanisms must be implemented to allow for the effective prioritization of clinical tasks following handover.*

1. Action Plan

An action plan has been developed and reviewed by the Steering Group. The final plan is due for approval by the Steering Group on 18 October 2017 (see attached Action Plan). Numerous steps have already been taken to address the required actions.

2. Risks

Risk	Status	Comment
Failure to address the issue of medical workload (required action 3) prior to accreditation review in	🔴	The process of service sizing is required to determine whether there are adequate SMOs in each service. Service sizing is outside of the scope of this project and would require dedicated resource to complete. **Mitigation**: This will be discussed at the steering group on 18

March 2018		October 2017.
Possible resistance by SMOs with regards to changes required to handover process	Amber	Requires strong clinical leadership to make this change. **Mitigation:** This work stream will be led by Chief Medical Advisor
Lack of an appropriate system for clinical task management	Amber	Clinical task management system (part of iMPACT project) won't be implemented until mid-2018. **Mitigation:** The interim solution is to improve current paging process
Changes to the RMO office may cause disruption to RMO rostering, and thus service delivery	Amber	**Mitigation**: A transition plan will be developed prior to release of the decision document to ensure disruption is minimised.
RMO reliever review may identify a requirement for additional RMOs that are not budgeted	Red	The NZRDA allege that the DHB is short of 18 RMO relievers (only two of which are at house officer level). A reliever review is underway. **Mitigation**: Once the reliever deficit is confirmed, a business case will be developed for consideration in the next financial year.
Allegations of bullying and harassment (relating to required action 10) will be difficult to address due to lack of specific information about the problem areas	Amber	The report makes a general comment about allegations of bullying and harassment but does not identify particular services. **Mitigation:** The plan is to extend the staff safety culture work to focus on RMOs, particularly with respect to the workplace support person initiative.
Status key:		
Red **= Urgent attention required**	Amber **= Some concerns exist**	Green **= Risk is well mitigated**

Recommendation	1) **THAT:** The Board notes the content of the report.

TANYA MALONEY
CHAIR, PREVOCATIONAL MEDICAL TRAINING ACCREDITATION STEERING GROUP

Prevocational Medical Training Accreditation – Action Plan

(For approval by Steering Group 18 October2017)

16 October 2017

This document outlines the actions to meet the Medical Council of New Zealand (MCNZ) accreditation standards for prevocational medical training. A steering group has been convened to oversee the development and implementation of the action plan outlined below. The steering group will work closely with house officers (interns), the NZRDA, the Clinical Education and Training Unit (CETU) and Prevocational Education Supervisors (PES) for the duration of this programme of work.

BACKGROUND

Prevocational medical training spans the two years following graduation from medical school and includes both postgraduate year one (PGY1) and postgraduate year two (PGY2). Prevocational medical training applies to all graduates of New Zealand and Australian accredited medical schools and doctors who have sat and passed NZREX, the registration exam for international medical graduates.

The Medical Council of New Zealand (MCNZ) conducted a review of Waikato DHB prevocational medical training on 1 and 2 August 2017. The review assessed the training provider (the DHB) against 22 sets of standards.

The report outlining the DHB's performance against the standards was received on 27 September 2017.

The report includes very positive feedback, and commendations, on the leadership provided by the Director of Clinical Training, the quality of supervision and support by the prevocational education supervisors and the CETU as a whole. The DHB was also commended for its excellent progress with the development of community based training attachments. However, the report indicates that the DHB has failed to meet four of 22 sets of standards and substantially met one standard. The MCNZ has specified 12 required actions and one recommendation as noted in the action plan below. The overall outcome of the review was "not met".

The DHB has been granted a further six months accreditation through until **30 March 2018** at which time there will be another review. The MCNZ requires a report from the DHB by 20 November 2017 which addresses the required actions.

ACTION PLAN

1. Governance & Management (Required actions 1 & 2)

The MCNZ report is highly critical of the Executive Team's commitment to prevocational medical training and of the perceived lack of understanding by the Executive Team of the workload pressures impacting on intern training. The report also states that: *"when issues pertaining to the intern training programme are escalated to the Executive Team, they do not get traction" (p10).*

The report also states that there is a lack of a clear governance structure for prevocational medical training. In practice, CETU reports to the Board of Clinical Governance once per year on the results of the RMO surveys (PHEEM and YETI) and to the Executive Team approximately once per year.

Required actions:

1. *Evidence of prevocational training as a key strategic priority must be reflected in Waikato DHB's strategic planning documents.*
2. *Waikato DHB must establish a governance group for the intern training programme with appropriate intern representation. This must have the authority to effect change and facilitate support in response to identified issues. This must also include advocating, at executive level, for the role and requirements to be an effective training establishment.*

The DHB is committed to developing a centre of excellence in learning, training, research and innovation as a key strategic priority. In line with this we are planning to consolidate our CETU, Skills and Simulation Centre, Library and Postgraduate Training initiatives under a single governance board that is linked to our Clinical Governance Board. This board will have a leader who has a strong emphasis on the provision of high quality health care and education, and will be part of the executive team.

PROJECT AREA	**ACTIONS**	**LEAD**	**DUE DATE**
Strategy priority **A centre of excellence in learning, training, research and innovation** *Required action 1*	Development of Education Faculty: *Centre of Excellence for Innovation, Learning and Development*	Ross Lawrenson & Tanya Maloney	March 2018

PROJECT AREA	**ACTIONS**	**LEAD**	**DUE DATE**
Governance of training programme and Executive support *Required action 2*	Monthly reporting to Executive	Tanya Maloney & Wayne de Beer	October 2017 (Ongoing)
	RMO membership on Board of Clinical Governance	Tom Watson	October 2017
	Establish RMO Council (including consideration of NZRDA proposal)	Tanya Maloney	December 2017
	Revise WIRED[1] scope and authority (in relation to the RMO council)	Wayne De Beer & Tanya Maloney	October 2017
Conclude the review of the RMO Office	Proposal for change document released	Tanya Maloney	1 November 2017
	Decision document released and commence implementation of new RMO office structure	Tanya Maloney	4 December 2017

[1] WIRED refers to Wellbeing and Innovations RMO Educational Development Group. The purpose of this group is to resolve issues that impact on the education and training environment for prevocational doctors.

2. Education and Training (Required Actions 4 & 7)

The report indicates that there are insufficient prevocational education supervisors (PES) for the number of interns. There are currently six PES for 76 interns; the Council's required ratio is one PES for up to 10 interns. Furthermore, the number of interns is projected to increase in the third quarter of 2017 to 84 interns; therefore 9 PES are required. Concerns were also raised about the communication between clinical supervisors and PES in relation to performance concerns of interns.

Required actions:

4. Clinical supervisors must be made aware of their responsibility to escalate any concerns about intern performance to the prevocational educational supervisors.

7. Council's required ratio of prevocational educational supervisors to interns (1:10), with FTE protected time, must be met at all times.

Recommendation:

The DHB should review orientation provided to interns who commence work part way through the year, to ensure they have an appropriate understanding of the DHB's policies and procedures prior to commencing practice.

PROJECT AREA	ACTIONS	LEAD	DUE DATE
Managing/communicating intern performance issues *Required action 4*	Remind clinical supervisors about the need to communicate with PES regarding performance issues	Wayne de Beer	November 2017
	Explore E-port functionality for recording performance matters	Jules Schofield	November 2017
Education Resources *Required action 7*	FTE approval for 3x PES	Tom Watson	Complete
	Recruitment to additional PES	Tom Watson	Complete
	Appointment of PES	Tom Watson and Wayne de Beer	November 2017
Recommendation: Review and improve mid-year orientation	Increase Medical Education Officer FTE from 0.5 to 1.0 FTE	Tom Watson	Complete
	Review and develop mid-year orientation	Helen Clark	November 2017

3. Clinical Support (Required Actions 3, 5 & 6)

The report outlines concerns about resource issues that impact on the delivery of the intern training programme. This resource issue is reportedly related to the high workload of SMOs that is believed to compromise their ability to provide adequate training and support of interns.

The report also outlines concerns about the lack of a consistent handover process across all services and notes instances of interns not being included in SMO and registrar handovers. This has the potential to impact on clinical quality and excludes interns from a valuable learning experience. The report also criticises the lack of an effective task management system and clear mechanism for the prioritisation of clinical tasks.

Required actions:

3. Waikato DHB must ensure appropriate resources for the delivery of the intern training programme, including Senior Medical Officer (SMO) staffing, to ensure the effective support and supervision of interns.
5. Waikato DHB must ensure appropriate engagement between consultants and interns during handover.
6. Mechanisms must be implemented to allow for the effective prioritization of clinical tasks following handover.

PROJECT AREA	ACTIONS	LEAD	DUE DATE
SMO support and supervision *Required action 3*	*See related work-stream below - DHB wide service and job sizing	See below	
Consistency and quality of handover *Required action 5*	Survey house officers and registrars about handover practices	Tanya Maloney & Sam Anderson	October 2017
	Development of Medical Handover Policy	Tom Watson	November 2017
	Implement Handover policy	Tom Watson	November 2017
Clinical workflow *Required action 6*	*See related work-stream below iMPACT implementation	See below	
	Redesign process for Paging House Surgeons	Tanya Maloney	November 2017

Related work-streams

PROJECT AREA	ACTIONS	LEAD	DUE DATE
DHB-wide job sizing	Recommend the timely completion of service and job sizing, particularly across Medicine specialties	HR/Service Directors	TBA
iMPACT implementation		Marc ter Beek	June 2018 TBC

4. Intern Workload (Required Actions 8 & 9)

The Council raised serious concerns about the lack of support for interns working at night, particularly in Medicine. Whilst there is a registrar assigned to support the intern, the registrar is often fully committed to work in the emergency department.

Furthermore, concerns were raised about having only one intern covering all medical wards at night (noting that there is a registrar assigned to Medicine but the roles of an intern and registrar are quite different). This is deemed by the Council to be insufficient, particularly given the geography of the hospital and the distances between wards.

Required actions:

8. Council's serious concerns regarding medical night cover must be addressed. Interns must be appropriately supported and supervised by qualified medical staff at all times.

9. The workload of interns must be consistent with the delivery of safe patient care within a safe working environment.

PROJECT AREA	ACTIONS	LEAD	DUE DATE
Registrar support & supervision of interns *Required action 8*	Memo clarifying roles and responsibilities of house officers and registrars afterhours	Graham Mills	Complete
	Memo regarding the responsibility of registrars in supervising house officers	Tom Watson	October 2017
Workload management *Required action 9*	Increase night shift house surgeon numbers in medicine	Tanya Maloney	October 2017
	Develop a document describing the allocation of work on night shift	Sam Anderson	October 2017 Complete
	Revisit hospital out of hours recommendations	Tanya Maloney	November 2017
	RMO reliever review (*Includes registrar relievers)	Amanda Wright	November 2017

5. Intern Wellbeing (Required Actions 10, 11 & 12)

The primary concerns about welfare and support relate to the workload of interns, particularly at night and in weekends; these issues are addressed in point 4 (intern workload) above.

It was also noted that interns have reported that the process of applying for and accessing annual leave, professional development and study leave is ineffective.

Furthermore, there appears to be a perception that EAP counselling may not be confidential; the report states that those using the service have been asked to waive their right to privacy. However, this issue appears to have been confused with the matter of confidentiality of health and safety reports commissioned by the DHB. Whilst the DHB is firm in its position that EAP is confidential and those accessing EAP will not be asked to waive their right to privacy, steps must be taken to ensure that the interns are aware of this.

The other concern mentioned in relation to welfare and support relates to harassment and bullying. The report refers to a specific allegation of bullying within General Medicine but also makes broad reference to other *'allegations of harassment and bullying'* noting that interns are reluctant to report these matters due to potential repercussions.

Required actions:

10. *Waikato DHB must ensure a safe working environment that is free from bullying and harassment.*
11. *Access to confidential counselling services for interns must be ensured.*
12. *Waikato DHB must implement an effective and transparent system for annual leave applications.*

PROJECT AREA	ACTIONS	LEAD	DUE DATE
Confidential counselling *Required action 11*	Ensure EAP information (e.g. pamphlets) include statements about confidentiality of counselling	Health & Safety Service	November 2017 Complete
	Memo to intern's about EAP counselling (including confidentiality)	Greg Peploe	January 2018
	Orientation – wellness session information	Wayne de Beer	November 2017
	Include information about EAP counselling on RMO intranet page	Amanda Wright	October 2017
Access to leave *Required action 12*	Improvements to leave process including: - leave transparency (visibility via electronic system) - 12 month advance leave planning	Amanda Wright	December 2017
Staff safety culture Perceived workplace bullying *Required action 10*	Explore opportunities to enhance focus of Staff Safety Culture working group on RMO's Target specific services to improve culture of collegiality	Tanya Maloney & Greg Peploe	November 2017
	Multi source feedback/360 degree reviews	Tom Watson	Ongoing

Prevocational medical training accreditation report: Waikato District Health Board

Date of site visit: 1 and 2 August 2017
Date of report: 13 September 2017

Medical Council of New Zealand

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Background

Under the Health Practitioners Competence Assurance Act 2003 (HPCAA) the Medical Council of New Zealand (Council) is required to accredit and monitor educational institutions that deliver medical training for doctors and to promote medical education and training in New Zealand under section 118 of the HPCAA.

Accreditation of training providers recognises that standards have been met for the provision of education and training for interns, which is also referred to as prevocational medical training. Prevocational medical training spans the two years following graduation from medical school and includes both postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2). Doctors undertaking this training are referred to as interns. Prevocational medical training applies to all graduates of New Zealand and Australian accredited medical schools and doctors who have sat and passed NZREX.

Council will accredit training providers for the purpose of providing prevocational medical education through the delivery of an intern training programme to those who have:

- structures and systems in place to enable interns to meet the learning outcomes of the *New Zealand Curriculum Framework for Prevocational Medical Training* (NZCF)
- an integrated system of education, support and supervision for interns
- individual clinical attachments to provide a high quality learning experience.

Process

The process of assessment for the accreditation of Waikato District Health Board (DHB) as a training provider of prevocational training involved:

1. A self-assessment undertaken by Waikato DHB, with documentation provided to Council.
2. Interns being invited to complete a questionnaire about their education experience at Waikato DHB.
3. A site visit by an accreditation team to Waikato Hospital on 1 and 2 August 2017 that included meetings with key staff and interns.
4. Presentation of key preliminary findings to the Chief Executive, Chief Medical Officer (CMO) and other relevant Waikato DHB staff.

The Accreditation Team is responsible for the assessment of the Waikato District Health Board intern training programme against Council's *Accreditation standards for training providers.*

Following the accreditation visit:

1. A draft accreditation report is provided to the training provider.
2. The training provider is invited to comment on the factual accuracy of the report and conclusions.
3. Council's Education Committee considers the draft accreditation report and response from the training provider and make recommendations to Council.
4. Council will consider the Committee's recommendations and make a final accreditation decision.
5. The final accreditation report and Council's decision will be provided to the training provider.
6. The training provider is provided 30 days to seek formal reconsideration of the accreditation report and/or Council's decision.
7. The accreditation report is published on Council's website 30 days after notifying the training provider of its decision. If formal reconsideration of the accreditation report and/or Council's decision is requested by the training provider then the report will be published 30 days after the process has been completed and a final decision has been notified to the training provider.

The Medical Council of New Zealand's accreditation of Waikato District Health Board

Name of training provider:	Waikato District Health Board
Name of site(s):	Waikato Hospital
Date of training provider accreditation visit:	1 and 2 August 2017
Accreditation team members:	Professor John Nacey (Chair) Dr Greig Russell Ms Kim Ngārimu Mr Philip Pigou Ms Joan Crawford Ms Eleanor Quirke Ms Elmarie Stander
Key staff the accreditation team met:	
Acting Chief Executive:	Mr Neville Hablous (Chief Executive was absent at the time of the site visit)
Chief Medical Officer	Dr Tom Watson
Prevocational Educational Supervisors:	Dr Jules Schofield Mr Nand Keijrwal Dr Etuini M'au Dr Erana Gray Dr Ryan Paul Dr Asad Khan
Other staff:	Mr Paul Miller Ms Penny Simpson Ms Ripeka Harrison Ms Marjory Gibbison Professor Ross Lawrenson Mr Greg Peploe Ms Maureen Chrystall Mr Brett Paradine Mr Mark Spittal Ms Barb Garbutt Mr Alex Gordon Ms Mo Neville Ms Helen Clark Ms Carol Stevenson
Number of interns at Waikato DHB:	76
Postgraduate year 1 interns:	40
Postgraduate year 2 interns:	36

Section A – Executive Summary

Waikato District Health Board (DHB) encompasses a population of around 400,000 and has broad geographic extent from Northern Coromandel to Mt Ruapehu. Approximately 23 percent of the DHB population are Māori and 60 percent live outside the main urban areas. A large proportion live in areas of high deprivation. The 2016 Waikato DHB strategy document acknowledges "the need to change dramatically" in order to meet the needs of its population. The first pre-requisite to the success of this strategy is "strong and unambiguous leadership" with one of the aims to build "a centre of excellence in learning, training, research and innovation."

There are different levels of commitment to prevocational medical training within the DHB. There is not a clearly stated commitment to prevocational medical training by the Executive Team, and no governance structure has been put in place to provide oversight and support. In addition, there is no obvious understanding demonstrated by the Executive Team of the current workload pressures that are impacting on intern training. This is in contrast to the very high level of commitment demonstrated by the Clinical Education and Training Unit (CETU) and the prevocational educational supervisors. Through this, a comprehensive formal education programme is provided in the context of good intern participation and protected teaching time. Furthermore, there is a variety of departmental training opportunities, including grand rounds, case presentation seminars, multidisciplinary team meetings and clinical audit.

Serious concerns were raised regarding the lack of consistent handover processes across all services at the DHB. Some senior medical staff are reluctant to engage with interns and other resident medical officers during handover, and in some services intern-to-intern handover is conducted in parallel to that conducted by registrars and consultants. As a result, it is unclear to interns whether the appropriate people have been notified of any clinical issues or concerns identified in previous shifts. This is compounded by the lack of an effective task management system. It is unclear to interns following handover what clinical tasks are outstanding, and the priority that should be accorded to these tasks.

These serious concerns are in the context of a high workload for both senior medical staff and interns. Clinical supervisors describe the pressures of a high clinical workload impacting on a growing number of trainees and their capacity to provide interns with adequate supervision. Several interns reported feeling overwhelmed with the volume of tasks they are expected to complete each shift, in particular at night and during the weekend.

These issues overlap. An example of this are the concerns raised regarding the support of interns working at night where there is only one intern covering all medical wards. While a registrar has been appointed to support that intern, the registrar is often fully committed within the emergency department and unable to assist the intern, even in an acute situation. Appropriate cover is compromised by the geography of the hospital where the distances that the intern is expected to cover precludes any effective response to an urgent or emergency medical situation. This situation is compounded by the lack of triaging of calls, or any indication of the level of priority that should be assigned to a call.

The issues of handover, task management and prioritisation, and workload all represent risks to patient safety. The DHB must address each issue as a matter of priority.

The Accreditation Team was advised of some allegations of harassment and bullying. With respect to this, an external review is being undertaken in the General Medicine Department. It was further advised that allegations of harassment and bullying are under-reported because interns have concerns about potential repercussions.

The DHB met 17 of the 22 sets of standards of Council's *Accreditation standards for training providers*. There are four set of standards that are not met and one set of standard which is substantially met.

The four standards that were not met are:

- 1 - Strategic Priorities
- 2.1 – The context of intern training
- 4.2 - Supervision
- 6.2 – Welfare and support

The one set of standards that were substantially met is:

- 3.2 – Programme components

12 required actions were identified, along with recommendations and commendations. The required actions are:

1. Evidence of prevocational training as a key strategic priority must be reflected in Waikato DHB's strategic planning documents.
2. Waikato DHB must establish a governance group for the intern training programme with appropriate intern representation. This must have the authority to effect change and facilitate support in response to identified issues. This must also include advocating, at executive level, for the role and requirements to be an effective training establishment.
3. Waikato DHB must ensure appropriate resources for the delivery of the intern training programme, including Senior Medical Officer (SMO) staffing, to ensure the effective support and supervision of interns.
4. Clinical supervisors must be made aware of their responsibility to escalate any concerns about intern performance to the prevocational educational supervisors.
5. Waikato DHB must ensure appropriate engagement between consultants and interns in the handover process.
6. Mechanisms must be implemented to allow for the effective prioritisation of clinical tasks following handover.
7. Council's required ratio of prevocational educational supervisors to interns (1:10), with 0.1FTE protected time, must be met at all times.
8. Council's serious concerns regarding medical night cover must be addressed by Waikato DHB. Interns must be appropriately supported and supervised by qualified medical staff at all times.
9. The workload of interns must be consistent with the delivery of safe patient care within a safe working environment.
10. Waikato DHB must ensure a safe working environment that is free from bullying and harassment.
11. Access to confidential counselling services for interns must be ensured.
12. Waikato DHB must implement an effective and transparent system for annual leave applications.

Overall outcome of the assessment

The overall rating for the accreditation of the Waikato DHB as a training provider for prevocational medical training is:	NOT MET

Waikato DHB holds accreditation **until 30 March 2018**, for a period of 6 months, subject to Council receiving an interim report from Waikato DHB **by 20 November 2017** that addresses the following required actions:

1. Evidence of prevocational training as a key strategic priority must be reflected in Waikato DHB's strategic planning documents.
2. Waikato DHB must establish a governance group for the intern training programme with appropriate intern representation. This must have the authority to effect change and facilitate support in response to identified issues. This must also include advocating, at executive level, for the role and requirements to be an effective training establishment.
3. Waikato DHB must ensure appropriate resources for the delivery of the intern training programme, including Senior Medical Officer (SMO) staffing, to ensure the effective support and supervision of interns.
4. Clinical supervisors must be made aware of their responsibility to escalate any concerns about intern performance to the prevocational educational supervisors.
5. Waikato DHB must ensure appropriate engagement between consultants and interns in the handover process.
6. Mechanisms must be implemented to allow for the effective prioritisation of clinical tasks following handover.
7. Council's required ratio of prevocational educational supervisors to interns (1:10), with 0.1FTE protected time, must be met at all times.
8. Council's serious concerns regarding medical night cover must be addressed by Waikato DHB. Interns must be appropriately supported and supervised by qualified medical staff at all times.
9. The workload of interns must be consistent with the delivery of safe patient care within a safe working environment.
10. Waikato DHB must ensure a safe working environment that is free from bullying and harassment.
11. Access to confidential counselling services for interns must be ensured.
12. Waikato DHB must implement an effective and transparent system for annual leave applications.

Section B – Accreditation standards

1 Strategic Priorities

1	Strategic Priorities
1.1	High standards of medical practice, education, and training are key strategic priorities for training providers.
1.2	The training provider is committed to ensuring high quality training for interns.
1.3	The training provider has a strategic plan for ongoing development and support of a sustainable medical training and education programme.
1.4	The training provider has clinical governance and quality assurance processes that ensure clear lines of responsibility and accountability for intern training in the overall context of quality medical practice.
1.5	The training provider ensures intern representation in the governance of the intern training programme.
1.6	The training provider will engage in the regular accreditation cycle of the Council which will occur at least every three years.

1. Strategic Priorities			
	Met	**Substantially met**	**Not met**
Rating			X
Commentary:			

Comments:
Prevocational medical training is not accorded specific strategic priority by Waikato DHB.

There are different levels of commitment to prevocational medical training within the DHB. The Clinical Education and Training Unit (CETU) and the prevocational educational supervisors are committed to providing a comprehensive intern training programme, with the CETU having a strategic vision for ongoing programme development. The prevocational educational supervisors provide comprehensive support to interns and advocate effectively on their behalf. This is greatly appreciated by interns. The Clinical Director of Training provides excellent leadership in the delivery of the intern training programme.

Acknowledging the excellent work undertaken by the CETU, it is disappointing that this is not supported by a clearly stated commitment to prevocational medical training by the Executive Team. In addition, there is no obvious understanding demonstrated by the Executive Team of the current workload pressures that are impacting on intern training.

The intern training programme is not supported by a clear governance structure. The Board of Clinical Governance is the primary governance mechanism for clinical matters at the DHB. However, it is not utilised as a governance structure for the intern training programme. The Wellbeing and Innovations Resident Medical Officer Educational Development (W.I.R.E.D) group provides a forum for identifying and addressing issues that pertain to the Resident Medical Officer (RMO) training environment. This group includes supervisor and intern representation, however, the group has limited ability to effect appropriate change. The

DHB must establish a governance group for the intern training programme with appropriate intern representation that also has the authority to effect change and facilitate support and appropriate decision-making in response to identified issues. This must also include advocating, at executive level, for the role and requirements to be an effective training organisation.

A number of staff raised concerns regarding the lack of transparency of reviews undertaken by the Executive Team. Furthermore, the lack of an outcome from the review of the RMO Unit has created uncertainty for staff.

The DHB did not provide Council with all relevant information relating to the issues affecting the prevocational medical training, such as the review currently underway in the General Medicine Department about bullying and harassment.

Commendations:

- The Clinical Director of Training provides excellent leadership in the delivery of the intern training programme.
- The prevocational educational supervisors provide comprehensive support to interns and advocate effectively on their behalf.

Required actions:

1. Evidence of prevocational training as a key strategic priority must be reflected in Waikato DHB's strategic planning documents.
2. Waikato DHB must establish a governance group for the intern training programme with appropriate intern representation. This must have the authority to effect change and facilitate support in response to identified issues. This must also include advocating, at executive level, for the role and requirements to be an effective training establishment.

2 Organisational and operational structures

2.1 The context of intern training

2.1.1 The training provider can demonstrate that it has the responsibility, authority, and appropriate resources and mechanisms to plan, develop, implement and review the intern training programme.

2.1.2 The Chief Medical Officer (CMO) or their delegate (for example a Clinical Director of Training) has executive accountability for meeting prevocational education and training standards and for the quality of training and education.

2.1.3 There are effective organisational and operational structures to manage interns.

2.1.4 There are clear procedures to address immediately any concerns about intern performance that may impact on patient safety.

2.1.5 Clear procedures are documented to notify Council of changes in a health service or the intern training programme that may have a significant effect on intern training.

2.1 The context of intern training			
	Met	**Substantially met**	**Not met**
Rating			X
Commentary:			

Comments:
Waikato DHB has not met its responsibility to address the resource issues that are significantly impacting on the delivery of the intern training programme. Medical staff reported a high workload that has been compounded by workforce shortages. Despite a clear willingness among senior medical staff to provide appropriate supervision and training to interns, high workload has compromised their ability to do so.

The Clinical Director of Training, with support from the Clinical Education and Training Unit (CETU) and the prevocational educational supervisors, oversees the delivery and development of the intern training programme. The Chief Medical Officer (CMO) has delegated accountability for the intern training programme to the Clinical Director of Training, however this accountability does not come with the authority to make changes. When issues pertaining to the intern training programme are escalated to the Executive Team, they do not get traction.

The Clinical Director of Training, the CETU and the prevocational educational supervisors have sound structures and robust processes in place to manage the prevocational training programme. The intern programme is well managed within the authority of the Clinical Director of Training, the CETU and prevocational educational supervisors. As previously stated in this report, these structures and processes are adversely affected by resource constraints.

The DHB has procedures to address concerns about intern performance that may impact on patient safety. However, the assistance provided to interns in difficulty is impeded by clinical supervisors not consistently sharing information with the prevocational educational supervisors. Fortunately, once the prevocational educational supervisors become aware of any concerns about intern performance, they have effective processes in place to address such concerns.

The DHB has documented procedures to notify Council of changes in a health service or the intern training programme that may have a significant effect on intern training.

Required actions:

3. Waikato DHB must ensure appropriate resources for the delivery of the intern training programme, including Senior Medical Officer (SMO) staffing, to ensure the effective support and supervision of interns.
4. Clinical supervisors must be made aware of their responsibility to escalate any concerns about intern performance to the prevocational educational supervisors.

2.2 Educational expertise

2.2.1 The training provider can demonstrate that the intern training programme is underpinned by sound medical educational principles.

2.2.2 The training provider has appropriate medical educational expertise to deliver the intern training programme.

2.2 Educational expertise			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
The intern training programme at Waikato DHB is underpinned by sound medical educational principles. Apprentice style training is supported by a formal education programme that is structured to cover the key

competencies outlined in the *New Zealand Curriculum Framework for Prevocational Medical Training* that are not available through the completion of clinical attachments.

The DHB's senior medical staff are enthusiastic about teaching interns, and have the appropriate skills and experience to provide sound teaching and assessment.

Commendation:
All prevocational educational supervisors are experienced and well qualified for their role. Three of the prevocational educational supervisors, as well as the Clinical Director of Training, hold postgraduate qualifications in medical education.

Required actions:
Nil.

2.3 Relationships to support medical education

2.3.1 There are effective working relationships with external organisations involved in training and education.

2.3.2 The training provider coordinates the local delivery of the intern training programme, or collaborates in such coordination when it is part of a network programme.

2.3 Relationships to support medical education			
	Met	**Substantially met**	**Not met**
Rating	**X**		
Commentary:			

Comments:
Waikato DHB has an effective working relationship with the University of Auckland. As part of a cooperative venture between the DHB and the University, a skills centre is available to nursing, medical, surgical, allied health, general practice, paramedical and other community health staff.

In addition, the Clinical Education and Training Unit (CETU) collaborates with other DHBs and educational training units to share medical education resources and processes.

Commendation:
The CETU is to be commended for its collaboration with other DHBs and educational training units.

Required actions:
Nil.

3 The intern training programme

3.1 Professional development plan (PDP) and e-portfolio

3.1.1 There is a system to ensure that each intern maintains a PDP as part of their e-portfolio that identifies the intern's goals and learning objectives, informed by the NZCF, mid and end of clinical attachment assessments, personal interests and vocational aspirations.

3.1.2 There is a system to ensure that each intern maintains their e-portfolio, to ensure an adequate record of their learning and training experiences from their clinical attachments, CPD activities with reference to the NZCF.

3.1.3 There are mechanisms to ensure that the clinical supervisor and the prevocational educational supervisor regularly review and contribute to the intern's PDP.

3.1 Professional development plan (PDP) and e-portfolio			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
Waikato DHB has effective systems that ensure each intern maintains a Professional Development Plan (PDP). Clinical and prevocational educational supervisors assist the interns to set PDP goals and review their progress.

The prevocational educational supervisors and the CETU are developing resources on the formulation of relevant PDP goals.

Required actions:
Nil.

3.2 Programme components

3.2.1 The intern training programme overall, and the individual clinical attachments, are structured to support interns to achieve the goals in their PDP and substantively attain the learning outcomes in the NZCF.

3.2.2 The intern training programme for each PGY1 consists of four 13-week accredited clinical attachments which, in aggregate, provide a broad based experience of medical practice.

3.2.3 The training provider has a system to ensure that interns' preferences for clinical attachments are considered, mindful of the overall learning objectives of the NZCF and their individual PDP goals in the context of available positions.

3.2.4 The training provider selects suitable clinical attachments for training on the basis of the experiences that interns can expect to achieve, including the:

- workload for the intern and the clinical unit
- complexity of the given clinical setting
- mix of training experiences across the selected clinical attachments and how these, in aggregate, support achievement of the goals of the intern training programme.

3.2.5 The training provider, in discussion with the intern and the prevocational educational supervisor shall ensure that over the course of the two intern years each intern spends at least one clinical attachment in a community setting. This requirement will be implemented over a five year period commencing November 2015 with all interns meeting this requirement by November 2020.

3.2.6 Interns are not rostered on night duties during the first six weeks of their PGY1 intern year.

3.2.7 The training provider ensures there are mechanisms in place for appropriate structured handovers between clinical teams and between shifts to promote continuity of quality care.

3.2.8 The training provider ensures adherence to the Council's policy on obtaining informed consent.

3.2 Programme components			
	Met	**Substantially met**	**Not met**
Rating		X	

Commentary:

Comments:
The intern training programme is aligned to the core competencies outlined in the *New Zealand Curriculum Framework for Prevocational Medical Training (NZCF),* and is structured to provide a broad-based experience of medical practice.

Interns complete eight accredited clinical attachments during the course of their prevocational training. Postgraduate year 1 interns are allocated a combination of medical and surgical clinical attachments. The interns submit their requests to the Resident Medical Officer (RMO) Unit for the clinical attachments they would like to complete during postgraduate year 2. The RMO Unit endeavours to match interns with at least two of their preferred clinical attachments.

The DHB has implemented four community based attachments, and intends to implement a further six community based attachments before 2020. Funding for four of the six planned community based attachments has been secured. Prior to placing interns into a community based attachment, the Clinical Director of Training or a prevocational educational supervisor conducts a site visit to the community setting. Accredited community based attachments are reviewed each quarter to ensure that the quality of the attachment is maintained. Interns who have completed a community based attachment commented positively on their experience, and the clinical supervisors based in the community found the experience valuable and rewarding.

Interns are not rostered on night duties during the first 6 months of postgraduate year 1.

Significant concerns were raised regarding the lack of consistent handover across all services. Some senior medical staff are reluctant to engage with interns and other Resident Medical Officers (RMOs) during handover. Furthermore, interns expressed concern that in some clinical attachments there was an expectation of intern-to-intern handover that was in parallel to a handover involving registrars and consultants. As a result, it was unclear to interns whether the appropriate people had been notified of any clinical issues or concerns identified in previous shifts, or of what tasks were outstanding and their respective priorities. This raises issues of patient safety. It also prevents an important learning experience for the interns. These issues related to handover must be addressed as a matter of priority.

There is a clear informed consent policy which is operating effectively. Interns did not report any concerns associated with the DHB's processes for obtaining informed consent. Interns feel comfortable to decline to consent patients for procedures with which they are unfamiliar, and this is supported by the senior medical staff and registrars.

Commendations:
- Excellent progress has been made with developing and implementing community based attachments.
- The DHB's policy on informed consent is comprehensive and clear, and all medical staff understand their respective roles and responsibilities. The DHB's policy and processes for obtaining informed consent are consistently applied.

Required actions:
5. Waikato DHB must ensure appropriate engagement between consultants and interns during handover.
6. Mechanisms must be implemented to allow for the effective prioritisation of clinical tasks following handover.

3.3 Formal education programme

3.3.1 The intern training programme includes a formal education programme that supports interns to achieve those NCZF learning outcomes that are not generally available through the completion of clinical attachments.

3.3.2 The intern training programme is structured so that interns can attend at least two thirds of formal educational sessions, and ensures support from senior medical and nursing staff for such attendance.

3.3.3 The training provider provides opportunities for additional work-based teaching and training.

3.3.4 The training provider ensures the formal education programme provides opportunity for interns to develop skills in self-care and peer support, including time management, and identifying and managing stress and burn-out.

3.3 Formal education programme			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
The formal teaching programme is developed by the Clinical Education and Training Unit (CETU) with input from interns. There are separate programmes for each of the postgraduate year 1 and 2 years, which are reviewed annually. That review includes intern focus groups, the results of which inform the topics and scheduling of the programme for the following year.

The DHB ensures protected teaching time for interns. As a result, interns are able to attend at least two thirds of the formal educational sessions. The CETU sends regular reminders regarding the purpose and the protected nature of sessions, and pagers are held by the CETU during teaching. This allows regular and undisturbed intern participation in the formal education programme. Attendance at formal teaching sessions is recorded by the CETU, and the prevocational educational supervisors actively follow up interns who do not attend.

Teaching time is incorporated into the roster of interns working in community based attachments. This allows interns to travel to the DHB and attend the formal education programme.

There are many training opportunities across the DHB. This includes grand rounds, case presentation seminars, multidisciplinary team meetings and clinical audit. Interns are actively encouraged by their clinical supervisors to attend these additional learning opportunities. Interns also have access to simulation training, practical courses such as Acute Life Threatening Events Recognition and Treatment (ALERT), and postgraduate courses including the postgraduate diploma in child health.

The DHB ensures interns have the opportunity to develop skills in self-care and peer support. The formal education programme includes sessions on wellbeing, the unwell doctor, coping with complaints and professional boundaries.

Commendation:
The CETU coordinates and delivers a comprehensive and high quality formal education programme for each of the postgraduate year 1 and 2 intern cohorts, and makes considerable effort to ensure that teaching time is protected.

Required actions:
Nil.

3.4	Orientation
3.4.1	An orientation programme is provided for interns commencing employment, to ensure familiarity with the training provider and service policies and processes relevant to their practice and the intern training programme.

3.4 Orientation			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
The DHB provides a comprehensive orientation programme at the beginning of the intern year. Interns are able to provide input into the ongoing refinement of this programme.

Interns who commenced partway through the year reported very little formal orientation. The DHB should ensure interns have an appropriate understanding of policies and procedures prior to commencing practice.

The quality of orientation interns receive at the beginning of each clinical attachment is inconsistent across departments. Interns reported that they receive good orientation in orthopaedics, obstetrics and gynaecology, respiratory medicine and paediatrics. Orientation to other clinical attachments and departments was described as “self-directed”. The Clinical Education and Training Unit (CETU) acknowledged that orientation at the beginning of each clinical attachment requires improvement, and has devised excellent “cheat sheets” and orientation documentation for each clinical attachment.

Commendation:
The CETU has developed excellent orientation “cheat sheets” for each clinical attachment.

Recommendation:
The DHB should review orientation provided to interns who commence work partway through the year, to ensure they have an appropriate understanding of the DHB’s policies and procedures prior to commencing practice.

Required actions:
Nil.

3.5	Flexible training
3.5.1	Procedures are in place and followed, to guide and support supervisors and interns in the implementation and review of flexible training arrangements.

3.5 Flexible training			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
Waikato DHB has clear procedures to consider and support requests for flexible training. Special arrangements have been made for interns taking parental leave. Although there is an option for job sharing, the DHB has not received any requests for this to date.

Required actions:
Nil.

4 Assessment and supervision

4.1 Process and systems
4.1.1 There are processes to ensure assessment of all aspects of an intern's training and their progress towards satisfying the requirements for registration in a general scope of practice, that are understood by interns, prevocational educational supervisors, clinical supervisors and, as appropriate, others involved in the intern training programme.

4.1 Process and systems			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
Intern progress is monitored in ePort by the prevocational educational supervisors. The Clinical Education and Training Unit (CETU) also play an active part in ensuring each intern is making appropriate progress towards their registration requirements.

Combined meetings are held every 6 weeks between the CETU and the prevocational educational supervisors. Standing agenda items include tracking intern progress and identifying and assisting interns in difficulty. The Resident Medical Officer Unit monitors the occurrence of clinical supervisor meetings with interns in ePort and sends electronic reminders to interns if meetings have not occurred.

The process for meeting training and registration requirements is understood by the interns, prevocational educational supervisors, and broadly by the clinical supervisors.

Required action:
Nil.

4.2 Supervision
4.2.1 The training provider has an appropriate ratio of prevocational educational supervisors in place to oversee the training and education of interns in both PGY1 and PGY2.
4.2.2 Mechanisms are in place to ensure clinical supervision is provided by qualified medical staff with the appropriate competencies, skills, knowledge, authority, time and resources.
4.2.3 Interns are clinically supervised at a level appropriate to their experience and responsibilities at all times.
4.2.4 Administrative support is available to prevocational educational supervisors so they can carry out their roles effectively.

4.2 Supervision			
	Met	**Substantially met**	**Not met**
Rating			X
Commentary:			

Comments:
There are currently six prevocational educational supervisors for 76 interns, with a projected increase in the number of interns for the third quarter of 2017. This falls short of Council's required ratio of one

prevocational educational supervisor for up to 10 interns with a 0.1 full-time equivalent (FTE). Additional prevocational educational supervisors must be appointed with immediate effect.

Clinical supervision is provided by Council approved vocationally registered doctors. Interns are aware of who their clinical supervisors are and are aware of alternative avenues for support should their clinical supervisor be unavailable.

Serious concerns have been raised with respect to appropriate support of interns working at night. There is only one intern covering all medical wards at night. While a registrar has been appointed to support that intern, the registrar is often fully committed within the emergency department and unable to assist the intern, even in acute cases. Appropriate cover is also compromised by the geography of the hospital where the distances that the intern is expected to cover precludes any effective response to an urgent or emergency medical situation. This represents a serious risk to patient safety. This situation is compounded by the lack of triaging of calls, or any indication of the level of priority that should be assigned to a call. The lack of support for interns during medical night cover must be addressed immediately.

The clinical supervisors raised concerns about their capacity to supervise interns during the day. The clinical supervisors described the pressures of a high clinical workload impacting on a growing number of trainees, including medical students, interns and vocational trainees, attached to each clinical supervisor. The resulting time pressures impact on the ability of clinical supervisors to provide informal teaching and feedback to interns. Interns also reported that they had little interaction with their clinical supervisors outside of the formal supervisory meetings.

The prevocational educational supervisors are well supported by the Clinical Education and Training Unit (CETU).

Commendations:
The Clinical Education and Training Unit provides excellent support to the prevocational educational supervisors.

Required action:

7. Council's required ratio of prevocational educational supervisors to interns (1:10), with FTE protected time, must be met at all times.
8. Council's serious concerns regarding medical night cover must be addressed. Interns must be appropriately supported and supervised by qualified medical staff at all times.

4.3 Training for clinical supervisors and prevocational educational supervisors

4.3.1 Clinical supervisors undertake relevant training in supervision and assessment within three years of commencing this role.

4.3.2 Prevocational educational supervisors attend an annual prevocational educational supervisor training workshop conducted by Council.

4.3.3 All staff involved in intern training have access to professional development activities to support improvement in the quality of the intern training programme.

4.3 Training for clinical supervisors and prevocational educational supervisors			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
Clinical supervisors are actively encouraged to attend training workshops and attendance is monitored by the Resident Medical Officer (RMO) Unit. Reports are presented to the prevocational educational supervisor meetings every 6 weeks. There has been good uptake of training by the clinical supervisors. At the time of the accreditation site visit, a proposal was being considered for on-site clinical supervisor training sessions conducted by the prevocational educational supervisors.

All prevocational educational supervisors attend Council's annual prevocational educational supervisor workshops.

Staff involved in training have the opportunity to access professional development activities including a medical education programme and diploma at the University of Auckland. Staff are also encouraged to attend workshops and medical college supervisor training.

Required actions:
Nil.

4.4 Feedback to interns

4.4.1 Systems are in place to ensure that regular, formal, informal and documented feedback is provided to interns on their performance within each clinical attachment and in relation to their progress in completing the goals in their PDP, and substantively attaining the learning outcomes in the NZCF. This is recorded in the intern's e-portfolio.

4.4.2 Mechanisms exist to identify at an early stage interns who are not performing at the required standard of competence; to ensure that the clinical supervisor discusses these concerns with the intern, the prevocational educational supervisor (and CMO or delegate when appropriate); and that a remediation plan is developed and implemented with a focus on patient safety.

4.4 Feedback to interns			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
The Resident Medical Officer (RMO) Unit staff monitor ePort to ensure that clinical supervisors meet with interns at the beginning, middle and end of clinical attachments. Staff follow up with any clinical supervisors who have not recorded feedback in ePort for each of these meetings. Notifications about compliance sent through ePort are monitored by the prevocational educational supervisors and discussed at each of the 6-weekly meetings with the Clinical Education and Training Unit (CETU).

The CETU and the prevocational educational supervisors have appropriate and efficient structures in place to manage interns. A draft policy has been developed regarding the supervisory and management approach of the intern in difficulty to formalise the processes already in place. However, the assistance provided to interns in difficulty can be impeded by the lack of information shared by the clinical supervisors with the prevocational educational supervisors. There must be effective communication between the clinical supervisors and prevocational educational supervisors to ensure the timely and appropriate management of concerns around an intern not performing at the required standard of competence.

Commendation:
The RMO Unit and prevocational educational supervisors effectively monitor intern progress and ensure that clinical supervisor meetings occur and are recorded in ePort.

Required actions:
Nil.

4.5 Advisory panel to recommend registration in a general scope of practice

4.5.1 The training provider has an established advisory panel to consider progress of each intern during and at the end of the PGY1 year.

4.5.2 The advisory panel will comprise:
- a CMO or delegate (who will Chair the panel)
- the intern's prevocational educational supervisor
- a second prevocational educational supervisor
- a lay person.

4.5.3 The panel follows Council's *Guide for Advisory Panels*.

4.5.4 There is a process for the advisory panel to recommend to Council whether a PGY1 has satisfactorily completed requirements for a general scope of practice or should be required to undertake further intern training.

4.5.5 There is a process to inform Council of interns who are identified as not performing at the required standard of competence.

4.5.6 The advisory panel bases its recommendation for registration in a general scope of practice on whether the intern has:
- satisfactorily completed four accredited clinical attachments
- substantively attained the learning outcomes outlined in the NZCF
- completed a minimum of 10 weeks (full time equivalent) in each clinical attachment
- developed an acceptable PDP for PGY2, to be completed during PGY2
- advanced cardiac life support (ACLS) certification at the standard of New Zealand Resuscitation Council CORE level 7 less than 12 months old.

4.5 Advisory panel to recommend registration in a general scope of practice			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
The advisory panels are well established and are work effectively. The panels meet biannually, with separate meetings held to consider progress the of the postgraduate year 1 and 2 interns. Additional advisory panel meetings are scheduled during the year as needed for interns who complete postgraduate year 1 outside the usual period.

Required actions:
Nil.

4.6 Signoff for completion of PGY2

4.6.1 There is a process for the prevocational educational supervisor to review progress of each intern at the end of PGY2, and to recommend to Council whether a PGY2 has satisfactorily achieved the goals in the PDP.

4.6 Signoff for completion of PGY2			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
The advisory panel reviews and makes recommendations to Council about the satisfactory completion of postgraduate year 2 for each intern. This is an effective process.

Required action:
Nil.

5 Monitoring and evaluation of the intern training programme

5	**Monitoring and evaluation of the intern training programme**
5.1	Processes and mechanisms are in place to ensure the currency of accredited clinical attachments.
5.2	Processes and systems are in place to monitor the intern training programme with input from interns and supervisors.
5.3	There are mechanisms that allow feedback from interns and supervisors to be incorporated into any quality improvement strategies for the intern training programme.
5.4	There is a process to address any matters raised by Council in relation to training, including those arising from accreditation visits.

5. Monitoring and evaluation of the intern training programme			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
Waikato DHB has processes and mechanisms in place to ensure the currency of accredited clinical attachments. Each prevocational educational supervisor is allocated specific departments to oversee and review.

The Clinical Education and Training Unit (CETU) develops the formal teaching programme with input from interns. There are separate programmes for each of the postgraduate year 1 and postgraduate year 2 years. The formal teaching programme is reviewed annually, which includes intern focus groups. The results inform the topics and scheduling for the following year.

The Wellbeing and Innovations RMO Educational Development (W.I.R.E.D) group contributes to quality improvement initiatives. The Clinical Director of Training reports annually to the Board of Clinical Governance and the Executive Team on intern training and education.

The DHB has reported progress on issues raised during the course of the last accreditation visit.

Required actions:
Nil.

6 Implementing the education and training framework

6.1 Establishing and allocating accredited clinical attachments

6.1.1 The training provider has processes for applying for accreditation of clinical attachments.

6.1.2 The process of allocation of interns to clinical attachments is transparent and fair.

6.1.3 The training provider must maintain a list of who the clinical supervisors are for each clinical attachment.

6.1 Establishing and allocating accredited clinical attachments			
	Met	Substantially met	Not met
Rating	X		
Commentary:			

Comment:
Waikato DHB has processes in place for applying for accreditation of clinical attachments. These have recently been redrafted to accommodate the requirements of accreditation for community based attachments.

The DHB has clear processes for allocating interns to clinical attachments. The DHB aims to ensure that interns are allocated to at least two of their four preferred attachments. Although interns confirmed that they were allocated to some of their preferred attachments, they do not consider the process transparent.

The DHB maintains a register of the clinical supervisors for each clinical attachment.

Required actions:
Nil.

6.2 Welfare and support

6.2.1 The duties, rostering, working hours and supervision of interns are consistent with the delivery of high quality training and safe patient care within a safe working environment, including freedom from harassment.

6.2.2 Interns have access to personal counselling, and career advice. These services are publicised to interns and their supervisors.

6.2.3 The procedure for accessing appropriate professional development leave is published, fair and practical.

6.2.4 The training provider actively encourages interns to maintain their own health and welfare and to register with a general practitioner.

6.2.5 Applications for annual leave are dealt with properly and transparently.

6.2 Welfare and support			
	Met	Substantially met	Not met
Rating			X
Commentary:			

Comments:

Several interns reported feeling overwhelmed with the volume of tasks they are expected to complete each shift. This is particularly at night and during the weekend. This is compounded by the lack of an effective triage system. The current paging-system and lack of an effective task manager impact on interns' ability to prioritise clinical tasks.

Interns expressed considerable concern about instances where their roster only became available on or after their clinical attachment had commenced. This occurred when the Resident Medical Officer (RMO) Unit was particularly short-staffed. The DHB has undertaken a review of its rostering processes. It is expected that concerns raised by the interns will be addressed by the review.

Interns and senior medical staff advised of allegations of harassment and bullying. In addition, an external review addressing harassment and bullying is being undertaken in the General Medicine Department. It was further advised that instances of bullying are under-reported because interns have concerns about confidentiality and potential repercussions.

While it is recognised that the interns can access career advice and personal counselling, the confidentiality of the DHB's Health and Safety Service has been compromised. The Accreditation Team was advised that staff using this service have been asked to waive their right to privacy.

Information about the process for accessing professional development leave is provided in the Resident Medical Officer (RMO) Manual of Generic Processes for Managers. Leave applications must be submitted three months in advance. Applications are considered by the department educator (in the case of study leave which becomes available in the postgraduate year 2), Clinical Directors and Clinical Supervisors (in the case of conference leave). However, interns hold significant concerns about leave procedures, including the procedures for accessing professional development leave.

Interns are actively encouraged to maintain their own wellbeing, and to enrol with a general practitioner. Formal education sessions on wellbeing are included in the intern orientation programme and the formal education programme.

All staff reported that the process of applying for, and having annual leave approved, is ineffective. Interns do not get timely responses to leave requests. The RMO Unit report that the reason for delays is related to understaffing.

Required actions:

9. The workload of interns must be consistent with the delivery of safe patient care within a safe working environment.
10. Waikato DHB must ensure a safe working environment that is free from bullying and harassment.
11. Access to confidential counselling services for interns must be ensured.
12. Waikato DHB must implement an effective and transparent system for annual leave applications.

6.3 Communication with interns

6.3.1 Clear and easily accessible information about the intern training programme is provided to interns.

6.3 Communication with interns			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:

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An online handbook, notification of e-learning courses, and the formal education course programme are provided via a mix of direct email and through the intern website. The formal education programme is also discussed, in a half-day introductory session, at orientation.

Required actions:
Nil.

6.4 Resolution of training problems and disputes

6.4.1 There are processes to support interns to address problems with training supervision and training requirements that maintain appropriate confidentiality.

6.4.2 There are clear impartial pathways for timely resolution of training-related disputes.

6.4 Resolution of training problems and disputes			
	Met	Substantially met	Not met
Rating	X		
Commentary:			

Comments:
Waikato DHB has developed a draft policy *Monitoring and Evaluation of Resident Medical Officer Training*, which outlines pathways for interns to access help to address training related concerns and this includes an appeals process. The DHB described a graduated system for resolving training related disputes, involving the prevocational education supervisors, clinical supervisors and ultimately recourse could be sought through the Chief Medical Officer.

Required actions:
Nil.

7 Communication with Council

7.1 Process and systems

7.1 There are processes in place so that prevocational educational supervisors inform Council in a timely manner of interns whom they identify as not performing at the required standard of competence.

7. Process and systems			
	Met	Substantially met	Not met
Rating	X		
Commentary:			

Comments:
The process for reporting an unsatisfactory end-of-clinical attachment assessment are clear and documented within ePort. Prevocational educational supervisors at the DHB meet on a 6-weekly basis, and these meetings include a standing agenda item on interns in difficulty. The prevocational educational supervisors are aware of when to notify Council of interns who are not performing at the required standard of competence.

Required actions:
Nil.

8 Facilities

8	Facilities
8.1	Interns have access to appropriate educational resources, facilities and infrastructure to support their training.
8.2	The training provider provides a safe working and learning environment.

8. Facilities			
	Met	**Substantially met**	**Not met**
Rating	X		
Commentary:			

Comments:
The interns have access to computers across the campus. There are appropriate computer resources located in the library and wards. Wireless internet is available across much of the campus to allow access for the intern's access via portable devices.

There is an excellent clinical skills simulation laboratory, which is run as a joint venture with University of Auckland School of Medicine. This has an operating theatre and ward area for the interns to develop and practice skills in a realistic environment. Scenarios are remotely managed, with recording facilities available for later playback and review.

A RMO lounge is provided in the newly rebuilt part of the hospital. The Resident Medical Officer (RMO) lounge includes a computer area with four computers and an available printer. Interns have facilities for hot drinks and hot snacks with various recreational options available. It also includes sleeping and change areas, with a separate locker room for intern use.

There is a large library with access to online journals and textbooks. Attached to the library is a series of well-resourced meeting rooms.

The DHB has a Health and Safety policy, which is available on the DHB intranet.

Commendations:
- The DHB is to be commended on the range and quality of the educational facilities provided to their interns.
- A facilities upgrade has resulted in an excellent living environment for the interns.

Required actions:
Nil.

Next Board Meeting: 23 November 2017.