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

- Dr N Murray, Chief Executive
- Mr B Paradine, Executive Director, Waikato Hospital Services
- Ms M Chrystall, Executive Director, Corporate Services
- Mr N Hablous, Chief of Staff
- Mr D Hackett, Executive Director, Virtual Care and Innovation
- Mrs S Hayward, Director of Nursing & Midwifery
- Ms M Berryman, Executive Director, Maori Health (acting)
- 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
- Mr D Wright, 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:
Telephone 07-834 3622
Facsimile 07-839 8680
www.waikatodhb.health.nz

Next Meeting Date: 26 April 2017

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

A g e n d a

Board

Date: **22 March 2017**

Time: **1.30pm**

Place: **Level 1**
Hockin Building
Waikato Hospital
Pembroke Street
HAMILTON

Meeting of the Waikato District Health Board

to be held on Wednesday 22 March 2017
commencing at 1.30pm at Waikato Hospital

AGENDA

Note: Board member 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 MATTERS ARISING**
- 3.1 Board Minutes: 14 February 2017 and 22 February 2017
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 2 March 2017
  - 3.2.2 Performance Monitoring Committee: 8 March 2017
  - 3.2.3 Health Strategy Committee: 8 March 2017

4. **CHIEF EXECUTIVE REPORT**

5. **FINANCE**
- 5.1 Finance Report

6. **PERFORMANCE REPORTING**
- 6.1 Health Targets
- 6.2 Provider Arm Key Performance Dashboard
- 6.3 Strategy and Funding Key Performance Dashboard

7. **PLANNING**

No items

8. **WAIKATO DHB POSITION STATEMENTS AND POLICIES**
- 8.1 Waikato DHB Management of Policies and Guidelines Policy

9. **PRESENTATION**
- 9.1 Programme Business Case: Midland eSPACE Programme 2015-20
  Presentation by Maureen Chrystall, Dr Andrew Darby and Dr Ian Martin at 2.30pm

10. **PAPERS FOR INFORMATION**
- 10.1 Mental Health & Addictions Service S99 (Mental Health (CAT) Act 1992) Inspection Report Action Plan

11. **NEXT MEETING**
- 11.1 26 April 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 12: Minutes – Various
- **(i) Waikato District Health Board for confirmation: Wednesday 22 February 2017 (Items taken with the public excluded)**
- **(ii) Audit and Corporate Risk Management Committee – verbal update to be received: Wednesday 22 March 2017 (All items)**
- **(iii) Performance Monitoring Committee – to be adopted: Wednesday 8 March 2017 (Items 15-16)**
- **(iv) Health Strategy Committee – to be adopted: Wednesday 8 March 2017 (Items 13-14)**

Item 13: Risk Register – Public Excluded

Item 14: Waikato DHB Working Draft Annual Plan 2017/18 – 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 12(i-iv): Minutes	Items to be adopted / confirmed / received were taken with the public excluded
Item 13: Risk Register	Avoid inhibiting staff advice about organisational risks
Item 14: Draft Annual Plan 2017/18	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 12: As shown on resolution to exclude the public in minutes.

Item 13: 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 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

12. MINUTES – PUBLIC EXCLUDED

12.1 Waikato District Health Board: 22 February 2017
To be confirmed: Items taken with the public excluded

12.2 Audit and Corporate Risk Management Committee: 22 March 2017
Verbal update: All items

12.3 Performance Monitoring Committee: 8 March 2017
To be adopted: Items 15-16

12.4 Health Strategy Committee: 8 March 2017
To be adopted: Items 13-14

13. RISK REGISTER – PUBLIC EXCLUDED

14. WAIKATO DHB WORKING DRAFT ANNUAL PLAN 2017/18 – PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

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.

Waikato District Health Board

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO MARCH 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, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Chairman, Orchestras	TBA	TBA	
Member, Waikato Regional Council	Pecuniary	Perceived	
Director, Rotoroa LLC	TBA	TBA	
Director, Simcock Industries Ltd	TBA	TBA	
Trustee, RM & AI Simcock Family Trust	TBA	TBA	
Wife is CEO of Child Matters, Trustee of 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, Health Workforce NZ	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 Partnership 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 (contracts with Waikato 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	Pecuniary	Perceived	
Son is an employee of Hongkong and Shanghai Banking Corp Ltd (NZ)	Non-Pecuniary		

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, Sustainability Advisory 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	
Iwi: Ngati Pahauwera, Ngati Ranginui, Ngati Haua, Tuwharetoa, Maniapoto	Non-Pecuniary	Perceived	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	
Trustee/Shareholder, Whanau.com Trust	Pecuniary	None	
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	
Justice of the Peace	Non-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	
Councillor, Hamilton City Council	Pecuniary	Perceived	
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	

Note 1: Interests listed in every agenda.

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

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	

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	
Deputy 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	
Daughters are employees of Deloitte, Hamilton	Non-Pecuniary	Potential	

Clyde Wade

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

Note 1: Interests listed in every agenda.

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

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	

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

Waikato District Health Board

Minutes
and
Matters Arising

MINUTES OF THE SPECIAL MEETING OF THE WAIKATO DISTRICT HEALTH BOARD HELD ON TUESDAY 14 FEBRUARY 2017 COMMENCING AT 4.00PM IN THE WHAKAPAKARI MEETING ROOM, LEVEL 9, KPMG BUILDING, 85 ALEXANDRA STREET, HAMILTON

Present: Mr B Simcock (Chair)
Mr M Gallagher
Mrs P Mahood
Ms MA Gill
Dr C Wade

Present by Phone: Ms C Beavis

In Attendance: Mrs M Chrystal (Executive Director Corporate Services)
Mr A McCurdie (Chief Financial Officer)

ITEM 1: APOLOGIES FOR ABSENCE

The Board received apologies from Ms S Webb, Ms S Christie, Ms S Mariu Mr D McPherson, Ms T Hodges.

ITEM 2: WAIKATO DHB DEBT TO EQUITY CONVERSION

The Chair explained the background to this agenda item. Waikato DHB received a letter from the Minister of Health advising that the Government had changed its policy on capital financing for the District Health Board sector. From 15 February 2017, DHBs would no longer be able to access Crown debt financing for funding capital investment. The Government directed the District Health Boards to convert their existing Crown loans into equity.

The Board discussed the contents of the letter and considered the advice provided by the Executive Director of Corporate Services and Chief Financial Officer. It was noted:

- Waikato DHB holds Crown debt of $211.659 million. Its equity is approximately $240 million.
- The conversion was consistent with the overall Government approach with regard to Crown entity funding.
- Waikato DHB's overall risk profile did not change. It remained highly dependent on the discretion of the Crown.
- The loan would be subjected to a capital charge of 7%.
- A letter had been prepared to send to the Minister of Health agreeing to the debt to equity conversion of its Crown debt of $211.659 million and set out that the loan portfolio at the date of conversion. The letter also expressed the Board's concerns that the "make good" revenue provision would not adequately cover the true costs that would be incurred had the debt to equity conversion not taken place.
- 17 District Health Boards had already approved this conversation and it was expected that the remaining 3 District Health Boards would approve it.
- The differential would be funded through additional top-sliced revenue for the difference until such time as a new capital financing and investment

system for DHBs could be implemented. This has been estimated as being 2 years away.

Resolved
THAT
The Board approved:

- the motion to convert the debt to equity and authorised two Board members to sign the relevant documentation; and
- a letter to be sent to the Minister of Health setting out the Board's concerns for future discussion.

SPECIAL BOARD MEETING
MINUTES OF 14 FEBRUARY 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 4: Employment Negotiation with Junior Doctors – 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 4 Update on employment negotiations with RDA	Negotiations with the Union are occurring

(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 4 **As shown on resolution to exclude the public in minutes.**

This Item was removed from the Agenda.

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: 4.45 pm

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 22 February 2017 commencing at 1.30 pm in the Board Room, Hockin Building at Waikato Hospital Campus

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

In Attendance:
Dr N Murray (Chief Executive)
Mr B Paradine (Executive Director, Waikato Hospital Services)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Mr D Wright (Executive Director, Mental Health and Addictions Service)
Mr M Spittal (Executive Director, Community and Clinical Support)
Mrs M Chrystal (Executive Director Corporate Services)
Mr A McCurdie (Chief Financial Officer)
Ms T Maloney (Commissioner, Women's Health Transformation Taskforce)
Mr M ter Beek (Executive Director, Operations and Performance)
Prof R Lawrenson (Clinical Director, Strategy and Funding)
Ms M Neville (Director, Quality and Patient Safety) for part of the meeting
Mrs J Wilson (Executive Director, Strategy and Funding)
Mrs S Haywood (Director Nursing and Midwifery)
Dr D Tomic (Clinical Director, Primary and Integrated Care)

ITEM 1: APOLOGIES FOR ABSENCE

There were no apologies for absence recorded at this meeting.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

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

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes, 14 December 2016

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 14 December 2016 taken with the public present were confirmed as a true and accurate record.

3.2 Committees

No Committee Meeting had been held during this period.

3.3 Committee Structure and Appointments

The Chair tabled a redrafted paper that included the suggested changes to the Committee Structure and Appointments paper as discussed at the December meeting.

The Board noted the recommendations made in this report:

1. The Board established as per legislation a Hospital Advisory Committee, Community and Public Health Advisory Committee and Disability Support Advisory Committee.

   The Board agreed a change to the suggested membership for these two committees. There would be two members upon recommendation of the Consumer Council and not one as set out in the report.

2. The Board also established an Audit and Corporate Risk Management Committee and Remuneration Committee.

3. The Hospital Advisory Committee is for our purposes named the Performance Monitoring Committee and the Community and Public Health Advisory Committee is for our purposes named the Health Strategy Committee.

4. The Disability Support Advisory Committee functions would be under the umbrella of the Health Strategy Committee.

5. Membership of the Committee would be as described in this paper.

6. Two Board members were nominated to attend the Waikato DHB Board of Clinical Governance.

7. The external committee members of the existing statutory committees were advised that:

   a. A decision had been made to discontinue appointing external members once the Consumer Council was able to propose members for committees;

b. Present arrangements would be maintained until the Consumer Council was up and running;
c. A farewell function would be arranged for an appropriate time.

8. The Board policy 0301 "Appointment of External Members to Board Committees" was withdrawn

9. The meeting schedule would be as follows:

   a. Performance Monitoring Committee and Health Strategy Committee – every two months

   b. Audit and Corporate Risk Management Committee – four times per year

   c. Sustainability Advisory Committee and Remuneration Committee as required.

10. The attached meeting schedule was adopted.

Resolved
THAT
The Board received the report subject to the amendment mentioned in Item numbered 1 above and adopted the recommendations.

3.4 Committee Membership 2017

The Chair tabled a report setting out his recommendations for the makeup of the Board's committees. The Chair had written to the current external members of the committees advising them that the Board had decided to seek nominations from the Consumer Council for the Performance Monitoring Committee and the Health Strategy Committee. He invited the external members to stay on the committees until the Consumer Council had been established.

Resolved
THAT
The Board received the report that outlined the membership of the committees of the Waikato DHB Board and other representation.

3.5 Board Code of Conduct

The Chair asked the Board members to read and understand the Code of Conduct for Board Members and accept it for the current three year term.

Resolved
THAT
The Board adopted the Waikato DHB Code of Conduct for Board Members.

ITEM 4: CHIEF EXECUTIVE REPORT

The Chief Executive provided the Board with an update on:

- Movement of Staff – the refurbishment of the Chief Executive's wing of the third floor of the Hockin Building was complete. Refurbishment of the remainder of the third floor of the Hockin Building was proposed to allow for more open space working. To cater for this work being carried out, staff elsewhere on the third floor of the Hockin Building would be decanted into the Chief Executive's wing.

  The Chair advised that the Board had expressed a reasonably firm view in their pre-board meeting that board meetings should be held in the board room in the Hockin Building. The Chief Executive's view was that it was important for the board meeting to be held around the Waikato region in the DHB's locations, including level 9 of the KPMG building.

- Waikato DHB Strategy Refresh – the refresh strategy that had been completed and approved by the Board in 2016 had been included with this agenda item for the benefit of the three new board members.

- Official Information Act Requests – as this is an election year it was expected that the number of Official Information Act requests would likely increase. It was suggested that the DHB publish all Official Information Act requests along with their replies on the DHB website. The DHB's website was being upgraded in April and this change would be made at that time.

Resolved
THAT
The Board received the report.

ITEM 5: FINANCE REPORT

The Chief Financial Officer asked that his report for the month to 31 January 2017 be taken as read highlighting the following:

1. January was a positive month.
2. It was forecasted that the budget would have a surplus of $4.5m for the year.

- The provider was unfavourable to budget for January 2017:

1. Revenue unfavourable to budget $6.5m (1.3%) due to lower than planned Provider volumes.
2. Employed personnel costs were unfavourable to budget $3.4m the dominant variances being within nursing and a smaller positive offset by medical personnel.
3. Outsourced personnel unfavourable to budget $7.4m – this related to medical locums ($2.5m), Nursing ($0.9) and admin/management contractors for the National Oracle Solution (NOS) project ($3.7m) which had an offset in other revenue (2.9m).
4. Outsourced services were favourable at $1.8m
5. Clinical supplies were unfavourable at $0.8m
6. Infrastructure and non-clinical supplies were on budget at $1.6m.

7. Interest depreciation and capital charges were favourable to budget $2.8m

It was noted that:

- Acute cases excluding ED: episodes 2.0% above plan; case-weights 5.6% above plan
- Elective cases: episodes 16.2% below plan; case-weights 22.6% below plan
- Overall 2.9% below plan for cases and 3.1% below plan for case weights
- ED attends: YTD ED attends are 1.7% higher than the same period last year
- It was noted that analysis was being done to ensure that the volume differences were clearly understood and the impacts managed.
- The result for the Funder was favourable due to favourable Provider payment costs
- The result for Governance was on budget.

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

ITEM 6: PERFORMANCE REPORTING

6.1 Health Targets

The Health Targets report summarising Quarter One performance was submitted for information. Quarter Two information was not yet available.

Management noted:

- **Shorter stays in emergency department** – the most recent result was 88.8%. To manage within the 6 hour total it was broken down for operational purposes into:
  - 3 hours for the ED to complete the initial assessment and investigation of patient, including a decision if the patient needed to be referred to a specialty; and
  - 2 hours for the specialty to review the patient and to make a decision if they need to be admitted; and
  - 1hour to secure a bed and transfer the patient if admitted.
- **Improved Access to Elective Surgery** – most recent result was 101.6%. .
- **Faster Cancer Treatment** – the target for quarter one showed a result of 86.7%.

- **Better help for smokers to quit – primary care** – 86.7% was the most recent result.

- **Better help for smokers to quit – maternity** – 92.9% was the most recent result.

- **Increased immunisation for 8 month olds** – the most recent result was 91.2%.

- **Raising healthy kids** – The latest quarterly result was 79% putting the DHB above the national average of 72%.

Resolved
THAT
The Board received the report.

6.2 Provider Arm Key Performance Dashboard

The high level Provider Arm Key Performance Dashboard for January 2017 was submitted for the Board's information.

Clinical and Community Support

The report was taken as read and no areas of concern in the KPI Report were noted.

Mental Health and Addictions Service

The report was taken as read. Management noted:

- **ED Presentations** – There had been 111 ED presentations for the month of January.

- **Seclusion** – seclusion hours were 377 against a target of 371. The uses of advanced directives were being considered. This would mean discussing with the consumer what triggers these episodes and how they can be managed during the episode.

- **Inpatient occupancy** – occupancy during January was 85.7%.

- **Annual leave taken** – annual leave planning was continuing to have a positive result.

- **Sick leave taken** was 2.3% against a target of 1.7%. It was acknowledged that this target might need to be reviewed.

- **Community Report Card** – Issue 4 had been published in the local press.

- **Better help for smokers to quit** – the service continue to offer advice along with alternatives such as patches and gum.

- **Complaint Resolution** – two complaints remained open in January. One closed on 3 February and the other whilst still open had a meeting schedule for the week of 13 February for resolution and closure.

Waikato Hospital Services

The report was taken as read. Management noted:

- **Long wait patients on outpatient waiting lists** – a new spinal surgeon had started and a foot and ankle specialist were due to start in April. The RMO strike had a negative impact on the volumes delivered during January and would continue to do so beyond January.

- **Number of long wait patients on inpatient waiting lists** – this target continued to be hampered by reduced elective operating theatre capacity as a result of an extended Christmas theatre closure and the RDA RMO strike.

Resolved
THAT
The Board received the report.

6.3 Strategy and Funding Key Performance Dashboard

The Strategy and Funding key performance dashboard was submitted for the Board's information.

Management noted:

- **AOD and Mental Health waiting times (% of new clients seen with 8 weeks of referral)** - wait times at 3 weeks for adults in AOD services continued to lag behind the target.

- **Proportion of older people waiting greater than 20 days for assessment or reassessment** – a significant amount of work had been undertaken in this area largely focussed on improving timeliness of more urgent referrals and slowly addressing the backlog.

- **Breast Screening** – The new Ministry of Health contracts were split between Pinnacle and Hauraki. It was anticipated that the new contracts would lead to an improvement in resources.

- **Two year old immunisations** – this result remained static at 92%.

Resolved
THAT
The Board received the report.

ITEM 7: PLANNING

7.1 Investor Confidence Rating and Long Term Investment Plan Update

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A new approach to long term investment in public services had been approved by the Cabinet. The Treasury had assessed how well major public agencies and Government departments managed their investments. The assessment was based on eight elements:

1. Asset management maturity
2. Portfolio, Programme and Project (P3M3) maturity
3. Quality of Long term Investment Plan
4. Organisational change management maturity
5. Benefits delivery performance
6. Project delivery performance
7. Asset performance
8. System performance (compliance)

A workshop was to be held in April for Board members.

Resolved
THAT
1) The Board received the report.
2) A Board workshop to be scheduled for April to consider and discuss the scenario modelling.

7.2 Waikato DHB Annual Plan 2017/18 Update

The Ministry of Health had revised the structure of the Annual Plan and prescribed two key changes to the development process:

1) The Annual Plan was to consist of 30 to 33 pages in length plus appendices.

2) Maori Health Plans were no longer to be submitted. Instead Maori health equity would be incorporated within the Annual Plan.

The funding envelope advice had not been received. An indicative signal had been provided for 2017/18 show an a national increase of $400 million.

There would be a presentation on the Annual Plan at the next meeting.

ITEM 8: WAIKATO DHB POSITION STATEMENT AND POLICIES

8.1 Serious Event Review Process

A report setting out the serious event review process was taken as read.

It was noted that the process was still evolving and up to now it had not been usual practice to share final reports at the Board meetings. It was acknowledged that if a serious incident was seen as 'high risk' for the DHB then it would be appropriate for the findings and recommendations to be presented at the Board. This could be in the public section if the patient/family concerned consented to the wider sharing of the report; otherwise the findings would need to be presented in the public excluded section of the Board meeting.

Increasingly, the Coroner and HDC were using the final DHB serious event review reports to support their investigations.

8.2 Fluoridation Submission

Felicity Dumble and Richard Hoskins attended for this item.

The Board adopted a Position Statement on the Fluoridation of Drinking water in August 2016. Waikato DHB had prepared a submission on the Health (Fluoridation of Drinking Water) Amendment Bill. However due to the timing that the submissions need to be submitted, it had not been formally considered by the Board and was therefore presented at this meeting for its consideration.

The submission presented made clear the view of Waikato DHB in that there should subsequent comment once the Board had an opportunity to discuss the matter. The submission was consistent with the principles of the position statement.

To summarise:

- The DHB welcomed and strongly supported the Bill as drafted.
- The DHB believed that decision-making should sit with the Minister of Health and while decision making by individual DHBs was an option it was more complex and less preferred.
- The DHB had conveyed a strong view a framework was needed for decision making.
- The Board were comfortable with submission.

Resolved
THAT
The Board noted the report and discussed the Fluoridation submission.

ITEM 9: PAPERS FOR INFORMATION

9.1 Women's Health Transformation Programme

This report updated the Board on the progress that had been made over the previous two months. It was noted:

- Progress made to the changes to the model of care for elective caesareans, the women's assessment unit and outpatient's day assessment unit.
- Recruitment of midwives, SMOs and registrars.
- Development of a recruitment and retention plan for midwives.
- Review of midwifery rostering process.
- The service was still under considerable pressure due to workforce vacancies and continued to diversify recruitment strategies and explore changes that would attract registrars and midwives and retain the current workforce.

Resolved
THAT
The Board received the report.

9.2 Elective Services Improvement Commissioner Progress Report

This report updated the Board on work undertaken in the area of elective services improvement over the last three months since the commencement of the elective services improvement commissioner. The key areas of focus were noted:

- **Wait list management and ESPI compliance**
  - Slow progress was being made on the management of waitlists and ESPI compliance.
  - ESPI2 had been breached for the fourth month in January. A large number of spinal assessments had been outsourced.
  - ESPI5 had not been achieved primarily in orthopaedics, spinal and paediatrics.

- **Delivery of elective volumes**
  - It was planned to outsource over 500 orthopaedic patients before the end of the year.
  - Looking at delivery options for the next financial year and considering how best to maximise both internal and external capacity on a more planned basis.

- **Systems and Processes**
  - Resource documents had been developed and linked through the electives intranet page.
  - Relevant inpatient letters had been reviewed and updated.

- **Clinical Decisions**
  - A framework for assessing the relative priority of first and follow-up outpatient assessment had been drafted and being trialled with one specialty with a view to rolling it out to all services.

- **Project Governance and operational oversight**
  - The Electives Taskforce had met for the first time to focus on progress against the agreed Action Plan together with EPSI compliance.
  - The Internal Action Group had been set up to assess how the DHB might be able to shift volumes to provide the most funded services.

Resolved
THAT
The Board received the report.

ITEM 10: NEXT MEETING

Date of Next Meeting

The next meeting to be held on Wednesday 22 March 2017, commencing at 1.30 pm in the Board Room, Hockin Building, Waikato Hospital.

BOARD MINUTES OF 22 FEBRURAY 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 14 December 2016 (Items taken with the public excluded)**
- **(ii) Midland Regional Governance Group: 3 February 2017 to be received (All Items)**

Item 12: Risk Register – Public Excluded
Item 13: Employment Negotiations with Junior Doctors – Public Excluded
Item 14: Patient Flow Manager Business Case – Public Excluded
Item 15: Replacement General Computerised Tomography (CT) Scanner – Public Excluded
Item 16: Sustainability and Enhancement of Primary level services in the Waikato Progress Update – 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-ii): 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:	Employment Negotiations with Junior Doctors	Neogiaions with Unions are occuring
Item 14:	Patient Flow Manager Business Case	Negotiations will be required
Item 15:	Replacement General Computerised Tomography (CT) Scanner	Negotiations will be required
Item 16:	Sustainability and enhancement of primary level services in the Waikato, progress update	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:	**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.**
Items 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 negotiations.**

ACTION LIST

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

	ACTION	BY	WHEN
1.	Agenda Item 3.3 – Tania Hodges suggested a future agenda item – the board should consider its relationship with the IWI Maori Council – there should be more guidance	Board	
2.	Agenda Item 4 - CE Report – instructions to be placed on the website about how people can access copies of their medical records.	Neville	
3.	Agenda Item 7.1 – a date to be set in April for the Board Workshop	Donna	
4.	Agenda Item 7.2 – presentation on the 2017/18 Annual Plan	Julie	
5.	Agenda Item 16 - Half a day on this to consider what journey the board might want to take with regard to Primary Care	Donna	

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Māori Council

Held on Thursday 2nd March 2017 at 9.30am

Present:

Mr H Mikaere (Chair)	Hauraki Māori Trust Board
Ms T Moxon (Deputy)	Te Rūnanga o Kirikiriroa
Mr G Tupuhi	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

In Attendance:

Ms M Berryman (Acting Executive Director of Māori Health)
Mr G Berghan (Acting Executive Director of Māori Health)
Matua H Curtis* (Pou Herenga Te Puna Oranga)
Ms P Mahood* (WDHB Board member)
Ms G Roberts (Kaunihera Kaumātua Chair)
Ms N Haereroa (Minute taker)

**Present for some of meeting*
(Following items are in order of appearance)

Karakia: Mr H Mikaere

Item 1: 9.30 Ms E McKenzie-Norton update on Waikato DHB strategy and values.

1.1 Work on the values is being conducted through the hospital. This work includes:

- information on the intranet around the values- audio recordings of the values in Te Reo Māori and English, explaining what the values mean and correct pronunciation are underway
- workshops for staff on what the values are and their meaning. Led by the Safety Culture Working Group (SCWG)
- Feedback from sessions: staff do not feel confident enough to try to pronounce Māori kupu and staff revert to the English words, recordings should help staff to practice and build confidence. Te Puna Oranga is assisting with development of these recordings.

<u>Response from IMC members and follow on response from Esmae:</u>

- Concerns raised about competency data and how, and if, this is being captured so that we (Waikato DHB) can see if the workshops are effective, or have an impact. Specific questions regarding competency with Te Reo/ Tikanga practices 'what are the baseline measures?' 'Where are they [SCWG] starting?'.

- Esmae: The SCWG could comment on these and maybe an invitation for a representative to attend IMC hui.

- The values should be embedded throughout the Priority Programme Plans (PPP's)
- Sue Haywood should attend and present on progress on PPP "1.4 Enable a workforce to deliver culturally appropriate services" as this relates directly to the values and staff competency

1.2 PPP's

- 4x phases (previously discussed at IMC meeting)
- 1st Phase is Alpha meetings, 2nd phase is the Alpha/ Bravo meetings which have taken place for the priorities that started in February 2017.
- Progress of PPP "1.1 Radical improvement in Māori health outcomes by eliminating health inequities for Māori".
  - Good start point
  - #1 Alpha and Bravo Hui- completed
  - #2 Another Alpha and Bravo Hui- due 2nd March 17
  - #3 Working Group to be established
- All PPP's to go to Health Strategy Committee and Esmae to report back at IMC meeting when confirmed.

Response from IMC members and follow on response from Esmae:

- IMC more familiar with Health Equity Tool operations
- Concerns raised about individual Alpha and Bravo appointments
- Great to see Senior Management present but need a balance of Māori on the expert/working group. Māori to be seen as equal
  - Millie response: Role of Bravo to support the Alpha and contribute to the work of the priority plan. Alpha/ Beta and working group will create the plan, Alpha's are the drivers.

Actions:

1	Add Esmae to IMC agenda as a regular agenda item to update, with a clear reporting template of what should be fed back to IMC as opposed to ad hoc feedback	IMC/TPO to create template.
2	Esmae to attend Kaunihera Kaumaatua hui.	Gaylene to inform KK to write a formal invitation to Esmae to attend meetings

Item 2: 10.00 am Mr N Murray CE Waikato DHB update

2.1 Executive Director Position:

- Interviews are coming up
- Will be concluded within the next few weeks
- There is no preferred candidate at this stage.

- Timeframe to appointment an approximate estimate of 3 months minimum.

Response from IMC members:

- Waikato-Tainui CE will write a letter to the CE expressing disappointment with the long timeframe to appoint the Executive Director of Māori Health.
    - The CE looks forward to receiving the letter
- Who will Ex. Dir Māori Health report to?
    - CE: Directly to the CE
- Will there be Kaumātua support, during the shortlisting and interview process?
    - CE: Sought advice from IMC by letter and followed the guidance provided by IMC, including incorporating an IMC member onto the interview panel. It was believed that this was sufficient given advice was provided directly by IMC.
- Can Kaumātua cultural processes be incorporated with the next intake of candidates?
    - IMC supportive of suggestion.
    - CE: If we change the process now it could open us up to an appeal from the previous candidates Check DHB policy for mandatory inclusion of Kaumātua on high level Māori positions within the DHB.
    - Mr Mikaere affirmed his confidence in the cultural processes and practices that were undertaken in the interview processes..
- What actions will be put in place to look after the new appointee?
    - CE: The new appointee will have the full support of the CE and Waikato DHB Board.

2.2 Waikato DHB Strategy

- Thank you to IMC for their participation in creating and developing this document. Commitment to this work and key words that stand out 'eliminate', 'radical'. And to do that we need the PPP's.
- Radical improvement in Māori health outcomes by eliminating health inequities for Māori-

CE: "[This is] what we have committed to and when we make a commitment we take it very seriously. So words like 'eliminate' feature predominately here. 'Radical improvement' of Māori Health outcomes by eliminating health inequities for Māori, eliminate health inequities for rural communities. Remove barriers for people experiencing disabilities to enter the workforce and culturally appropriate services… to do that we need a Priority Programme Plan (PPP). To signal the importance of it [the first plan 1.1] I am the leader of it, along with Millie, we have a meeting about it today advancing that plan. As we develop that plan IMC participation and endorsement in that plan will be really important. So we will be working with you [IMC] to develop it, bringing it to you for critique and nurturing, and need to make sure it is bold enough and strong enough and ambitious enough to tackle the priorities that we set ourselves within this plan. So I can't think of anything more important on my agenda,

there are lots of things that are important but this is really, really important…I'm excited to make regular contributions to you and the organisation to see how we are all going to achieve this. So we will look at resource in that process. The review that had been done recently highlighted the opportunity for potentially a research think tank type capability will be considered but it's got to be different, tell ya what I'm not going to be happy just producing the same old same old that you see in many district health boards, it's always 'were going to work on this and that' its called planning to plan, I don't want to do that I plan to deliver action. So it will be very action orientated and it will hold us all to account to those who we service, which is the Māori population in our communities, in the Waikato.
The PPP will give us the roadmap, timing, resources. The Waikato DHB Board has to sight and sign that off as well so it is an organisation wide commitment to achieve this."

- All PPP's will be available to the public on the website

Response from IMC members and follow on response from CE:

- IMC members excited that the CE is on board and this is a priority.
- Need to know how we measure success and if anyone is better off? Strengthens the need for the MOU between IMC and WDHB Board
- Page 19 of the strategy supports the need for resources to make changes. Change cannot be effected without adequate resourcing.

2.3 MOU and TOR to go to CE for comment.

Actions:

3	Forward MOU and TOR to Chair of WDHB Board and CE for comment	Mr Mikaere to send a letter to the Chair, WDHB, and the CE to inform them that there have been amendments to the MOU and TOR, and to request a meeting to discuss the import of such changes.

Item 3: 10.30 Ms J Wilson Financial Breakdown of Waikato DHB.

3.1 Financial situation very tight this year with no financial envelope for 2017-2018 yet.

- Nationally there will be a $400 million increase but this will not be based on demographics
- The Annual plan will be submitted before receiving financial indication. Nationally we won't know until the budget is released. We will plan for costs but will need to revisit in June.

3.2 Annual planning document 2017/2018 Māori health targets will be included in Annual Plan at the direction of the MOH.

- Different to previous year AP's
- No separate Māori Health Plan
  Will be around 35 pages long
- Activity focus on achieving equity, very prescriptive

Response from IMC members:

- Can IMC review AP before submission?
  - Ms Wilson: There are different submission dates for drafts and final versions. There will be no time to review first draft however IMC will be able to view before last submission, date TBC.
- Concern over cost cutting and what that involves. IMC appreciate and understand cost cutting but would like to make it clear they do not support moves that disadvantage provider arms or loss of contracts from Māori providers to mainstream providers, as well as organisations that cover large areas as opposed to a locality focus.
- IMC would like to see more transparency on how Waikato DHB money is spent
- How will our new strategy impact on financial planning?
  - Ms Wilson: we need to look at data and analyse what we can do from here. Potential to change focus to 10 year plans as opposed to short term plans. Investigate what our alliance with primary care partners should look like.
  - Data on website will show transparency and where resources need to be allocated
  - Cost Pro can calculate how much money it costs an organisation when a person DNA's to an appointment. How can IMC support closing this gap?

Actions:

4	A Māori health needs analysis can assist with this work. Damian could potentially present to IMC.	Chair IMC to invite Damian to present on Māori Health needs analysis

Item 4: 10.45 IMC debrief of guest presenters

4.1 Interview for senior management positions.

- IMC surprised with the information that a Kaumātua was not present on interview panel as it was assumed that this was a regular occurrence on senior Māori positions within the DHB as this has been done in the past.
- What is and what should be the requirement of an IMC representative on the interview panel, when reporting back to IMC?
- An issue was raised around what level of Tikanga and cultural awareness is in the position description.

Actions:

5	View current policy on interviewing to determine whether a Kaumātua is mandatory	TPO to bring to next IMC hui

	on Māori senior level position interviews	
6	The role of the Kaumātua on an interview panel needs to be explained to CE	Mr Mikaere to speak to CE and Chair of WDHB Board around the role and function of Kaumātua on an interview panel
7	IMC would like feedback around previous interviews for Executive Director of Māori Health vacancy from IMC panel member	Ms Eketone to report back to IMC on previous interviews

Item 5: Apologies

Apologies received:

- Ms K Hodge
- Ms K Gosman
- Ms F Chase
- Ms T Hodge

Moved: Ms T Moxon Seconded: Ms P Mahood

Item 6: Governance

6.1 Minutes and matters arising from previous meeting.

- Change Ms McClintock to reflect correct title Dr Clintock
- Query regarding the correct title of Mr Berghan. Mr Berghan's title 'Acting Executive Director of Māori Health' is correct. Mr Berghan's role was to complete a review of Te Puna Oranga and to support Millie, which is continuing to do. This is a .2 position until the new Executive Director of Māori Health is appointed.
- Change matter arising page 2 from 'Mr Sewell requested...' to 'Mr Mikaere requested…"

Moved: Ms Thompson-Evans Seconded: Dr McClintock

6.2 Status of action list items from 2nd February 2017.

- Sub-committee would like an IMC representative. Previous groups HWAC, DSAC and CPHAC have now consolidated into Health Strategy Committee.
- A consensus that two IMC representatives should be on the Performance Monitoring Committee and Health Strategy Committee was agreed.
- IMC should set expectations to those IMC representatives who sit on other groups so that they report back to IMC regularly.
- IMC representatives that sit on other committees need to be resourced.

- Audit and Risk- Ms T Hodges is the chair fo this group. This is a tight group with WDHB Board members only. IMC to ask for a representative on this group and then make an appointment with IMC on who that will be.
- Ms Mahood to explain the purpose and role of Waikato Health Trust at next IMC hui.

6.3 Approval of the amended Memorandum of Understanding (MOU) and Terms of Reference (TOR).

- Discussion on the mandate of Kaumauta and Kaunihera (KK) as this related to the MOU and TOR currently tabled. Issues discussed include:
  - What documentation is there explaining the mandate/whakapapa of KK?
  - How does KK function and who is responsible for that?
  - During inception of IMC there was discussion of KK membership and MOU created with all Iwi sitting around the table at that time.
  - The current TOR provides the clarity for going forward.
- MOU approved by Ms Turiti and Mr Tupuhi and unanimously passed based on the following immediate changes being completed:
  - Change point 8.2 in document "Memorandum of Understanding Between The Waikato District Health Board and Iwi Within Its District: Guiding Principles" to match the first 7x bullet points in the "Terms of Reference of The Iwi Māori Council" document.
  - Change the 'Te Tiriti o Waitangi' to reflect the same format as is in the strategy which is "Te Tiriti o Waitangi/ The Treaty of Waitangi"
  - Put capitals on the following kupu 'Tikanga' and 'Kawa'
  - Put correct macrons on Māori kupu
  - No macron on Kiingitanga
- Process once changes have been completed are as follows:
  - Mr Berghan to write letter on behalf of Mr Mikaere addressed to Chair of WDHB and CE.
  - Meeting between Mr Berghan, Chair of WDHB and CE to smooth the process for the WDHB Board (amendments from original to latest version to be highlighted).

6.4 IMC training needs.

- Be prepared for Government change this year
- Ms Berryman and Mr Berghan in discussions with HR around IMC governance training.

8	Check with Ms Eketone to see if she is willing and able to stay on the Health Strategy Committee as the IMC representative.	Ms Berryman to check with Ms Eketone to see if she is willing and able to

		stay on the Health Strategy Committee as the IMC representative. If not Ms Moxon will replace.
9	If Ms Eketone is no longer able to continue on HSC Ms Moxon will replace with Ms Thompson-Evans to represent IMC on the HSC. A recommendation that two IMC representatives should sit on HSC	Mr Mikaere to write letter to HSC with recommendation that two IMC representatives (Ms Eketone/Ms Moxon and Ms Thompson-Evans) sit on the HSC.
10	Mr Tupuhi and Dr McClintock would like to represent IMC on the Performance and Monitoring Committee. A recommendation that two IMC representatives should sit on PMC.	Mr Mikaere to write letter to PMC with recommendation that two IMC representatives (Mr Tupuhi and Dr McClintock) sit on the PMC.
11	Need for expectations of IMC representatives on committees which needs to include, what to report on, how frequently to report, expectations attendance (minimum of quarterly basis, issues relevant to IMC table). Feedback needs to align with TOR and MOU	TPO to provide template for IWC to complete
12	An explanation on the purpose and role of Waikato Health Trust to be presented at next IMC hui.	Ms Mahood to explain the purpose and role of Waikato Health Trust at next IMC hui.
13	Changes need to MOU document- 1. Change point 8.2 in document "Memorandum of Understanding Between The Waikato District Health Board and Iwi Within Its District: Guiding Principles" to match the first 7x bullet points in the "Terms of Reference of The Iwi Māori Council" document. 2. Change the 'Te Tiriti o Waitangi' to reflect the same format as is in the strategy which is "Te Tiriti o Waitangi/ The Treaty of Waitangi" Put capitals on the following kupu 'Tikanga' and 'Kawa' 3. Put correct macrons on Māori kupu 4. No macron on Kiingitanga	Nikki to make following changes to MOU document
14	Finalised MOU document to WDHB Board and CE process	Mr Berghan to write letter on behalf of Mr Mikaere addressed to Chair of WDHB and CE.
15	Finalised MOU document to WDHB Board and CE process	Mr Berghan to organise time to meet with Chair of WDHB and CE.

16	IMC governance training	Ms Berryman and Mr Berghan update IMC on progress of governance training

Item 7: Management

7.1 Trendly presentation from Ms Berryman

- Electronic measuring tool with data from all DHB's in New Zealand with data focused on the Māori Health targets found in the 2016/2017 Māori Health plans.
- Shows measurements of Māori targets vs non-Māori which clearly highlights the inequities.
-

Response from IMC members:

- Suggestion that Ms Berryman show to the relevant departments in the hospital so we can ask what they are doing to achieve equity for Māori.
- Where is the data coming from?
  - It is the most up to date Ministry of Health released data
- Is there any data on workforce?
  - Not on the Trendly tool.
- IMC endorse Ms Berryman position to talk to WDHB management and staff about Trendly Tool.

Item 8: Risk and Opportunity

8.1 Māori Think Tank business case

- Recommendation from Mr Berghan post TPO review to have a Māori Think Tank. CE indicated there is no money however will continue to push as this is always a stance financial has.
- IMC to encourage CE to attend every hui to put pressure on him to perform, to the extent that resources will be allocated as a result of pressure put on CE.
- Ms Berryman and Mr Berghan to continue putting pressure on CE.

17	Send thank you letter of attendance to CE on behalf of IMC and Invite CE to attend every IMC hui	Mr Mikare to draft letter send to CE

Item 9: General Business

9.1 Letter from Mr Rahui Papa

- As the letter was not addressed to IMC it was agreed that IMC should not respond to Mr Papa
- In committee:
  Concerns around the interpretation of the recommendations that all Iwi Governance Chairs attend the final signing of the Iwi Māori Council Memorandum of Understanding.

- Future action options for IMC to discuss is the possibility to either Wananga or workshop around how to deal with issues that arise in IMC hui, resolving issues at the table, expectations of one another and creating a safe environment for all members.
- There is also to be a strong push to encourage all members to be present at next IMC hui.

9.2 Health Treaty Claim due 13th March 2017

- Ms Moxon sought permission from IMC members to use previous IMC letters addressed to Minister of Health to use for this Treaty Claim.
    - Moved: Mr Tupuhi Seconded: Ms Roberts

18	Collate previous IMC letters addressed to Minister of Health	Ms Berryman and Ms Moxon to work togetehr to compile those letters.

Karakia whakamutunga: 1.30pm Mr Tupuhi
Next Hui: Thursday 6th April 2017

Full Action list from minutes

1	Add Esmae to IMC agenda for regular updates with a clear reporting template of what should be fed back to IMC as opposed to ad hoc feedback	IMC/TPO to create template on what they want Esmae to report back on
2	Esmae to attend Kaunihera and Kaumātua hui	Gaylene to request KK to invite Esmae to attend meeting to give an update on Priority Programme Plans
3	Forward MOU and TOR to the Chair and CE WDHB for comment	Mr Mikaere to send MOU and TOR to Mr Simcock and the CE.
4	A Māori health needs analysis can assist with this work. Damian could potentially present to IMC.	Chair IMC to invite Damian to present on Māori Health needs analysis
5	View current policy on interviewing to determine whether a Kaumātua is mandatory on Māori senior level position interviews	TPO to bring to next IMC hui
6	The role of the Kaumātua on an interview panel needs to be explained to CE	Mr Mikaere to speak to CE and Chair of WDHB Board around the role and function of Kaumātua on an interview panel
7	IMC would like feedback around previous interviews for Executive Director of Māori Health vacancy from IMC panel member	Ms Eketone to report back to IMC on previous interviews
8	Check with Ms Eketone to see if she is willing and able to stay on the Health Strategy Committee as the IMC representative.	Ms Berryman to check with Ms Eketone to see if she is willing and able to stay on the Health Strategy Committee as the IMC representative. If not Ms Moxon will replace.
9	If Ms Eketone is no longer able to continue on HSC Ms Moxon will replace with Ms Thompson-Evans to represent IMC on the HSC. A recommendation that two IMC representatives should sit on HSC	Mr Mikaere to write letter to HSC with recommendation that two IMC representatives (Ms Eketone/Ms Moxon and Ms Thompson-Evans) sit on the HSC.
10	Mr Tupuhi and Dr McClintock would like to represent IMC on the Performance and Monitoring Committee. A recommendation that two IMC representatives should sit on PMC.	Mr Mikaere to write letter to PMC with recommendation that two IMC representatives (Mr Tupuhi and Dr

		McClintock) sit on the PMC.
11	Need for expectations of IMC representatives on committees which needs to include, what to report on, how frequently to report, expectations attendance (minimum of quarterly basis, issues relevant to IMC table). Feedback needs to align with TOR and MOU	TPO to provide template for IWC to complete
12	An explanation on the purpose and role of Waikato Health Trust to be presented at next IMC hui.	Ms Mahood to explain the purpose and role of Waikato Health Trust at next IMC hui.
13	Changes need to MOU document- 1. Change point 8.2 in document "Memorandum of Understanding Between The Waikato District Health Board and Iwi Within Its District: Guiding Principles" to match the first 7x bullet points in the "Terms of Reference of The Iwi Māori Council" document. 2. Change the 'Te Tiriti o Waitangi' to reflect the same format as is in the strategy which is "Te Tiriti o Waitangi/ The Treaty of Waitangi" Put capitals on the following kupu 'Tikanga' and 'Kawa' 3. Put correct macrons on Māori kupu 4. No macron on Kiingitanga	Nikki to make following changes to MOU document
14	Finalised MOU document to WDHB Board and CE process	Mr Berghan to write letter on behalf of Mr Mikaere addressed to Chair of WDHB and CE.
15	Finalised MOU document to WDHB Board and CE process	Mr Berghan to organise time to meet with Chair of WDHB and CE.
16	IMC governance training	Ms Berryman and Mr Berghan update IMC on progress of governance training
17	Send thank you letter of attendance to CE on behalf of IMC and Invite CE to attend every IMC hui	Mr Mikare to draft letter send to CE
18	Collate previous IMC letters addressed to Minister of Health	Ms Berryman and Ms Moxon to work togetehr to compile those letters.

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Performance Monitoring Committee Meeting held on Wednesday 8 March 2017 commencing at 8:30am

Present:
Ms S Christie (Chair)
Ms C Beavis (Deputy Chair)
Mr M Gallagher
Mrs MA Gill
Mr D Macpherson
Dr P Malpass
Mr K Price
Ms S Webb

In Attendance:
Mr N Murray (Chief Executive)
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
Mrs B Garbutt (Director Older Persons Rehabilitation and Allied)
Mr A Gordon (Director Oncology & Medicine)
Ms J Farley (Acting Director, Surgery, CCTVS, Care & Theatre
Ms P Fitzgerald (Acting Director Women's and Children)
Ms M Neville (Director Quality and Patient Safety)
Ms L Aydon (Executive Director Public and Organisational Affairs)
Mr G King (Director, Information Services)
Mr G Peploe (Director, People and Performance)
Ms J Wilson (Executive Director Strategy and Funding)
Mr A McCurdie (Chief Financial Officer)
Mr N Hablous (Chief of Staff)
Mr C Wade (Chair Health Strategy Committee)

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

The Chair welcomed members to the inaugural meeting of the Performance Monitoring Committee.

ITEM 1: APOLOGIES

Apologies were received for Mr B Simcock, Mr D Macpherson (for leaving early) and Ms MA Gill (for lateness).

ITEM 2: INTERESTS

2.1 Changes to Register
No changes to the register of interests were advised.

2.2 Conflicts Related to Any Item on the Agenda

No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 3: MINUTES AND MATTERS ARISING

3.1 Health Waikato Advisory Committee: 10 August 2016

Resolved
THAT
The minutes of a meeting of the Health Waikato Advisory Committee held on 10 August 2016 be confirmed as a true and correct record.

3.2 Bay of Plenty DHB – Hospital Advisory Committee: 2 November 2016

Minutes were noted.

3.3 Lakes DHB – Hospital al Advisory Committee: 25 October 2016

Minutes were noted.

ITEM 4: COMMITTEE STRUCTURE

4.1 Committee Structure at Waikato DHB

Resolved
THAT
The Committee received the report.

4.2 Role of Committee and How We Will Work

Discussion on the committee structure was deferred for discussion at the end of the meeting.

ITEM 5: SYSTEM LEVEL MEASURES

5.1 System Level Measures Report

Mrs J Wilson presented this agenda item.

The intention was for future reports to be expanded to allow the Committee to gain an overview but also understand where gaps exist. Committee members requested sub-regional breakdown into areas such as age, population to be provided where data was available.

Resolved
THAT
The Committee received the report.

ITEM 6: OPERATIONS AND PERFORMANCE

6.1 Operations and Performance Report

Mr M ter Beek presented this agenda item.

Future reports to the Committee would be split into two parts:

- DHB wide performance report on operational performance. Additional measures would be reported on in the future
- Operations and Performance achievements and challenges.

Resolved
THAT
The Committee received the report.

ITEM 7: SERVICES

7.1 Community and Clinical Support

Presented by Mr M Spittal.

- The new regime to support the significant legislative changes in terms of liability and supervision of radiology license holders as previously reported to the Health Waikato Advisory Committee had been delayed.
- Radiologist Staff were under pressure due to the number of vacancies compounded by abnormal long term sick leave.
- The use of offshore support to provide radiology imaging reporting was proving invaluable. The current contracts required a stronger level of checking than was currently set for internal checking.
- Titanium, the new oral health information system is now live.
- Mr M Spittal agreed to seek clarification as to what was the earliest age childrens data could be captured under the new titanium programme. Note: The clarification is that the details for each baby is entered into Titanium as soon as possible after birth. In the hospital system when a baby has a formal name they are assigned an NHI in iPM. That hospital patient management software automatically populates Titanium. Babies born outside the hospital system are picked up through a regular data match with the NCHiP (primary care) register of children which is populated by information supplied by lead maternity carers.
- The first community Hui around the new model for primary maternity services was well attended. Feedback will be presented to the Board in April.
- The Committee expressed interest in receiving data on women stopping smoking during pregnancy. Smoking cessation in pregnancy metrics would be captured as part of monitoring the rural health and Maori health priority plans.
- A change in service model and the move to the new site on Gallagher's Dr and the old Farmers building would reduce the number of properties currently leased in Hamilton by the DHB.
- End of year financial forecast had improved but further work still required to achieve budget.

Resolved
THAT
The report be received.

7.2 Mental Health & Addictions

Presented by Mr D Wright.

- Occupancy had reduced over the summer period, but numbers had increased again over February.
- A draft Model of Care was ready to be tested with the original stakeholder group. Both the Ministry and Treasury had been engaged with the model of care and investment logic model, with approval of the first draft being given. Treasury had been given a tour of the Henry Bennett facilities. A new inpatient facilities to replace the Henry Bennett Centre was being appraised by a group of stakeholders (which included ex-service users and whanau). The proposal would then be presented to the board and be put out for public consultation. The new designs would include more space for individuals.
- The Peoples Project had made good progress of housing assistance for repeat offenders with short sentences, and mental health and addiction needs. It was acknowledged that the project did not cover all homeless people, especially the transient homeless population.
- There was currently a shortage of social housing, which created challenges with the transition for patients from Henry Bennett Centre to the community.
- Planning was underway for a new initiative to assist with the significant increase of patients presenting due to methamphetamine use.
- Consideration was being given to have a mental health nurse work alongside the triage nurse in ED (including extended hours) to help achieve the 6 hour target in ED.
- Discussions are underway regarding a Midland Regional Model of Care for Eating Disorders. Currently Waikato DHB inpatients were being treated in Auckland. Whilst the number of Waikato patients were small, they were seen as significant. Perception was that the reducing age of eating disorder patients seen overseas was not happening in New Zealand.
- There had been a significant increase of demand on community mental health teams. Work had commenced on workload numbers, scoring systems and comparing model of care work to analyse how Waikato DHB could be more effective with productive flow.

Resolved
THAT
The report be received.

7.3 Waikato Hospital Services overview report

It was highlighted that the reports circulated in the agenda were for the period to January, not June as indicated in the report.

Mr B Paradine introduced Ms J Farley (Acting Director Surgical and Critical Care) and Ms P Fitzgerald (Acting Director Women's & Children). Recruitment was currently underway for both of these positions

Older Persons, Rehabilitation and Allied Health

Mrs B Garbutt presented this agenda item.

- Busy period over January, with a full ward closed and further impact by the RMO RDA industrial action. Staff support during the strike was acknowledged.
- Mr John Parsons had been appointed to the position of research fellow in rehabilitation within the Institute of Healthy Ageing with funding given from Bupa NZ.

Internal Medicine Oncology, Emergency and Ambulatory Care

Mr A Gordon presented this agenda item.

- Waikato DHB has been one of the first DHBs to achieve the national 62 days Faster Cancer Treatment (FCT) target, and had strong performance against the 31days FCT target.
- A Medical Oncologist had been appointed which would help to address risk in this service previously reported to the Committee.
- February performance had been impacted by the Resident Medical Officers industrial action.
- Additional staff and investment in replacement equipment had allowed Radiation Oncology to reduce the wait time to start treatment from 16.5 days to 12.3 days.
- Waikato DHB would be rolling out the National Bowel Screening Programme as part of the 2nd tranche of the national programme, which would result in approximately 1,000 extra endoscopy procedures and 70 additional cancer patients being treated. Appropriate plans are being put in place to ensure successful implementation.
- The waiting time of patients referred for sleep studies had been reduced from 13 months (maximum) to a 3 months average.
- The acute patient flow 6 hour Health Target continued to be challenging with performance at 87.6% for Q2. Current focus was on the admittance pathway with each speciality reviewing why breaches are occurring. The Full Capacity Protocol was now being activated as required. It was acknowledged that transferring these additional patients to a ward spread the risk from the Emergency Department to one or two extra patients to be managed on each ward.
- The transit lounge continued to be promoted but it was acknowledged that further work could be focussed here.

Mr D Macpherson left the meeting at 10:00am.

Surgical and Critical Care

This item was presented by Mrs J Farley.

Meeting the Elective Service Performance Indicator (ESPI) 2 and 5 targets continued to be a challenge, particularly in the areas of

orthopaedics. ESPI5 was acknowledged as being a significant risk for March, meaning a possibility of funding being withheld.

Womens and Children Health
Ms P Fitzgerald presented on this agenda item.

- The Transformation Project continued to make good progress with a number of work streams, with a key focus on recruitment.
- Moving planned (elective) caesarean sections to the main theatres was proving positive. A second theatre was being considered in the Delivery Suite area which would enable keeping mother and baby together.
- Work was expected to be completed by May 2017 on the paediatric negative pressure rooms.
- Good progress continued to be made on addressing concerns raised by the Royal Australian College of Physicians (RACP), which was on track to get accreditation back.
- No concerns had been raised regarding accommodation of mothers following the closure of the Hilda Ross building.

Resolved
THAT
The report be received.

ITEM 8: QUALITY

8.1 Q2 Quality Report

Ms M Neville presented this agenda item.

- It was still under consideration whether future quality reports would be brought to PMC or the Audit and Risk Committee.
- Quality and Patient Safety were considering ways to improve complaint resolution due to the last disappointing compliance result.
- Changes were being made to the process of items being reported to the Board of Clinical Governance to assist with improving compliance with the policy currency target.
- Advanced Care Planning implementation was a priority, with the aim of training to improve staff confidence when having patient conversations.

Resolved
THAT
The Committee received the report.

ITEM 9: FINANCE REPORT

9.1 Provider Arm Finance Report

The two finance reports (Provider Arm and Funder Arm & Governance) were presented in the historic Committee format. A single report would be provided at the next Committee meeting.

Resolved
THAT
The Committee received the report.

9.2 Funder Arm and Governance Finance Report

Resolved
THAT
The Committee received the report.

ITEM 10: PEOPLE

10.1 People and Resources Report

Mr G Peploe attended for this item.

- With the exception of a few services, recruitment was in a relatively stable position.
- The new Waikato DHB values had been positively received.
- The Disability Support Advisory Committee had previously maintained a watching brief over the employment of people with disabilities. Whilst the DHB had a number of initiatives in place, it did not currently capture data in a useful way to report to the Committee.

Resolved
THAT
The Committee received the report.

ITEM 11: INFRASTRUCTURE

11.1 Next report due 12 April 2017

ITEM 12: INFORMATION SERVICES

12.1 Information Services Plan Report

Mr G King attended for this item.

A report on the IS plan was submitted for the Committee's information.

Of note:

- It was still to be decided if this report would continue to be presented to the PMC or whether it should be provided to the Audit and Risk Committee.
- A buoyant IS market was presenting a challenge to recruit skilled employees, with people choosing to contract due to the benefits this brought.

Resolved
THAT
The report be received.

ITEM 13: PERFORMANCE OF FUNDED ORGANISATIONS

13.1 Performance of Funded Organisations

Mrs J Wilson provided background to the reporting of the performance of funded organisations that had previously been presented to the Community and Public Health Advisory Committee.

Members were invited to provide feedback on areas that could be included or expanded in the activity report.

ITEM 14: DATE OF NEXT MEETING: 12 APRIL 2017

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Health Strategy Committee held on Wednesday 8 March 2017 commencing at 12.30pm

Present:
Mr C Wade (Chair)
Ms T Hodges (Deputy Chair)
Ms S Webb
Ms S Mariu
Mrs P Mahood
Ms C Beavis
Mr F Mhlanga
Mr J McIntosh
Mr D Slone

In Attendance:
Ms J Wilson, Executive Director, Strategy & Funding
Ms N Middleton (Minutes)
Dr N Murray, Chief Executive
Mr M ter Beck, Executive Director, Operations and Performance
Mr D Wright, Executive Director, Mental Health and Addictions Service
Mr N Hablous, Chief of Staff
Ms M Chrystall, Executive Director, Corporate Services
Mr D Hackett, Executive Director, Virtual Care and Innovation
Mr B Paradine, Executive Director, Waikato Hospital Services
Ms E McKenzie Norton, Strategy and Funding
Ms N Parker, Change Team
Ms J Hudson, Strategy and Funding
Mr M Gallagher, Waikato DHB Board member
Ms MA Gill, Waikato DHB Board member
Ms S Christie, Waikato DHB Board member
Mr A McCurdie, Chief Financial Officer
Mr A Leaman, Waikato Times

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

ITEM 1: APOLOGIES

Apologies from Mr B Simcock and Ms J Eketone were received.

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 Community & Public Health Advisory Committee and Disability Support Advisory Committee held on 10 August 2016 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 17 October 2016 be noted.

3. The minutes of a meeting of the Bay of Plenty DHB combined Community & Public Health Advisory Committee and Disability Advisory Committee held on 5 October 2016 be noted.

ITEM 5: COMMITTEE STRUCTURE AT WAIKATO DHB

Mr N Hablous attended for this item. The standard items within Health Strategy Committee are significant pieces of work that are ongoing at the Waikato DHB. These items will be reported to this Committee. There will be an overlay of items between the Health Strategy Committee and the Performance Monitoring Committee.

The Committee has asked for assurance that the needs of key populations (e.g. disability, migrant community) will continue to be represented at this Committee. This was confirmed and deemed a statutory requirement. Mr D Slone noted his concern in relation to whether these interests will continue to be well represented at this Committee.

Resolved
THAT

1. The Committee received the report;
2. The Terms of Reference will be altered to incorporate both The Community Public Health Advisory Committee and the Disability Support Advisory Committee.

ITEM 6: PRIORITY PROGRAMME PLAN

Mr D Hackett attended for this item. These Priority Programme Plans are key to the Strategy Refresh and will be actively worked on by the Waikato DHB. The Priority Programme Plans offer structure to enable staff an opportunity to do things differently, where staffs are able to identify areas where they want to create change. Ms M Neville and Mr D Hackett will be guiding this piece of work. The Committee was tasked with determining how these plans will be presented. A success matrix will be presented to the Committee that is to report on what has occurred and how the matrix integrates, and rated against other priorities.

Resolved
THAT
1. The report be received;
2. Recommendations 1, 2, 3, 4, and 5 be accepted.

ITEM 7: STRATEGICE PROGRAMMES UPDATE

The following items were tabled for information:

7.1 eSPACE

Mr D Page, Ms S Baker and Ms M Lacey and Ms M Chrystall attended for this item. eSPACE is currently implementing a new clinical system that will be integrated across the Midland DHBs. This was approved three years ago by all five of the DHBs however the project hasn't run smoothly and a new approach was agreed in 2016. The project is broken into three phases and is currently in the testing phase with the system to go live in July 2017.

7.2 Mental Health and Addictions Model of Care

Ms J Wilson presented and Mr D Wright and Ms J Hudson attended for this item. This programme of work covers Adult Mental Health services and Adult addiction service. An update was presented to the Community Public Health Advisory Committee in 2016. Health Needs Analysis update in April. A Steering group has since been established. Timeframes to be presented at the April meeting.

Resolved
THAT
The updates be received.

ITEM 8: STRATEGY AND FUNDING OVERVIEW REPORT

The Annual Plan has been altered nationally and is now reduced to 33 pages; previously the Plan was in excess of 180 pages. A specific list of reporting areas were provided from the Ministry of Health. The Draft Annual Plan is due to be submitted 31 March 2017 without financials. Where possible a clinical champion has been assigned to each measure with five of the six measures each having a champion.

Raising health kids target was not met nationwide however the Waikato DHB is sitting above the national average. An evaluation of this target was requested for a future meeting.

It was noted that the Community Health Forums were evaluation in 2016. These will be completed as part of the priority programme plan 'Authentic collaboration with partner agencies'.

Resolved
THAT
The report be received.

ITEM 9: PAPERS FOR ACTION

9.1 Workplan

Additional items for inclusion on the 2017 workplan to include:

- Improving access to primary care for the intellectual disability community;
- Younger persons in resthomes;
- Support for immigrants and refugees with a disability;
- Government disability strategy;
- Health of Older People strategy;
- Prevention programme assessment;
- Translation services funding.

Resolved
THAT
The items be submitted to the workplan.

ITEM 10: PAPERS FOR INFORMATION

No papers for information.

ITEM 11: GENERAL BUSINESS

No general business.

ITEM 12: DATE OF NEXT MEETING

12 April 2017.

Waikato District Health Board

Chief Executive Report

Financial Report

MEMORANDUM TO THE BOARD
22 MARCH 2017

AGENDA ITEM 5.1

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 Result for February 2017	Year to Date			Budget
	Actual $m	Budget $m	Variance $m	Jun-17 $m
Funder	43.0	32.7	10.3 F	42.9
Governance	(0.4)	(0.4)	0.0 F	(0.3)
Provider	(33.1)	(18.2)	(14.9) U	(38.1)
DHB Surplus/(Deficit)	**9.5**	**14.1**	**(4.6) U**	**4.5**

Note: $ F = favourable variance; ($) U = unfavourable variance

FINANCIAL PERFORMANCE MONTHLY COMMENT:

This report includes commentary on current year to date performance compared to the year to date budget.

For February 2017 YTD we are unfavourable to budget by $4.6m. This is due in part to phasing of cost reduction plans. However, specific areas are of concern and are being focused on in order to develop comfort in how we will meet our forecast results for the year. Clearly there are risks to manage in this regard and we are very actively managing such risks, with improved bottom up forecasting processes continuing to be a key tool.

Forecast:

The DHB has a budget for a surplus of $4.5m for the year.

We are currently running unfavourable to YTD plan. We have done a great deal of work to bring this back on track in order to deliver to the plan and we continue to work in this space. However, a number of unexpected and uncontrollable costs have been incurred or are expected to be incurred in FY16/17. This needs to be considered in the context of over the last few years demand and thus costs together with inflation have grown at a faster rate than revenue and this has eroded most of our ability to respond to unexpected cost aspects. We have come to the view that delivery of a surplus for FY16/17 just isn't possible. The forecast position communicated to the Ministry is thus breakeven. This forecast assumes that we will not incur ESPI penalties and also that we will find a way to deliver our elective service volume targets in order to avoid a negative washup. Delivering such break even result will be extremely challenging, thus the risk profile remains high.

There are the usual risks related to not achieving forecast including:

1. Unbudgeted costs
2. The impact of the required outsourcing to meet key targets
3. Achievement of elective service volumes and avoidance of ESPI penalties
4. The achievement of the budgeted savings or alternate savings
5. Our ability to extract favourable variances through the balance of the year to counter the current unfavourable YTD variance

Negative

Provider:

The Provider is unfavourable to budget for February 2017, variances include:

1. Revenue unfavourable to budget $4.3m (0.8%) due to lower than planned Provider volumes.
2. Employed personnel costs unfavourable to budget $5.6m, the dominant negative variance being within nursing and a smaller unfavourable variance in allied health personnel. Medical & administrative personnel have small favourable variances and support personnel are close to budget.
3. Outsourced Personnel costs unfavourable to budget $8.5m, the dominant variances relate to medical locums ($2.8m), Nursing ($0.9m) and admin/management contractors for the National Oracle Solution (NOS) project ($4.4m) which has an offset in Other Revenue of ($3.0m).
4. Outsourced Services favourable to budget $0.7m.
5. Clinical supplies favourable to budget $0.2m.
6. Infrastructure & Non Clinical supplies are unfavourable to budget $1.7m.
7. Interest, depreciation and capital charge favourable to budget $4.3m

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

- Acute cases, excluding ED: episodes 2.2% above plan; case-weights 5.8% above plan
- Elective cases: episodes 12.6% below plan; case-weights 19.4% below plan
- Overall 1.8% below plan for cases and 1.9% below plan for case-weights
- ED attends: YTD ED attends are 1.7% higher than the same period last year.

Funder and Governance:
The result for the Funder is favourable mainly due to favourable Provider payment costs. Governance is on budget.

RECOMMENDATION(S):

That this report on February 2017 year to date result be received.

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD

YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$2.1 F**	Neutral
CFA Revenue		
Favourable to budget mainly due to: ● 15/16 elective surgery wash-up $1.5m received ● additional funding received which is offset by cost in External Provider Payments: Palliative Care $0.5m Rheumatic fever $0.2m Healthy Homes initiative $0.4m ● PHO Care Plus wash-up & VLCA $0.5m Offset by unfavourable variances relating to: ● Reduction in revenue received relating to the change in rate for the capital charge $1.6m. This reduction is offset by a reduction in capital charge paid. ● In between travel wash up relating to 2016/17 $0.7m (offset by reduced cost in External Provider payments) and to 2015/16 $0.3m.	$0.6 F	Favourable
Crown Side-Arm Revenue		
Side-arm contracts revenue favourable due mainly to: ● Funds received for the 2015/16 Colonoscopy project $0.3m ● A contract variation on the main Public health contract $0.2m (offset by costs) ● Breast screening running ahead of contract volumes $0.1m (offset by costs)	$0.7 F	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is $0.6m favourable mainly due to: ● Reimbursement of costs associated with the implementation of NOS $3.0m favourable (offset in Outsourced Personnel) ● Catch up invoicing for outreach clinics at Bay of Plenty and Lakes DHBs $0.6m ● Higher than budgeted invoicing for Blood and Laboratory $0.2m Offset by: ● ACC unfavourable $0.8m due to non acute rehab contract running lower than planned due to less discharges and the focus on Elective Service Performance Indicators meaning the elective surgical treatments contract patients are being delayed. ● Inter District Flows (IDF) in which is $2.4m unfavourable due to reduced IDF inflow when compared with Ministry of Health budget file.	$0.6 F	Neutral
Other Revenue		
Other revenue is favourable primarily due to higher sales in the Café than expected $0.5m and the favourable revenue washup from Urology Services Limited relating to 2015/16 of $0.2m. This is offset by lower than budget volumes of non resident patients $0.2m unfavourable and other revenue $0.2m unfavourable.	$0.2 F	Favourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($6.7) U**	Unfavourable
Personnel (employees and outsourced personnel total)	**($14.1) U**	
Employed personnel are unfavourable to budget mainly due to:	($5.6) U	Unfavourable
• Medical costs are favourable by $0.3m. Senior Medical Officers (SMO's): SMO costs are $0.7m favourable mainly due to: - paid FTE costs favourable $0.8m arising from vacancies, - favourable course and conference costs which is as a result of reduced accrual for CME costs following SMO resignations $0.5m, - annual leave movement $0.1m unfavourable due to less leave earned offset by less leave taken - allowances $0.5m unfavourable due to payments made for RMO strike cover Resident Medical Officers (RMO's) RMO costs are $0.4m unfavourable due to vacancies offset by annual leave taken running lower than budgeted. The net direct financial YTD impact of the RMO strike in October 2016 on personnel costs is currently $0.2m: SMO claims to date to cover RMO shifts $0.3m Savings on payments to RMO's $0.1m The net direct financial impact to date of the RMO strike in February 2017 on personnel costs is currently $0.2m. The far greater cost of the strikes is the impact on volume delivery. • Nursing costs are unfavourable to budget by $5.4m. Paid FTE (Full Time Equivalent employee) cost is $1.7m unfavourable due to budgeted vacancy savings not being achieved. In addition to this the annual leave movement is running $3.7m unfavourable. • Allied Health costs are unfavourable to budget by $1.1m. Base costs are $0.1m favourable offset by unfavourable overtime $0.4m due to vacancies. In addition annual leave taken unfavourable to budget $0.8m. • Other favourable variances, largely in Management, Administration and Support $0.6m		
Outsourced personnel are unfavourable mainly due to:		
• Higher than planned use of locums within medical personnel to cover vacancies $2.9m. Nursing is $0.9m unfavourable due to external agency costs to fill roster gaps and watches.	($4.1) U	Unfavourable
• Higher than planned use of contractors in management/admin $4.4m primarily due to contractors working on the NOS implementation. Costs recovered in Other Government Revenue - $3m.	($4.4) U	Neutral

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$0.7 F**	
Outsourced corporate services $1.1m favourable primarily due to reduced spend on Clinical Work Station - budget set on business case but expected spend has been revised and is lower due to reduced costs over the first months of the year. In addition the actual calculation of Health Share Limited (HSL) operating costs has come in lower than budget for the first half of the financial year. Outsourced clinical service costs are unfavourable to budget $0.4m due to higher than planned outsourcing of electives.	$0.7 F	Neutral
Clinical Supplies	**$0.2 F**	
Instruments & equipment are $0.5m favourable primarily due to favourable service contract costs.	$0.5 F	Favourable
Implants & prosthesis are $2.5m favourable due to underspends on spinal plates and screws and implants and prosthesis due to a combination of outsourcing to private providers and lower than planned orthopaedic volumes.	$2.5 F	Neutral
Treatment disposables unfavourable due to savings allocation of $3.9m offset by favourable variances across a range of areas such as dressings, staples, tubes/drainage/suction, IV fluids and rebates.	($1.9) U	Unfavourable
Pharmaceuticals $0.8m unfavourable primarily due to cytotoxic drug costs running higher than budgeted. This in part due to the newly approved melanoma treatment.	($0.8) U	Unfavourable
Diagnostic Supplies & Other Clinical Supplies - close to budget.	($0.1) U	Neutral
Infrastructure and non-clinical supplies	**($1.7) U**	
Infrastructure and non-clinical supplies are $1.7m unfavourable primarily due to: ● Savings allocation unfavourable by $1.7m, ● Cost of Goods Sold (COGS) is $1.2m unfavourable as a result of higher sales by Pharmacy on Meade resulting in higher cost of goods sold. Offset in Non Government Organisations (NGO) provider payments ($1.2m) ● IT costs $0.6m unfavourable due to minor hardware purchases and telecommunication costs for Virtual Health ● Offset by favourable facilities variance $1.1m due to delayed start of maintenance programme and Hilda Ross House demolition and cleaning costs running favourably by $0.7m due to a focus on this contract.	($1.7) U	Neutral

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$4.0 F**	
IDF out unfavourable by $1.3m due to increased outflow to Counties Manukau DHB due to timing of a GP practice PHO change not aligning with budget assumption and two high cost patients who have gone to Counties Manukau for treatment.	($1.3) U	Unfavourable
External Provider payments are favourable largely due to: ● a revised PHARMAC forecast $2.7m favourable. However this is offset in clinical supplies (Pharmaceutical costs - oncology drugs $0.8m) and Infrastructure costs (Retail Pharmacy COGS $1.2m). ● PHO Quality Indicator pool - prior year over accrual $0.6m ● Dental FSS volumes favourable to budget $0.5m ● Reduction in costs for in between travel (offset by reduced revenue) $0.7m ● Post acute convalescent care $0.5m favourable as the cost is being reflected in Outsourced Services ($0.2m) ● Other favourable variances across MH, DSS FFS, Urology and residential care offset by unfavourable variances arising mainly from additional costs relating to additional funding (Healthy Homes Initiative, Palliative Care, Rheumatic Fever) $0.3m	$5.3 F	Neutral
Interest, depreciation and capital charge	**$4.2 F**	
Interest charge favourable due to higher than planned cash balances	$0.6 F	Favourable
Capital charge is favourable to budget as a result of the reduction in the rate from 8% to 7%. Largely offset in CFA revenue	$1.8 F	Neutral
Non Cash Depreciation favourable mainly due to: ● Timing of capitalisation of IS projects.	$1.8 F	Favourable

TREASURY

Opinion on Result:	
Cash flows are favourable to budget	Favourable

YTD Actuals Feb-16 $'000	Waikato DHB Cash flows for year to February 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				
865,994	Operating inflows	895,013	894,212	801	1,345,020
(826,942)	Operating outflows	(857,578)	(838,741)	(18,837)	(1,285,884)
39,052	**Net cash from operating activities**	**37,435**	**55,471**	**(18,036)**	**59,136**
	Cash flow from investing activities				
1,123	Interest income and proceeds on disposal of assets	1,081	840	241	1,260
(15,177)	Purchase of assets	(15,107)	(45,336)	30,229	(68,003)
(14,053)	**Net cash from investing activities**	**(14,026)**	**(44,496)**	**30,470**	**(66,743)**
	Cash flow from financing activities				
1	Equity repayment	211,659	0	211,659	(2,194)
(6,393)	Interest Paid	(6,626)	(5,754)	(872)	(8,645)
(212)	Net change in loans	(211,803)	(143)	(211,660)	(198)
(6,604)	**Net cash from financing activities**	**(6,770)**	**(5,897)**	**(873)**	**(11,037)**
18,394	**Net increase/**(decrease) in cash	**16,639**	**5,078**	**11,561**	**(18,644)**
(8,948)	Opening cash balance	856	856	(0)	856
9,446	**Closing cash balance**	**17,495**	**5,934**	**11,561**	**(17,788)**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($18.0) U**	
• **Operating inflows**	**$0.8 F**	
Revenue favourable primarily as a result of: - Prior year elective funding washup received $1.5m - Additional care and other initiatives funding $1.6m - Reimbursement of costs associated with the implementation of NOS $3m Favourable inflow offset by: - reduction relating to the change in rate for the capital charge $1.6m - Interdistrict flows unfavourable by $2.0 - ACC unfavourable $0.8m - reduction in revenue relating to the unfavourable washup of In Between Travel $1.0m	$0.8 F	
• **Operating outflows**	**($18.8) U**	
○ Personnel cost variances are unfavourable against budget due to the timing of fortnightly pay runs.	($0.6) U	
○ Operating cash outflows for non-payroll costs are unfavourable as a result of: - Higher prepayments than budgeted $5.7m primarily as a result of timing of payments for IS related costs - the remaining unfavourable variance includes unfavourable P&L expenditure variances together with differences between timing of budgeted and actual payments.	($20.8) U	
○ GST cash movement is favourable due to timing variances on GST transacted.	$2.6 F	

Cash flow variances resulted from:	Variance $m	Impact on forecast
Net cash flow from Investing Activities	**$30.5 F**	
○ Interest received is favourable due to a slightly higher than expected funds with NZHPL.	$0.3 F	
○ Capital spend is slower than planned for the year to February - refer to capital expenditure report for further details.	$30.2 F	
Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Net cash flow from Financing Activities	**($0.9) U**	
○ Cash flow from financing activities is unfavourable mainly due to the timing of the final payment of interest due to MoH on term loans prior to loan/equity swap.	($0.9) U	

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
CASHFLOW FORECAST (GST INCLUSIVE)

As at 28-Feb-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	1,972	4,520	7,580	4,520	4,300	5,969	4,564	4,228	4,448	4,452	4,116	4,340	4,116
Funder inflow (MoH, IDF, etc)	119,524	124,965	118,565	118,565	124,965	124,542	124,523	121,878	121,680	124,523	130,923	124,523	124,523
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	115
Other Income (excluding interest)	2,690	2,645	2,300	2,645	2,415	2,415	2,645	2,415	2,530	2,530	2,400	2,415	2,070
Rents, ACC, & Sector Services	2,948	2,826	2,397	2,749	2,634	2,623	2,754	2,547	2,603	2,691	2,585	2,585	2,500
	127,132	134,956	130,842	128,479	134,314	135,550	134,487	131,068	131,261	134,196	140,025	133,863	133,324
Cash was applied to:													
Personnel Costs (incl PAYE)	(45,545)	(50,385)	(41,696)	(45,155)	(40,844)	(43,760)	(53,088)	(43,820)	(43,700)	(49,260)	(43,790)	(52,870)	(43,760)
Other Operating Costs	(24,024)	(33,800)	(32,128)	(29,300)	(29,900)	(34,460)	(31,300)	(32,000)	(31,000)	(31,200)	(24,560)	(25,700)	(25,500)
Funder outflow	(45,312)	(48,218)	(42,807)	(44,863)	(43,782)	(53,884)	(46,464)	(49,511)	(46,022)	(46,127)	(45,116)	(45,790)	(45,116)
Interest and Finance Costs	(2,220)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
Capital Charge	0	0	0	0	(8,251)	0	0	0	0	0	(15,721)	0	0
GST Payments	(8,095)	(7,000)	0	(14,000)	(7,000)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(14,420)	(9,000)
	(125,197)	(139,408)	(116,636)	(133,323)	(129,783)	(139,320)	(138,068)	(132,547)	(127,938)	(133,803)	(129,193)	(138,786)	(123,382)
OPERATING ACTIVITES	**1,935**	**(4,452)**	**14,205**	**(4,844)**	**4,531**	**(3,770)**	**(3,581)**	**(1,479)**	**3,322**	**393**	**10,832**	**(4,923)**	**9,942**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	95	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
	95	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(2,121)	(1,200)	(2,300)	(2,300)	(4,600)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
Investment in NZHPL (Finance project)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(2,121)	(1,200)	(2,300)	(2,300)	(4,600)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
INVESTING ACTIVITIES	**(2,026)**	**(1,125)**	**(2,225)**	**(2,225)**	**(4,525)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from NZHPL	108,651	5,577	0	7,095	2,189	5,995	5,832	3,704	0	1,858	0	7,148	0
MoH loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	108,651	5,577	0	7,095	2,189	5,995	5,832	3,704	0	1,858	0	7,148	0
Cash was applied to:													
Capital Repayment	0	0	0	0	(2,194)	0	0	0	0	0	0	0	0
Transfer to NZHPL	(108,534)	0	(11,981)	0	0	0	0	0	(1,097)	0	(8,607)	0	(7,692)
MoH loan repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)
	0	0	0	0	0	0	0	0	0	0	0	0	0
	(108,560)	0	(11,981)	(26)	(2,194)	0	(26)	0	(1,097)	(26)	(8,607)	0	(7,718)
FINANCING ACTIVITIES	91	5,577	(11,981)	7,069	(6)	5,995	5,805	3,704	(1,097)	1,832	(8,607)	7,148	(7,718)
Opening cash balance	0	0	0	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0	0	0
Overall increase/(decrease) in cash	0	(0)	(0)	(0)	0	(0)	(0)	0	0	0	0	(0)	(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)	17,447	11,869	23,850	16,754	14,566	8,570	2,739	(965)	132	(1,726)	6,881	(267)	7,424
Long-term Loans													
Ministry of Health	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA Loan	(299)	(299)	(299)	(273)	(273)	(273)	(247)	(247)	(247)	(221)	(221)	(221)	(195)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	17,148	11,571	23,551	16,481	14,293	8,297	2,491	(1,213)	(115)	(1,947)	6,661	(488)	7,229
LOANS AVAILABLE													
MoH loans	0	0	0	0	0	0	0	0	0	0	0	0	0
Working capital facility (NZHPL)	(64,367)	(64,367)	(64,367)	(64,367)	(64,367)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(64,367)	(64,367)	(64,367)	(64,367)	(64,367)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)

BALANCE SHEET

Opinion on Result:	
There are no material concerns on the balance sheet and all performance indicators are within acceptable tolerances.	On Target

Prior Year Feb-16 $'000	Waikato DHB Financial Position	As at February 2017 Actual $'000	Budget $'000	Variance $'000	Budget Jun-17 $'000
49,321	Total current assets	84,840	56,643	28,197 F	50,193
(154,967)	Total current liabilities	(170,956)	(165,740)	(5,216) U	(198,229)
(105,647)	**Net working capital**	**(86,115)**	**(109,097)**	**22,982 F**	**(148,036)**
568,417	Term assets	557,500	585,933	(28,433) U	611,664
(227,011)	Term liabilities	(14,480)	(226,936)	212,456 F	(226,771)
341,406	**Net term assets**	**543,020**	**358,997**	**184,023 F**	**384,893**
235,759	**Net assets employed**	**456,905**	**249,900**	**207,005 F**	**236,857**
235,759	**Total Equity**	**456,905**	**249,900**	**207,005 F**	**236,857**

Prior Year Feb-16 $'000	Waikato DHB Ratios	As at February 2017 Actual $'000	Budget $'000	Achieved	Trend	Budget Jun-17 $'000
54,520	Borrowing facilities available at month end	64,172	64,172	✓	⇔	46,394
0.9	Debt to Equity ratio	0.0	0.8	✓	⇔	1.0
0.5	Debt to Debt + Equity	0.3	0.6	✓	⇔	0.6
0.3	Current ratio	0.5	0.3	✓	⇔	0.3
38.2%	Equity to total assets	71.1%	38.9%	✓	⇧	35.8%
1.6%	Return on equity	2.1%	5.6%	✓	⇩	1.9%
5.90	Interest covered ratio	8.53	8.83	✓	⇔	6.96

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital		
Net working capital is favourable against budget mainly due to: - Cash held with New Zealand Health Partnerships Limited is higher than planned by $11.5m, mainly due to lower than budgeted capital spend. - Prepayments are higher than planned by $5.7m due to the timing of annual IS spend. - Total accounts receivable and accrued debtors is higher than planned by $10.8m largely due to the actual timing of cash received compared to budget assumptions. - Payroll liabilities are $7.7m higher than budgeted, mainly due to the timing of pay runs and IRD payments resulting in higher month end accruals - Other current liabilities are lower than budgeted $2.4m mainly due to the reversal of the accrual for interest on MoH loans $1.3m and the decrease in the accrual for capital charge as a result of the rate reduction $0.7m.	**$23.0 F**	
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $30.2m and favourable YTD depreciation $1.8m. Please see attached for latest forecast of capital spend for the year for further detail.	**($28.4) U**	
Non Current Liabilities:		
The unbudgeted Debt to Equity swap for MOH loans has been transacted in February 2017	**$212.5 F**	
Equity		
Variance due to : - Debt to Equity swap for MOH loans transacted February 2017 - $212m - Unfavourable variance in overall result against budget $4.5m	**$207.0 F**	
The MoH debt to equity swap also resulted in the movement in financial ratios relating to return on equity and equity to total assets: Equity to Total Assets: Budgeted 38.9%, Actual 71.1% Return on Equity: Budgeted 5.6%, Actual 2.1%		

CAPITAL EXPENDITURE AT 28 February 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 28 Feb-17 (J)	Approved Forecast Expenditure from 1st Mar 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
Total Under $50K Projects:	**2,300**		-	**2,300**		-	**2,300**	**1,325**	**-**	**975**	-		**2,300**	**0**
CLINICAL EQUIPMENT				-										
SUB TOTAL CLINICAL	**12,455**	**27,218**	**210**	**39,883**		**2,031**	**23,400**	**4,020**	**3,368**	**16,012**	**13,961**		**39,392**	**491**
INFORMATION SYSTEMS														
SUB TOTAL INFORMATION SYSTEMS	**30,660**	**38,198**	**-244**	**68,614**		**8,323**	**32,707**	**4,136**	**9,337**	**19,233**	**26,237**		**67,266**	**1,347**
PROPERTY & INFRASTRUCTURE - PLANT									-					
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	**1,493**	**4,601**	**-**	**6,094**		**1,180**	**4,142**	**568**	**829**	**2,744**	**731**		**6,053**	**41**
PROPERTY PROJECT SERVICES								-						0
SUB TOTAL PROPERTY PROJECT SERVICES	**21,188**	**8,370**	**-175**	**29,383**		**10,173**	**16,224**	**3,376**	**6,618**	**6,231**	**3,004**		**29,401**	**(18)**
VEHICLES								-						0
SUB TOTAL VEHICLES	**950**	**700**	**47**	**1,697**		**235**	**1,233**	**3**	**-**	**1,230**	**220**		**1,688**	**9**
STRATEGIC PROJECT OFFICE								-						0
SUB TOTAL STRATEGIC PROJECTS	**25,077**	**60,992**	**0**	**86,069**		**0**	**577**	**10**	**67**	**500**	**85,333**		**85,910**	**159**
CORPORATE								-						0
SUB TOTAL CORPORATE PROJECTS	**8,000**	**800**	**-691**	**8,109**		**1**	**5,492**	**165**	**351**	**4,977**	**1,470**		**6,963**	**1,146**
MOH Projects (funded externally)							-	-						
SUB TOTAL MOH PROJECTS	**426**	**-**	**-**	**426**		**197**	**230**	**116**	**114**	**-**	**-**		**427**	**(1)**
Trust Funded Projects (funded externally)							-	-						0
SUB TOTAL TRUST FUNDED PROJECTS	**-**		**-**	-		**333**	**266**	**266**	**-**	**-**	**-**		600	(600)
PROJECT SAVINGS				-			**(20,025)**			**(20,025)**			**20,025**	**20,025**
CAPITALISED COMPLETED PROJECTS	4,189		275	4,464		3,150	1,455	1,455					**4,605**	**(142)**
TOTALS	**106,738**	**140,879**	**-578**	**247,039**		**25,623**	**68,001**	**15,442**	**20,683**	**31,876**	**130,956**		**224,580**	**22,459**

CAPITAL EXPENDITURE AT 28 February 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 28 Feb-17 (J)	Approved Forecast Expenditure from 1st Mar 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
Total Under $50K Projects:	**2,300**		-	**2,300**		-	**2,300**	**1,325**	**-**	**975**	-		**2,300**	**0**
CLINICAL EQUIPMENT				-										
Urology - Equipment	-	300	-	300		-	200	-	-	200	-		200	100
Heart Lung machines - Cardiac surgery	-	680	-	680		-	680	-	-	680	-		680	0
Heater Cooler units	-	156	-	156		-	156	-	156		-		156	0
Echo vivid - Cardiology - portable	-	400	-	400		-	150	-	-	150	250		400	0
Trans-Oesophageal Echo (Toe)		329		329		-	-	-	-	-	250		250	79
Cardiac output machines (critical care) EV1000	90	-		90			90	-	-	90			90	0
Radiation Dispenser manual - Oncology	-	90	-	90		-	90	-	-	90	-		90	0
Supra laser - Opthalmology	-	170	-58	112		-	112	-	-	112	-		112	0
Retinal Camera Head	-	-	58	58			58	58	-	-			58	(0)
Ultrasound Replacement (Endoscope, Operating Table & EMG System)	-	100	-	100		-	100	-	-	100	-		100	0
Cytogenics Incubators NICU	25	-	-	25		-	-	-	-	-			0	25
Endoscopy scope cleaning equipment	-	174		174		-	193	193	-	-	-		193	(19)
Endoscopes 16/17		1,040	-	1,040		-	414	-	-	414	626		1,040	0
Theatre Instruments	300	-	-	300		-	150	-	-	150	-		150	150
Transeosophageal Echo machine (Philips IE33)	-	226		226			226	-	-	226			226	0
Equipment and Supply Washer	50	-	-	50		-	-	-	-	-	50		50	0
Washer/Disinfector (Thames)	125	-	-92	33		-	-	-	-	-			0	33
Washer Decontaminator for Thames Sterile Services	-	-	92	92		-	92	85	7	-			92	0
Il Machine (Thames)	120	-	-	120		-	-	-	-	-	120		120	0
Transport Monitors (Critical Care)	75	-	-	75		-	-	-	-	-	75		75	0
Endoscope Camera (Thames)	103	-	-	103		-	-	-	-	-	103		103	0
ENT Zeiss S21 (Theatres)	50	50	-	100		-	50	-	-	50			50	50
X-ray Specimen (Theatres) Faxitron	85	-	-	85		-	-	-	-	-	-		0	85
Gynae Urodynamics	55	-	-	55		-	-	-	-	-	55		55	0
GP Pumps (Biomed)	450	-	-	450			450	-	-	450			450	0
Bed Replacement Programme	800	-	-330	470			470	-	-	470	-		470	0
Bed Replacement	-	-	330	330			354	354	-	-			354	(24)
Gamma Camera (Nuclear Med Imaging Scanner)	1,200	-	-	1,200		-	1,200	880	320				1,200	(0)
Home Haemo Dialysis Replacement 16/17	-	62	-	62			62	-	-	62	-		62	0
Haematology Main Analyser (to be approved for hA negotiationing for all hospital	715	-	-	715		-	715	44	549	122	-		715	(0)
Bio Chemistry Lab - Mass Spectrometer	500	-	-	500		-	500	-	-	500	-		500	0
Linear Accelerator (approved by BRRG Nov-15)	4,000	-	-	4,000		2,031	2,190	2,190	-		-		4,221	(221)
-Rapid ARC Licences (Oncology)	123	-	-	123		-	123	-	123	-	-		123	0
PCA Pumps (Biomed)	500	-	-	500		-	500	-	-	500	-		500	0
Treon Plus Stealth station OE9823	-	450		450			-	-	-	-	450		450	0
Haemodialysis (Incentre)	650	-	-	650		-	527	-	-	527	-		527	123
Eyese Heidelberg - Theatres	200			200			-	-	-	-	200		200	0
CT Replacement - Thames (to be approved)	1,500	-	-	1,500		-	1,500	-	-	1,500	-		1,500	0
Non-Invasive Ventilator	-	-	-	-		-	-	-	-	-	-		0	0
Oversize Operating theatre table RX500	-	83	-	83		-	83	-	-	83	-		83	0
Bipap Respironics (CCD x 4) - Respiratory	-	120	-	120		-	120	-	-	120	-		120	0
Bronchosopes (CCD x $) - Respiratory	-	70	-	70		-	70	61	6	3	-		70	0
Scopes - eBus - Respiratory	-	120	-	120		-	120	-	-	120	-		120	0
Trolley Washer - SSU	-	276	-	276		-	276	-	-	276	-		276	0
Telemetry	-	800	-	800		-	200	-	-	200	600		800	0
Cordless Driver (incl wore collect) - Theatres	-	69	-	69		-	69	-	-	69	-		69	0
IMM4 Anaesthethic Monitoring system	-	114	-	114		-	114	-	-	114	-		114	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No1	-	93		93			-	-	-	-	93		93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No2	-	93		93			-	-	-	-	93		93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No3	-	93		93			-	-	-	-	93		93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No4	-	93		93			-	-	-	-	93		93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No5	-	93		93			-	-	-	-	93		93	0
MONITOR IMM4 FM FLEXIBLE MONITOR & LIC E13191	-	60	-	60		-	60	-	-	60	-		60	0
Replacement of Task Operating Theatre Lighting in OT7 & OT8	-	-	70	70		-	70	14	56	-	-		70	(0)
Replacement of Task Operating Theatre Lighting in OT 9 - 12	-	-	140	140		-	140	140	-	-	-		140	(0)
Orthopeadic Cordless Driver 4300 sets x 7	-	141	-	141		-	141	-	-	141	-		141	0
Orthopeadic system - 6 rotary sets x 2	-	63	-	63		-	63	-	-	63	-		63	0
System 6 dual Trigger Rotary Hand Piece	-	65	-	65		-	65	-	-	65	-		65	0

CAPITAL EXPENDITURE AT 28 February 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 28 Feb-17 (J)	Approved Forecast Expenditure from 1st Mar 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
System 6 Sag Saw	-	65	-	65		-	65	-	-	65	-		65	0
Ultrasound - diagnostic E14773	-	224	-	224		-	224	-	-	224	-		224	0
Cardotokograph	-	510	-	510		-	170	-	-	170	340		510	0
Colposcope	-	66	-	66		-	22	-	-	22	-		22	44
Dinamap	-	150	-	150		-	60	-	-	60	-		60	90
Echocadiograph (Wakids)	-	272	-	272		-	272	-	-	272	-		272	0
Foetal heart detector	-	100	-	100		-	60	-	-	60	40		100	0
Foetal monitor, CTG	170	-	-	170		-	170	-	-	170	-		170	0
Humidifier	-	150	-	150		-	69	-	-	69	81		150	0
Infusion pumps (Thames)	-	408	-	408		-	212	-	-	212	196		408	0
Intellivue physiologic monitor	-	352	-	352		-	192	-	-	192	160		352	0
Immunology - Molecular Micro Array	50	-	-	50			-	-	-	-	-		0	50
Monitor cardiac , multi parameter	-	320	-	320		-	80	-	-	80	240		320	0
Scanner, ultrasonic	-	300	-	300		-	150	-	-	150	150		300	0
Scanner, ultrasonic ob/gyn	-	320	-	320		-	320	-	-	320	-		320	0
Warmer, radiant, infant IW930	-	72	-	72		-	72	-	-	72	-		72	0
Cathlabs	-	2,500	-	2,500		-	1,000	-	-	1,000	1,500		2,500	0
Incubator	400	1,440	-	1,840		-	880	-	-	880	960		1,840	0
Haematology Flow Cytometry Robotics system	-	200	-	200		-	200	-	-	200	-		200	0
Histology Pathvision Radiographic system	-	400	-	400		-	400	-	-	400	-		400	0
Building Refurnishment - free up space	-	77		77			77	-	-	77			77	0
Biochemistry LC Tandom Mass Spectrometer	-	500	-	500		-	500	-	-	500	-		500	0
Cytogenetics Digital Imaging system	-	800		800			350	-	350		450		800	0
Scanner 3D Cone Beam (maxFac)	-	150	-	150		-	150	-	-	150	-		150	0
Med - Dispense Units	-	900	-	900		-	100	-	-	100	800		900	0
Licensing (breast screening)	-	52	-	52		-	52	-	-	52	-		52	0
CT Scanner	-	5,200	-	5,200		-	1,600	-	-	1,600	3,600		5,200	0
Digital Mobile X - ray	-	1,500	-470	1,030		-	130	-	-	130	900		1,030	0
Fluro Room units	-	750	-619	131		-	131	-	-	131	-		131	0
Combi Diagnost Fluoroscopy Unit			619	619		-	619	-	589	30	-		619	0
Mobile Image Intensifier - Waikato	-	1,500	-550	950		-	50	-	-	50	900		950	0
X-ray machines and Image Intensifiers	-	-	1,020	1,020		-	1,020	-	1,020	-	-		1,020	0
Ultasound (medical Photography / imaging)	-	200	-	200		-	200	-	-	200	-		200	0
Infusion pumps (Thames)	-	67	-	67		-	67	-	-	67	-		67	0
Steriliser Autoclave (Thames)	-	200	-	200		-	200	-	-	200	-		200	0
Blood gas analysers	-	800	-	800		-	400	-	-	400	400		800	0
GE Logiq - 9 Vascular Ultrasound	-	-	-	-		-	-	-	-	-	-		0	0
CEP - Pool - 2016/17	119			119		-	192	-	192	-	-		192	(73)
SUB TOTAL CLINICAL	**12,455**	**27,218**	**210**	**39,883**		**2,031**	**23,400**	**4,020**	**3,368**	**16,012**	**13,961**		**39,392**	**491**
INFORMATION SYSTEMS														
PLATFORM							-	-	-					
ISSP - Decommission Galen 15/16	300	-	15	315		53	261	53	208		-		314	1
ISSP - Decommission Galen 16/17	-	251	-	251			159	-	-	159			159	92
ISSP - File Server -(profile , home drive, appv)rearchitecture	-	150	-	150		-	150	-	-	150	-		150	0
NIPS - Local Capacity Augments	-	700	-	700		-	400	-	-	400	300		700	0
ISSP - Lifecycle - Infrastructure Application Workplan 16/17	-	1,000	-	1,000		-	249	46	204		750		999	1
ISSP - Lifecycle - Infrastrucure 15/16	300		-	300		232	67	63	4		-		299	1
ISSP - Clinical and Corporate Platform		500		500			500	-	-	500			500	0
ISSP - Clinical and corporate Platform SQL Server consolidation	475		-	475		99	265	74	191		-		363	112
ISSP - Disaster Recovery Solution 15_16	1,150		-	1,150		2	221	42	129	50	900		1,123	27
ISSP - Backup Capacity Augment	200		-	200		0	199	46	4	150	-		200	0
ISSP - Contingency (IS)	100		-64	36		-	36	-	36	-	-		36	0
ISSP - Windows Server Migration 2003-2008 (DIA)	491		-221	270		-	270	-	-	270	-		270	0
STORAGE & REPORTING							-	-	-					0
ISSP - Clinical PhotographyImage Management	-	300	-	300		-	300	-	-	300	-		300	0
ISSP - DataWarehouse Phase 2 - after 16/17	-	400	-200	200		-	200	-	-	200	-		200	0
ISSP - Enterprise Reporting Content remediation -after 16/17	-	250	-	250		-	250	-	-	250	-		250	0

CAPITAL EXPENDITURE AT 28 February 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
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ISSP - Data Analyst Toolset Implementation (16/17)	-	700	-	700		-	350	-	-	350	350		700	0
ISSP - Lifecycle - Sharepoint Workplan (e.g. replace fileshares, online sharepoint)		1,100		1,100			200	-	-	200	900		1,100	0
ISSP - San Controller		322		322			-	-	-	-	322		322	0
ISSP - SharePoint (Doc Management Pilot)	700		-	700		237	117	14	102	-	346		699	1
ISSP - Data Warehouse Phase 1	400		-	400		175	225	73	152	-	-		400	1
ISSP - Data Warehouse Phase 2			200	200		-	199	5	194	-	-		199	1
NETWORK & COMMUNICATIONS				-			-	-	-					0
ISSP - Paging System Replacement	-	350	-	350		-	350	27	323	-	-		350	0
ISSP - Unified Comms Phase 4 (16/17)	-	174	-112	62		-	62	-	-	62	-		62	0
ISSP - Jabber Instant Messaging and Guest			201	201		-	201	-	-	201	-		201	0
ISSP - Lifecycle - 1-2 Communication Tools Workplan	-	400	-	400		-	100	-	100	-	300		400	0
ISSP - WiFi Rollout	-	1,000	-	1,000		-	500	341	159	-	500		1,000	(0)
ISSP - Network Remediation Work Package 2015/2016	400			400		262	138	0	138	-	-		400	0
ISSP - Network Remediation Lifecycle Work Plan 16/17	300			300		-	299	202	81	17	-		299	1
ISSP - Comms Rooms remediation 2015/2016	230		-	230		44	186	34	152	-	-		230	0
ISSP - Unified Comms Phase 4	147		-	147		35	55	55	-	-	-		89	58
ISSP - Hylafax replacement	96			96		-	95	7	88	-	-		95	0
DEVICES				-			-	-	-					0
ISSP - Telehealth- replacement schedule	-	1,800	-	1,800		-	200	-	-	200	1,600		1,800	0
ISSP - Telehealth- Expansion		200	-27	173		-	173	-	-	173	-		173	0
ISSP - Southern Rural Outpatient Video Units			27	27			27	25	2	-	-		27	0
ISSP - Tablets to enable mobile workforce	-	500	-	500		-	300	-	-	300	200		500	0
ISSP - Touch screens	-	300	-	300		-	150	-	-	150	150		300	0
ISSP - Desktop - increase coverage		200		200			100	-	-	100	100		200	0
ISSP - Desktop upgrade from windows 7 to windows 10		2,000		2,000			-	-	-	-	2,000		2,000	0
ISSP - Desktop environment replacement >$2k	100		-	100		-	100	-	-	100	-		100	0
ISSP - Mobile device management	90		-54	36		-	90	-	-	90	-		90	(54)
ISSP - iPads for Virtual Health	745		-	745		-	745	-	-	745	-		745	0
ISSP - Hardware Solution - Medication Room	20		-	20		-	9	9	-	-	-		9	11
ENTERPRISE SERVICE BUSINESS / RULES ENGINE				-			-	-	-					0
ISSP - Clinical Business Rules	-	250	-	250		-	250	-	-	250	-		250	0
ISSP - Web Applications -S_Web_Services Infra_Mess Standards	-	500	-	500		-	500	-	-	500	-		500	0
ISSP - Web Applications -S_Web_Services Infra_Solution Select_Impl	-	500	-	500		-	500	-	-	500	-		500	0
TOOLS				-			-	-	-	-				0
ISSP - PVS Citrix	39	-	-	39		-	15	15	-	-	-		15	24
ISSP - Citrix Sharefile	150	150	-150	150		98	43	42	0	-	-		141	9
ISSP - Archiving Tool	-	380	-	380		4	356	7	-	349	-		360	20
ISSP - TQUAL Reporting	50	50	-	100		1	54	14	39	-	-		55	45
ISSP - Toolsets (after 16/17 refer to Lifecycle plan line items)		452		452			19	-	-	19	433		452	0
ISSP - Toolsets (IS Toolsets 15/16)	563		-	563		178	384	182	202	-	-		562	1
ISSP - Toolsets (14/15)	130		-	130		72	60	34	26	-	-		131	(1)
ISSP - Toolsets (13/14)	471	-	-	471		474	5	5	-	-			479	(8)
ISSP - Citrix Netscaler10.5 upgrade	-	150	-	150		-	141	-	-	141	-		141	9
ISSP - Rapid Logon	-	700	-	700		-	500	-	-	500	200		700	0
ISSP - e2e Clinical Docs		499		499			46	-	-	46	453		499	0
ISSP - EMRAM compliance to lvl 6 - upgrade / implementation	-	700	-	700		-	700	-	-	700	-		700	0
ISSP - Lifecycle integration Tools workplan - Rhapsody etc	-	1,000	-	1,000		-	250	-	-	250	750		1,000	0
ISSP - Anivirus / Malware - Toolset upgrade / replacement	-	150	-	150		-	150	-	-	150	-		150	0
ISSP - Lifecycle - Desktop Workplan (Outlook, Flexplus, etc)	-	1,200	-	1,200		-	300	-	-	300	900		1,200	0
ISSP - Lifecycle - Development tools (Visual studio, Kendo etc)	-	200	-	200		-	50	-	-	50	150		200	0
ISSP - Team foundation Server - Source Code management	-	250	-	250		-	250	-	-	250	-		250	0
ISSP - LIS Reporting Development	200		-	200		83	116	15	102		-		199	1
SECURITY				-			-	-	-				0	0
ISSP - Perimeter Redesign		598	-262	336			87	-	-	87	249		336	0
ISSP - Perimeter Remediation Work Plan 16/17			173	173		-	173	-	173		-		173	0
ISSP - Lifecycle - 1-2 Security tools Workplan (cardex, etc)		600	-	600		-	150	-	-	150	450		600	0
ISSP - Perimeter Redesign	150		-	150		33	49	49	-	-	-		81	69
ISSP - Security Defence in depth	500		-122	378		29	348	30	82	236	-		377	1
LICENSING				-			-	-	-				0	0
ISSP - MS Licensing True-Up (16/17)	300		-	300		-	300	-	-	300	-		300	0
ISSP - Other Licensing True-Up (16/17)	300		-	300		-	300	-	-	300	-		300	0
ISSP - Other Licensing True-Up	300		-251	49		49	16	16	-	-	-		65	(16)
ISSP - MS Licensing True-Up	300		-124	176		129	47	-	47		-		176	0

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CLINICAL SYSTEMS							-	-	-				0	0
ISSP - Lifecycle: LIS Workplan	150		-79	71			71	-	-	71			71	0
ISSP - Healthviews DC Uploader replacement		150	-150	-			-	-	-	-			0	0
ISSP - Clinical Workstation Core Component Workplan	-	-	480	480			479	137	342				479	1
ISSP - NCAMP. 3M, MKR	250	250	-250	250		78	171	63	108		-		249	1
ISSP - NCAMP 2017			250	250		-	250	-	250		-		250	0
ISSP - Workflow eData	250	-	-	250		3	247	102	145		-		250	(0)
ISSP - Workflow eData		2,100		2,100		-	1,500	-	-	1,500	600		2,100	0
ISSP - Database Replacements		300	-	300		2	297	15	282		-		299	1
ISSP - Oral Health system		1,000	-	1,000		165	835	474	319	41	-		999	1
ISSP - eTasks	-	230	-	230		-	100	2	98	-	130		230	0
ISSP - Cardiac Dendrite Phase 3	200	200	-116	284		-	84	-	-	84	200		284	0
ISSP - Surgical Services Audit Systems			116	116		-	116	36	80				116	0
ISSP - eProgesa replacement impacts - NZ Blood Service	-	150	-	150		-	150	-	-	150	-		150	0
ISSP - Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense		250		250			80	-	-	80	150		230	20
ISSP - Life cycle - cat 1-2 Medical Records Workplan (eg Kofax)	-	600	-	600		-	150	-	-	150	450		600	0
ISSP - Life cycle - cat 1-5 In house Apps Workplan(eg Whitboards)	-	1,400	-350	1,050		-	-	-	-	-	1,050		1,050	0
ISSP - Cat1-5 In-House Developed Applications Work Plan	-	-	350	350		-	350	58	292	-	-		350	0
ISSP - Life cycle - cat 2 Clinical Apps Workplan(eg NHI Gateway)	-	600	-150	450		-	-	-	-		450		450	0
ISSP - Cat 2 Off-the-shelf Applications Work Plan	-	-	150	150		-	150	5	144	-	-		150	0
ISSP - Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	-	1,400	-	1,400		-	350	55	294		1,050		1,400	0
ISSP - Life cycle - CWS / Healthviews Workplan	-	1,000	-654	346		-	176	-	-	176	170		346	0
ISSP - Software Upgrades (Apps Lifecycle 15/16)	250		-	250		149	101	66	34		-		250	0
ISSP - Master Data Implementation- after 16/17	-	100	-	100		-	100	-	-	100	-		100	0
ISSP - Laboratory Information Systems June 2016 GA upgrade	-	400	-	400		-	400	-	-	400	-		400	0
ISSP - Lab Analysers	-	600	-	600		-	150	-	-	150	450		600	0
ISSP - HealthViews - External eReferrals	-	300	-	300		-	222	2	-	220	-		222	78
ISSP - Clinical workstations - Document Tree search	-	100	79	179		-	101	2		99	-		101	78
ISSP - Access to community pharmacy	-	100	-100	-		-	-	-	-	-	-		0	0
ISSP - Data collection	-	100	-	100		-	50	-	-	50	-		50	50
ISSP - Procedure based Booking / Scheduling	-	1,250	-	1,250		-	250	-	-	250	1,000		1,250	0
ISSP - Structured programme - scanned history	-	200	-	200		-	100	-	-	100	100		200	0
ISSP - Cardiology - Xcelera to ISCV	-	100	-	100		-	100	-	-	100	-		100	0
ISSP - ipm upgrade to V10 - after 16/17	-	450	-	450		-	450	105	345		-		450	0
ISSP - SSU re-engineering	-	666	-	666		-	466	-	-	466	200		666	0
ISSP - eCWB Infrastructure	-	739	-	739		-	611	-	-	611	128		739	0
ISSP - Maternity (CleverMed)	760		-	760		12	740	-	740	-	-		752	8
ISSP - LIS Lifecycle upgrade (LIS Drop 6)	200		79	279		218	60	60	-	-	-		279	0
ISSP - HealthViews access to Primary Encounters (GP to Workstations)	300		-	300		69	231	218	13	-	-		300	(0)
ISSP - LIS Print solution	80		-	80		-	-	-	-	-	80		80	0
ISSP - HealthViews Internal eReferrals	300		-300	-		-	-	-	-	-	-		0	0
ISSP - Internal eReferrals			499	499		-	505	34	471				505	(6)
ISSP - eOrders	350		-	350		3	197	0	197		150		350	0
ISSP - Radiology - PACS/RIS Upgrade 16/17	500	200	-	700		-	653	-	-	653	-		653	47
ISSP - RIS Upgrade (Project split) (PACS Upgrade 15)	223		-	223		93	135	75	61		-		228	(5)
ISSP - RIS Upgrade 2016	124		-	124		1	122	1	122		-		124	0
ISSP - Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense	250		-	250		-	150	-	-	150	-		150	100
ISSP - Laboratory Phlebotomy (Te Kuiti)	40		-	40			40	-	-	40			40	0
ISSP - HealthViews - e2e Clinical Documents	350		-	350		53	297	151	146	-	-		350	0
ISSP - Clinical Workstation Metadata Scoping			50	50		1	49	3	-	46	-		50	(0)
ISSP - Speech Recognition			100	100		1	99	-	99		-		100	0
ISSP - Clinical Workflow Integration Work Plan			430	430		-	429	34	395		-		429	1
ISSP - Provation Host Tairawhiti	27		-	27		-	27	-	27		-		27	0
ISSP - e-Discharge Summaries	100		-100	-		-	-	-	-		-		0	0
CORPORATE SYSTEMS & PROCESSES				-			-	-	-				0	0
ISSP - Costpro Upgrade		103		103			26	-	-	26	77		103	0
ISSP - Costpro Tactical Improvements & Upgrade	400		-	400		238	162	1	161		-		400	0
ISSP - HRIS Lifecycle Upgrade 15_16		400	-	400		4	396	27	370		-		400	(0)
ISSP - Lifecycle HRIS / Peoplesoft Workplan		950		950		-	150	-	-	150	800		950	0
ISSP - HRIS Self Service implementation - payroll improvement	400	-	-	400		-	400	-	-	400	-		400	0
ISSP - Attendants System - enhancements or replacement	-	100	-	100		-	100	-	-	100	-		100	0
ISSP - Hockin Conversion	21		-	21		12	9	4	5		-		21	0
REGIONAL							-	-	-				0	0

CAPITAL EXPENDITURE AT 28 February 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 28 Feb-17 (J)	Approved Forecast Expenditure from 1st Mar 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
RSSP - Regional Netscaler Reconfiguration	-	33	-	33		-	33	-	-	33	-		33	0
RSSP - Regioanl Microsoft Reporting Services	-	225	-	225		-	131	-	-	131	94		225	0
RSSP - SEEMAIL	-	26	-14	12		-	12	-	-	12	-		12	0
RISSP - HSL - File sharing technology	42			42		-	-	-	-		42		42	0
RISSP - HSL - ANZAC - Q1	40		-	40		-	-	-	-		40		40	0
RISSP - HSL - Core Intrastructure	644			644		-	-	-	-		644		644	0
RISSP - HSL - Enhanced Identity Management	46		-	46		-	-	-	-		46		46	0
RISSP - HSL - Enhanced Regional Integration	502		-	502		-	-	-	-		502		502	0
RISSP - HSL - e Space Clinical Workstation	7,831		-	7,831		-	2,500	-	-	2,500	5,331		7,831	0
RISSP - Risk Management Solution (Regional)	369		-	369		306	63	-	63		-		369	0
MRISSP - Pharmacy System Phase II – Implementation	2,462		-	2,462		2,356	106	-	106		-		2,462	0
RISSP - Midland Regional Platform Project	409		-	409		245	164	-	164		-		409	0
RISSP - Clinical Workstation - Phase II (License)	500	500	-	1,000		500	500	500	-		-		1,000	0
ISSP - Netscaler Infrastructure			343	343		1	342	222	119		-		342	1
OTHER PROJECTS				-			-	-	-				0	0
ISSP - FMIS Replacement - Phase I	792		-	792		499	-	-	-		-		499	293
ISSP - Clinical whiteboard - eCWB Infrastructure	442		-	442		128	88	88	-		-		216	226
ISSP - Portfolio Resource Management Upgrade	130		-	130		85	10	10	-		-		95	35
ISSP - Printer Architecture Upgrade	130		-	130		9	120	4	116	-	-		130	0
ISSP - Application Lifecycle 2014/15 WorkPlan	470			470		454	4	4	-		-		458	12
ISSP - Baseline - Infrastructure Lifecycle Management	465		-	465		318	151	24	127		-		469	(4)
ISSP - Windows 10 COE (Part deduction see below for balance of deduction	45		-	45		27	18	18	-		-		45	0
ISSP - Cobas IT 1000	120		-	120		2	118	0	118		-		120	0
ISSP - Spark Consultancy Services			64	64		-	64	12	52	-	-		64	(0)
SUB TOTAL INFORMATION SYSTEMS	**30,660**	**38,198**	**-244**	**68,614**		**8,323**	**32,707**	**4,136**	**9,337**	**19,233**	**26,237**		**67,266**	**1,347**
PROPERTY & INFRASTRUCTURE - PLANT									-					
Waikato Waiora Chillers	643		-	643		626	2	2	-	-	-		628	15
Waikato Distribution Board stuff 11/12	250		-	250		196	54	16	38	-	-		250	0
Waikato Switchboards - Menzies,Kemp,Waiora & ERB	-	600	-	600		-	600	-	-	600	-		600	0
Theatre - Air conditioning upgrades	-	400	-250	150		-	150	-	-	150	-		150	0
Kempthorne Plantroom Upgrade	-	-	250	250		-	252	237	15	-	-		252	(2)
Thames - Air conditioning inpatient unit upgrade	-	200	-	200		-	200	-	-	200	-		200	0
Carpark Lighting - Upgrade	-	50	-	50		-	50	32	5	13	-		50	0
HV System - upgrade- SCADA to BMS	-	160	-	160		-	160	-	-	160	-		160	0
Ward 32 - Air conditioning	-	45	-	45		-	45	-	-	45	-		45	0
Hockin sewage system	-	65	-20	45		-	45	-	-	45	-		45	0
Hockin Sewer Pumping Stations and Heating Controls	-	-	20	20		-	20	-	20	-	-		20	0
Marsh Insurance Items	-	150	-	150		-	150	-	-	150	-		150	0
Mothercraft Fire Panel - upgrade	-	20	-	20		-	20	-	-	20	-		20	0
NICU ERM's to 4 x 4 upgrade	-	36	-18	18		-	18	-	-	18	-		18	0
Extension to Current ERM Manifolds for NICU	-	-	18	18		-	18	-	18	-	-		18	0
Tunnel lighting	-	30	-	30		-	30	-	-	30	-		30	0
Maternity Refurb / Electrical	-	44	-	44		-	44	-	-	44	-		44	0
EWIS communications solution	-	170	-	170		-	170	-	-	170	-		170	0
Lift car upgrades	-	72	-	72		-	72	-	-	72	-		72	0
ERB chilled water buffer tank installation	-	20	-	20		-	20	-	-	20	-		20	0
ERB Fire panel upgrade	-	200	-	200		-	200	-	-	200	-		200	0
Menzies Fire panel upgrade	-	200	-	200		-	200	-	-	200	-		200	0
Avigilon DVR's in all building x9	-	117	-	117		-	39	-	33	6	78		117	0
Carpark CCTV	-	300	-	300		-	100	-	-	100	200		300	0
Convert CCTV from analogue to IP	-	60	-	60		-	30	-	-	30	30		60	0
Develop Web based payment for Multicash	-	150	-48	102		-	150	-	-	150			150	(48)
Change Readers X 125	-	60	-	60		-	30	-	27	3	30		60	0
Gallagher door controllers - upgrade to 6000 model	-	300	-	300		-	100	-	100	-	200		300	0
Virtual controller for Monitoring stations	-	80	-	80		-	80	-	-	80	-		80	0
Intercoms at all barrier arms	-	110	-	110		-	55	-	-	55	55		110	0
CCTV for Hockin building	-	80	-	80		-	80	-	-	80	-		80	0
Master key - Waikato buildings (2 x bldgs)	-	112	-	112		-	54	-	-	54	58		112	0
Ward - standard install	-	120	48	168		-	40	-	40	-	80		120	48
Monitoring centre (setup, 24/7 manning)	-	50	-	50		-	50	-	-	50	-		50	0
Infrastructure Replacement Pool (15/16)	600			600		358	281	281	-	-			639	(39)
Infrastructure Replacement Pool (16/17)		600		600		-	533	-	533		-		533	67
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	**1,493**	**4,601**	**-**	**6,094**		**1,180**	**4,142**	**568**	**829**	**2,744**	**731**		**6,053**	**41**

CAPITAL EXPENDITURE AT 28 February 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 28 Feb-17 (J)	Approved Forecast Expenditure from 1st Mar 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
PROPERTY PROJECT SERVICES								-						0
Priority Roading Works		565		565		-	565	-	-	565	-		565	0
MCC - Edge roof protection		30		30		-	30	-	-	30	-		30	0
OPRS - Roof access		30		30		-	30	-	-	30	-		30	0
ERB improvements (counter cold & wind)		150		150			150	-	-	150			150	0
Greening Programme	875	-	-280	595			-	-	-		595		595	0
Concept Design- Oncology/Haematology Facility	300	-	-	300		62	238	19	219				300	0
Virtual Care Office	46	-		46		57	35	35	-				92	(46)
Boiler House Upgrade	1,833	-	-	1,833		1,833	33	33	-				1,866	(33)
Hilda Ross - Remediation	3,403	-	280	3,683		-	3,684	1,113	1,321	1,250			3,684	(0)
Lift Upgrade	1,835	-	-	1,835		1,610	225	-	-	225			1,835	0
Electrical Systems Improvement	6,889	-	-175	6,714		5,789	960	134	-	826			6,749	(35)
Consolidation of CBD facilities	-	5,557	-	5,557		-	5,557	863	4,695	-	-		5,557	(0)
Office Relocations	2,000	-	-95	1,905		-	405	-	-	405	1,500		1,905	0
Hockin - Open planning/ Modernisation of Level 3 Executive Wing			95	95		-	95	46	49				95	0
Seismic Remediation	3,207	-		3,207		123	2,175	1,113	-	1,062	909		3,207	(0)
Internal Reconfiguration - Gallaghers	-	863	-	863		-	863	-	-	863			863	0
Internal Reconfiguration - Room Pressure	-	210	-	210		-	210	-	210				210	0
Internal Reconfiguration - Pain Clinic - L3 Menzies	-	100	-	100		-	100	-	-	100			100	0
Internal Reconfiguration - Coffee outlet L1 MCC	-	75	-	75		-	75	-	-	75			75	0
Internal Reconfiguration - Refurb - Waiora L2	-	200	-	200		-	200	-	-	200			200	0
Outdoor staff facility- Rest & Recovery off red Corridor	-	100	-	100		-	100	-	-	100			100	0
Ward Block A & environs	-	300	-	300		-	300	-	-	300			300	0
Landscape Ward Block A		50		50		-	50	-	-	50			50	0
Tokoroa / Te kuiti / Rhoda Road / Matariki Refurb	-	140	-140	-		-	-	-	-		-		0	0
Combining Matariki and Princess Street Bases			140	140		-	140	15	125				140	0
Legacy SCR - Still Required - decanting	800		-	800		700	4	4	-	-	-		704	96
SUB TOTAL PROPERTY PROJECT SERVICES	**21,188**	**8,370**	**-175**	**29,383**		**10,173**	**16,224**	**3,376**	**6,618**	**6,231**	**3,004**		**29,401**	**(18)**
VEHICLES								-						0
Vision Hearing Truck (Moblie Ear Clinic)	**200**		47	247		235	3	3	-		-		238	9
Mobile Dental Unit Replacements level 1		700		700			700	-	-	700			700	0
Mobile Dental Unit Replacements level 2	**750**		-	750		-	530	-	-	530	220		750	0
SUB TOTAL VEHICLES	**950**	**700**	**47**	**1,697**		**235**	**1,233**	**3**	**-**	**1,230**	**220**		**1,688**	**9**
STRATEGIC PROJECT OFFICE								-						0
Education; Research and supporting amenities	25,000	-		25,000			-	-	-		25000		25,000	0
Mental Health Facility - scoping	77	-	-	77		-	77	10	67		-		77	0
Mental Health Facility	-	60,992	-	60,992		-	500	-	-	500	60,333		60,833	159
SUB TOTAL STRATEGIC PROJECTS	**25,077**	**60,992**	**0**	**86,069**		**0**	**577**	**10**	**67**	**500**	**85,333**		**85,910**	**159**
CORPORATE								-						0
COS - Contingency (was CFO)	1,000		-492	508		-	508	-	-	508			508	0
Catalyst Initiatives	2,500		-574	1,926		-	356	-	-	356	1,470		1,826	100
Service & Capacity Planning Tool			98	98		-	98	-	98				98	0
BPAC eReferral Phase 2			247	247		-	247	-	247	-			247	0
Production & Meal ordering S/W	-	300	-	300		-	300	-	-	300			300	0
Positive NPV Projects	1,000		-	1,000		-	1,000	-	-	1,000			1,000	1
Oracle - Mop ups and Budgeting solution	-	500	-	500		-	500	-	-	500			500	1
Taleo - Transition module			30	30		-	30	24	6				30	0
Project Elevate-Upgrade to NOS			118	118		1	141	141	-				142	(24)
Transition to National Oracle System	3,500		-118	3,382		-	2,314	-	-	2,314			2,314	1,069
SUB TOTAL CORPORATE PROJECTS	**8,000**	**800**	**-691**	**8,109**		**1**	**5,492**	**165**	**351**	**4,977**	**1,470**		**6,963**	**1,146**
MOH Projects (funded externally)							-	-						
National Patient Flow-Phase 2	177		-	177		174	2	2	-		-		177	0
National Patient Flow Phase 3	249			249		23	228	114	114		-		251	(2)
Telestroke Pilot	-	-	-	-		-	42	42	-	-	-		42	(42)
SUB TOTAL MOH PROJECTS	**426**	**-**	**-**	**426**		**197**	**230**	**116**	**114**	**-**	**-**		**427**	**(1)**
Trust Funded Projects (funded externally)							-	-						0
15/16 Trust Account	-			-		250	226	226	-		-		476	(476)
16/17 Trust Account				-		-	35	35	-		-		35	(35)
15/16 Other Donated Assets				-		84	5	5	-				89	(89)
SUB TOTAL TRUST FUNDED PROJECTS	**-**		**-**	-		**333**	**266**	**266**	**-**	**-**	**-**		600	(600)
PROJECT SAVINGS				-			**(20,025)**			**(20,025)**			**20,025**	**20,025**
CAPITALISED COMPLETED PROJECTS	4,189		275	4,464		3,150	1,455	1,455					**4,605**	**(142)**
TOTALS	**106,738**	**140,879**	**-578**	**247,039**		**25,623**	**68,001**	**15,442**	**20,683**	**31,876**	**130,956**		**224,580**	**22,459**

Performance Reporting

MEMORANDUM TO THE BOARD
22 MARCH 2017

AGENDA ITEM 6.1

HEALTH TARGETS REPORT

Purpose	For information.

Most recent results

Table 1 shows a summary of performance for Waikato DHB's health target results including 2016/17 quarter two results. DHB comparison rankings for 2016/17 quarter two performance are now available and have been included. The most recent results in the last column give the most up to date picture of performance.

Table 1- Health targets performance summary

HEALTH TARGETS		2014/15 Q4 results & ranking	15/16 Target	2015/16 Q1 results & ranking	2015/16 Q2 results & ranking	2015/16 Q3 results & ranking	2015/16 Q4 results & ranking	16/17 Target	2016/17 Q1 results & ranking	2016/17 Q2 results	Target achieved	2016/17 Most recent result
Shorter stays in emergency departments		94% 16th ✗	**95%**	89% 18th ✗	92% 16th ✗	90% 19th ✗	**91% 18th** ✗	**95%**	89.3% 19th ✗	87.6% 20th ✗	X	88.6% Feb 17 YTD
Improved access to elective surgery		115% 3rd ★	**100%**	119% 4th ★	120% 2nd ★	120% 2nd ★	**119% 2nd** ★	**100%**	108% 7th ★	106% 10th ●	√	104.6% Feb 17 YTD
Faster Cancer Treatment (FCT)	Achievement	56% 17th ✗	**85%**	57% 17th ✗	68% 17th ✗	**73% 13th**	77% 10th ●	**85%**	81.1% 5th ★	86.1% 5th ★	√	86.1% Dec 16 6 mth rolling
Better Help for Smokers to quit	Primary Care	84% 10th ●	**90%**	84% 12th ●	88% 7th ★	**89% 8th**	88% 6th ★	**90%**	87.0% 7th ★	87% 12th ●	X	87% 16/17 Q2 result
	Maternity	91% 14th= ✗	**90%**	91% 16th ✗	89% 15th ✗	**95% 13th**	97% 8th ●	**90%**	93% 12th ●	98% 4th ★	√	98% 16/17 Q2 result
Increased immunisation (8 months)		91% 15th ✗	**95%**	90% 17th ✗	92% 13th ●	91% 15th ✗	**90% 17th** ✗	**95%**	92.3% 13th ●	92% 15th ●	X	90.4% Feb 17 3 mth rolling
Raising Healthy Kids[1]				9%	18%	19%	31%	**95%[1]**	47% 11th ●	79% 6th ★	X	79% 16/17 Q2 result (Jun-Nov16 data)

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

[1] Target by Dec 2017

Target: Shorter stays in Emergency Departments (ED)

Table 2 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 2016/17**	**Q2 2016/17**
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% 19th Ranking**	**87.6%**

Table 3 –2017 ED results for February

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:	24046	27439	87.6%
Waikato	15668	18672	83.9%
Taumarunui	1483	1549	95.7%
Thames	4052	4282	94.6%
Tokoroa	2843	2936	96.8%

Graph 1 - Waikato DHB's shorter stays in emergency department.

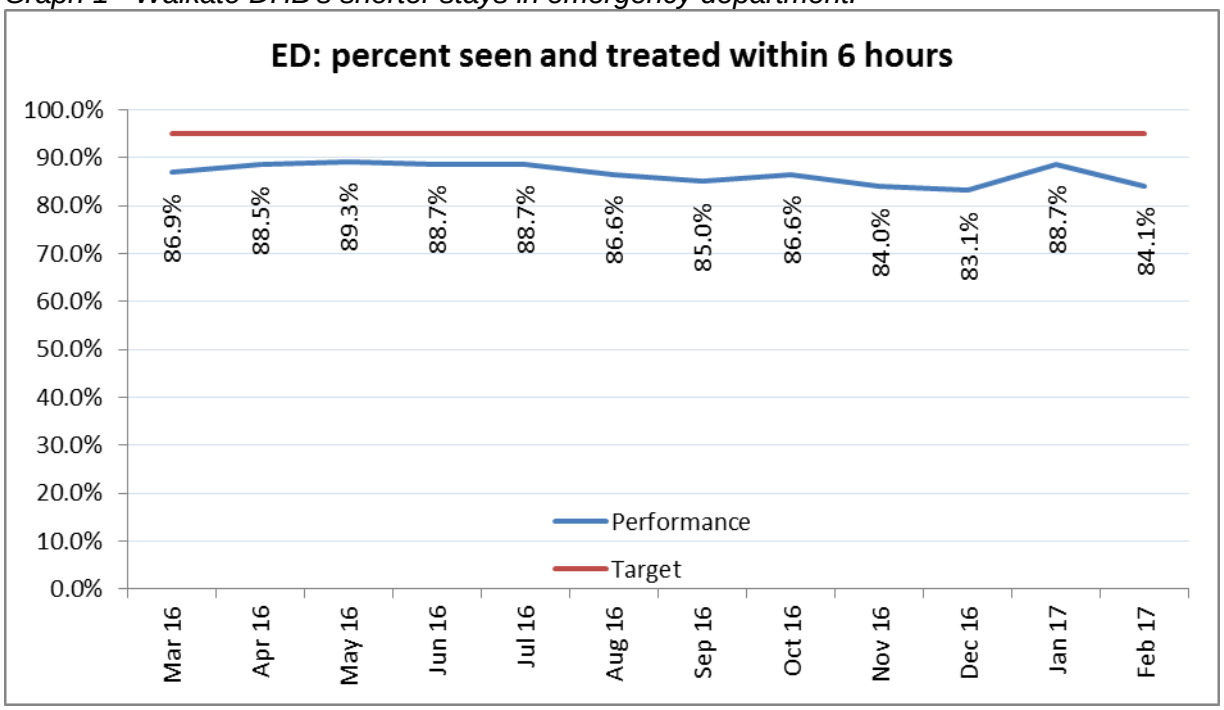
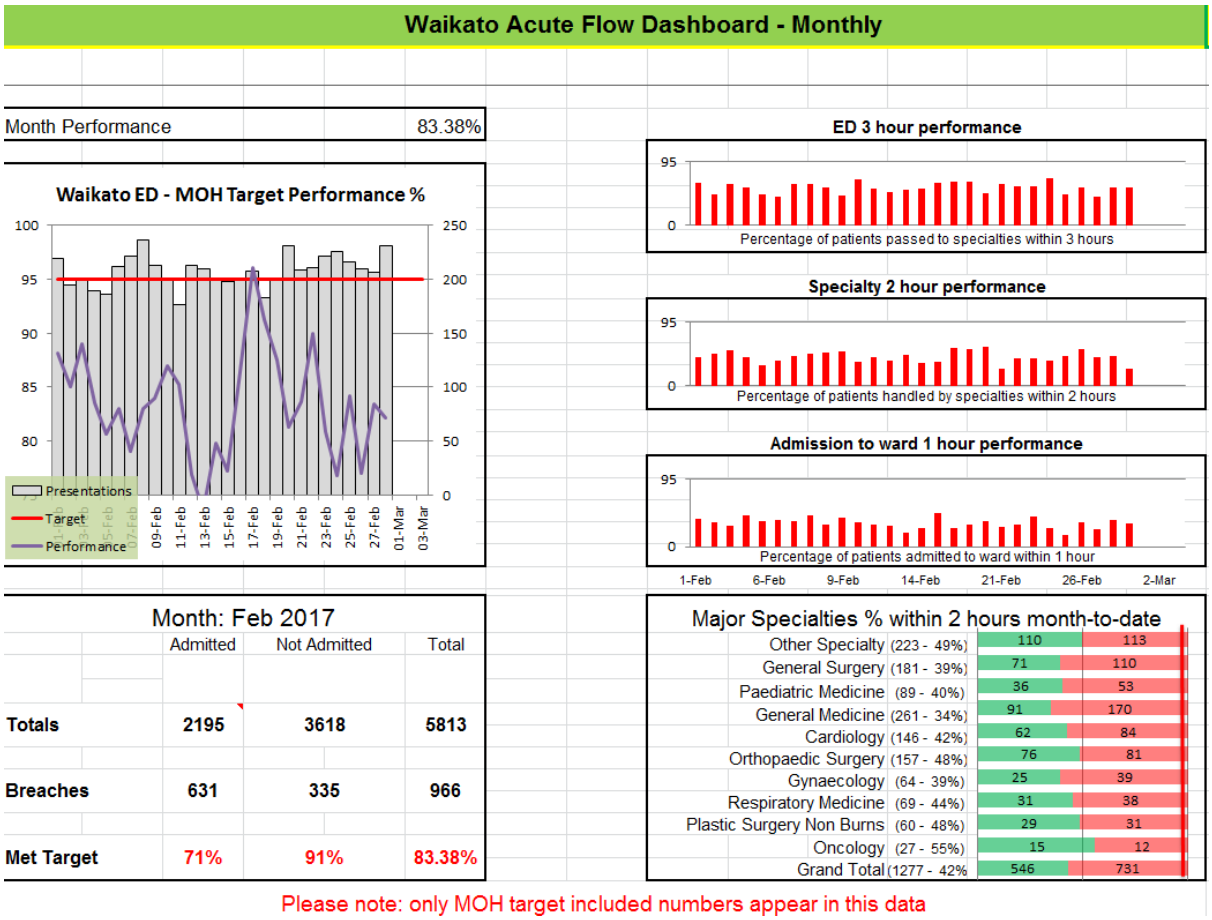


Table 4 - Emergency Department February 2017 results by site and by clinical unit

	Clinical Unit	Month: Feb-2017 Departures	%	Year To Date Departures	%
By Specialty/Division (Waikato Hospital Only)	General & Specialty Surgery	815	73.0%	6497	78.6%
	Cardiology	195	62.1%	2001	57.8%
	Cardiothoracic Surgery	8	100.0%	57	91.2%
	Critical Care	0		0	
	Paediatrics	298	88.6%	3355	88.9%
	Emergency Department	3327	91.8%	27907	93.0%
	Internal Medicine	764	69.7%	6595	71.8%
	Womens Care	134	69.9%	906	78.3%
	Oncology	74	82.2%	578	78.8%
	Orthopaedics	307	77.0%	2116	76.1%
	Renal	51	78.4%	384	80.2%
	Vascular Surgery	29	69.0%	275	89.1%
	Allied health	0		0	
	Community Services	0		0	
	Older Persons	0		3	100.0%
	Mental Health	90	83.1%	713	87.8%
By Site	Waikato Hospital	6092	83.4%	51387	85.3%
	Thames Hospital	1335	93.2%	11521	94.6%
	Tokoroa Hospital	948	97.5%	8003	97.2%
	Taumarunui Hospital	467	95.6%	4180	96.6%
	Total Health Waikato	**8842**	**87.0%**	**75091**	**88.6%**

Table 4 shows all Health Waikato hospitals emergency department performance up to the latest result of 88.6% for YTD February 2017, noting that Tokoroa and Taumaranui hospitals achieved >95%, but both Waikato and Thames have not achieved it for the month.

The ED dash board continues to be used daily at Waikato Hospital in the Emergency Department operations meeting. This was also discussed at the Acute Patient Governance Group and the members are to review the data behind the dashboard and use the information to identify an improvement plan for the admitted patients.



Please note: only MOH target included numbers appear in this data

Recruitment continues for the approved Emergency Department business case. Medical recruitment is under way for Senior Medical Officer positions. The recruitment in March will focus on the fellowship and medical officer positions that have been agreed.

Nursing recruitment continues with a focus on RN. The senior nurse positions have been appointed.

The Emergency Department Senior Medical Officer planning session ensured the team were aligned with the recruitment model and the orientation and training plans that will be required to support it. The team also met with the change team and discussed the areas of opportunity for the removal of waste and duplication in Emergency Department processes.

The Genral Practice referral process to Emergency Department remains on the agenda and a new process has been agreed to be implemented from 1 April 2017. This time frame will enable good communication to all involved in the process.

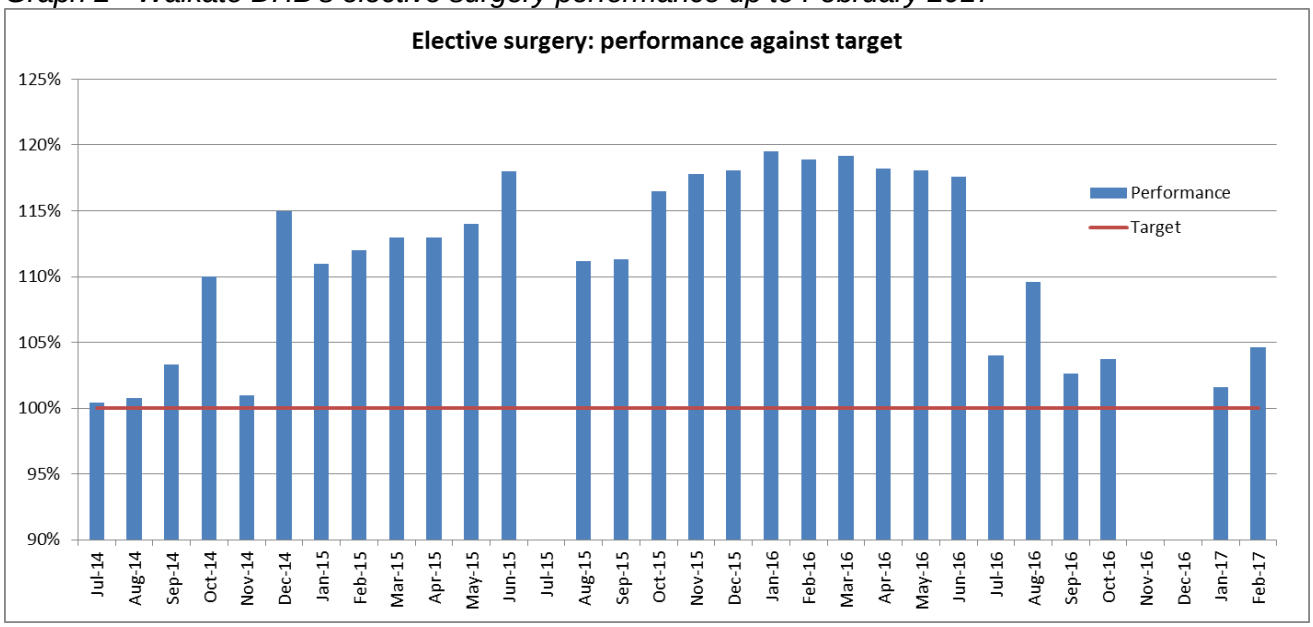
The ED leadership team is to focus on identifying a number of clinical agreements that would support the patients on the admitted pathway and to re-engage with individual clinical teams.

Target: Elective Surgery

DHB Q4 result 14/15	DHB Q4 result 15/16	**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**	**Most recent result**
115.5% YTD 3rd ranking (target 13,583 discharges)	119% YTD (target 15,858 discharges)	**100%** **(target 16,805 discharges)**	120% YTD 2nd ranking (target 7,858 discharges)	120% YTD 2nd ranking (target 11,546 discharges)	119% YTD (target 15,858 discharges)	108% YTD 7th ranking (target 4,651 discharges)	**106% YTD 10th ranking** **(target 8,966 discharges)**	**104.6% YTD February 17** **(target 11,253 discharges)**

The 2016/17 target is 16,805 discharges. Graph two below provides the most recent result of 105%, a total of 11,773 actual discharges for the period from 1 July 2016 to 28 February 2017. Our official ranking result for Q2 was released this month and Waikato was 10th.

Graph 2 - Waikato DHB's elective surgery performance up to February 2017



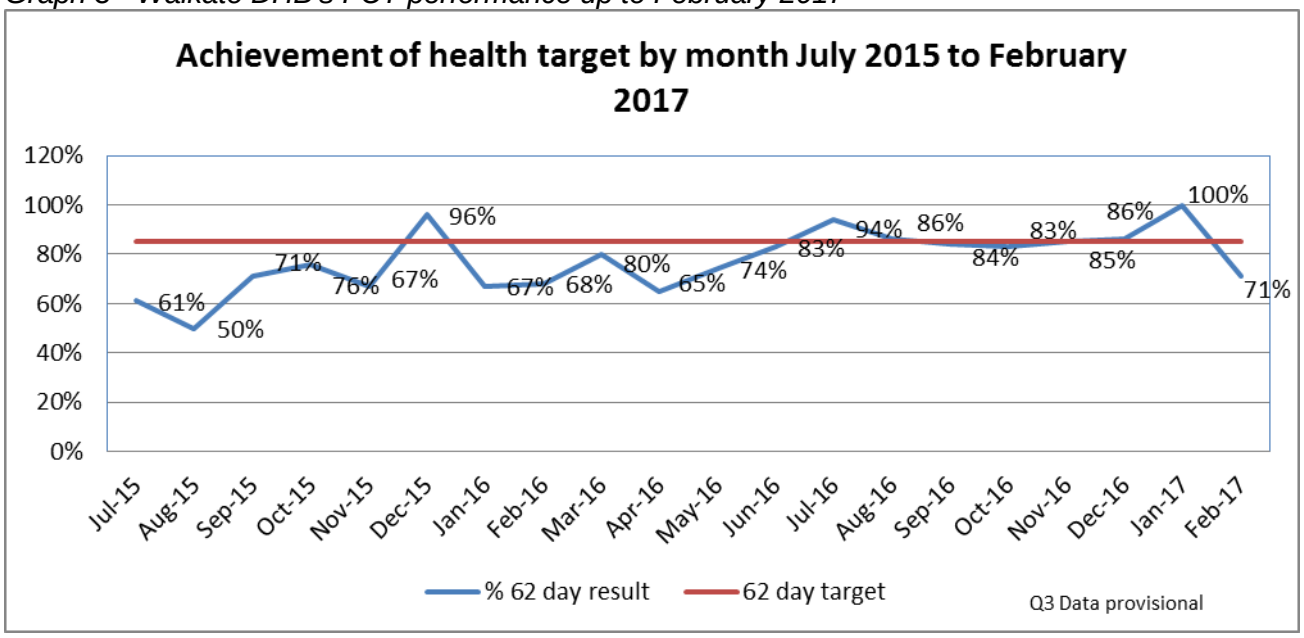
Target: Faster Cancer Treatment (FCT)

FCT 62 DAY HEALTH TARGET								
DHB Target by July 2017	**DHB Current Target**	DHB Q1 Result 15/16*	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	**Most recent six monthly result**
90.00%	**85%**	57.0% 17th ranking	68.0% 17th ranking	76.5% 10th ranking	72.6% 14th ranking	81.4% 5th ranking	86.1% 5th ranking	**86.1%** **Dec-16**
FCT VOLUME TARGET								
DHB Target by July 2017	**DHB Current Target**	DHB Q1 Result 15/16*	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	**Most recent six monthly result**
25.00%	**15%**	17% 11th ranking	16% 14th ranking	14% 15th ranking	14%	17%	19%	**19%** **Dec-16**

The 2016/17 quarter two result of 86.1% shows a steady improvement in Waikato DHB's performance from the previous quarter performance of 81.4%. This is further demonstrated in the DHB's performance ranking provisionally remaining 5th overall.

Graph 3 below shows the historical monthly percentage performance against the target.

Graph 3 - Waikato DHB's FCT performance up to February 2017



Q2 was the first financial quarter we delivered the 85% target for a full quarter, making Waikato DHB one of the first DHB's in the country to achieve >85% for a full quarter.

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

In Q3 we achieved a record high of 100% for January, but unfortunately had a decline in February with 71%. There are a number of reasons for this decline.

- 4 public holidays falling on Mondays over January and February meant FSAs for medical oncology were delayed
- some theatre lists cancelled due to anaesthetist unavailability
- Patient choice, patients do not always want to come in for investigations/ treatment over the December/January period
- Junior doctors strike caused all outpatient clinics to be cancelled, which had a significant impact.

Currently concerns remain with the pressures on the gynaecology service, with a number of breaches in February and a few predicted for March which will impact on the DHB's Q3 performance and the 6 month rolling average. This is being followed up directly with the service.

A number of operational measures are being undertaken to maintain performance:

- Business manager and nurse tracker working very closely with cancer care coordinators and Clinical Nurse Specialists monitoring the patient pathway from initial date of referral;
- Business manager working closely with gynaecology team in Waikato and Auckland to ensure patients receive their surgery in Auckland in timely manner;
- Early notification to oncology booking clerks highlighting patients on the 62 day pathway being referred for first treatment.
- High Suspicion of Cancer red stamps now been issued to all departments to be used when requesting diagnostics histology etc for High Suspicion of Cancer patients

Graph 4 - Waikato DHB's FCT performance (rolling six month result)

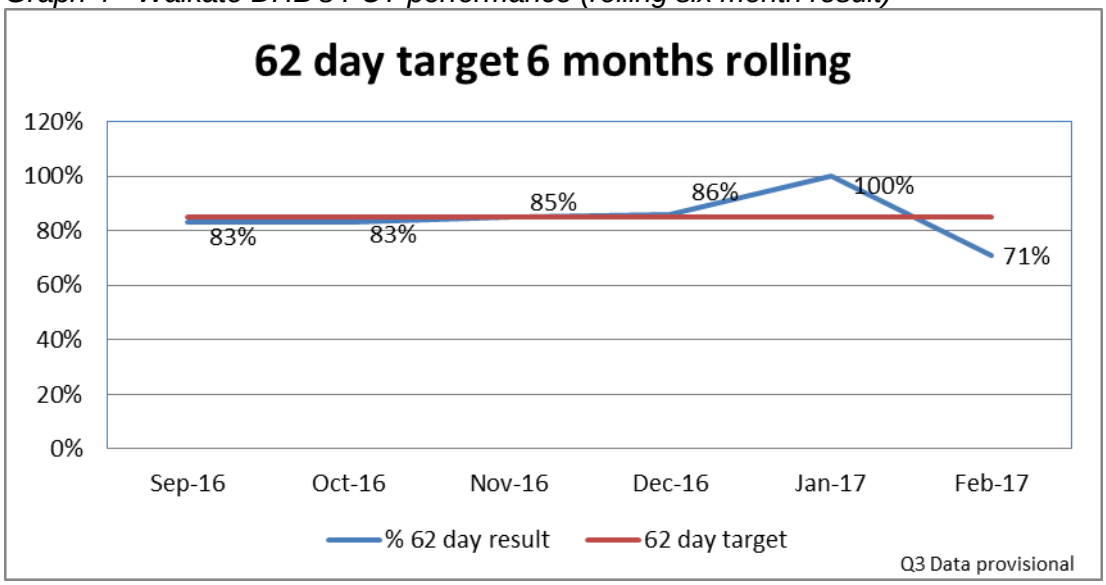


Table 5 – Latest six month data for 62-day FCT cohort, by month of first treatment

Local FCT Database	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Total
Number of records submitted	29	23	34	42	21	24	173
Number of records within 62 days	24	19	29	36	21	17	146
% 62 day Target Met (85%)	83%	83%	85%	86%	100%	71%	84%
% Volume Target Met (15%)	18%	14%	21%	26%	13%	15%	18%

In addition to the target for Faster Cancer Treatment (there is a sub-measure to check that around the expected proportion of patients are in the Faster Cancer Treatment pathway. The expected rate is over 15% of cancer registrations being identified as high suspicion of cancer. Results are also included in the table above. Our latest six month volume result is 19%, which is also a marked improvement on previous quarters.

Target: Increased immunisations for 8 months

DHB Q4 result 13/14	DHB Q4 result 14/15	DHB Q4 result 15/16	**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**	**Most recent 3 monthly result**
89% 17th ranking	91% 15th ranking	89% 17th ranking	**95%**	92% 13th ranking	91% 15th ranking	89% 17th ranking	92% 13th ranking	**92% 15th ranking**	**90% Feb 17**

Data for this target is reported on a three month rolling basis. Graph 5 shows our most recent result of 90% for the three month period from 1 December 2016 to 28 February 2017. This is a slight decrease from quarter 2, however delivery against this target over the Christmas break is often low.

We still have not yet met the target of 95%. An Immunisation Resolution Plan was developed prior to Christmas in conjuction with the Immunisation Steering Group members capturing all current and planned activity. The Ministry has agreed the detailed actions outlined to improve immunisation

performance. This resolution plan is led by the Immunisation Steering group which has delegated representative's from PHOs, Strategy and Funding, Population Health and the NIR.

High level activities being implemented under the Waikato Immunisation Resolution Plan include:

- Leadership – clear roles and leads across Waikato DHB and PHOs;
- Early enrolment of newborns primary care – newborn enrolment champions in each PHO (unenrolled babies have an imms rate of 65%);
- Service reconfiguration - NIR service team relocated back from MHN to Waikato DHB;
- Outreach Immunisation Services - reviewing opportunities for shared efficiencies and amalgamation;
- Missing events coordination – weekly teleconferences between PHOs, NIR and Outreach Immunisation Service using a traffic light system to immunise babies at risk of missing their immunisation milestones;
- Reduced declines - annual training for health professionals with best practice embedded; and
- Waikato Child Health Co-ordination Service - a key change that has been agreed is to move the Child Co-ordination Service managed by Midlands Health Network to a formal contract with KPIs and outputs to be agreed between the DHB and all PHOs to be jointly monitored.

Graph 5 - Waikato DHB's fully immunised rates for 8 month olds (rolling three month result)

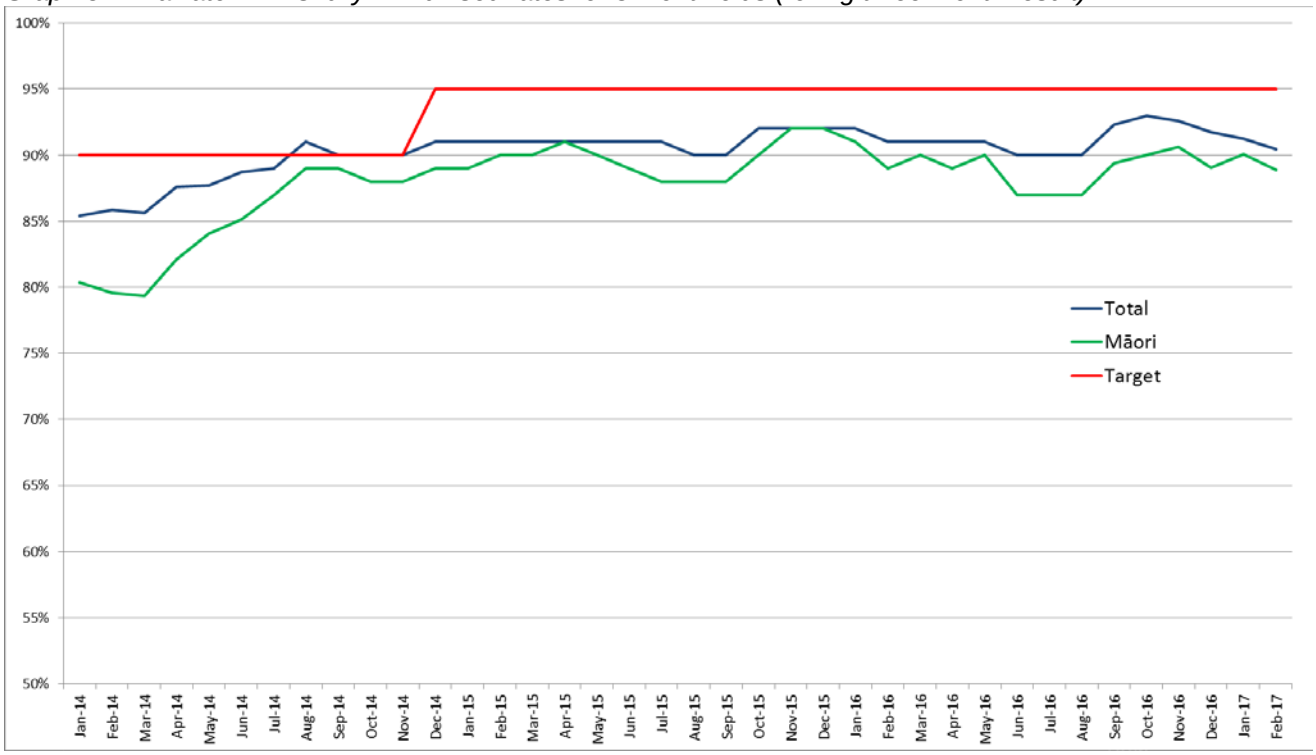


Table 6 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 52 additional children need to be immunised to meet the 95% target.

Table 6 - Waikato DHB 8 month old immunisations ethnicity breakdown from December 2016 to February 2017

Ethnicity	**Number Eligible**	**Fully immunised**	**Result**	**Increase needed to meet the target (95%)**
Asian	153	146	95%	
Māori	539	479	89%	34
NZ European	507	459	91%	23
Other	124	109	88%	9
Pacific	48	47	98%	
Total across ethnicities				64
Total	**1,381**	**1,260**	**91%**	**63**
Opt off			6	
Declined			75 (5.5%)	

Table 7 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 7 - Waikato DHB's PHO level results for 8 month old immunisation from December 2016 to February 2017

PHO	**Total population**			**Maori population**		
	No eligible population	*No fully immunised population*	*Percent immunised*	*No eligible population*	*No fully immunised population*	*Percent immunised*
Hauraki PHO	502	467	93%	248	228	92%
Midlands Health Network – Waikato	780	711	91%	252	226	90%
National Hauora Coalition	23	21	91%	8	7	88%
Not Enrolled with a Waikato DHB based PHO *	66	41	62%	31	18	58%
DHB Total	1,371	1,240	**90%**	539	479	89%

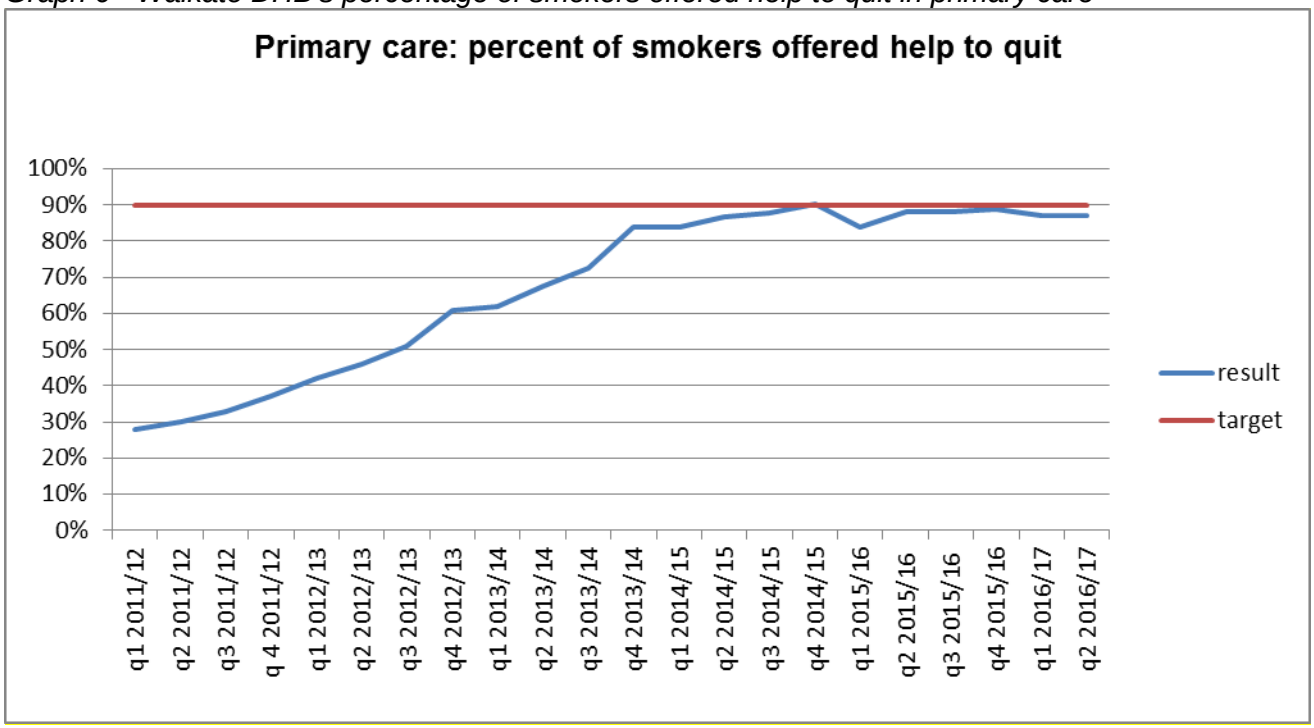
* Indicative splits based on prior quarters data of the children not enrolled with a Waikato based PHO are:
Enrolled with a PHO outside of Waikato = 33% (with immunisation rate of 88%)
No GP = 42% (with immunisation rate of 14%)
Has a nominated GP on the NIR but are not enrolled with a PHO = 25% (with an immunisation rate of 42%
A further breakdown of these splits will be provided in the Q3 results.

Target: Better help for smokers to quit - primary care

DHB Q4 result 13/14	DHB Q4 result 14/15	DHB Q4 result 15/16	**DHB Target 16/17**	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	**Most recent result Q2 16/17**
84% 10th ranking	90.4% 10th ranking	89% 8th ranking	**90%**	88% 7th ranking	88% 6th ranking	89% 8th ranking	87% 7th ranking	**87% 12th ranking**

Graph 6 of the quarter two final result of 87.0% shows Waikato DHB has remained steady from the previous quarter.

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



Communications are occurring with all PHOs in relation to this measure and actions needed to enable the target to be achieved by the end of 2016/17.

Table 8 shows a breakdown of primary care smoking results by PHOs for 2016/17 quarter two.

Table 8 – 2016/17 Q2 primary care smoking results by PHOs (target 90%)

PHOs	**Tobacco Numerator**	**Tobacco Denominator**	**2016/17 Q2 result**	**2016/17 Q1 result**	**2015/16 Q4 result**	**2015/16 Q3 result**	**2015/16 Q2 result**
Midlands Health Network	26,716	29,858	88%	88%	88%	87%	87%
Hauraki PHO	19,490	22,617	86%	86%	86%	90%	89%
National Hauora Coalition	1,168	1,365	86%	87%	92%	84%	84%
Total	47,050	54,283	**87%**	**87%**	**89%**	**88%**	**88%**

Target: Better help for smokers to quit - maternity

DHB Q4 result 13/14	DHB Q4 result 14/15	DHB Q4 result 15/16	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	**Most recent result Q2 16/17**
95.3% 10th ranking	91.2% 14th= ranking	95% 13th ranking	89% 15th ranking	97% 8th ranking	95% 13th ranking	93% 12th Ranking	**98% Q1 result 4th Ranking**

Graph 7 quarter one result of 98% shows we continue to met this target and Waikto has improved significantly up the rankings from the previous quarter.

Graph 7 - Waikato DHB's percentage of smokers offered help to quit in maternity

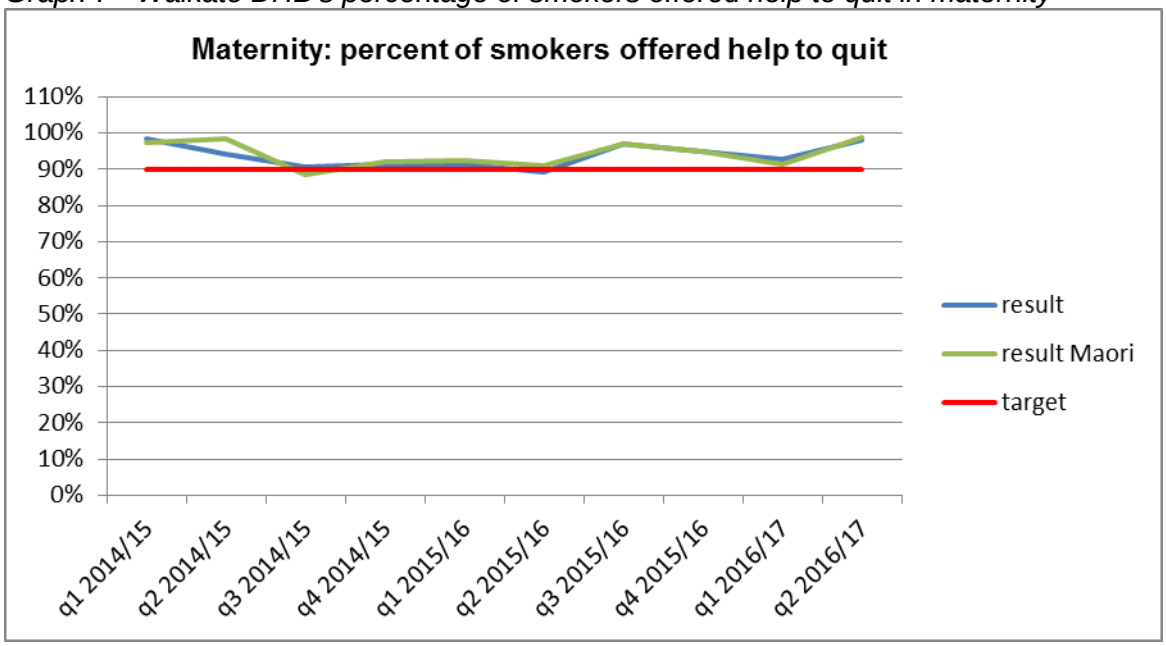


Table 9 shows our quarter two results provided by the Ministry for our total and Maori population.

Table 9 – 2016/17 Q2 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	164	73	72	39.4%	98.6%
Total	607	108	106	17.8%	98.1%

**Data comes from three sources: Midwifery and Maternity Providers Organisations (MMPOs), Lead Maternity Carers Services (LMCs) and from DHB employed midwives (if available)*[2]

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 age 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.

Our quarter one feedback from the Ministry stated that '*Waikato DHB has demonstrated strong leadership in addressing childhood obesity and are to be congratulated on their development of tools to assist healthcare workers to help whânau adopt healthy lifestyle change'.*

[2] 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.

The latest quarterly result is now 79% putting the DHB above the national average of 72%.

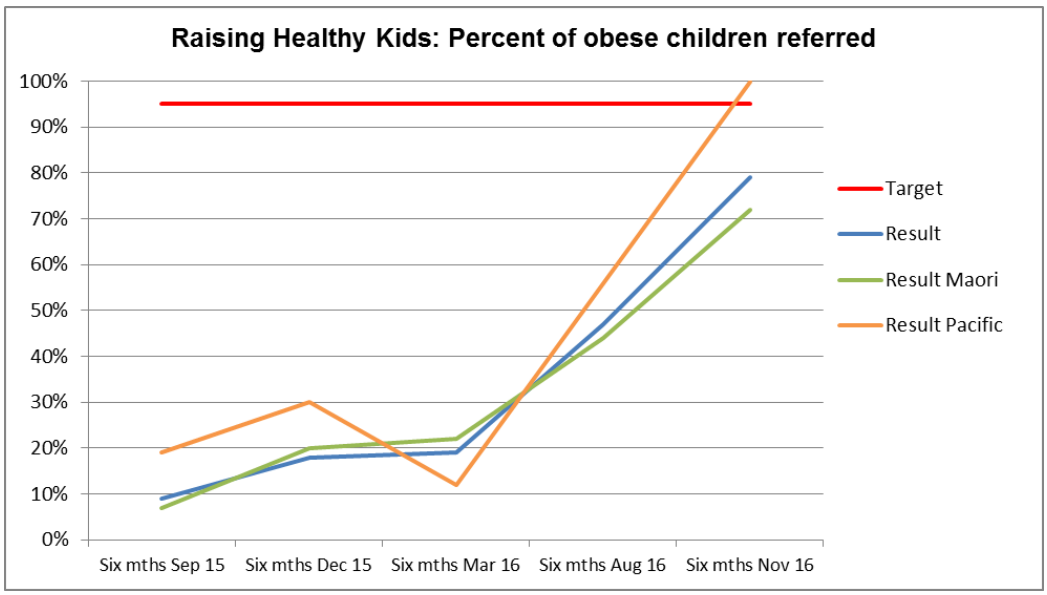
Locally the introduction of the target is led out by the Waikato Child Health Network chaired by our primary care clinical lead and GP Child health liaison doctor. The health target is just one part of both a national and district wide multifaceted approach to tackle child hood obesity including amongst 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 10 – 2016/17 Q2 Raising Healthy Kids Results (target 95%)

		Waikato DHB					National
		2015/16 Q2	**2015/16 Q3**	**2015/16 Q4**	**2016/17 Q1**	**2016/17 Q2**	**2016/17 Q2**
		Six mths Sep 15	**Six mths Dec 15**	**Six mths Mar 16**	**Six mths Aug 16**	**Six mths Nov 16**	**Six mths Nov 16**
Total	Referral Sent	13%	18%	23%	50%	82%	78%
	Referral Sent and Acknowledged	**9%**	**18%**	**19%**	**47%**	**79%**	**72%**
Maori	Referral Sent	12%	21%	30%	49%	76%	75%
	Referral Sent and Acknowledged	**7%**	**20%**	**22%**	**44%**	**72%**	**70%**
Pacific	Referral Sent	26%	30%	12%	56%	100%	86%
	Referral Sent and Acknowledged	**19%**	**30%**	**12%**	**56%**	**100%**	**77%**

Graph 8 - results for new 'raising healthy kids' health target



Data for a 6 month rolling period up to Nov 2016

Recommendation
THAT
The Board receives this report.

BRETT PARADINE
EXECUTIVE DIRECTOR
WAIKATO HOSPITAL SERVICES

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

SUE HAYWARD
DIRECTOR
NURSING AND MIDWIFERY

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY AND CLINICAL SUPPORT

MEMORANDUM TO THE BOARD
22 MARCH 2017

AGENDA ITEM 6.2

PROVIDER ARM KEY PERFORMANCE DASHBOARD

Purpose	For information.

The high level provider arm key performance dashboards for February 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
EXECUTIVE DIRECTOR
COMMUNITY &
CLINICAL SUPPORT

DEREK WRIGHT
EXECUTIVE DIRECTOR
MENTAL HEALTH

BRETT PARADINE
EXECUTIVE DIRECTOR
WAIKATO HOSPITAL
SERVICES

Key Performance Dashboard

Community & Clinical Support

February 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	95.1	95.0	0.1	95.8	95.0	0.8		
Number of long wait patients on outpatient waiting lists	# > 4 mths	0	0	0	0	0	0		
Number of long wait patients on inpatient waiting lists	# > 4 mths	0	0	0	0	0	0		
CTs reported within 6 weeks of referral	%	92.6	90.0	2.6	94.3	90.0	4.3		
MRIs reported within 6 weeks of referral	%	85.0	85.0	0.0	89.0	85.0	4.0		

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			33,786	33,726	(60)		
Elective Surgery Volumes vs Elective Health Target	% of target	Under development - see separate Elective Health Target Report							
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			84.2	87.7	(3.5)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			93.9	99.4	(5.5)		1
Laboratory – Histology specimens reported within 7 days of receipt	% for Jan YTD	25.0	80.0	(55.0)	44.6	80.0	(35.4)		2
Pharmacy - Chart turnaround times, % within 2.5 hours	%	92.0	80.0	12.0	92.9	80.0	12.9		
Pharmacy on Meade script turnaround time in minutes	minutes	6.9	10.0	3.1	6.9	10.0	3.1		
Outpatient DNA Rate	%	10.5	10.0	(0.5)	10.8	10.0	(0.8)		3
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	107.4	100.0	7.4	95.4	100.0	(4.6)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	95.6	100.0	(4.4)	93.0	100.0	(7.0)		4
Output Delivery Against Plan - Inpatient CWD Volumes	%	89.7	100.0	(10.3)	91.9	100.0	(8.1)		5
District Nurse Contacts (DHB Purchased)	Numbers	8,950	-	-	77,924				
District Nurse Contacts (ACC Purchased)	Numbers	1,862	-	-	16,113				
School Dental Service - Clients assessed and treated	Numbers	Under development							
Radiology - total imaging events	Numbers	Under development							
Lab - total tests	Numbers	Under development							
pharmacy - scripts processed	Numbers	Under development							
pharmacy - medications reconciled	Numbers	Under development							

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			3.58	3.78	0.20		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			0.98	0.96	(0.02)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			0.33	0.39	0.06		
DOM101 Avg Length of Stay	Days	Under development							

Quality and Patient Safety KPI measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	93.4	95.0	(1.6)	92.2	95.0	(2.8)		

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	3,699	3,000	699	26,574	27,000	(426)		
Breast screening Maori volumes - Waikato DHB	Numbers	174	305	(131)	1,656	2,122	(466)		6
Hospital Acquired MRSA (Department)	Numbers	0	0.0	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	Numbers	20	8	(12)	104	62	(42)		7
Complaints resolved within 20 wd (1 month lag)	% for Jan-17	82	70	12	71	70	1		
Falls Resulting in Harm	Numbers	2		(2)	17		(17)		
Pressure Injuries - Total	Numbers	15	14	(1)	96	119	23		
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	2,615	2,456	160	21,064	19,421	1,642		
Actual Expenditure vs Budget ($000s)	$000s	11,885	11,677	(209)	99,859	97,323	(2,537)		
Actual Contribution vs Budget ($000s)	$000s	(9,270)	(9,221)	(49)	(78,795)	(77,901)	(894)		
Actual FTEs vs Budget	FTEs	986.9	989.3	2.4	998.7	995.8	(2.9)		
Sick Leave	% of paid hours	2.4	2.1	(0.2)	2.9	2.8	(0.1)		
Overtime $'s	$000s	148	93	(55)	1,373	1,042	(332)		8
Annual Leave Taken	% of Budget	Rolling 12 month measure			92.6	100.0	(7.4)		9

Governance Indicators (for Service use only)

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Unacknowledged Results > 10 days	Numbers	Under development							

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: Community & Clinical Support, February 2017

Commentary on the current KPI report is given in the table below.

Note	Indicator	Commentary
1	Elective and Arranged Day of Surgery Admissions	Phenomenally good performance in Australasian terms. The KPI target requires resetting.
2	Laboratory – Histology specimens reported within 7 days of receipt	Actual specimens are triaged on the basis of clinical risk. Significant work has been done to successfully improve histology turnaround times. No concerns of significance are noted. The KPI target requires resetting to measure time critical histology only.
3	Outpatient DNA rate	No concerns of note.
4	Output delivery against plan – inpatient episodes	Lower than planned demand in general surgery and general medicine. This reflects (i) a deliberate service change to reduce acute surgical admissions (utilising Waikato instead) and (ii) the lack of influenza in the community in winter.
5	Output delivery against plan – inpatient cwd	Refer above. The average cwd per case for both acute and elective is consistent with the plan. The difference is due to the reduced volume not altered case-mix.
6	Breast Screening – Māori volumes	Increasing overall coverage by reducing unutilised appointment slots is being intensively managed by the service. The Service Agreement with TPO to uplift attendance by wahine has not been delivered at planned levels to encourage opportunistic screening due to staff vacancies.
7	Complaints	Overall: Community & Southern: 4; pharmacy 1; population health 1; screening 2, laboratory 2 (about one person); Thames: 9. An above average number of complaints received in relation to Emergency Department services at Thames during their peak summer period. Staff attitudes and clinical treatment are the main themes. Each is being investigated more fully.
8	Overtime $'s	No particular concerns are evident that have not been reported in prior periods.
9	Annual leave taken	No particular concerns are evident that have not been reported in prior periods. A rate of 92.6% is an exemplary result by national standards across all industries.

Key Performance Dashboard

Mental Health

February 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	83.8	95.0	(11.2)	88.9	95.0	(6.1)		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	400	371	(30)	7,953	2,966	(4987)		2
Mental health treatment plans	% Cases	90.2	95.0	(4.8)	91.7	95.0	(3.3)		
Mental health HoNos matched pairs	% Cases	98.9	95.0	3.9	98.4	95.0	3.4		
Mental health inpatient bed occupancy	%	93.9	87.1	(6.8)	92.6	87.1	(5.5)		3
Mental health GP methadone cases	Cases	96.0	76.0	20.0	93.3	76.0	17.3		

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	%	82.9	90.0	(7.1)	91.9	90.0	1.9		
Mental health follow up - numbers seen in 7 days	Number of Cases	34	36.9	(2.9)	464	454.5	9.5		
Mental health community contract positions filled	% FTEs	99.8	95.0	4.8	97.0	95.0	2.0		
Mental health 28 day readmission rate	%	12.2	15.0	2.8	12.3	15.0	2.7		

Quality and Patient Safety KPI 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	98.4	95.0	3.4		

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	3	7	4	62	55	(7)		4
Complaints resolved within 20 wd (1 month lag)	% for Jan-17	0	70	(70)	11	70	(59)		5
Falls Resulting in Harm	Numbers	2		(2)	9		(9)		

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	193	201	(7)	1,722	1,712	10		
Actual Expenditure vs Budget ($000s)	$000s	5,956	5,532	(424)	48,376	47,772	(604)		
Actual Contribution vs Budget ($000s)	$000s	(5,763)	(5,332)	(431)	(46,653)	(46,060)	(594)		
Actual FTEs vs Budget	FTEs	739.3	728.5	(10.9)	737.1	732.0	(5.1)		
Sick Leave	% of paid hours	2.8	2.3	(0.5)	3.3	3.0	(0.3)		6
Overtime $'s	$000s	67	76	9	628	605	(23)		
Annual Leave Taken	% of Budget	Rolling 12 month measure			88.8	100.0	(11.2)		7

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, February 2017

The following is a current state KPI dashboard for the directorate.

Note	Indicator	Commentary
1	Emergency Hours <6 hours	Mental Health and Addictions Services continue to complete monthly audits on all ED presentations not seen within the allocated time since April 2016. In February 84% of people were seen within the 6 hours. 68% of the presentations arrived after hours. This equates to 69 presentations to ED for mental health related conditions and 22 of these arrived between 8am and 5pm, with 47 arriving after hours. Of the 11 cases who breached, 9 of these were for overdose/ suicide presentations and 2 with psychotic presentations. 4 of the 11 individuals who breached, breached by 1-2 hours. There continues to be challenges with being able to see people who require medical clearance before being seen, caused by being too sedated (following overdose) to be seen within the timeframe. On nights where 2-3 people breached, there were more than the usual 1-2 people waiting to be seen. At night there is one registrar for the 118 mental health inpatient beds and work generated by the crisis team, police station and ED. There are two crisis clinicians on-call at night for the whole DHB district.
2	Seclusion	Overall seclusion hours were 400 with a target of 371. 12 individuals were secluded during the month of February, 10 within Adult wards and 2 within Forensic wards. 6 of the 12 users were Maori (4 adult, 2 forensic). Maori accounted for 28% (78% last month) of the time spent in seclusion. The longest seclusion episode lasted for 85 hours (110 hours last month), the shortest ~5 hours. Total hours spent in seclusion for the adult service was 352 hours. Total hours spent in seclusion for the Forensic service was 48 hours. For the adult service February continued to see a lower number of seclusion hours, compared with August 16-Dewcember 16, where seclusions hours peaked at 986 hours. The average number of hours spent in seclusion for the 10 adult service users was 35.19 hours, the average hours per incident being 21.99 indicating that a small number of individuals utilized seclusion more than once.

		As part of the National KPI project, Seclusion reduction is the key indicator that is being focused on nationally. In addition to the work that we are carrying out in the Seclusion Minimisation Steering Group, there are a number of additional actions for consideration: • A focus on offering PRN medication in advance of transfer for admission into the HRBC. • A focus of offering PRN medication at the time of admission. • Advanced plans for an individuals next admission following and admission where seclusion was required. This involves engagement with the individual and their treating community team in identifying actions which may prevent the use of seclusion in the future.
3	Occupancy	Occupancy on the adult wards (34,35,36) was 101%, with large numbers of individuals also going on short term leave, pushing the actual occupancy to 119%. The trend of the HRBC adult wards being 100% occupied or over continues and it is becoming increasingly difficult to manage the demand for beds in the physical facility that exists. Optimum occupancy for wards of this size would be 85%, an occupancy that has not been seen for well over a year. The forensic occupancy includes 2 alcohol and drug stabilisation beds, which are not always occupied at the weekend. Occupancy for these 50 beds was 87.5% without leave and 97.25% with leave. A number of service users also spend part of the week out of the inpatient beds as they transition (as per Ministry of Health requirements) to community facilities.
4 & 5	Complaints	We have four complaints that have gone over the 20 days, these were awaiting meetings and all four will be closed off this week.
6	Sick Leave	Sick leave was at 2.8% in February, with the ytd actual of 3.3%. this was a slight increase from 2.3% in January and may have been affected by the Flu outbreak in ward 34, where 8 staff were symptomatic and absent from work.
7	Contribution	Good performance to budget for February and increasing contribution to budget against target. As our FTE position continues to improve our ability to meet budged contribution remains unachievable. Whilst overtime was below budget in total, there are areas where overtime is being used extensively as the number of individuals requiring high risk observations (1 to 1 care 24/7) continue to drive demand for staff time.

Key Performance Dashboard

Waikato Hospital Services

February 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	83.3	95.0	(11.7)	85.2	95.0	(9.8)		1
Faster Cancer Treatment - Referral received to first treatment <= 62 days	% of patients	73.9	85.0	(11.1)	86.2	85.0	1.2		
Chemotherapy treatment < 4 Weeks Wait	% of patients	100.0	100.0	0.0	100.0	100.0	0.0		
Radiotherapy < 4 Weeks Wait	% of patients	100.0	100.0	0.0	100.0	100.0	0.0		
Number of long wait patients on outpatient waiting lists	# > 4 mths	173	0	(173)	2,304	0	(2304)		2
Number of long wait patients on OPRS outpatient waiting lists	Patients	0	0	0	0	0	0		
Number of long wait patients on inpatient waiting lists	# > 4 mths	147	0	(147)	712	0	(712)		3

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	%	77.3	85	(7.7)	75.8	85.0	(9.2)		4
Hospital initiated elective theatre cancellations	%	5.9	2.5	(3.4)	6.0	2.5	(3.5)		5
Waiting Time for acute theatre < 24 hrs	%	71.2	80	(8.8)	73.7	80.0	(6.3)		6
Waiting Time for acute theatre < 48 hrs	%	86.7	100	(13.3)	87.8	100.0	(12.2)		7

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			185.9		185.9		
Elective Surgery Volumes vs Elective Health Target	% of target	Under development - see separate Elective Health Target Report							
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			50.0	50.3	(0.3)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			74.8	81.2	(6.4)		8
Number of long stay patients (>20 days length of stay)	Discharges	46	50	4	486	399	(87)		9
Number of long stay patient bed days (>20 days los)	Bed Days	1,489	1,620	131	16,699	13,508	(3191)		10
Outpatient DNA Rate	%	10.0	10.0	(0.0)	9.9	10.0	0.1		
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	114.7	100.0	14.7	99.3	100.0	(0.7)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	110.0	100.0	10.0	98.8	100.0	(1.2)		
Output Delivery Against Plan - Inpatient CWD Volumes	%	103.5	100.0	3.5	98.5	100.0	(1.5)		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Presentation to ED < 14 Days after discharge as an Acute InPatient	%	Under development							
Acute Readmissions to Hospital	%	Rolling 12 month measure			8.9	8.5	(0.4)		
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			4.15	4.01	(0.14)		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			2.07	2.00	(0.07)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			1.09	1.14	0.05		

Quality and Patient Safety KPI measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	94.2	95.0	(0.8)	95.6	95.0	0.6		

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 Jan-17	96.3	90.0	6.3	95.0	90.0	5.0		
Compliance with good hand hygiene practice (WDHB Rate)	%	84.6	80.0	4.6	85.9	80	5.9		

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	90	69	(21)	579	554	(25)		
Complaints resolved within 20 wd (1 month lag)	% for Jan-17	61	70	(9)	60	70	(10)		11
Falls Resulting in Harm	Numbers	15		(15)	121		(121)		

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	9,373	9,448	(75)	77,985	75,932	2,054		
Actual Expenditure vs Budget ($000s)	$000s	36,391	34,518	(1,873)	292,844	281,655	(11,189)		
Actual FTEs vs Budget	FTEs	3,086.4	3,071.3	(15.1)	3,093.9	3,095.5	1.6		
Sick Leave	% of paid hours	2.6	2.5	(0.2)	2.9	3.0	0.0		
Overtime $'s	$000s	462	238	(224)	3,559	2,119	(1,440)		12
Annual Leave Taken	% of Budget	Rolling 12 month measure			86.6	100.0	(13.4)		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	

KPI Report: Waikato Hospital Services, February 2017

Notes re Operational Plan Items.

Note	Indicator	Commentary
1	Emergency Department < 6 hours	This target continues to remain challenging for the DHB. February saw the non-admitted pathway delivering 91% whilst the admitted pathway achieved 71%. The ED team are focused on improving the non-admitted pathway performance, which is discussed and monitored on a daily basis at the ED operations meeting with the EPIC (Emergency Physician in Charge) and the Nurse in Charge of the day's shift. Four interview times and dates have been arranged in February for SMO interviews, in order to fit in with the various time zones of the international applicants. Recruitment to additional RN posts is progressing well, but there have been a number of resignations due to the on-going operational pressures. All acute specialties have been offered the opportunity to apply the newly developed acute flow dashboard to understand their breaches and develop plans to improve performance. The Acute Patient Governance group will be the forum for monitoring specialty actions to improve current performance against the admitted pathway. Failure to do so will be escalated to the Waikato Hospital Leadership group. A Full Capacity Protocol has been introduced to assist with additional temporary bed provision during times of pressure. There remains some operational issues with implementing this protocol, but once successfully embedded it should assist at times of peak demand.
2	Long wait patients on outpatient waiting lists	Work continues on this on a daily basis with a number of specialities, against the MOH ESPI2 target with initiatives in managing inflows, recruitment and implementation of the orthopaedic action plan well underway. A new spinal surgeon has commenced however our new foot & ankle surgeon has been delayed from April till May as we work with MCNZ in supporting her registration. An additional locum general orthopaedic surgeon is also due to start by July, depending on the time needed for MCNZ approval. Funding is not at risk as a result of ESPI2 performance as long as we achieve compliance for orthopaedic services by April; we are projected to be ESPI2 compliant by this date.
3	Number of long wait patients on inpatient waiting lists	Meeting this target continues to be challenging with significantly reduced elective operating theatre capacity as a result of anaesthetic RMO vacancies and demand increase putting pressure on anaesthetic SMO numbers. We did not achieve compliance in February – the third month of noncompliance. Again the issues are primarily restricted to orthopaedics subspecialties. With two new orthopaedic sub-speciality surgeons recruited, and a general orthopaedic surgeon starting by July, planning is underway to right size anaesthetic capacity. In the meantime we have been accessing outsourced capacity and facility lists across a number of specialities; this may be slightly more than planned due to the May start date of one new surgeon. Ongoing monitoring continues, as well as forward planning to ensure that the waitlist acceptance volumes match the capacity.

Note	Indicator	Commentary
		Plans are in place to achieve ESPI5 compliance for March, however risk remains around the orthopaedics result. Following the impact of two junior doctors strikes this risk, is shared by a number of DHBs.
4	Theatre Utilisation – Elective Sessions	This remains an area of concern. While this will improve with the internal capacity restrictions related to delay in arrival of subspecialty orthopaedic surgeons, the deficit in budgeted anaesthetic resource will continue to adversely affect this marker. Planning has started to examine the sustainable resource required to better utilise the capacity within our operating room suite to deliver next year's plan.
5	Hospital Initiated elective theatre cancellations	This KPI requires further analysis as part of the pre hospital preparedness project but is being hampered by the small amount of data and the delay in proposed change to the collection of data via IPM. The paper based audit of reasons for cancellations is still being analysed to understand where further improvement can be gained. Stage 3 of the pre hospital preparedness project has been successfully implemented in the orthopaedic service. Stage 4 which involves implementation for Plastics, Ophthalmology and Endoscopy has been delayed till May pending analysis of the data.
6	Waiting time for acute theatre less than 24 hours	Slight plateauing of this result this month; the establishment of a group to determine the reasons for this and also develop a business case with some options to address this is yet to gain traction but will be a focus over the next month.
7	Waiting time for acute theatre less than 48 hours	Slight plateauing of this result this month; the establishment of a group to determine, the reasons for this and also develop a business case with some options to address this is yet to gain traction but will be a focus over the next month.
8	Elective and arranged day of surgery admissions	Every case bought in prior to surgery is reviewed to ensure, where possible, admission occurs on the day of surgery. This measure will be enhanced as rollout of the Pre-Hospital Preparedness Project continues and more services are brought on board.
9	Number of long stay patients (> 20 days length of stay)	A DHB wide discharge initiative is being planned, led by the Executive Director Operations and Performance with involvement from the Director of Medicine, Oncology, ED and Ambulatory Care and the Director of OPR and Allied Health. This programme includes emphasis on long stay patients, which has been enhanced with weekly reporting to the capacity and demand management forum and higher scrutiny of long stay reasons. There has been some improvement in recent months, however, YTD still higher than target.
10	Number of long stay patient bed days	As per item 9. A DHB wide discharge initiative is being planned, led by the Executive Director Operations and Performance with involvement from the Director Internal Medicine, Oncology, ED & Ambulatory Care and the Director OPR & Allied Health.
11	Complaints resolved within 20 working days	Performance on resolving complaints for surgery and CCTVS (one of the areas with the largest volume of complaints) remains challenging; as of 10 March 22% of their complaints are >20 days. Focused work on clearing this is underway with an expectation of compliance by May. Medicine, Oncology, ED and Ambulatory care are on top of their complaint responses, with the only ones not resolved within 20 working days being due to issues with arranging family meetings that have been requested and arranged as part of the complaints resolution process. For OPR& Allied Health achievement was 100% of complaints responded to within 20 days. Child Health achieved 100% compliance in complaints responded to within 20 days.
12	Overtime $'s	Overtime for the month was significantly lower than the year to date trend. Both Ambulatory services and ED delivered improved performance in

Note	Indicator	Commentary
		month, whilst Internal Medicine had a slightly higher rate, principally due to the need to cover key internal vacancies. The Surgical and Critical Care directorate also continues to experience pressure on overtime which is being closely monitored. The upward spike this month occurred as a result of high levels of escalation lists required over the holiday used to clear acute load and as cover due to the shortage of Anaesthetic Registrars. Overtime in Older Persons, Rehabilitation (OPR) and Allied Health is minimal and reflects unrelieved meal breaks in the Continuing Care facilities and some on call time for allied health. Minimal overtime paid within Child Health. Overtime in Women's Health required due to current vacancies in Midwifery and Medical staffing.
13	Annual leave taken	While the ambitious target of 100% of annual leave being taken within year was not met, there was as planned a high level of leave taken over the December/January period. That helped to produce the year to date result of 86.6%, which is very high by historical standards. Critical Care and Operating Theatre Suite continues to trend upwards as a result of pushing leave balance reduction and ensuring rosters have full allocation of leave where possible. 100% annual leave taken for Allied health, 86% for OPR. OP&R services continue to focus on leave reduction and plans to ensure leave is taken with staff holding high leave balances. Child Health are actively managing high annual leave balances. Difficult to address with the currently staffing levels in Women's Health.

MEMORANDUM TO THE BOARD
22 MARCH 2017

AGENDA ITEM 6.3

STRATEGY & FUNDING KPI DASHBOARD

Purpose	For information.

The Strategy & Funding KPI dashboard is attached as Appendix A. Items updated are noted on the dashboard and items noted as having negative variances have a commentary provided excluding items already reported on within the health target report.

A revised indicator set will be prepared for discussion at the April Committee meetings along with recommendations around frequency of updates. This is expected to include additional reporting on key areas of:

- System level measures
- Smoking cessation (referrals, enrolments and successful quits)
- B4 school
- Oral health
- Measures around the enrolment in primary care.

Existing measures will also be reviewed as part of the update to ensure that the listed indicators from Strategy and Funding do not duplicate items in the dashboards from other divisions

Recommendation
THAT
The report be received.

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY & FUNDING

Strategy and Funding KPI Dashboard

Note	Indicator	Commentary
1	Proportion of older people waiting greater than 20 days for assessments or reassessment	This is a quarterly indicator that has not yet been updated with data for the Jan-Mar quarter however interim results indicate the expected efficiency gain is beginning to be achieved. The table below demonstrates the improvement in the timeliness of initial assessments undertaken in February. January data is being reviewed for accuracy.
2	Cervical Screening	Information from the national screening programme has been released based on ethnicity and shows small but consistent improvements over the last few years.
3	2 year old immunisations	Latest 24 month coverage result is 92% (target 95%) which is the same as the prior period. The 3% point gap represents 38 children not immunised on time. For children aged 24 months, this quarter the highest coverage was for Asian children (98%) and lowest for Other (not Maori, Pacific, NZ European, Asian) (86%). Our latest results also show little disparity between NZ European and Maori for this cohort by 24 months (Maori at 92%). This measure is a contributory measure in the recently signed off Service Level Measure for ASH rates for 0-4 year olds.

Appendix A **Strategy and Funding KPI RESULTS**

Strategy and Funding - Key Performance Dashboard

February 2017

Health Targets

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Quarter Actual	Target	Variance		Trend
CVD risk assessments	%	↑	Jul-Sep16	No	93%	90%	3%	✓	92%	90%	2%	✓	
8 month old immunisations	%	↑	Rolling 3 months	Yes	90%	95%	-5%	✗	91%	95%	-4%	!	
Better help for smokers to quit (primary care)	%	↑	Dec-16	No	87%	90%	-3%	!	87%	90%	-3%	!	

Finance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Month Actual	Target	Variance		YTD Actual	Target	Variance		Trend
IDF inflow estimate	$		Feb YTD	Yes	10,381	10,993	-612	✗	85,503	87,944	-2,441	!	
IDF outflow estimate	$		Feb YTD	Yes	4,600	4,559	41	!	37,784	36,472	1,312	!	

Other Performance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Period Actual	Target	Variance		Trend
AOD waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Oct 16	No	77%	80%	-3%	!	77%	80%	-3%	!	
MH waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Oct 16	No	81%	80%	1%	✓	82%	80%	1%	✓	
AOD waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Oct 16	No	94%	95%	-1%	!	94%	95%	-1%	!	
MH waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Oct 16	No	94%	95%	-1%	!	94%	95%	-1%	!	
Proportion of Health of Older people initial needs assessments Waiting greater than 20 days	%	↓	Oct-Dec 16	No	38%	0%	-38%	✗	29%	0%	-29%	✗	
Proportion of health of older people need re-assessments Waiting greater than 20 days	%	↓	Oct-Dec 16	No	8%	0%	-8%	✗	8%	0%	-8%	✗	
Proportion of older person funding in community based services	%	↑	Dec YTD	No	26%	25%	1%	✓	27%	25%	2%	✓	
Pharmacy Items claimed	Items		Jan-17	Yes	497,942	N/A			555,129	N/A			
Laboratory turnaround tmes	%	↑	Jul-Sep16	No	100%	97%	3%	✓	100%	97%	3%	✓	
Primary options referrals	Referrals				These areas will be reported in the future once expected volumes are seasonalised/targets set								
	%												
Breast Screening (total eligible population)	%	↑	Dec-16	No	67%	70%	-3%	!	66%	70%	-4%	✗	
Cervical screening (total eligible population)	%	↑	Oct - Dec 16	Yes	77%	75%	2%	✓	76%	75%	1%	✓	
Cervical screening (High Need)	%	↑	Oct - Dec 16	Yes	68%	75%	-7%	✗	69%	75%	-6%	✗	
2 year old immunisations (total population)	%	↑	Rolling 3 months	Yes	92%	95%	-3%	!	92%	95%	-3%	!	
2 year old immunisations (Maori)	%	↑	Rolling 3 months	Yes	92%	95%	-3%	!	92%	95%	-3%	!	
Green Prescriptions	%	↑	Oct - Dec 16	No	1,404	1,675	-271	✗	1,708	1,675	33	✓	

Ambulatory Sensitive Admissions - Rates per 100,000 Population

Indicator	Unit	⇵	Data period	Updated from prior report	YT Sep 2016 result				YT Jun 2016				
Ambulatory sensitive admissions 0-4	rate	↓	YT Sep 2016	N	7477	7298	-179	!	7668				New ASH Definitions
Ambulatory sensitive admissions 0-4 (Maori)	rate	↓	YT Sep 2016	N	8538	7936	-602	✗	8898				New ASH Definitions
Ambulatory sensitive admissions 45-64	rate	↓	YT Sep 2016	N	4089	3936	-153	!	4177				New ASH Definitions
Ambulatory sensitive admissions 45-64 (Maori)	rate	↓	YT Sep 2016	N	7758	5838	-1920	✗	8104				New ASH Definitions

Key	
At or above target	✓
Below target by less than 5%	!
Below target by more than 5%	✗

Waikato District Health Board

Planning

Waikato District Health Board

Waikato DHB Position Statements and Policies

MEMORANDUM TO THE BOARD
22 MARCH 2017

AGENDA ITEM 8.1

WAIKATO DHB MANAGEMENT OF POLICIES AND GUIDELINES POLICY

Purpose:	For approval.

The purpose of this policy is to guide Waikato District Health Board staff in the:

- Preparation of new clinical and non-clinical policies, procedures, protocols, clinical pathways and guidelines.
- Review of existing policies and guidelines.
- Endorsement and publication of policies and guidelines.

The Board of Clinical Governance received a report at their March meeting with regard to a number of changes and improvements to the management of policies and guidelines in the DHB, this included decision making around approval and endorsement processes and additional support for clinical guideline facilitators.

A list of policies currently endorsed by the Board is attached for information.

Recommendation
THAT
The Board approves the Waikato DHB Management of Policies and Guidelines Policy.

MO NEVILLE
DIRECTOR OF QUALITY AND PATIENT SAFETY

Management of Policies and Guidelines

Policy Responsibilities and Authorisation

Department Responsible for Policy	Quality and Patient Safety
Position Responsible for Policy	Policy Coordinator
Document Facilitator Name	Tony Haigh
Document Owner Title	Director of Quality and Patient Safety
Document Owner Name	Mo Neville
Target Audience	All staff
Committee Approved	Policy Committee
Date Approved	25 August 2016
Committee Endorsed	Board of Clinical Governance
Date Endorsed	21 December 2016
Committee Endorsed	Waikato DHB Board
Date Endorsed	22 March 2017

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Policy Review History

Version	Updated by	Date Updated	Summary of Changes
06	Tony Haigh	May 2016	Policy rewritten as part of developing new policy and guideline system (on intranet) and processes.

Management of Policies and Guidelines

Contents

1. Introduction

1.1 Purpose

The purpose of this policy is to guide Waikato District Health Board (Waikato DHB) staff in the:

- preparation of new clinical and non-clinical policies, procedures, protocols, clinical pathways and guidelines (hereafter referred to as 'policies and guidelines'). Where this does not include policies, this will be referred to as 'guidelines et al'
- review of existing policies and guidelines
- endorsement and publication of policies and guidelines

1.2 Background

Waikato DHB policies and guidelines advise and guide clinical and non-clinical staff, patients and visitors on clinical procedures, administrative procedures and compliance with legislative, regulatory and professional requirements.

1.3 Scope

This policy applies to all Waikato DHB employees and Board members.

1.4 Exclusions

This policy does not cover the management of Waikato DHB standing orders or Lippincott procedures. The management of these documents is covered in *Standing Orders – Process and Documentation* procedure (2524) and *Management of Lippincott Procedures* policy (1236).

This policy does not cover the management of Map of Medicine pathways.

2. Definitions

Best Practice	Sackett (1996)[1] described evidence-based practice as a bottom-up approach that integrates the best external evidence with individual clinical expertise and patient choice. Best practice refers to practices and processes known, through research evidence or benchmarking, to be the most effective in the circumstances. Best practice within Waikato DHB is determined within the confines of Waikato DHBs resource prioritisation processes.
Clinical Pathways	A procedure, protocol or guideline (as below) but designed specifically for when a Clinical Pathway is the primary focus of the document.
Controlled Document	Any document that requires approval by an authorised person within Waikato DHB as being a fit and proper document (e.g. policy, procedures, protocols and guidelines) for the purpose intended by the organisation.
Document Facilitator	The person is identified through a role title and must represent a permanent role. The document facilitator is delegated responsibility by the document owner to develop or revise a policy or guideline. The document facilitator may in some instances be the document owner or be in the best position to identify the appropriate document owner. The document facilitator will have the appropriate knowledge, expertise and experience to determine that the content of the document is based on current best practice and literature, legislation and standards compliance. The document facilitator is responsible for facilitating the development, consultation and authorisation process and to ensure there is a system in place to communicate and educate staff about new or revised documents.
Document Owner	The person with overall responsibility for the content of the document and is responsible for the area of practice that the policy/guideline pertains to (i.e. is in a position of responsibility within that area of practice). The document owner is responsible for ensuring the document is reviewed by the due date.
Drug Guideline	A guideline (as below) but designed specifically for when a medication is the focus of the guideline.
Guideline	A guideline is a systematically developed statement of principles and/or best practice to be used in specific circumstances. Staff are advised to be guided by these, and while compliance with guidelines is not mandatory, the rationale for not following a guideline must be documented, either in the patient's clinical record or to the manager or clinical leader as appropriate.
Lippincott Procedure	A point-of-care procedure guide based on best evidence to assist nurses, midwives and clinicians in providing safer and more effective care. It is mandatory for staff to follow a Lippincott Procedure unless there is a good reason for not doing so, and this reason is documented to the manager or clinical leader at the time the procedure is not followed.
Map of Medicine	Map of Medicine is an internationally recognised web-based software tool that has evidence based clinical care pathways covering all major areas of healthcare.

[1] Sackett D, Rosenberg W, Gray JAM, Haynes RB, Richards S. Evidence based medicine: what it is and what it isn't. BMJ 1996;312:71-72

Policies and Guidelines	A collective term for policies, procedures, protocols, clinical pathways, guidelines and drug guidelines.
Policy Coordinator	The policy coordinator is responsible for managing the *Finding policies and guidelines* pages of the intranet, uploading policies and guidelines when they have been through the appropriate authorisation process and advising document owners and facilitators through the appropriate processes. The policy coordinator will also prompt when policies and guidelines are due for update.
Policy	A policy is a systematically developed document based on legislation, standards, regulations and/or Waikato DHB requirements. It is mandatory for all Waikato DHB employees to comply with Waikato DHB policies.
Procedure	A procedure is a written set of instructions conveying the approved and recommended steps for a particular act or series of acts. It is mandatory for staff to follow a Waikato DHB procedure unless there is a good reason for not doing so, and this reason is documented to the manager or clinical leader at the time the procedure is not followed.
Protocol	A descriptive practical guide, developed through research and expert opinion, on management of a typical clinical case in a typical situation. It is mandatory for staff to follow a Waikato DHB protocol unless there is a good reason for not doing so, and this reason is documented in the patient's clinical record at the time the protocol is not followed.

3. Policy Statements

- Waikato DHB will operate a policy framework that ensures the:
  - implementation of effective governance
  - provision of safe and effective clinical care
  - provision of effective and efficient service delivery
  - provision of a safe work place.
- The recognised current version of Waikato DHB policies and guidelines is the copy available from the *Finding policies and guidelines* page of the intranet.
- Waikato DHB policies and guidelines will be
  - available to all staff via the intranet
  - dated, version controlled and reviewed on a regular basis.

4. Management of Policies and Guidelines

4.1 Roles and Responsibilities

All Staff

- Will know how to access Waikato DHB policies and guidelines via the intranet.
- Will be familiar with key policies and guidelines relevant to their area of practice or to the DHB as identified by their manager, e.g. all staff will be familiar with the 'Leave' policy.

Clinicians

- Will be familiar with key service specific policies and guidelines developed by their service relevant to their area of practice, e.g. all clinical staff will be familiar with the Clinical Records Management Policy.

Managers

- Will ensure their staff know how to access Waikato DHB policies and guidelines via the intranet.
- Will ensure their staff are familiar with all relevant DHB policies and guidelines e.g. Clinical Records Management Policy, Medicines Management, Incident Management.
- Will ensure their staff are familiar with all service specific policies and guidelines developed by their service.

Document Owners

- Will have overall responsibility for the content of a policy or guideline.
- Will provide leadership and direction on behalf of the organisation or service regarding the content of the policy or guideline.
- Will ensure the policy or guideline is a key part in or is essential to current or future work.
- Will delegate responsibility for developing or revising a policy or guideline as required.
- Will be responsible for authorising the development of new policies or guidelines.
- Will ensure appropriate and sufficient consultation and review has taken place where documents are issued by their service.
- Will ensure there is a system in place to communicate to staff about new, revised and withdrawn policies and guidelines.
- Will be responsible for developing an implementation plan for the policy or guideline.
- Will ensure their current policies and guidelines are reviewed prior to the review date.
- Will ensure the content of their policies and guidelines is kept up to date.
- Will hand over management of the policy or guideline when they change roles or leave the organisation.
- Will consider the pathway for general disposal based on minor or significant categories of their policy or guideline as per District Health Board General Disposal Authority (*see 4.12 below*).

Document Facilitators

- Will coordinate the development of the policy or guideline on behalf of the document owner.
- Will ensure the policy or guideline is on the correct template.
- Will identify the appropriate subject matter experts involved in the development and review of the policy or guideline.
- Will discuss the document with the key service stakeholders during the development process which may include presenting to their clinical governance forum/governance process groups.
- Will be responsible for updating the Policy Review History table when the document is reviewed or revised.
- Will supply the policy coordinator with the final policy or guideline and signed approval form via internal mail.
- Will supply the policy coordinator with an electronic copy of the final policy or guideline via email.
- Will complete the appropriate report cover sheet where a policy or guideline requires endorsement by the Waikato DHB Board, Executive Group (EG) or Board of Clinical Governance (BoCG).

Policy Coordinator

- Will ensure all approved and endorsed policies and guidelines are uploaded to the intranet.
- Will ensure all policy and guideline templates and forms are available from the intranet
- Will coordinate the consultation of DHB wide policies and guidelines.
- Will be responsible for updating the Policy Review History table when the document is extended.
- Will ensure document owners and facilitators are advised when their policies and guidelines are due for review within six months for DHB-wide policies and guidelines and three months for others.
- Will manage the agenda of the Waikato DHB policy committee.
- Will guide document facilitators through the development, review and authorisation process.
- Will maintain original signed copies off all current policies and guidelines and archive superseded and withdrawn policies and guidelines.
- Will be the main administrator for the Policies and Guidelines intranet page.
- Will provide metrics in relation to Policies and Guidelines as requested.

Policy Committee

- Will ensure that policies and guidelines are fit for purpose for use within the Waikato DHB including the cost impact on the Waikato DHB.
- Will be the final body to rigorously critique and recommend authorisation of Waikato DHB policies, procedures, protocols and guidelines to the Waikato DHB Board, EG or BoCG where such authorisation is required.

- Will confirm the pathway for general disposal based on minor or significant categories of policy or guideline as per District Health Board General Disposal Authority (GDA) as identified by the document owner (*see 4.12 below*).

Pharmacy

- Will review all new and revised drug guidelines and standing orders to ensure they are appropriate and meet current legislation, drug regulations and Waikato DHB standards.

Chairperson Medicines and Therapeutics (M&T) Committee

- Will authorise all drug guidelines and standing orders for use within Waikato DHB on behalf of the M&T Committee.

4.2 Levels of Policies and Guidelines

Policies and guidelines at Waikato DHB can be in one of the following categories:

Level 1:	Waikato DHB Wide policies and guidelines – relate to all or a majority of Waikato DHB staff, e.g. Human Resources and Health & Safety policies
Level 2:	Group wide guidelines et al - relate to groups of services, e.g. Mental Health, Allied Health, Rural Hospitals
Level 3:	Clinical management guidelines et al - relate to an individual service or area, e.g. PACU or Oral Health.

Note: All policies will be considered level 1 documents. Procedures, protocols and guidelines may be level 1, 2 or 3 as appropriate.

4.3 Ownership of Policies and Guidelines

The minimum level of ownership of policies and guidelines will be as follows:

Level 1:	Member of Waikato DHB Executive Team
Level 2:	Director of relevant group of services Associate director of nursing or midwifery Clinical Unit Leader
Level 3:	Clinical Director Nurse Manager Service Manager

4.4 Distribution of Policies and Guidelines

- All current Waikato DHB policies and guidelines will be available from the Finding policies and guidelines page of the Waikato DHB intranet.
- All policies and guidelines will be on approved Waikato DHB templates.
- The version of the policy or guideline on the Finding policies and guidelines page of the intranet is deemed to be the official current version.
- Printed policies and guidelines are deemed to be valid only for the day of printing.
- Overdue versions of policies and guidelines are deemed to be 'in force' until such time as they are either superseded or withdrawn. Please refer to *4.5 Overdue policies*.

4.5 Overdue Policies

- Overdue policies and guidelines will be removed from the intranet if not superseded one (1) year after their review date unless permission is granted from the Board of Clinical Governance (BoCG) or Executive Group.
- Overdue policies and guidelines will remain accessible from the policy coordinator upon request.
- Overdue policies and guidelines will be withdrawn and archived if not superseded three (3) years after their review date.

4.6 Review of Policies and Guidelines

- When a policy or guideline is due for review, there are three options:
  i) Review - revise and review the document as per process.
  ii) Withdraw – if the document is no longer required, it may be withdrawn. Withdrawal of a document must be authorised by the document owner.
  iii) Extend – a one-off extension is available to Level 1 documents in exceptional circumstances, approved by the BoCG or Executive Group, where a policy or guideline is dependent on the release/publication of new/revised legislation, regulations or standards.

- The document facilitator will receive a system generated email at the following times advising that their policy or guideline is due for review:

	First Email (time before review date)	Second Email (time before review date)	Third Email (time before review date)
DHB-Wide	6 months	3 months	1 month
Clinical Management	3 months	2 months	1 month
Drug Guidelines	3 months	2 months	1 month
Standing Orders	3 months	2 months	1 month

- The third system generated email will also be sent to the document owner.

4.7 Reissue with minor changes

- It may become necessary to make minor changes to a policy or guideline prior to the review date. The document may by re-issued without going through the full consultation and authorisation process.
- A re-issue with minor changes will increase the version number and update the issue date.
- A re-issue with minor changes will not change the review date of a policy or guideline.
- A re-issue with minor changes cannot be requested on an overdue policy or guideline. A reissue with minor changes is not required to insert or correct a hyperlink or reference in a policy or guideline

4.8 Extending a Level 1 document

- In exceptional circumstances it may become necessary to extend the currency of a policy or guideline where a policy or guideline is dependent on the release/publication of new/revised legislation, regulations or standards.
- An one-off extension will need to be approved by the BoCG or Executive Group and will extend the currency period of a policy or guideline for a period not exceeding one (1) year.

4.9 Consultation

- Relevant committee consultation should take place prior to being sent for wider consultation. These include Clinical Records, Medicine and Therapeutics, Restraint, Infection Control and Patient Safety committees.
- All Waikato DHB wide policies and guidelines will be sent out for consultation via email to all relevant staff, committees, external unions and specified interest groups.
- The document owner and document facilitator can supply additional names of whom they would like to be part of the consultation process.
- Consultation will be no less than two (2) weeks and no more than three (3) weeks.
- All feedback will be directed to the document facilitator or their delegate for collation and review.
- All feedback will be recorded on the Consultation Feedback Record.

4.10 Approval and Endorsement

- All Waikato DHB wide (Level 1) policies and guidelines will be presented to the Waikato DHB Policy Committee for final review.
- Waikato DHB Policy Committee will recommend endorsement of Waikato DHB-wide policies and guidelines by the Waikato DHB Board, Executive Group (EG) or Board of Clinical Governance (BoCG) where such authorisation is required.
- There are a number of key Waikato DHB policies that must be endorsed by the Waikato DHB Board as part of the authorisation process. The policies requiring Waikato DHB Board endorsement are listed in Appendix A.
- All one-off extensions will need approval from the Executive Group (EG) or Board of Clinical Governance (BoCG).
- All policies or guidelines submitted for endorsement will require the completion of the appropriate report cover sheet for that group or board.

4.11 Publication of Documents

- When final endorsement has been received, the document facilitator or delegate will send the signed approval form and final copy of the policy or guideline to the policy coordinator.
- The policy coordinator will upload the policy or guideline to the intranet.

4.12 Storage and archiving

- Signed original paper copies of all current policies and guidelines will be retained by Quality and Patient Safety.
- Superseded and withdrawn policies and guidelines will be archived in accordance with the District Health Boards General Disposal Authority. (In Policy and Procedure Records, Section 16, page 43).
- Electronic copies of all current, superseded and withdrawn policies and guidelines will be stored in SharePoint.

4.13 Externally developed policies and guidelines

In some cases, Waikato DHB will adopt policies or guidelines developed by external parties, either nationally or regionally (Midland DHBs).

- Externally developed policies and guidelines will require a Waikato DHB reference number, document owner and document facilitator.
- Externally developed policies and guidelines will go through the Waikato DHB consultation process and will then be endorsed by either the Board of Clinical Governance or the Executive Group.
- All externally developed policies and guidelines that are to be entered onto the policies and guidelines intranet will have a DHB front cover to show the required information identified above.

4.14 Publication of policies and guidelines on service specific intranet pages

Where a service or department wants to make a Waikato DHB policy or guideline available via their own service or area specific intranet page:

- The document will be developed as a formal policy or guideline using the process defined in this policy
- When published, the policy or guideline will be hyperlinked from the '*Finding policies and guidelines*' page of the intranet to the service specific page. Waikato DHB policies or guidelines will not be uploaded directly to individual intranet pages.

4.15 Publication of policies and guidelines to the internet

- All Waikato DHB policies and guidelines, including clinical management (service specific) documents will be published on the Waikato DHB website.
- Drug guidelines and standing orders will not be published on the intranet
- Any service or area wanting to withhold their policies and guidelines from the intranet will require approval from the Director of Quality and Patient Safety.

5. Policy Processes

5.1 Developing a New Policy or Guideline

5.1.1 Identify the need for a policy or guideline

A policy or guideline is needed if it:

- promotes lean efficient standardised processes.
- supports quality and patient safety – patient, staff, environment.
- is required for compliance with legislation or standards.
- meets unmet need identified from:
  - external review findings
  - incidents, complaints or reviews
  - audit recommendations and corrective actions
  - coroner's findings
  - Health and Disability Commissioner reports
  - quality improvement initiatives
  - recognised risks

5.1.2 Check if a similar policy or guideline already exists

This should involve reviewing Waikato DHB policies and guidelines, Lippincott Procedures and Map of Medicine. The development of new service-specific policies and guidelines are discouraged where the organisation would benefit from these being DHB-wide and it increases standardisation across the organisation.

If a similar policy or guideline exists, three options are available:

i) adopt the existing policy or guideline as it stands if it aligns with your service.
ii) review and revise the existing policy or guideline in consultation with the document owner or facilitator.
iii) develop a new organisation-wide policy or guideline and withdraw the existing service specific policy or guideline.

5.1.3 Register the policy or guideline

- When the need for a new policy or guideline has been identified, the document facilitator must complete the controlled document registration form available from the '*Finding policies and guidelines*' page of the intranet and submit it to the policy coordinator.
- The policy coordinator will register the policy or guideline and issue a reference number.

5.1.4 Develop the policy or guideline

- Download the appropriate template from the '*Finding policies and guidelines*' page of the intranet.
- Develop the policy or guideline as appropriate based on best practice, legislation, standards, and other existing Waikato DHB documentation.
- Ensure all key stakeholders are involved in the development of the policy or guideline.

5.1.5 Review the policy or guideline

- The document facilitator will coordinate a review of the document with all relevant staff within their own department, and other departments as appropriate.

5.1.6 Consultation (Waikato DHB wide policies or guidelines)

- The document owner will submit the draft policy or guideline to the policy coordinator.
- The policy coordinator will send out for consultation to a group including all relevant staff, committees, external unions and specified interest groups.
- The document facilitator will ensure that all feedback received during the consultation period is recorded on the Consultation Feedback Record.
- At the conclusion of the consultation period the document facilitator or delegate will submit to the policy coordinator the following documents for distribution to the policy committee members:
  - the final draft of the policy or guideline for review.
  - the completed Consultation Feedback Record.

5.1.7 Authorising the policy or guideline for publishing

Waikato DHB wide policies and guidelines

- Waikato DHB wide policies or guidelines will be presented to the policy committee for final review by the document owner or document facilitator.
- The policy committee will either:
  i) recommend endorsement of the policy or guideline by the Board of Clinical Governance, Executive Group or Waikato DHB Board; or
  ii) return the policy or guideline to the document owner for further work.
- The document facilitator will complete the appropriate report cover sheet for the board or group.
- The policy coordinator will advise the coordinator of the relevant board or group of the recommendation to endorse a policy or guideline.
- The coordinator of the relevant group will then arrange for endorsement by the group or board.
- The policy coordinator will publish the policy or guideline in accordance with *see 4.11 Publishing of Documents*.

Group wide policies and guidelines

- Group wide policies and guidelines will be authorised by the group's governance forum or quality group.

Clinical management policies and guidelines

- Clinical management policies and guidelines may be authorised by the document owner.

5.1.8 Publishing a policy or guideline

- When final endorsement has been received, the document facilitator or delegate will arrange for the controlled document approval form to be signed by the document owner and facilitator.
- The document facilitator will submit to the policy coordinator the following documents:
  - the original signed copy of the policy and guideline approval form;
  - a hard copy of the policy or guideline; and
  - the final Microsoft word version of the policy or guideline (email to: policies@waikatodhb.health.nz).
- When the policy coordinator receives the documents listed above, the policy or guideline will be uploaded to the intranet.

5.1.9 Implementation of a policy or guideline

- When a policy or guideline has been published it is the responsibility of the document owner to ensure:
  - the implementation plan is carried out;
  - that all relevant staff are notified of the changes to the policy; and
  - that the effectiveness of the policy or guideline is evaluated within 12-24 months

5.2 Reviewing an Existing Policy or Guideline

- Determine if need for the policy or guideline still exists (*see 5.1.1 above*).
- Obtain the Microsoft word version of the policy or guideline from the policy coordinator – email policies@waikatodhb.health.nz.
- Ensure the policy or guideline is on the correct template.
- Review and revise policy or guideline as necessary, checking evidence, references and associated documents.
- If policy or guideline is Waikato DHB wide, it will need to undergo consultation (*see 5.1.6 above*).
- Update the Procedure Review History table.
- Authorise the policy or guideline (*see 5.1.7 above*).
- Publish the policy or guideline (*see 5.1.8 above*).
- Implement the policy or guideline (*see 5.1.9 above*).

5.3 Extending a Policy or Guideline

To extend the currency of a policy or guideline,

- download and complete the policy and guideline extension form from the intranet; and
- send the signed form to the policy coordinator in Quality and Patient Safety.

Note: The form must be signed by both the document owner and the facilitator

The policy coordinator will

- send it to the BoCG or Executive Group for approval;
- if approved, increase the expiry date of the policy or guideline to a date one (1) year from the original expiry date of the policy or guideline, or earlier if requested;
- update the Procedure Review History table; and
- upload the new pdf to the intranet.

5.4 Re-issuing a Policy or Guideline

Where it becomes necessary to make minor changes to a policy or guideline prior to the review date, the document may by re-issued without going through the full consultation and authorisation process:

- make the necessary changes to the policy or guideline
  - increase version number
  - change the issue date
  - **DO NOT** change the review date
- download and complete the policy and guideline re-issue with minor changes form

  Note: The form must be signed by both the document owner and the facilitator.

- The document facilitator will submit to the policy coordinator the following documents:
  - the original signed copy of the policy and guideline re-issue with minor changes form;
  - a hard copy of the policy or guideline; and
  - the final Microsoft word version of the policy or guideline (email to: policies@waikatodhb.health.nz).
- When the policy coordinator receives the documents listed above, the policy or guideline will be uploaded to the intranet.

5.5 Withdrawing a Policy or Guideline

To withdraw a policy or guideline from the intranet:

- download and complete the policy and guideline withdrawal form from the intranet; and
- send the signed form to the policy coordinator in Quality and Patient Safety.

Note: The form must be signed by both the sponsor and the document owner

The policy coordinator will:

- withdraw the policy or guideline from the intranet;
- inform the Policy Committee every quarter; and
- prepare the pathway for disposal as per prior GDA identification.

5.6 Developing or reviewing and publishing a drug guideline

The development and review of drug guidelines shall involve representatives from pharmacy, medical and nursing professions.

5.6.1 Developing a drug guideline

- Identify the need for a drug guideline – consult with a pharmacist to determine if one is already under development.
- Register the drug guideline (*see 5.1.3 above*).
- Develop the drug guideline (*see 5.1.4 above*).
- Submit the drug guideline to relevant disciplines for review. Include
  - CNS infusion and related therapies
  - Medicines information pharmacist.
- Send the drug guideline to the policy coordinator who will forward to the Nursing and Midwifery directorate for review from a nursing profession perspective. Any requests for change will be communicated back to the document facilitator.

5.6.2 Reviewing an existing drug guideline

- Confirm the drug guideline is still required.
- Determine if need for the policy or guideline still exists (*see 5.1.1 above*).
- Obtain the Microsoft word version of the policy or guideline from the policy coordinator – email policies@waikatodhb.health.nz.
- Review and revise the drug guideline as necessary, checking evidence, references and associated documents.
- Submit the drug guideline to relevant disciplines for review. Include
  - CNS IV therapies / medicines management
  - Medicines information pharmacist.
- Send the drug guideline to the policy coordinator who will forward to the Nursing and Midwifery directorate for review from a nursing profession perspective. Any requests for change will be communicated back to the document facilitator.

5.6.3 Authorising and publishing a drug guideline

- The document facilitator will:
  - print the completed drug guideline;
  - send the signed drug guideline to the policy coordinator via internal mail; and
  - email the final Microsoft word version of the drug guideline to the policy coordinator policies@waikatodhb.health.nz.

- The policy coordinator will:
  - Arrange for the drug guideline to be signed by the Chair of the M&T committee; and
  - Upload the drug guideline to the intranet.

6. Audit

6.1 Indicators

Policy coordinator:

- All Waikato DHB policies and guidelines are current.
- Time points through policy development are monitored and meet policy and guideline acceptable timeframes.
- The renewal of policies and guidelines are continuous as shown by the issue and review dates and policy extensions are given a maximum one-year extension.
- Policies and guidelines that are superceded/withdrawn have processes documented and documents for archiving and destruction are satisfactorily disposed of.
  Quality control of documents: reviewed for correct hyperlinks, direction, correct referencing.

Other staff:

- Finding and utilising policies and guidelines are assessed using an annual staff survey.
- Document facilitators are surveyed to assess satisfaction with the policies and guidelines process.
- The document review history table is updated when there is a change to document or to the review date when an extension is approved.

6.2 Tools

- Audits of policies and guidelines processes and those of the policy coordinator will be based on the following table and the attached flowcharts (Appendices B-J).

Policy process time points

Process	Time Frame
Document Registration*	2 days
Consultation	2-3 weeks
Policy Committee	2-4 weeks**
Board of Clinical Governance (meet monthly)	2-6 weeks**
Executive Group (meet fortnightly)	1-3 weeks**
Waikato DHB Board (meet monthly)	2-6 weeks**
Policy or guideline upload to intranet*	3 days
Policy or guideline withdrawal*	3 days

* From receipt of all necessary documentation (electronic and/or original)

** The level of approval and endorsement required will depend on the policy or guideline.

7. Legislative Requirements

7.1 Legislation

Numerous Acts and regulations specify Waikato DHB's legislative compliance responsibilities, including:

- Health and Disability Services (Safety) Act 2001
- NZ Public Health and Disability Act 2000
- Health and Safety in Employment Act 1992
- Code of Health and Disability Services Consumers' Rights 1996
- Privacy Act 1993
- Health Information Privacy Code 1994

7.2 External Standards

Waikato DHB requires compliance with the following external standards (amongst others), which include the requirement to have appropriate policies and procedures in place to ensure safety:

- Health and Disability Sector Standards ratified in the Health and Disability Services (Safety) Act 2001
- International Accreditation New Zealand Standards.

8. Associated Documents

8.1 Associated Waikato DHB Documents

Waikato DHB Corporate Records Management policy (Ref. 0905)
Waikato DHB Electronic Recordkeeping Metadata policy (0150)
Waikato DHB Management of Lippincott Procedures policy (Ref. 1236)
Waikato DHB Medicines Management policy (Ref. 0138)
Waikato DHB Standing Orders - Process and Documentation procedure (Ref. 2524)
Waikato DHB policy and guideline templates and forms

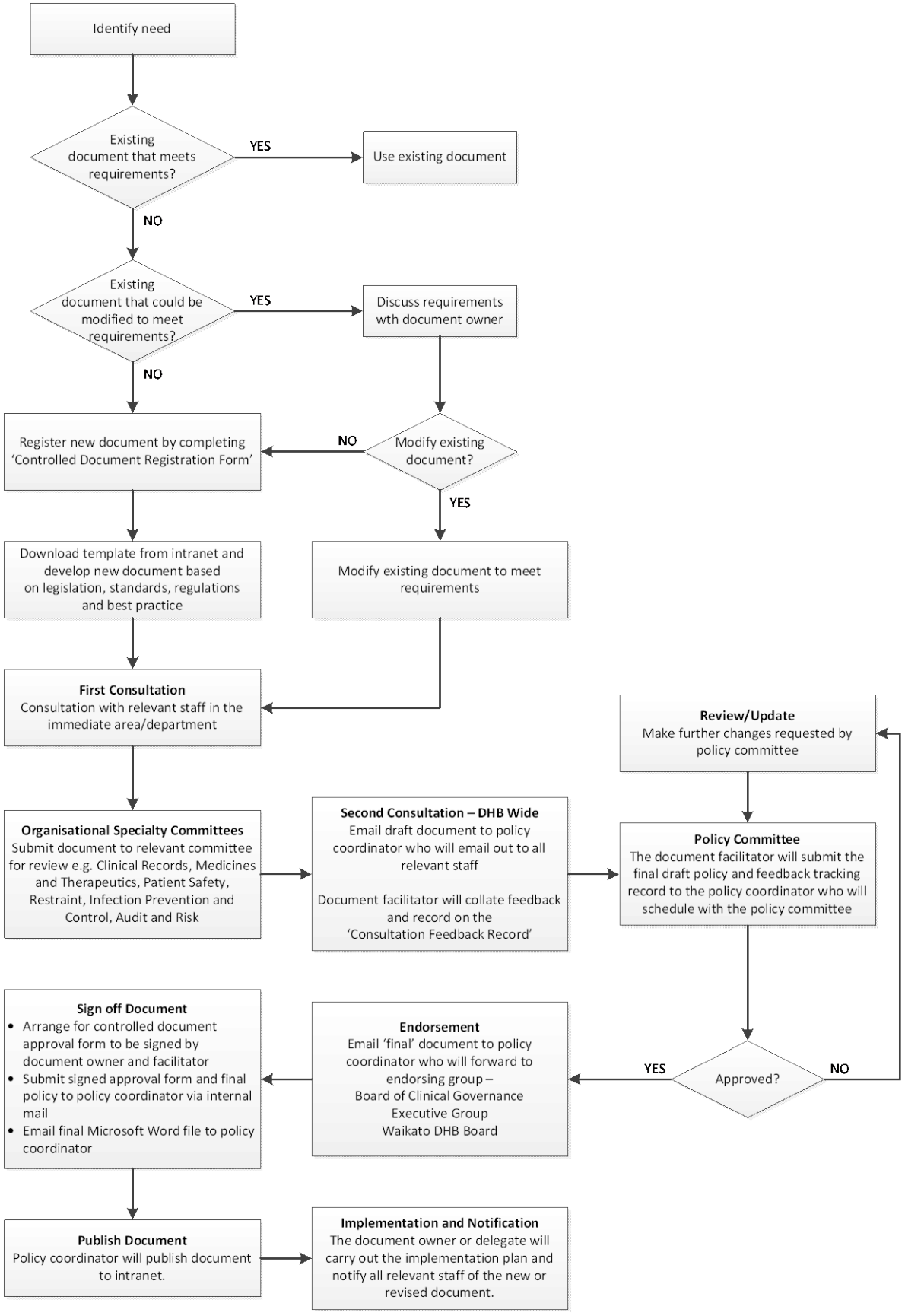
Appendix A Policies Requiring Waikato DHB Board Endorsement

The following Waikato policies must be endorsed by the Waikato DHB Board as part of the authorisation process.

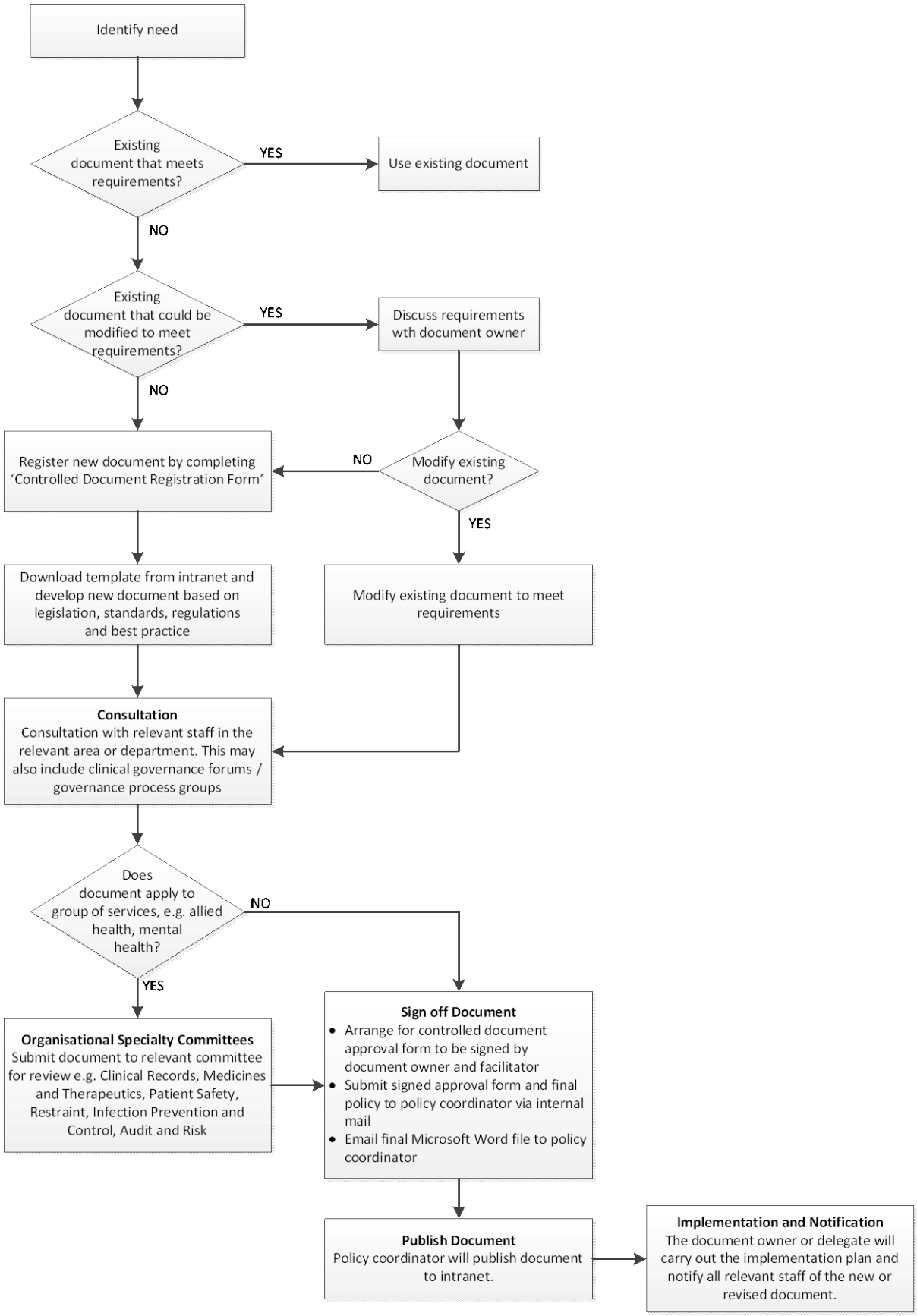
Note: All finance policies are endorsed by the Audit and Risk Committee on behalf of the Waikato DHB Board.

Reference	Policy Name
2175	Delegations of Authority
0102	Management of Policies and Guidelines
0108	Māori Health
0298	Naming Rights of Waikato DHB Owned Facilities
0170	Procurement and Contracts
1829	Receiving and Giving of Gifts
0118	Risk Management
0121	Smokefree
0122	Sponsorship
	Finance Policies
1839	Asset and Equipment Management
0034	Capital Expenditure Framework
0038	Catering
1813	Financial Accounting
3274	Fraud
2214	Identifying Persons not Eligible for Publicly Funded Health and Disability Services
0440	Purchasing Card (P Card)
1035	Recovery of Overpaid Salaries and Wages
0042	Treasury Management

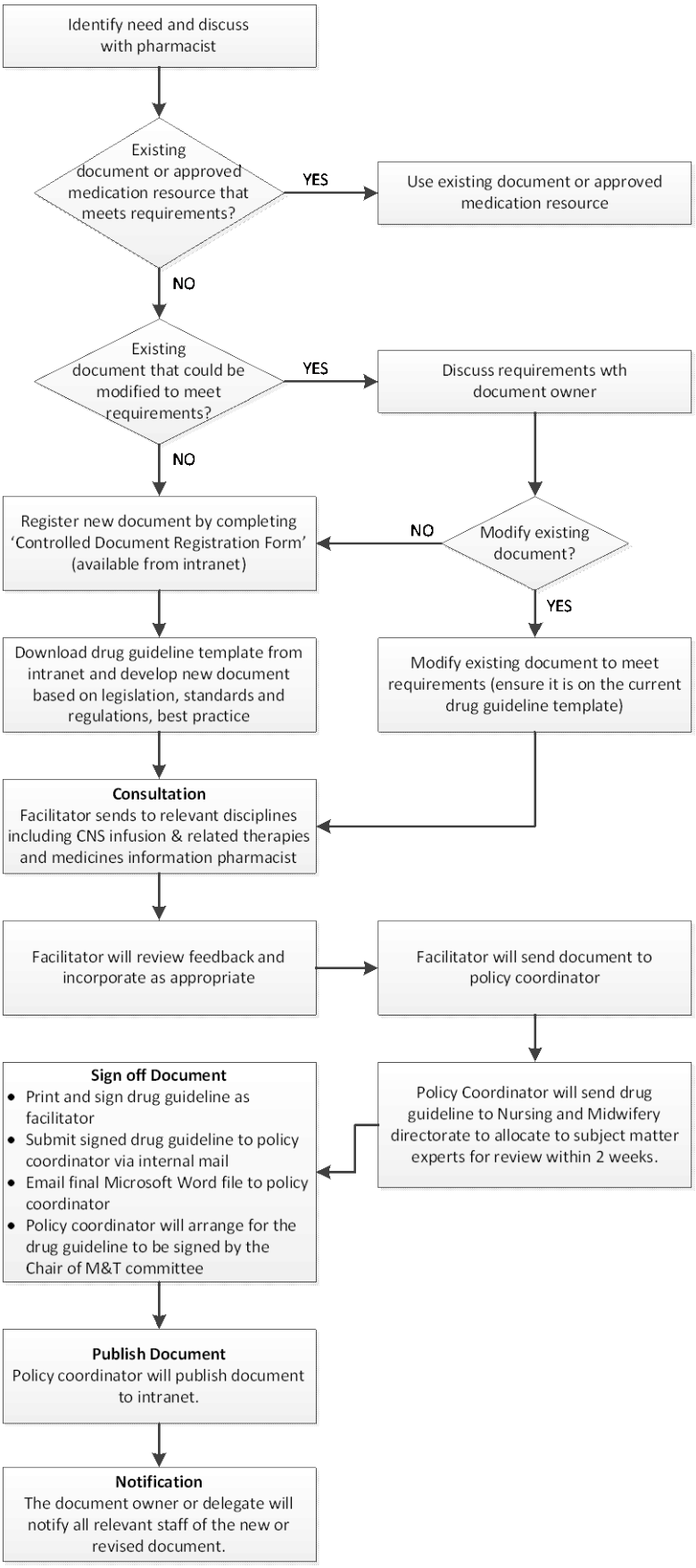
Appendix B Flowchart: Developing a New DHB-wide Policy or Guideline



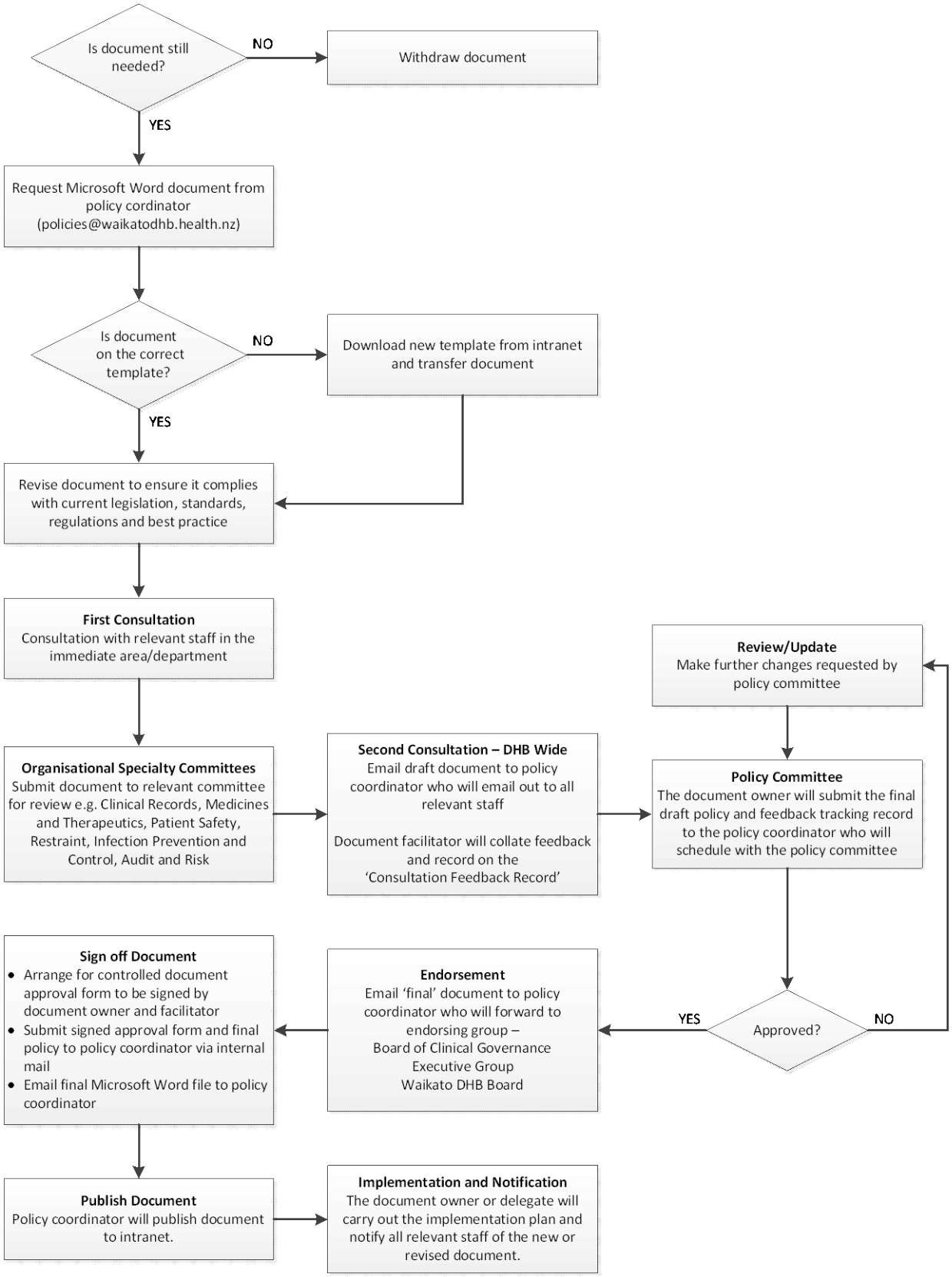
Appendix C Flowchart: Developing a New Clinical Management Policy or Guideline



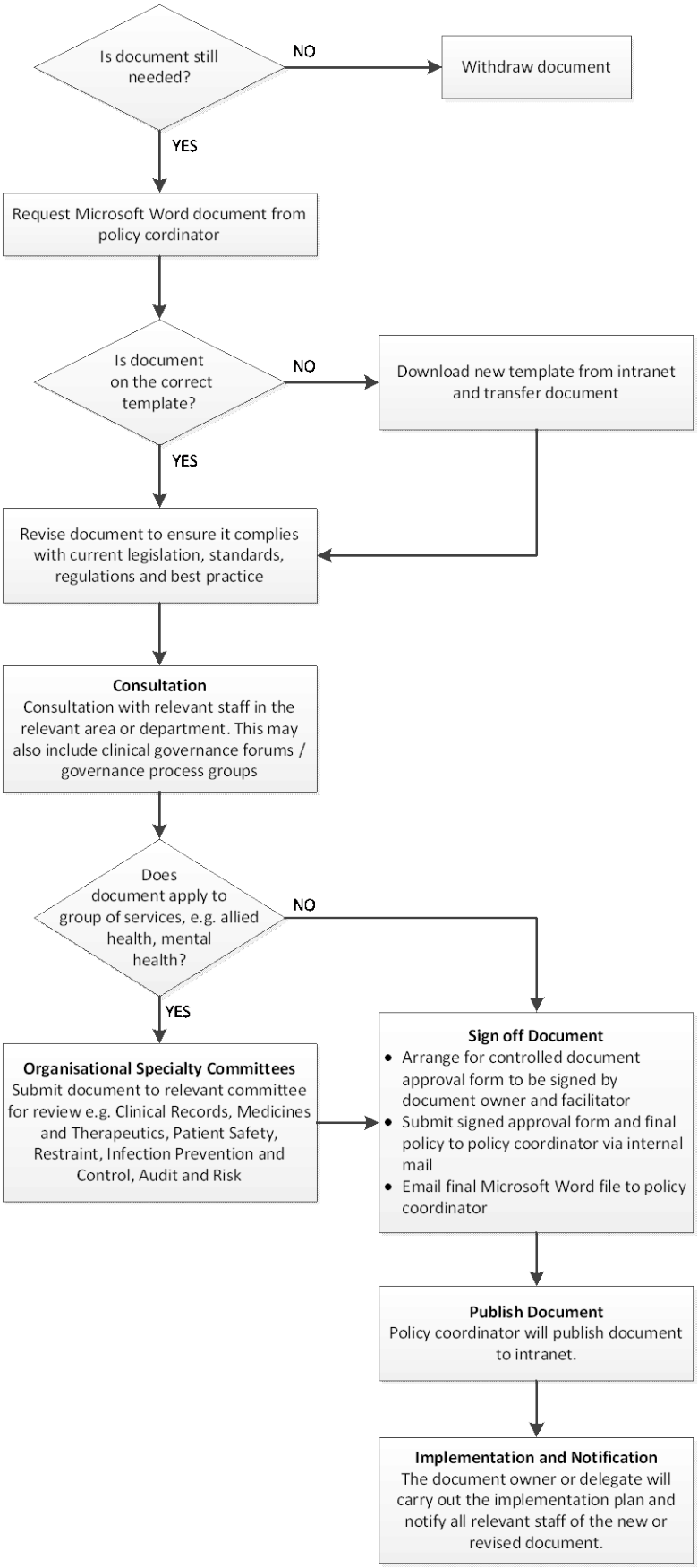
Appendix D Flowchart: Developing a New Drug Guideline



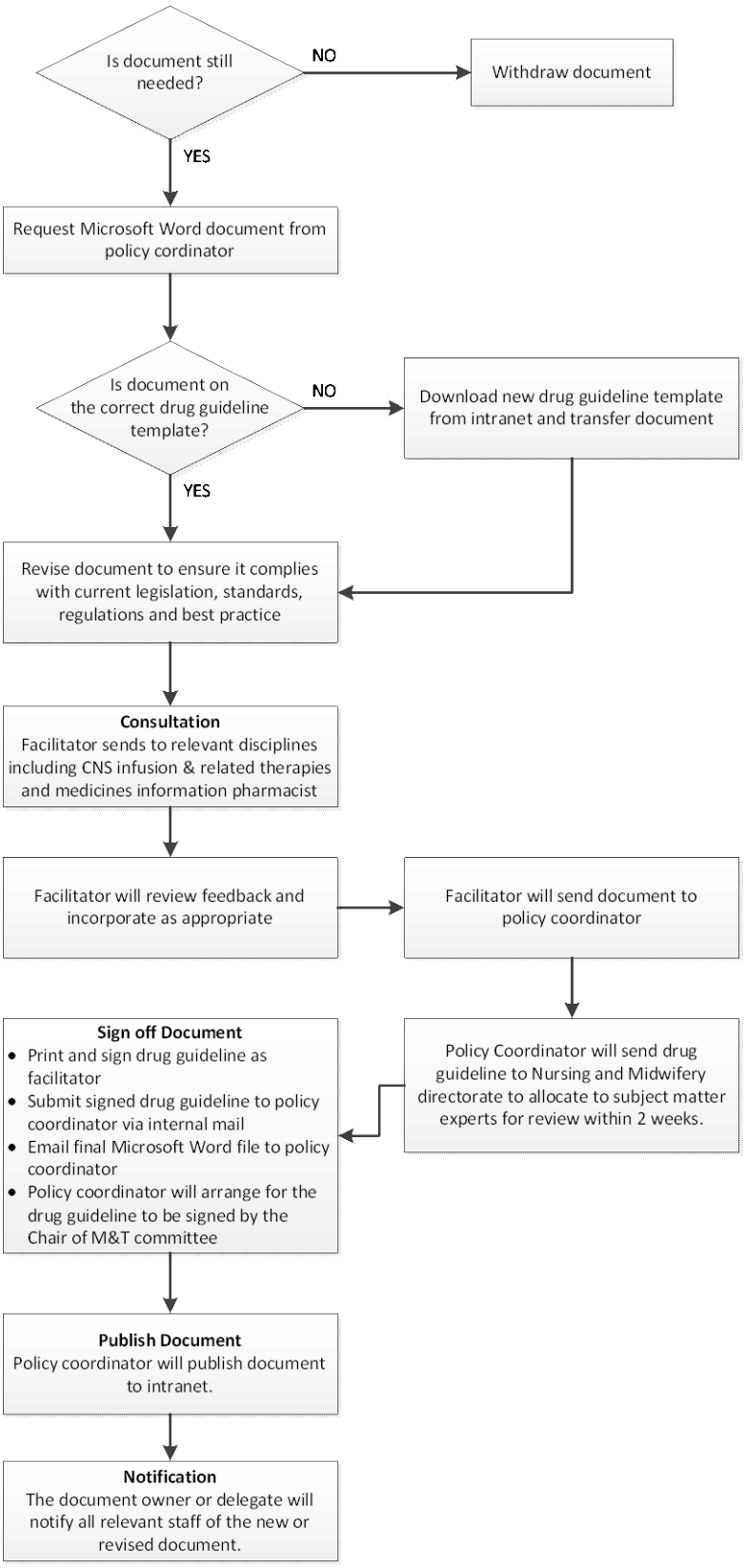
Appendix E Flowchart: Reviewing an Existing DHB-wide Policy or Guideline



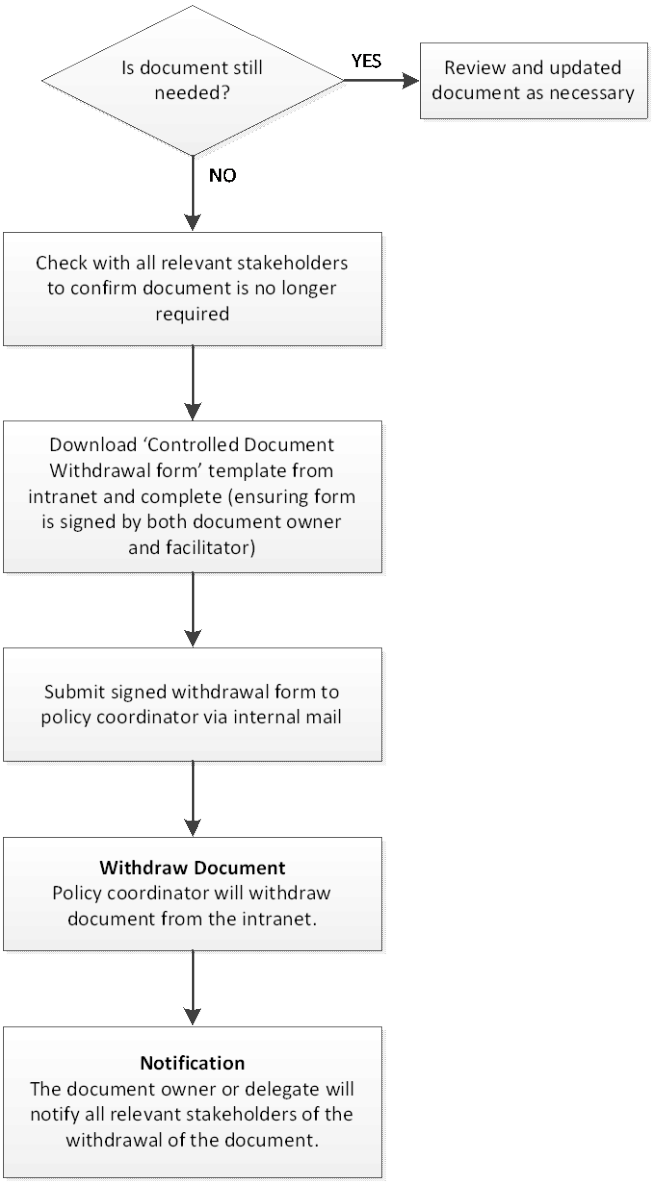
Appendix F Flowchart: Reviewing a Clinical Management Policy or Guideline



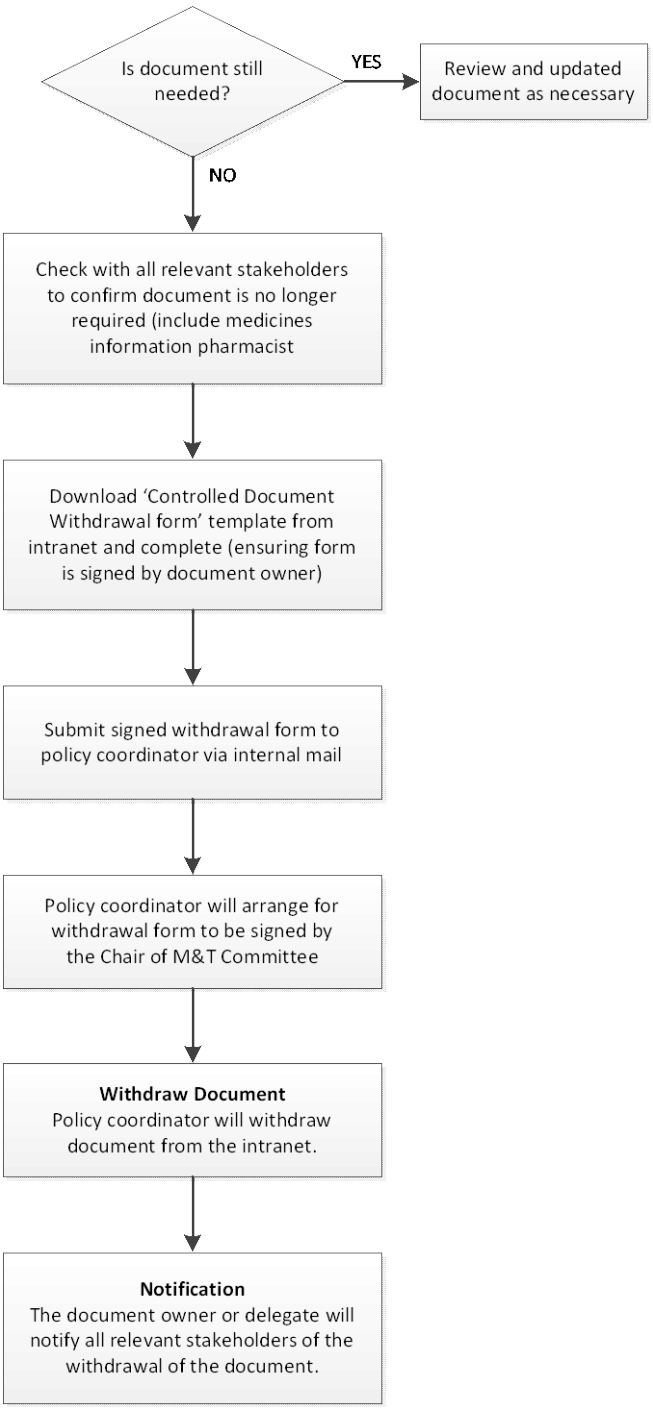
Appendix G Flowchart: Reviewing an Existing Drug Guideline



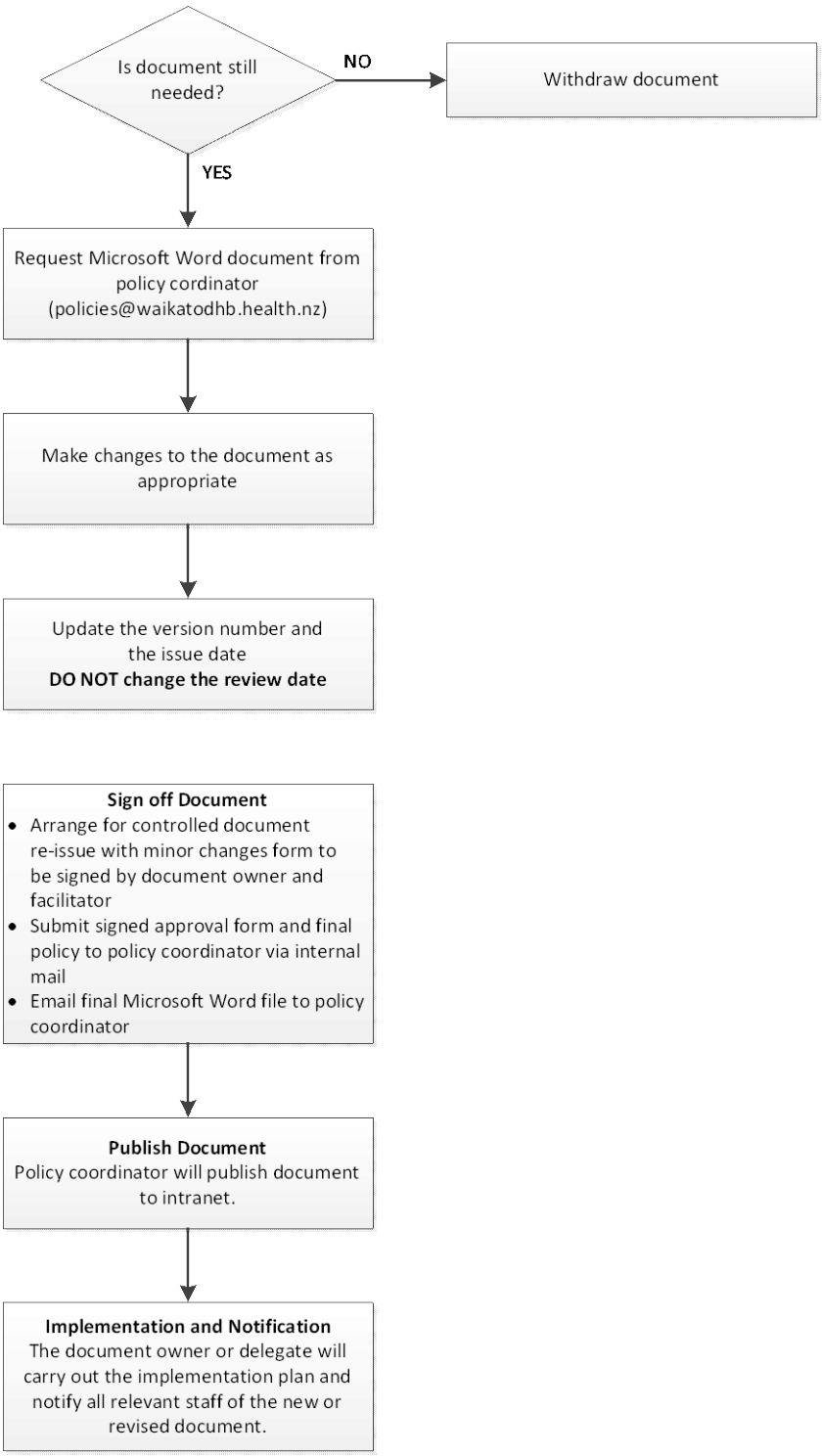
Appendix H Flowchart: Withdrawing a Policy or Guideline



Appendix I Flowchart: Withdrawing a Drug Guideline



Appendix J Flowchart: Re-issuing a Policy or Guideline with Minor Changes



Policies approved by Waikato DHB Board

Reference	Policy Name	Review Date
Waikato DHB Policies		
2175	Delegations of Authority	30/09/2017
0102	Management of Policies and Guidelines	10/04/2015
0108	Māori Health	30/04/2018
0298	Naming Rights of Waikato DHB Owned Facilities	01/08/2019
0170	Procurement and Contracts	30/11/2018
1829	Receiving and Giving of Gifts	31/08/2017
0118	Risk Management	09/02/2018
0121	Smokefree	31/05/2017
0122	Sponsorship	01/10/2019
Waikato DHB Board Policies		
0301	Appointment of External Members to Board Committees	27/02/2017
1040	Appointment of Waikato DHB Employees as Board Members	27/04/2019
2177	Board Remuneration and Expenses	27/02/2017
2134	Campaigning for District Health Board Elections	27/04/2019
5456	Code of Conduct for Board Members	26/05/2019
0114	Political Candidates Wishing to Visit Waikato DHB Facilities	27/04/2019
2178	Training for Board Members	27/02/2017
Waikato DHB Finance Policies (endorsed by the Audit and Risk Committee on behalf of the Waikato DHB Board)		
1839	Asset and Equipment Management	01/09/2014
0034	Capital Expenditure Framework	01/07/2013
1813	Financial Accounting	31/05/2017
3274	Fraud	31/05/2017
2214	Identifying Persons not Eligible for Publicly Funded Health and Disability Services	01/10/2015
0440	Purchasing Card (P Card)	30/06/2018
1035	Recovery of Overpaid Salaries and Wages	31/05/2017
0042	Treasury Management	24/02/2019

MEMORANDUM TO THE BOARD
22 MARCH 2017

AGENDA ITEM 9.1

PROGRAMME BUSINESS CASE : MIDLAND ESPACE PROGRAMME 2015-20

Purpose	For approval.

The Programme Business Case is attached.

1. INTRODUCTION

Timely access to a complete source of accurate patient information is crucial to providing quality care in a modern health system. Increasing patient mobility, multi-provider treatment plans and complex clinical pathways present challenges to ongoing record-keeping, especially when care is delivered in different locations and by different parts of the health sector.

These challenges affect clinicians, patients and health outcomes. Incomplete or missing patient information at the point of care increases cost, carries clinical risks and negatively impacts the quality of patient care.

This eSPACE Programme Business Case builds on the previous approval of all five DHBs to proceed with funding of $47 million to deliver the previously proposed regional clinical workstation. It now addresses issues raised by the 2015 Phase 0 Gateway Review and reflects additional Treasury requirements regarding the treatment of estimated costs.

The first phase of delivery is the Midland Clinical Portal (MCP). This is a regional portal accessed from current clinical portal so:

1. DHB clinicians still have full access to the information they currently available
2. But they will also be able to access a limited set of regional demographic and clinical information in patient context.

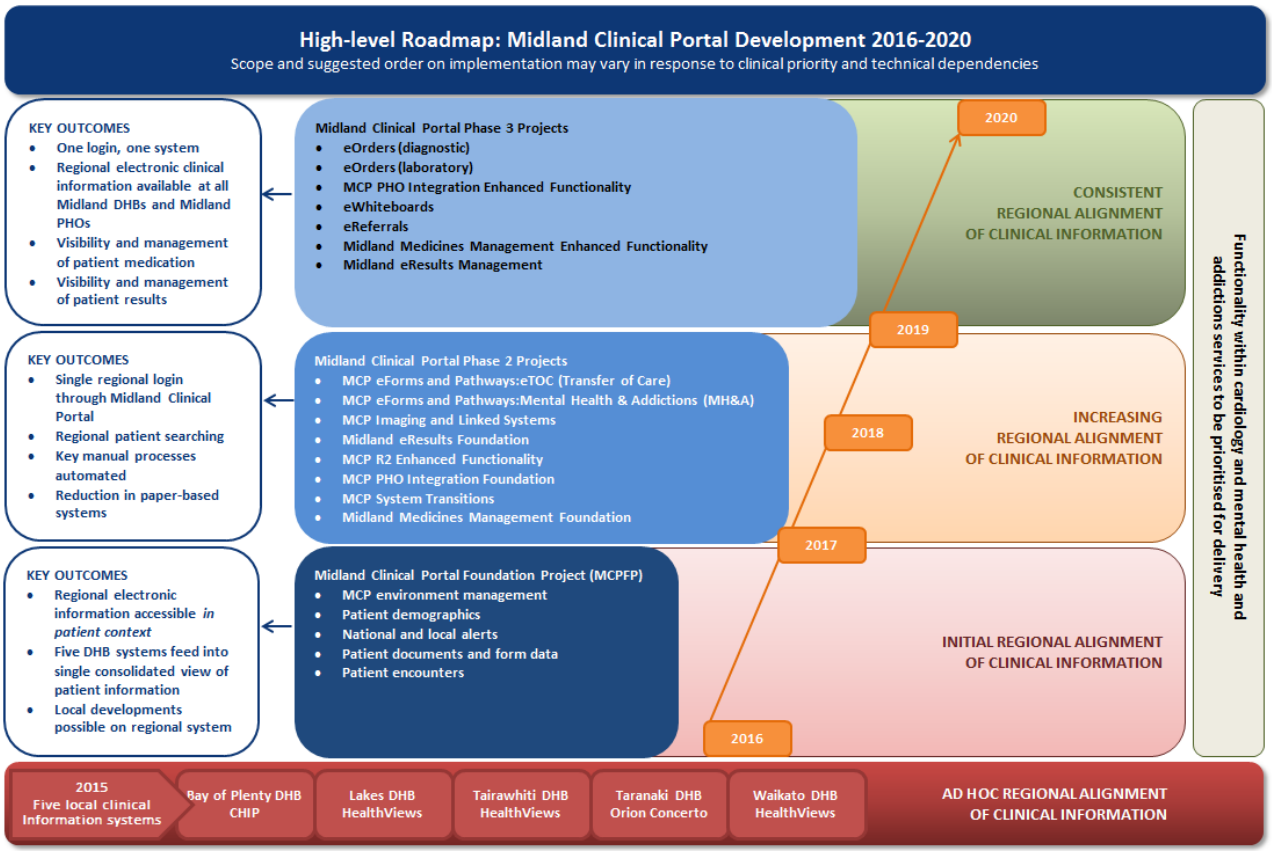
This phase is in test and will be delivered to the five DHBs in July 2017.

2. WHAT

The overarching eSPACE Programme of work will deliver a regional clinical workstation, known as the ‘Midland Clinical Portal’ (MCP), supported by unified Clinical Data Repositories (CDRs) and an integrated electronic Medicines Management solution through a series of strategic projects across the five Midland DHBs.

The eSPACE Programme is a clinically-led programme of change, not an 'IT implementation'.

The programme will provide a single point of access for clinical information across the Midland region, delivering a consistent and accurate view of regional patient records and medication to support sound clinical decisions, reduce risk and improve the experience of patients, clinicians and administrators. Clinicians from across the region have prioritised the iterative steps the programme will take to make MCP increasingly more valuable to them – and to their patients – over the life of the programme by recently confirming the eSPACE Programme Roadmap.



Prepared using Treasury's Better Business Cases five-case model, this investment proposal:

- strategically aligns to national and regional priorities and is supported by a compelling case for change
- identifies a range of programme options and recommends a preferred programme solution that optimises value for money
- adopts an implementation plan that is both informed and led by clinicians
- demonstrates the preferred programme is commercially viable and supported by a strategic procurement approach
- evidences an approach that provides DHBs with safeguards to stop or proceed before committing additional resources, at each stage of the eSPACE Programme Roadmap
- sets out the funding requirements of the preferred option and demonstrates that the preferred programme can be funded from committed resources and revenue sources
- demonstrates the programme can be delivered successfully from a management perspective.

It should be stated from the outset that the eSPACE Programme does not set out to provide a region-wide shared care pathway or a complete regional solution to electronic patient records. Rather, it provides very strong foundations for regionalisation of clinical information by creating a standardised tool for Midland DHB clinicians to treat their patients; it includes capability for integration with Midland-based Primary Health Organisations (PHOs) and other non-hospital based health professionals in the Midland region; it will allow for the retirement of legacy systems if this is the preference of individual Midland DHBs; and it will amply meet Digital Health 2020 requirements for the regional aggregation of patient data which are pre-requisite to the development of a national electronic health record (EHR).

While Medicines Management was previously excluded from the scope of the eSPACE Programme, it has been identified as a clinical priority and at the request of the Chief Executives of the Midland region has been added to the scope.

3. BENEFITS

This programme is partly a system replacement and partly delivers new functionality. The benefits largely fall into three categories:

1. Financial benefits – these are mainly non-cash releasing but will increase capacity so growth can be absorbed at a much lower cost point.
2. Clinician benefits – reduction in search time as timely and relevant information is presented in an easy to digest format
3. Patient benefits – improved patient safety as clinician has access to comprehensive regional clinical information for clinical treatment decision making.

(Figures in $000)	Status Quo Option	Preferred programme Option Five
Estimated Monetary Benefits		
Clinician Time	0	20,367
Reduced Duplication	0	8,147
Clinical Outcomes	0	48,879
Forecast Cash Inflow	**0**	**77,393**
Forecast Cash Outflows	56,053	99,919
Forecast Net Cashflow	**(56,053)**	**(22,526)**
Annual Discount Rate	8%	8%
Net Present Value (NPV)	**(39,944)**	**(33,779)**
Marginal NPV		**$6.2 million**

This analysis demonstrates that, on the basis of current mid-point estimates of costs and benefits, that the marginal NPV of the preferred programme compared to the status quo is approximately $6.2 million over the 10 year period of the analysis.

4. WHY (DRIVERS)

The New Zealand Ministry of Health ('the Ministry') mandates investment in clinical IS as a national priority. Previously, the Ministry and the former National Health IT Board (NHITB) have strongly endorsed taking a regional approach to clinical IS, as a key enabler for integrated healthcare across regions. With the release of Digital

Health 2020 in late 2016, it was clarified that there is a clearly stated expectation that all DHBs will adopt aligned and consistent clinical data repositories and Clinical Workstation (CWS) solutions, implemented as regional platforms and based on national standards and alignment.

There are currently five separate clinical workstations in the Midland region. These are:

DHB	Current Clinical Portal	Support Arrangement	Status of Current Clinical Portal
Waikato DHB	HealthViews	Owns source code and maintains and develops system in-house	Not sustainable – technology changes will require a major re-write.
Bay of Plenty DHB	CHIP	DHB developed the system and maintains and develops system in-house	Ongoing support challenging from a small team
Lakes DHB	HealthViews	CSC support agreement	• End of life notice issued. • Maintenance only. • No development.
Tairawhiti DHB	HealthViews	CSC support agreement	
Taranaki DHB	Orion Clinical Portal	Orion support agreement	Older version, support issues.

DHBs will be able to decommission these local systems as sufficient functionality will be delivered by the programme to enable decommissioning.

This programme is strongly aligned to delivering enablers that support national strategy and the five Midland DHB's strategic objectives.

5. HOW

This is a regional collaborative programme of work and will be delivered by the region using appropriate programme and project methodologies. Governance will include all five DHB's and the following principles will be followed:

a. Clinically led
b. Change enabled by IT
c. Architecturally sound
d. Standards based
e. Resilient
f. One size may not fit all so designed to meet needs of tertiary as well as secondary DHBs.

6. FINANCIAL OVERVIEW

This Programme Business Case (PBC) seeks approval to proceed with the Midland eSPACE Programme within an estimated funding envelope of $75 million over a five-year period from 2015 to 2020. This PBC now reflects a fully costed, whole-of-life-cost approach totalling $109 million over 10 years.

Consistent with BBC guidance, the basis of allocating costs among DHBs in this programme-level business case is PBFF. It is recognised, however, that PBFF may

not always be the most appropriate basis at project level. As such, the programme will work with the region's Chief Executives to determine the best approach on a project by project basis. Each individual project within the eSPACE Programme will develop documentation incorporating a full cost-benefit analysis to be approved before **any** funds are allocated.

7. NEXT STEPS

This business case requires approval by the five Midland DHBs as well as by the Ministry of Health, Treasury and Cabinet. The Ministry of Health present the business case to Cabinet and this requires clean approvals (i.e. no caveats).

Recommendation
THAT
The Board:

1) Receives this report.
2) Approves:
    a. the funding envelope of $75 million over a five-year period from 2015 to 2020
    b. the programme scope and approach as outlined in this eSPACE Programme Business Case
    c. the Programme Governance structure and Senior Responsible Officer (SRO) having the delegated authority to make project by project decisions within the approved programme scope and funding envelope on behalf of the Midland DHBs
    d. the programme delivering agreed scoped projects within the authorised funding envelope, subject to proper governance controls and funding through annual budget processes, without the need for subsequent individual project business cases.
3) Agree:
    a. that the eSPACE Programme submit this Programme Business Case, on behalf of the region, for Ministry of Health endorsement and Ministerial/Cabinet approval as appropriate
    b. that all Midland DHBs will deploy the Midland Clinical Portal to replace existing Midland DHB systems as soon as is practicable and, where possible, within the programme timescales
    c. that Midland DHBs will, within the programme scope, prioritise programme implementation alongside local priorities
    d. that any projects not within approved scope and outside of the agreed funding envelope will require either formal change control or individual business cases to be submitted.
4) Note:
    a. That Maureen Chrystall (Executive Director Corporate Services, Waikato DHB) is the Senior Responsible Officer
    b. That the whole-of-life-cost are estimated at $109 million
    c. Note that costs will be funded by the five DHBs on a population based funding formula (PBFF) share unless there is a more appropriate method identified and agreed by the five DHBs.

MAUREEN CHRYSTALL
EXECUTIVE DIRECTOR CORPORATE SERVICES

Programme Business Case

Midland eSPACE Programme 2015-2020

Prepared for	Maureen Chrystall, David Page
Prepared by	Kyna Hart
Issue Date	10 March 2017
Version	3.0
Status	Final

Primary Distribution

Name	Role
Maureen Chrystall	eSPACE Programme SRO and eSPACE Programme Board Chair
David Page	eSPACE Programme Director
Neil Gyde	Ministry of Health Representative
Midland eSPACE CEO Governance Group	Governance
eSPACE Programme Board	Governance

Reference Documents

Available on request

Document Name	Version	Status	Date
Digital Health 2020 Overview		Final	November 2016
Eclair Case Study: Northern Regional EMR New Zealand		Final	Not available
2016 eSPACE Programme Lessons Learnt Report - Project REFLECT: April to August 2016	v0.3	Final	7 September 2016
HealthShare Risk Management Strategy ICT-enabled Programmes and Projects	v1.0	Final	22 March 2016
eSPACE Programme Strategy	v2.0	Approved	30 October 2015
Midland Region 2016/19 Regional Service Plan - Strategic Direction		Approved	July 2016
Midland Region 2016/19 Regional Service Plan - Initiatives and Activities		Approved	July 2016
Government ICT Strategy 2015		Final	June 2013
Health Technology Engagement Overview		Final	Not available
eSPACE Programme Quality Assurance Plan	v1.1	Approved	24 August 2015
Programme Procurement Strategy – Midland eSPACE Programme 2015-2020	V1.0	Final	9 February 2017
New Zealand Health Strategy 2016: Future Direction		Final	April 2016
Midland Region Clinical Services Implementation Plan		Final	20 May 2011
Midland Region Information Services Plan	v0.12	Draft	5 October 2011
eSPACE Programme Implementation Strategy for Change - 1 August 2016 to 30 June 2019	V0.3	Draft	29 July 2016
HealthShare eSPACE Foundation Programme - Resource Profiles and Estimates Assurance Review (Genesis Consulting)		Final	26 August 2016
Programme Assurance Plan: Midland eSPACE Programme	V0.4	Final	27 August 2015
Midland Region CWS Phase 0 Benefits Realisation Strategy and Toolset	v1.0	Final	October 2013

Acronyms and Names

ADKAR: Prosci ADKAR change model (Awareness, Desire, Knowledge, Ability, Reinforcement)

AOG: All of Government

BBC: Treasury's Better Business Cases

BMP: Benefits Management Planning

CDR: Clinical Data Repository

CEOGG: (eSPACE) Chief Executive Officer Governance Group

CWS: Clinical Work Station

DIA: Department of Internal Affairs

DHB: District Health Board

GCIO: Government Chief Information Officer

IaaS: Infrastructure as a Service

ICT: Information and Communications Technology

IS: Information Systems

ISLT: Information Systems Leadership Team (of Midland Region)

MCP: Midland Clinical Portal

MCPFP: Midland Clinical Portal Foundation Project

MSP: Managing Successful Programmes

NHITB: National Health IT Board

PAS: Patient Administration System

PBFF/PBF: Population Based Funding Formula

PER: Project Evaluation Review

PBC: Programme Business Case

PIR: Post Implementation Review

PMO: Project Management Office

PRINCE2: PRojects IN Controlled Environments

RAID: Risk Assumptions Issues Dependencies

RSP: Regional Services Plan

RCWS: Regional Clinical Workstation

SOW: Statement of Work

SRO: Senior Responsible Officer

SWOT: Strengths, Weaknesses, Opportunities and Threats

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1 Executive Summary

Timely access to a complete source of accurate patient information is crucial to providing quality care in a modern health system. Increasing patient mobility, multi-provider treatment plans and complex clinical pathways present challenges to ongoing record-keeping, especially when care is delivered in different locations and by different parts of the health sector.

These challenges affect clinicians, patients and health outcomes. Incomplete or missing patient information at the point of care increases costs, carries clinical risks, and negatively impacts the quality of patient care.

Investment in electronic health records and the clinical information systems (IS) that support them are strongly correlated with improvements in clinical and operational outcomes. A growing body of international evidence demonstrates the financial, clinical and community benefits of integrated, fit-for-purpose clinical IS.

The New Zealand Ministry of Health ('the Ministry') mandates investment in clinical IS as a national priority. Previously, the Ministry and the former National Health IT Board (NHITB) have strongly endorsed taking a regional approach to clinical IS, as a key enabler for integrated healthcare across regions. With the release of Digital Health 2020 in late 2016, it was clarified that there is a clearly stated expectation that all DHBs will adopt aligned and consistent clinical data repositories and Clinical Workstation (CWS) solutions, implemented as regional platforms and based on national standards and alignment.

All five District Health Boards (DHBs) in the Midland region currently operate local systems with limited ability to integrate, creating inefficiencies and increasing the risk of clinical error. Collectively, Midland DHBs have resolved to invest in a regional clinical IS, through the development of the eSPACE Programme.

The overarching eSPACE Programme of work will deliver a regional clinical workstation, known as the 'Midland Clinical Portal' (MCP), supported by unified Clinical Data Repositories (CDRs) and an integrated electronic Medicines Management solution through a series of strategic projects across the five Midland DHBs.

The eSPACE Programme is a clinically-led programme of change, not an 'IT implementation'.

The programme will provide a single point of access for clinical information across the Midland region, delivering a consistent and accurate view of regional patient records and medication to support sound clinical decisions, reduce risk and improve the experience of patients, clinicians and administrators. Clinicians from across the region have prioritised the iterative steps the programme will take to make MCP increasingly more valuable to them – and to their patients – over the life of the programme by recently confirming the eSPACE Programme Roadmap. (See figure 1 over page.)

It should be stated from the outset that the eSPACE Programme does not set out to provide a region-wide shared care pathway or a complete regional solution to electronic patient records. Rather, it provides very strong foundations for regionalisation of clinical information by creating a standardised tool for Midland DHB clinicians to treat their patients; it includes capability for integration with Midland-based Primary Health Organisations (PHOs) and other non-hospital based health professionals in the Midland region; it will allow for the retirement of legacy systems if this is the preference of individual Midland DHBs; and it will amply meet Digital Health 2020 requirements for the regional aggregation of patient data which are pre-requisite to the development of a national electronic health record (EHR).

While Medicines Management was previously excluded from the scope of the eSPACE Programme, it has been identified as a clinical priority and at the request of the Chief Executives of the Midland region has been added to the scope.

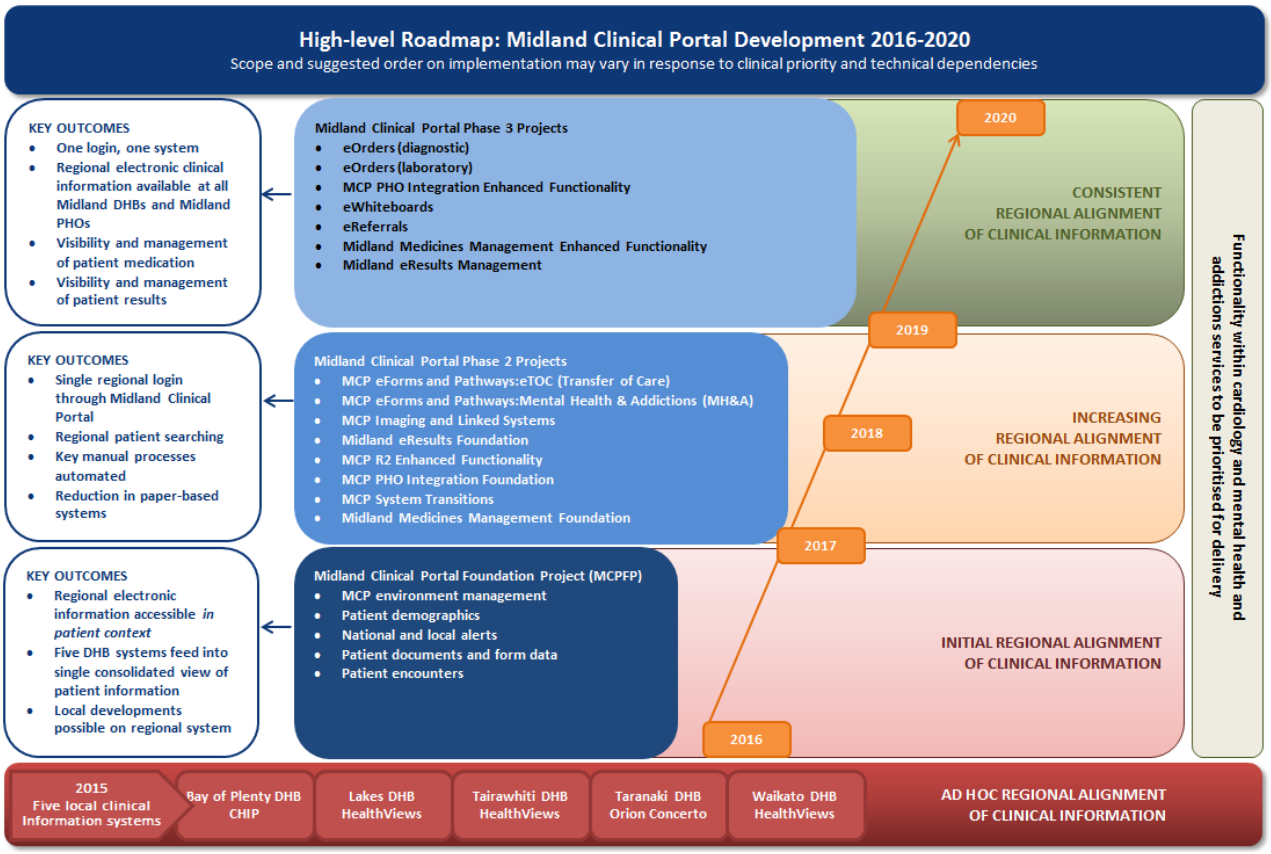

Figure 1 – eSPACE Programme Roadmap

This eSPACE Programme Business Case builds on the previous approval of all five DHBs to proceed with funding of $47 million to deliver the previously proposed regional clinical workstation. It now addresses issues raised by the 2015 Phase 0 Gateway Review and reflects additional Treasury requirements regarding the treatment of estimated costs. Having addressed these matters, and after a complete programme review, this Programme Business Case (PBC) now seeks approval to proceed with the Midland eSPACE Programme within an estimated funding envelope of $75 million over a five-year period from 2015 to 2020. This PBC now reflects a fully costed, whole-of-life-cost approach totalling $109 million.

Consistent with BBC guidance, the basis of allocating costs among DHBs in this programme-level business case is PBFF. It is recognised, however, that PBFF may not always be the most appropriate basis at project level. As such, the programme will work with the region's Chief Executives to determine the best approach on a project by project basis. Each individual project within the eSPACE Programme will develop documentation incorporating a full cost-benefit analysis to be approved before **any** funds are allocated.

In August 2016, the revised eSPACE Programme estimate of $75 million was the subject of an external assurance review by Genesis Consulting. This review assessed the resource profiles and estimates which underpin the programme (then known as the 'eSPACE Foundation Programme') Business Case. The *Genesis Consulting Assurance Review Report*, included as Appendix A, noted the following.

"The revised eSPACE Foundation Programme estimates resulted in an apparently substantial increase in the total Programme budget from approximately $47m to approximately $75m." The report also noted: *"costs of original Programme scope are unchanged from September 2015. However, the re-profiled Programme resources have significantly increased and therefore (so have) the total costs. The methodology for resource profiling and estimations appears sound."*

Prepared using Treasury's Better Business Cases five-case model, this investment proposal:

- strategically aligns to national and regional priorities and is supported by a compelling case for change
- identifies a range of programme options and recommends a preferred programme solution that optimises value for money
- adopts an implementation plan that is both informed and led by clinicians
- demonstrates the preferred programme is commercially viable and supported by a strategic procurement approach
- evidences an approach that provides DHBs with safeguards to stop or proceed before committing additional resources, at each stage of the eSPACE Programme Roadmap
- sets out the funding requirements of the preferred option and demonstrates that the preferred programme can be funded from committed resources and revenue sources
- demonstrates the programme can be delivered successfully from a management perspective.

A summarised overview of each case is provided below, with full detail in the following sections of this Programme Business Case.

1.1 The Strategic Case

1.1.1 The Strategic Context

Access to accurate, integrated patient information is a strategic national, regional and local priority. Regional integration of digital clinical information represents the first phase of the Ministry's path toward a single electronic national health record.

This Programme Business Case supports national strategies that identify accessible, standardised clinical information across sectors and borders as a high priority for all New Zealand DHBs. This includes the *New Zealand Health Strategy 2016*, the National Health IT Plan and now *Digital Health 2020*, which prioritise electronic health records and regional integration for the future of IS investment.

Regionally, these priorities are implemented through the *Midland Regional Strategic Direction 2016-2019*, the *Midland Regional Clinical Services Plan* and the *Midland Regional Information Services Plan*. Together, these key documents provide a strategic framework that outlines the implementation of unified Clinical Data Repositories and a regional clinical workstation as a key step toward health practitioners having online access to complete clinical records.

1.1.2 The Case for Change

This section outlines the key drivers for change, sets objectives for the investment proposal and considers the potential scope of a new solution, outlining key benefits and risks.

The existing arrangements for clinical IS in the Midland region are aging, out of step with clinical demand and patient expectations and unsustainable in the medium term. Characterised by localised patient information, end-of-life IS and paper-based workflows, Midland's electronic health management lags behind national initiatives and DHB progress in other regions. In recognising the need to combat a legacy of ineffective IS-led change, Midland DHBs have developed the following objectives for a clinically-led IS strategy:

1. Improve the quality of patient care and reduce risks to patients by providing a consistent, complete and integrated view of patient information.
2. Better support clinical practice through improved access to clinical information and tools.
3. Provide information systems that more effectively align with clinical outcomes.
4. Create a clinical information system solution that is supportable, consistent, responsive to change and able to efficiently accommodate an increase in service demand over a 10-year period.

The gap between the existing arrangements and the desired future state described by the above investment objectives is represented by a set of business needs, which include:

- integrated information for clinicians

- transformation in clinical practice
- consistent standards for data entry
- elimination of manual systems
- alignment of clinical and IS requirements
- robust data
- an intuitive, convenient interface
- strategic change and transformation with strong governance
- strategic alignment, and
- responsiveness to change.

Potential programme scope is considered in this section, outlining a range of options for which data sources might be available and the range of potential users that will have access, as well as key service requirements. A high-level description of financial and qualitative benefits and risks is provided, along with the key constraints and dependencies that might hinder or assist the achievement of stated investment objectives.

1.2 The Economic Case

With the strategic context of the investment proposal determined and a robust case for change established this section:

- identifies evaluation criteria
- generates a range of potential Programme options, and
- appraises these options to determine a Programme solution that will potentially optimise value for money.

It also appraises potential benefits and risks further, to determine the marginal value for money compared to the status quo. The economic case concludes by recommending a roadmap of enabling projects, to form the preferred eSPACE Programme.

1.2.1 The Long List

In 2015, a long list of programme options was identified by using the Better Business Cases best-practice options framework and considering potential choices for each of the five dimensions of choice. These dimensions are comprised of: service scope, service solution, service delivery, implementation and funding. Long-listed options were appraised qualitatively against the investment objectives and a set of critical success factors, to determine the preferred choices for each of the five dimensions.

This programme business case retains this 2015 analysis as the basis for identifying the long list, short list and preferred programme option.

The critical success factors used for appraising the long list options are:

- affordability
- feasibility
- Midland capability and integrity
- partner capability and integrity
- stakeholder commitment
- change impact and effort.

1.2.2 The Short List

On the basis of an initial analysis of the long-list options, a short-list of six Programme options were selected and subjected to further and more detailed qualitative appraisal. Short-listed options are as follows:

- Option 1: status quo, do nothing or do minimum.
- Option 2: local change, where existing standalone systems are upgraded individually.
- Option 3: aligned change, where existing systems are upgraded with a common solution.

- Option 4: collaborative change, where existing systems are upgraded with a regionally designed workstation solution.
- Option 5: regional staged change, where a standardised solution is implemented at a regional level with staged implementation of regional clinical IS functionality.
- Option 6: regional 'big bang' change, where a standardised solution is implemented at a regional level with big bang implementation through a single regional project.

Analysis revealed that option five – regional change through a staged implementation – offers the optimal balance of advantages and disadvantages, and scores the highest against investment objectives and critical success factors.

1.2.3 The Preferred Programme Option

On the basis of detailed analysis, the preferred programme is **Option Five: Regional Staged**. This is described in more detail below and is recommended as the eSPACE Programme approach.

Table 1 – Preferred Programme Option

Description of the Preferred Programme Option Five: Regional Staged
Regional – standardised solution implemented at regional level. ▪ This would take a regional approach to implementation of clinical workstation solutions. ▪ Responsibility for delivery to meet DHB and regional needs would rest with a regional programme team. ▪ Capability would be built at a regional level to undertake implementation and ongoing support.
▪ Use in-house IS and change management capability within HealthShare and individual DHBs to deliver service transformation and ongoing IS support.
▪ Access to core clinical hospital data and patient information available to registered users only.
Staged implementation of regional clinical IS functionality. ▪ This would take a phased approach to meeting immediate DHB and longer term regional needs.
▪ Fully funded by the five DHBs and based on a Population Based Funding Formula (PBFF) for splitting capital and operating expenses.

A five-year eSPACE Programme Roadmap to deliver the preferred programme option has been defined. This roadmap is based on clinical priorities identified through regional governance groups, the capability available within the Midland region and from potential partners, and existing or planned Midland DHB activity.

The preferred programme option and the Status Quo (or do nothing) option were appraised further by an economic cost benefit analysis, assessing estimated costs and benefits that could be represented in monetary terms.

This analysis demonstrated that, on the basis of current mid-point estimates of costs and benefits, the marginal NPV of the preferred programme compared to the status quo is approximately $6.2 million, over a 10 year period. The preferred programme option thus best meets the objectives and needs of this proposal.

Further economic analysis demonstrated that the preferred programme also potentially provides significant qualitative benefits compared to the status quo. This section reviews a case study for a comparable New Zealand implementation, and supports a targeted approach to realising benefits from delivery of the preferred programme.

It should be noted that NPVs compare two options of a future state: the existing systems and the proposed eSPACE Programme. The latter includes the full benefits of the proposed programme – benefits which would not be delivered to the same scope by upgrades to existing systems. NPV analysis does not, therefore, provide a direct 'apples with apples' comparison and as such should be regarded as indicative.

1.3 The Commercial Case

The commercial case outlines a strategic approach to procurement that will deliver the services required by the eSPACE Programme.

1.3.1 Procurement Strategy

Waikato DHB procurement will advise eSPACE in sourcing IS partners. This includes partners for the regional clinical workstation, known as the Midland Clinical Portal (MCP), unified Clinical Data Repositories (CDRs) and supporting services. Leveraging existing agreements, collective sourcing and in-house resources whenever possible, eSPACE will comply with the *Government Rules of Sourcing*.

1.3.2 Procurement Plans

An effective procurement methodology will guide all future sourcing across the programme. This methodology, outlined in the procurement plan for the programme, includes well-defined governance structures, independent quality assurance (IQA) when appropriate, and robust contract processes.

The Orion Health Clinical Portal (formally known as 'Concerto') product will be used for the Midland Clinical Portal, due to the extensive reach of this solution across New Zealand DHB regions. Orion Health have been pre-selected as a critical partner and a regional contract has been awarded based on advice received from the Ministry of Health and a set of evaluation criteria that assesses alignment with national and regional strategies and product reach across other New Zealand DHBs. eSPACE is yet to select partners for CDR software or Midland Medicines Management solutions and services. The programme will evaluate technology on a project by project basis using a 'best of breed' approach, with the most appropriate partners selected for each aspect of the programme via the approved procurement methods.

1.3.3 Contract Details

Contract lengths, where decided, have been determined based on the expected useful life of the required services. Contract lengths confirmed to date are six years for the Midland Clinical Portal and three years for website development services.

Payment mechanisms will be negotiated to provide incentives for partners to deliver ongoing value for money. Performance-based, time and materials basis and embedded model contracts will be used as appropriate for specific partners and solutions.

1.4 The Financial Case

The purpose of this section is to set out the funding requirements of the preferred option and demonstrate that the preferred programme can be funded from committed resources and revenue sources.

The eSPACE Programme financials were assessed by Genesis Consulting in 2016. The Assurance Review Report confirmed the forecasting process used by eSPACE provides a viable estimate for the delivery of the programme.

This Programme Business Case is based on an estimated cost of approximately $75 million over the expected five-year development and implementation of the Programme. The whole-of-life cost is estimated as being approximately $109 million over 10 years.

Consistent with BBC guidance, the basis of allocating costs among DHBs in this programme-level business case is PBFF. It is recognised, however, that PBFF may not always be the most appropriate basis and the programme will work with the region's Chief Executives to determine the best approach on a project by project basis.

1.5 The Management Case

This section demonstrates that the eSPACE Programme is achievable, and sets out the plans required to ensure successful delivery.

1.5.1 Programme Management Arrangements

The eSPACE Programme will be managed using industry standard methodologies including MSP, PRINCE2 and ADKAR for Programme management, project management and service transformation. These methodologies, widely accepted as best-practice, are scalable and adaptable to support both business and IS-centric projects. The strategy, framework and plan to effectively manage risk are outlined in the *HealthShare Risk Management Strategy – ICT-enabled Programmes and Projects*.

A robust structure for governance and reporting, along with a clearly identified suite of roles and responsibilities, complement a comprehensive framework of programme milestones.

To facilitate success across the board, the programme is divided into five areas of management responsibility:

1. Programme Management
2. Technology
3. Financial
4. Change and Transformation
5. Communications and Quality.

All areas contribute to strategic planning, reviews and reporting. Each area has a framework and protocols articulated through key programme documents. These frameworks provide clear operating parameters for all individual projects within the programme and are designed to support an empowered and responsive working environment for project teams.

1.5.2 Benefits Realisation and Risk Management

Working with the region, benefits planning gives detailed consideration of the conditions required to realise benefits, along with a clearly defined framework for benefits measurement and management. Responsibility for benefits measurement and management will sit collaboratively with the programme and the region's DHBs.

The Benefits Realisation Framework draws from the National 'Triple Aim' which reflects high-level outcomes for individuals, populations and systems.

This approach, combined with a five-step risk management process and alignment with the HealthShare Risk Management Strategy, aligns fully with PRINCE2 principles to identify, assess and manage both risk and benefits on an ongoing basis.

1.5.3 Post Project Evaluation Arrangements

Post project evaluation for the eSPACE Programme follows the Better Business Cases methodology. This methodology includes Gateway reviews at regular milestones, Independent Quality Assurance (IQA) and Technical Quality Assurance (TQA), regular Post Evaluation Reviews (PER) and a Post Implementation Review (PIR) within six to 12 months of programme closure. Ongoing monitoring and evaluation round out a continuous improvement approach to addressing recommendations.

1.6 Next Steps

This Programme Business Case seeks approval to proceed with the Midland eSPACE Programme, with an estimated funding envelope of $75 million over the five year period from 2015 to 2020.

Over 10 years, whole of life costs are estimated to be approximately $109 million. All individual projects within the eSPACE Programme are dependent on this core programme funding envelope. The Midland Chief Executives have been clear in their expectation that eSPACE will be run as a programme with regular checkpoints so that Midland DHBs can validate the ongoing process and ensure alignment with their regional priorities. The programme is required to plan and formally advise milestones where the next 'module' of work can be reviewed by the Midland DHBs.

Approval of this Programme Business Case provides eSPACE with authority to formally initiate the Midland eSPACE Programme. The core programme deliverable is the development and implementation of an integrated Midland Clinical Portal (MCP) which is aligned to an agreed eSPACE Programme Roadmap.

In signing this document the Chief Executives and Chairs, on behalf of the Midland DHBs approve and agree the following.

1. Approve:
    a. the funding envelope for capital and operating expenditure for the eSPACE Programme
    b. the programme scope and approach as outlined in this eSPACE Programme Business Case
    c. the Programme Governance structure and SRO having the delegated authority to make project by project decisions within the approved programme scope and funding envelope on behalf of the Midland DHBs
    d. the programme delivering agreed scoped projects within the authorised funding envelope, subject to proper governance controls and funding through annual budget processes, without the need for subsequent individual project business cases.

AND

2. Agree:
    a. that the eSPACE Programme submit this Programme Business Case, on behalf of the region, for Ministry of Health endorsement and Ministerial/Cabinet approval as appropriate
    b. that all Midland DHBs will deploy the Midland Clinical Portal to replace existing Midland DHB systems as soon as is practicable and, where possible, within the programme timescales
    c. that Midland DHBs will, within the programme scope, prioritise programme implementation alongside local priorities
    d. that any projects not within approved scope and outside of the agreed funding envelope will require either formal change control or individual business cases to be submitted.

For signing authority please refer to section 7.2 of this document.

The strategic context provides an overview of the organisation and demonstrates that the proposal is well-aligned to relevant Government strategies and Ministry of Health (the Ministry) outcomes. The case for change outlines how patient information is currently managed, identifying business needs and the potential scope of solutions to address these issues.

2 The Strategic Case

The Strategic Context

Access to accurate, integrated patient information is a strategic national, regional and local priority. Regional IS integration represents the first phase of the Ministry of Health's path toward a single electronic national health record (EHR).

This programme business case supports national and regional strategies that identify accessible, standardised clinical information across sectors and borders as a high priority for all New Zealand DHBs.

2.1 The Midland Region

2.1.1 Population Overview

The North Island Midland region stretches from Cape Egmont in the West to East Cape. With a population of approximately 889,000 in 2015, the Midland region constitutes approximately 19 per cent of New Zealand's population.

Distinguishing features compared to New Zealand as a whole are:

- a much higher proportion of Māori
- a lower proportion of the population identifying as Asian or Pacific
- a higher number of people living in rural areas
- a higher proportion of people living in areas identified as high deprivation.

2.1.2 Midland Health

The region comprises five District Health Boards: Bay of Plenty, Lakes, Tairāwhiti, Taranaki, and Waikato. These encompass the major population centres of Tauranga, Rotorua, Gisborne, New Plymouth and Hamilton.

The wider health sector in Midland includes:

- eight Public Health Organisations (PHOs)
- 189 health centres/family practices/medical centres
- 173 pharmacies
- 43 private health providers.

Figure 2 – Midland DHBs

There are 2,226 hospital beds available in the region. Collectively, Midland DHBs employ 11,913 staff members across 331 services, 77 per cent of whom are clinical staff.

2.2 Organisational Overview – HealthShare

All five of the Midland DHBs are shareholders in HealthShare Ltd, a shared services agency that provides operational support for regional functions. HealthShare is custodian to the eSPACE Programme.

Originally established in 2001 for third-party audit and assurance, HealthShare now employs a permanent staff of 51 and coordinates a number of cross-sector programmes and workstreams to support Midland DHBs.

While shareholder-DHBs seek direct impacts on local health outcomes in their area, HealthShare plays a regional support role. As an independent entity with representation from across the Midland region, HealthShare supports clinical change by providing regional planning, clinical networks, workforce development and shared services.

2.3 Organisational Structure – HealthShare

The following graphic outlines HealthShare's organisation structure. In accordance with the HealthShare Shareholders Agreement, each Midland DHB appoints one director to the five-member Board. In practice, the Chief Executive (CE) of each Midland DHB is usually appointed to represent their area. Appointments are open-ended, usually linked to the tenure of each CE, and are not remunerated.

The CE is accountable to the Board, through the Chairman, for the management of HealthShare and day-to-day operations. The Board meets monthly to monitor performance and progress against organisational strategies.

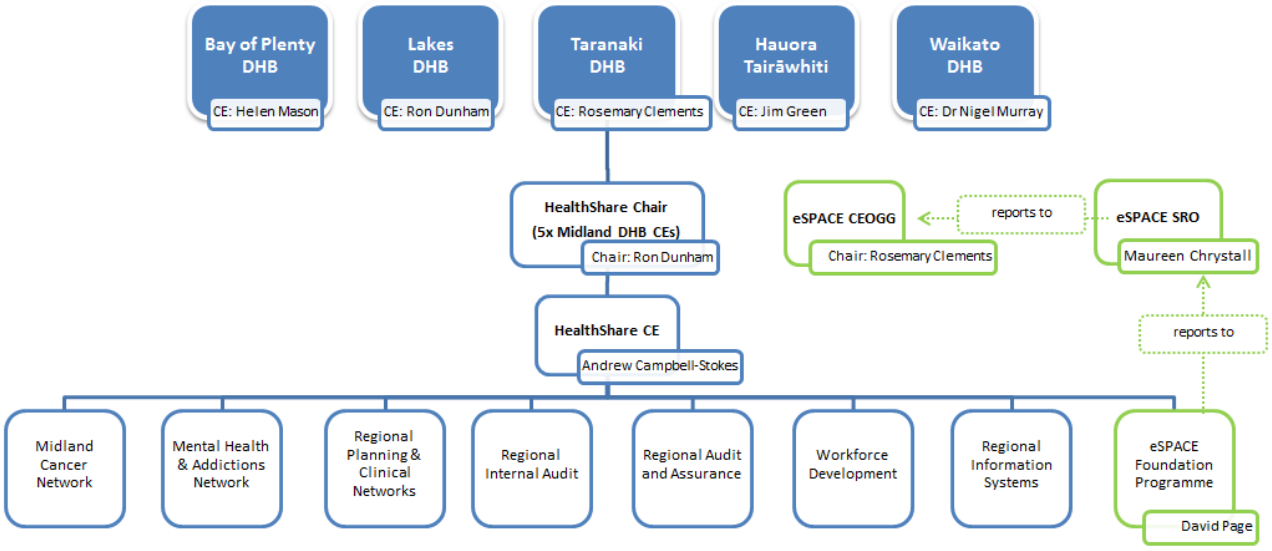

Figure 3 – HealthShare Organisational Structure

Functional Areas

HealthShare's activities are represented by four key functional areas. Each functional area delivers a cooperative approach to the strategic and administrative needs of the five DHBs:

1. Regional Planning and Cooperation. Strategic planning, reporting and analysis to support cooperative activities.

2. **Regional Information Systems.** Building regional IS capability, including the development and implementation of clinical information systems initiatives.
3. **Workforce Development.** Regional training programmes for DHB staff.
4. **Shared Services**. Support functions including audit and assurance.

The eSPACE Programme rests alongside the 'information systems' functional area; however, it is a regional activity that has significant reach into regional planning and cooperation activities.

2.4 Organisational Overview – eSPACE Programme

2.4.1 Vision – eSPACE Programme

In mid-2016 the Midland Chief Executives clarified the need for an updated vision specific to the eSPACE Programme. On Friday 25 November 2016, senior Midland DHB executives met to discuss the programme's vision and principles. Existing versions of the eSPACE vision (2013, 2015 and 2016) were considered for relevance to the ongoing aspirations of the programme, and the following statement selected as preferred:

'**Transformation of clinical care through digital strategies**'.

2.5 Organisational Structure – eSPACE Programme

The eSPACE Programme currently retains a core team of approximately 12.0-14.0 FTEs, supported by specialist contractors as required. Contracting resource and Midland DHB secondments can be scaled up or down according to programme and/or project need.

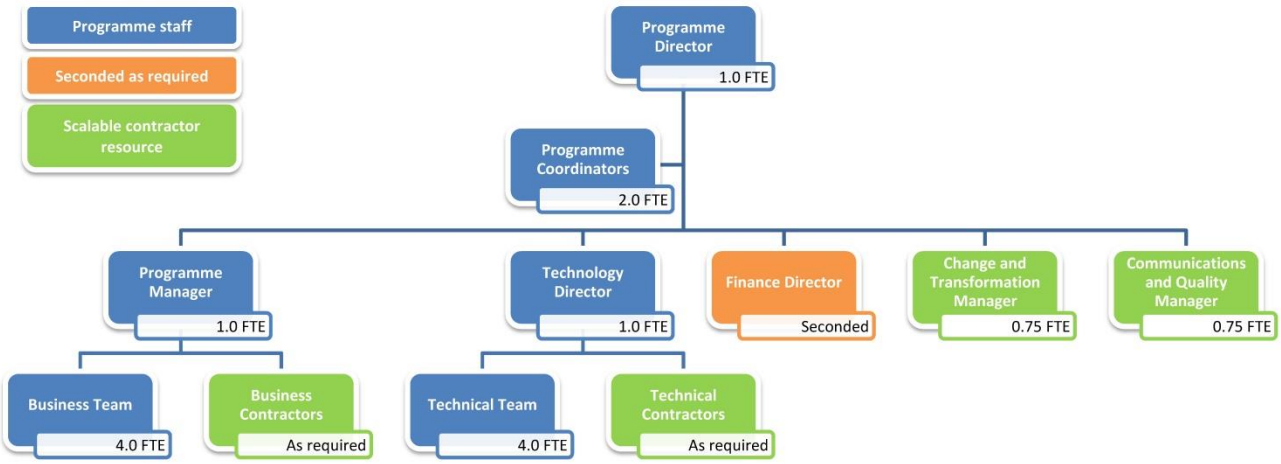

Figure 5 – eSPACE Programme Organisational Structure

2.6 Strategic Direction – National

This section outlines the key national priorities which inform and shape the direction of the eSPACE Programme. The Government and Midland region's shared strategic approach is to encourage and facilitate the sharing of consistent electronic patient information as a critical enabler to safer, more efficient healthcare. Government is encouraging movement toward a single electronic national health record, starting with regionally integrated clinical data.

2.6.1 New Zealand Health Strategy 2016

The *New Zealand Health Strategy* sets the direction of health services to improve the health of people and communities. The vision of a more 'fit for the future' system is that "all New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system [1]." Effective management of clinical information is a clear priority, with a strong emphasis on integration across geographic borders and health sectors.

Action 26c of the *National Health Strategy Roadmap* specifies that public hospital-based health providers should use a common provider portal to access medical records, standardised to enable effective sharing of medical records.

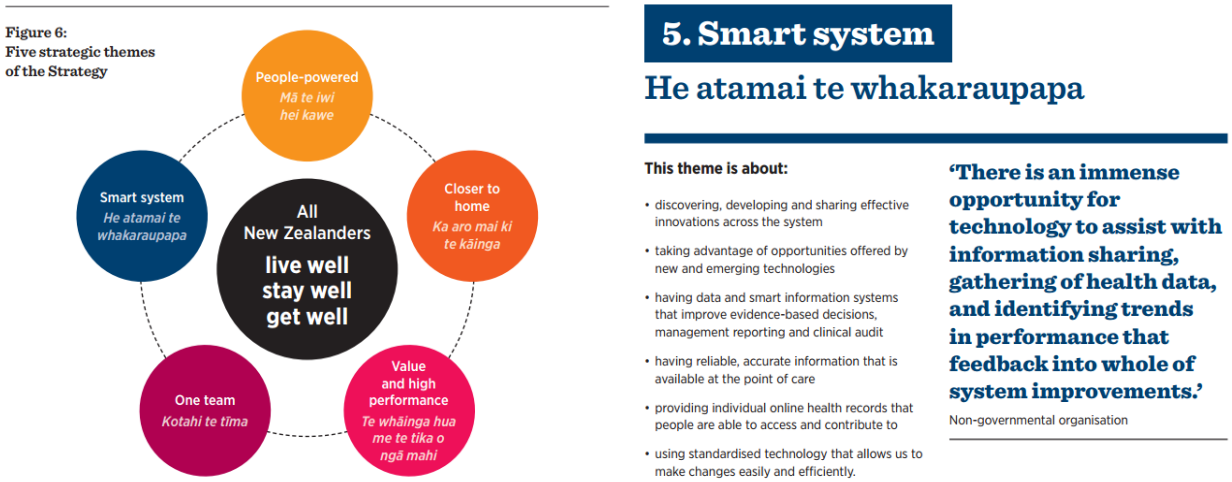

Figure 6 – New Zealand Health Strategy 2016 Strategic Themes

2.6.2 Digital Health 2020

Digital Health 2020[2] was released in November 2016. Developed in response to the New Zealand Health Strategy, *Digital Health 2020* is designed "to progress the core digital technology opportunities presented in the strategy. It delivers on the strategy's focus areas that together will drive towards a uniform information platform and a consistent data approach across the sector". *Digital Health 2020* has clarified and refined the expectations of the (former) National Health IT Board's National Health IT Plan, initially released in 2010 and updated in 2013/14.

Like the National Health IT Plan before it, *Digital Health 2020* reflects an expectation for greater cooperation among health sector participants – from sharing of data to convergence on consistent regional and national solutions. *Digital Health 2020*, however, has a stronger practical focus which reflects recent advancements in thinking around Electronic Medical Records (EMRs) and Electronic Health Records (EHRs).

[1] The latest strategy was published online at http://www.health.govt.nz/new-zealand-health-system/new-zealand-health-strategy-future-direction/future-we-want, updated 14 April 2016.
[2] See http://healthitboard.health.govt.nz/health-it-programme-2015-2020-0

The overarching goal of *Digital Health 2020* is to deliver on the focus areas of the New Zealand Health Strategy. Together, these focus areas will drive towards a uniform information platform and a consistent data approach across the sector. The intersection between Ministry and DHB-led projects is clearly defined, with regional integration initiatives such as the eSPACE Programme at the foundation level of the work.

There is a clearly stated expectation that all DHBs will adopt aligned and consistent clinical data repositories and Clinical Workstation (CWS) solutions, implemented as regional platforms and based on national standards and alignment.

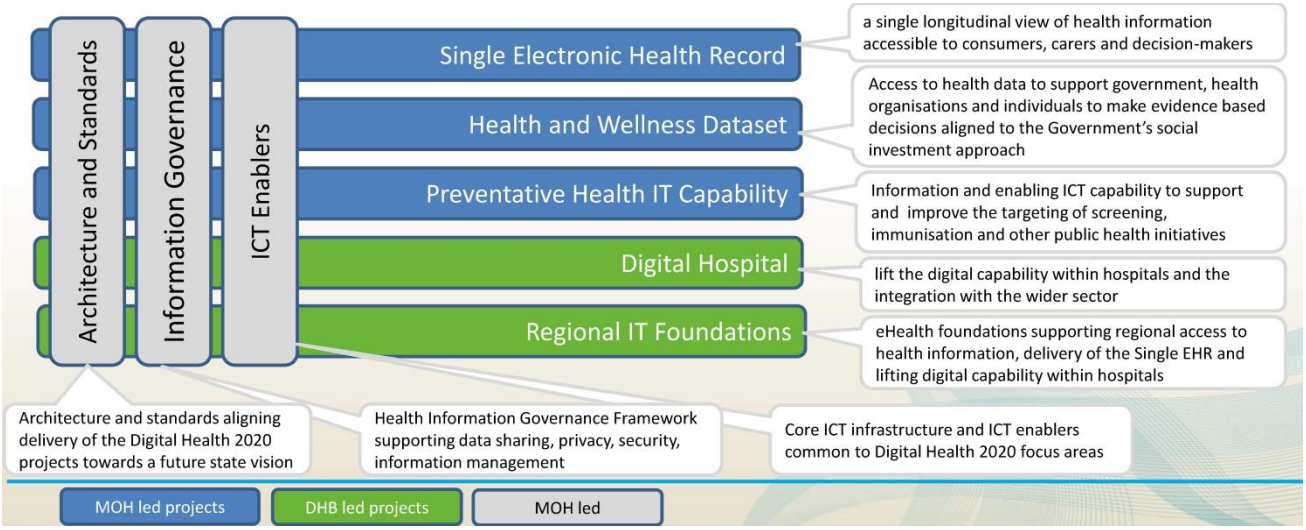

Figure 7 – *Digital Health 2020* Overview

2.6.2.1 Principles: National to Programme

When describing the importance of IT to the health sector, *Digital Health 2020* outlines seven overarching principles, all relevant to IT investment at both the regional and national level. There is significant alignment between the national principles for *Digital Health 2020* and the principles developed for the eSPACE Programme, outlined below.

Strategic Alignments: National to Programme Principles		
National Principles	**eSPACE 'Working Together' Principles**	**eSPACE Programme Principles**
Work in partnership with people and communities at all levels.	▪ We are committed to collective success in the achievement of our regional vision for clinical information. ▪ We will work together with openness, honesty, integrity and transparency. ▪ We will communicate with each other simply, clearly and effectively.	▪ Stakeholders who will be affected by our work are identified; and we commit to involving them in the process at an appropriate level.
Focus on clinical and executive leadership, governance and buy-in.	▪ We respect, and seek to understand, each Midland DHBs unique needs. ▪ Collective cabinet responsibility applies to everyone involved with eSPACE: once there has been opportunity for discussion and debate within a contributing group, all members will publicly support the decisions of their group, even if they do not privately agree with them.	▪ Our vision is aspirational and as a region we are ready and willing for radical change around the delivery and use of clinical information.
Design solutions end-to-end by considering business operating models, processes and systems.		▪ Midland DHBs agree to free up time for clinicians to engage with and contribute to the programme at appropriate levels. ▪ Scoping of potential future strategic solutions for the region will continue while funding eSPACE implementation and other local tactical initiatives.
Insist on clear accountability for delivery and actively manage progress.	▪ We will act responsibly, work efficiently and do everything we can to achieve our milestones.	
Leverage existing government and sector capabilities and align existing activities; stop misaligned activities.		▪ Sub-regional implementation of the regional solution is acceptable, if all Midland DHBs agree and if there is regional agreement on what longer-term alignment looks like and when it will happen. ▪ New local initiatives should align to the region's strategy, with potential and pathways for development and/or learnings to be fed back into the regional process.
Target those investments that deliver most value.		▪ Adopt a 'no regrets' policy to early failures: allow for strategic scoping of possibilities, identify the most significant risks/assumptions and resolve/test them for viability as soon as possible, recognising and accepting not all will proceed.
Strengthen the role of standards and architecture and work collaboratively with partners on compliance.		

Table 2 – Strategic Alignments

2.7 Strategic Direction – Regional

Through a regional strategic plan, Midland DHBs give effect to national strategies and priorities in accordance with regional needs. For 2016-2019, this takes the form of a Regional Strategic Direction and a Regional Services Plan. Regional IS priorities are further delineated in a Midland Regional Information Services Plan. All three regional documents inform and connect with the eSPACE Programme strategic approach.

2.7.1 Midland Regional Strategic Direction 2016-2019

The Midland Regional Services plan for 2016-19 has as its central focus the greater achievement of health and wellbeing for the populations served by the Midland DHBs. It focuses on the achievement of two regional strategic outcomes – improving the health of the Midland populations and eliminating health inequalities – and outlines six regional strategic objectives.

2.7.2 Midland Regional Service Plan 2016-2019

The *Regional Service Plan* identifies the development of a regional clinical information system as a priority objective: **Regional Objective 5: Improve Clinical Information Systems**. A regional clinical information system is considered key to enabling the Midland region to support local, regional and national priorities.

Implementation of Objective 5, over the next three years, is to focus on regional deployment of:

- a Regional Clinical Workstation (the Midland Clinical Portal)
- a regional clinical data repository
- the *Midland Regional Telehealth Strategy*, and
- processes outlined in *Digital Health 2020*. (Note this is referenced in the Regional Services Plan as *'National Health IT Programme 2015 – 2020'*, as at the time of regional plan publication *Digital Health 2020* had not yet been finalised.)

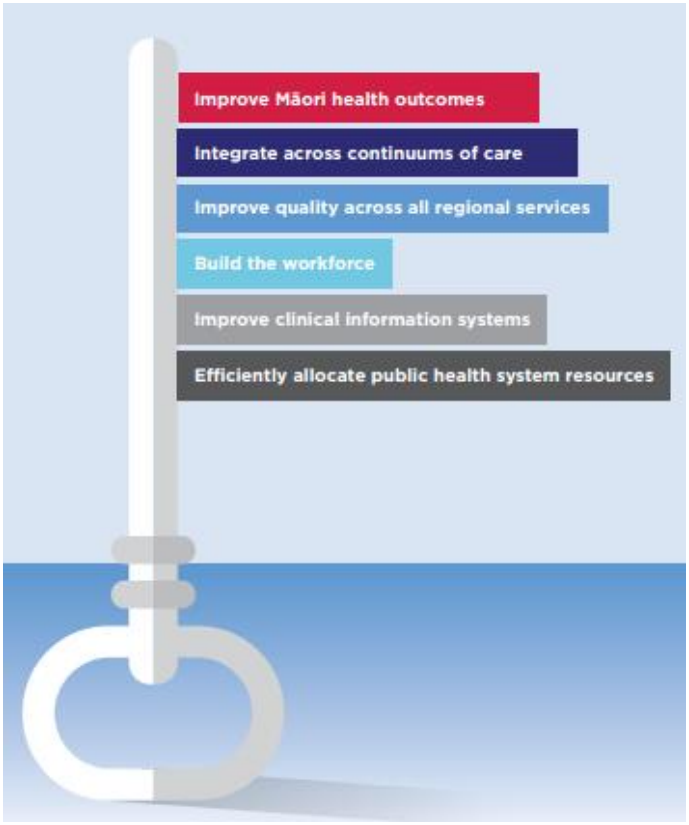

Figure 8 – Midland Regional Strategic Objectives

2.7.3 Midland Region Information Services Plan (MRISP)

The *MRISP* describes the regional IS priorities to support local, regional and national action. The *MRISP* aligns to the *Regional Services Plan, the Midland Regional Clinical Services Plan* and describes the regional IS priorities to support local, regional and national action.

The *MRISP* outlines six programmes of work to support the goal of an integrated shared care solution for the Midland region, three of which (programmes 1, 2 and 3) are now delivered from within the eSPACE Programme:

1. Clinical Data Repository Programme.
2. Clinical Workstation Programme.
3. Medications Management Programme.
4. Integrated Patient Care Programme.
5. Business Intelligence Programme.
6. Midland One Health Programme.

The *MRISP* is currently under review, with a new *Midland Regional Information Services Strategy* (MRISS) for 2016-2020 in development.

The Case for Change

The existing arrangements for clinical IS in the Midland region are ineffective and unsustainable in the medium term. This section outlines the key drivers for change, sets objectives for the investment proposal and considers the potential scope of a new solution, including key benefits and risks.

2.8 Existing Arrangements

2.8.1 Localised Patient Information

Any change process should begin with a clear understanding of the current state. The existing clinical workstation arrangements across the five Midland DHBs are characterised by:

1. localised patient information isolated in silos
2. paper-based clinical workflows
3. end-of-life information systems
4. progress lags relative to national initiatives and DHB progress in other regions
5. a legacy of ineffective IS change.

Historically, the five DHBs in the Midland region have undertaken clinical IS investments on the basis of satisfying immediate local business needs. This has resulted in a relatively siloed environment, with five disparate patient data silos. While local developments have in many cases provided substantial local DHB benefits, regionally this approach has had significant impacts on information flow:

- Access to patient information is predominantly restricted to clinicians working within organisational boundaries.
- Many of the information systems currently in place across the region do not support the standards that would allow sector access to patient information between organisations and systems. (Examples are SNOMED CT, HPI-CN.)
- Four of the five Midland DHBs have their own existing clinical workstation, underpinned by the system's data repository.
- Each DHB continues to run its own IS function led by a local CIO, with HealthShare's regional IS function coordinating some regional strategic alignment of information services via the *Midland Regional IS Plan* (MRISP).
- Some sub-regional integration has occurred over time: some primary care clinicians have restricted access and there has been some sub-regional aggregation of laboratory and radiology information – but overall there is no consistent regional DHB access to Midland patient information.

A comparison with other regions highlights the extent of the Midland fragmentation compared to other regions.

Table 3 – Regional DHB Clinical Information Systems

Region	DHBs	Clinical Workstation
Northern	Northland, Waitemata, Auckland, Counties Manukau	▪ Orion Concerto, implementing Orion's e-Referrals module and supported across some needs by Sysmex Éclair. (Note: the Northern region is currently researching an enterprise solution, EPIC.)
Midland	▪ Lakes	▪ CSC HealthViews, sub-regional Sysmex Éclair.
	▪ Tairāwhiti	▪ CSC HealthViews.
	▪ Waikato	▪ Locally customised and enhanced CSC HealthViews.
	▪ Bay of Plenty	▪ CHIP (in-house development), sub-regional Sysmex Éclair.
	▪ Taranaki	▪ Locally customised Orion Concerto, Sysmex Éclair.
Central	Hawkes Bay, Whanganui, MidCentral, Wairarapa, Capital and Coast, Hutt Valley	▪ Orion Concerto, first implementation of the regional clinical portal at Whanganui DHB.
Southern	Nelson Marlborough, West Coast, Canterbury, South Canterbury, Southern	▪ A DHB-led model with CDHBs' existing Orion Concerto being progressively rolled out to the Southern DHBs, with considerable development at CDHB, implementation of Orion's Clinical Workflow Suite, integration with primary healthcare and partnership with Pegasus.

2.8.2 Paper-Based Clinical Workflows

Existing clinical workstations offer limited tools to electronically support specific clinical workflows such as transfer of care, mental health assessments or referral management. A lack of electronic capability at some Midland DHBs results in predominantly paper-based systems in some areas (notably mental health), which significantly limits access to clinical information across the spectrum of care settings. There is also limited ability to integrate cross-sector clinical pathways into an electronic workflow.

Information collection in some areas relies extensively on paper forms and manual data entry, an inefficient practice that leads to duplication of effort, time lags in the availability of updated information and is out of step with recognised best practice.

2.8.3 End-of-Life Information Systems

As each of the Midland DHBs has an existing clinical workstation providing access to patient information, each DHB has an individual contract with their clinical workstation partner and supporting information technology, resulting in IS resources being duplicated across the region.

Table 4 – Midland DHBs Clinical Information Systems Status

End-of-Life Information Systems		
Midland DHB	Information Systems	Comments/Status
Bay of Plenty (BOP)	Clinical Health Information Portal (CHIP), sub-regional Sysmex Éclair	▪ Clinical intranet developed in-house based on CDC's HealthViews. ▪ Designed for secondary healthcare. ▪ Consolidates patient information and results. ▪ Not partner-supported, has a legacy technology stack and is largely dependent on a specific local resource.
Lakes	CSC HealthViews, sub-regional Sysmex Éclair	▪ End of life product with a legacy technology stack. ▪ Partner support ends 30 June 2019.

End-of-Life Information Systems		
Midland DHB	**Information Systems**	**Comments/Status**
		▪ Potential of purchasing the source code from CDC and upgrading to the Waikato DHB code base to allow the option of procuring support from the Waikato DHB IS team – short-term mitigation only.
Tairāwhiti	CSC HealthViews, MKM forms, local Sysmex Éclair	▪ End of life product. ▪ Partner support ends 30 June 2019. ▪ Potential of purchasing the source code from CDC and upgrading to the Waikato DHB code base to allow the option of procuring support from the Waikato DHB IS team – short-term mitigation only.
Taranaki	Orion Concerto, local Sysmex Éclair	▪ Local development of Orion software. ▪ Additional local functionality and customisations unsupported by Orion. ▪ Additional older, unsupported version of Orion's Concerto product also in use for elements of mental health functionality. ▪ Consolidated view of significant aspects of the patient's electronic record; however, no single, unified view of a patient's overall electronic medical record. ▪ Using Orion's end of life forms toolkit (Soprano Medical Templates – SMT), not its replacement, Clinical Workflow Suite. ▪ Will require migration to newer versions of Orion product, notably around the upgrade to Orion's CDR.
Waikato	CSC HealthViews	▪ End of life product – source code purchased in 2013. ▪ No partner support, reliant on a local development team. ▪ Unsustainable and in need of replacement over the medium term. ▪ Lack of require functionality to support evolving clinical needs (e.g. mobile technology, workflow, complex electronic forms). ▪ Silo of laboratory results.

CSC's HealthViews is still used by three Midland DHBs (as three separate local instances) and cannot be sustainably partner-supported, which increases support costs and the risk of system failure for these districts.

HealthViews is an end of life product, with Microsoft platform and workstation upgrades no longer supported.

2.8.4 Current Costs

Each Midland DHB incurs annual cost to maintain the status quo for clinical IS in their DHB. 2016 estimates placed this cost at a combined total of $4.1 m per annum increasing to 6.7 m per annum over time for staffing resource costs and partner support and maintenance across the five Midland DHBs.

2.8.5 Midland Region Lags Behind National Initiatives

Regional clinical IS have been progressed across New Zealand, in accordance with National Health IT Plan and *Digital Health 2020* targets.

The most recent regional clinical IS readiness assessment by the former National Health IT Board (NHITB) was undertaken in January 2016. It has been suggested a new assessment will be completed in 2017; but formal advice regarding this process has not been received by the region. It demonstrates that the overwhelming majority of DHBs across New Zealand are implementing or operating a clinical information system that aligns with an agreed regional solution. As the summary below shows, **the Midland region has the lowest score for clinical information system readiness**. (Regional score 4 for Midland vs regional score 8 for Northern.)

NATIONAL HEALTH IT BOARD

Regional Readiness Assessment - ACTUAL (as at 1 January 2016)

Version 17.1 Final

Region / DHB / Regional Project	Workstream	Northern: Northland	Northern: Auckland	Northern: Waitemata	Northern: Counties Manukau	Midland: Waikato	Midland: Bay of Plenty	Midland: Lakes	Midland: Tairawhiti	Midland: Taranaki	Central: Capital & Coast	Central: Hutt Valley	Central: Wairarapa	Central: Mid-Central	Central: Whanganui	Central: Hawkes Bay	South Island: Nelson Marlborough	South Island: Canterbury	South Island: West Coast	South Island: South Canterbury	South Island: Southern
Continuum of Care		Regional Score: 7 ➡				Regional Score: 4 ➡					Regional Score: 6 ➡						Regional Score: 7 ➡				
e-referrals	2	4	5	5	5	5	5	5	5	5	4	4	4	3	3	4	5	5	5	5	5
e-discharges		4	4	5	5	1	1	1	1	4	4	4	4	3	4	4	4	4	4	4	3
Clinical Information System		Regional Score: 8 ➡				Regional Score: 4 ➡					Regional Score: 6 ➡						Regional Score: 7 ➡				
Clinical Workstation	4	4	4	4	4	1	2	3	3	4	4	4	4	5	4	3	4	5	5	5	3
Clinical Data Repository		5	5	5	5	1	5	5	3	4	4	4	4	5	4	3	5	5	5	5	3
Imaging/Picture Archive		Regional Score: 7 ➡				Regional Score: 7 ➡					Regional Score: 6 ➡						Regional Score: 7 ➡				
Radiology/PACS	4	4	4	5	5	5	5	2	5	2	4	4	4	4	4	4	5	5	5	5	4
Regional Archive		1	5	5	5	5	5	2	5	1	5	5	5	5	5	5	5	5	5	5	4
Clinical Support Systems		Regional Score: 6 ➡				Regional Score: 8 ➡					Regional Score: 4 ➡						Regional Score: 5 ➡				
Laboratory	4	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	4
Pharmacy		3	5	1	2	5	5	5	5	5	1	1	1	3	1	4	1	4	1	1	1
Patient Administration System		Regional Score: 3 ➡				Regional Score: 5 ➡					Regional Score: 6 ➡						Regional Score: 6 ➡				
	5	3	2	2	2	4	4	4	4	4	4	4	1	3	3	4	3	3	3	3	2
Regional Summary		*Range 3 - 7*				*Range 4 - 8*					*Range 4 - 6*						*Range 5 - 7*				

Scoring for the Individual DHBs

Red	1	DHB is operating a legacy (going out of support) or orphan solution, or has no solution in place
Pink	2	DHB is operating a local solution not aligned with agreed regional solution
Amber	3	DHB is implementing a local (or regional) solution aligned with agreed regional solution
Pale Green	4	DHB is operating a local solution aligned with agreed regional solution
Green	5	DHB is operating on the agreed regional solution

Scoring for the Region

Red	1	No DHB has experience operating a regional solution and there is no plan
Red	2	At least one DHB plans to implement a regionally capable solution
Pink	3	At least one DHB is operating a regionally capable solution
Pink	4	At least one DHB is operating the agreed regional solution locally
Amber	5	At least half of the DHBs are operating the agreed regional solution locally
Amber	6	Region has a plan (and funding) to implement the agreed regional solution in the next 12 months
Pale Green	7	At least half of the DHBs are operating on the agreed regional solution
Pale Green	8	All DHBs are operating on the agreed regional solution
Green	9	All DHBs are operating on the agreed regional solution: primary and community health organisations use the solution regularly
Green	10	All DHBs are operating on the agreed regional solution: benefits are measured and service improvements made as a result

Figure 9 – NHITB Regional Readiness Assessment 1 January 2016

2.9 Drivers for Change

The existing arrangements for clinical IS in the Midland region are ineffective and unsustainable in the medium term. This section outlines the key drivers for change, sets objectives for the investment proposal and considers the potential scope of a new solution, including key benefits and risks.

2.9.1 Investment Logic Mapping: Important Context

Consistent with Treasury guidance, Investment Logic Mapping (ILM) has been utilised as the most appropriate technique to ensure that robust discussion and thinking is done up-front, resulting in a sound problem definition, before solutions are identified and before any investment decision is made.

In the case of the eSPACE Programme, the ILM process requires additional context as two ILM processes have been undertaken with regard to the eSPACE Programme.

The first process was held in 2013. The second more extensive process was undertaken in late 2016, with problem statements and high level benefits being validated by the Clinical Reference Group Chairs in February 2017. The second process supported that the 2013 investment statements would remain unchanged. This table shows the final validated investment name and problem statements.

	Investment Name	Problem Statements	Weighting
Midland Clinical Portal	One Patient. One Record. *Safer region-wide care by getting the right information to the right people at the right time and place for the right need.*	Fragmented, inaccessible and unreliable records delays sharing of health information which is inefficient and increases risk to patient and clinician safety.	45%
		Lack of effective regional governance, processes and standards delays communication, promotes health care silos, increases duplication, reduces clinician engagement, and increases risk to patients.	40%
		Lack of visible IT progress and associated transition planning to meet the needs of respective DHBs results in clinician and administration frustration, disengagement and further delays in IT implementation.	15%

2.9.2 Investment Logic Mapping with Benefits Identification: 2013

In 2013, facilitated Investment Logic Mapping (ILM) problem definition and benefit definition workshops were held with key stakeholders at the Bay of Plenty, Tairāwhiti and Waikato DHBs[3] to identify and agree the key problems and issues being faced by the Midland DHBs.

These 2013 workshops were facilitated by an experienced and accredited ILM facilitator and attended by selected stakeholders including Chief Executives (CEs), Chief Operating Officers (COOs), hospital management, CIOs and senior clinicians and informed early iterations of the eSPACE Programme Business Case.

The results of the 2013 process are outlined below as they informed the development of an initial Benefits Register for the programme. The identified benefits also aligned to the results of international research and have been shown to be achievable in practice.

It is expected the eSPACE Programme benefit statements will be updated and/or validated in regional benefits workshops scheduled for March 2017. Additionally, throughout the programme, benefits specific to each individual project will be identified and baselined as part of *Project Initiation Documents* (PIDs).

[3] Taranaki DHB and Lakes elected to accept the input of the other Midland DHBs rather than participating directly in the ILM process.

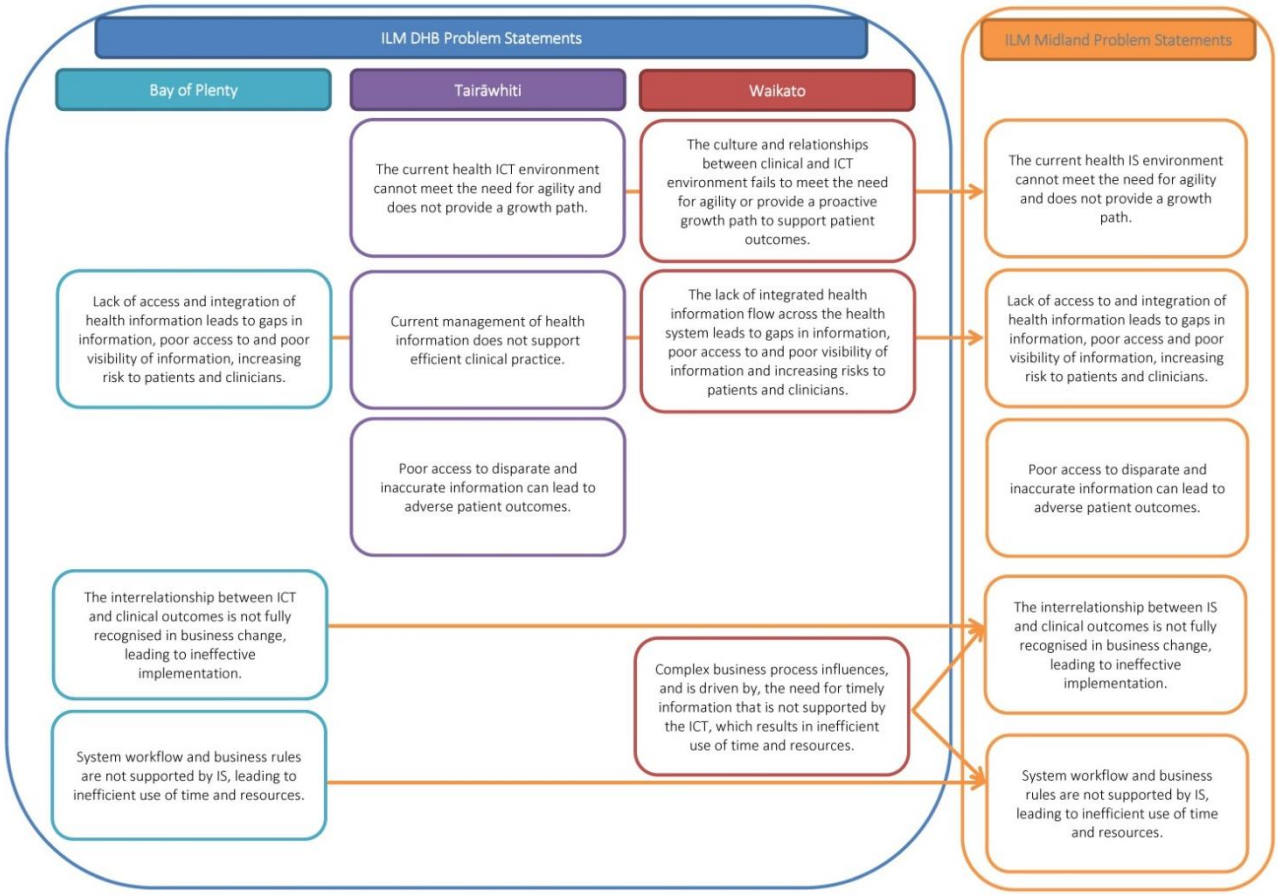

Figure 10 – 2013 ILM Problem Statements

2.9.3 Investment Logic Mapping: 2016

In December 2016, five Investment Logic Mapping (ILM) workshops were held in five locations around the region, in conjunction with a wider consultation around clinical priorities for the eSPACE Programme. The purpose of these new ILM workshops was to:

- revisit the investment drivers for the eSPACE Programme, originally developed through the 2013 ILM process
- invite stronger clinical representation in the process than was the case in 2013
- ensure *current* input from all five Midland DHBs was informing investment decisions
- identify material changes (if any) from the 2013 ILM statements, which had been the basis for benefits assessment.

Participants in these workshops were asked to identify and agree the *current-state* key problems and issues being faced by the Midland DHBs. As noted previously, due to time constraints and the need to prioritise discussion of clinical priorities, this series of workshops explored problem statements but did not proceed to benefits mapping.

The ILM map derived from these workshops is reproduced below. A table summarising the outcomes and weightings of the ILM engagements is included as Appendix B.

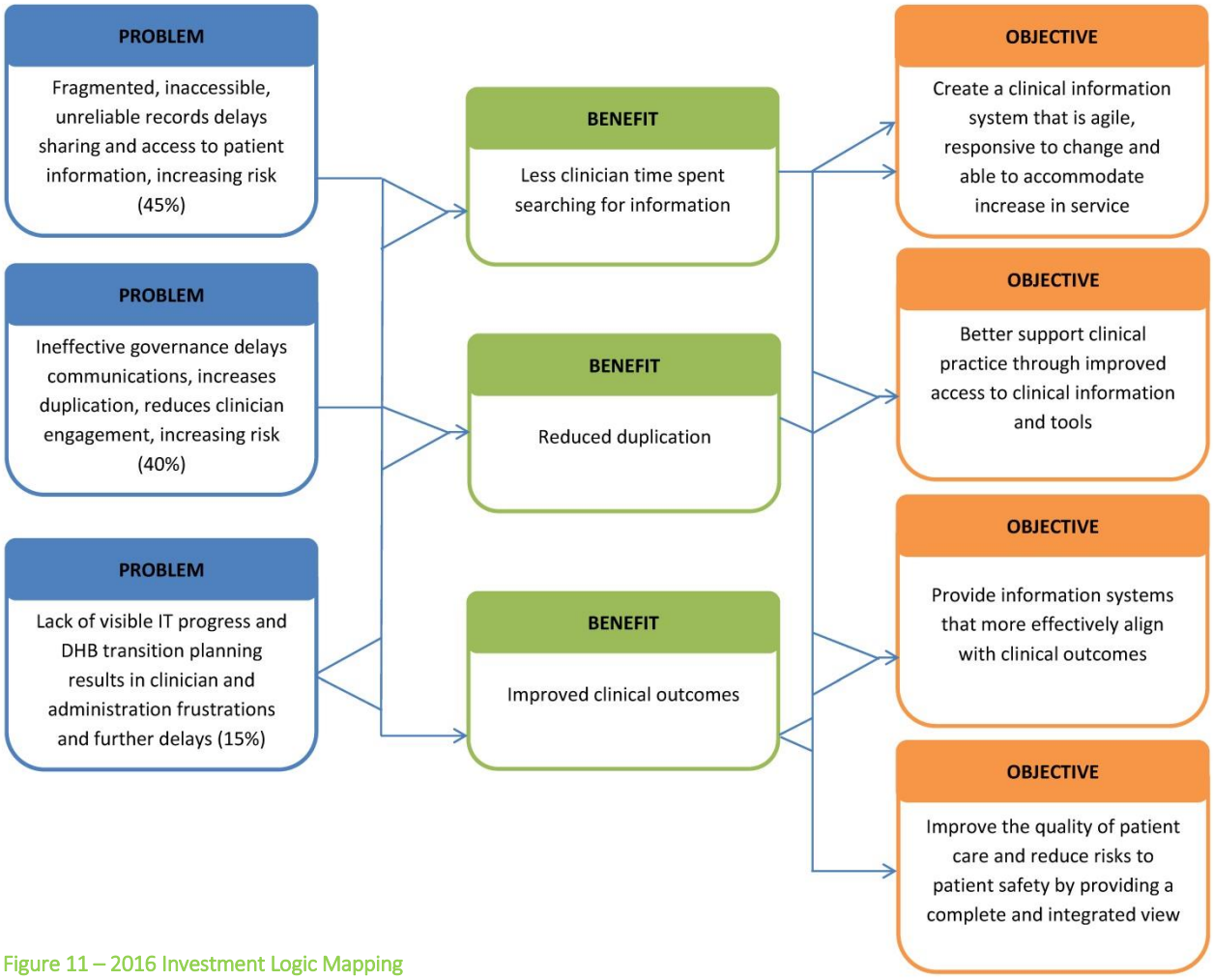

Figure 11 – 2016 Investment Logic Mapping

2.9.4 Clinical Priorities Survey 2016-2017

As a follow-up to the clinical priorities workshops undertaken in December 2016, a formal online survey was run from 23 December 2016 to 9 February 2017. The survey was designed to give all clinical staff at Midland DHBs an opportunity to indicate their preferred priorities for regional electronic records functionality.

A total of 152 staff responded with 40 of these responses incomplete. The remaining 112 complete responses informed the summary data below.

A significant feature of the survey responses was the even distribution of results. In all categories, there was very little difference between the functionality assessed as most important and that assessed as least important. This suggests having an overall regional solution is the main need; rather than any particular functionality within that regional package.

Table 5 – Clinical Priorities Survey Summary Data

Category	Category Ranking with weighted average		Most important functionality within category	Importance of [the category] to your personal practice: top result.
Electronic Imagery: Viewing	=2	4.12	Radiology	Extremely
Electronic Ordering/Referrals	3	4.11	Laboratory	Very
Electronic Results (Viewing and Acknowledgement)	1	5.66	Laboratory	Extremely
Medicines Management	=2	4.12	Electronic reconciliation	Extremely
Electronic Forms and Pathways	5	3.96	Handover	Extremely
Integration or Links to Other Clinical Systems	4	3.99	Secondary Care	Very
Other Functionality (five options defined)	6	2.04	Electronic documents (conversion from paper to digital)	Very

2.10 Investment Objectives

The investment objectives have been developed through a series of workshops and discussions with key personnel. These objectives describe the outcomes stakeholders want to achieve from this investment proposal. They have been further refined and provide KPIs to ensure that they are as SMART[4] as possible, so that success can be measured.

To this end, a series of Key Performance Indicators (KPIs) are proposed that may enable comparison between the current state baseline (described by the existing arrangements) and the desired future state outlined in the objectives and the following pages.

Table 6 – Investment Objectives

	Objective	KPIs
Investment Objective One	Improve the quality of patient care and reduce risks to patient safety by providing a complete and integrated view of patient information.	▪ Record consistency. ▪ Data quality. ▪ Accessible patient records. ▪ Errors in records.
Investment Objective Two	Better support clinical practice through improved access to clinical information and tools.	▪ Availability of records. ▪ Speed to retrieval of data. ▪ Clinician satisfaction survey.
Investment Objective Three	Provide information systems that more effectively align with clinical outcomes.	▪ Clinical user satisfaction. ▪ User satisfaction.
Investment Objective Four	Create a clinical information system solution that is agile, responsive to change and able to efficiently accommodate an increase in service demand over a 10-year period.	▪ System capacity.

2.11 Business Needs

Where the existing arrangements describe 'where we are now' and the above investment objectives describe 'where we want to be', the gap between the two represents the business needs.

[4] SMART = Specific, Measurable, Achievable, Realistic, Time bound

2.11.1 Summary of Business Needs

Table 7 – Summary of Business Needs

Investment Objective	Business Needs
One Improve the quality of patient care and reduce risks to patient safety by providing a complete and integrated view of patient information.	Integrated Information for Clinicians ▪ An aggregated view of core and common clinical information for a patient should be available regardless of care setting or clinician type. ▪ A regional clinical data repository should provide a complete record of diagnostic information such as laboratory results and radiology reports. ▪ A framework, and supporting processes, should be introduced to govern and manage access to patient information.
	Consistent Standards for Data Entry ▪ Consistent data entry and coding to make patient information accessible across other stakeholder systems such as specialty clinical systems, patient portals and other regional information systems. ▪ Consistent standards for information collection and entry will ensure that information is accessible to other stakeholder systems.
Two Better support clinical practice through improved access to clinical information and tools.	Eliminate Manual Systems ▪ Removal of inefficient paper-based clinical workflows to reduce clinicians' administrative burden and enhance patient care. ▪ Tailored functionality is required to meet the specific requirements of Midland DHBs' complex clinical processes and workflows and support more efficient and accurate electronic management.
	Align Clinical and IS Requirements ▪ Improve information systems to accurately reflect the nature and complexity of clinical workflows and business rules, enabling efficient use of time and resources. ▪ A consistent user interface for clinicians in the secondary and tertiary sectors, enabling alignment of clinical processes and workflow, reduction in creates frustrations and inefficiencies in clinical practice and simplification of movement across organisational and sector boundaries.
	Robust Data ▪ The insights offered by robust and reliable data can be used to evolve practice and improve patient care.
	Intuitive, Convenient Interface ▪ The portal must require a single-sign in process that is fast and easy. A consistent and familiar support interface, accessible from mobile, will save administrative time and burden for clinicians.
Three Provide information systems that more effectively align with clinical outcomes.	Strategic Change and Transformation ▪ Establishment of a regional governance structure with appropriate knowledge and expertise is required to fully realise any intended benefits. ▪ A comprehensive change and transformation programme will be required to support effective implementation and foster engagement across the regional workforce.
Four Create a clinical information system solution that is agile, responsive to change and able to efficiently accommodate an increase in service demand over a 10-year period.	Strategic Alignment ▪ Clinical information systems should fulfil national and regional directives. This includes a regionally agreed solution that encompasses both a clinical workstation and data repository.
	Responsive to Change ▪ New systems must include the flexibility to support and respond to evolving clinical and business requirements. ▪ An integrated or shared regional solution will enable more efficient implementation of change across the region.

2.12 Scope and Key Requirements

This section describes the potential business scope (coverage) and key requirements for the eSPACE Programme in relation to the above business needs – the extent of the services offered and the range of customers to which they are offered. The geographical scope of this programme is currently constrained to authorised users working within the Midland region.

The potential business scope elements are set out below. Key service requirements for a clinical information system have been assessed against a continuum of need. This continuum is comprised of the following:

- **Minimum scope** – the essential, or **core** requirements.
- **Advanced scope** – **core plus desirable** requirements.
- **Aspirational scope** – **core plus desirable and optional** requirements.

Table 8 – Potential Scope and Key Service Requirements

	Minimum	Advanced	Aspirational
Potential Scope	Access to core clinical hospital data and patient information.	▪ Core clinical hospital data ***plus*** ▪ primary care (GP) data.	▪ Core clinical data ***plus*** ▪ primary care (GP) data ***plus*** ▪ wider health and social care data (e.g. social services data).
	Service available to registered users only.	▪ Service available to registered users and a broader range of defined primary care services.	▪ Service available to registered users, primary care services and wider health sector providers. ▪ Patient/consumer access (including all of Government users).
Key Service Requirements	Provision of access to a health data service that meets key service requirements as follows. ▪ Always available and no data is ever lost. A fully resilient solution using AoG infrastructure and recoverable systems (disaster recovery), so that the user is unaware of any service disruption. ▪ Is secure, reliable and provides scalable storage. ▪ Provides integrated information for clinicians via an aggregated view of core and common clinical information available regardless of care setting or clinician type with a complete record of diagnostic information. ▪ Provides consistent standards for data entry to improve data quality. This will ensure that patient information is accessible across other stakeholder systems such as specialty clinical systems, patient portals and other regional information systems. ▪ Consolidates patient records to reduce gaps in the information available and visibility to clinicians, reducing inefficiency and risks to patient safety. ▪ Reduces administrative burden through digitisation of records. Tailored functionality is required to meet the specific requirements of the Midland DHBs' complex clinical processes and workflows and support more efficient and accurate electronic management. ▪ Aligns data with clinical flows. Current information systems do not accurately reflect the nature and complexity of clinical workflows and business rules, leading to inefficient use of time and resources. ▪ Delivers an intuitive, convenient interface. This should include a sign-in process that is fast and easy. The interface should be consistent and familiar and support access from a range of devices. This will save administrative time and reduce burden for clinicians.		

These service requirements are likely to require investment in two key foundation elements – a Midland Clinical Portal (regional workstation) that clinicians can access, supported by associated unified data repositories to store patient information. The economic case of this proposal outlines the potential solutions that were considered in the selection and recommendation of a preferred programme option.

2.12.1 Out of Scope

To ensure the programme is focussing on key priorities and the scope is achievable, the eSPACE Programme scope specifically excludes a range of potential projects and/or functions from the eSPACE Roadmap. A list of these exclusions is detailed in section 3.5.2 of this business case.

2.13 Main Benefits Criteria

Provisional work on the benefits validation process for this business case took place in February 2017 which determined the delivery of the following high-level operational benefits for the eSPACE Programme:

1. Less clinician time spent searching for information.
2. Reduced duplication.
3. Improved clinical outcomes.

2.13.1 Non-Monetary Benefits

Table 9 – Non-Monetary Benefits

High-level Operation Benefits	Benefit ref no.	Description	Type
1, 2,3	QB1	**Improved quality of care and clinical outcomes** through access to patient information that supports higher-quality, more patient-centered care and standardisation of the care experience across sectors and care settings.	Qualitative
3	QB2	**Improved patient satisfaction** from receiving better quality care.	Quantitative
1,3	QB3	**Improved system responsiveness** improving the work environment of clinicians.	Qualitative
1, 2,3	QB4	**Improved regional collaboration**. Cooperating to deliver shared services will improve relationships and communication between Midland DHBs.	Qualitative
1,2	QB5	**Improved sustainability.** Moving toward paperless workplaces will improve environmental outcomes.	Quantitative

Note: benefits are referenced to the high-level operational benefits outlined in 2.13 above.

2.13.2 Monetary Benefits

Table 10 – Monetary Benefits

Stakeholder beneficiary	Benefit ref no.	Description	Type
1,3	MB1	**Clinician productivity gains.** Administrative time redirected into patient interactions and improvements in care quality.	Financial, non-cash-releasing
1,2,3	MB2	**Improved patient throughput and decreased treatment times**. More targeted and timely care and error reduction will reduce timeframes and resource requirements. Shorter patient journeys and reduced hospital admissions.	Financial, non-cash-releasing
2,3	MB3	**Reduced testing and improved accuracy.** A reduced need to duplicate testing. Will only be fully realised when all of health are fully utilising the service.	Financial, cash-releasing
1,2,3	MB4	**Reduced staff travel time and costs**. Reduction in the number of 'return-to-base' events due to lack of information and increased usage of the clinical workstation.	Financial, non-cash releasing

Note: benefits referred to as financial non cash-releasing are measured in respect of time made available to clinicians. The determination of how increased clinician time is then utilised by individual Midland DHBs in respect of managing costs, patient volumes and quality of care has not been defined in this business case.

2.14 Main Risks

A *programme-level risk, assumptions, issues and dependencies (RAID) register* has been established along with the key risks that might create, enhance, prevent, degrade, accelerate or delay the achievement of the investment objectives. The *RAID* is monitored at the programme level by the Programme Director.

Any project-specific risks will be monitored at a project level and only escalated to the programme register if they have programme-level potential impact.

They key potential business and service risks associated with the potential scope for this programme are as below.

2.14.1 Non-Financial Risks

Table 11 – Non-Financial Risks

Ref	Risk
NFR1	Service failure or transformed service quality lower than expected and does not fully meet Functional requirements.
NFR2	Service failure or transformed service does not meet non-functional requirements leading to disruptions to Midland DHB operations/business continuity.
NFR3	Change management effort under-estimated and not well-managed, resulting in clinician needs and expectations not being met and staff dissatisfaction.
NFR4	Low quality service solution or implementation creates reputational risk to Midland DHBs.
NFR5	Proposed solution is not flexible enough to deal with fluctuating service demand.
NFR6	Delivery risk (internal capacity and resources and supply side appetite).
NFR7	Transitional reduction in quality, consistency and timeliness of service delivery.
NFR8	Ineffective and unresponsive programme governance.
NFR9	Immature programme management process negatively impacts the effectiveness of implementation.
NFR10	Orion Health's enabling technology is not developed enough to handle complex requirements.
NFR11	Poor staff engagement in service transition will prevent genuine transformational change.
NFR12	Unable to source required programme resources, delaying or jeopardising programme outputs.
NFR13	Midland DHBs engaged in competing priorities fail to properly integrate into a regional model.
NFR14	Failure to successfully engage internal and external stakeholders.
NFR15	Change fatigue could be experienced due to the volume of projects being implemented within the programme time frame.

2.14.2 Financial Risks

Table 12 – Financial Risks

Ref	Risk
FR1	Clinical IS and service transformation costs are higher than expected.
FR2	Upfront capital investment costs are higher than expected.
FR3	Ongoing operating costs are higher than expected, efficiency savings are not realised.
FR4	Implementation delays, including delayed decisions.
FR5	Statutory changes and National Collections Annual Maintenance Project requirements cannot be delivered by current product set.
FR6	The lack of resources in the region may force the use of contractors, whose costs may be higher than the indicative Midland Region rate card.

FR7	The addition of Midland Medicines Management into the scope of the eSPACE Programme could challenge the integrity of the budget.

2.15 Constraints and Dependencies

The eSPACE Programme is subject to the following constraints and dependencies, which will be carefully monitored and managed throughout the lifespan of the programme.

Table 13 – Constraints

Constraints	Notes
Partner Obligations	The eSPACE Programme Business Case is constrained by the existing agreement with Orion Health to provide clinical workstation software. (See section 4.3.1 for detail.)
Business Continuity	All Midland DHBs need to ensure ongoing availability of existing clinical information systems during the transition to a new solution.
Funding Cycles	Alignment of programme funding to annual budget cycles constrains the amount of development and implementation that can take place in any given year.
Financial Affordability	Constraint arising from funding cycles and challenging operational environments.

Table 14 – Dependencies

Dependencies	Notes
Regional Projects	The eSPACE Programme Business Case requires approval for the implementation of individual projects and regional IS initiatives.
Funding Approval	Obtaining the required capital funding from Midland DHBs.
Stakeholders	Maintaining stakeholder support.
Suppliers	Commitment, competence and capability.

3 The Economic Case

This section identifies the preferred programme option that optimises value for money. Having determined the strategic context for the investment proposal and established a robust case for change in the strategic case, this section:

- identifies the critical success factors used for options appraisal
- generates a wide range of long-list options for delivering the required services
- undertakes economic appraisal of the long-list options to identify the preferred programme that is likely to optimise value for money
- undertakes cost benefit analysis of the monetary costs and benefits
- considers non-monetary benefits
- recommends a set of enabling projects (a Roadmap) for delivering the preferred programme option.

3.1 The Options Framework

Long list options have been continually identified and refined throughout the development of this eSPACE Programme Business Case.

PLEASE NOTE: this programme business case **retains the 2015 options analysis** as the basis for identifying the long list, short list and preferred programme option, as this process was robust and options were identified using the Treasury Better Business Cases (BBC) options framework and considering potential choices for each of the five dimensions of choice.

These dimensions are comprised of: service scope, service solution, service delivery, implementation and funding.

Long-listed options were appraised qualitatively against the investment objectives and a set of critical success factors, to determine the preferred choices for each of the five dimensions.

The Critical Success Factors (CSF) used for appraising the long list options are:

- affordability
- feasibility
- Midland capability and integrity
- partner capability and integrity
- stakeholder commitment
- change impact and effort.

3.1.1 Critical Success Factors

The options were appraised against a) the agreed investment objectives and b) the extent to which they meet each of the critical success factors detailed below.

Table 15 – Critical Success Factors

Critical Success Factor	Description
Affordability	How well the option can be met from the IS portfolio funding and overall Midland DHB cashflows.
Feasibility	How well the option: ▪ integrates with other strategies ▪ matches known dependencies and constraints including meeting regional architecture standards ▪ has an achievable and realistic programme scope ▪ clearly identified benefits ▪ allows risks to be minimised and managed effectively.
Midland capability and integrity	How well the option: ▪ matches the ability of Midland region to deliver within the band-with of change and resource capacity ▪ is capable of being supported regionally during the programme and post implementation.
Partner capability and integrity	How well the option matches the ability of partners to deliver; and matches the known dependencies and constraints.
Stakeholder commitment	How well the option is supported by senior stakeholders at local, regional and national level, including clinicians.
Change impact and effort	How well the option: ▪ delivers change to optimise clinical processes ▪ is likely to be delivered given the organisation's ability to respond to changes required.

3.2 Options Identification and Initial Appraisal

A wide range of potential options for meeting the investment objectives has been considered, within the boundaries determined by the scope and constraints. The long list options have been systematically generated by considering potential solutions within five dimensions of choice:

1. The scope of the programme – the 'what' in terms of service coverage.
2. The service solution – the 'how' in terms of service delivery.
3. The service delivery solution – the 'who' in terms of service delivery.
4. The implementation options – the 'when' in terms of service delivery.
5. The funding options – 'how' the programme might be funded.

Each long-list option is qualitatively assessed against how well it meets the programme's investment objectives and the above CSFs, which are used to help identify the trade-offs between different options. A five-point ranking basis was agreed for this qualitative appraisal, as follows.

Table 16 – Option Ranking Descriptors

Rank	Descriptor
5	Very strongly meets the criteria
4	Strongly meets the criteria
3	Broadly meets the criteria
2	Weakly meets the criteria
1	Does not meet the criteria

This initial appraisal of the long list resulted in options either being discounted from further consideration, carried forward for further consideration or identified as preferred as part of the short-list. The long-list is summarised in the following table with the short-list of six options described in more detail in the following sections.

Table 17 – Long List Options

Options	Detailed Description	Initial Appraisal
Service Scope		
Do nothing	No update to clinical information systems. No functional extension in coverage of current clinical data-sets or current registered users.	Carried forward as the status quo option
Minimum scope	Access to core clinical hospital data and patient information available to registered users only.	**Preferred**
Advanced scope	Core clinical hospital data *plus* primary care (GP) data, with access available to registered users and selected primary care users.	Discounted
Aspirational scope	Core clinical data *plus* primary care (GP) data *plus* wider health and social care data (e.g. social services data).	Discounted
Service Solution		
Local	**Replace and upgrade existing standalone DHB systems.** This would see the three DHBs currently using HealthViews replacing this system as a local activity. Regional collaboration and engagement would be at the discretion of each DHB and clinical group.	Consider further
Aligned	**Replace and upgrade existing DHB systems with a common IS solution.** This would install local instances of regionally aligned clinical workstation solutions. This would consist of the Orion Clinical Portal and other solutions for unified CDRs.	Consider further
Collaborative	**Replace and upgrade existing DHB systems with a regionally designed clinical IS.** This would install local instances of regionally designed clinical workstation solutions. Responsibility for delivery would remain with the individual DHBs with support from a small regional IS team.	Consider further
Regional	**Regional – standardised solution implemented at regional level.** This option would take a regional approach to implementation of clinical workstation solutions. Responsibility for delivering to meet DHB and regional needs would be with a regional programme team and capability would be built at a regional level to undertake implementation and ongoing support	Consider further
Service Delivery		
In House	Use in-house IS and change management capability within HealthShare and individual DHBs to deliver service transformation and ongoing IS support.	**Preferred**
Outsource	Hire an external team to implement change and provide ongoing IS support across Midland DHBs.	Discounted
Implementation		
Staged	**Staged implementation of regional clinical IS functionality**. This would take a phased approach to meeting immediate DHB and longer term regional needs.	**Preferred**
Big Bang	Implement a single regional clinical IS solution **through a single regional project**.	Discounted
Funding		
Formula-based DHB funding	Fully funded by the five DHBs and based on a Population Based Funding Formula (PBFF) for splitting capital and operating expenses.	**Preferred**
Plus user charging	Capital costs initially partly funded by the DHBs with recoveries sought from DHB and other users.	Discounted

3.2.1 Appraisal of Service Scope Choices: 2015 Analysis

Preferred option: minimum. *Access to core clinical hospital data and patient information. Service available to registered users only.*

The minimum option best represents an appropriate scope for the eSPACE Programme. The iterative provision of integrated clinical information to registered users and clinical data is an achievable, affordable option that will deliver clinical benefit project by project; and provide a robust platform and protocols for ongoing additions of functionality.

The advanced and aspirational options detailed in 3.2 above represent the desired future state of clinical information/functionality in the region and further steps toward the goal of a regional electronic medical record. While more likely to strongly meet the objectives of the programme and the long-term needs of the business, it was considered that these options could not be achieved in the short to medium term for the eSPACE Programme. This was both in terms of being affordable to the Midland DHBs and the capability and capacity to deliver the amount of change required during the implementation period. This does not preclude the possibility that the functionality outlined in these options could be provided in later phases of the programme; however, if these options are considered in the future any consideration should be fully within the context of work on the national electronic health record.

3.2.2 Appraisal of Funding Choices: 2015 Analysis

Preferred option: formula-based DHB funding. *Fully funded by the five DHBs and based on a Population Based Funding Formula (PBFF) for splitting capital and operating expenses.*

This option is considered most likely of the feasible funding alternatives. The PBFF has been agreed as the most equitable approach to share the impacts of capital and ongoing operating costs over the five Midland DHBs. It is achievable and consistent with identified business needs.

It is recognised, however, that PBFF may not always be the most appropriate basis.

Alternative pricing models have been considered should capital funding gaps emerge as the business case development proceeds and better estimates of overall Programme costs are determined. One alternative is to meet funding gaps with short-term borrowing and recoveries from Midland DHBs and other users who benefit from the service. While a pricing mechanism may assist in meeting capital requirements, it could potentially discourage uptake from users and be more complex to administer than the PBFF. The programme will work with the region's Chief Executives to determine the best approach on a project by project basis.

3.2.3 Further Consideration of Service Solution, Service Delivery and Implementation Choices

Six options for the service solution, service delivery and implementation dimensions of choice have been carried forward to the short-list for more detailed qualitative appraisal. This more detailed analysis is outlined in the following tables.

3.3 Short-list Options Appraisal – Advantages and Disadvantages

Table 18 – Detailed Options Appraisal: Advantages and Disadvantages

	Advantages	Disadvantages
Option One: Status Quo	▪ No change would be required. ▪ Low up-front cost. ▪ No regional collaboration overhead. ▪ Retain DHB autonomy.	▪ Risk of orphaned silos of patient data if existing end-of-life clinical workstations are not mitigated. ▪ Long term cost increases. ▪ Investment in ongoing maintenance costs without development of the Midland Clinical Portal platform to meet clinical and business needs. ▪ Functional and information deficiencies remain. ▪ Core regional clinical IS foundations not in place. ▪ Unable to support clinical process change and RSP. ▪ DHBs cannot stand still; hence 'Status Quo' is not acceptable.
Option Two: Local	▪ Gradual change based on each DHB's capacity and need. ▪ Able to take an evolutionary approach to implementation and risk management, recognising that clinical needs are not well defined and subject to ongoing change. ▪ No regional collaboration overhead. ▪ Risk of existing platforms able to be mitigated. ▪ Retain DHB autonomy.	▪ Long-term cost of the programme is higher, due to supporting multiple systems and unable to leverage regional scale. ▪ Functional and information deficiencies can only be mitigated within the bounds of each DHB's capacity. ▪ Implementation speed constrained by need to install and support multiple systems. ▪ Vendor capacity and capability issues from need to support multiple installations ▪ Core regional clinical IS foundations not in place. ▪ Unable to support clinical process change across region and RSP. ▪ Incongruous with the direction set by the NHITB. ▪ Ongoing local investment into deprecated systems and technology leading to inevitably high cost individual DHB initiatives to migrate to a supported functionally complete solution.
Option Three: Aligned	▪ Gradual change could be based on each DHB's capacity and need. ▪ Able to take an evolutionary approach to implementation and risk management recognising that clinical needs are not well defined and subject to ongoing change. ▪ Risk of existing platforms able to be mitigated. ▪ Consistency of solution across the region giving the potential to develop regional expertise and some degree of alignment of business practice. ▪ Retains DHB autonomy. ▪ Use of national standard CWS.	▪ Overall cost to region is higher due to implementing and supporting multiple systems. ▪ Implementation speed constrained by need to install and support multiple systems. ▪ Supporting clinical process change across region and RSP is more difficult due to the lack of a regional IS foundation. ▪ Is not congruous with the direction set by the NHITB. ▪ Core regional clinical IS foundations not in place. ▪ Vendor capacity and capability issues from need to support multiple installations.
Option Four: Collaborative	▪ Gradual change could be based on each DHB's need, regional capability and affordability. ▪ Risk of existing platforms able to be mitigated. ▪ Able to take an evolutionary approach to implementation and risk management, recognising that clinical needs are not well defined and subject to ongoing change. ▪ Able to support clinical process change across region and RSP through a collaborative approach. ▪ Able to leverage capability across the region. ▪ Retain some degree of DHB autonomy. ▪ Use of national standard CWS. ▪ Economies of scale associated with collaborative approach.	▪ Overall cost to region is higher due to implementing and supporting multiple systems. ▪ Implementation speed constrained by need to install and support multiple systems. ▪ Some regional collaboration overhead. ▪ Core regional clinical IS foundations not in place. ▪ Critical dependence on strong stakeholder alignment and commitment across region.
Option Five: Regional and Staged – standardised solution is implemented at a regional level with staged implementation of regional clinical IS functionality	▪ Gradual change could be based on each DHB's need and regional capability and affordability. ▪ Risk of existing platforms able to be mitigated. ▪ Able to take an evolutionary approach to implementation and risk management. ▪ Recognising that clinical needs are not well defined and subject to ongoing change. ▪ Able to support clinical process change across region and RSP ▪ Able to leverage and optimise capability across the region to increase speed of delivery. ▪ Overall cost impact can be managed and optimised by consolidating system. ▪ Core clinical IS foundation for Midland established. ▪ Use of national standard clinical information systems. ▪ Economies of scale associated with collaborative approach.	▪ Loss of DHB autonomy. ▪ Regional collaboration overhead. ▪ Core regional clinical IS foundations not in place.
Option Six: Regional and Big Bang – standardised solution is implemented at a regional level with big bang implementation through a single regional project	▪ Risk of existing platforms able to be mitigated. ▪ Able to support clinical process change across region and RSP. ▪ Able to leverage and optimise capability across the region to increase speed of delivery. ▪ Overall long term cost impact can be managed and optimised by consolidating systems aggressively. ▪ Core clinical IS foundation for Midland established. ▪ Use of national standard CWS.	▪ Cost impact will be in a compressed timeframe and is likely to be unaffordable. ▪ Implementation risk is high. ▪ Existing DHB functional gaps and risks will only be addressed when the regional clinical workstation is ready to be deployed and this will take some time. ▪ Unable to take an evolutionary approach to implementation and requires agreements to requirements up front. ▪ Loss of DHB autonomy. ▪ Regional collaboration overhead. ▪ Critical dependence on strong stakeholder alignment and commitment across region.

3.4 Summary of the Short List Options Appraisal

Table 19 – Summary of the Short List Options Appraisal

Appraisal Criteria			Ranking Scores against the Appraisal Criteria					
			Option One: Status Quo	Option Two: Local	Option Three: Aligned	Option Four: Collaborative	Option Five: Regional – Staged	Option Six: Regional – Big Bang
Investment Objectives	1	Improve the quality of patient care and reduce risk to patient safety by providing a complete and integrated view of patient information.	1	2	2	3	5	5
	2	Better support clinical practice through improved access to clinical information and tools.	1	2	2	3	5	4
	3	Provide information systems that more effectively align with clinical outcomes.	1	1	2	3	5	4
	4	Create a clinical information storage system that is agile, responsive to change and able to efficiently accommodate an increase in service demand over a 10-year period.	1	1	2	4	5	4
CSFs	1	Affordability.	2	3	3	4	4	1
	2	Feasibility.	3	4	4	4	4	3
	3	Midland capability and integrity.	5	3	3	4	5	3
	4	Vendor capability and integrity.	1	2	3	3	4	4
	5	Stakeholder commitment.	1	2	2	3	4	4
	6	Change impact and effort.	5	4	4	4	4	2
CONCLUSION			DISCOUNTED	DISCOUNTED	DISCOUNTED	POSSIBLE	PREFERRED	POSSIBLE

3.5 The Preferred Programme Option

On the basis of the analysis above, the preferred programme is **Option Five: Regional Staged**. This is described in more detail below and is recommended as the eSPACE Programme approach.

Table 20 – Preferred Programme Option

Description of the preferred programme option five: Regional Staged
Access to core clinical hospital data and patient information available to registered users only.
Regional – standardised solution implemented at regional level. This would take a regional approach to development and implementation of the Midland Clinical Portal. Responsibility for delivering to meet DHB and regional needs would be with a regional programme team and capability would be built at a regional level to undertake implementation. Ongoing support will be provided by the agreed DHB service provider.
Use in-house IS and change management capability within HealthShare and individual DHBs to deliver service transformation and ongoing IS support.
Staged implementation of regional clinical IS functionality. This would take a phased approach to meeting immediate DHB and longer term regional needs.
Fully funded by the five DHBs and based on a Population Based Funding Formula (PBFF) for splitting capital and operating expenses.

3.5.1 Proposed Mix of Projects

Through early 2016, a five-year eSPACE Roadmap for the delivery of the preferred programme option was defined, based on the clinical priorities identified throughout the regional governance groups, the capability available within the region and from potential partners, and existing or planned Midland DHB activity.

The resulting eSPACE Roadmap was provisionally endorsed, with caveats, by the Midland region's Information Systems Leadership Team (ISLT) on 1 July 2016.

In November 2016, the Midland Chief Executives requested a further review of the eSPACE Roadmap to re-test assumptions and ensure the prioritisation of current-state clinical needs.

The proposed priorities were tested, with clinicians using online tools and through a series of clinical engagement workshops held across the region throughout December 2016. Both engagement mechanisms allowed for potential introduction of new topics. This consultation has resulted in a minimally revised high-level eSPACE Roadmap, provided overleaf in summary form and considered more fully as part of planning for successful delivery within the management case.

While this process largely affirmed the previous priorities/eSPACE Roadmap, it did identify and confirm a number of critical areas that were outside of the present scope and funding envelope of the eSPACE Programme. One such area is Medicines Management, which has now been added at the request of the Chief Executives of the Midland region.

The proposed mix of projects within the five-year eSPACE Programme is as follows.

Table 21 – Proposed Mix of Projects

Delivery Phase	Estimated Timeframes*	Project	Description	Key Outcome/s
Phase 1	2016-2017	Midland Clinical Portal Foundation Project (MCPFP)	▪ MCPFP creates the basis for achieving first-stage change across the Midland region, through a consolidated view of accurate, accessible and available regional patient information. ▪ MCPFP will install Midland Clinical Portal. It is deliberately narrow in scope with functionality limited to a consolidated regional view of core electronic data (patient demographics, national and local alerts and patient's documents and form data) provided by the five Midland DHBs. The Midland Clinical Portal will be accessed by clicking a link within each DHB's local clinical workstation in patient context only.	▪ In patient context the following information: ▪ visibility of regional clinical documents ▪ patient demographics ▪ patient encounters (inpatient, outpatient, ED) ▪ patient timeline ▪ national and local alerts.
Phase 2	2017-2019	MCP eForms and Pathways: eTOC (Transfers of Care)	▪ The regional eTOC solution will replace all existing TOC processes, systems and forms in the Midland region. ▪ The project will provide centralised reporting and data extracts capability to allow Midland DHBs to run standard eTOC KPI reports and data extracts.	▪ Consistent process in the Midland region when a patient is transferred.
		MCP eForms and Pathways: Mental Health and Addictions (MH&A)	▪ Standardise clinical pathways across the region. ▪ Standardise clinical documentation across the region. ▪ Deliver a regional solution that supports best clinical practice. ▪ Deliver a regional solution that facilitates safe and effective transfer of care across the continuum of care. ▪ Identify common data requirements for MH&A in the Midland region. ▪ Improve data integrity and collection across the region. ▪ Reduce the level of duplicate data entry by utilising a 'capture once, use many times' information capture philosophy.	▪ End to end electronic solution for Mental Health and Addictions.
		MCP Imaging and Linked Systems	▪ All MCP users will have access to selected Midland DHB diagnostic archives.	▪ Visibility of knowledge base links. ▪ Visibility of diagnostic imaging acquired in the Midland DHBs.
		Midland eResults Foundation	▪ Move the current Bay of Plenty (BOP) DHB hosted Éclair instance (populated by a number of BOP DHB and Lakes DHB data feeds) onto the Midland Regional platform, as 'Midland Éclair'. ▪ Deliver additional Radiology and Laboratory data feeds from the other Midland DHBs. ▪ Scoping for enhanced functionality for phase 3 projects.	▪ Visibility of diagnostic results. ▪ Replatform Éclair to the Midland Regional Platform.

Delivery Phase	Estimated Timeframes*	Project	Description	Key Outcome/s
		MCP R2 Enhanced Functionality	▪ Switch to Midland Clinical Portal as system of record. ▪ Replatform if required to support Category 1 system. ▪ Proof of concept information sharing with Starship and Testsafe North. ▪ Provide capability to enable the migration of historic data to MCP from Midland DHBs. Proof of concept of mobile solutions.	▪ Clinicians' primary access to clinical information is through MCP.
		MCP PHO Integration Foundation	▪ Provide the capability for PHO Patient Management Systems (PMS) to visually integrate to MCP. ▪ Provide a read-only data interface for accredited third parties to access MCP information.	▪ PHOs able to seamlessly access MCP information from their PMS. ▪ Third parties able to access MCP information.
		MCP System Transitions	▪ Transition of all five Midland DHB Clinical Workstations (CWS) to MCP. ▪ Migration of historic data to the MCP. ▪ Remaining functionality gap analysis. ▪ Mitigation of identified mandatory gaps. ▪ Training. ▪ Operational Support.	▪ Parity is reached in MCP enabling decommissioning of the existing CWS. ▪ Ready for decommissioning.
		Midland Medicines Management Foundation	▪ Developing and agreeing the regional requirements. ▪ Analysis of current state of Midland region Medicines Management processes and systems. ▪ Evaluation of Medicines Management solutions against requirements.	▪ Selection of the Medicine Management solutions based on the evaluation.
Phase 3	2018-2020	eOrders (diagnostic)	▪ Electronic ordering of diagnostic procedures.	▪ Availability of Electronic ordering
		eOrders (laboratory)	▪ Electronic ordering of laboratory procedures.	▪ Availability of Electronic ordering
		MCP PHO Integration Enhanced Functionality	▪ Provision of standards-based interface to allow the two-way exchange of information.	▪ Accessible and visible regional information.
		eWhiteboards	▪ Enablement of whiteboards through the provision of standard data.	▪ Visibility of information.
		eReferrals	▪ Electronic referrals within and between Midland DHBs, as well as to external providers.	▪ Referrals received and sent electronically.
		Midland Medicines Management Enhanced Functionality	▪ Implementation of the Midland Medicines Management solutions	▪ Capability to ePrescribe, eDispense, eReconciliation and eAdministration.

Delivery Phase	Estimated Timeframes*	Project	Description	Key Outcome/s
		Midland eResults Management	▪ Provide the ability to acknowledge results in Midland Éclair for Waikato DHB, Taranaki DHB and Tairawhiti DHB. ▪ Transition Waikato DHB, Taranaki DHB and Tairawhiti DHB to the Midland Eclair.	▪ All Midland region DHBs acknowledging results on the Midland Éclair.

***** The timeframe overlap of phases allows for projects within the next phase to be undergoing initiation while the previous phase is being delivered. This approach is designed to mitigate 'stop-starts' and ensure continuous and efficient delivery of clinical benefit.

3.5.2 Out of Scope

The eSPACE Programme scope does **not** include the following.

Table 22 – Out of Programme Scope

Project: out of scope	Comments
Enabling IT infrastructure	While the eSPACE Programme does require this, the programme is not identified as responsible for its delivery. It is to be delivered through the existing Midland Regional Platform infrastructure provisioning mechanism, which is delivered by the Midland regional support provider (currently Waikato DHB).
Integration of non-clinical systems	The eSPACE Programme will not integrate non-clinical systems (for example Payroll, Oracle financials, OneStaff) with the Midland Clinical Portal.
Systems outside of the Midland region	The eSPACE Programme will not integrate systems outside the Midland region, with the exception of the proof of concepts detailed as part of Phase 2.
Data cleansing of Midland DHB source systems	The eSPACE Programme will not undertake data cleansing of Midland DHB source systems.
Patient Portals	The eSPACE Programme will not deliver patient portal(s).
Provation	The eSPACE Programme will not deliver Provation as it is being undertaken as a sub-regional activity by local DHBs.
Decommissioning of existing systems	Once the Midland Clinical Portal becomes a.) the clinical system of record for the region and b.) reaches the full functionality outlined within the eSPACE Programme, individual Midland DHBs may choose to decommission part or all of their existing DHB clinical workstation systems, or make historic data read-only. Decommissioning activity/projects are the responsibility of the individual DHBs and are outside the scope of the eSPACE Programme.

3.5.3 High-level Roadmap: eSPACE Programme

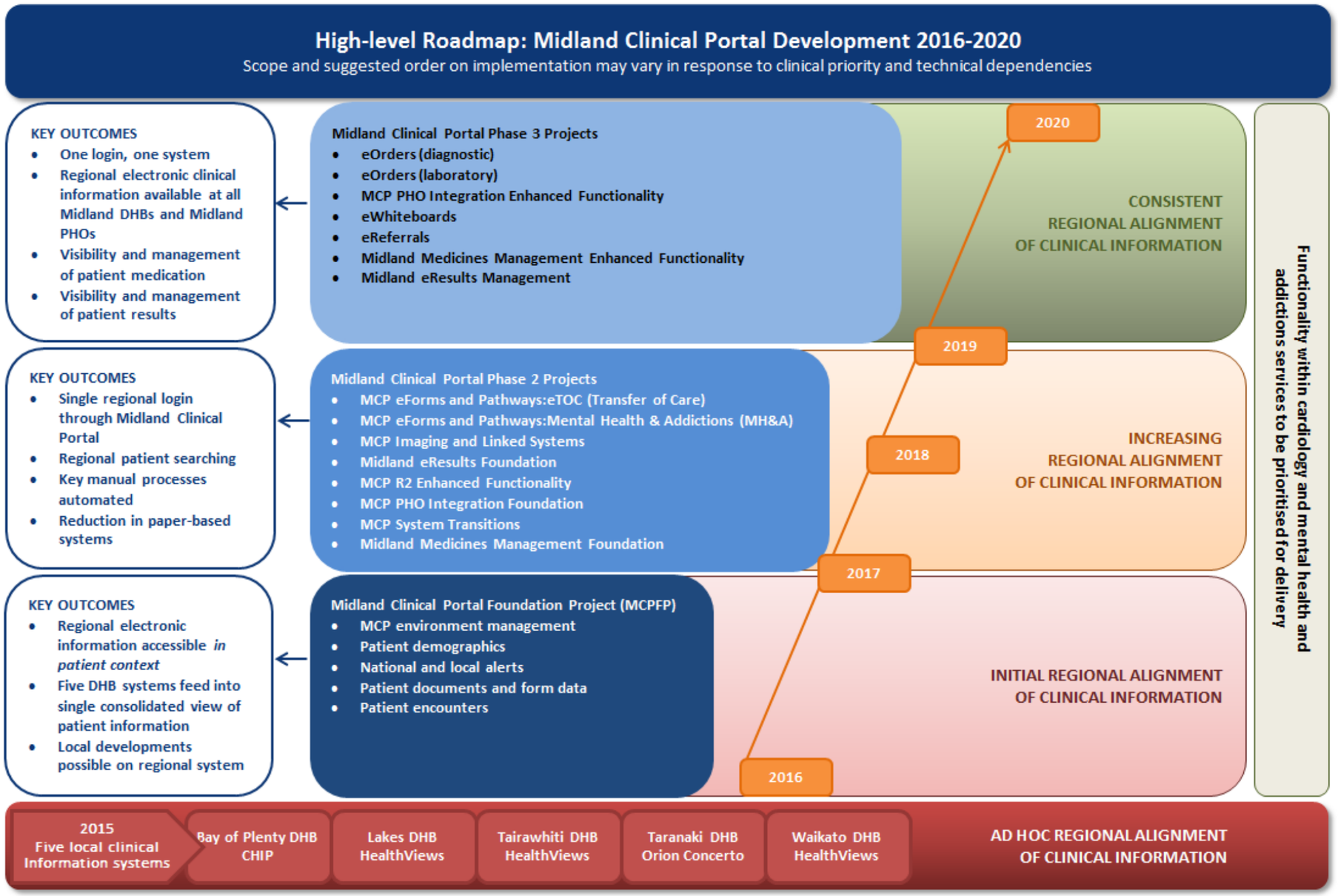

Figure 12 – eSPACE High-level Roadmap

NOTES

1. The Midland CEOGG has indicated cardiology and mental health and addictions (MH&A) must be the two priority areas of focus within Midland Clinical Portal implementations. Wherever these services have speciality clinical requirements that can be addressed and prioritised within a planned project, these will be identified within the initiation phase.
2. The roadmap is a 'living document'. In order to deliver clinical benefit as soon as possible and in response to clinical reprioritisation and/or technical dependencies, the order of delivery may change. Any potential changes will be proposed and managed through the programme's defined change management protocols.
3. The timeframe overlap of phases allows for projects within the next phase to be undergoing initiation while the previous phase is being delivered. This approach is designed to mitigate 'stop-starts' and ensure continuous and efficient delivery of clinical benefit.
4. If project initiation work identifies other work that can be brought forward or additional functionality that can be proactively added to the overall programme scope within the context of an existing project, this work should be considered for inclusion, the aim being to maximise clinical benefit from every project.

3.6 Main Benefits

Table 23 – Main Benefits

Benefit Grouping	Outcomes	Strategic	Quality	Non-Cash Releasing	Cash Releasing
Less clinician time spent searching for information	Reduced waste of clinician time taken with administrative/ searching type activities		✓	✓	
	Comprehensive, up-to-date, patient information at point of care through access to multiple regional systems		✓	✓	
	Single quick logon		✓		
	Access to disparate Midland DHB systems		✓		
	Borderless access for healthcare teams		✓		
	Access to patient data using a timeline approach		✓		
	Improved ability for ICT to keep pace with clinical and business drivers	✓			
Reduced duplication	Efficiencies through regional provision of CWS support and management	✓	✓		
	Midland CWS alignment to National expectations	✓			
	Privacy of patient data appropriately supported		✓		
Improved clinical outcomes	Complete patient information at point of care		✓		
	Reduced risk of poor clinical decision making through lack of timely comprehensive information		✓	✓	
	Information management/decision support is driven by the use of meta data sets		✓		
	Improved patient episodes of care through access to a single source of patient information by all carers regardless of location		✓	✓	
	A comprehensive view of patient alerts through the ability to pull data from multiple systems		✓		

3.7 Quantitative Analysis of Monetary Costs and Benefits

The preferred programme option and the status quo (do nothing) options were appraised further using economic cost benefit analysis (on estimated costs), prior to the inclusion of Midland Medicines Management in the scope of the eSPACE Programme.

For the purposes of the cost benefit analysis the following assumptions were made:

- The period over which costs and benefits are assessed is assumed to be 10 years.
- The public sector discount rate specified by Treasury for projects of this type is currently 8.0% per annum, and as this is a real discount rate, all costs and benefits are expressed in today's dollar terms.
- All dollar figures exclude GST.
- Depreciation, capital charges, interest and other financing costs are excluded from the analysis.
- The inclusion of Midland Medicines Management will change the benefits profile.

Table 24 – Net Present Value Calculation

(Figures in $000)	Status Quo Option	Preferred programme Option Five
Estimated Monetary Benefits		
Clinician Time	0	20,367
Reduced Duplication	0	8,147
Clinical Outcomes	0	48,879
Forecast Cash Inflow	**0**	**77,393**
Forecast Cash Outflows	56,053	99,919
Forecast Net Cashflow	**(56,053)**	**(22,526)**
Annual Discount Rate	8%	8%
Net Present Value (NPV)	**(39,944)**	**(33,779)**
Marginal NPV		**$6.2 million**

This analysis demonstrates that, on the basis of current mid-point estimates of costs and benefits, that the marginal NPV of the preferred programme compared to the status quo is approximately $6.2 million over the 10 year period of the analysis.

The Better Business Cases methodology recommends the application of adjustments for optimism bias to allow for the inherent uncertainties and biases in our mid-point estimates of costs and benefits. For programmes of this type, the degree of uncertainty over the above cost and benefit estimates is very high – although this uncertainty can be mitigated and is anticipated to be lower during the development of the subsequent project-based business cases.

3.8 Analysis of Qualitative Benefits

Economic analysis of the preferred programme option indicates the potential for the option to provide significant qualitative benefits compared to the status quo.

This section reviews a New Zealand case study from a similar implementation, and supports an approach to realising these benefits in the delivery of the preferred programme.

3.8.1 Case Study: Northern Region Staged Approach

Enterprise-level (or 'big bang') implementations of electronic medical record (EMR) functionality are relatively common internationally. In New Zealand, however, factors such a small population base and funding

limitations have seen attempts at enterprise-wide implementations encounter significant obstacles, particularly with regard to affordability and risk.

In 2011, the Northern region DHBs implemented a regional clinical workstation (Orion Concerto) and a Clinical Data Repository (Sysmex Éclair) using an iterative, staged approach similar to that proposed for the eSPACE Programme. This case study provides useful insight into potential benefits of the eSPACE Programme, as it is specific to the New Zealand environment and early benefits of the implementation have been well documented.[5]

CASE STUDY: Northern Region DHBs Deliver More Efficient, Safer Patient Care

Prior to 2011, when people in the Northern region relocated, were referred to a specialist or needed emergency care outside of their DHB area, patients and healthcare providers struggled with manual and paper-based records, as well as delayed access to patient information during emergencies. Laboratory tests and X-ray examinations were being unnecessarily repeated, patients experienced delays in treatment delivery and clinical and administrative time and resources were being wasted.

The four Northern DHBs worked together to deliver an integrated solution, which has resulted in delivery of significant key benefits as shown below.

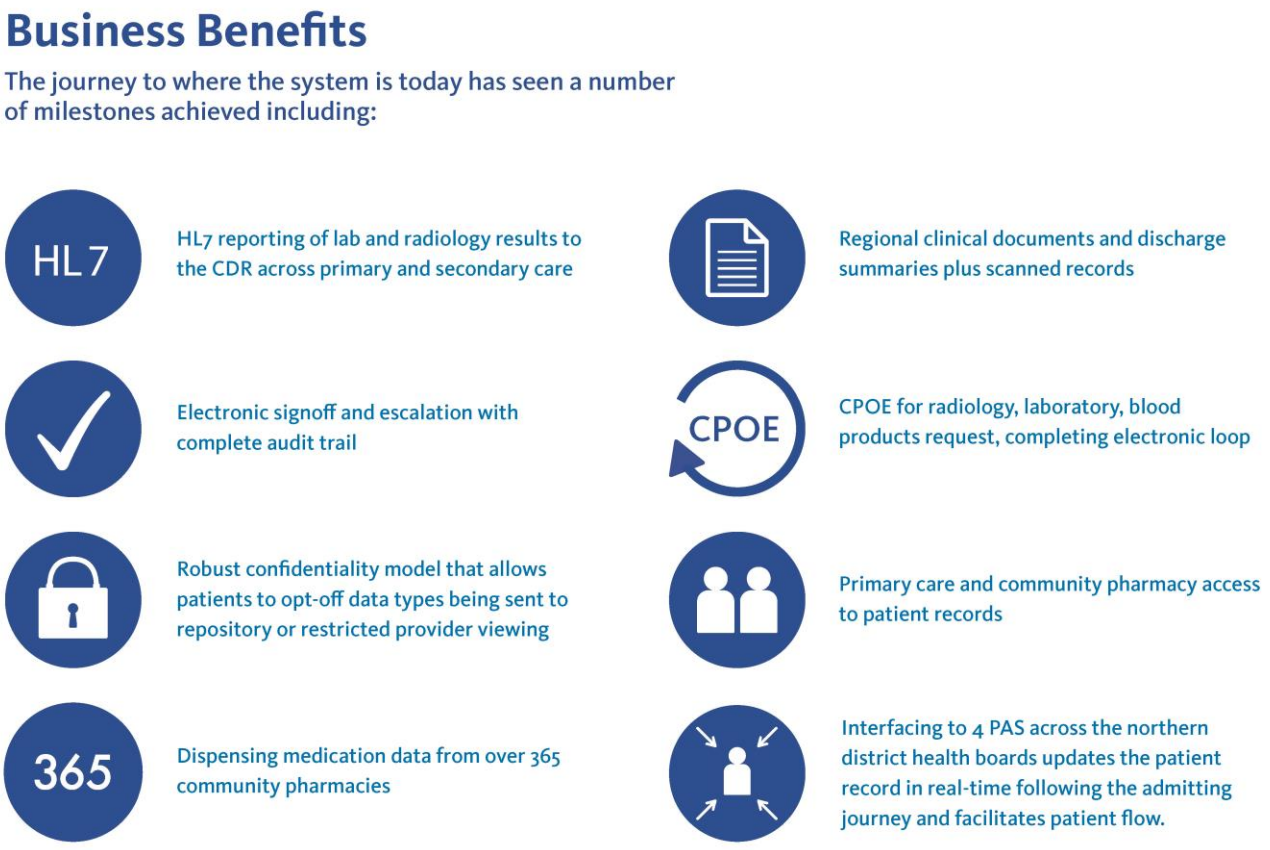

Figure 14 – Northern Region Published Benefits

Overall, the Northern region regional electronic patient record now provides faster and more accessible access to patient data. Using existing unique identifiers, universal coding, secure messaging, data security and an intuitive user interface, this initiative has resulted in the following outcomes:

- Removal of paper reporting.
- Traceability and patient safety improvements, with more results being followed up.
- Reductions in repeat testing and procedures.

[5] See http://www.sysmex.co.nz/wp-content/uploads/2015/03/Eclair-CS-Northern-regional-EMR-web.pdf

- More efficient clinical workflows.
- Reduced administration flows.
- Access to over 80 sources of diagnostic data.
- Primary care and community pharmacy access.
- Real-time updates across the region.

3.8.2 Adherence to Evidence Based Guidelines

In the Midland region, there has been an investment in tools to develop and support evidence based clinical guidelines. Aligning implementation of additional digital health functionality with this focus will be crucial to optimise the realisation of benefits.

Examples of outcomes observed in other settings include:

- an increase from 0% to 35% and 50% respectively for influenza and pneumococcal vaccination in appropriate hospitalised patients
- an increase from 47% to 65% for influenza and 19% to 41% for pneumococcal vaccination in immunosuppressed rheumatology patients
- a 19% increase in venous thromboembolism prophylaxis in high risk inpatients (translating to a 41% reduction of risk for DVT or PE at 90 days)
- a 5% reduction in pressure ulcers in an inpatient setting
- an 11.3% increase in appropriate hypertension treatment in primary care.

3.8.2.1 Reduction in Diagnostic Testing

It is widely believed that there is both inappropriate testing and duplication of testing, especially between community and hospital settings, in the Midland region. A single view of all diagnostics across sectors and Midland DHBs (through regionally unified CDRs) and electronic order entry with associated Clinical Decision Support are key capabilities. Examples of outcomes observed in other settings include:

- 14.3% decrease in the number of diagnostic tests ordered per visit, which translated to a 12.9% decrease in test costs
- 18% decrease in tests ordered in an ED setting
- 27% reduction in ‘redundant’ tests of antiepileptic medications
- 24% reduction in ‘redundant’ lab tests in a hospital setting.

3.8.2.2 Recommendation

In the Midland region, potential benefits should be quantified early in the eSPACE Programme’s development. Defining programme and project objectives for benefits delivery will provide a framework to optimise the probability of benefits realisation.

Additionally, it is recommended that each project business case carries out benefit mapping and realisation planning at the project level.

4 The Commercial Case

This section outlines the commercial propositions in relation to the preferred option outlined in the economic case.

Procurement will be required for the provision of software to provide a clinical workstation – the Midland Clinical Portal (MCP) – and unified clinical data repositories, plus supporting products and tools under a vendor licensing contract.

This programme will utilise a 'best of breed' multiple vendor approach to ensure functional requirements are met while providing optimal value for money. The MCP will be underpinned by one or more core vendors who will be selected based on their ability to deliver the required functionality, their New Zealand and Midland region relevant experience and their alignment to the National Health IT strategy.

4.1 Procurement Strategy and Required Services

The required services in relation to the preferred option are:

- Midland Clinical Portal software and services
- unified Clinical Data Repositories (CDRs)
- website development services
- benefits realisation management software and services.

The proposed sourcing strategy meets the specific needs of Midland DHBs, while managing the strategic requirements of the Ministry of Health. As Waikato DHB (WDHB) is the provider of procurement support to the eSPACE Programme, the programme will adhere to WDHB procurement policies and processes.

To this end, acting on behalf of the region, the eSPACE Programme will:

- leverage existing supply contracts/agreements and All of Government (AoG) contracts
- comply with the Government Rules of Sourcing
- use collective sourcing with the DHBs to procure as a preference
- use in-house resources and expertise, where possible.

4.1.1 Procurement Methodology

A robust and consistent procurement methodology will be applied for this programme, based on the following:

- Clear regional and programme governance, based on defined roles and responsibilities.
- Independent verification of activities where appropriate and necessary.
- Application of procurement best-practice and compliance to with Government Rules of Sourcing.
- Robust commercial and contract processes.

Contracts are managed during implementation by the eSPACE Programme Director, who will approve Statements of Work (SoW) for specific activities within their delegation. The Programme Director provides nominal approval for SoWs outside their delegation: final approval rests with the SRO and Programme Board. SoWs will be created, reviewed, and agreed to ensure risks are mitigated and managed, and commercially robust payment terms are included in each SoW.

4.1.2 Procurement Strategy by Service

The following table details key strategy elements for each required service. More detailed service requirements will be developed as part of the later business cases for individual projects.

Table 25 – Procurement Strategy by Service

Service	Scope of Spend	Current State
Midland Clinical Portal (MCP) Provider of software and services core to the delivery of the Programme.	▪ The partner license and implementation services budget is approx. $8.3m with annual ongoing support costs once fully implemented of circa $1.2m.	▪ Contract awarded to Orion Health in July 2014. ▪ Heads of Agreement exits with overarching terms. ▪ Statement of Work (SoW) used to scope projects.
Clinical Data Repositories (CDRs) Includes electronic management and orders investigations.	▪ Sysmex Licences at $519,662 year one (2017) and $169,662 thereafter annually: total for programme $1,028,649 plus maintenance and support $245,081 p.a. total for the programme $980,325. ▪ There is risk relevant to Sysmex licensing and any shortfall will be covered by contingency.	▪ A combination of electronic and paper based systems are currently in place across the region. ▪ Local licences are held by four of the five Midland DHBs with Sysmex for some aspects of the CDRs. ▪ Perpetual regional licences have been acquired for Orion products that can also potentially provide this functionality, as part of the existing agreement with Orion Health.
Website services A programme-specific website is to be developed.	▪ The partner license and implementation services costs are between $20k and $40k. Ongoing support costs, once fully implemented, are $5k per annum. ▪ The total cost is estimated to be $45k to $80k.	▪ An Expression of Interest (EOI) has been completed. ▪ A Request for Proposal (RFP) has been completed. ▪ The final evaluation and selection has been made and a provider (Koda) contracted.
Benefits realisation systems and services The Amplify benefits management software (published by Connexions) is being piloted as an option for the eSPACE Programme to identify, analyse, plan for, realise, monitor, report, all programme-level and related projects benefits.	▪ Connexions – Amplify Benefits software: $9,639 for nine licences ▪ Quick Start Programme – $9,995 = one-off cost for a three-day workshop ▪ Annual cloud storage costs: $3,000.	▪ Privacy Impact Assessment completed 15.11.16 ▪ DIA Cloud security and cloud endorsement has been completed. ▪ A procurement process has been completed.

4.2 Procurement Plan

A procurement plan has been completed for the eSPACE Programme. The key aspects of this plan are outlined below.

4.2.1 Evaluation Criteria

Orion Health as the core partner has been pre-selected based on:

- alignment with the National Health IT Strategy (the primary programme reference document at the time of selection)
- the level of NZ and Midland region 'reference-ability'
- alignment to Midland requirements.

Exemptions to the Government Rules of Sourcing have been sought for Orion with details of the exemption shown under section 4.3.1.

Other partners will be selected based on their functional, technical and commercial fit through standard procurement processes as and when appropriate to programme need.

4.2.2 Partners

Midland Clinical Portal (Clinical Workstation) Partner. Orion Health is the partner of choice for the delivery of the clinical workstation user interface nationally, as signalled by the National Health IT Board. A regional contract has been established with Orion Health. The solution selected for the Midland Clinical Portal is Orion Health's Concerto Portal product.

An exemption to the Government Rules of Sourcing has been sought for Orion and may be sought for a potentially closed tender for CDR requirements.

4.3 Procurement Exemption

4.3.1 Orion Health for MCP

In November 2013, the Midland CEO Governance Group (CEOGG) resolved to establish a regional contract directly with Orion Health, which was signed in July 2014. The CEOGG considered that a contestable procurement process for Orion Health was not warranted for the following reasons:

- The NHITB had a strong preference for a single CWS solution using Orion, a preference that was publically stated by NHITB and widely known in the market. A procurement process in that context would be compromised.
- Orion is a proven solution that is operational in over 14 DHBs and has been selected in three regions. No other product in the New Zealand market has a comparable degree of usage.
- Sector decisions that selected Orion in Central and Southern regions support the Midland decision to proceed directly with Orion as the best solution for Midland requirements.

The exemption was sought under Rule 15 (9c) of the Government Rules of Sourcing for the following reasons:

- There is only one supplier and there is no reasonable alternative or substitute because for technical reasons there is no real competition.
- The products and services are necessary for complete delivery and a change of supplier cannot be made for economic and technical reasons, and would cause significant inconvenience or substantial duplication of costs for HealthShare.

4.4 Key Contract Issues

For new partners, standard contractual terms (both industry and government) will be utilised where possible, to take advantage of market familiarity and to minimise programme administration costs and time.

Key contract issues will be addressed as part of individual contract negotiations to ensure that all sourcing represents value for money.

4.5 Potential for Risk Transfer

Key procurement risks have been identified, evaluated and recorded in the *programme RAID register*. The procurement risks are proposed to be apportioned between the parties best placed to manage them as outlined in the following table.

Table 26 – Risk Transfer Matrix

Risk Category	Potential Allocation		
	Midland Region	Supplier	Shared
1. Design risk			✓
2. Construction and development risk			✓
3. Transition and implementation risk	✓		
4. Availability and performance risk			✓
5. Operating risk			✓
6. Technology and obsolescence risks	✓		
7. Financing risks			✓
8. Legislative risks	✓		
9. Other project risks			✓

4.6 Proposed Contract Lengths

Table 27 – Proposed Contract Lengths by Service

Service	Proposed Contract Length	Comments
Midland Clinical Portal (MCP)	Six years + yearly rights of renewal.	10 years is the useful life of the clinical workstation software.
Clinical Data Repositories (CDRs)	To be confirmed	This will be determined in the next stage of procurement activity.
Website services	Three years + one yearly rights of renewal.	Contract covers initial development and ongoing hosting and support.
Benefits Realisation Management software and services	To be determined if pilot approved.	

4.7 Proposed Payment Mechanisms

The eSPACE Programme will negotiate payment mechanisms with all key suppliers to provide incentives for suppliers to continue to provide value for money over the contract terms.

The programme will require HealthShare to make payments in relation to the proposed products and services based on the three following types of engagement.

Outcomes-based. Outcomes-based SoWs are the preferred method of contracting for HealthShare for goods and services. The suppliers will determine how to meet the specifications and performance objectives set out by HealthShare. When the results meet or exceed these objectives, the supplier will get paid. These will generally be on a fixed fee basis and any variations carefully managed.

Time and Materials. Time and Materials SoWs will be used to contract additional human resources with the primary deliverable under this type being hours of work to complete a set of tasks. If the supplier uses the hours and has not finished the SoW, HealthShare can either extend the SoW as required, or find an alternative solution to complete the tasks.

Embedded Model. Similar to an existing arrangement between Orion and Canterbury DHB, under this model Orion commits physical resources to the programme for an agreed cost. The use of those resources is for the programme to decide, but the allocation is of tactical importance to both parties. With both parties now working in close physical proximity to each other, there needs to be strong governance and alignment of activities.

5 The Financial Case

The purpose of this section is to set out the funding requirements of the preferred option and demonstrate that it is affordable and can be funded from committed resources and revenue sources.

The eSPACE Programme has been assessed as financially viable, at the cost of approximately $75 million over the expected five-year delivery of the programme. The eSPACE Roadmap is adaptive to clinical priorities: as such, annual expenditure is determined through the annual budgeting process to ensure DHB funding capacity constraints are recognised.

5.1 Funding Arrangements and Affordability

The overall funding envelope to deliver the scope of functionality specified in section 3.5.1 of this programme business case has been estimated at $65 million from 2015/16-2019/20, covering development and implementation. This includes a technical risk allowance of $10 million that results in an estimated programme funding envelope of **$75 million**.

Whole of life costs are estimated at $109 million over the 10-year expected lifespan of the IS.

The programme recognises that affordability is an issue for the Midland region and the programme will be managed within a level that Midland DHBs can absorb. This will be assessed and agreed on an annual basis.

5.1.1 Overall Affordability

The eSPACE Roadmap is adaptive to clinical priorities and annual expenditure is determined through the annual budgeting process to ensure Midland DHB funding capacity constraints are recognised.

The original eSPACE Roadmap included project workstreams for four MCPFP project groupings plus eOrders, eResults, eReferrals, Mental Health and Whiteboards. (This scope has remained consistent for this business case.) The funding envelope estimate of $75 million to deliver this functionality over a five-year period was subsequently reviewed by the Genesis Consulting Group New Zealand with no major estimating variances noted. (See Appendix A for report.)

Annual estimates will be managed within the eSPACE Programme funding envelope total of $75 million with a detailed governance oversight to ensure delivery of value.

The eSPACE Programme accepts that projects will be prioritised through regular clinical engagement and some projects may be substituted, such that the forecast is an estimate for work across a programme of projects, dictated by both clinical priority and affordability.

5.1.2 Processes and Checks

Funding drawdown is subject to the following processes and checks:

- Annual funding is allocated via the annual regional budgeting approvals process.
- No later than February of each year, the eSPACE Programme will be required to deliver a 12-month work-in-progress plan, in order to inform the year's budget allocation to the programme and to individual projects.
- Drawdown of funds throughout the year is subject to the detailed project-by-project approval protocols.
- As a guide to cost centres and funding splits, *indicative* annual budgets are included as Appendix C.
- These indicative budgets are 'best estimates currently available'; however it should be noted that costings cannot be fully confirmed for any project within the programme until scoping and initiation processes are complete.

5.1.3 Financial Notes

1. Non-costed Midland DHB Resources will be incurred by the Midland DHBs but not charged to the programme. An example of this would include the loss of clinical time take up by a clinician attending the user training.
2. The programme budget will be managed to deliver as much functionality as affordable and will prioritise the earliest possible delivery of clinical benefits within funding constraints.
3. The Midland region's goal of decommissioning HealthViews will influence the priority assigned to implementing functionality that exists within this product; however, this will need to be regularly reviewed to ensure the programme remains aligned with clinical priorities.

5.1.4 Assumptions

Midland DHBs have agreed that the following assumptions be applied to determine the costs:

1. Development costs are estimated over a five-year period.
2. Additional operational costs of approximately $3 million per annum will apply after December 2020.
3. Orion licenses and software support costs are based on contracted prices and the cost allocation agreed by Midland CEOs in June 2014.
4. Service management and professional services are based on an estimate of required services and are allocated on a Population Based Funding Formula (PBFF) basis.
5. Infrastructure costs are based on the use of Infrastructure as a Service (IaaS) but do not include any DIA charges and are allocated on a PBFF basis.
6. Resource costs are based in the regional rate card approved by Midland CFOs. These standard costs are an approximation of the cost of the resources engaged and a wash-up of these costs is performed annually.
7. Midland DHB ICT resource costs are based on an estimate of required capability and the intent to build internal capability rather than be reliant on partner services. They are budgeted using the regional rate card and allocated to Midland DHBs on a PBFF basis.
8. Other costs such as disbursements, project assurance and contingency are allocated on a PBFF basis.
9. Operational service management will, where possible, utilise existing support capability in the Midland DHBs and is costed against each project-level implementation, although some increase in Midland DHB FTE support is budgeted.
10. Regional service transformation leadership roles have been included and are allocated on a PBFF basis. These costs include ICT, business resources and leadership roles across the eSPACE Programme team, regional networks and Midland DHBs.
11. Costs associated with Assurance include allocations for two Gateway Review and Independent Quality Assurance reviews (IQA) for each operational phase.
12. Partners and Licensing includes a five-year instalment payment arrangement for Orion licenses and product maintenance which provides perpetual licensing thereafter, subject to the annual maintenance fee. Additional Sysmex licenses and maintenance are also costed where it is considered likely additional licenses across Midland DHBs will become a necessity.

5.1.5 Local Costs

Midland DHBs have agreed that the following assumptions be applied to cost allocations:

1. Local IS team change costs for each Midland DHB's deployment of MCP to replace legacy systems are included, based on an estimate of required effort and capability and are allocated specific to each Midland DHB.
2. Some roles may utilise existing Midland DHB staff and be treated as opportunity cost at the Midland DHBs' discretion.
3. Clinician and business stakeholder time (for example for assisting with user testing or attending training) for each Midland DHB's deployment of regional MCP is included.

4. The cost to each Midland DHB to migrate historic data into the new system has been excluded as the Midland Clinical Portal will capture defined data feeds from the outset, so regional data will build within the system from its implementation. It will also provide the environment for historic data migration if individual Midland DHBs wish to undertake data cleansing and migration projects: these projects are not, however, included or funded within the scope of the eSPACE Programme.
5. Midland DHB testing and implementation of individual project integration has been estimated.
6. Transformation team resources are costed but clinician and business stakeholder time (for example for defining target state processes and attending training) for regional service transformation activity is assumed to be a function of the existing regional network, except where backfilling costs are necessary. There is some allowance for backfilling.

5.1.6 Midland DHB Payment Mechanisms and Cost Allocations

The eSPACE Programme estimates are inclusive of the direct eSPACE Programme and Projects expenditures including partner licences/support and Midland DHB resources provided on a regional basis (similar to third parties).

Where expenditures relate to a specific Midland DHB in areas such as testing, training, change management etc. these costs have been included in the programme estimates, but will be budgeted independently by Midland DHBs and subject to their respective approval procedures.

The eSPACE Programme will act in a budgetary co-ordination and reporting capacity, with the expectation that it will be able to report on the combined eSPACE Programme and Midland DHB costs included in the programme financials. In order for the programme to meet Treasury requirements for Whole of Life reporting, Midland DHBs will be required to report back to the eSPACE Programme on their respective local expenditure.

This section confirms that the eSPACE Programme is achievable, and sets out the plans required to ensure successful delivery and management of programme risks. Effective governance is key to programme success: as such, this management case begins with an outline of the programme's regional governance arrangements. Programme management arrangements are covered at an overview level, with supporting documentation provided in the appendices.

6 The Management Case

6.1 Governance Arrangements

In February 2017 the Midland Chief Executives approved a revised governance structure of the programme, designed to bring a stronger clinical focus to governance and provide each project within the programme with appropriately specialised governance support. The revised governance structure for the eSPACE Programme is summarised in 6.2.1.

Governance activities include the following:

- Developing and interpreting policy.
- Creating an environment that fosters sustainable momentum for the programme (i.e. removing barriers both inside and outside the Midland DHBs).
- Periodically reviewing programme progress and interim results to ensure alignment with the overall strategic vision and delivery timeframes.
- Taking responsibility for delivery of projects on time, to budget and within scope.

6.2 Governance Roles and Responsibilities

The eSPACE Programme will be governed through an integrated structure.

The **eSPACE CEO Governance Group (CEOGG)** monitors the performance of the programme and are an escalation point for executive intervention where the Programme Board is unable to reach a decision or considers that risks require CEO action.

The **Senior Responsible Owner (SRO)** is accountable for delivery of the programme as delegated by the Midland DHB CEs on the basis of approved business cases. It is the SRO's responsibility to ensure the delivery of all activities within the Programme and realise the projected benefits.

The **Programme Board** reviews programme progress and interim results on a frequent, scheduled cycle, taking responsibility for delivery and ensuring alignment with the overall strategic vision and delivery timeframes.

The Programme Board is supported by a **Clinical Authority**, a **Design Authority** and an **Operational Advisory Group**. These authorities own and oversee the implementation of the programme's business and service transformation activities and ensure alignment with national and regional strategies. Most programme artefacts need to pass through at least one of these three authorities.

Additionally, the programme is supported by a **Regional Key Stakeholder Group** which holds a collaborative 'checkpoint' role only, with no formalised governance responsibilities. This group offers an opportunity for key senior stakeholders from within Midland DHBs to come together periodically with the Chief Executives to:

- receive an update on CEs' current thinking on eSPACE and any decisions made or programme guidance they have provided
- have open-forum discussion on eSPACE progress
- raise any key concerns or issues in an environment where they can be worked through transparently.

Following each meeting, attendees may be asked to provide further feedback on matters discussed. The programme management hierarchy is led by the Programme SRO, supported by the Programme Director, the Programme Manager, the Technology Director and the Programme Board.

6.2.1 eSPACE Programme Governance Structure

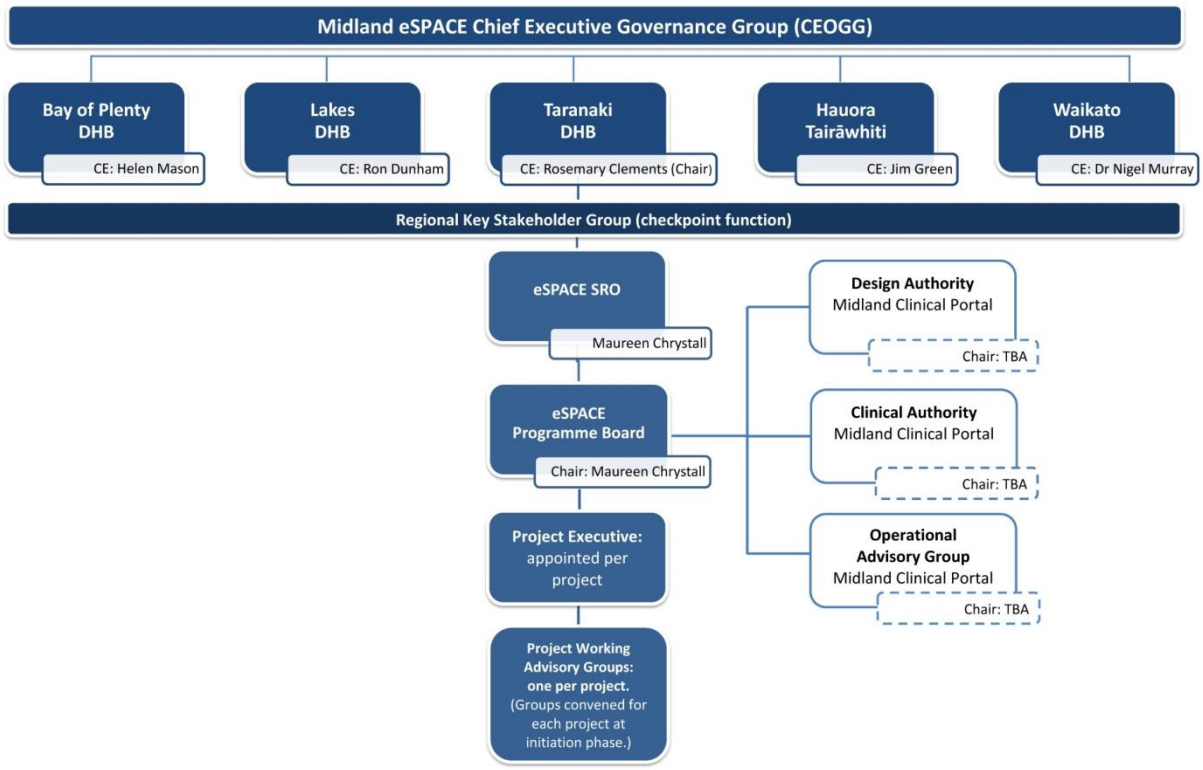

Figure 15 –eSPACE Governance Structure

6.3 Programme Management Strategy and Framework

The eSPACE Programme will create a new clinical IS platform – the Midland Clinical Portal – that will enable Midland DHBs to transform current regional clinical and business services. This will be achieved by implementing an integrated view of patient information across the region's secondary and tertiary DHB services, regardless of clinical setting, using centralised sources of clinical data.

6.3.1 Programme-level Arrangements

The eSPACE Programme will be managed using industry-standard methods aligned to Managing Successful Programmes (MSP), as well as to the Midland Regional IS management methodology, which has been developed and refined through successful delivery of regional IS projects, services and products to the Midland DHBs and customers.

The programme will utilise regional resources within the Midland DHBs. Regional resources will provide a quality assurance function, which ensures that all projects are meeting their objectives within HealthShare and Midland DHBs' quality standards.

In any large-scale transformation project, there are a number of variables that exist simultaneously and affect the acceptance of change by an organisation. These variables range from legislation and Ministry mandates, to the organisation's culture and leadership, to the attitude and behaviour of every employee.

The programme will look to establish regionally agreed change principles, and will agree a library of change planning tools and templates that Midland DHBs' will use for change and training purposes. Effectively,

change will be managed by DHBs, where the ADKAR approach using Prosci® change management processes are largely adopted.

The strategy, framework and plan for managing risk are articulated in the *HealthShare Risk Management Strategy ICT-enabled Programmes and Projects* document.

The eSPACE Programme has agreed with the Ministry of Health that it will request periodic Gateway Reviews upon achieving significant milestones.

6.3.2 Project-level Arrangements

Individual projects within the eSPACE Programme will be managed through the most relevant project methodology for the project and aligned to industry-standard best practice frameworks.

Following eSPACE Programme Business Case approval, the following project initiation process will be implemented within the agreed escalation, reporting and governance arrangements:

1. An Executive Brief will be prepared for each project and submitted for approval to the Programme Board, following endorsement by the Clinical Authority and Design Authority – this will provide an executive level overview of a request for investment. The anticipated outcome of the Executive Brief is approval to proceed to the next appropriate approval/review step.
2. Next, a Project Initiation Document (PID) will be prepared where the project aligns to this Programme Business Case. The PID will be used as an alternative to the implementation business case and will authoritatively define the cost, scope and quality parameters of the project.
3. Projects within the scope and contingency of the programme will require their PID to be authorised by the Programme Board, following endorsement by the Clinical Authority and Design Authority. This is then sufficient authority for that project to proceed.
4. If the Programme Board identifies a project as being beyond the scope and contingency of the eSPACE Programme, the PID will need to be submitted to the Midland eSPACE CEO Governance Group for consideration/authorisation.

Under this approach (and as agreed with the Ministry of Health), periodic Individual Quality Assurance (IQA) will be required for each project. To ensure IQA assessments can contribute to ongoing programme learning and development, and due to the technical nature of some of the projects, the eSPACE Programme will not appoint a single agency to undertake all IQA projects. IQA providers will instead be selected for each project using the All of Government panel and a closed procurement process, using a 'best fit' approach for the specific project.

6.3.3 Programme-level Reporting

All reporting will be in line with agreed standard reporting formats and timings. The standard programme highlight report will include:

- performance against baseline tolerance (schedule, budget, scope, benefit, quality)
- general progress statements
- key milestone performance
- dependencies
- all high/critical risks and issues
- decisions and changes
- progress against the assurance plan
- items for escalation.

6.3.4 Project-level Reporting

Each individual component project within the eSPACE Programme is led by a Clinical Executive and supported by a Technical Sponsor. They work collaboratively with the Project Manager. Projects may also be guided by subject-specific working advisory groups to ensure alignment with current-state practice and frameworks.

Project-level reporting requirements are as for the programme and are in line with agreed standard reporting formats and timings.

6.3.5 Programme Management Roles and Responsibilities

A summary of programme management roles and responsibilities for the eSPACE Programme is outlined below.

Table 28 – Roles and Responsibilities

Role	Responsibilities	Key Relationships	Direct Reports
Senior Responsible Owner (SRO)	▪ Ultimately responsible for programme outputs that are required to meet business objectives. ▪ Highest level of accountability and delegated authority.	▪ CEOGG ▪ Ministry of Health ▪ Programme Board ▪ Programme Director ▪ Midland DHB executives ▪ Regional key stakeholder group	▪ Programme Director
Programme Director	▪ Develops and oversees the strategic direction of the programme, in close consultation with the SRO and Midland DHB executives. ▪ Capacity building role responsible for delivery of all programme outputs and reporting. ▪ Ensures alignment and integration of all programme activity with relevant regional and national strategic frameworks.	▪ CEOGG ▪ SRO ▪ Ministry of Health ▪ Programme Board ▪ Programme Manager ▪ Technical Director ▪ Regional key stakeholder group	▪ Programme Manager ▪ Technology Director ▪ Finance Director ▪ Change and Transformation Manager ▪ Communications and Quality Manager ▪ Programme Administrators
Programme Manager	▪ All management and oversight of programme operations, with a particular focus on engagement, business development, oversight of project delivery and reporting.	▪ SRO ▪ Programme Director ▪ Technology Director ▪ Finance Director ▪ Programme Board ▪ Clinical Authority ▪ Midland DHB CMOs ▪ Clinical stakeholders	▪ Project Managers ▪ Business Analysts
Technology Director	▪ Provides overall direction, guidance, definition and facilitation for the development of current and future architectures and strategies required to meet eSPACE needs, goals, and strategic directions. ▪ Drive the planning, engineering, and delivery of strategic business capabilities needed to support the eSPACE strategic direction.	▪ Programme Director ▪ Programme Manager ▪ Programme Board ▪ Design Authority ▪ Midland DHB CIOs ▪ Regional IS team ▪ DHB IS teams	▪ Configuration Manager ▪ Testing team ▪ Development team
Finance Director	▪ Programme support role with	▪ SRO	▪ None

Role	Responsibilities	Key Relationships	Direct Reports
	responsibility for planning and managing all financial aspects of the programme and individual projects. ▪ Ensures PID review and endorsement for affordability	▪ Programme Director ▪ Programme Manager ▪ Midland DHB CFOs	
Change and Transformation Manager	▪ Programme support role that provides the bridge between the overall programme outputs and Midland DHB business operations. ▪ Includes change and transformation management, Midland DHB business alignment, benefits realisation, learning and training ('train the trainer' model), readiness toolkits. ▪ Responsibility for benefits management.	▪ Programme Director ▪ Programme Manager ▪ Technology Director ▪ Project Managers ▪ Midland DHB COOs ▪ Operational Advisory Group ▪ DHB Change Managers and Change Agents ▪ Learning and Development Managers ▪ Training Leads	▪ None
Communications and Quality Manager	▪ Programme support role with responsibility for managing stakeholder communications at programme and project levels. ▪ Additionally responsible for Ministry communications support, research support and quality and consistency of programme-level documentation.	▪ Programme Director ▪ Programme Manager ▪ Technology Director ▪ Programme Board ▪ Change and Transformation Lead ▪ Project Managers ▪ Midland DHB Communications Leads	▪ None
Project Managers	▪ Manage individual project/s on a day-to-day basis, within agreed frameworks and in close collaboration with the Clinical Executive and Technical Sponsor for each project.	▪ Programme Manager ▪ Technical Director ▪ Finance Director ▪ Transformation and Change Lead ▪ Communications and Quality Lead ▪ Clinical Executive ▪ Technical Sponsor ▪ Allocated project team	▪ None

Also vital to individual projects within the programme is the role of Clinical Executive. The responsibilities of the Clinical Executive include the following:

- Represents the needs of those who will use the project's products and provides liaison between users and the project team.
- Responsible for accepting the outputs of the project into business as usual.
- Represents the interests of all those who will use and support the project's products.
- Monitors that the solution will meet those needs, within the constraints of the business case in terms of quality, functionality and ease of use.
- Monitors products against requirements.
- Acts as a champion for the project within organisations and the sector.
- Supports resolution of user requirements and priority conflicts.
- Maintains business performance stability during transition from the project to business as usual.

6.4 Programme Plan Overview

The overarching eSPACE Programme of work will deliver a regional clinical workstation, known as the 'Midland Clinical Portal' (MCP), supported by unified Clinical Data Repositories (CDRs) through a series of strategic projects across the five Midland DHBs.

The programme will provide a single point of access for clinical information across the Midland region, delivering consistent, accurate and complete patient records to support sound clinical decisions, reduce risk and improve the experience of patients, clinicians and administrators.

The eSPACE Programme is a clinically-led programme of change, not an 'IT implementation'.

To facilitate success across the board, the programme is divided into five areas of management responsibility.

The five management areas – which all contribute to strategic planning, reviews and reporting – are:

1. Programme Management
2. Technology
3. Financial
4. Change and Transformation
5. Communications and Quality.

Each area has a framework and protocols articulated through key programme documents. These frameworks provide clear operating parameters for all individual projects within the programme and are designed to support an empowered and responsive working environment for project teams. The approach for each management area is outlined below.

6.4.1 Programme Approach

The programme management area is responsible for all management and oversight of programme operations, with a particular focus on engagement, business development, oversight of project delivery, and reporting. All reporting will be done in line with agreed standard reporting formats and timings. The standard programme highlight report covers the following information:

- Performance against baseline tolerance (schedule, budget, scope, benefit).
- General progress statements.
- Key milestone performance.
- Dependencies.
- All high/critical risks and issues
- Decisions and changes.
- Progress against the assurance plan.
- Items for escalation.

6.4.2 Technology Approach

The technology area of the programme touches all aspects of the programme and takes an approach of ensuring that the underlying technology for the programme is fit for purpose, cost-effective and aligned with regional and national standards and strategies.

Practically, this will be achieved by utilising the regional Design Authority to gain regional agreement and input on key technology decision points. At the project level, this area will institute reviews of technology solutions where necessary to ensure that effective solutions are designed, costed and implemented in accordance with the programme strategies.

6.4.3 Financial Approach

Financial management for the eSPACE Programme employs Midland DHB-agreed models for financial forecasting, budget management and reporting for the programme. The Finance Director works closely with

Midland DHB CFOs to ensure alignment on affordability and funding, as well as co-managing the benefits realisation project to ensure programme and project benefits are appropriately baselined and quantified.

6.4.4 Change and Transformation Approach

The Change and Transformation area is a key focus for the eSPACE Programme. In facilitating a region-wide approach to change management and modern workplace learning and training methods, the programme is proposing an overarching strategy supported by a set of principles. This ensures that staff and stakeholders are engaged with appropriately and at key milestones. With a strong focus on lessons learned and ensuring readiness, the change management element of this programme sets the scene for successful implementation of change by Midland DHBs across the Midland region.

Benefits planning and realisation is also a key responsibility of this area. Working with the region, benefits realisation management gives detailed consideration of the conditions required to realise benefits, along with a clearly defined framework for benefits measurement and management. Responsibility for benefits measurement and management will sit collaboratively with both the programme and the Midland DHBs.

The Benefits Realisation Framework draws from the National 'Triple Aim' which reflects high-level outcomes for individuals, populations and systems.

This approach, combined with a five-step risk management process and alignment with the HealthShare Risk Management Strategy, aligns fully with benefits realisation management best practice and PRINCE2 principles to identify, assess and manage both risk and benefits on an ongoing basis.

6.4.5 Communications and Quality Approach

Clear, timely and transparent communication is fundamental to the success of the eSPACE Programme.

Throughout the scoping and development of the eSPACE Programme, there has been a strong preference to prioritise engagement with clinicians. Early engagements were, however, inadequately executed and as such poorly received, prompting a review and re-assessment of the mechanisms and procedures by which eSPACE links to clinicians in the Midland DHBs. Later engagements have been closely managed to maximise clinical input into the programme while limiting the time impact on clinicians. These improvements have been well received and now provide the frameworks for ongoing engagement.

The eSPACE Strategic Communications and Engagement Plan includes programme-level stakeholder mapping, a communication strategy with key messages, analysis of target audiences, distribution channels, media protocols and timing and frequency of communications. This fully scoped plan is to be supported by programme-level 90-day tactical plans for each quarter, plus project-level communications plans for each approved project. These project-level plans align to the programme plan but utilise tactics specific to the deliverables of each project.

6.4.6 Key Programme Documents

Each management area within the eSPACE Programme has a framework and protocols articulated through a strategic framework. These frameworks provide clear operating parameters for all individual projects within the programme and are designed to support an empowered and responsive working environment for project teams. Individual projects within the programme will align to and reference the key agreed programme documents. These programme documents will be reviewed and approved by the Programme Board and provide the frameworks and protocols for all key aspects of eSPACE Programme management.

All key documents will be retained in the HealthShare Knowledge Library, an online resource which also houses applicable programme protocol documents, framework resources and programme templates.

6.4.7 Programme Milestones

The Midland Chief Executives have been clear in their expectation that eSPACE will be run as a programme with regular checkpoints so that Midland DHBs can validate the ongoing process and ensure alignment with their regional priorities. The programme is required to plan and formally advise milestones where the next 'module' of work can be reviewed by the Midland DHBs.

The eSPACE Programme scope will be delivered in three phases against the following high level milestones. To ensure the programme retains momentum, planning and project initiation work for the next phase will be undertaken during delivery of the previous phase.

Clinical consultation has informed the suggested scope and order of delivery; however, the order of delivery may change in response to ongoing consultation, Midland DHB deployment sequences and/or the requirement to deliver clinical benefits as soon as possible. This process will be subject to governance-level approval – as will any potential additions to programme scope suggested by ongoing engagement.

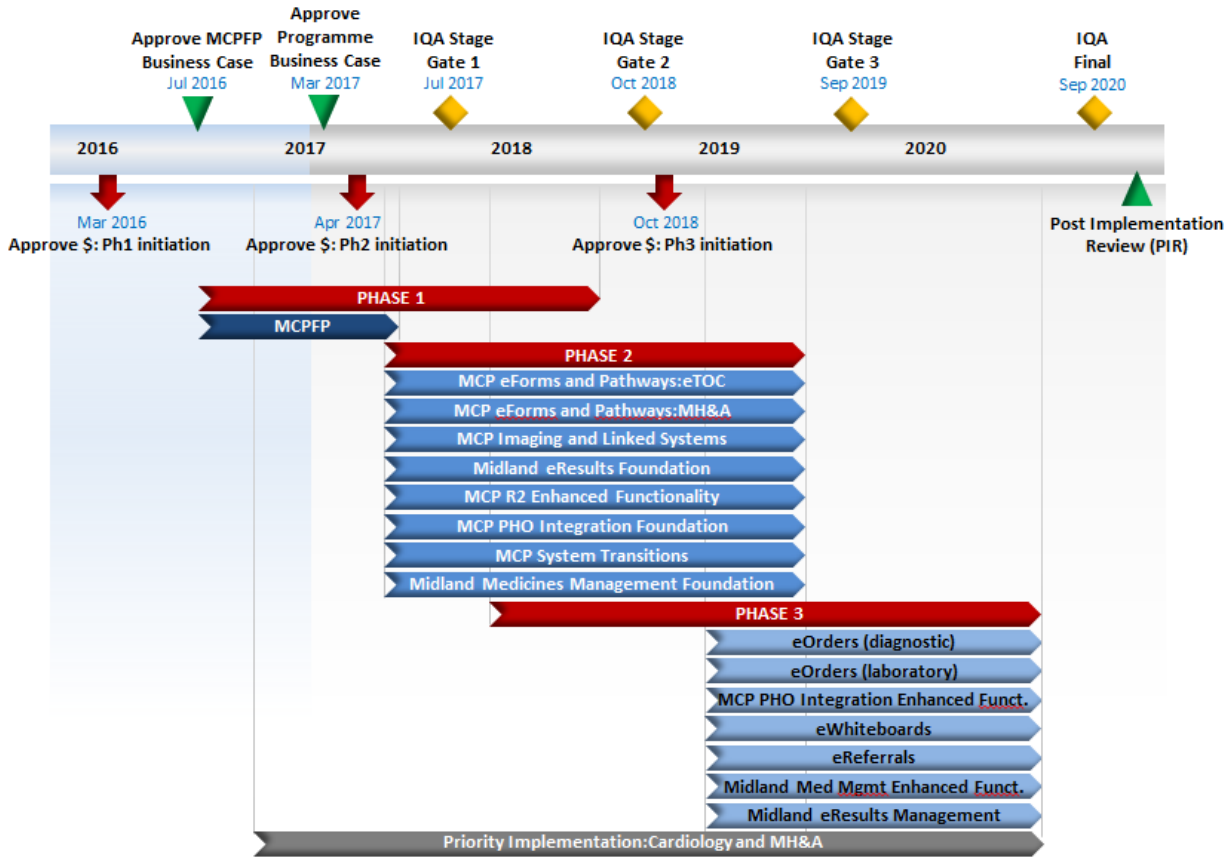

Figure 16 – eSPACE Programme High-level Milestones

6.5 Programme Risk Management

Risk management will follow the approved Risk Management Strategy, which applies to all regional ICT-enabled projects and programmes. The strategy has been designed to fully align to the guidance contained within PRINCE2 and conforms to the standards embedded in the Midland region risk management system (Datix). The key points of the Risk Management Strategy are as follows:

- It adopts the five-step risk management process. (Identify. Assess. Plan. Implement. Communicate.)
- It mandates the use of a common toolset.
- It specifies common standards for:
    - information gathered

- monitoring and reporting requirements
- timing of risk management activities and workshops
- roles, responsibilities and escalation
- risk scales and categories.

6.5.1 Risk Register

The eSPACE Programme's risk, assumptions, issues and dependencies are described using the acronym 'RAID'. They are managed in accordance with the Regional IS management methodology, which has been developed and refined by the Midland region through successful delivery of regional IS projects, services and products to the Midland DHBs and customers.

Numerous programme risk reviews have been held in establishing the eSPACE Programme, which have emphasised the identification of the top 20 per cent of risk events. These risk events can potentially account for 80 per cent of the total potential risk of the programme.

A programme-level RAID has been established along with the key risks that might create, enhance, prevent, degrade, accelerate or delay the achievement of the investment objectives. This RAID is monitored at the programme level by the Programme Director. Any project-specific risks will be monitored at a project level and only escalated to the programme register if they have programme-level potential impact.

6.6 Programme Assurance Arrangements

The Programme will adopt an integrated assurance approach as defined in the *Programme Assurance Plan: Midland eSPACE Programme.* This will provide the SRO, Midland DHB Chief Executives and other key stakeholders with confidence that the Programme is well managed within agreed parameters, that standards are met and that the agreed strategic outcomes will be delivered.

The key focus of the assurance approach is on the programme's achievement of strategic outcomes and benefits. Each component project within the programme will be subject to assurance activities that are undertaken in line with a specific agreed project assurance plan.

Key features of the eSPACE Programme assurance approach are as follows:

- A focus on achievement of the strategic objectives, outcomes and benefits.
- Robust programme (and aligned project) governance based on clear roles and responsibilities.
- Independent verification of activities where appropriate and necessary.
- Suitable line of sight and alignment of individual project assurance plans with this programme strategy.
- Incorporation of all national (Government Chief Information Officer (GCIO) and Gateway) reviews as necessary.
- Ongoing consideration of the alignment of the project with wider strategic direction and objectives.
- Considering salient lessons learned from similar programmes, within and beyond the Midland Region.
- Ongoing Programme management controls such as status reporting, governance activities, risk and issue review.

The Plan outlines assurance roles and responsibilities, and specifies ongoing and milestone assurance activities aligned with the eSPACE Programme Roadmap.

6.6.1 Independent Quality Assurance

Independent Quality Assurance (IQA) is a cornerstone of the assurance approach for the eSPACE Programme. Third-party reviewers will be engaged to undertake an independent review and assessment of project/programme design, performance and strategic alignment and any other appropriate project or programme aspects throughout its lifecycle. This includes periodic reviews, as well as reviews to be carried out at key decision points.

6.6.2 Technical Quality Assurance

Technical Quality Assurance (TQA) may be required to independently ensure that the technical design and development aspects of eSPACE projects are fit for purpose. Review aspects might include technical infrastructure, applications and information architecture design, code and configuration reviews, testing, technical implementation and associated performance, security, privacy and resilience. As with IQA, third-party reviewers will be engaged using approved government procurement processes.

6.6.3 Gateway Reviews

A series of Programme-level Gateway reviews will be undertaken during the course of the programme upon achieving significant milestones.

6.7 Post Project Evaluation

The outline arrangements for project evaluation review (PER) and post implementation review (PIR) have been established in accordance with best practice and are as follows.

6.7.1 Project Evaluation Reviews

Each approved component project of the eSPACE Programme will include an internal evaluation review to measure agreed project outputs against actual deliverables across time, scope, budget and quality. Any benefits realised during the course of the project will be reported at the time and consolidated in the PER.

Each PER will be conducted by the eSPACE Programme Team, with and findings reported to the Programme Board.

6.7.2 Post Implementation Review (PIR)

Regular benefit realisation reviews will be carried out over the course of the programme to measure and record the delivery of anticipated improvements and benefits. These reviews will be undertaken three to six months after each programme-level milestone.

A Post Implementation Review (PIR) will be undertaken between six and 12 months following programme closure. The PIR will be conducted by a Midland DHB appointee reporting to the SRO. The PIR will be reviewed and authorised by the Midland CEOGG. The PIR will evaluate the ongoing performance of the specialist outputs, services, process change, support arrangements and capacity planning delivered by the project.

An end of programme report, including lessons learned, will be created, during the closing stage of the eSPACE Programme. This will formally evaluate the performance of the eSPACE Programme against:

- the business objectives agreed in this business case
- the wider delivery performance targets
- tolerance for time, cost and scope
- benefits realisation across the eSPACE Programme.

7 Next Steps

Following approval of this eSPACE Programme Business Case by the Midland DHB CEOs, it will then go to Midland DHBs for Board approval, followed by submission to Treasury. If approved, the eSPACE Programme will formally commence implementation of the scoped five-year programme.

The work outlined in this eSPACE Programme Business Case will deliver core MCP functionality to the Midland DHBs, mitigating risks and problems identified over a number of years and enhancing regional capabilities considerably. It will build on the regional foundation established for ePharmacy, and secure sound communications by providing a Midland Clinical Portal solution that can evolve and grow over time.

As part of this programme the Midland region will develop its ability to continuously improve the regional clinical networks and Midland DHB services to meet future clinical challenges and the changing economic needs of its population.

7.1 Approval

The eSPACE Programme now seeks formal approval from the Midland DHB CEOs for the eSPACE Programme outlined in this business case.

Approval of this Programme Business Case provides eSPACE with authority to formally initiate the Midland eSPACE Programme. The core programme deliverable is the development and implementation of an integrated Midland Clinical Portal (MCP) which is aligned to an agreed eSPACE Programme Roadmap.

In signing this document the Chief Executives and Chairs, on behalf of the Midland DHBs approve and agree the following.

1. Approve:
    a. the funding envelope for capital and operating expenditure for the eSPACE Programme
    b. the programme scope and approach as outlined in this eSPACE Programme Business Case
    c. the Programme Governance structure and SRO having the delegated authority to make project by project decisions within the approved programme scope and funding envelope on behalf of the Midland DHBs
    d. the programme delivering agreed scoped projects within the authorised funding envelope, subject to proper governance controls and funding through annual budget processes, without the need for subsequent individual project business cases.

AND

2. Agree:
    a. that the eSPACE Programme submit this Programme Business Case, on behalf of the region, for Ministry of Health endorsement and Ministerial and Cabinet approval as appropriate
    b. that all Midland DHBs will deploy the Midland Clinical Portal to replace existing Midland DHB systems as soon as is practicable and, where possible, within the programme timescales
    c. that Midland DHBs will, within the programme scope, prioritise programme implementation alongside local priorities
    d. that any projects not within approved scope and outside of the agreed funding envelope will require either formal change control or individual business cases to be submitted.

7.2 Signing Authority

Bay of Plenty DHB		
	Chair	CEO
Lakes DHB		
	Chair	CEO
Hauora Tairāwhiti DHB		
	Chair	CEO
Taranaki DHB		
	Chair	CEO
Waikato DHB		
	Chair	CEO
HealthShare		
	Chair	CEO

8 Appendices

Appendix A: Genesis Consulting Assurance Review Report

Appendix B: ILM 2016: full regional results with weightings

Appendix C: Financial Analysis: NPV and Benefits Change

Appendix D: Indicative Annual Costings – eSPACE Programme

All appendices in associated PDF file.

Waikato District Health Board

Papers for Information

MEMORANDUM TO THE BOARD
22 MARCH 2017

AGENDA ITEM 10.1

MENTAL HEALTH & ADDICTIONS SERVICE S99 (MENTAL HEALTH (CAT) ACT 1992) INSPECTION REPORT ACTION PLAN)

Purpose	For information.

An update on progress on the recommendations in the S99 (Mental Health Act) Inspection Report Action Plan is submitted for the Board's information.

Recommendation
THAT
The report be received.

DEREK WRIGHT
EXECUTIVE DIRECTOR, MENTAL HEALTH AND ADDICTIONS SERVICE

WAIKATO DHB MENTAL HEALTH & ADDICTIONS SERVICE

S99 (Mental Health Act) Inspection Report Action Plan

Recommendation 1: There needs to be an immediate appointment to the role of Executive Director, to enable the Director of Clinical Services to concentrate on leading clinical changes. The DHB needs to give careful consideration to appointing someone who is the right fit for this service given its transformational change and operational challenges.			
Appointment of Executive Director.	Feb 2016	Complete	Derek Wright appointed as Executive Director.
Recommendation 2: There needs to be a clear strategy on positive clinical risk management that ensures appropriate human rights while at the same time educating and assuring the public.			
Models of care and staff education support "positive risk taking"	Dec 2016	Partially Complete	Training in positive risk training was implemented in June 2016 and continues. Phase 1 on the Model of Care development is currently underway as this aligns to the development of the business case for the new inpatient and rather than rush to completion, a consultative process, including Investment Logic Mapping and community, family and cross sector engagement is underway.
Current framework of audit and evaluation of inpatient services to continue	April 2016	Complete and ongoing	A specific audit framework and evaluation plan has been developed and audits are reported quarterly to the MHAS Clinical Governance Forum on an ongoing basis.
Communication strategy and communications plan for internal and external stakeholders	April 2016	Complete and ongoing	A communications strategy which includes increased engagement and communication with the wider community has been developed and implemented. The Waikato DHB Board receives bi-

			monthly updates on progress against the implementation action plan for the S99 report, along with continued reporting of MHAS service development. Mental Health and Addictions Services publishes a "Community Report Card" on a quarterly basis in regional and local press. In addition, Mental Health and Addictions Services have linked with Waikato DHB's Suicide Prevention and Rural Health Teams to deliver presentations and seminars to a number of community focus groups, at Field Days and at rural mental health sites. We plan to continue and grow all of these initiatives on an ongoing basis, making our services more transparent to the wider Waikato community.
Recommendation 3: *The DHB needs to devote attention to some immediate staffing relief in critical areas (especially in some of the community teams) to reduce staff burn-out and churn, fill vacancies and improve staff retention.*			
Increase inpatient staffing levels	July 2016	Complete	An additional 6 Full Time Equivalent (FTE) registered nursing staff have been employed in the inpatient services.
Right sizing of budget/staff ratios	July 2017	Incomplete	Whilst work continued on the safe rostering project and implementation of right-size roster models for inpatient services, it is acknowledged this piece of work will take longer than initially

			anticipated due to the requirement for ongoing union discussion and the national issues relating to rosters.
Improved staff recruitment and retention	July 2016	Complete	A specific Mental Health and Addictions Service recruitment and retention strategy has been developed and implemented across the service.
Particular areas/teams of concern to be identified and strategies developed to attract and retain staff to those areas	July 2016	Complete	This issue has been partially addressed with the implementation of the strategy noted above. In addition, specific areas such as the challenges facing inpatient psychiatrists, have been identified as requiring specific focus.
Capacity within PVS (Price Volume Schedule) to consider deployment of staff to respond to demand	July 2016	Complete	Planning and Funding have agreed to increase inpatient pricing to national pricing. There is also agreement around increased ability to offset between services within the Price Volume Schedule (PVS) to best meet demand .
Recommendation 4: *Because of the magnitude of the change agenda, the MHAS needs strong engagement and support from the wider DHB at all levels.*			
Needs Assessment and Service Reconfiguration review	July 2017	Partially complete	The first draft of the needs analysis has been prepared for discussion. Further stakeholder review/forums will occur prior to finalisation over the next few months.
Development of the business case for the new build.	July 2017	Incomplete	The Draft Model of Care for Adult Acute has been developed and the Investment Logic Mapping Exercise has been

			undertaken. The Stakeholder Working Group, that includes DHB staff, consumers, family, NGO staff & Primary Care will reconvene and review the draft Model of Care The Business Case is in development and we are working closely with the MOH & Treasury. Good progress is being made
Increased change management capacity for implementation of ICP project	July 2016	Complete	Review of the ICP project and the need for further planned change has resulted in the addition of specific project resource, in addition to a planned programme of change (Creating Our Futures), which will see significant change delivered over the next 5 years.
Recommendation 5: *The strategic direction is one of system change in the district; therefore, a systems-wide change process is needed that includes the MHAS, its strategic NGO partners, primary care services, iwi, consumers and family/whānau.*			
Mental Health and Addictions Service Needs Assessment Review of the Waikato Region 2016 - 2026			See update at Recommendation 4
Strategic Plan For MHAS Service Delivery 2016 – 2020	August 2016	Complete	
Recommendation 6: *Integrated clinical and operational governance that includes planning and funding is necessary across this continuum.*			
Development of an operational governance structure across all elements of the MHA sector with clear reporting through to the CEO and Board.	August 2016	Partially complete	A steering group for the overall programme of work has been developed which includes representation from the DHBs mental health and addiction services along with NGOs from the

			sector, consumer representative and Strategy and funding. Approaches to clinical governance across the mental health sector will be considered as part of this overall programme of work
Recommendation 7: *The service should report progress to the DHB Board and the Director of Mental Health.*			
	May 2016 July 2016 Sept 2016 Nov 2016	Complete and ongoing.	
Recommendation 8: *The current direction of travel is appropriate and necessary. The agenda for transformational change cannot be discarded. However, to give effect to change of this magnitude, the following are required:* *a. There needs to be appropriate shared leadership, supported by a change team with experience in embedding transformational change.* *b. There needs to be adequate resourcing for the change (including fiscal resources and staffing resources).* *c. There needs to be support for embedding practice change at the front line/consumer level, with effective feedback loops.* *d. Industrial relationships need resetting to ensure partnership in change.* *e. Professional leads need time to participate in and develop support for change (including service and clinical leads).* *f. The renewed strengthened nursing and allied leadership model needs ongoing monitoring and support.* *g. The MHAS needs to build up a sufficient group of 'in-service leads and champions' to support change within teams.* *h. There needs to be a clear and detailed communication and engagement strategy at all levels. The strategy needs to include the DHB's*			

strategic partners, the people using the service and the community. The strategy should have a clearly articulated narrative that supports the transformational change agenda.			
All transformational change in MHAS is brought under one programme of change and delivered via a Project Methodology Programme management resource as #4 The development of a Consumer advisory board to ensure effective feedback loops Executive Directors has met with unions and agreed "how we work together". We have agreed to develop a Joint Consultative Committee that will meet quarterly Prof leads to be brought into workforce development group chaired by DCS Exec Director meets regularly with professional leads of all disciplines reporting against agreed workplans With the ICP development group we will develop service champions/user groups to head the various work projects. Implementation of the MHAS communication strategy.		Complete Complete Complete Complete Complete Complete Complete Complete	
Recommendation 9: *The ICP, while appropriate as a high-level organising principle, needs to be customised to fit local circumstances. This would effectively complement the existing level of co-design and increase future levels of acceptance among service users.*			
Defined Programme of Change Plan for ICP implementation.		Complete	Please see update on recommendation 4 – Creating Our Futures, Programme of Change.

WAIKATO DHB MENTAL HEALTH & ADDICTIONS SERVICE

S99 (Mental Health Act) Inspection Report Action Plan

Recommendation10: *Good cultural practice must be embedded, effective and consistent*			
Full implementation of the Culturally Responsive Services Review Recommendations		Incomplete	Whilst there has been some delay in implementation of all of the recommendation from the review of Culturally Appropriate Services, MHAS continues to work closely with Te Puna Oranga, to ensure all elements of the change programme are culturally appropriate.
Recommendation11: *Planning must incorporate realistic timeframes, based on best practice and how to embed change.*			
Planning will incorporate realistic timeframes, based on best practice and how to embed change.		Complete	
Recommendation 12: *The service needs to galvanise community relationships to support and protect the change.*			
Community and sector engagement is clear in service planning and delivery		Complete	Whilst there is always an opportunity for wider community involvement, the actions detailed in recommendations 2 and 5 continue to demonstrate increasing engagement with the community both in terms of how we deliver services currently, what issues we face and planning processes for future development.
Community are aware and informed of Mental Health and Addictions Services in the Waikato		Complete	