Waikato District Health Board

MEMORANDUM

TO: Board Members

FROM: Donna Straiton

DATE: 14 November 2017

SUBJECT: **Board and Committee Meetings – 22 November 2017**

0845: Visit new facilities at Gallagher Drive
Please meet in front of the Hockin building by 8.45am
A shuttle has been arranged to transport Board members to Gallagher Drive at 8.45am and will return to the Waikato Hospital by 9.45am

1000: Audit and Corporate Risk Management Meeting
Venue: Board room, level 1, Hockin building

1230: Board Members Only Meeting and Working Lunch
Venue: Board room, level 1, Hockin building

1300: Board Members/Interim Chief Executive Meeting
Venue: Board room, level 1, Hockin building

1330: Assurance Framework Workshop
Venue: Board room, level 1, Hockin building

1430: Board Meeting
Venue: Board room, level 1, Hockin building

DISTRIBUTION

Board Members (1 copy each)

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

Executive Management Team

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

Contact Details:
Telephone 07-834 3622
Facsimile 07-839 8680
www.waikatodhb.health.nz

Next Meeting Date: 28 February 2018

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

Agenda

Board

Date: **22 November 2017**

Time: **2.30pm**

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

Waikato District Health Board

Meeting of the Waikato District Health Board

to be held on Wednesday 22 November 2017
commencing at 2.30pm at Waikato Hospital

AGENDA

Item

1. Apologies

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

3. **MINUTES AND BOARD MATTERS**
- 3.1 Board Minutes: 25 October 2017
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 2 November 2017
  - 3.2.2 Maori Strategic Committee: 15 November 2017
  - 3.2.3 Audit and Corporate Risk Management Committee Work Plan November 2017

4. **INTERIM CHIEF EXECUTIVE REPORT**

5. **QUALITY AND SAFETY**
No report this month

6. **DECISION REPORTS**
- 6.1 Quality Account 2016/17
- 6.2 Asset Performance Indicators
- 6.3 Proposed Alliancing Structure for Waikato DHB

7. **FINANCE MONITORING**
- 7.1 Finance Report
- 7.2 2017/18 Long Term Financial Model and Capital Plan Summary

8. **PRESENTATION**
No presentations this month

9. **PAPERS FOR INFORMATION**
- 9.1 Health Targets - Immunisation
- 9.2 Provider Arm Performance Monitoring – Red Flags
- 9.3 Very Low Cost Access Practice in Cambridge

10. **NEXT MEETING: 28 February 2018**

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

THAT:

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

Item 11: Minutes – Various

- **(i) Waikato District Health Board for confirmation: Wednesday 27 September 2017 (Items taken with the public excluded)**
- **(ii) Waikato District Health Board Special Meeting for confirmation: Wednesday 19 July 2017**
- **(iii) Audit and Corporate Risk Management Committee – verbal update to be received: Wednesday 22 November 2017 (All items)**
- **(iv) Midland Regional Governance Group – to be received: Friday 6 October 2017 (All items)**

Item 12: Risk Register – Public Excluded
Item 13: Annual Serious Adverse Event Report – Public Excluded
Item 14: Presentation on NZ Health Partnerships – Public Excluded
Item 15: Primary Care Practice Concern – Public Excluded
Item 16 Rongo Atea – Youth Residential Alcohol and Other Drug Services – Public Excluded
Item 17: Interim Chief Executive's Key Performance Indicators – 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	SECTION OF THE ACT
Item 11(i-iv): Minutes – Public Excluded		Items to be adopted / confirmed / received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 12:	Risk Register – Public Excluded	Avoid inhibiting staff advice about organisational risks	Section 9(2)(a)
Item 13:	Serious adverse event report – Public Excluded	Negotiations may be required with HQSC on form and content of information	Section 9(2)(j)
Item 14:	NZ Health Partnerships presentation – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 15:	Update on primary care practice – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 16:	Youth residential alcohol and other drug services – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 17:	Interim Chief Executive KPIs – Public Excluded	Negotiation will be required	Section 9(2)(j)

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

Item

11. MINUTES – PUBLIC EXCLUDED

11.1 Waikato District Health Board: 25 October 2017
To be confirmed: Items taken with the public excluded

11.2 Waikato District Health Board Special Meeting: 19 July 2017
To be confirmed: All items

11.3 Audit and Corporate Risk Management Committee: 22 November 2017
Verbal update: All items

11.4 Midland Regional Governance Group: 6 October 2017
To be received: All items

12. RISK REGISTER – PUBLIC EXCLUDED

13. ANNUAL SERIOUS ADVERSE EVENT REPORT – PUBLIC EXCLUDED

14. PRESENTATION ON NEW ZEALAND HEALTH PARTNERSHIPS – PUBLIC EXCLUDED

15. PRIMARY CARE PRACTICE CONCERN – PUBLIC EXCLUDED

16. RONGO ATEA – YOUTH RESIDENTIAL ALCOHOL AND OTHER DRUG SERVICES – PUBLIC EXCLUDED

17. INTERIM CHIEF EXECUTIVE KEY PERFORMANCE INDICATORS – 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.

Apologies.

Waikato District Health Board
Te Hanga Whaioranga Mō Te Iwi – Building Healthy Communities

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO NOVEMBER 2017

Bob Simcock

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

Sally Webb

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

Note 1: Interests listed in every agenda.

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

Crystal Beavis

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

Sally Christie

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

Martin Gallagher

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

Note 1: Interests listed in every agenda.

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

Mary Anne Gill

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

Tania Hodges

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

Dave Macpherson

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

Note 1: Interests listed in every agenda.

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

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

Pippa Mahood

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

Sharon Mariu

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

Note 1: Interests listed in every agenda.

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

Clyde Wade

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

Note 1: Interests listed in every agenda.

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

Conflicts related to items on the agenda.

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 25 October 2017 commencing at 1.30pm in the Conference Room, at Taumarunui Hospital

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

In Attendance:
Mr D Wright (Interim Chief Executive)
Mr B Paradine (Executive Director, Waikato Hospital Services)
Ms M Chrystall (Executive Director, Corporate Services)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Mrs J Wilson (Executive Director, Strategy and Funding)
Ms L Elliott (Executive Director, Maori Health)
Mrs V Aitkens (Acting Executive Director, Mental Health and Addictions Service)
Mr M Spittal (Executive Director, Community and Clinical Support)
Mr A McCurdie (Chief Financial Officer)
Ms M Ch'ng, Director, Business and Support Services

ITEM 1: APOLOGIES FOR ABSENCE

There were no apologies for absence.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

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

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 27 September 2017

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 27 September 2017 taken with the public present were confirmed as a true and accurate record.

3.2 Committee Meeting Minutes

3.2.1 Iwi Maori Council: 5 October 2017

Resolved
THAT
The Board noted the minutes of this meeting.

3.2.2 Maori Strategic Committee: 18 October 2017

Resolved
THAT
The Board noted the minutes of this meeting.

3.2.3 Performance Monitoring Committee: 11 October 2017

Resolved
THAT
The Board noted the minutes of this meeting.

3.2.4 Health Strategy Committee: 11 October 2017

Resolved
THAT
The Board noted the minutes of this meeting.

ITEM 4: INTERIM CHIEF EXECUTIVE REPORT

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

Of note:

Evaluation of HealthTap

- HealthTap is the technical platform that the DHB chose to use for its virtual health strategy.

- It was always intended that an external review of the HealthTap platform would be carried out in order to prepare for decision-making around the renewal of the HealthTap contract that expires in May 2018.

- The Executive Group would consider the draft terms of reference at their meeting on 27 October 2017.

- Board members would be invited to attend a workshop to discuss the draft terms of reference on a date to be notified.

Theatre Performance and ESPIs
A Surgical Services Re-invention Project had commenced and was expected to influence process controls and lead to improved results.

2018 Meeting Schedule
The Board members discussed the draft 2018 Board meeting schedule. They expressed a preference for all of the Board meetings to be held in Hamilton and separate dates added for the Board members to visit the community towns (Thames, Tokoroa, Te Kuiti and Taumarunui). The Board members felt it would be more beneficial to attend health organisations, such as, visits to the PHOs and link in with the community health forums and other groups in those towns.

Resolved
THAT
The Board received the report.

ITEM 5: QUALITY AND SAFETY REPORT

There was no report this month.

ITEM 6: DECISION REPORTS

6.1 Smoke Free Policy

Mr M Spittal presented this agenda item.
The Waikato DHB Smoke Free Policy had expired. An updated policy based on Hawkes Bay DHB's policy was presented for the Board's consideration.

It was agreed that the current policy would remain in place until early next year when a decision on vaping therapy and electronic smoking could be made.

Nicotine replacement therapy would be made much more broadly available to staff and patients.

It was noted that the Ministry of Health had recently changed its stance on vaping therapy and electronic smoking. The Board members requested an explanation on the status of vaping with a recommendation on what stance the DHB should take.

Resolved
THAT
The current policy was endorsed and would remain in place for a further period of time.

ITEM 7: FINANCE MONITORING

7.1 Finance Report

Mr A McCurdie attended for this agenda item.

The Chief Financial Officer asked that his report for the month of September 2017 be taken as read highlighting the following:

- The provider was unfavourable to budget $1m.
  - Elective cases: episodes 7.7% below plan, case-weights 8.0% below plan;
  - Overall 2.3% below plan for cases, 2.6% below plan for case weights.
- Funder results were $1.6 favourable to budget. Partially due to higher funding received across a number of areas and a favourable provider payment variance as a result of lower provider volumes.
- Governance was close to budget.
- Cash flow was unfavourable to budget as a results of:
  - Operating cash outflows for non-payroll costs being unfavourable as a result of unfavourable operating costs including outsourced personnel and clinical supplies;
  - Timing of vendor payments.

Resolved
THAT
The financial statements of the Waikato DHB to 30 September 2017 were received.

7.2 Creating our Futures Programme – Indicative Business Case

Mrs V Aitken and Ms V Endres attended to present this indicative business case.

The services that were considered to be in scope for the purposes of this business case were:

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

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

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

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

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

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

a) HRBC full refurbishment of existing HRBC space
b) Co-location in new acute mental health build

The highest scoring Puawai (forensic) increased capacity options against the criteria were:

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

Resolved
THAT the Board:
1) Received the Mental Health and Addictions Service indicative options assessment.
2) Considered the highest scoring possible options within the Waiora Hospital Campus strategic build plan.

ITEM 8: PRESENTATIONS

There were no presentations this month.

ITEM 9: PAPERS FOR INFORMATION

9.1 Health Targets

Mr B Paradine presented this agenda item.
The paper was taken as read. It was noted:

The Emergency Department struggled with performance against the six hour target during September. The result for the first quarter was 82.1%.

It was noted that there had been a significant increase in ED presentations at both Thames and Tokoroa compared with the same period last year.

Faster Cancer Treatment – a number of operational measures continue to be undertaken.

Increased Immunisation for 8 month olds – good communication channels have been developed to promote and support immunisation with well Child/Tamariki Ora providers.

9.2 Provider Arm Key Performance Dashboard

Mr B Paradine, Mrs V Aitken and Mr M Spittal attended for this item. The paper was taken as read. Of note:

9.2.1 Community and Clinical Support

Breast screening – volumes are behind plan, except for Maori screening rates that were target.

9.2.2 Mental Health

Emergency Department - A pilot project to introduce a specific mental health nurse resource into ED was being considered.

Seclusion – no new seclusion episodes had occurred across the adult or forensic service since August 2017.

9.2.3 Waikato Hospital

The Surgical Re-invention Project was expected to focus on areas such as:

- Theatre Utilisation – elective sessions
- Hospital initiated elective theatre cancellations
- Waiting time for acute theatre less than 24 hours
- Waiting time for acute theatre less than 48 hours
- Elective and arranged day of surgery admissions
- Output delivery against plan – volumes for FSA, F/UP and nurse consults.

Assigned ECC - A new KPI measure had been launched called SAFER.

Falls resulting in harm – no falls resulting in hip fracture had occurred since January 2017.

Resolved
THAT
The Board received the report.

9.3 Prevocational Medical Training Accreditation

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

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

The report indicated that the DHB had failed to meet four of the 22 sets of standards and substantially met one standard. The report specified 12 required actions and one recommendation.

An action plan had been developed and reviewed by a Steering Group. The final plan was due to be approved by the Steering Group on 18 October 2017.

Resolved
THAT
The Board noted the contents of the report.

ITEM 10: NEXT MEETING

Date of Next Meeting

The next meeting to be held on Wednesday 22 November 2017 commencing at 2.30am at in the Board Room in the Hockin Building, Waikato hospital.

BOARD MINUTES OF 25 OCTOBER 2017

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

THAT:

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

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

Item 12: Risk Register Report – Public Excluded
Item 13: Annual Financial Statements – Public Excluded
Item 14: 2017-18 Long Term Financial Model and Capital Budget - Public Excluded
Item 15: Nutrition Plan and Food Management System – Public Excluded
Item 16: Planned Caesarean Section Theatre – Public Excluded
Item 17: Provider Concern - Public Excluded
Item 18: Appointment to Waikato DHB Statutory Committee – Public Excluded
Item 19: Provider request – 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-v): Minutes		Items to be adopted/ confirmed/ received were taken with the public excluded
Item 12:	Risk Register Report	Avoid inhibiting staff advice about organisaitonal risks
Item 13:	Annual Report Financial Statements	Negotiations will be required
Item 14:	2017-18 Long Term Financial Model and Capital Budget - Public Excluded	Negotiations will be required
Item 15:	Nutrition Plan and Food Management System	Negotiations will be required

Item 16:	**Planned Caesarean Section Theatre**	**Protection the privacy of a natural person**
Item 17:	**Provider Concern**	**Negotiations will be required**
Item 18:	**Appointment to Waikato DHB Statutory Committee**	**Protection the privacy of a natural person**
Item 19:	**Provider Request**	**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**
Item 13 – 15	**Section(9)(2)(j) of the Official Information Act 1982 – to enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**
Item 16:	**Section 9(2)(a) of the Offical Information Act 1982 – to protect the privacy of natual persons**
Item 17:	**Section(9)(2)(j) of the Official Information Act 1982 – to enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**
Item 18:	**Section 9(2)(a) of the Official Information Act 1982 – to protect the privacy of natual persons**
Item 19:	**Section(9)(2)(j) of the Official Information Act 1982 – to enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

ACTION LIST

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

	ACTION	BY	WHEN
1	Item 4 – 2018 Meeting Schedule: • Revise meeting schedule. All Board meetings to be held in the Board Room, Hockin Building. • Replace the dates for the Board meetings to attend Thames and Te Kuiti hospitals with a full day to be spent in those communities. • Review dates for SAC • Add IWI Maori Council and DHB Board Joint Meeting in May and September	Donna Straiton	ASAP
2	Item 6 Smoke Free Policy – a recommendation to the Board on the status of vaping	Mark Spittal	February 2018

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Maori Council

Held on Thursday 2nd November 2017 at 9.30am

Venue: Board Room Hockin Building, Waikato Hospital.

Present:

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

In Attendance:

Bob Simcock	Waikato DHB Board Chair
Pippa Mahood	Waikato DHB Board
Matua H Curtis	Pou Herenga Te Puna Oranga
Ms S Greenwood	Minute taker

In attendance: Dr Derek Wright, Ms Nina Scott, Ms Sue Hayward, Ms Christine Baker, Mr Greg Jacobson, Ms Julie Wilson, Mr Jonni Koia, Ms Erana Severne

(Following items are in order of appearance)

AGENDA ITEM 1 KARAKIA: Matua Hemi Curtis

AGENDA ITEM 2 MIHI: Mr H Mikaere

AGENDA ITEM 3 APOLOGIES

Ms T Hodges
Ms L Elliott
Ms K McClintock
Mr Tio Sewell

Received by: Ms Thompson-Evans
Seconded by: Ms Moxon

AGENDA ITEM 4A MINUTES OF LAST MEETING

Action 1: Spelling error noted on agenda, item 9.

Minutes passed
Received by: Ms Hodge
Seconded by: Ms Gosman

AGENDA ITEM 5 GOVERNANCE

Māori Strategic Committee

Noted by Mr G. Tupuhi that KPI's to be constructed and drafted were not minuted in the last MSC meeting despite discussion on other points that were minuted.

Health Strategic Committee

Action 2: Summary of agenda for commentary for IMC – Ms T. Thompson-Evans

AGENDA ITEM 6C/D/E

Monthly CEO report
Finance Report
Provider Arm Key

Received by: Ms Hodge
Seconded by: Ms Gosman

GENERAL BUSINESS

Mr B. Simcock mentioned the possibility of KPI's included at Exec level to improve Maori staffing.

Statistics presented of Maori workforce at Waikato DHB – still not reflecting percentage of Maori population. Issues around retaining and/or attracting Maori workforce from within our region.

Mr H. Mikaere requested that Sue Hayward/Chris Baker to present again at next IMC meeting and to be the only presentation in Dec.

Mr T. Sewell and Mr G. Tupuhi wanted to highlight that three significant Maori service providers are currently under review. IMC to request a report from Strategy and Funding.

Action 3: A full review, report and discussion to be requested from Strategy and Funding.

Hui Closed: Matua Hemi Curtis.

Next IMC Hui: 9.30am 7th December 2017

Full Action List		**Completed**
1.	Ms S. Greenwood to set up times to meet with final signatories of the MOU. Hauraki will be ready at the end of the month (Nov) after their next Board meeting.	**In progress.**
2.	Summary of HSC agenda for commentary for IMC – Ms T. Thompson-Evans	
3.	A full review, report and discussion to be requested from Strategy and Funding regarding review of three significant Maori Health providers. Who will follow up on this?	

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Maori Strategic Committee held on Wednesday 15 November 2017 commencing at 10:00am in the Committee Room, Hockin Building

Present: Ms T Hodges (Chair)
Dr C Wade (Deputy Chair)
Mr B Simcock
Ms J Eketone
Mr G Tupuhi
Ms T Moxon

In Attendance: Mr D Wright
Ms L Elliott
Mr H Curtis
Mr N Hablous
Mrs R Walker (Minutes)

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Mr Hemi Curtis

Ms T Hodges welcomed all attendees.

ITEM 2: APOLOGIES

Apologies were received from Ms T Thompson-Evans.

ITEM 3: MINUTES OF 16 AUGUST 2017

Minutes moved and accepted.

ITEM 4: MATTERS ARISING FROM MINUTES OF 16 AUGUST 2017

No matters arose.

ITEM 5: MINUTES OF 15 OCTOBER 2017

It was highlighted that the minutes reflected the agreed three key ideas, but did not record the full discussions. It was agreed that the workshop notes of the 15 October 2017 should be added as an attachment to the 15 October 2017 minutes.

The minutes were accepted on the above proviso and with the spelling correction of the word “whakamutunga” under Item 9.

ITEM 6: MATTERS ARISING - MINUTES OF 15 OCTOBER 2017

It was highlighted that the 2018 Maori Strategic Committee meeting dates had been updated slightly from those listed in the minutes of 15 October 2017. The correct dates were included in the Maori Strategic Agenda 15 November 2017.

ITEM 7: WORKPLAN FOR 2018

Members were invited to provide ideas to be included on the work plan. The work plan would align with the Ministry of Health Maori Health Strategy, and should include the programmes reported on and agreed by the Maori Strategic Committee (MSC).

The implementation plan is due in June 2018.

ITEM 8: PROGRESS UPDATE ON IMPLEMENTATION PLAN FOR MAKING RADICAL IMPROVEMENTS IN MAORI HEALTH:

Ms L Elliott updated members on programmes of work that should be incorporated into the Implementation Plan:

- 280 identified programmes and or processes that need to have a Maori lens cast across them (these programmes and or processes were identified by PPP Project team)
- Concern expressed over capacity to progress work. A template could be adopted for Executive Directors to enable their services to action
- Derek Wright advised that Priority 1.1 would be written into all Executive Directors Key Performance Indicators as a key deliverable
- Mental Health and Addictions Creating our Futures and Te Pai Tawhiti work will be incorporated in the Implementation Plan
- Recruiting/interviewing for a Research/Strategy Analyst to work on this plan should have someone in place beginning 2018. No luck with the recruitment of Health Economist

Ms L Elliott reminded MSC of key Health priority areas affecting Maori

- Lung Cancer
- Breast Cancer
- Bowel Cancer
- Cardio Vascular diseases
- Diabetes
- Rheumatic Fever

Ms L Elliott will use the Maori Strategic Committee to sound out ideas as the implementation plan is developed.

ITEM 9: PRESENTATION ON WHY ORA (FUTURE PROGRAMME OF WORK)

Presented by Ms L Elliott, members were advised about a potential future programme of work for Waikato DHB, the “Why Ora” programme currently being run in Taranaki DHB. A copy of the presentation will be distributed to

Committee members. The programme is funded a third by the DHB and two thirds by philanthropic funding. The total funding for the programme in set up required from Waikato DHB is $1.5 million, estimated philanthropic funding @ $5 million over 3 - 5 years. General discussion highlighted potential support from Iwi, Labour Market Projects, other government agencies and our own Population Health as well as philanthropy, and schools.

Further work up of the proposal including finer details to be brought to a future meeting for further discussion. This needed to be considered alongside the wider strategic thinking of how to best provide radical improvements to Maori Health inequalities whilst ensuring funding was prioritised in the best way possible.

ITEM 10: DISCUSSION ON DHB TIKANGA BEST PRACTICE, VALUES AND TE TIRITI O WAITANGI TRAINING AND PROPOSED FUTURE INDUCTION PROGRAMME

Ms L Elliott provided information on the idea of including a powhiri at a marae as part of the current Waikato DHB staff induction programme. It would likely occur 5-6 times a year based around the timing of large intakes of staff. It was noted that the powhiri should include the question, “How does this influence my practice to contribute to making radical improvements in Maori health?”

ITEM 11: UPDATE FROM EXECUTIVE DIRECTOR MAORI HEALTH ON RESEARCH AND OTHER PROGRAMMES OF WORK IN THE PIPELINE

Ms L Elliott provided a snap shot of the programmes of work currently underway in Te Puna Oranga.

- One of the key ideas agreed at the October workshop was to have a Maori Health Plan developed for every ward/service at Waikato Hospitals. The Harti Hauora programme was part of this, and a Research programme is currently underway in Paediatrics. A checklist of holistic health needs was competed when Maori presented to the service. This information was also forwarded to the patients GPs to ensure they were aware of all of the patient’s needs.
- Work was underway with the Mr Marc ter Beek (Executive Director Performance and Operations) following a request from Iwi Maori Council for more accessible and accurate ethnic data. It was agreed that staff should be reminded that all patients presenting to ED, or services should be asked to confirm the ethnicity they identify with, at the same time they are being asked to confirm other personal credentials. Ideally, this would also be incorporated into the iPM programme as a mandatory question.
- The DHB alongside other Providers had participated in the Mongrel Mob Hearty Forum which had been very successful. Approximately 300 passport health checks across a range of services were distributed with the majority being returned completed. Noted by Ms Hodges that this is a real live example of radical improvement in Maori Health outcomes by eliminating health inequities for Maori, a different way of doing things.

ITEM 12: UPDATE ON PROGRESS FROM OCTOBER WORKSHOP

Three key ideas were identified at the October Workshop for further workup;

- *Improving attendance at clinical appointments*
  Mr Mark Spittle was working on this initially in the area of Radiology. Research had showed that a better attendance rate was made when patients were reminded of appointments by SMS or Txt. Accordingly, it was intended to send text reminders to patients with a go live date of 18 April 2018. A further update would be provided at the February 2018 meeting.

- *Maori Health Plans to be developed for every ward/service at Waikato Hospitals*
  This has started with the Harti programme. The importance of including compliance of this in staff KPIs was again raised.

- *Implementation of a Navigator Service for Maori aged 18years+ who are admitted to hospital more than 2 times in the last 6-12 months to reduce fragmentation of chronic disease management.*
  Ms S Hayward had agreed to take the lead on this.

ITEM 13: NEXT MEETING

Wednesday 21 February 2018

ITEM 14: KARAKIA WHAKAMUTUNGA

Karakia by Mr Hemi Curtis.

Chairperson: _____

Date: _____

Meeting closed at 12:01 pm

AUDIT AND CORPORATE RISK MANAGEMENT COMMITTEE – WORK PROGRAMME

Introduction
The current schedule of regular reports to the Audit and Risk Management Committee is as follows:

Meeting	Scheduled Report	Author	Purpose
First Quarter (March)	Legal and Risk Case Book	Chief of Staff	Regular report
	Summary of key internal audit findings	HealthShare	To enable the committee to monitor the state of the organisation as revealed by internal audit
	Integrated IT Work Programme	Executive Director Corporate Services	To provide details annually
Second Quarter (May)	Legal and Risk Case Book	Chief of Staff	Regular report
	Annual Report	Executive Director Corporate Services	To enable the committee to address any matters arising from the audit and discuss the report with the auditors
	Summary of key internal audit findings	HealthShare	To enable the committee to monitor the state of the organisation as revealed by internal audit
	Progress report on significant outstanding audit recommendations	HealthShare	To enable the committee to satisfy itself that audit recommendations, where accepted, are being implemented
	Integrated IT Work Programme	Executive Director Corporate Services	To provide full details annually
	Supply Chain Update	Executive Director Corporate Services	
	Leave balance report	Executive Director of Corporate Services	To ensure leave balances are not increasing
	Post Implementation Review Schedule for the year.	Executive Director Corporate Services	To enable the Committee to determine which planned capital projects will be reviewed.
Third Quarter (August)	Legal and Risk Case Book	Chief of Staff	Regular report.
	Summary of key internal audit findings	HealthShare	To enable the committee to monitor the state of the organisation as revealed by internal audit

Meeting	Scheduled Report	Author	Purpose
Fourth Quarter (November)	Legal and Risk Case Book	Chief of Staff	Regular report
	Summary of key internal audit findings	HealthShare	To enable the committee to monitor the state of the organisation as revealed by internal audit
	Annual Funder Audit Plan	Executive Director Strategy & Funding	To enable the Committee to approve the funder audit programme (ex HealthShare) for the year
	Procurement Update	Executive Director Corporate Services	To enable the Committee to approve the internal audit programme for the year.

Chief Executive Report

MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information and approval.

Current financial status

For October 2017 year-to-date our overall volumes delivered, based on cases and caseweighted discharges, were:

- Acute cases 0.3% above plan and caseweights 1.3% above plan
- Elective cases 9.3% below plan and caseweights 9.0% below plan
- Overall cases 2.2% below plan and caseweights 1.7% below plan.

A great deal of work is in progress to create clarity around planned volumes and an organisational measure of "busyness" with an ability to provide volume variance explanations.

Financial year-to-date results reflect a deficit of $3.4m compared to a budget of a $2.7m deficit; thus a $700k unfavourable variance. However, this result includes $1.2m one off favourable variances, so a normalised result is $1.9m unfavourable. It should be noted that $22.2m of the centrally held savings plans, which contains high risk initiatives, is phased in the budget over the balance of the year.

ED performance and acute flow

Shorter stays in emergency departments

For October 2017 the Shorter Stays in Emergency Department Health Target performance for Waikato Hospital was 86.9%, which demonstrated an improved position from September's 78.2% result.

A number of measures were undertaken in the month to improve acute flow:

- A week's trial "A better way" was undertaken of moving the AMU assessment area into ED. The initial findings of the trial have been positive, but further work is being undertaken by the Clinical Unit Leader to review the findings and to explore how sustainable it would be to implement more permanently;
- A three day facilitated Rapid Improvement Event (RIE) focusing on the time to admit from ED into Medical and Respiratory wards identified a number of opportunities for stream-lining this part of the patient's journey;
- A new SMO has started in the department, with another due to join in December;

- The SAFER discharge programme rolled out during September and was reinforced at a 5 October Grand Round by Dr Ian Sturgess, who led this initiative in the English National Health Service;
- A visit and review on 13 October from Dr Peter Jones (the Ministry of Health "Shorter stays in emergency departments" champion) was encouraging regarding our approach to patient flow.

Theatre performance and ESPIs

Wait list management and ESPI Compliance

ESPI results to the end of September have been published by the Ministry. ESPI 5 has continued to produce compliance for the second month in a row while ESPI 2 has slipped back into non-compliance as was projected in last month's board report.

Preliminary internal results for October have ESPI 5 as non-compliant and ESPI 2 moving back into compliance as dermatology and orthopaedics were able to increase clinics to deliver the required volumes of patients for the month.

ESPI 2 (outpatients waiting more than four months for treatment)
November ESPI 2 data is tracking at non-compliance two weeks into the month. Orthopaedics have signalled that their outsourced FSA contract has come under some pressure which has meant their additional resource to deliver spinal FSAs is exceeding supply. Discussions with the private provider have been pursued with urgency and agreement reached to continue with delivery onsite for the next six months.

ESPI 5 (inpatients waiting more than four months for treatment)
While October reverted us back to non-compliance, November is again tracking towards compliance as part of an ongoing improving trend. Last month's blip was due to orthopaedics, endoscopy, cardiology, cardiac surgery, maxillofacial and ENT volumes, all low volumes individually but enough collectively to make the DHB non-compliant in ESPI 5.

Delivery of elective volumes

Ministry results for September and internal results for October show that we easily delivered the health target for quarter one.

Results also show that our elective initiative volumes for September at an overall level have been delivered as well as our case weighted volumes. Preliminary internal DHB data for October shows volume delivery achieved the targeted level and while internal case-weighted data is still being coded it is already showing at 96%. Improvement is needed in the volume of general surgery, gynaecology and ENT delivery. Recovery plans are being developed by those services.

Electives funding for 2017/18

We are continuing to deliver on all of our targets year to date at a global level. Intraocular injections have been removed from the Health Target reporting as at 31 September 2017 and are now being counted in the ambulatory initiative. We anticipate continuing to achieve the Health Target volume.

Cardiac waiting list

The cardiac wait list has remained within the maximum waitlist target of 67 since the last week of August, including the most recent reporting period in in early November.

There has been careful planning to ensure service continuity and wait list management is maintained over the Christmas and New Year period, which will be a timely test of process changes that the service has made to these processes.

Primary and Community Care

Following discussion at the Inter-Alliance forum it is intended to incorporate a workforce plan as one of the key areas of focus within the primary and community care plan. This will include the activity occurring within PHOs, other sector groups and national forums to ensure the workforce is available to meet the needs of the Waikato population. This plan is expected to encompass new models of service delivery and workforce structures that are effective.

Prevocational Medical Training Accreditation

There has been significant progress to address many of the required actions of the NZ Medical Council accreditation report.

The most significant action was the appointment and commencement of an additional house officer in Medicine on nights. Another key action was the release of a consultation document proposing changes to the structure and organisation of the RMO unit. The proposal seeks to address the unit workload issues, ensure appropriate staff resourcing, improve the responsiveness of the unit to RMOs and services, and to ensure the management structure is appropriate to deal with strategic and operational workforce issues. The consultation will conclude on 24 November and a decision is expected on 8 December.

One of the main areas of risk for accreditation is the absence of an electronic clinical task management system that would help interns prioritise and manage their workload; whilst a new system is due for implementation in mid-2018, this will not be in place by the time the accreditation team undertake the review in April. The other significant risk relates to the required action to ensure appropriate SMO staffing to enable adequate support and supervision of interns. The issue of SMO workload across the hospital is not able to be addressed within the timeframe, nor the scope of this work programme. SMO workload is being addressed through the service and job sizing process for SMOs under the remit of Directors and Human Resources.

Ronald McDonald House

Recently publicity has indicated that some District Health Boards are resistant to having a Ronald McDonald House on campus because of the association with fast-food of the same name.

Waikato DHB Executives have, with the awareness of the Board, been talking to Ronald McDonald House representatives over a number of years with a view to establishing such a facility either on campus or on land off our campus potentially avoiding use of DHB capital when our capital programme allows.

We'd just like to "check in" to ensure that the Executive's view still aligns with that of the Board.

Deprivation Profile

Dr. Dan Exeter and his team at the University of Auckland School of Population Health have recently launched the Index of Multiple Deprivation (IMD), a new way of measuring social deprivation in New Zealand. They have used it to create deprivation profiles of NZ's 20 DHBs. The Waikato DHB profile is attached for information.

The IMD uses administrative data from national health, social development, taxation, education, police databases, geospatial data providers and the 2013 Census to measure deprivation at the neighbourhood level using 28 indicators which represent seven domains of deprivation: Employment; Income; Crime; Housing; Health; Education; and Geographical Access. The IMD is the combination of these seven domains. A suggested strength of the IMD's domains is that they can be used separately or combined to explore the drivers of deprivation in a particular area, or links between different forms of deprivation and a particular health or social outcome.

HealthShare Director

With the resignation of Dr Nigel Murray, the Board is required by resolution to formally remove Dr Murray as a HealthShare Director and appoint a Director and Alternate Director to HealthShare.

HealthTap Review – Terms of Reference

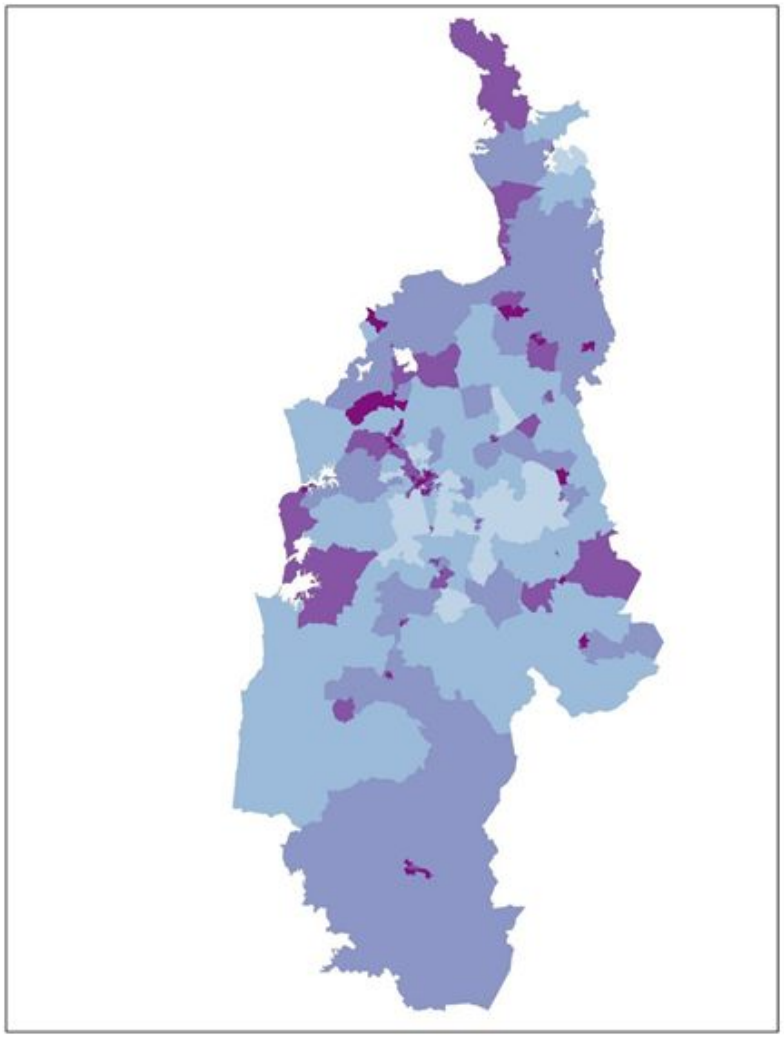
Following the Board workshop held on 14 November 2017, the draft terms of reference for the review of HealthTap was emailed to Board members for further review and comment by close of business, 16 November. A final version of this document will be available for consideration by the Board at their November meeting.

Recommendation
THAT
The Board:

1) Receives the report.
2) Removes Dr Nigel Murray as a HealthShare Director.
3) Appoints Mr Derek Wright as a Director of HealthShare.
4) Appoints Mr Neville Hablous as Alternate Director of HealthShare.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

A deprivation and demographic profile of the Waikato DHB



Waikato DHB, showing overall IMD deprivation
with the most deprived areas shaded darkest

Rachael Yong, Michael Browne, Dr Jinfeng Zhao, Dr Arier Chi Lun Lee, Dr Nichola Shackleton, Dr Sue Crengle, Dr Daniel Exeter

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
MEDICAL AND HEALTH SCIENCES

hrc Health Research Council of New Zealand

Statistics New Zealand Disclaimer

The results in this report are not official statistics, they have been created for research purposes from the Integrated Data Infrastructure (IDI), managed by Statistics New Zealand. The opinions, findings, recommendations, and conclusions expressed in this paper are those of the author(s) not Statistics NZ or the University of Auckland.

Access to the anonymised data used in this study was provided by Statistics NZ in accordance with security and confidentiality provisions of the Statistics Act 1975. Only people authorised by the Statistics Act 1975 are allowed to see data about a particular person, household, business, or organisation and the results in this paper have been confidentialised to protect these groups from identification. Careful consideration has been given to the privacy, security, and confidentiality issues associated with using administrative and survey data in the IDI. Further detail can be found in the Privacy impact assessment for the Integrated Data Infrastructure available from www.stats.govt.nz.

The results are based in part on tax data supplied by Inland Revenue to Statistics NZ under the Tax Administration Act 1994. This tax data must be used only for statistical purposes, and no individual information may be published or disclosed in any other form, or provided to Inland Revenue for administrative or regulatory purposes. Any person who has had access to the unit-record data has certified that they have been shown, have read, and have understood section 81 of the Tax Administration Act 1994, which relates to secrecy. Any discussion of data limitations or weaknesses is in the context of using the IDI for statistical purposes, and is not related to the data's ability to support Inland Revenue's core operational requirements.

Acknowledgments

The research team are grateful to the Health Research Council of New Zealand for funding this research project. This research would not have been possible without the provision of data, expert guidance and support of many individuals and the following organisations: Accident Compensation Corporation, Action on Smoking and Health, *Aotearoa* People's Network *Kaharoa*, ANZ Bank, ASB Bank, Association of Public Library Managers Inc., Auckland Uniservices Ltd, Auckland University of Technology, Beacon Pathway, BNZ Bank, BRANZ, Child Poverty Action Group, COMET Auckland, Counties-Manukau DHB, Department of Corrections, Energy Efficiency and Conservation Association, Family Start, Heart Foundation, Housing New Zealand Corporation, Inland Revenue, Kiwibank, Leeds University, Maritime NZ, Massey University, Ministries of Business, Innovation and Employment, Education, Health, Justice and Social Development, National Collective of Independent Women's Refuges, *Ngāti Whātua o Ōrākei*, Northland DHB, New Zealand Certified Builders Association, NZ Fire Service, NZ-Libs, NZ Police, NZ Post, NZ Racing Board, Royal New Zealand College of General Practitioners, Ollivier & Company, Otago University, Participants in the Feb 2014 and Feb 2017 hui, Pharmac, Plunket, Prisoners Aid and Rehabilitation Trust, Problem Gambling Foundation, Salvation Army, St John's Ambulance, Southern African Social Policy Research Institute, Statistics New Zealand, TSB Bank, *Tairāwhiti* DHB, *Te Kāhui Mana Ririki Trust*, *Te Kupenga Hauora Māori*, *Te Matapihi he tirohanga mō te iwi* Trust (National Maori Housing Trust), *Te Rūnanga o Ngāti Hine, Te Wānanga o Aotearoa*, *Te Whānau O Waipareira Trust*, Telco2 Ltd, Tenancy Tribunal, University of Auckland, University of Canterbury, University of Otago, University of Oxford, Waikato University, *Waitemata* DHB, Wellington Free Ambulance, Westpac Bank, and Woopa Design.

A deprivation and demographic profile of the Waikato DHB

The New Zealand Index of Multiple Deprivation (IMD) allows one to look at disadvantage in overall terms, as well as in terms of seven domains of deprivation: Employment, Income, Crime, Housing, Health, Education and Access. The seven domains are weighted to reflect the relative importance of each domain in representing the key determinants of socio-economic deprivation, the adequacy of their indicators and the robustness of the data that they use. Figure 1 shows the IMD's 28 indicators and weightings of the seven domains.

The IMD measures deprivation at the neighbourhood level using custom designed data zones that were specifically developed for social and health research. The New Zealand (NZ) land mass has 5,958 neighbourhood-level data zones that have a mean population of 712 people. In urban settings, they are just a few streets long and a few streets wide. Data zones are ranked from the least to most deprived (1 to 5958) and grouped into five quintiles. Q1 (light shading) represents the least deprived 20% of data zones in the whole of NZ; while Q5 (dark shading) represents the most deprived 20%. This multidimensional deprivation information is combined with demographic information from the 2013 census to produce a DHB profile.

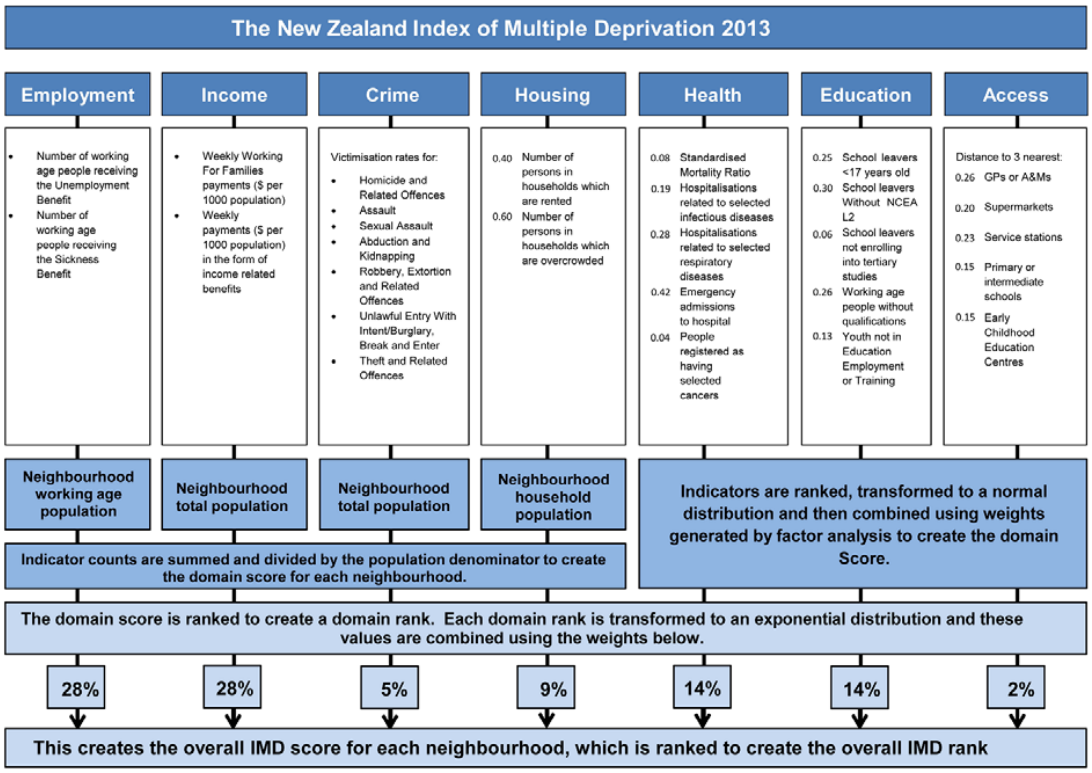


Figure 1. Flow diagram showing the IMD, its indicators, domains and weights. Adapted from Figure 4.2 SIMD 2012 Methodology, in Scottish Index of Multiple Deprivation 2012. Edinburgh: Scottish Government (Crown copyright 2012).

The stacked bar chart in Figure 2 shows the proportion of data zones in the Waikato DHB (WDHB) that belonged to each deprivation quintile for overall IMD deprivation and the seven domains in 2013. If the deprivation circumstances in the WDHB were the same as for all of NZ, we would see 20% of the WDHB's 511 data zones in each quintile. However, Figure 1 shows that the proportion of data zones with Q5 deprivation was greater than 20% for the IMD and all domains except for Housing. Q4 deprivation was greater than 20% for all seven domains. The WDHB had high levels of overall IMD deprivation, with 50.7% (259/511) of its data zones in Q4 or Q5.

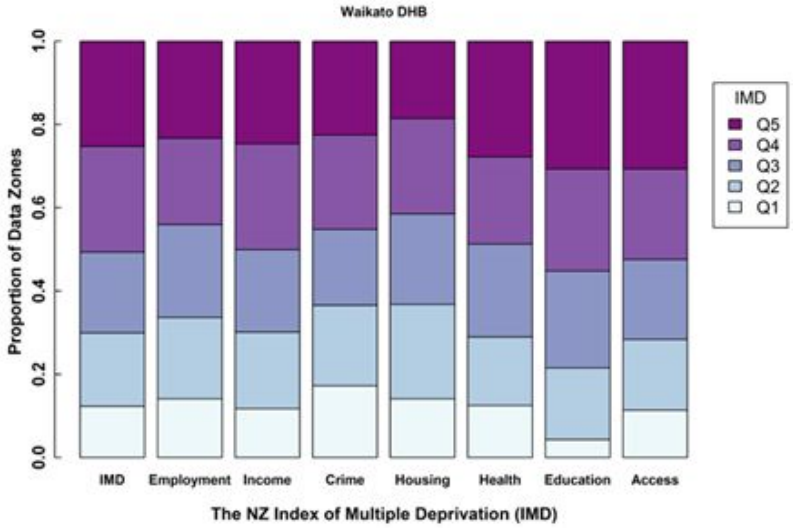


Figure 2. Stacked bar chart showing overall deprivation and seven domains in the WDHB

Table 1 shows summary statistics by domain for 129 WDHB data zones that were among NZ's 20% most deprived (Q5) for the overall IMD, and reveals the contributions of different domains. In descending order, high (Q5) median deprivation ranks for Education (5557), Income (5408), Employment (5369), Health (5285), Crime (4904) and Housing (4884) were contributing to high overall deprivation in these 129 data zones in 2013, bearing in mind that these domains carry different weights in the IMD (see Figure 1).

Min, max and median[1] deprivation ranks by domain for 129 data zones with Q5 IMD								
	IMD	Employment	Income	Crime	Housing	Health	Education	Access
Min	4779	3812	3586	1233	2409	3296	2128	23
Max	5951	5948	5957	5937	5890	5956	5957	5628
Median	5421	5369	5408	4904	4884	5285	5557	2391

Table 1. Minimum, maximum and median deprivation ranks by domain for 129 data zones in the WDHB with Q5 IMD deprivation

[1] When discussing the 20% most deprived data zones, ranks will usually be skewed, so it is better to discuss the median rank (the middle value) rather than the mean rank (the average, which can be disproportionately affected by very high values).

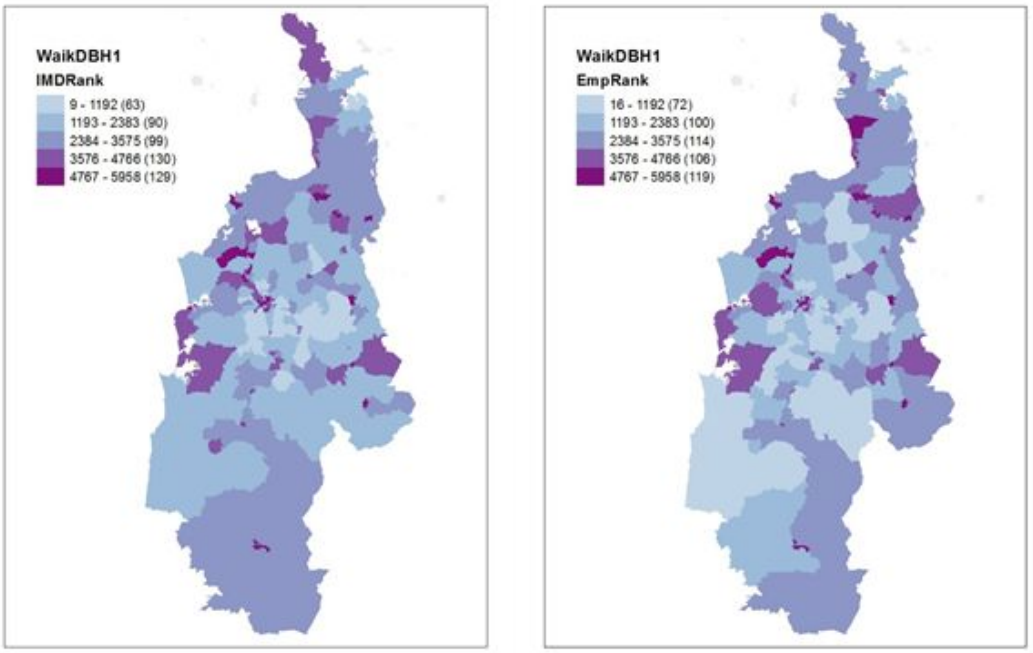


Figure 3. Distribution of overall IMD and employment deprivation in the WDHB

The values in brackets in the legends of the maps that follow are counts of data zones in the relevant quintile. The map for overall deprivation (IMD) on the left of Figure 3 shows moderate levels of deprivation in the WDHB in 2013 with 25.2% (129/511) of data zones among the most deprived 20% in NZ (Q5). Only 12.3% (63/511) of data zones were in the least deprived 20% in NZ (Q1). The median IMD rank was 3597, 10.4% (618 ranks) worse than the NZ median of 2979. There was one large rural data zone with Q5 deprivation to the west of Huntly, but most of the Q5 deprivation occurred in urban areas such as Hamilton and in smaller towns such as Huntly, Waihi, Te Awamutu, Raglan and Tokoroa. Urban data zones are difficult to see on these maps, so we suggest that readers use the interactive maps at the IMD website to explore the WDHB further.

The map of the Employment Domain on the right of Figure 3 reflects the proportion of working age people who were receiving the Unemployment or Sickness Benefits in 2013. In the WDHB, 23.3% (119/511) of data zones were among the 20% most deprived in NZ for the Employment Domain, while 14.1% (72/511) of data zones were among the least deprived 20%. The median employment deprivation rank in the WDHB was 3356, 6.3% (377 ranks) worse than the NZ median of 2979. The distribution of Q5 employment deprivation followed a similar pattern to overall IMD deprivation, except that it had ten fewer Q5 data zones.

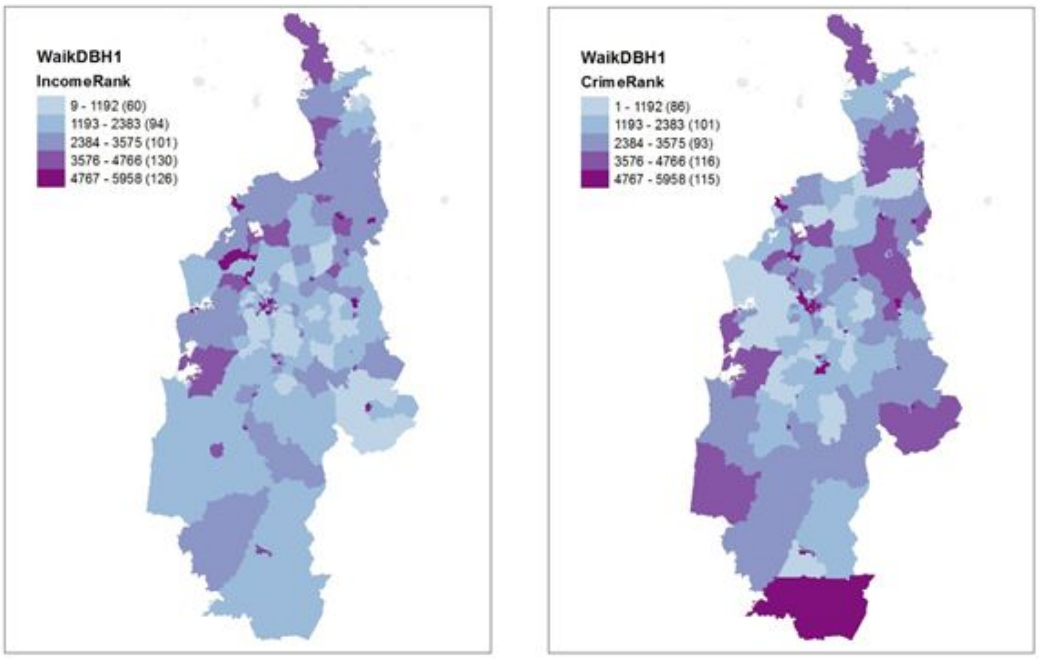


Figure 4. Distribution of income and crime deprivation in the WDHB

The Income Domain measures the amount of money per person paid by the government in the form of Working for Families payments and income-tested benefits. In the WDHB, 24.7% (126/511) of data zones were in NZ's 20% most income deprived, while 11.7% (60/511) were in the 20% least income deprived. The median income deprivation rank in the WDHB was 3582, 10.1% (603 ranks) worse than the NZ median. The distribution of Q5 income deprivation followed a similar pattern to overall IMD deprivation, but there were fewer large rural data zones with Q4 income deprivation.

The Crime Domain measures victimisations per 1000 people and is largely driven by thefts (55%), burglaries (24%) and assaults (18%). In the WDHB, 22.5% (115/511) of data zones were among the most deprived 20% for the Crime Domain, while 17.2% (88/592) were among the least deprived 20%. The median crime deprivation rank in the WDHB was 3178, 3.3% (199 ranks) worse than the NZ median. High (Q5) rates of crime victimization occurred in large urban areas like Hamilton and in most towns. There was one small rural data zone with Q5 rates of crime victimization south of Te Awamutu and a large one around National Park.

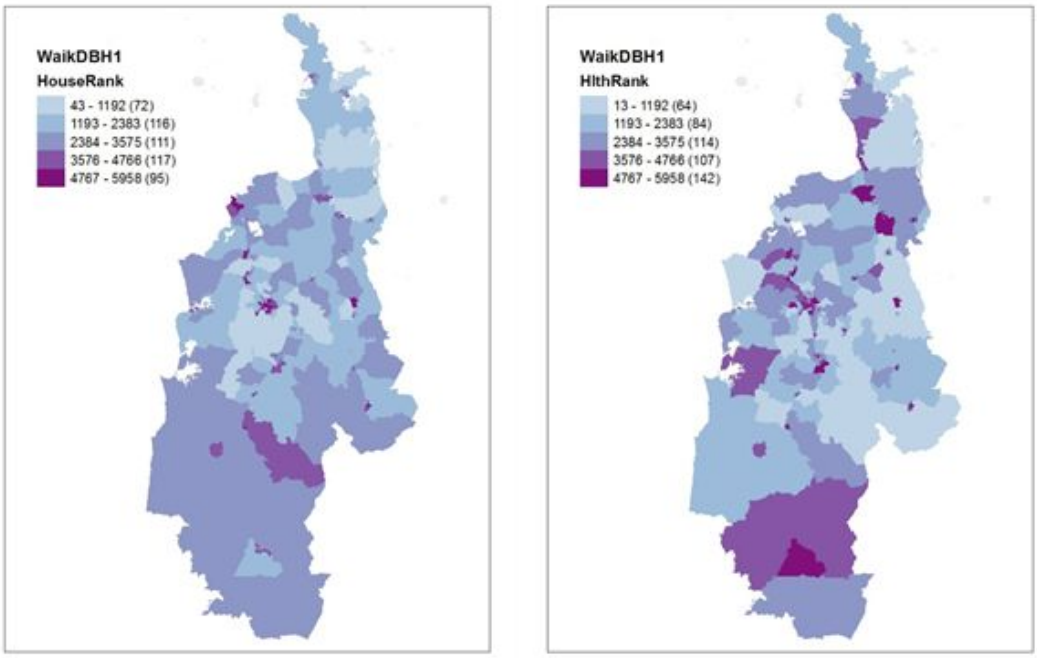


Figure 5. Distribution of housing and health deprivation in the WDHB

The Housing Domain measures the proportion of people living in overcrowded households (60% of the weighting) and rented dwellings (40%) in 2013. In the WDHB, 18.6% (95/511) of data zones were among the most deprived 20% in NZ, while 14.1% (72/511) were among the least deprived 20%. The highest proportions of data zones were in quintiles two, three and four. The median housing deprivation rank in the WDHB was 3029, just 0.8% (50 ranks) worse than the NZ median. Q5 housing deprivation was less concentrated than overall IMD deprivation with 34 fewer Q5 data zones. In addition, there were few large rural data zones with Q4 housing deprivation — the exception being the data zone that includes Te Kuiti and Benneydale.

The Health Domain consists of five indicators: standard mortality ratio, acute hospitalisations related to selected infectious and selected respiratory diseases, emergency admissions to hospital, and people registered as having selected cancers. In the WDHB, 27.8% (142/511) of data zones were among the 20% most health deprived in NZ, while 12.5% (64/511) were among the least deprived 20%. The median health deprivation rank in the WDHB was 3490, 8.6% (511 ranks) worse than the NZ median. Most of the data zones with high (Q5) health deprivation were located in the north and central parts of the WDHB, in urban areas such as Hamilton, Thames, Ngaruawahia and Huntly, but there were also large rural data zones with Q5 health deprivation in Ngatea, Kerepehi, to the south of Paeroa and south of Taumarunui.

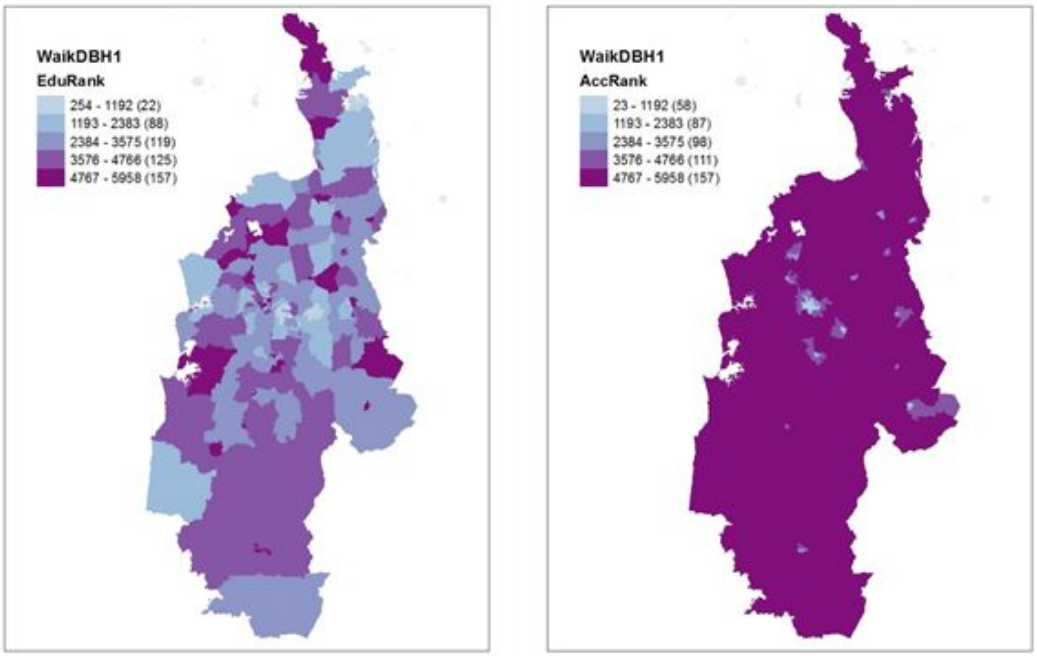


Figure 6. Distribution of education and access deprivation in the WDHB

The Education Domain measures retention, achievement and transition to education or training for school leavers; as well as the proportion of working age people 15-64 with no formal qualifications; and the proportion of youth aged 15-24 not in education, employment or training (NEET). In the WDHB, 30.7% (157/511) of data zones were among NZ's 20% the most education deprived, while only 4.3% (22/511) were among the least deprived 20%. The median education deprivation rank in the WDHB was 3824, 14.2% (845 ranks) worse than the NZ median. The distribution of Q5 data zones followed a similar pattern to overall (IMD) deprivation, but there were 28 more Q5 data zones for the Education Domain. Many of these were located in rural areas in Coromandel, around Putaruru and Meremere, and in a large rural data zone which stretched from Te Ahurei around the Kāwhia Harbour to Owhiro.

The Access Domain measures the distance from the population weighted centre of each neighbourhood to the nearest three GPs, supermarkets, service stations, schools and early childhood education centres. In the WDHB, 30.7% (157/511) of data zones were among NZ's 20% most access deprived, while 11.4% (58/511) were among NZ's 20% least deprived. The median access deprivation rank in the WDHB was 3660, 11.4 % (681 ranks) worse than the NZ median. Predictably, the entire rural hinterland of the WDHB was Q5 access deprived. Access to services was good in Hamilton and larger towns like Huntly, Cambridge, and Morrinsville, but not in small towns like Coromandel, Meremere, Raglan and National Park.

Age profile of the Waikato DHB

According to the 2013 census, the WDHB had a total population of 359235 people living in 511 data zones, with a mean of 703 people each (range: 498 to 1278).

Mean data zone proportions for five age groups in the WDHB					
Age group	0-14	15-24	25-44	45-64	65+
Waikato	21.6%	14.0%	24.4%	25.2%	14.8%
New Zealand[2]	20.4%	13.8%	25.6%	25.8%	14.3%
Difference	1.2%	0.2%	-1.2%	-0.6%	0.5%

Table 2. Mean data zone proportions for five age groups in the WDHB

Table 2 shows that the age profile of the WDHB differs most from the national age profile in that it has 1.2% more children aged 0-14 and 1.2% fewer people aged 25-44. Figure 7 shows the distribution of people in these two age groups.

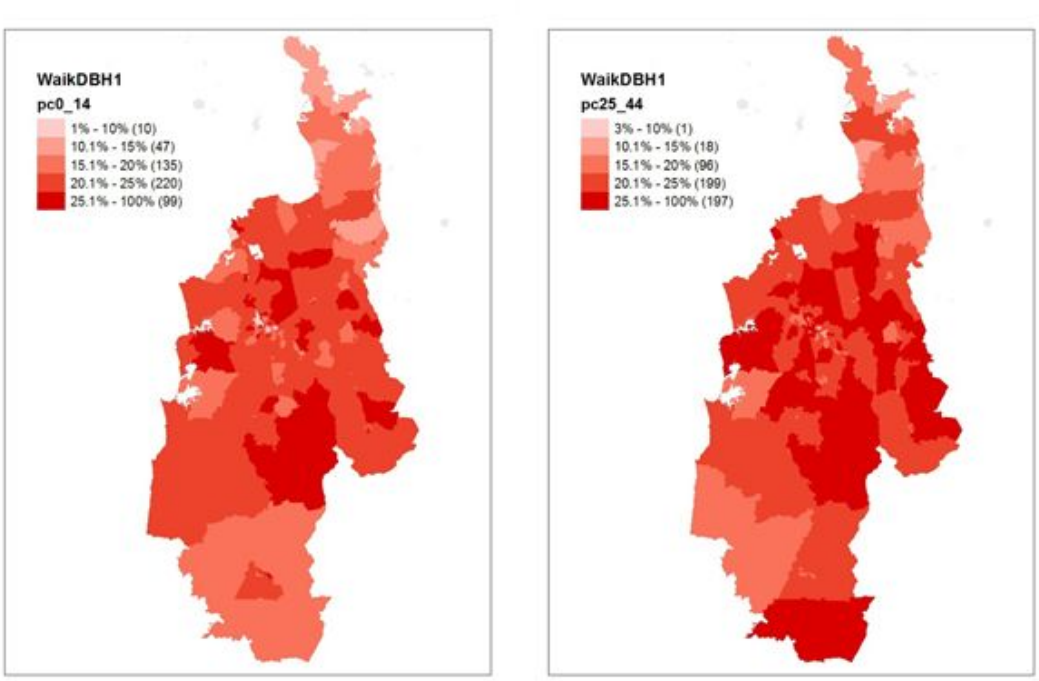


Figure 7. Distribution of children aged 0-14 and people aged 25-44 in the WDHB

[2] Proportions for age groups and ethnicities at the national level are calculated using data zone counts to ensure fair comparison with DHB values, which also use data zone counts.

Ethnicity profile of the Waikato DHB

This section uses Total Response to calculate proportions for each ethnicity from the 2013 census. Individuals who identify as more than one ethnicity are counted in more than one category. The proportion of Māori living in data zones within the WDHB in 2013 ranged from 2.4% to 80.3%. The overall proportion of Māori in the WDHB was 21.7%, which was higher than the national proportion of 14.9%. The proportion of Māori per data zone was greatest in two data zones in Huntly West (80.3% and 80.2%), followed by one in Ngaruawahia (78.3%).

The proportion of Pacific ethnicity living in data zones within the WDHB ranged from 0.0% to 33.1%. The overall proportion of Pacific ethnicity in the WDHB was 3.8%, significantly lower than the national proportion of 7.3%. A data zone in Ngaruawahia had the greatest proportion of Pacific (33.1%), and there were relatively high proportions of Pacific ethnicity (>20%) in Tokoroa, Strathmore, Aotea, Papanui and Meremere.

The percentage of New Zealand European and Other ethnicities (NZEO) in the WDHB ranged from 29.8% to 99.7%. The overall proportion of NZEO was 85.7%, slightly lower than the national proportion of 87.5%. The lowest proportions of NZEO (<40%%) lived in data zones in Meremere, Huntly West, Enderley and Te Kuiti.

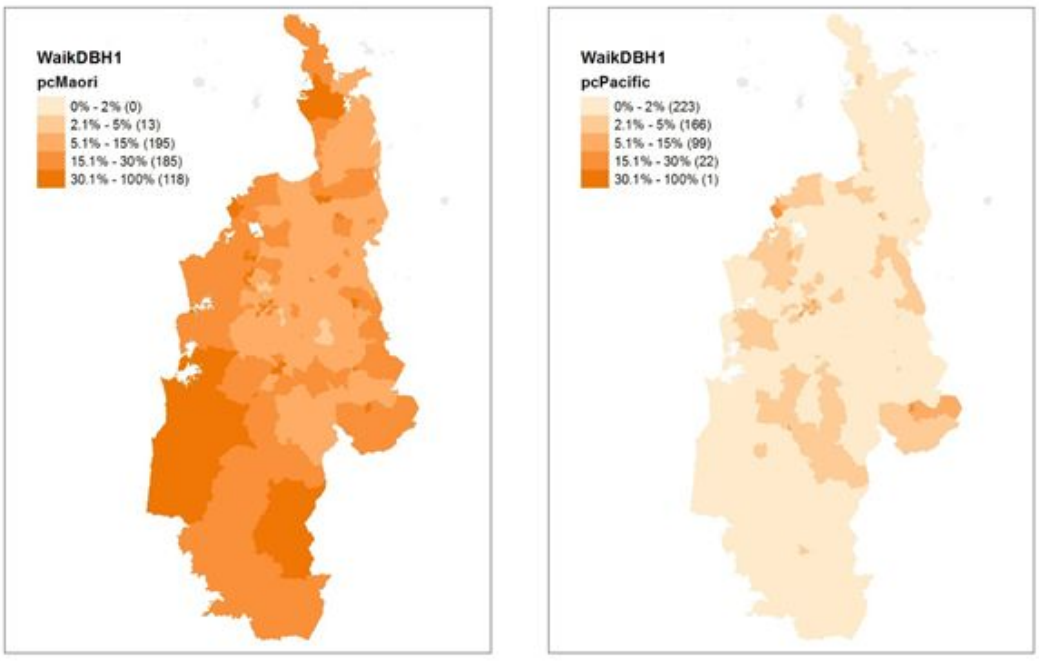


Figure 8. Distribution of Māori and Pacific people in the WDHB

For more information about the IMD, NZ data zones or this profile, please contact Dan Exeter at d.exeter@auckland.ac.nz. For downloadable spreadsheets of the IMD or NZ data zones, online interactive maps, publications and technical documentation, please go to the IMD website.

14 November 2017

REVIEW OF IMPLEMENTATION OF HEALTHTAP TECHNOLOGY

Introduction

Virtual Health Care is a key strategy for the Waikato DHB to meet the challenges of the growing health needs of our district and region. The strategy itself will grow and evolve to enable greater self-management of conditions by patients and more patient centred access capabilities.

The virtual health care strategy aims to:

- Deliver care closer to people's homes.
- Put patients at the centre of their healthcare, and give them a greater say.
- Reduce the number of people coming to the hospital emergency department and outpatients.
- Reduce inequities for our rural and Maori communities.
- Improve and enhance clinical productivity and effectiveness.

The following terms refer to our virtual health activities:

- Virtual Health is the Waikato DHB health focused use of information and communication technologies to connect with our population. Examples of this are Telehealth, which uses video technology to connect our hospitals and clinics, and the use of cellular network and traditional phone conversations to deliver care to patients.
- SmartHealth is a brand we developed to communicate our new virtual health offerings to the consumer. HealthTap comes under this brand and we can use the same SmartHealth brand for other future technologies.
- HealthTap is an app based solution using consumer grade technology to deliver care direct to the patient wherever they might be.

HealthTap is a health operating system that allows connection of patients and clinicians to provide virtual clinical and patient self-managed care. The system itself has multiple unique providers and patients and is interoperable with all other clinical systems. It is based on "software as a service" business model, functioning via consumer based technology with a mobility first focus.

The initial contract for the use of the HealthTap technology ends in May 2018. In order to assist the Waikato DHB in determining the next step in the implementation of SmartHealth, Waikato DHB wishes to undertake an independent external review of progress in the implementation of the HealthTap technology at the Waikato DHB, as well as some wider issues related to Virtual Health generally.

Terms of Reference for the Review

The independent external review of the HealthTap technology and related matters will cover the following:

- An assessment of the patient and citizen acceptance and perceived or possible benefit of the services offered in Virtual Health care via the HealthTap platform.
- An assessment of the progress made and barriers encountered in implementing HealthTap including areas where it has been implemented and how it is being used.
- The extent and reasons for any reluctance or inability on the part of clinicians to use the technology and the resultant service change required.
- An assessment of the costs of implementation to date where this is defined as covering expenditure directly connected with and arising from the implementation of HealthTap.
- An assessment of the costs of implementation to establish the mobility platform that is a key enabler for SmartHealth.
- An assessment of the benefits of implementation to date quantified to allow comparison with costs. This is to include tangible and intangible benefits where practical.
- An assessment of where the next logical milestone for implementation might be (assuming we haven't reached it) which provides a stable operating model for the Waikato DHB and allows time for future decision-making around both technology and the virtual health care strategy (this point to be known as phase one completion).
- An assessment of the costs and quantified benefits of phase one completion which will be completed in May 2018.
- An assessment of the reliability and usefulness of the HealthTap technology in the New Zealand context, noting that integration with other systems is a key requirement in New Zealand and the degree of complexity is considerably higher than in the United States context, in which HealthTap operates. The focus for this assessment is in the Waikato DHB internal system environment and partner health providers' system environments.
- An assessment of the use and experience of third parties (such as BUPA, Primary Health Organisations and Non-Government Organisations) that access the technology under the auspices of Waikato DHB along with an assessment of the potential for further development of secondary uses.
- An assessment of the capability of the HealthTap application and its ability to be interoperable with other regional clinical systems.
- An assessment of technology options to advance the Virtual Health Care strategy including HealthTap and technology available through our primary health partners or other suppliers, giving an indication of costs and benefits and a recommended way forward and taking account of the regional dimension as mentioned.

- Meetings with the other Midland District Health Boards (Bay of Plenty, Lakes, Tairawhiti, and Taranaki) and the Ministry of Health to create an assessment of the potential (from the perspective of strategy alignment, technological alignment and enthusiasm) for them to join with us in SmartHealth.
- An assessment of the extent to which SmartHealth and the technology HealthTap may (or has already) be able to reduce Maori health inequity.
- Any other findings that in the opinion of the reviewer would be of value to the Board and Executive in deciding the way forward with respect to the technology dimension of HealthTap, and its impact on SmartHealth itself.

As part of this review the original criteria for the establishment of HealthTap is to be evaluated as below. This is to include a review of success in attaining the original scope as per the implementation process:

- Establishment of Virtual Health Care as a key component of every clinical service model of care.
- Development of clinical protocols to deliver Virtual Health safely for all clinical services.
- The effectiveness of the change management process and Executive leadership in the implementation of SmartHealth including engagement of all relevant workforces (Clinicians, IS, Administrative, PHOs, NGOs) and service users.
- Implementation of the technical solution from HealthTap and integration into the clinical record held by the Waikato DHB and other partner health service providers.
- New Zealand'ising of the HealthTap content and promotion of the updated content.

The following measures also need to be reviewed as to the level of success that was obtained:

Patient

- Reducing outpatient visits by 5% - for example, by home-monitoring congestive heart failure patients.
- 1% of all patient outpatient appointments carried out in the patient's home via video conference.
- 10% of all appropriate (appropriate to be defined) outpatient appointments carried out in their general practitioner office.
- 15% of all identified high needs patients are enrolled in the Virtual Health solution.
- Enrolled patients with Virtual Health Care have 24/7 access to peer-reviewed patient information.

Clinical Staff

- Have clear concise clinical protocols to use to deliver Virtual Health Care.

- Virtual Health Care is recognised as a routine part of clinical practice within Waikato DHB.

Sustainability

- No growth in the physical environment or staffing required in the Meade Clinical Centre to deliver outpatient services.
- 10% reduction in the cost of running the Meade Clinical Centre to deliver outpatient services in the second year of operation of the Virtual Health Care enablement project.

Alignment/Dependencies

- All Virtual Health Care strategies are aligned with and work effectively and complementary with each other.
- HealthTap clinical records integrated back into Waikato DHB and partner organisation clinical records.
- The electronic clinical record agenda progresses at pace in order to support virtual health.

As part of the review unintended benefits and dis-benefits are to be identified and, if possible, quantified.

Expressions of Interest

Expressions of interest are invited from parties able to undertake this review from the All of Government panel arrangement.

Process

The process will be:

- Draft terms of reference reviewed and agreed by Waikato DHB Executive team.
- Workshop held with Waikato DHB Board and Executive team with lead Senior Medical Officers.
- Approved terms of reference to be released for quote from appropriate reviewers on the New Zealand All of Government panel.
- Review to commence before end of 2017 with report to Waikato DHB Board by the end of March 2018.
- Decision and way forward to be agreed with Waikato DHB Board in April 2018.

Quality and Safety

Quality and Safety: No report.

Decision Reports

MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 6.1

QUALITY ACCOUNT 2016/17

Purpose	For approval.

Quality Accounts are designed to give prominence to the reporting of quality of care, alongside the traditional reporting of financial performance.

The Health Quality and Safety Commission (HQSC) recommend the structure and content of the account. The Ministry of Health have requested that all DHBs complete an annual quality account.

The final draft account looks back at activity during 2016/ 2017, highlighting some key improvements in the 'feature stories' section and outlines progress made against last year's priority areas.

Proposed areas for focus in 2017/18 are noted with links made with the strategic imperatives.

The Health Strategy Committee received this account in October with positive feedback. There were issues raised with the map used from Strategy and Funding, and hopefully this has been resolved. The final account will be sent to the Ministry of Health, HQSC and published on the DHB website.

Recommendation
THAT
The Board:

1) Notes the content of the report/proposal.
2) Approves the Quality Account 2016/19 for publication.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

Waikato District Health Board

ANNUAL QUALITY ACCOUNT 2016-2017

Waikato District Health Board

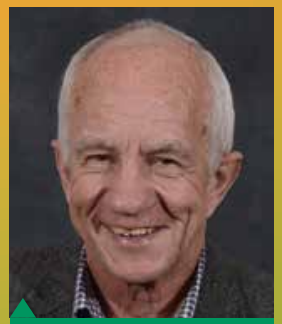
Welcome to our annual Quality Account

Mo Neville
Executive Director of Quality and Patient Safety

This Quality Account describes what we do well and also where we need to make improvements. It outlines the quality priorities that we will focus on over the next 12 months and reviews our progress against the 'priority for improvement' areas that we set ourselves during the 2016/17 financial year.

Leadership team statement

It's important to us that we are relentless in our drive to continually improve the quality of all the services we provide. We are committed to delivering high quality, safe and effective care within a variety of settings that enables our clinicians to care for patients in local health centres, hospitals and equally importantly – in people's own homes. Central to this is our core value of keeping People at Heart – *Te iwi Ngakaunui*.



Bob Simcock
Board Chair

Neville Hablous
Chief of Staff

Our job is to understand what our patients want from us, to listen to what people tell us about their care, their experiences about what worked well and what could be done better. The quality of care we provide to our patients is our highest priority – this needs to be evident in the everyday experiences of people accessing our services.

It has been a tough year for Waikato District Health Board (DHB), with rising demand across all of our services particularly mental health and addictions services, our emergency departments at Waikato Hospital, our rural hospitals particularly Tokoroa and Thames and a particularly busy winter period with flu and respiratory illness. Despite these pressures our staff can be really proud of the many achievements we have delivered during the year, some of which are set out in this Quality Account.

Our aim over the next few years is to eliminate inequity in health for our high risk populations, particularly for Māori. We need to be work with our community to ensure our services continue to be developed with them and for them. We are very excited about the formation of our first consumer council which will help us achieve the improvements we are striving for.

We would like to take this opportunity to thank our staff who continuously strive to improve the care they deliver; and our patients and communities for taking their time to tell us when we got it right but also where we could do better; *kotahitanga 'stronger together'*.

Did you know?

Summary statistics from 2016-17

260,283 **outpatients** attended appointments

65,594 **children** enrolled with Community Oral Health

32 **Waikato DHB funded NGOs** provided mental health and/or alcohol and drug services in the community

82 **pharmacies** are located around the Waikato DHB area

797,751 **patient meals** were served

3,402,513 **blood tests** were performed within the 2017 calendar year

41,723 **breast screening tests** were performed

55 **residential care facilities** are located within the Waikato

18 **Māori providers** are contracted within the Waikato

6,398,007 items were dispensed by **community pharmacies**

3867 **births** took place in Waikato DHB funded facilities

35,398 **influenza vaccinations** were given to people 65 years of age and older

384,316 **people enrolled with Waikato GPs**

162,673 **mental health community visits** were made across Waikato DHB

17,401 **adolescents** received free dental care

1603 **mental health admissions** occurred

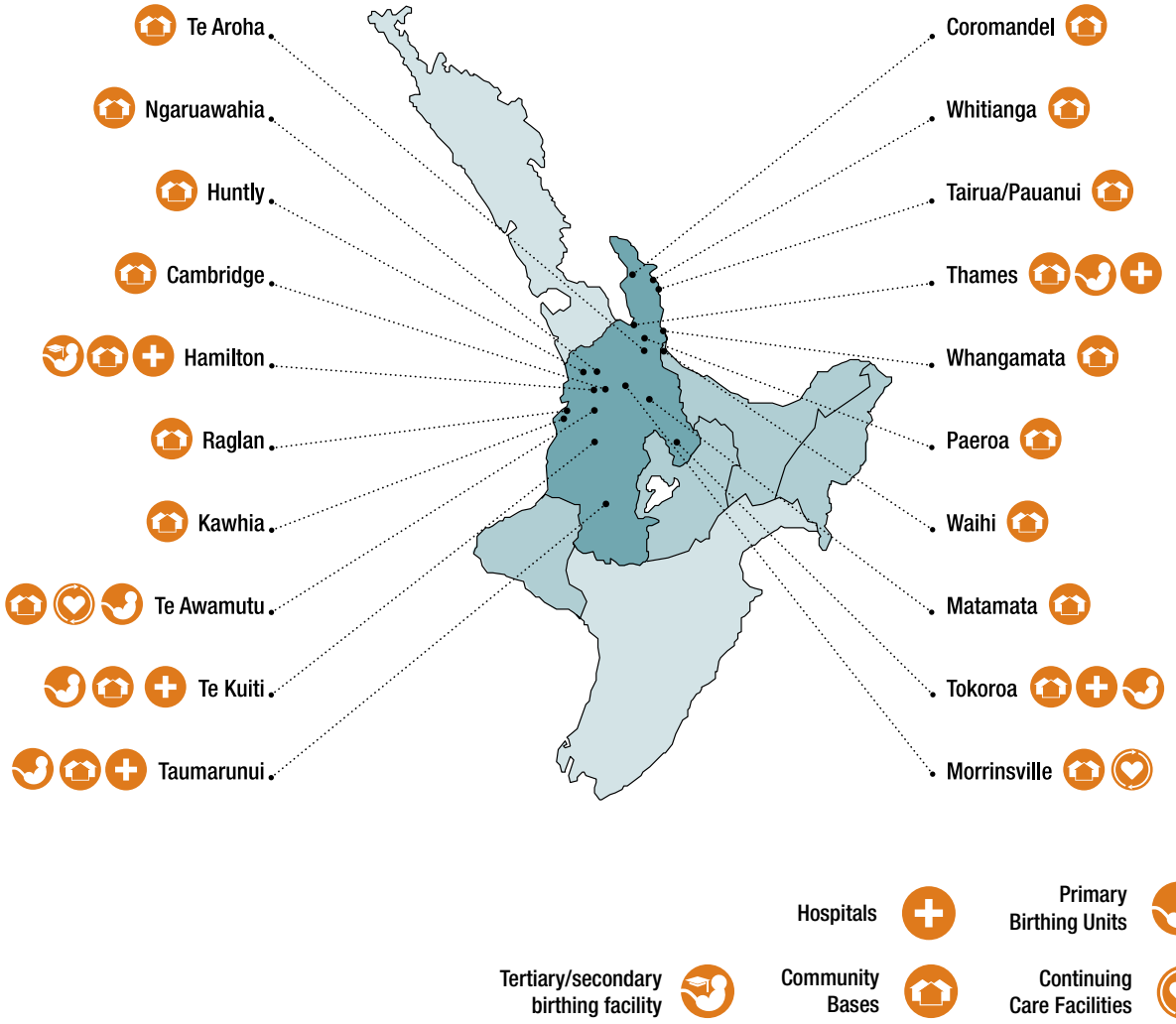
2,255,433 **community laboratory tests** were conducted

Waikato District Health Board

Facts and figures

- Waikato DHB is one of 20 district health boards in New Zealand.
- It covers an area of more than 21,000 square kilometres and serves a population of 400,820
- 23 percent of our population are Māori and three percent Pacific people who are often impacted by chronic conditions such as diabetes and smoking related diseases
- More than 60 percent of our population live outside the main urban area with a large proportion of people living in areas of high deprivation
- Our population is ageing with increasing chronic and complex health needs.

Waikato DHB region showing health care centres



The Waikato DHB strategy was launched in 2016 and outlines the plans and intentions required to meet the changing health needs of our population. The strategy includes six strategic imperatives which are long term goals designed to meet the needs of our population and achieve our vision of Healthy people – Excellent care.

Under each of the six strategic imperatives is a programme of work which has already begun. Quality and Patient Safety feature prominently within four of the six programmes including:

- Safe, quality health services for all
- People centred services
- Effective and efficient care and services
- Health equity for high needs populations

All of the programmes are monitored and reported on in the Waikato DHB Annual Report, which can be accessed via the Waikato DHB website under 'About Us' and key publications or the following link:
www.waikatodhb.health.nz/key-publications

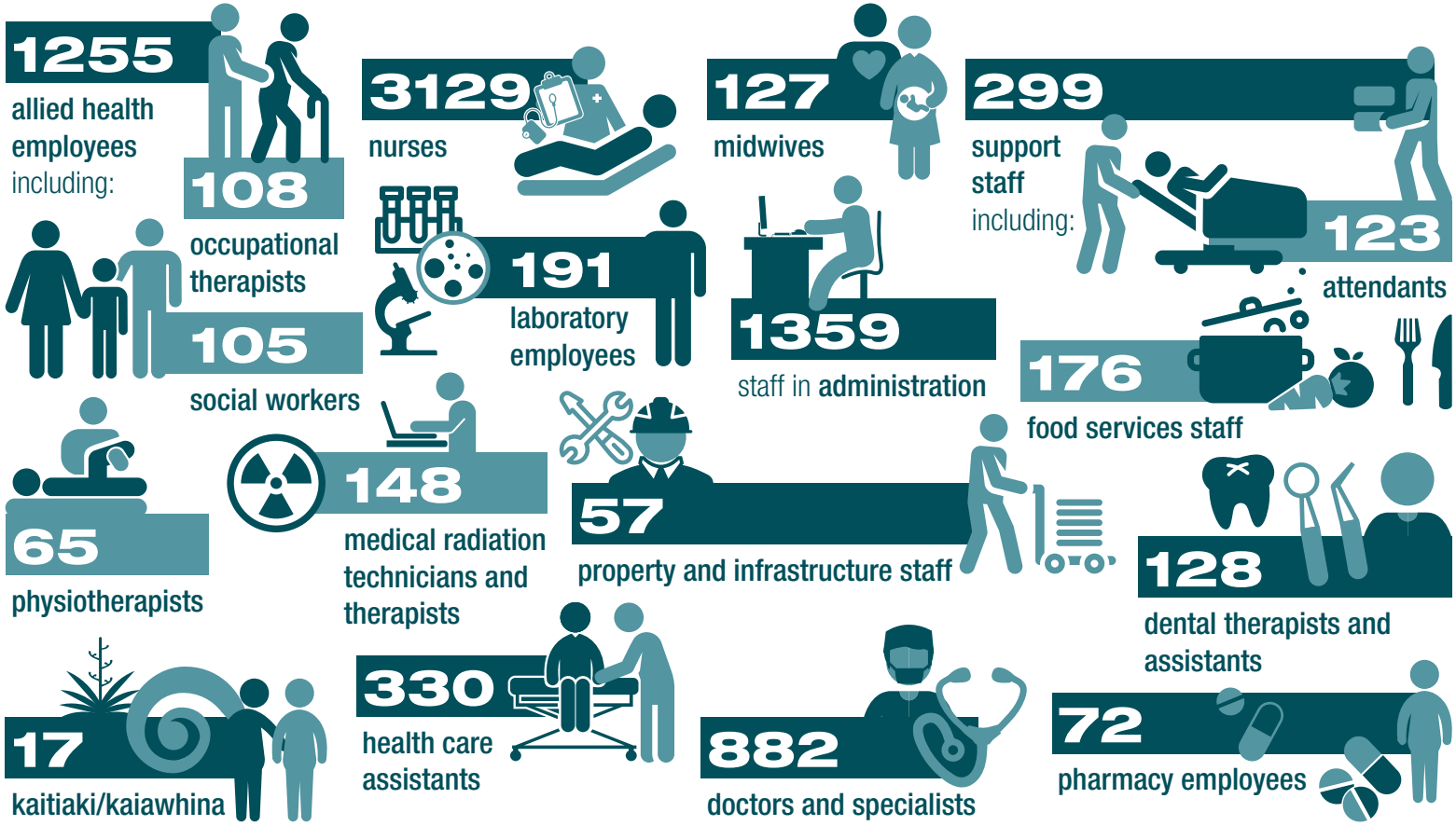
Improving the quality and reliability of our services and staying responsive to changing needs, takes time and commitment. We are increasingly including the public/consumers in our planning, service development and quality improvement, in order to provide services that meet local needs. With an organisation that includes many rural facilities, what works in a major centre is not always the right way to provide a service for a rural community. It is important to include all service providers and work across primary and secondary settings as much as possible.

We continue to work towards achieving the organisational vision of 'Healthy people – Excellent care' and the quality account demonstrates some of the work in progress to achieve this aim. The Quality Account reports on our priorities over the past year and details the progress made. The national targets and quality and safety markers continue from year to year and are a good benchmark as to how our organisation is performing and where additional focus and effort needs to be directed. We include reports of additional quality improvement initiatives that have occurred outside the planned Quality and Patient Safety programme which illustrate the passion and commitment of staff to make a difference to the patients and communities they serve. Patient stories are included as they illustrate the impact on patients of how we provide services and of course, the people who work alongside those patients.

Our staff

Staffing one tertiary hospital, four rural and remote rural hospitals and two continuing care facilities requires multiple staff with many different skills and qualifications.

These are some of the **6783** staff across the Waikato DHB working together to provide the best possible services to our patients and consumers in our communities.



PATIENT EXPERIENCE WEEK

TAVANYA BENNETTO
WAIKIDS DAY STAY PATIENT

> I like being treated like a normal kid, and that's how the nurses treat me.

I am 10 and I have a very rare auto immune condition that only four other people in New Zealand have that we know of. It's called Opsoclonus Myoclonus syndrome – or dancing eyes, dancing feet.

I come to Waikids Day Stay at Waikato Hospital for treatment every 10 weeks. I have to stay for the whole day.

I like coming to the hospital even though my treatment makes me feel unwell and I get headaches and feel sick for a few days afterwards.

I love the nurses because I know they care about me and they make me feel happy. They bring me presents on my birthday and at Christmas. I feel like I know them. I've been coming here since I was very little and they've watched me grow. I really like Wendy and Kat, and Sue who works behind the desk.

When I come to hospital I get to play games and mess up my room. I also come to the Christmas parties and get to laugh at my paediatrician when he dresses up. Sometimes I go to see the District Nurses. Karen is my District Nurse, she's funny and makes me smile.

I don't want to be treated differently. I like being treated like a normal kid, and that's how the nurses treat me.

Tavanya's mum, Sharna: *"I get treated like one of the staff. They're very nice. They ask how I am, they supported me when I gave up smoking, and encouraged me when I took up study. It's just the little things, we're included in everything.*

"They have gone the extra mile by caring. It's great that staff treat Tavanya like a regular kid and if we need anything they're there."

Manaaki – People centred services
Provide care and services that are respectful and responsive to individual and whānau needs and values

Waikato District Health Board

PATIENT EXPERIENCE WEEK

HANNAH, KIERAN AND BABY OLIVIA
WOMEN'S HEALTH

> Really happy with the care we received. The speed, control, calmness and care from all the staff was incredible.

I'd taken quite a bad fall and put my hips out that brought on my labour. This changed me and my partner Kieran's plan to have our baby girl Olivia at River Ridge East Birth Centre. I was getting excruciating pain in my legs and was taken by ambulance to Waikato Hospital.

The Women's Health team at hospital were really quick, they put me straight into a room and got an anaesthetist called Amy there within five minutes to treat my pain. Amy was great, so calm and fast.

Then we had a midwife called Ria. Again she was so lovely and so calm. At this stage I couldn't feel much, and she just chatted away about so many different things making us feel relaxed and OK.

It had been a very long time, my heart rate started to go up, I hadn't dilated properly, and Olivia wasn't sitting properly. They thought I may have needed a C-section but thankfully after some medication I was able to deliver Olivia naturally.

There were always lots of medical staff in the room. It was quite serious but we had the best possible care which reduced our worries. The staff gave me confidence and did everything they could to get Olivia out safely. There was one obstetrician who was great; she explained everything she was going to do so I wasn't scared.

A few days later we had to go back to get Olivia's shoulder checked at NICU. We had a second year student doctor, who was also at the birth, and was so awesome – she was pretty much another support person for me. I had to stay one night in the Women's Assessment Unit and the nurses always came within a couple of minutes to help with things like feeding and changing Olivia.

Really happy with the care we received. The speed, control, calmness and care from all the staff was incredible.

Manaaki – People centred services
Provide care and services that are respectful and responsive to individual and whānau needs and values

Waikato District Health Board

The national picture – how did we get on last year?

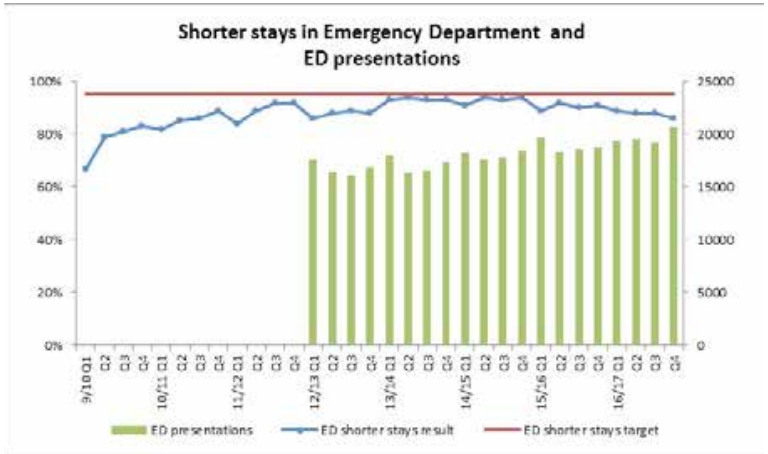
The health targets are reported by all hospitals across New Zealand and reflect public and government priorities. They are important indicators for performance and in improving the health of all New Zealanders. The targets span both primary and secondary health areas and include three measures related to patient access and three for prevention.

Waikato DHB performance against national Health Targets 2016-2017

Health Targets		Q1	Q2	Q3	Q4
Shorter stays in Emergency Departments	95% patients will be admitted, discharged or transferred from an emergency department (ED) within six hours	89%	88%	88%	86%
Improved access to Elective Surgery	The volume of elective surgery will be increased by an average of 4000 discharges per year	108% ✓	106% ✓	110% ✓	114% ✓
Faster Cancer Treatment	85% patient receive their first cancer treatment (or other management) within 62 day of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016. Target will be 90% by June 2017	81%	86% ✓	86% ✓	86% ✓

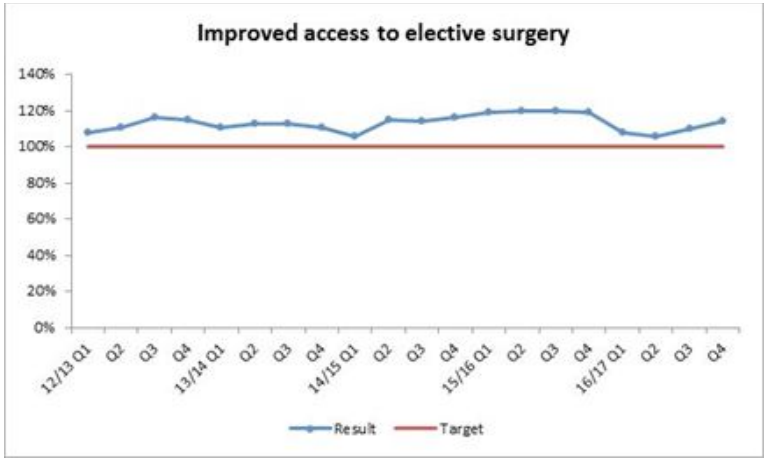
Health Targets		Q1	Q2	Q3	Q4
Increased Immunisation	95% of 8 month-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time	92%	92%	90%	89%
Better help for Smokers to Quit	**Primary care:** 90% PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Hospital and maternity targets now reported directly to Ministry of Health (MoH) website	84%	88%	88%	89%
Raising Healthy Kids	**Primary care:** By December 2017, 95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family – based nutrition, activity and lifestyle interventions	47%	79%	84%	81%

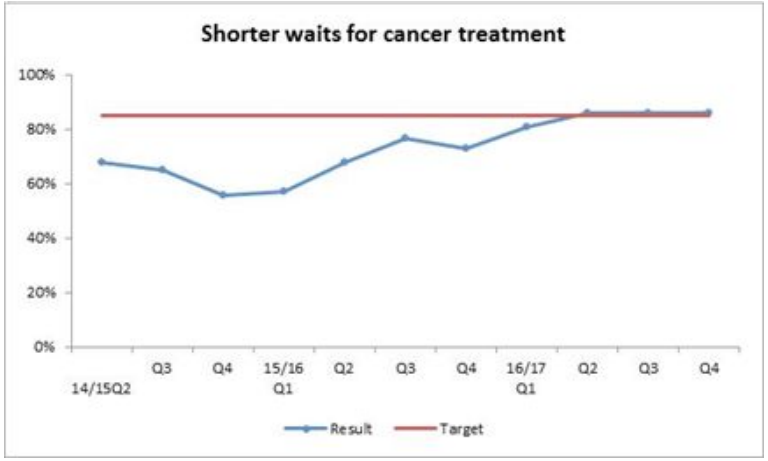
Improvements and change take time and presenting results over a number of years show how changes are being made. Not all targets are being achieved and there are some challenges that may be seasonal or come with changing demographics that impact the outcome. The following graphs show the targets and results over the past five years.



117,142

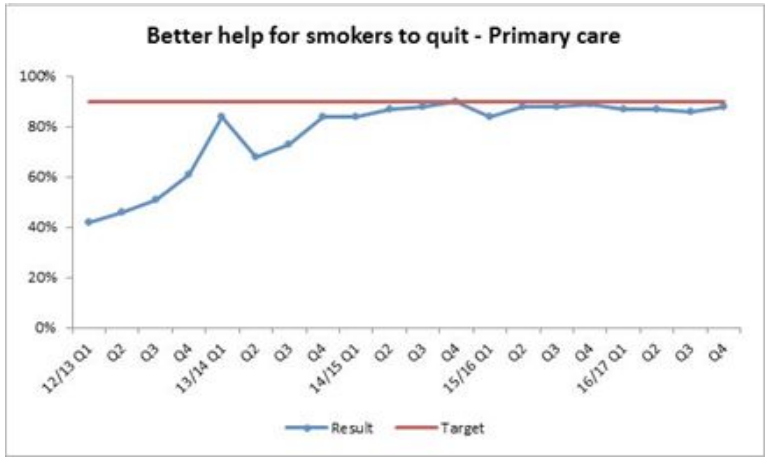
people presented at emergency departments across Waikato DHB

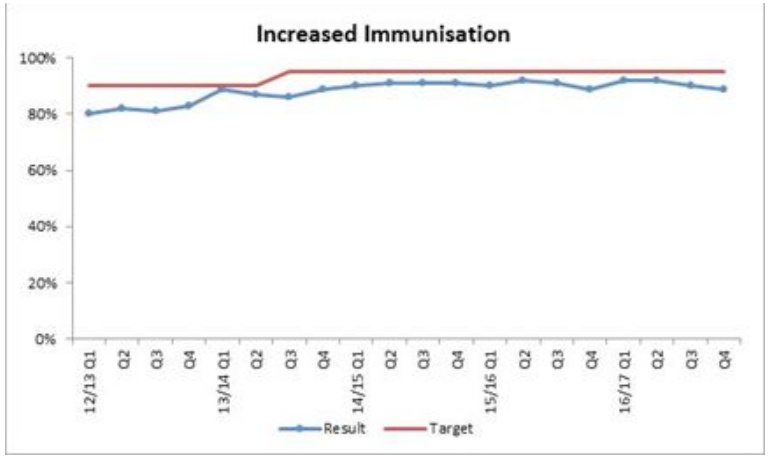


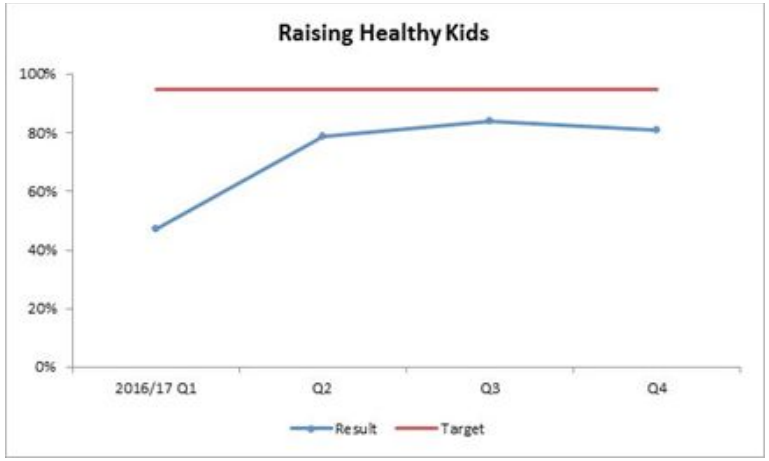


18,349

elective surgeries
were performed across
Waikato DHB







The new target 'Raising Healthy Kids' was introduced over the past year. This target focuses on managing childhood obesity as this can affect a child's health, quality of life and educational achievement. It is associated with a wide range of health conditions and increases the risk of premature onset of illness. Children are screened at their B4 School Check and if they are identified as obese, will be offered support and services for healthy eating and activity as well as referral to manage any medical complications that may be present.

The heart and diabetes checks are no longer reported on as a target but have been included in the DHB target measures. GPs continue to provide heart and diabetes checks to their patients.

The emergency department target has not yet been achieved and continues to pose a challenge to the department. This year, the graph shows the number of attendances as well as the target. There has been a steady increase in the number of patients attending the emergency department and combined with the seasonal increase in presentations, the department's workload is growing steadily. Achieving the target is impacted by many different factors, such as timely specialist review of the patient, waiting for particular tests and investigations and accessing a bed on a specific ward. A number of ongoing initiatives are in place to better understand and manage the workflow and patient management within the department.

Shorter waits for cancer treatment have achieved the target over the last three quarters of the year through improving referral management and first appointment time frames.

Elective surgery continues to exceed the target. This surgery is important, as it often significantly improves the quality of life for patients suffering from medical conditions that can be improved through surgery. This includes such operations as hip or knee replacements, which improve mobility, cataract surgery to improve sight, or inserting grommets in a child's ear to improve hearing.

Immunisation rates for 8 month old infants have fluctuated over the past few years, and have yet to achieve the target. This is a good measure to show young children are protected from such diseases as whooping cough or measles and other vaccine preventable diseases, which can result in needing hospital admission. Work continues in primary care to increase immunisation rates and opportunistic immunisation is offered when children are admitted to the emergency department or children's wards.

Serious adverse events

Many people pass through the doors of our DHB facilities every day, whether as inpatients, outpatients, visitors or staff. Keeping everyone safe is a priority, but there are times when accidents or mishaps occur.

We have developed a strong culture of reporting incidents and are able to access more useful information since the introduction of Datix, two years ago. Datix is an electronic incident, risk and complaints management system and we can use the information gathered to monitor and report much more effectively and to know where we need to direct our improvement efforts.

During 1 July 2016 to 30 June 2017 Waikato DHB discharged 101,825 patients (this excludes patients discharged/transferred to other parts of the DHB, self-discharges, and those who died). In this period, 7 Severity Assessment Code (SAC) 1 and 36 SAC 2 events were reported at a rate of approximately 0.007 percent and 0.035 percent respectively per 1000 inpatient admissions. In 2015/2016, there were 97,521 discharges and 12 SAC 1 and 29 SAC 2 events, with a rate of 0.01 percent and 0.04 percent, which indicates an overall reduction in the number and severity of serious adverse events.

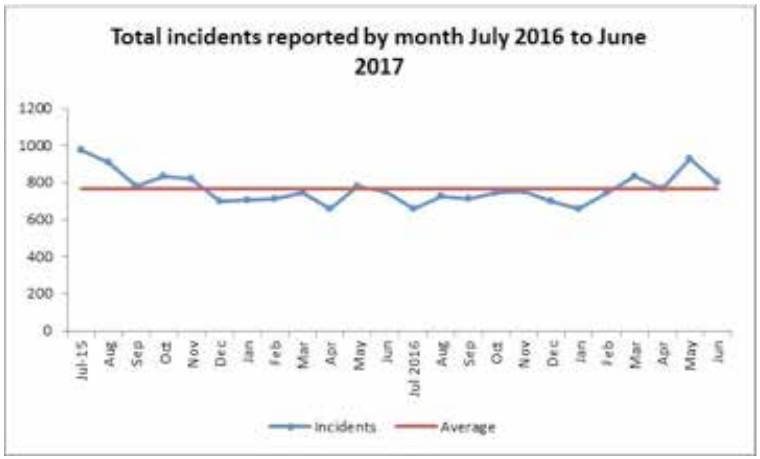
All the adverse events are graded and given a SAC rating from 1 to 4. All events graded a 1 or 2 are considered serious events and each case is independently reviewed and reported on. This is usually done with close cooperation of the patient/family/whānau involved. The review will:

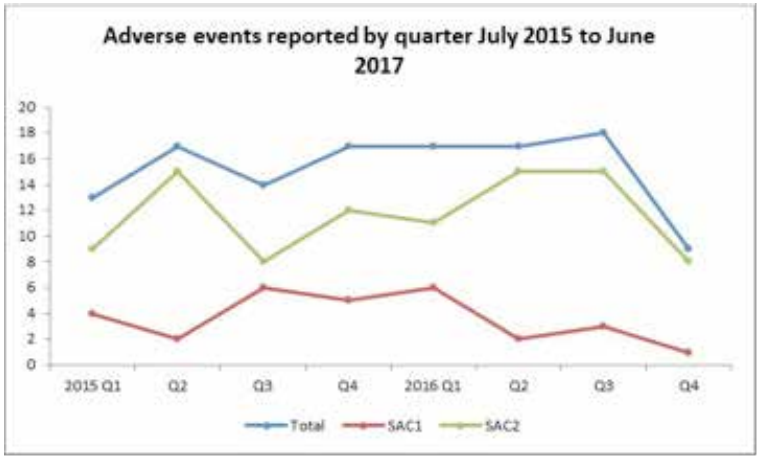
- establish the facts – what happened, to whom, where, how and why
- identify opportunities for improvement
- identify the most effective way to prevent such an event happening again
- establish action plans and follow up plans to make sure changes are effective and progress is monitored.

The table below shows the main sources of adverse events graded 1 and 2. Unfortunately, patient falls continue to be the most common source of patient harm, which most often results in a fracture. We know that falls with harm can have long term effects, especially to our elderly population and are constantly working towards improving how we identify patients at risk and working with those patients to prevent falls from happening.

Serious adverse events June 2016 to July 2017		
Source	Number of patients SAC1	Number of patients SAC2
Treatment decisions and delays	5	10
Medication related	1	
Healthcare acquired infection		6
Patient accident – not falls		1
Clinical handover		1
Resources/organisational management	1	
Falls with harm		18 falls which included: 12 femur fractures 4 arm fractures 1 shoulder fracture 1 dislocated shoulder

The two graphs show the total number of incidents reported since Datix was introduced in 2015 and the breakdown of SAC 1 and 2 events.





Learning from adverse events

Each adverse event review includes recommendations for corrective or preventive action. These are tracked, measured and reported on. Some of the corrective actions that have arisen over the past year include:

Falls

- Nursing staff have developed a resource kit for staff to use for patients who have been identified as high falls. The resource kit includes all risk minimisation strategies available and guidance regarding discussion with patient and/or their family/whānau to identify what interventions are most appropriate for this patient.
- Implemented a Mobility Plan at the bedside as a visual display of mobility requirements.
- Safety warning tape on floor, grab rails and signs on walls, entry/egress points of the bathroom ensuite areas

Hospital acquired infection

- The cleaning regime for cardiac theatres has been reviewed and revised and is monitored through ongoing quarterly audit.
- Stricter protocols around management of staff traffic in and out of theatre and where items are stored for easy access have been implemented.
- Implementation of the anti-staphylococcal bundle for skin and nasal decolonisation now in place to reduce the threat of infection to high risk patients.

Treatment processes and delays

There have been ongoing issues with ensuring patient results are acknowledged within a specific time frame and that any abnormal results are escalated appropriately. Clarification of responsibilities now requires that the clinician who acknowledges the results must act on any abnormal results. This may include requesting further tests, commencing medication or notifying or escalating to another clinician that the patient needs to be reviewed in person. Radiology now carry out a 'time out' process, prior to all Interventional Radiology procedures, at which time the correct site/side/patient is confirmed.

These are just a few of the many corrective actions taken over the past year. Many of the actions relate to the transfer of information and communication between staff and involving the patient where appropriate.

Quality and safety markers

Quality and safety markers (QSM) are measurements that look at specific areas of harm that can occur to patients when they are in hospital.

Each QSM has a target and each is reported quarterly by every DHB in New Zealand. These are good indicators regarding areas of patient care and of certain processes. They help to show where changes or improvements can be made and how effective those changes have been. These measures include:

Falls

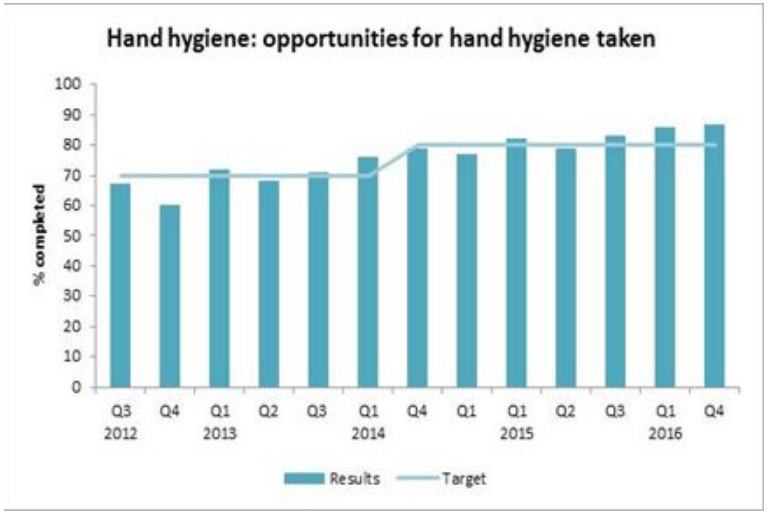
- 90 percent of older patients are given a falls risk assessment
  - Those patients who are identified at high risk of falling will have an individualised care plan

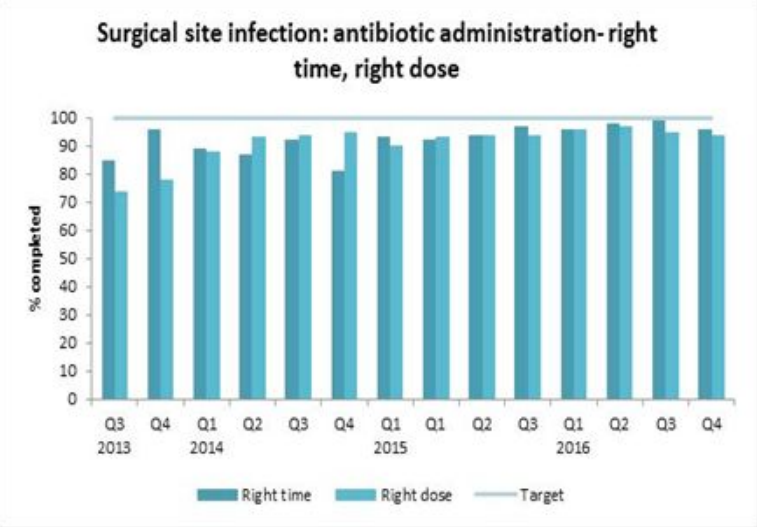
Healthcare associated infections

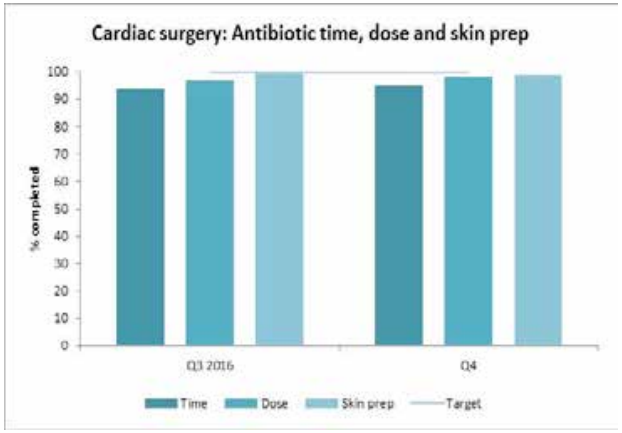
- Hand hygiene
  - 80 percent compliance with hand hygiene
- Surgical site infection for cardiac, hip and knee surgeries
  - 100 percent of primary hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision
  - 95 percent of hip and knee replacement patients receive 1.5g or more of cefazolin or 1.5g or more cefuroxime
  - 100 percent of hip and knee replacement patients have appropriate skin antisepsis in surgery. This marker is no longer reported on as a quality and safety marker but is monitored within the organisation

Safe surgery

- This measures the levels of teamwork and communication around the use of the paperless surgical check list with its three components of sign in, time out and sign out. A minimum of 50 audits are to be carried out each quarter
  - 100 percent of audits show all three parts of the check list were completed and 95 percent of audits show an engagement score of five or higher







Surgical safety check list – process completion		
Target 100%	Sign in	77%
	Time out	61%
	Sign out	*Insufficient audits completed*
Surgical safety check list – team engagement		
Target 100%	Sign in	98%
	Time out	86%
	Sign out	*Insufficient audits completed*

The QSMs show our results over time. The cardiac surgery measurements are new and have only been reported on since quarter three. This is reported by all five of the New Zealand hospitals where cardiac surgery is performed. The outcome measure is the **surgical site infection** rate which currently sits at six percent for all cardiac surgeries.

Falls risk assessment is carried out on all patients being admitted to hospital. Falls occur for many reasons and we have a range of equipment and strategies to use in order to protect patients who are assessed to be at risk of falling. Reducing the number of falls and the injuries from falls is an ongoing area of concern, as they continue to be a major cause of injury to our patients. Most falls happen to our older and frailer patients and can have a long lasting impact on both the patient and their family. Many need ongoing care and rehabilitation and falls can result in loss of confidence and mobility.

Hand hygiene is one of the simplest ways to keep our patients safe and to avoid **hospital acquired infections**. The QSM was introduced in 2012 and it involves monitoring the five moments – which are key contact points with a patient or their immediate environment, when hand washing or gelling is required. We continue to work closely with front line staff to maintain and increase hand hygiene results and compliance.

The surgical safety check list is designed to ensure the right procedure is carried out on the right person. The **safe surgery** QSM measures the level of teamwork and communication around the paperless surgical safety checklist. The audits are carried out through observation to monitor how well the check list is followed over the three key steps and how effectively the teams communicate with each other.

How did we perform against our priority areas?

Each year we review our priority areas for quality improvement and track the progress that has been made over the previous 12 months.

A number of our priorities do continue from year to year, because they are key areas for providing safe and effective patient care. Also, it can take a long time to implement successful change and improvement and embed new processes across the organisation.

The changing nature of health needs and health provision influences our priorities and we use a lot of local data to show where the needs are greatest. We use information from our incident, risk and complaints management system, serious event reviews, Infection Prevention and Control data and the Trigger Tools reviews amongst various other sources. We are also involved in nationally driven programs through the Health Quality and Safety Commission.

Each priority area has a description of why this has been chosen, what will be done and how progress will be measured and monitored.

This section provides the opportunity to report on the progress made and each section is marked with the following symbols:

= Achieving our goals

= Making good progress and on target to achieve our goals

= Not meeting our goals

Priorities for 2016 to 2017 included:

Patient safety

Priority 1: Continue to keep patients safe in our care

- Reduce falls
- Improve hand hygiene
- Reduce harm from medicines

Priority 2: Improve end of life care for patients and their family/whānau

- Develop an end of life care framework to be used across the organisation and in ongoing care facilities
- Roll out the Advance Care Planning process (ACP)

Patient outcomes

Priority 3: Reduce the number of people dying from preventable conditions

- Continue to advise and support our patients and consumers, pregnant women and general population to quit smoking
- Continue with heart and diabetes checks
- Continue to increase the uptake of immunisation especially for infants up to eight months of age

Patient experience

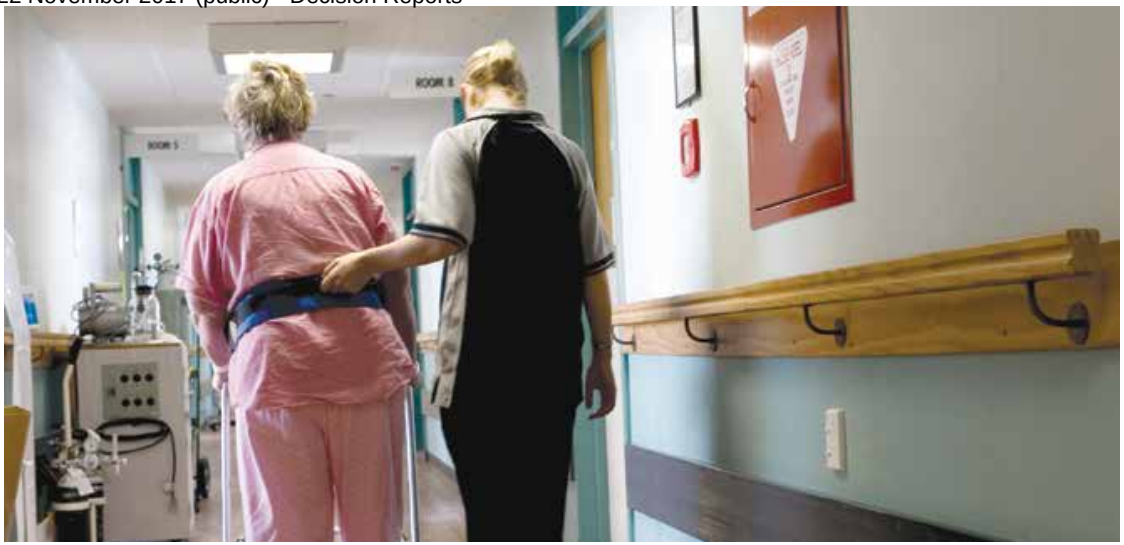
Priority 4: Listening to our patients and community – ensuring a safe and welcome environment in DHB services

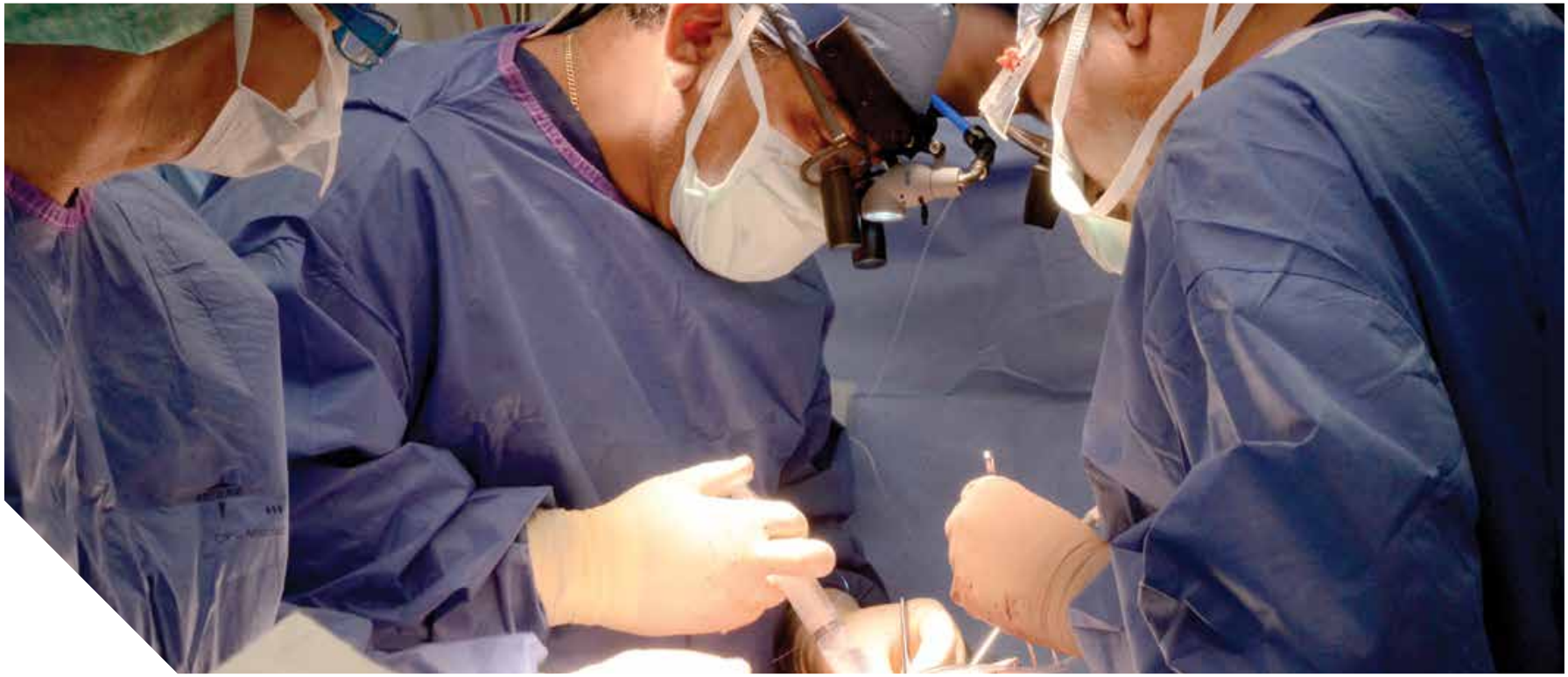
- Monitor complaints and feedback and identify key themes for improvement
- Establish the Consumer Council

Priority 5: Continue to improve care around deteriorating patients

- Introduce a ‘Sepsis’ bundle of care
- Develop and introduce a process to support family escalation of concern


STERIGEL





Patient **safety**

PRIORITY **1**

Continue to keep our patients safe in our care

Reduce falls with harm

What is this?

Patients who sustain an injury following a fall whilst under the care of Waikato DHB. Injuries may range from minor cuts or bruises through to falls with serious harm. Falls with harm result in additional treatment and longer inpatient stays.

Background

Falls can occur at any age but are more common, with more serious consequences, in our older patients. A fall after the age of 55 is more likely to cause injury and around one in three people aged 65 or over will fall in any one year.

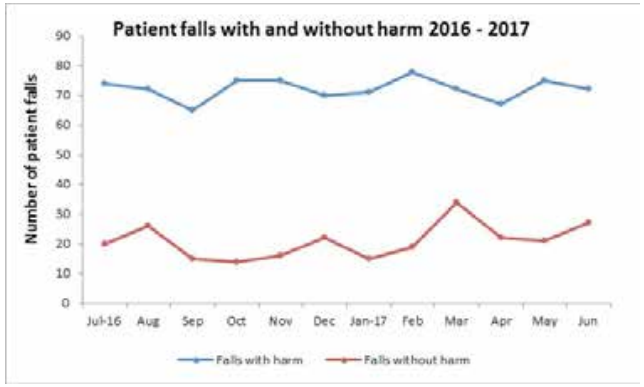
Patients admitted to hospital are particularly vulnerable due to their illness or the medications they are taking.

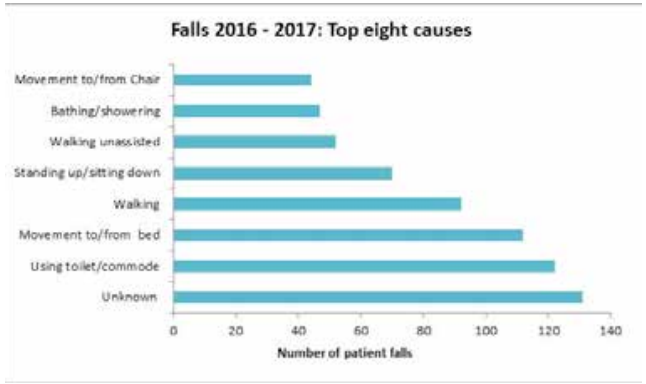
Over the past year there have been 251 patient falls with harm which is 22 percent of all our reported falls. The graphs show the number of falls with harm against the number of falls without harm, along with the top eight causes of falls.

Being able to identify how falls occur supports the type of interventions put in place. We have a wide range of equipment to use where patients are at risk of falling, as well as making sure care plans are personalised and appropriate to individual needs.

Steps taken to improve

Releasing Time to Care is a programme of modules driven by front line staff to improve patient care processes and streamline working environments to support better workflows and reduce duplication and waste. A new Falls Prevention module has been added to the programme and this has initially been introduced across the medical block.





The four medical wards and their outpatient department worked together to review their patient falls for causes and themes. Surveys assessed staff knowledge, current processes and barriers to helping patients mobilise safely. The four focus areas that resulted from this support their aim to:

- increase awareness of patient mobility status
- increase communication regarding patient mobility status
- increase patient, family/whānau involvement and participation in mobility and falls safety
- decrease patient falls

Patient **safety**

As a result, a colour coded mobility chart has been designed and introduced as a visual aid and prompt to identify patient's mobility status and needs.

The flip chart is displayed for each patient so that the patient themselves, their family/whānau and their health care providers are able to see at a glance what assistance is required.

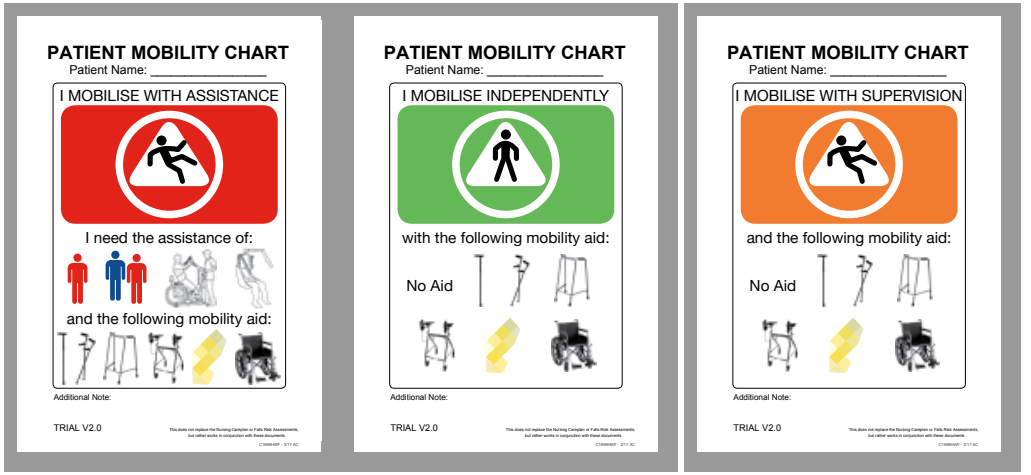
Areas for improvement were identified, trialled and refined. They now have a mobility flip chart.

We worked together as cluster (Medicine, Respiratory, Renal, and Oncology – including outpatient settings) and reviewed falls to look at themes, but there was nothing significant that could be improved.

The staff also trialled a number of different types of equipment and found that the sensor mats were most effective at preventing harm from falls. These are now readily available for staff to use as appropriate.

The falls module is now under way in Older Person's and Rehabilitation and is soon to be introduced across other inpatient areas. Each inpatient area will need to follow the same processes as each area has different types of patients with different needs.

Waikato DHB has an active Falls Committee which has representation from nursing, allied health, medical and pharmacy. Nursing staff attend and present their improvement work and progress to the committee on a regular basis. This provides an excellent avenue for supporting quality improvement work, sharing ideas and celebrating successes. We are also part of the Midlands Falls Group which supports a collaborative approach to falls minimisation, and measure how we compare to other hospitals in the region. Falls are reported nationally, and falls risk assessment and care planning are a continuing quality and safety marker.



TARGET

Sustain improvements in reducing the number of patient falls with harm

OUTCOME

Partially achieved with reduction in number of patient falls resulting in fractured femur

2017/18 FOCUS

- Continue to reduce the number of patient falls with harm

Patient **safety**

PRIORITY **1**

Continue to keep our patients safe in our care

Improve hand hygiene

What is this?

Hand hygiene is a collective term that applies to handwashing and/or the use of alcohol based hand rub. Hand hygiene is the single most important procedure that can prevent cross infection and the transmission of micro-organisms patients and health care workers.

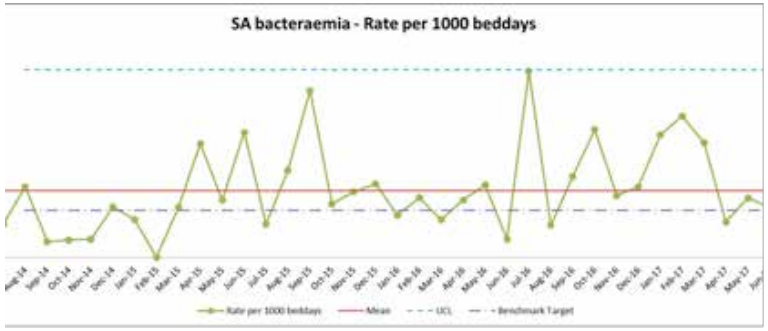
Background

Keeping our patients safe when they are in hospital includes preventing the spread of infection. Good hand hygiene is the simplest and most effective way to protect our patients who are often sick and vulnerable. Hospital acquired infections can result in extra treatment and longer inpatient stays. All staff who have patient contact are educated in the 'five moments' of contact with the patient and their environment and the need for handwashing or using gel hand rubs. We also encourage visitors to use gel hand rubs when visiting patients on the wards.

Steps taken to improve

The Infection Prevention and Control team closely monitor hospital acquired infections, surgical site infections and hand hygiene. Some of the measures are reported nationally as quality and safety markers and others are managed locally to identify areas of concern or to track improvement. All wards and inpatient areas take responsibility for managing their own hand hygiene practices and keeping staff engaged and involved. Each area is audited regularly and these results are fed back to the wards and are monitored so that education can be targeted where improvement is required. Audits are carried out on a range of staff who have patient contact, including nurses, doctors, allied health, health care assistants, blood collection staff, domestic staff and attendants. The national target for achieving all five moments is 80 percent though our local target is 85 percent. We are currently achieving just below that at 84 percent.

One of the ways we monitor the success of hand hygiene is to measure the rate of Staph Aureus Bacteraemia (SAB). The past two years have seen a rise in the rate – the main cause of this rise has been linked back to peripheral intravenous lines or drip sites. A large amount of work is underway to ensure that staff inserting IV lines, use the correct technique and prevent contamination of the site. The graph below tracks our progress since 2014 and shows how SAB rates have increased well above the target. The strategies now being put in place are expected to show a clear reduction in SAB rates which continue to be monitored closely.



TARGET

Continue to improve hand hygiene practices to exceed the local target of 85%

OUTCOME

National rate 80%
Local rate 84%

2017/18 FOCUS

- Continue to improve hand hygiene practices across the organisation to exceed the Waikato DHB target of 85%
- Reduce the rate of Staph Aureus Bacteraemia

PATIENT EXPERIENCE WEEK

PAMELA SHARP
SMARTHEALTH

> I can see it being especially useful in winter, when it's cold and raining. Not having to come out in bad weather, especially if I'm not very well, will be brilliant.

Sitting on my deck with a cup of tea is where I have some of my appointments now with my specialist, Dr Kannaiyan Rabindranath.

I received a kidney transplant in 2016 and need ongoing follow up appointments as I recover. I was travelling weekly with three-hour return trips between Rotorua and Hamilton, as well as waiting time in the renal clinic at Waikato Hospital.

Everything changed when I signed up to SmartHealth, powered by HealthTap. I started having online appointments with Dr Rabindranath from home and I'm so grateful because I can easily fit the 10-15minute appointment into my day instead of hours of travelling and waiting.

It's a brilliant service. I'm still talking one-to-one with Dr Rabindranath, I can ask questions, get answers and we can make a plan for my care.

I use a blood pressure monitor connected to my iPhone, which sends readings through to Dr Rabindranath via HealthTap, so he has all the information he needs before each appointment.

It's all very straightforward and very simple and my partner thinks it's great too, because he doesn't have to drive me to Hamilton every time. One appointment used to take two of us out for the day.

I can see it being especially useful in winter, when it's cold and raining. Not having to come out in bad weather, especially if I'm not very well, will be brilliant.

But while the weather is good, I'll continue my meetings with Dr Rabindranath from my deck, in a fraction of the time I use to spend in my car.

Manaaki – People centred services
Provide care and services that are respectful and responsive to individual and whānau needs and values

Waikato District Health Board

PATIENT EXPERIENCE WEEK

DEANNA BURKE
MENTAL HEALTH PATIENT

> If it hadn't been for the wonderful caring staff there I would not be alive to tell my story.

I was admitted to ward 35 at the Henry Rongomau Bennett Centre over 18 months ago suffering severe depression and mood disorders, with suicidal and self-harm tendencies and eating disorders. I had always struggled with my mental health but it had finally become too much going it alone and I was at absolute rock bottom.

I believe to this day that if it hadn't been for the wonderful caring staff there I would not be alive to tell my story. They put up with the worst from me. I was unrecognisable to myself and my family, yet this did not stop them from treating me as the decent human I was deep down, hidden by pain.

One vivid memory I will always have is the way the staff physically held me like a child as I screamed and tried to hurt myself, all the while swearing at them and abusing them.

They were so patient, empathetic and caring and for that I owe them my life. The staff reconnected me with my family, helped me to form my own supports in the form of family, and built up my resilience coping strategies to go out into the world and heal.

They gave me the chance to make something of myself. Now, 18 months on I am holding down a steady successful career and am about to purchase my first property. There is always hope, the bad days won't last forever but taking the first step to healing and asking for help is the hardest part. I did it and came out on top, you can too. Take the time to talk.

Manaaki – People centred services
Provide care and services that are respectful and responsive to individual and whānau needs and values

Waikato District Health Board

Patient **safety**

PRIORITY **1**

Continue to keep our patients safe in our care

Reduce harm from medicines

What is this?

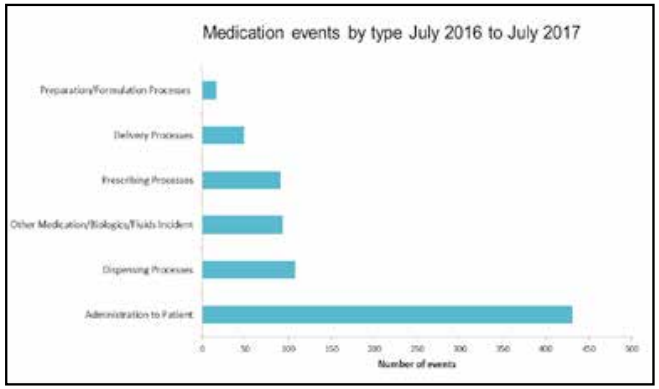
A medication error is any preventable event that may cause or result in incorrect medication use or patient harm, while the medication is in the control of the health care professional, patient, or consumer.

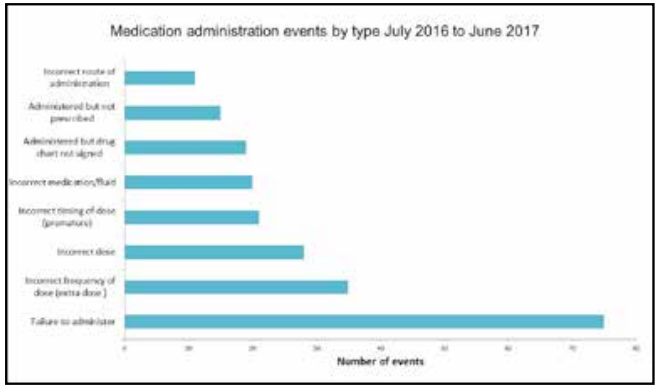
Background

Medication management is an important part of patient care both in hospital and at home. It is a multidisciplinary responsibility and we have good processes in place to manage medications for our inpatients.

Pharmacists check that medications are documented and prescribed correctly, doctors prescribe medications and nurses administer medications to their patients. Unfortunately, with the vast numbers of medications administered every day, errors do occur. The information we gather from our incident data base shows the causes of the majority of incidents and it helps us target improvement efforts where they will be most effective.

The two graphs show the main areas reported from incidents. Administration of medications is the highest cause of error and this has been broken down further to show what impacts the ability to administer the medication.





Patient **safety**

Steps taken to improve

and Therapeutics Committee. The group provides leadership and direction in all matters relating to medicine management and ensure we remain up to date with national and international developments. They promote the safe, rational and cost effective use of medications within our organisation, monitor and analyse medication errors and adverse drug reactions and support improvement initiatives.

The Medication Improvement programme is being led by Pharmacy. They have a new pharmacist role to coordinate the programme across the DHB. This new programme is looking at a wide variety of issues related to medications management, such as medicine storage, guidelines, medicine reconciliation, reviewing how medicines are used, prescribing process and the development of e-learning programmes.

There are many other quality improvement initiatives underway that are associated with medicines safety. Some examples include:

- Involvement with the national Health Quality and Safety Commission Patient Safety Week. This year the focus is on medicine safety and key questions to encourage patients to ask will be:
  - What is my medicine called?
  - What is it for?
  - When and how do I take it?
- Continuing involvement with the national collaborative aimed at reducing constipation related to opioid medication. Developments include a patient information leaflet about constipation and another about opioid analgesics
- Review of medicine related incidents to see what lessons can be learnt
- Pharmacy intern projects, with a look at safety from different perspectives
  - In what format do patients prefer to receive information about medicines?
  - Is patient weight recorded so that weight-based medicine doses can be more accurately prescribed?
- Increased number of electronic medication storage systems installed
- Prioritisation tool development and implementation to enable pharmacists to prioritise patient care

TARGET
- Develop and implement a medicines safety programme
- Scope out a project relating to patient hydration and fluid management

OUTCOME
Achieved with programme implemented

On hold

2017/18 FOCUS
- Continue to develop the different work streams within the medication safety programme

Patient **safety**

PRIORITY **2**

Improve end of life care for patients and their family/whānau

What is this?

End of life care is support for people who are in the last months or years of their life. As there is a wide range of different conditions, end of life for some people, refers to the last few years of life whereas for others, this could be a matter of months, weeks, days or hours. In the case of sudden unexpected death, the focus of end of life care may be in the period following death.

People who are approaching the end of life are entitled to high-quality care, to live as well as possible until they die and to die with dignity, wherever they are being cared for.

We, who are providing care should ask about the person's wishes and preferences, and take these into account as we work with them to plan future care. We should also support their family/whānau who are important to them.

Background

Healthcare providers are becoming aware of the need to provide care in a different way for people who are dying. This is about changing the approach from being about curing an illness or condition to initiating an end of life pathway.

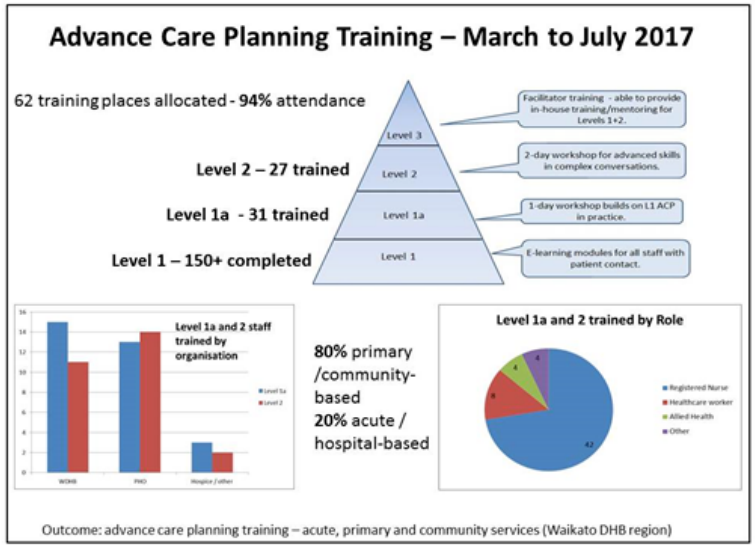
There are many different healthcare providers who contribute to end of life care and it is important that they work. Often each area has different processes and often work separately from other departments.

If the care of patients entering an end of life pathway is better coordinated, resources and healthcare support can be used more effectively and be more readily available, whether the patient is in hospital, hospice, aged care facility or at home.

Steps taken to improve

This year, Waikato DHB has been developing an end of life care programme across the district to address two of the four areas of the end of life pathway.

- **Advance Care Planning (ACP)** – opens up opportunities for early conversations with a person, their family/whānau and healthcare providers about their individual wishes and preferences for their own future healthcare. The DHB has promoted ACP to the public and healthcare workers in primary and acute care, within cultural communities and non-governmental organisations such as St John Ambulance or charitable trusts. National training has been provided for healthcare staff to improve their communication skills about ACP



Patient **safety**

- **Recognising people entering the end of life phase** – this opens further conversations with the person and family/whānau relating to deterioration, decisions around the treatment they would want and plans of care. This year, consumers, working with our palliative care teams in hospital, hospice and the community, have been working together to review the current pathways and identify how and where changes are needed. One key area is to improve urgent transition of care from hospital out to community care, for patients wishing to spend their last days out of a hospital setting or at home. The consumer viewpoint has shown us that it is necessary, and possible, for all different care providers to work together and provide a much more satisfying and supportive service through the end of life journey.

Working across primary and secondary providers is important and will improve continuity of patient care. Work is underway to ensure that a patient's Advance Care Plans can be viewed across organisations in the Waikato DHB region. We are also planning to develop a bereavement care service to support the family/whānau following a bereavement to manage both emotional and administrative needs.

Co-design process map at focus group

TARGET

- Develop an end of life framework
- Adoption and roll out of Advance Care Planning

OUTCOME

- ACP training to 58 primary and secondary staff
- On-line training for more than 150 staff

2017/18 FOCUS

- Continue to roll out the end of life programme in conjunction with acute care, primary care, community services and cultural communities

Patient **outcomes**

PRIORITY 3 Reduce the number of people dying from preventable conditions

What is this?
This is about preventing certain conditions that may arise due to particular lifestyle choices. We know that alcohol, smoking and diet can cause problems as we get older, but we also know that childhood obesity can give rise to sickness and lifelong problems.

Giving our children the best start in life can be supported through stopping smoking, breastfeeding and safe sleeping for babies.

There are increasing numbers of programmes and support networks for adults to engage in and improve their health outcomes.

Background
Many people seek medical help or are admitted to hospital as a result of conditions that have been made worse by lifestyle choices.

We are working closely with our community partners to provide health education and support to our population in order to promote healthy lifestyles, or where conditions exist, to support health improvement and reduce health inequalities for our Māori and Pacific communities.

Population Health is part of Waikato DHB and is a service that is responsible for health promotion, health protection and population based screening programmes.

Their current strategy is that:

People are supported to take greater responsibility for their health through:

- fewer people smoking
- reduction in vaccine preventable diseases
- improved health behaviours

People stay well in their homes and communities and:

- fewer people are admitted to hospital with avoidable conditions
- children and adults have better oral health

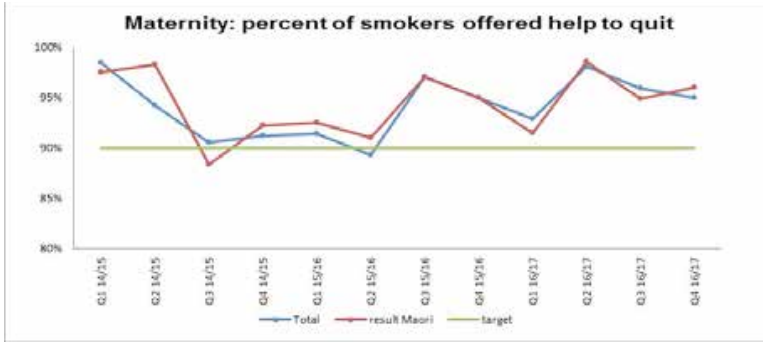
They are achieving these aims through:

- Planning, implementing and evaluating health promotion projects
- Creating supportive environments so that the healthy choice is the easy choice
- Influencing policy and organisational change for health improvement

Steps taken to improve
National health preventative targets include:

- **Helping smokers to quit smoking**, with targets now relating to people in the community and pregnant women. The target relating to patients in hospital is no longer reported nationally as that target was consistently met and good processes now exist within the hospital. This target continues to be monitored locally.

  The target for pregnant women who smoke, being offered help to quit, continues to exceed the 90 percent target for both Māori and non-Māori.



Patient **outcomes**

- **Increased immunisation**, with a focus on 8 month old infants being fully immunised. This target has not been met and there have been a number of different actions taken to enable easier access to immunisation through outreach services as well as increased public health messages around immunisation. There are ongoing campaigns to increase awareness of protection gained through immunisation, especially when there are outbreaks of communicable diseases such as measles, chicken pox or influenza.

  Waikato DHB have been offering free influenza vaccine to pregnant women which is the first of such initiatives in New Zealand.

- **Raising healthy kids** is a new target and part of the childhood obesity plan. Obesity is now the leading risk to health in New Zealand. The rates of obesity have been increasing over the past 30 years with people becoming obese at younger ages.

  Obesity in children is associated with a wide range of health conditions that can affect their quality of life and their educational achievement.

  With a focus on recognising obesity at a young age, it allows interventions and support to be put in place to improve healthy eating and activity during pregnancy and early childhood with government agencies, schools, community and private groups working together to achieve the best outcomes

TARGET

Align with DHB strategic imperative Health equity for high need populations

- Increased immunisation for 6 month old infants
- Raising Healthy kids
- Helping people in the community to quit smoking

OUTCOME

- Not met
- New target – results increasing
- Not met

2017/18 FOCUS

- Continue to work across primary and secondary sectors to achieve the targets
- Continue to support long distance clinical healthcare, patient health related education and public health

Patient **experience**

PRIORITY 4 Listening to our patients and community – ensuring a safe and welcome environment in DHB services

What is this?

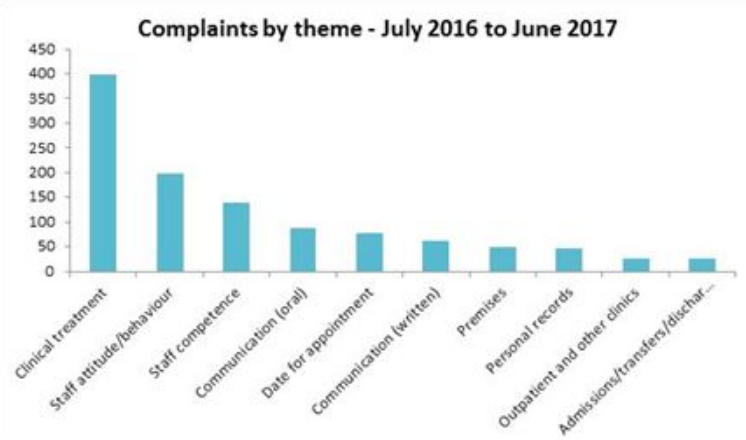
- It is about listening to the feedback from our patients and consumers and understanding their needs and 'what matters to you'
- Engaging consumers to work alongside us when we are designing new services or processes and using their experiences to inform what we do
- Monitoring complaints and feedback and identifying key themes for improvement

Background

Waikato DHB staff work hard to provide the best care and best environment for our patients, consumers, family/whānau and visitors. Coming into hospital, whether at Waikato or in one of our smaller facilities, can be a challenging experience. The environment is unfamiliar, patients and family/ whānau may be feeling anxious and vulnerable. How we treat our patients leaves a lasting impression and sometimes we do not do as well as we would wish. One of the best ways we have of improving how we provide services or improve the facilities or environment, is to listen to the people who use them. We have a variety of ways that patients and consumers can feedback to us.

Mental Health and Addictions service have introduced real time feedback for their service users. It is an on-line tablet survey that is easy to use. There are nine questions which ask people to rate their experience, with questions that range from how an individual feels they are respected or involved in their treatment, through to whether they would recommend the service. The responses inform the service where they are doing well or where there are opportunities for improvement.

We have the 'How did we measure up' feedback form and a more formal process for submitting complaints. The themes for complaints are shown below.



The main areas reported relate to clinical treatment and communication issues. Staff attitudes and behaviours can negatively impact a patient or family/whānau experience and they deserve to be treated with respect and kindness. We continue to work hard to improve staff communication style and approach with all of our consumers.

The national inpatient experience survey is carried out quarterly in every hospital in New Zealand and provides a good measure of patient experience and feedback about the care they received. It is a good indicator of how well health services are working for the patient and their family/whānau. The two areas that we perform least well in are:

- Did you feel you received enough information from the hospital on how to manage your condition after your discharge?
- Did a member of staff tell you about your medication side effects to watch for when you went home?

Steps taken to improve

- **Communication:** Waikato DHB has a comprehensive education plan every year with many different courses available to staff. There are a

Patient **experience**

number of courses dedicated to improving the way staff communicate with their patients and consumers and with other staff.
Flexible visiting time was introduced at the start of 2017. This is designed to ensure the patient receives the emotional and practical support they desire through nominating a key support person to be with them outside normal visiting hours. For all other visitors, we request they keep to regular visiting times as it is important for patients to rest and recover.

The nominated support person can play a vital part in in the sharing of treatment information and decision making, especially if the patient is unable to understand or to make decisions for themselves.

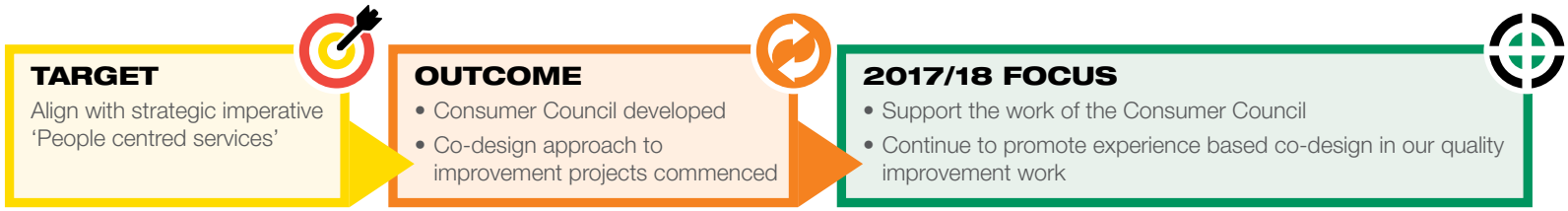
- **Medication information:** We have a large programme of work underway to improve medication safety. This includes making sure that patients are on the right medication, that they receive the appropriate information about their medication and that their discharge information is accurate and shared with their ongoing care provider or GP. Improving knowledge about the drugs that a patient takes is part of improving health literacy and helping patients to fully understand their treatment and medications.
- **Consumer Council:** Waikato DHB is setting up a new Consumer Council made up of members of the community who are passionate about healthcare and disability service provision.
  The Council will work in partnership with the DHB, to make sure its services are as good as they can be and meet the needs of people in our communities. We will be keeping People at Heart – *Te iwi Ngakaunui*, which encompasses the DHBs values.

  The Council will provide advice to the Board and senior management on:
  - the current direction and strategic priorities of the DHB
  - how we can improve specific aspects of some of the DHB services.

  They will promote and oversee consumer involvement in the planning and delivery of Waikato DHB services. The Consumer Council will be in place by January 2018.
- **Experienced based co-design:** This is about consumers and staff working together; to help understand and improve the way we provide some of our services. Customarily, DHB staff have made changes to the way services or treatments are provided, based on staff opinions and experiences. Feedback from consumers tells us that what staff think is important is not necessarily what matters to the patient or consumer. By using this approach, consumers are no longer solely involved in telling us about their experience of our service; they are also involved in helping to develop solutions to improve them. Waikato DHB is increasingly seeing the value of working with consumers and using an experience based co-design approach in its improvement work.

  We currently have a number of experience based co-design projects underway. All of them involve consumers working together with staff to make improvements.

  These include such projects as:
  - Effective transition of care from hospital to community for patient with a terminal illness, wishing to be cared for in their own home
  - The Thames Coromandel Patient Experience – care closer to home – where patients from rural areas can be cared for safely and for as long as possible in their rural hospital
  - Improving follow up for perinatal loss
  - Using SmartHealth to access emergency care after hours for two rest homes
- Improve services and access to Needs Assessment and Service Coordination (NASC) for Māori aged over 65.



Patient **experience**

PRIORITY **5**

Continue to improve care around deteriorating patients

What is this?

This is about recognising and responding to deterioration or worsening of a patient's condition when they are in hospital. It is important to be able to respond quickly and appropriately whatever time of day and where ever the patient is located.

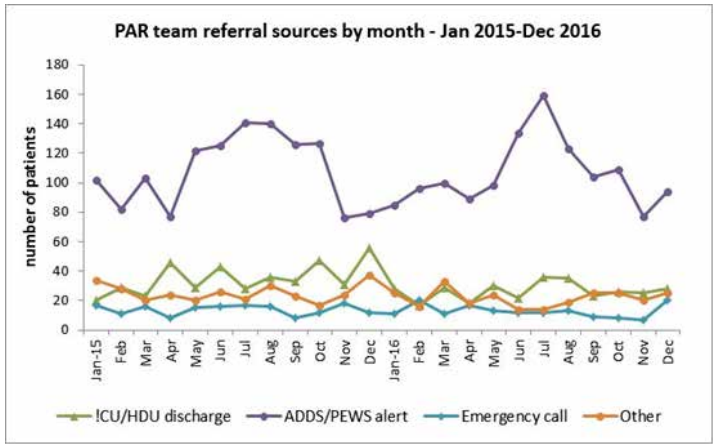
Background

We have a number of different tools and processes that help staff caring for patients to recognise a change or worsening of patient condition, or to recognise such conditions as sepsis (severe infection) or stroke. There are escalation processes that staff can follow in order to respond to changing condition and ensure the patient receives the right care at the right time.

There are occasions where the response or escalation does not happen early enough and patients may require additional treatment or even admission to the Critical Care unit. We collect a lot of information relating to patient deterioration, response and outcome and some will be reported as an adverse event. Reviews of such cases help us identify what went wrong and why and what needs to be done to prevent recurrence.

Waikato Hospital has a team of specialist nurses working as the Patient at Risk (PAR) team. They respond to calls relating to escalation of concern, where patient condition is deteriorating and recognised from the early warning score, they support nurses in managing complex care, especially for patients transferred out of the critical care unit to the ward plus attending emergency calls. The four main sources of referral are shown in the following graph.

This shows that the greatest referral source is in relation to early warning score concerns. We know that the number of calls is increasing steadily and aim to increase the size of the team and in time develop a Rapid Response team that includes nurses, doctors and specialists.



Steps taken to improve

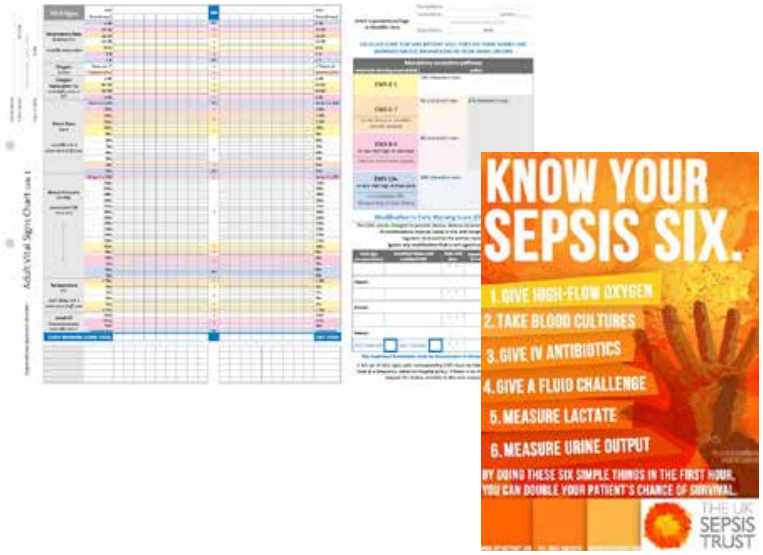
A new national programme supported by HQSC, has been introduced to improve early detection of patient deterioration. This is a five year programme with a number of work streams that meet both national and local criteria.

- The national vital signs Early Warning Score chart is soon to be introduced across the organisation and replace the current vital signs chart and early warning score chart. The intention is to have a standardised process across the whole of New Zealand. This is known to be more effective at recognising a worsening in patient condition and follows international best practice and research. The chart will include steps to escalate care to ensure early and appropriate response for the patient.
- Sepsis recognition and management. We know that a large number of people are admitted to the emergency department every year with sepsis. Sepsis is a severe infection that can result in complex treatment or even death. Many people have never heard of sepsis and it can be difficult to recognise, but if treated early, patients will recover well and without lasting effect.

Patient **experience**

There is an increasing worldwide focus on recognising and treating sepsis and preventing unnecessary deaths. At Waikato, a group of doctors, nurses, specialists and educationalists are working together to:

- increase public awareness of sepsis
- improve ways of recognising, responding and managing patients with sepsis when they are admitted to the emergency department or develop sepsis as an inpatient
- ensure we have effective ways of escalating care and managing patients if they do become seriously unwell.



TARGET	OUTCOME	2017/18 FOCUS
Continue to improve care for the deteriorating patient	Ongoing improvements as part of the Deteriorating Patient programme	• Complete roll out of the national vital signs and Early Warning Score chart to all adult inpatient areas
Introduce a Sepsis bundle of care	Planning and development of sepsis bundle in progress	• Launch the Sepsis bundle of care across Waikato DHB
Develop and introduce a pathway to support family escalation of concern	On hold until a Rapid Response team is initiated but partially addressed with the new Early Warning Score chart	

Our focus for 2017/2018

Patient safety

Priority one: Continue to keep patients safe in our care
Aligns with strategic imperative 'Safe, quality health services for all – *Haumaru*'

- Reduce harm from medicines

Tracking progress and achievements by :
- Implement the medicines safety programme
- Linking with the mental health quality improvement programme
- System level measure 'patient experience' work around health literacy and medicine information on discharge
- Reporting to the Medicines and Therapeutics Committee and the Patient Safety Group

Priority two: Improve end of life care for patients and their family/whānau
Aligns with strategic imperative 'People centred services – *Manaaki*'

- Continue to develop an end of life care framework to be used across the organisation and in continuing care facilities
- Continue to roll out the Advance Care Planning (ACP) process
- Develop and implement a bereavement service for Waikato DHB

Tracking progress and achievements by :
- Number of advance care plans available on iPM (electronic patient management system)
- Number of staff trained at level 1a and level 2 ACP training
- Complaints / compliments tracking in relation to bereavement care
- Reduction in return of incomplete medical certificate 'Cause of Death' forms

Patient outcomes

Priority three: Reduce the number of people dying from preventable conditions
Aligns with strategic imperative 'Health equity for high need populations – *Oranga*'

- Māori health plan

Tracking progress and achievements:
- Achieving the National Health Targets
- Linking with the system level measure

Patient experience

Priority four: Listening to our patients and community
– ensuring a safe and welcome environment in DHB services

Aligns with strategic imperative 'People centred services – *Manaaki*'

- Support the work of the Consumer Council
- Continue to promote experience based co-design in our quality improvement work

Tracking progress and achievements:

- Reviewing the numbers of consumers who partner with us in our improvement work

Priority five: Continue to improve care around deteriorating patients

Aligns with strategic imperative 'Safe, quality health services for all – *Haumaru*'

- Introduce a Sepsis Six bundle of care
- Roll out the national vital signs chart and Early Warning Score across the organisation

Tracking progress and achievements by :

- Reducing the number of patients dying from severe sepsis
- Reduce the number of patients with unplanned admission to the intensive care unit following patient deterioration
- Serious event themes
- Health Round Table data

Developing capability

The Quality Governance Strategy 2015-2018 'listen, learn, improve' emphasised the need for a cultural change on empowering front line staff to make continuous changes in their practice to achieve our objectives with a commitment to learning and continuous organisational development.

A systematic approach to capacity/capability building for improvement has been identified as one of the key characteristics of healthcare systems that deliver high performance in cost and quality. Quality Improvement (QI) capacity building increases the self-sustaining ability of organisations

Research suggests that a lack of knowledge and skills among clinicians and managers is a significant barrier to improving healthcare. Training health professionals in quality improvement has the potential to impact positively on attitudes, knowledge and behaviours.

A sustained 3-5 year programme needs to be put in place to become a learning organisation with a clear capability and capacity framework for improvement, underpinned by an effective model for implementation and a common language. This programme has been agreed by the executive team and work is now underway to implement a tiered approach.

The tiered approach means that support and coaching can be provided by internal staff, ensuring sustainability and retention of the knowledge within the organisation.

Our goal is to increase the capability of all Waikato DHB staff to use a common approach to problem solve and achieve sustainable improvement with 50 percent of staff trained in a common approach to performance improvement by the end of 2019.

144,795

community visits were made by our district nurses and Allied Health made **20,597**

Feature stories

There are many different improvement ideas and service changes underway across the organisation.

Often it is the little things that can make a big difference to our patients. Sometimes, the changes are innovative and take a different approach.

We are always trying to improve what we do and how we do it. The following are a few of the changes that have been made or are taking place.

SEPSIS: Prevent it. Spot it. Treat it – beat it.
The story of a Waikato man's experience of severe sepsis

Every few seconds, around the world, someone dies of sepsis. Sepsis is a common occurrence, yet very few people have heard of it.

Most infections will clear up on their own as a result of the body's immune system attacking any bacteria, or following medication such as antibiotics being prescribed by a doctor. Occasionally, the body's immune system has an overwhelming response to the infection and will injure its own tissues and organs. If sepsis is not recognised and treated early, it can lead to shock, multiple organ failure and death.

We know that 70 percent of patients who are diagnosed with sepsis present to the emergency department. Some in-patients can develop sepsis as a result of surgery or illness. The most common causes of sepsis arise from infections such as pneumonia, urine infections, skin infections or gut infections.

World Sepsis Day was held on 14 September and that day was used to launch the Sepsis Six programme at Waikato DHB, raise awareness of sepsis amongst staff and present a moving patient story about one of our community and how he survived sepsis.

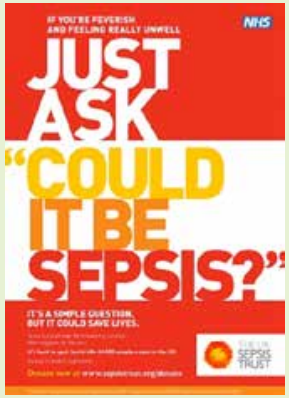
View the video via the link below or by accessing the Waikato DHB Newsroom website.
www.waikatodhbnewsroom.co.nz/2017/09/13/sepsis-have-you-heard-of-this-common-killer/

The aim of the Sepsis Six programme is to:

- **Raise awareness in the community about the risks of sepsis**, how it might present and what to do about it. Many people with worsening infections stay at home because they think it may be the flu and will get better. Most will get better; often following a course of antibiotics, but some will get worse and need urgent treatment.
- **Raise awareness amongst our clinical staff** – doctors, nurses and allied health, to make sure that patients with sepsis are recognised and appropriately managed.

We know that early intervention saves lives.

What are we doing now?
We have a dedicated group of specialists, doctors, nurses and educators from across the organisation, working together to plan the implementation of a package of care called Sepsis Six. We are working with our communications team to provide information to the public and improve knowledge and understanding about the risks of sepsis and when to seek help.



Keeping safe in hospital – safety video for children admitted to hospital

No matter your age, gender or if you're a dinosaur called Safetysaurus, coming to hospital can be quite scary, especially if you're a kid. So the Waikids team at Waikato Hospital rallied together to make a fun and informative video for unwell kids and their whānau when they need to stay in hospital. The aim is that it will alleviate some of the fear kids may face when coming to stay at Waikids, while highlighting important safety tips. The video includes real shots of the wards as well as using their nurses and doctors to show that patients have the best possible staff about to take care of them.

The character Safetysaurus was a big hit on some of the wards during the Health Quality and Safety Commission's 'Patient Safety Week' and it was decided to carry on with the theme. Safetysaurus is the perfect character to show kids that something normally big and strong like a dinosaur can be just like one of the hundreds of kids that need to come to hospital every day.

Everything was filmed in-house and included actors Grayson, from Hamilton West School, and Holly, from Maeroa Intermediate, who kindly donated a lot of their time to help narrate the video. The video demonstrates a number of safety tips and advises what to be aware of when making sure that personal details are correct. It encourages children to speak up if they have any concerns.

Waikids is the brand that includes all child and youth health services provided by Waikato DHB, whether they are provided in hospital, clinics, in the community or in people's homes. From the day a Waikato baby is born until they become an adult, they are a Waikid.

The video is available on Waikato DHB's webpage 'preparing for a hospital stay'.

Nurses in Day of Surgery Admission listen to their patient's feedback – "I am your nurse today" cards

Listening to feedback from patients led to the development of cards to keep patients informed during their wait for surgery.

Day of Surgery Admission (DOSA) is where many patients are admitted on the day of surgery and stay in the waiting room until it is their time to be prepared for surgery. Patients can often have a two or three hour wait, which is generally unavoidable and staff had a lot of negative feedback about these waiting times. The nursing team was unhappy with this situation and came up with an idea to better connect with their patients in the waiting room, to let them know that they had not been forgotten.

The result was the development of the 'I am your nurse today' cards. They started off as a basic photocopied piece of paper but were gradually improved to be a professionally printed card with a simple message on the back, taken from the patient safety briefing card. Each day, more than 50 patients are allocated to the nurses in the DOSA team, so the nurse knows throughout the day which patients they are responsible for. They can see on the whiteboard when their patients arrive and either they or the coordinator will go out to meet and greet the patient and hand them the card which gives the name of their nurse. It acknowledges that the wait can be long and if they have any questions or need assistance, they can take the card to the receptionist and ask them to call their nurse.

As a back-up to the electronic whiteboard, a paper based record is also kept, using a triangle to show where each patient is in their three-stage journey and a smiley face indicates they have been given a card.
Following the introduction of the card, the negative feedback has reduced significantly and the team feels that it has been a practical, patient focused and successful improvement to the way they work. It fits well with the 'What matters to you' feedback material that is displayed in their waiting area and the board displays how feedback results in action and improvement. It shows that we do listen when our patients, family or whānau give us feedback.

REACH – Realising Employment through Active Coordinated Healthcare

REACH is a new support service for people who are registered as job seekers and manage a health issue or disability.

The Waikato DHB and the Ministry of Social Development have collaborated to establish a new approach to supporting clients on a return to wellness and the workplace.

This programme helps unemployed people overcome their challenging health issues and return to work is going from strength-to-strength a year after it was launched as a pilot programme.

The programme, called REACH (Realising Employment through Active Coordinated Healthcare), is supporting clients to manage their health condition or disability so they can find suitable work. This gives them confidence and independence and improves their wellbeing.

An initial prototype for up to 30 clients in the Dinsdale and Raglan areas started in May last year and has now expanded into other areas of Hamilton, Te Awamutu, Cambridge, Matamata, Huntly, Waihi and Thames.

There are approximately 4,500 clients in the Waikato region who are temporarily unable to work due to a health condition.

Clients were invited to join the voluntary programme by their Ministry of Social Development case manager, will have been receiving a health or disability-related benefit for between six months and three years.

The Waikato DHB staff, in partnership with the Ministry of Social Development case manager, work with their local GP and other agencies in the client's life to help solve problems and use cognitive behavioural therapy to clear blocks that could be getting in the way of them being independent. They also help establish healthy behaviour and an activity plan that helps them prepare for a return to work if possible.

The REACH programme has been increasing the number of clients it is helping over the last year. So far it has engaged with 61 clients, with eight of those getting a job and back into employment and three being helped into a training course to help them get back to work.

The REACH team

One woman, Sue (not her real name) has just got her dream job with a pet store after overcoming major health issues. The 33-year-old was on a health related benefit, had been suffering from stress and was unable to get a job as she could only cope with working 15 hours a week. The REACH team helped with her anxiety management and her joint pain and a living well coach assisted Sue to prepare her CV and provided interview training. After finding work experience Sue was able to secure a full-time job with a pet store and is delighted she found something so quickly.

Another client, Dave (not his real name) had been out of work for three years. Suffering from diabetes, the 50-year-old's self-confidence was at rock bottom and his health was getting worse. The REACH team were able to help with diet and exercise to improve his health, get him IT training, and assist with his CV/job applications. Dave has had some good responses and a couple of interviews, and is feeling positive about his future.

People who are out of work for a long time with physical health issues often find it affects their mental wellbeing, they get stuck in a rut and can't see a way out and it is a downward spiral. The REACH team is able to help these people find a job and improve their physical health, give them hope and a sense of purpose. REACH clients are so appreciative of this approach, having often tried many different methods in the past which haven't worked. If they are prepared to commit to the 12 week programme, the REACH team can make a big difference to their lives.

Workplace Support Persons launch in September 2017 – first group to complete their training

Staff safety culture

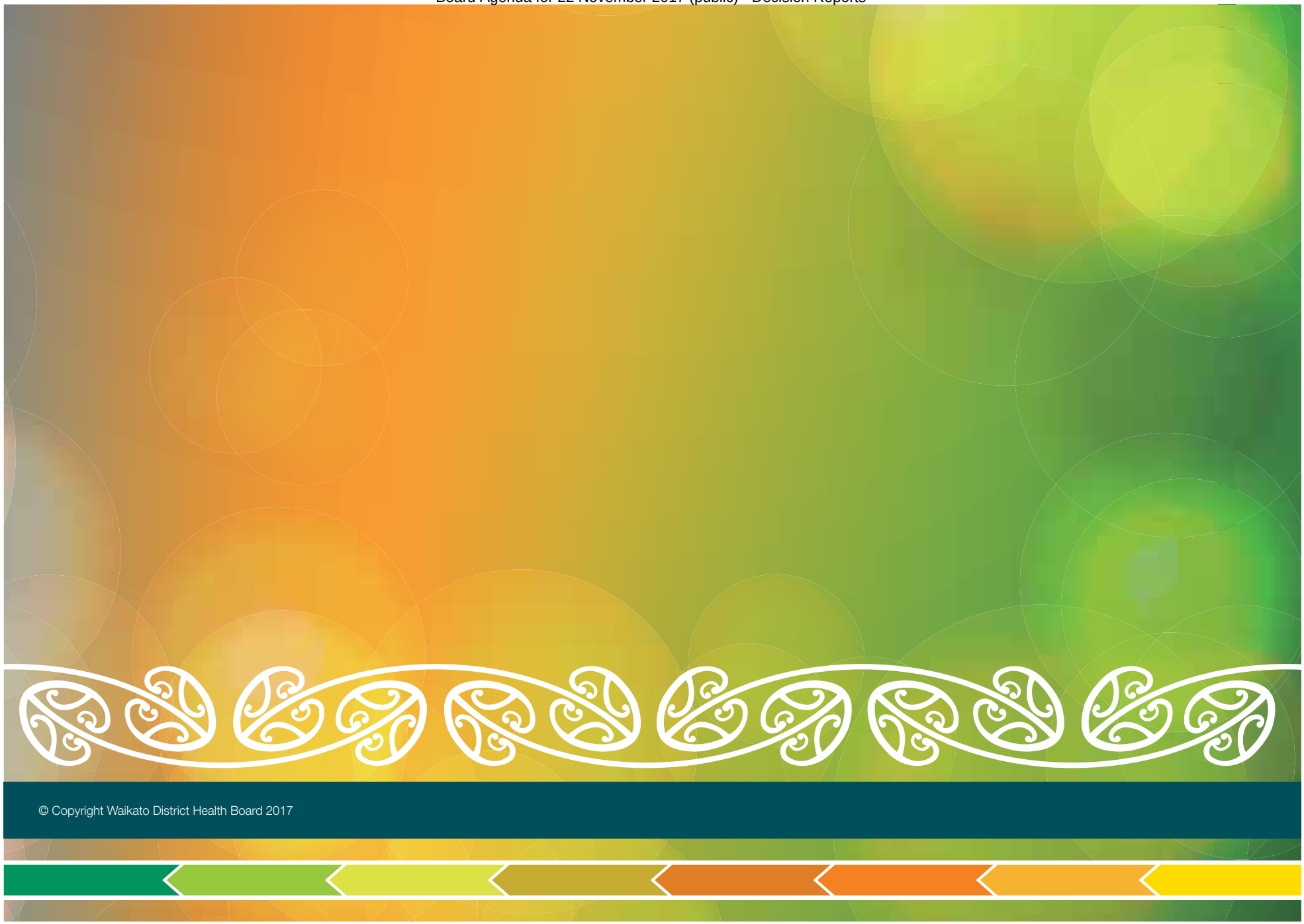
The staff safety culture group was set up in 2015 in response to staff views regarding workplace behaviours, staff wellbeing, values and various other issues.

It is important that staff have a way of raising concerns and that executive managers are able to hear their and respond to them, because a happy and safe working environment benefits all staff and the patients they care for.

A large number of surveys have been carried out across the organisation and the responses led to four priority areas and associated work streams being developed. The group meets regularly and group has wide representation from different staff from across the organisation, union members, health and safety, front line staff, human resources and executive members.

Four work streams were developed and are in progress, including:

- **Staff safety**
  - This relates to helping staff deal with challenging behaviours such as patient, visitor or staff aggression or violence
  - Supporting managers and local teams on hope to use tools and training to meet the needs of their staff and build a group of local champions who can support other staff in their workplace to develop good behaviour management skills
- **Values**
  - Developing, promoting and embedding new Waikato DHB values that staff can identify with and out into practice, helping to build a supportive, safe and constructive workplace and culture
  - Providing values workshops for staff across the DHB
  - Promoting behaviour that demonstrates the values
- **Perceived workplace bullying – or uncivil behavour**
  - Setting up a workplace support person (WSP) network. The scheme provides staff with a process to engage with peers and discuss their concerns confidentially with an unbiased person, before making a complaint. Training has been completed during 2017
  - Training provides the WSP with tools and skills to help staff deal with minor issues before they escalate and become more difficult to deal with
- **Wellbeing at work**
  - This is a free service which supports workplaces to 'work better through wellbeing' promoting long term strategies to explore what can be done within the organisation, physical environment or individual level to help staff become healthier.



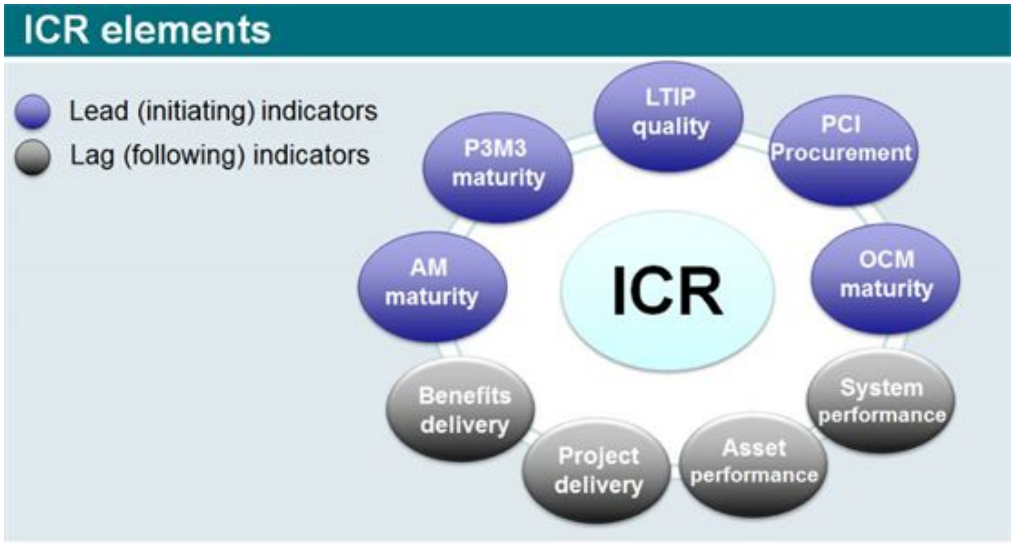
MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 6.2

ASSET PERFORMANCE INDICATORS

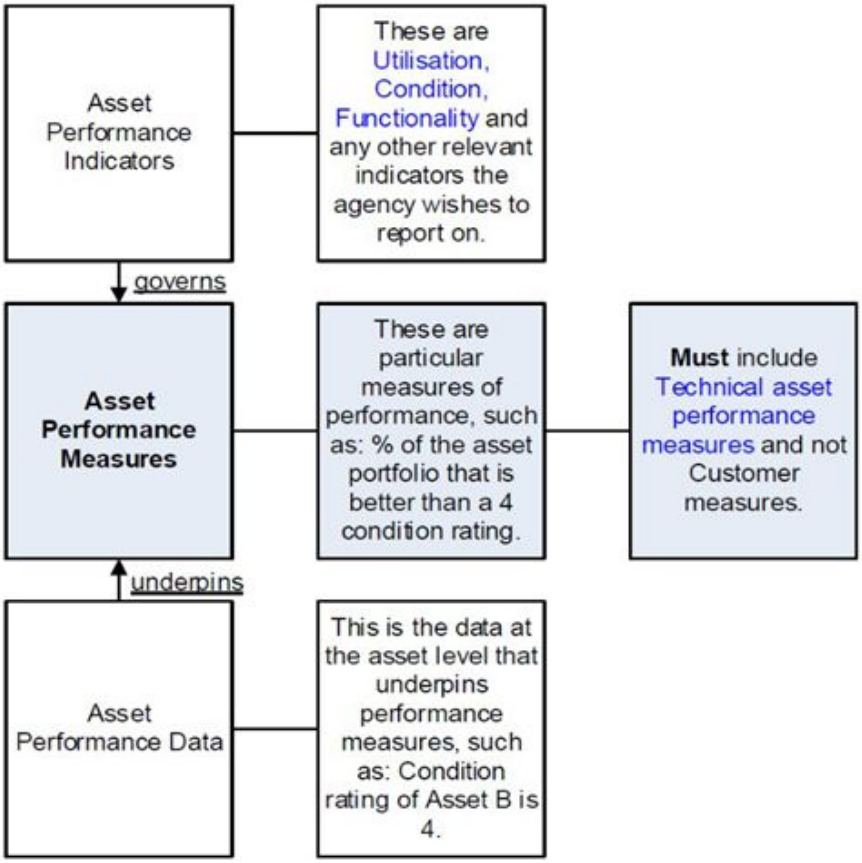
Purpose	For approval.

Waikato DHB is classed as an Investment Intensive Agency, and as a result is subjected to an Investor Confidence Rating (ICR) assessment by Treasury. The assessment is made up of nine elements, per the following diagram, which includes Asset Performance.



Robust asset performance measures are vital to effective asset management. It allows an organisation to assess how well it is meeting its expectations and objectives, both at an organisational and asset level. It provides a method for comparing performance across entities, and a tool for identifying and assessing areas for improvement and levels of service. This can lead to greater utilisation of Crown assets and helps ensure that assets meet needs more effectively. This in turn will allow Waikato DHB to provide more services at lower cost.

The definition and relationship between Asset Performance Indicators, Asset Performance Measures, and Asset Performance Data is as follows:



Waikato DHB assets have been grouped into

- Property
- Clinical and
- Information Communication and Technology (ICT) portfolios.

This grouping reflects our underlying asset management practices, and are those considered significant with regards to the delivery of core health services. Other assets have been excluded for reporting due to their lesser significance (criticality) to delivering our core services.

The ICR assessment in 2017 concluded that while the 2016/17 asset performance measures showed our assets often did not meet expectations, that at the time there were "some good asset performance measures in place." The measures and associated targets listed have been further refined with the business, Treasury and Ministry guidance, and with Waikato DHB's involvement in the "Asset Management Community of Interest (AMCOI)" national working group.

The attached table reflects our proposed Asset Performance Indicators and targets for the 17/18 financial year.

Recommendation
THAT
The Board approves the Asset Performance Indicators and Targets for the 2017/18 financial year.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

Waikato DHB

Asset Performance Indicators - Proposed Targets 2017/18

Reporting at a Portfolio level

Platform

Asset Portfolio Description	Asset Purpose	2017/2018		2016/2017	
		Quantity / Capacity	Net Book Value as at 01.07.17	Quantity / Capacity	Net Book Value as at 01.07.16
Property - Land & Buildings, Infrastructure Plant & Equipment & Fleet	To facilitate the delivery of Hospital Services through the establishment of purpose built Infrastructure and provision of building equipment & vehicles	135 owned Land & Buildings & 37 leased buildings, 24 clinical service vehicles	$644.6 m	135 owned Land & Buildings & 37 leased buildings, 24 clinical service vehicles	$458.4 m
Clinical	To facilitate the delivery of Hospital Services through the provision of fit for purpose clinical equipment	12,351 major clinical items	$51 m	12,345 major clinical items	$51.2 m
ICT = Information and Communication Technology	To facilitate the delivery of Hospital Services through the establishment of Computer Software and Hardware systems.	Over 2000 major computer hardware items with over 400 software apps / licence types supporting 6,622 staff	$15.9 m	Over 2000 major computer hardware items with over 400 software apps / licence types supporting 6,600 staff	$23.4 m

Asset Performance Indicators

Property and Fleet Performance measures

Asset	Measure	Indicator	2017/2018 Target	2017/2018 Target Explained
Waikato Campus buildings	Physical Waikato Campus buildings relative Earthquake risk	Condition	Greater than 77%	Waikato Campus buildings rated greater than score 6 or better per Holmes 2011 report which assessed portfolio for earthquake risk relative to current standard design & detailing. Where 6 = buildings that perform fairly well in a but have issues / vulnerabilities.
Waikato Campus Buildings - Core services within	Total physical down time (Hrs) for Core services at Waikato DHB as a % of total operating hours per annum	Condition	Less than 1%	Unplanned downtime for Core services Infrastructure Plant & Equipment, Lifts, Generators and Boilers at Waikato campus total operating hours calculated as = 8,736 hrs
Waikato Campus Buildings - Core services within	Total hours core services available (net of planned maintenance hours) / Total core services operating hours per annum.	Utilisation	Greater than 99%	Available hours less planned downtime Core services Plant & - Lifts, Generators, Boilers, availability at Waikato campus.
Waikato Campus Carparks	For the Waikato Hospital Number of mobility carparks as a % of total public car parking	Functionality	Greater than 5**%**	National standard measure for building functionality : There are 132 disability carparks out of 2280 available carparks across campus
Waikato Campus Buildings - Energy	**Energy Efficiency (savings) E**nergy savings per annum (Kwh /m2/year) across Hamilton campus buildings as a % of targeted consumption)	Functionality	Greater than 7 % saving	The calculation is provided by our energy consultant and presented at the quarterly Energy Management Group meeting. Total power used by all occupied buildings per annum versus Waikato campus buildings managed space usage, as measured Kwh /m2 per annum. Target is 464 Kwh /M2 against historical usage across Hamilton campus of 499 Kwh / M2

Clinical Performance measures

Asset	Measure	Indicator	2017/2018 Target	2017/2018 Target explained
CT Scanners & Linear Accelerators (Radiology & Oncology departments)	For Waikato hospital % of CT's and Linear's Accelerator's compliant with manufacturers specifications and Radiation Protection Act	Condition	100% compliant	For all CT's / Linear's Accelerator's Radiation certifications up to date, are compliant with Radiation Safety Act 2016 act and machines are functioning to manufacturers' specifications -external auditors provide confirmation.
CT Scanners - Radiology	For Waikato hospital Radiology CT planned patients versus actual patients scanned	Utilisation	Greater than 90% of planned volumes in planned time	Two CT Scanners: Mon - Friday 0800 to 16.30 then 1 CT Scanner on call Sat and Sun 0800 to 1700. 1 CT Scanner Mon - Friday 1630 to 1800. Planned utilisation 1 patient every 15 minutes or 74 patients per weekday and 64 patients over weekends. Total planned patients per week = 439 or 514 scans on average per week. A tolerance level of 10% set to allow for setups for non-standard scans.
Linear Accelerators-Oncology	For Waikato hospital Oncology LINAC available hours versus actual hours utilised	Utilisation	Greater than 86.40% of actual operating hours in planned time	For the Oncology Linear Accelerators K00364-367, Planned week day operating hours versus actual operating hours = 10 total hours (8am - 6pm) Monday - Friday less preventative maintenance plan per service contract. = 10,400 - 1406 =8,994 hours or 86.4%
Operating Theatres	For the Waikato hospital planned Theatre usage versus actual Theatre usage	Utilisation	Greater than 2016/2017 actual minutes achieved (to be revised once KEEZZ work has been concluded).	Day session Monday - Friday, Elective includes day acute list & acute sessions. Planned actual time (minutes) in Main Operating Theatres (22) per day when patient physically enters Op room. Target for 2017/2018 is 100% or better of 2016/2017 actual time.= 1,597,336 mins
Building facilities / theatres / clinical equipment	Outpatient Services across all Waikato facilities. Planned Outpatient services to be delivered versus Actual outpatient attendances	Utilisation	>= 212, 035 outpatient attendances.	Number of outpatients attending outpatient services. Planned contract number is 212,035

Clinical Performance measures (continued)

Asset	Measure	Indicator	2017/2018 Target	2017/2018 Target explained
Beds / Wards	For Waikato hospital Actual beds Occupied versus Planned bed Occupancy	Utilisation	Less than 93%	The data looks at all inpatient wards within CCTV/IM/Surgery/Orthopaedics/ Oncology/Paediatrics/ Women's Health/OPR and excludes Critical Care. Actual beds occupied (days) versus planned bed occupation (days) for 12 months from a total 214,255 available beds.
Theatres / Clinical Equipment	MOH Elective Surgery targets across Waikato DHB versus Actual Elective Surgery completed	Utilisation	Greater than 17,475 discharges	Per MOH Elective health target, includes patients who are: Domiciled in Waikato DHB, eligible for publicly funded treatment (not ACC) and are treated electively in any DHB in the relevant health speciality. MOH target is 17,475 patient discharges
CT scanners - Radiology	For Waikato hospital Radiology CT performing operationally to Hospital requirements	Functionality	Greater than 99% performed as per clinicians requirements.	CT scanners at Waikato Radiology / Oncology / Thames hospital are performing operationally as per clinician requirements, i.e. scan capability = requirements of Clinicians. This is measured through Clinician feedback where a 100% target = no negative feedback on CT capabilities

ICT Performance measures

Asset	Measure	Indicator	2017/2018 Target	2017/2018 Target explained
Laptops / Tablets / PC's	Physical % of Computers aged < 5 years	Condition	Greater than 90%	Computers = Tablets / PC's / Laptops. Target adjust due funding constraints "Tablets 11; nil life cycle, but all < 5 years old – 100%: Laptop 899; lifecycle is 3 years, but 883 < 5 years old – 98%: PC 4740; 4402 < 5 years – 92%. Average = 96.66%
Software systems	Physical Availability of Clinical IT systems across Waikato campus as a % of total hours, days per annum	Condition	Greater than 99.90%	Critical means Clinical systems: iPM = 100%, CWS = 100%, iSL = 100%, PACS = 99.79%. Average 99.95%.
Software systems	Number of IT system wide critical Priority 1 faults per annum	Condition	Less than 24	Priority 1 = Critical business impact - key service areas are unable to work or there is an IT security breach. There is no work around solution available and immediate restoration is required.
Software systems	Number of (relevant) users able to access clinical - non clinical system platforms remotely / total clinical non clinical staff	Utilisation	Greater than 30%	30% of total of 6,622 staff. Remote access = access to WDHB clinical / non clinical systems via Citrix software
Servers & storage facilities	% Of data centre server and storage assets used	Utilisation	Greater than 85%	Data storage target - subject to monthly capacity tracking & growth forecasting
Software & Network Systems	% Peak bandwidth usage	Utilisation	Less than 30%	Bandwidth target – Time IT systems running at peak through Core Network switches.
Software & Network Systems	Customer satisfaction with ICT measured on a 1 -10 scale	Functionality	Greater than 75%	6 monthly survey of senior business owners. Target of 75% = 7.5 on the IT customer satisfaction scale.
Software & Network Systems	Percentage of IT systems incidents resolved within agreed department service levels	Functionality	100%	All software and Wide Area Network bandwidth related incidents resolved as reported by Cherwell system

MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 6.3

PROPOSED ALLIANCING STRUCTURE FOR WAIKATO DHB

Purpose	For approval.

Current State
The Waikato DHB is currently engaged in four alliances in respect to primary care:

1. The Midland Region United Inter Alliance – (MURIAL) this alliance includes all DHBs and Primary Health Organisations (PHOs) in the Midland region and is focussed on integration opportunities across the region
2. The Midlands Health Network Alliance (regional four DHBs and Pinnacle)
3. The Hauraki Alliance
4. The National Hauora Coalition Alliance.

The DHB has also established a Waikato district Inter-Alliance meeting where each of the PHOs attend and discuss items of mutual interest alongside a representative from the Midland Community Pharmacy Group.

To address the population disparities within our own district and to improve the sustainability of our local services, it has been our view that a new approach to alliancing is required. One that brings multiple service delivery parties to the table, and has the focus to drive the strategic system and investment decisions we make across the Waikato health system.

We have therefore proposed establishing a new alliance with a mutually developed constitution/charter and work plan that would bring together the DHB, the PHOs and other critical service providers and community/consumer representatives. The focus of the alliance would align with the DHB strategy, along with a commitment to service integration in the Waikato and improving the health of the population.

The district wide Waikato alliance would also explore opportunities for:

- the development of clinical leadership
- focussed service design
- approaches for enhancing services
- service integration for local populations.

Waikato DHB had also previously proposed exiting the current alliancing arrangements to coincide with the establishment of the Waikato District alliance.

A formal proposal containing these changes has been provided to stakeholders and comment has been invited.

Following feedback from Pinnacle MHN and our Midland DHB partners particularly Taranaki that exiting the Pinnacle regional ALT would further damage relationships

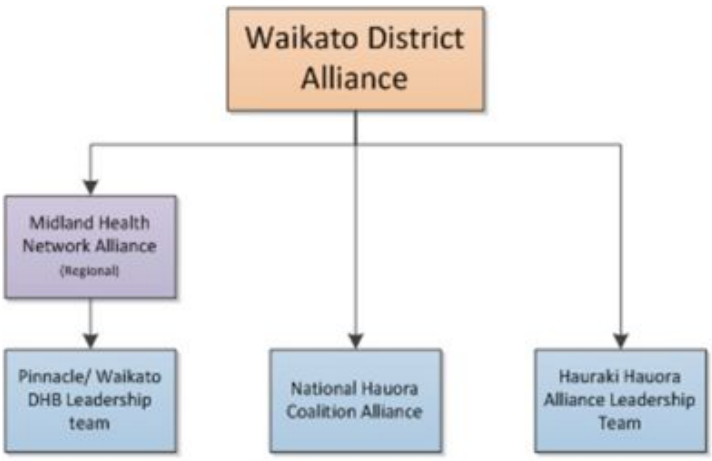
we have conisdered ways to proceed to a more effective alliancing arrangement without negatively impacting on regional arrangements.

The preferred option we have identified is to establish the Waikato District alliance with this alliance being our key alliance arrangement. Under this option the Waikato DHB would remain a member of all existing alliances under the following caveats:

- Waikato District Alliance would be confirmed as our key alliance arrangement. This would mean this is the alliance that has key sign-off and status. This alliance would need to approve all parts of our PHO alliance plans that have a district wide impact.
- In relation to the Midlands Health Network Alliance, this would mean details would need to be worked through with all partners to reflect that the DHBs Core Alliance arrangement is the Waikato alliance and that Waikato DHB would not sign-off significant changes without discussion with the Waikato Alliance.
- Pinnacle MHN/Waikato DHB leadership team meetings to ensure effective local engagement.
- MHN have confirmed that the proposed three year ALT plan would need to be renegotiated with all DHB partners in a more open way.

This approach has been developed as a compromise to try and maintain relationships and seek more effective planning for the Waikato population. It is proposed that this new approach would be trialled for 12 months to identify if this can assist in improved district wide planning and integration. It is further proposed that an evaluation occur with all parties to the MHN Alliance to identify the extent to which this regional Alliance is assisting the parties to improve the health outcomes for our populations.

The diagram below reflects this new local arrangement.



Recommendation
THAT
The Waikato DHB Board approves the revised approach.

DAMIAN TOMIC
CLINICAL DIRECTOR
PRIMARY AND INTEGRATED CARE

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

Finance Monitoring

MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 7.1

FINANCE REPORT

Purpose	For information.

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

Recommendation
THAT
The report be received.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Group Result for October 2017	Year to Date Group Actual $m	 Group Budget $m	 Variance $m	Group Budget Jun-18 $m
Funder	6.2	3.8	2.4 F	34.0 F
Governance	0.0	0.1	(0.1) U	0.2 F
Provider	(9.4)	(6.6)	(2.8) U	(44.7) U
Waikato Health Trust	(0.2)	0.0	(0.2) U	0.5 F
DHB Surplus/(Deficit)	**(3.4)**	**(2.7)**	**(0.7) U**	**(10.0) U**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

October 2017 YTD	Episodes			CWDS		
Acute	Actual	Plan	Variance %	Actual	Plan	Variance %
Surgical & CCTVS	5,805	5,847	-0.7%	10,048	10,045	0.0%
Medicine & Oncology	6,210	5,777	7.5%	7,461	6,987	6.8%
Child Health	3,451	3,493	-1.2%	2,184	2,360	-7.5%
Women's Health	2,932	3,232	-9.3%	1,682	1,706	-1.4%
	18,398	18,349	0.3%	21,375	21,098	1.3%

October 2017 YTD	Episodes			CWDS		
Elective	Actual	Plan	Variance %	Actual	Plan	Variance %
Surgical & CCTVS	5,051	5,441	-7.2%	7,129	7,728	-7.8%
Medicine & Oncology	217	376	-42.3%	159	219	-27.4%
Child Health	247	263	-6.1%	196	238	-17.6%
Women's Health	370	412	-10.2%	333	403	-17.4%
	5,885	6,492	-9.3%	7,817	8,588	-9.0%

Total Acute plus Electives	**24,283**	**24,841**	**-2.2%**	**29,192**	**29,686**	**-1.7%**

October 2017 YTD	Actual	Prior year	Variance
ED Attends	38,160	36,676	4.0%

MONTHLY COMMENTS

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

Delivery Plan Performance

We are making good progress on getting to a point of clarity re overall Planned volumes in order to allow for meaningful volume variance analysis and extrapolation into related cost variance analysis. Please note that whilst we have a detailed Price Volume Schedule as our key planned volume document, the level of detail here is not conducive to organisation wide analysis. In addition, a number of aspects require conversion in order to derive an organisation activity measure, such as caseweight equivalents for emergency department events and non caseweighted bed days. In addition, to be meaningful, we will accrue a caseweighted equivalent for patients not yet discharged at each month end – particularly relevant for long stay patients. Once we have this in place at both a planned and actual level, we will be able to explain volume variances as well as average length of stay variances and the mix impact between planned and actual.

Financial Performance Monthly Comment:

For October 2017 we have a unfavourable YTD variance to budget of $0.7m. However this result includes $1.2m one off favourable variances so a normalised result is $1.9m unfavourable. Furthermore,$22.2m of the centrally held savings plan, which contains high risk initiatives, is phased in the budget to take effect over the balance of the year.

Provider:

The Provider is unfavourable to budget $2.8m, variances include:

1. Revenue $0.4m favourable to budget due mainly to the reimbursement of NOS costs offset by unfavourable internal revenue as a result of lower elective volumes.
2. Employed personnel costs favourable to budget $5.9m due mainly to vacancies and leave taken. Partially offset in outsourced personnel costs.
3. Outsourced Personnel costs unfavourable $5.4m, the dominant variances relate to medical locums ($2.3m, partly offset by savings in medical personnel costs), nursing personnel ($0.7m) and Management and Administration $2.4m, due mainly to National Oracle Solution (NOS) contaractor costs $1.5m ($1.3m recovered in other government revenue) and vacancies (offset in personnel costs).
4. Outsourced Services favourable $1.2m due mainly to lower outsourcing of electives.
5. Clinical supplies unfavourable to budget $2.8m due mainly to treatment disposables and pharmaceuticals.
6. Infrastructure & Non Clinical supplies are unfavourable to budget $2.0m.
7. Interest, depreciation and capital charge unfavourable to budget $0.1m.

Funder and Governance:

The results for the Funder is $2.4 favourable to budget. This as a result of higher funding received across a number of areas and a favourable provider payments variance as a result of lower provider volumes, partially offset by unfavourable external provider payments. Governance is close to budget

Waikato Health Trust

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

RECOMMENDATION(S):

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

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Group Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$4.1 F**	
CFA Revenue		
CFA Revenue is favourable to budget mainly due to:		
● Increase in funding across In Between Travel (IBT), sleep over settlements and smoke cessation.	$0.4 F	Neutral
Crown Side-Arm Revenue		
Side-arm contracts revenue close to budget	($0.1) U	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is favourable to budget mainly due to:		
● Reimbursement of costs associated with the implementation of National Oracle Solution (NOS) $1.3m favourable (offset in Outsourced Personnel)	$3.7 F	Neutral
● ACC income $0.3m favourable which includes increases in income as a result of a change to a new annual contract.		
● Inter District Flow (IDF) income from other DHBs $0.5m favourable. Reason for variance under investigation.		
● Inter District Flow (IDF) income relating to 2016/17 $1.8m favourable. This as a result of the annual wash up of IDF activity across all DHBs. The final adjustment is not known until coding of all activity across all DHBs is completed. This variance is partly offset by an unfavourable variance on the IDF outflow wash up ($0.8m), which is included in NGO payments.		Favourable
Other Revenue		
Other revenue is close to budget.	$0.1 F	Favourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($4.8) U**	
Personnel (employees and outsourced personnel total)	**$0.5 F**	
Employed personnel are favourable to budget mainly due to:	$5.9 F	Neutral
● Medical costs are favourable to budget by $4.2m. This includes a higher than expected vacancy level, partly offset by an unfavourable annual leave movement for the year to date. This favourable variance is partly offset by outsourced personnel unfavourable variance.		
● Nursing costs are unfavourable to budget by $0.5m. This variance, along with the unfavourable outsourced personnel cost for nursing, is due to higher patient numbers entering ED (4% above plan), and a higher level of mental health inpatient services and acuity. There is also an unfavourable annual leave movement for the year to date.		
● Allied Health costs are favourable to budget by $0.7m. Variances are mainly as a result of higher than expected vacancy levels.		
● Management, Administration and Support costs are favourable to budget by $1.5m. Variances are spread across the DHB including clinical support and allied health, and are mainly as a result of higher than expected vacancy levels. Partially offset in Outsourced Personnel ($0.9m).		
Outsourced personnel are unfavourable to budget mainly due to:	($5.4) U	Neutral
● Medical personnel $2.3m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.		
● Nursing personnel $0.7m unfavourable. As for employed nursing personnel this is due to higher patient numbers entering ED (4% above plan), and higher level of mental health inpatient services and acuity and higher than budgeted patient watches.		
● Management, Administration and Support costs are $2.4m unfavourable largely due to contractor costs of $1.5m for the implementation of the new NOS ERP solution (to date $1.3m of this cost is offset by additional other government revenue) and management, administration and support vacancies (offset in favourable employed personnel variance).		
Outsourced services	**$1.2 F**	
Outsourced services are favourable to budget mainly due to:	$1.2 F	Neutral
● Outsourced clinical service costs are $1.1m favourable as facility lists run through external providers did not reach full capacity. This is reflected in total elective episodes being 9% below plan, despite in house throughput being to plan. There is a recovery plan in place to meet the elective services target.		
● Other favourable variances over a number of areas - $0.1m.		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Clinical Supplies	**($2.8) U**	
Clinical supplies are unfavourable to budget mainly due to:		
● Instruments & equipment - favourable to budget by $0.3m. These particular supplies are not volume related, and instead the variance is due to timing of ordering.	$0.3 F	Neutral
● Implants & prosthesis - favourable to budget by $0.2m. Reduced costs include high cost cardiothoracic devices for procedures that are no longer being completed on behalf of other DHB's.	$0.2 F	Favourable
● Treatment disposables - unfavourable to budget by $1.7m (8.9% of budgeted costs). High cost areas include theatres, blood, renal costs (renal dialysis 4% up on plan), and respiratory patient costs (case weights 9% up on plan).	($1.7) U	Unfavourable
● Pharmaceuticals - unfavourable to budget by $1.3m. Relates mainly to $0.9m unbudgeted increase in oncology drug costs. The Pharmac forecast included a lower usage assumption for new melanoma drugs.	($1.3) U	Unfavourable
● Diagnostic Supplies & Other Clinical Supplies - unfavourable to budget by $0.3m. Relates to pressure in several areas for diagnostic services (e.g. immunology, biochemist) across the hospital.	($0.3) U	Unfavourable
Infrastructure and non-clinical supplies	**($2.0) U**	
● Infrastructure and non clinical supplies - $1.0m favourable variance as a result of delays in moving in to new buildings. The net variance includes ongoing additional costs due to extended leases in existing buildings.	($2.0) U	Neutral
● Savings plan - $3.0m unfavourable variance in infrastructure relates to centrally held savings plan not specifically allocated. We continue to monitor closely actual savings achieved across the organisation.		
NGO Payments	**($1.6) U**	
External Provider payments are unfavourable to budget mainly due to:		
● Payments to providers are $1.4m unfavourable. This includes $2.1m relating to the under accrual of the 2016/17 Community Pharmaceutical budget. Other unfavourable variances arise due to timing, with payments not matching CFA revenue received. The most significant of these arrangements is for PHO system level measure capability. There is a partial offset in payments to mental health providers being favourable to budget by $1.0m due to a delay in commencement of a NGO contract.	($1.6) U	Neutral
● IDF out payments for the 2017/18 are $0.6m favourable. This continues to include coding being behind across all DHBs as a result of year end processes.		
● IDF out payments for 2016/17 are $0.8m unfavourable. As for IDF in receipts, this relates to the annual wash up of IDF activity across all DHBs. This final adjustment is not known until coding of all activity across all DHBs is completed. Variance is offset by a favourable variance on the IDF inflow wash up ($1.8m), which is included in Other Government and Crown Agencies Revenue.		
Interest, depreciation and capital charge	**($0.1) U**	
Interest charge is close to budget	$0.1 F	Favourable
Capital charge is close to budget	($0.1) U	Unfavourable
Depreciation is close to budget	($0.1) U	Unfavourable

TREASURY

Opinion on Group Result:

Cash flows are unfavourable to budget as detailed below.

YTD Actuals Oct-16 $'000	Waikato DHB Cash flows for year to October 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				
457,127	Operating inflows	497,194	488,695	8,498	1,438,153
(425,914)	Operating outflows	(468,340)	(451,864)	(16,476)	(1,396,156)
31,213	**Net cash from operating activities**	**28,854**	**36,831**	**(7,978)**	**41,997**
	Cash flow from investing activities				
528	Interest income and proceeds on disposal of assets	458	389	68	1,170
(8,643)	Purchase of assets	(12,627)	(18,352)	5,725	(55,056)
(8,115)	**Net cash from investing activities**	**(12,169)**	**(17,963)**	**5,793**	**(53,886)**
	Cash flow from financing activities				
0	Equity repayment	1	0	1	(2,199)
(2,886)	Interest Paid	(136)	(265)	129	(805)
(59)	Net change in loans	(129)	(98)	(31)	12,700
(2,945)	**Net cash from financing activities**	**(264)**	**(363)**	**99**	**9,696**
20,153	**Net increase/(decrease) in cash**	**16,421**	**18,505**	**(2,086)**	**(2,193)**
856	Opening cash balance	9,577	9,577	(0)	9,577
21,009	**Closing cash balance**	**25,998**	**28,082**	**(2,086)**	**7,384**

Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Total Net cash flow from Operating Activities	**($8.0) U**	
Operating inflows	**$8.5 F**	
Operating inflow is favourable to budget mainly due to:	$8.5 F	
○ Unbudgeted IDF 2016/17 wash-up revenue received in October $1.8m.		Favourable
○ Unbudgeted NOS implementation cost reimbursement ($1.3m), and ACC ($0.3m) funding due to the new annual contract.		Neutral
○ Income in Advance $1.9m higher than budgeted - Public Health contracts ($0.9m) funding received in October 2017, and net Pay Equity movement ($1.0m).		
○ Other operating inflow variance is due to timing of cash received compared to budget phasing and the impact of accounting treatment of debit balances included in payables in the YTD balances.		

Cash flow variances resulted from:	Variance $m	Impact on forecast
Operating outflows	**($16.5) U**	
Operating cash outflows for payroll costs are unfavourable mainly due to:		
○ Personnel costs are favourable against budget mainly due to higher than planned vacancies. Vacant positions are in many instances filled by outsourced personnel. Offset in unfavourable non payroll cash flows.	$8.7 F	Neutral
Operating cash outflows for non-payroll costs are unfavourable largely as a result of:	($27.2) U	
○ unfavourable operating costs including outsourced personnel (offset in personnel cost), clinical supplies, infrastructure & non clinical supplies and provider payments ($10.6m)		Neutral
○ higher prepayment balance due to timing of payments $0.9m.		
○ the timing of vendor payments against budget assumptions as the budget is evenly spread and the impact of accounting treatment of debit balances included in payables in the YTD balances.		
○ GST cash movement is favourable due to timing variances on GST transacted.	$2.0 F	Neutral
Net cash flow from Investing Activities	**$5.8 F**	
○ Interest received is close to budget.	$0.1 F	Favourable
○ Capital spend is slower than planned YTD. This is as a result of timing and spend is expected to be on budget for the year.	$5.7 F	Neutral
Net cash flow from Financing Activities	**$0.1 F**	
○ Cash flow from financing activities is close to budget.	$0.1 F	Neutral

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

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

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

As at 31-Oct-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	5,879	4,452	4,116	4,340	4,116	4,340	4,116	4,564	4,228	6,764	4,708	4,366	5,843
Funder inflow (MoH, IDF, etc)	145,326	133,756	133,046	128,366	128,366	132,480	126,810	126,810	131,490	130,880	130,880	135,560	130,880
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	2,015	2,530	2,400	2,415	2,185	2,415	2,185	2,645	2,300	2,530	2,645	2,300	2,645
Rents, ACC, & Sector Services	2,390	2,695	2,584	2,592	2,504	2,681	2,514	2,761	2,651	2,733	2,816	2,641	2,756
	155,610	143,432	142,146	137,713	137,170	141,916	135,625	136,780	140,669	142,907	141,049	144,867	142,124
Cash was applied to:													
Personnel Costs (incl PAYE)	(41,952)	(50,934)	(43,562)	(52,926)	(46,826)	(43,592)	(43,472)	(49,034)	(45,462)	(44,506)	(57,168)	(44,310)	(50,008)
Other Operating Costs	(32,691)	(34,100)	(35,900)	(30,100)	(27,000)	(34,200)	(30,900)	(37,433)	(34,300)	(32,426)	(31,824)	(33,122)	(30,524)
Funder outflow	(51,287)	(46,354)	(45,373)	(46,027)	(45,373)	(49,659)	(45,599)	(46,617)	(45,700)	(46,808)	(50,807)	(46,148)	(47,037)
Interest and Finance Costs	(11)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(12)	(10)	(25)	(25)
Capital Charge	0	0	(18,711)	0	0	0	0	0	(18,711)	0	0	0	0
GST Payments	(5,667)	(10,210)	0	(14,510)	(9,000)	(7,325)	0	(15,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)
	(131,607)	(141,608)	(143,556)	(143,573)	(128,209)	(134,786)	(119,981)	(148,304)	(151,394)	(130,962)	(147,020)	(130,816)	(134,805)
OPERATING ACTIVITES	**24,002**	**1,824**	**(1,410)**	**(5,861)**	**8,961**	**7,130**	**15,644**	**(11,524)**	**(10,725)**	**11,945**	**(5,971)**	**14,052**	**7,319**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	184	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
	184	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(2,717)	(3,500)	(3,500)	(2,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(3,500)
Investment in NZHPL (Finance project)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(2,717)	(3,500)	(3,500)	(2,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)	(3,500)
INVESTING ACTIVITIES	**(2,533)**	**(3,425)**	**(3,425)**	**(1,925)**	**(4,925)**	**(4,925)**	**(4,925)**	**(4,925)**	**(4,925)**	**(4,925)**	**(4,925)**	**(4,925)**	**(3,425)**
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from NZHPL	105,816	1,627	4,835	7,786	0	0	0	13,875	15,244	0	10,922	0	0
Finance Lease received	0	0	0	0	2,600	2,600	2,600	2,600	2,600	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	105,816	1,627	4,835	7,786	2,600	2,600	2,600	16,475	17,844	0	10,922	0	0
Cash was applied to:													
Capital Repayment	0	0	0	0	0	0	0	0	(2,194)	0	0	0	0
Transfer to NZHPL	(127,285)	0	0	0	(6,611)	(4,804)	(13,319)	0	0	(7,020)	0	(9,127)	(1,895)
Finance Lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	(127,285)	(26)	0	0	(6,637)	(4,804)	(13,319)	(26)	(2,194)	(7,020)	(26)	(9,127)	(1,895)
FINANCING ACTIVITIES	(21,469)	1,601	4,835	7,786	(4,037)	(2,204)	(10,719)	16,449	15,650	(7,020)	10,896	(9,127)	(1,895)
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	1	0	0	0	0	1	0	1,999
CLOSING CASH BALANCE	0	0	0	0	0	0	0	0	0	0	0	0	1,999
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	0	0	0	0	0	0	0	0	0	1,999
Funder Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Investment funds/(loan)													
NZ Health Partnerships Ltd (NZHPL)	19,031	17,404	12,568	4,782	11,393	16,198	29,517	15,642	398	7,417	(3,504)	5,623	9,517
Long-term Loans													
Finance Leases	0	0	0	0	(2,600)	(5,200)	(7,800)	(10,400)	(13,000)	(13,000)	(13,000)	(13,000)	(13,000)
EECA Loan	(247)	(221)	(221)	(221)	(195)	(195)	(195)	(169)	(169)	(169)	(143)	(143)	(143)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	18,784	17,183	12,347	4,562	8,598	10,804	21,522	5,073	(12,771)	(5,752)	(16,647)	(7,520)	(1,627)
LOANS AVAILABLE													
Working capital facility (NZHPL)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(66,968)	(66,968)	(66,968)	(66,968)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(66,968)	(66,968)	(66,968)	(66,968)

BALANCE SHEET

Opinion on Result:

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

Prior Year June 2017 $'000	Waikato DHB Group Financial Position	As at October 2017 Actual $'000	Budget $'000	Variance $'000	Budget Jun-18 $'000
88,517	Total current assets	93,197	91,212	1,985 F	65,434
(181,405)	Total current liabilities	(186,318)	(189,748)	3,430 F	(160,570)
(92,888)	**Net working capital**	**(93,121)**	**(98,536)**	**5,415 F**	**(95,136)**
736,618	Term assets	733,083	738,946	(5,863) U	739,628
(21,053)	Term liabilities	(20,757)	(20,697)	(60) U	(34,411)
715,565	**Net term assets**	**712,326**	**718,249**	**(5,923) U**	**705,217**
622,677	**Net assets employed**	**619,205**	**619,713**	**(508) U**	**610,081**
622,677	**Total Equity**	**619,205**	**619,713**	**(508) U**	**610,081**

Prior Year June 2017 $'000	Waikato DHB Group Ratios	As at October 2017 Actual $'000	Budget $'000	Achieved	Trend
64,198	Borrowing facilities available at month end	65,512	65,512	✓	⇔
0.5	Current ratio	0.5	0.5	✓	⇔
75.5%	Equity to total assets	74.9%	74.7%	✓	⇧
0.1%	Return on equity	-0.5%	-0.4%	✓	⇔

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is favourable to budget mainly due to:		
Current Assets		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $2.1m due to timing of receipts and payments.	**$2.0 F**	Neutral
• Total accounts receivable and accrued debtors is higher than planned by $3m largely due to the timing of cash received compared with budget assumptions.		
• Prepayments are higher than planned by $0.9 mainly due to the timing of annual IS spend.		
• Other favourable variances $0.2m.		
Current Liabilities		
• Payroll liabilities are $3m unfavourable mainly due to the timing of pay runs.	**$3.4 F**	Neutral
• Income in Advance $1.9m unfavourable to budget mainly due to unbudgeted pay equity settlement and Public Health Contract funds received in October.		
• GST $2.1m unfavourable to budget mainly due to the timing of processing of vendor invoices and unbudgeted income.		
• Other Current Liabilities are favourable to budget $10.4m mainly due to the variances arising from the actual timing of transactions.		
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $5.7m and unfavourable YTD depreciation $0.2m. Please see attached for latest forecast of capital spend for the year for further detail.	**($5.9) U**	Neutral
Non Current Liabilities:		
Close to provisional budget.	**($0.1) U**	Neutral
Equity:		
Driven mainly by variance in overall results.	**($0.5) U**	Neutral

CAPITAL EXPENDITURE AT 31 October 2017 ($000s)

Capital Plan					Cash Flow Forecast					Full Project Forecast		
Activity	Total Prior year Board Approvals	New Approvals FY17/18	Transfers During 17/18	Total Board Approved Capital Plans	Prior year expenditure for active Projects	Total Expenditure Forecast FY 17/18 (Actual + Planned)	Actual Expenditure YTD from 1 Jul-17 to 31 Oct 17	Approved and Planned Expenditure 01 Nov 17 - 30 Jun 18	Approved and Planned Spend Subsequent Years	Total Planned Expenditure (Actual + Forecast to Project completion)	Total Planned Expenditure Versus Total Board Approved	Commitments
Under $50K Subtotal		3,000		3,000		3000	558	2,442	0	3,000	0	727
Clinical Equipment Subtotal	17,533	20,354	-	37,887	7,918	16,750	2,992	13,758	12,689	37,357	530	3,516
Property & Infrastructure Subtotal	38,892	7,732	-	46,624	15,135	19,765	4,972	14,793	10,326	45,226	1,398	3,795
IS Subtotal	20,652	7,729	0	28,381	9,398	14,157	2,516	11,641	3,218	26,773	1,608	1,468
Corporate Systems & Processes Subtotal	1,000	8,325	0	9,325	290	2,516	164	2,352	6,525	9,331	-6	48
Regional Subtotal	9,419	798	0	10,217	270	9,947	2,259	7,688	0	10,217	0	114
MOH Subtotal	125	0	0	125	0	0	0	0	0	0	125	0
Trust Funded Subtotal	0	0	0	0	0	0	0	0	0	0	0	0
Savings to be manged during 17/18 approval process						-11,078		-11,078		-11,078	11,078	
REPORT TOTALS	87,621	47,938	0	135,559	33,011	55,056	13,460	41,597	32,758	120,825	14,734	9,669

Waikato DHB
CAPITAL EXPENDITURE AT 31 October 2017 ($000s)

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
Echo Ultrasound Machine Replacement / Portable	600	599	-	2
CT Machine Replacement Waikato x3	3,553	1,106	2,447	0
CT Machine Replacement Waikato x1	725	33	692	(0)
Cytogenetics Digital Imaging system	800	323	477	-
PCA Pumps (Biomed)	500	421	79	-
Combi Diagnost Fluoroscopy Unit	619	603	16	0
Ventilators (Critical Care)	400	-	400	-
Endoscopes	300	-	300	-
Glucose meters	275	-	275	-
Other items - identfied per Clinical asset review	1,000	-	1,000	-
New MCC Theatre (Ceasar Theatre) - clinical equipment components	616	-	616	-
Mobile Dental Unit Replacements - level 2	600	-	600	-
X-ray mobile (Taumarunui)	300	-	300	-
X-ray mobile (Te kuiti)	300	-	300	-
X-ray mobile (Thames)	300	-	300	-
X-ray mobile (Tokaroa)	300	-	300	-
Bed Replacement Programme	400	-	400	-
Digital Mobile X-Ray	600	-	600	-
X-ray general (Radiology ED Room 1)	350	-	350	-
X-ray general (Radiology MCC Room 5)	350	-	350	-
Mobile Image Intensifier - Waikato	300	-	300	-
Microscope - Platics- Plastics Theatre	300	-	300	-
Linear Accelerator (replacement)	4,000	-	4,000	-
Anaesthetic machine - Aisys Carestation	380	-	380	-
Heart Lung Machines	680	-	680	-
Vascular & Interventional Replacement	1,750	-	1,750	-
General X-Ray replacement Thames	700	-	700	-
Biochemistry main Analysers	900	-	900	-
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	-	825	-
Trauma Gantry (radiology)	350	-	350	-
Projects Removed to be capitalised	7,716	7,647	-	69

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
Other Clinical Services Projects Budgeted <$250K	9,378	736	8,183	460
Clinical Equipment Subtotal	40,887	11,467	28,889	530
Property and Infrastructure				
Mental Health Facility - scoping	606	139	467	0
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Gallagher Build - Fitout	4,238	2,765	1,408	65
Gallagher Building - Med Store & CSES Clinic	406	-	406	-
Gallagher Building - Racking System	362	175	187	0
Gallagher Building - Converyor System	348	247	100	1
SCEP racking - hospital wide	400	-	400	-
Hamilton Consolidation of CBD facilities - 9th Floor	894	894	-	-
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	837	8,287	(0)
Hamilton CBD - Collingwood Street Development - First Floor	5,584	52	5,532	(0)
ED - Reconfiguration of entry / Front of House (Potential substitution for ED Expansion)	400	-	400	-
Menzies L3 development (Potential substitution for ED Expansion)	450	-	450	-
Pain Clinic to L8 Menzies (Potential substitution for ED Expansion)	450	-	450	-
New MCC Theatre (Ceasar Theatre)	697	-	697	-
Hilda Ross - Remediation	2,080	2,057	23	0
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	-	550	-
Hague road carpark - Seismic and Beam support	375	-	375	-
Urology to L8 Menzies	320	1	320	(1)
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Waikato Hauora iHub	268	25	243	(0)
Waikato switchboard upgrades core buildings	675	-	675	1
Infrastructure Replacement Pool (17/18)	600	-	600	-
Infrastructure Replacement Pool (15/16)	600	705	26	(131)
Infrastructure Replacement Pool (16/17)	641	169	40	432
OCB Replacements	350	-	350	1
Waikato Distribution Boards	250	213	37	-
Lift car upgrades	1,835	2,059	-	(224)
Electrical Systems Improvement	6,714	5,965	749	0
Food & Nutrition Software	921	25	921	(25)
Projects Removed to be capitalised	2,932	3,174	2	(244)
Other P&I Projects Budgeted <$250K	3,004	509	2,532	(37)
Property & Infrastructure Subtotal	46,624	20,107	25,119	1,398
Regional				

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
HSL - eSpace Programme	4,994	2,149	2,845	(0)
National Oracle Solution / Elevate	4,399	380	4,019	0
Other Regional Projects Budgeted <$250K	824	-	824	-
Regional Subtotal	10,217	2,529	7,688	(0)
MOH & Trust Funded				
National Patient Flow Phase 3	377	240	147	(10)
Telestroke Pilot	449	42	272	135
16/17 Trust Account	303	303	-	(0)
Other MOH & Trust Funded Projects Budgeted <$250K	(1,004)	(585)	(419)	-
MOH & Trust Subtotal	125	(0)	-	125
Information Systems				
Platform	2,688	286	2,402	(0)
Storage & Reporting	738	318	427	(7)
Network & Communications	3,735	1,550	2,187	(2)
IAAS	1,686	483	1,203	0
Devices	2,253	386	1,867	(0)
Licensing	1,154	217	937	-
Enterprise Service Business	937	127	811	(1)
Tools	3,324	1,449	1,883	(8)
Security	817	92	725	0
Clinical Systems	7,112	3,284	3,865	(36)
Other Projects	485	399	247	(161)
CORPORATE SYSTEMS & PROCESSES	9,325	454	8,877	(6)
Projects to be Capitalised	3,452	3,323	-	129
IS Savings required			(1,694)	1,694
IS Subtotal	37,706	12,368	23,736	1,602
Savings to be managed during 17/18 approval process			(11,078)	11,078
Grand total	**135,559**	**46,471**	**74,355**	**14,734**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
OCTOBER 2017

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

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

Travel costs - Executive Group	Month			Year to Date			
October 2017	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AYDON LYDIA HELEN MS	25.00		25.00	152.87		152.87	
CHRYSTALL MAUREEN MS	-		-	422.49		422.49	
HABLOUS NEVILLE MR	557.25		557.25	557.25		557.25	Detail below
HACKETT DARRIN MR	-		-	126.35		126.35	
HAYWARD SUSAN MRS	307.00	245.00	552.00	1,605.99	3,144.68	4,750.67	Training related $2,779
LAWRENSON ROSS PROF	-		-	353.63		353.63	
MALONEY TANYA	(156.43)	131.20	(25.23)	156.62	1,264.17	1,420.79	
MURRAY NIGEL MR	0.00		0.00	6,478.89	(499.90)	5,978.99	Detail below
NEVILLE MAUREEN MS	262.09		262.09	698.05		698.05	
PARADINE BRETT MR	-		-	231.39		231.39	
STRAITON,DONNA MAREE	52.16		52.16	52.16		52.16	
TER BEEK MARC MR	-		-	551.58		551.58	
TOMIC DAMIAN MR	252.97		252.97	2,585.24		2,585.24	
WATSON TOM MR	-		-	426.73		426.73	
WILSON JULIE MS	459.13		459.13	1,659.26		1,659.26	
WOLSTENCROFT IAN	-		-	146.96		146.96	
WRIGHT DEREK MR	52.17		52.17	52.17	63.48	115.65	Detail below
Taxi	-		-	350.63		350.63	Largely N Murray
Grand Total	1,811.34	376.20	2,187.54	16,608.26	3,972.43	20,580.69	

CE Travel Expenditure: Nigel Murray

Travel charges for the year to 31 October 2017				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
8 to 12 April 2017	1,084.40	CEO activity	Accommodation 4 nights	Auckland
20 to 23 April 2017	940.12	Meetings with officials and organisations re Waikato Med School	Accommodation, 3 nights	Wellington
27 April to 1 May 2017	275.70	Cairns - Waikato Med School, Sydney - Theatres/surgical performance	Accommodation, 1 night	Sydney
7 to 9 May 2017	430.09	Waikato Medical School	Accommodation, 2 nights	Wellington
18 to 20 May 2017	330.68	Speaker - Healthcare Reform conference	Accommodation, 2 nights	Wellington
14 to 15 June 2017	744.86	Presentation Medical School to DHB Chairs/CEs	Airfare (return), accommodation, 1 night	Wellington
25 to 26 June 2017	1,433.59	Meeting with Lance O'Sullivan re Smarthealth	Airfare (return), accommodation, 3 nights	Kaitaia
2 to 4 May 2017	665.31	Meetings re Smarthealth (2/5) and Medical School (3/5)	Accommodation, 2 nights	Auckland
25 to 26 May 2017	478.05	Procurement meeting 25/5, Pharmac 26/5, returned late to Auckland	Accommodation, 2 nights	Auckland
Aug 2017	(403.81)	Corrections from Tandem Travel	Airfares - corrections to original charges Sept 16	Sydney
	5,978.99			

Acting CE Travel Expenditure Neville Hablous

Travel charges for the year to 31 October 2017				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
7 Sept 2017	557.25	National DHB CE meeting	Airfare (return)	Wellington

Interim CE Travel Expenditure Derek Wright

Travel charges for the year to 31 October 2017				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
October YTD	115.65	Prior to CE appointment	Prior to CE appointment	

MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 7.2

2017/18 LONG TERM FINANCIAL MODEL AND CAPITAL PLAN SUMMARY

Purpose	This paper requests the Long Term Financial Model and Capital Plan Summary be noted.

Long Term Financial Model

The September Board papers included the 2017/18 Operating Budget paper reflecting the DHB Consolidated Financial Statements derived from the Long Term Financial Model. As approved by the Board the Statement of Comprehensive Income and the Balance Sheet are presented in Appendix A. These statements include the adjustment for the depreciation impact of the fixed assets revaluation which has resulted in a $10m deficit budget for 2017-18 and flow on effect on subsequent years.

It should be noted that the 2017/18 result incorporates $14m savings plans devolved to functional areas and $25m savings plans held centrally – subsequent years assumes these savings are achieved and are sustainable and indeed further savings are achieved – these will rely heavily on the outcome of the strategic refresh in order to manage the tension between increasing clinical demand within constrained funding envelopes.

Key points of note are:

- The Statement of Cashflows reflects a capital spend that is considered affordable based on free cashflow from operations and finance leasing.
- Additional capital requirements beyond this level will require additional equity injections or fairly material finance leases, the servicing of which has not yet been incorporated as the latter years need further work in order to be firmed up.
- These additional funding requirements are relevant to 2018-19 onwards – note the additional $18m funding required for 2018/19 in Appendix B.

Capital Plan

The Capital Plan summary for 2017/18 is as follows

High Level Summary	Cashflow 2016-17	Capital Plan Approvals 2017-18	Cashflow on Previously approved	Cashflow on New Approvals	Total 2017-18 Cashflow
SPO and Property & Infrastructure	$6,324	$7,732	$12,439	$7,311	$19,750
Information technology	$12,385	$16,054	$10,313	$6,360	$16,673
Regional	$2,836	$797	$9,149	$797	$9,946
Clinical Equipment	$12,842	$23,354	$9,083	$10,665	$19,748
	$34,387	$47,937	$40,984	$25,133	$66,117
Contra: To be managed during 2017-18 approval processes					-$11,061
					$55,056

Key points of note are:

- Capital spend (cashflow) for 2016/17 was $34m.
- New Approvals during 2017/18 are $48m, with related cashflow in 2017/18 of $25m.
- Cashflow total for the Capital Plan for 2017/18 is $55m.
- To be funded from $42m free cashflow and $13m finance leases.

Capital Plan process

- The capital plan has been created through consultation across the organisation with a goal of being within a constrained capital spend of $55m for 2017/18.
- This $55m capital spend and the related finance leases are reflected in the Financial Statements in Appendix A.
- The Consolidated Statement of Cashflows reflects that we remain well within our working capital facility of circa $65m – it should be noted that this working capital facility is not permitted to be applied to the purchase of fixed assets beyond free cashflow from operations.
- The capital plan for 2017/18 has not been fully landed within this constraint – similar to the prior year.
- The required contra of $11m will be managed through the approval process to ensure that we stay within our authorised limits.
- A great deal of detailed work has been done in order to create an evidence based capital replacement schedule across the circa 12,000 clinical equipment line items – this work has not landed a definitive result yet, but will continue at pace in order to inform the current year prioritisation process and to better inform future years.
- A great deal of work has also been done in the context of Information Technology projects in order to ensure we apply our constrained cash as well as constrained access to skilled IT professionals to deliver the maximum benefits whilst ensuring we also address compliance and risk aspects – more work is required in this space.
- Obviously, the specificity diminishes over time, thus a line item has been added into later years in order to ensure the total planned spend for each category reflects a reasonable expectation of reality, reflected as Baseline.

Capital Plan amendments

We propose to continue to manage any amendments to the capital plan as follows:

- The total amount of the Board approved capital plan may not be exceeded in terms of cashflow in the year, without prior Board approval.
- Within this over-riding constraint, management may add in line items up to the value of $500k, providing the required internal approval processes have been complied with.
- Any new items greater than $500k, must have prior Board approval.
- The permanent removal of line items from the capital plan must have Board approval.

This is a continuation of the approval at the May 2016 board meeting.

Risks

- The main risk related to the $11m required contra relates to the effectiveness of prioritisation rather than our ability to constrain capital spend to the $55m.
- The $42m planned to be funded from free cashflow is directly dependent on our delivery of the operating budget – any adverse variances in this regard will have a direct impact on our ability to fund the capital plan.
- There is some degree of risk related to access of finance leases, albeit small
- The financials after 2017/18 will deteriorate once the impact of the additional funding requirements have been added which will further increase savings targets.
- There is an operational and clinical risk if we don't find a way to fund the replacement schedule.
- The years beyond 2017/18 reflect material risks in terms of access to funding, which will need to be actively addressed over the coming months.

Next steps

- Continue the longer term campus plan deliberations, aligned to the strategic refresh, in order to be clear about the longer term campus development needs and high level costs.
- Continue the detailed work across the circa 12,000 clinical equipment items in order to achieve an agreed, detailed replacement schedule for future years.
- Transition all assets onto the Oracle Enterprise Asset (EAM) manager module once the National Oracle Solution has been deployed for the Waikato DHB. Noting that as Oracle will be a national system deployment of the EAM module will have some dependency on the National Oracle programme of work, which we will attempt to influence as best we can in order to achieve this goal.
- Enhance our Project, Programme and Portfolio Management (P3M3) capability to ensure we are prioritising and starting and stopping projects within an appropriate framework that recognises return on investment and risk mitigation. Improvement in P#M# capability is also required to improve our Investor Confidence Rating (ICR).
- Engage with the Ministry of Health regarding the longer term funding requirements with a goal of agreeing an outline of such funding over time and the timing of the development of relevant business cases to achieve access to the required funding.

Recommendation
THAT
The Board

1. Receives this report
2. Notes the Long Term Financial Model aspects, specifically the dependency on achieving savings plans in 2017/18 and onwards and the projected requirement for additional funding for the capital plan in 2018/19 onwards.
3. Recognises the Risks set out above.
4. Recognises the outline of Next Steps above.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

Appendix A

DHB Consolidated Statement of Comprehensive Income 2015-16 to 2020-21						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
REVENUE						
MOH Devolved Funding	($1,094,144)	($1,144,436)	($1,203,798)	($1,242,320)	($1,282,073)	($1,323,101)
MOH Non-Devolved Contracts (provider arm side contr	($33,000)	($33,838)	($32,955)	($33,779)	($34,623)	($35,489)
Other Government (not MoH or other DHBs)	($22,423)	($22,982)	($20,942)	($21,468)	($22,005)	($22,555)
Non-Government & Crown Agency Sourced	($23,145)	($22,894)	($22,292)	($22,842)	($23,405)	($23,980)
Inter-DHB & Internal Revenue	($129,177)	($133,263)	($139,105)	($142,948)	($146,717)	($150,469)
REVENUE TOTAL	($1,301,891)	($1,357,413)	($1,419,093)	($1,463,357)	($1,508,823)	($1,555,594)
EXPENSES						
Personnel costs						
Medical Personnel	$158,174	$161,809	$183,606	$190,033	$196,683	$203,567
Nursing Personnel	$198,292	$207,587	$216,489	$224,066	$231,908	$240,025
Allied Health Personnel	$72,651	$75,155	$80,253	$83,061	$85,968	$88,977
Support Personnel	$16,194	$16,560	$17,299	$17,646	$18,000	$18,358
Management/Administration Personnel	$70,685	$75,931	$80,606	$81,966	$83,362	$84,780
Outsourced Services	$61,715	$78,420	$78,126	$78,908	$80,484	$82,092
Clinical Supplies	$129,109	$135,599	$136,778	$135,425	$136,991	$138,983
Infrastructure & Non-Clinical Supplies	$70,393	$82,529	$63,391	$52,601	$35,372	$17,626
Sub-Total Payments to Providers	$457,075	$463,749	$484,348	$520,432	$560,130	$601,611
Internal Allocation	$0	$0	$0	$0	$0	$0
EXPENSES TOTAL	$1,234,287	$1,297,339	$1,340,897	$1,384,137	$1,428,899	$1,476,019
NET RESULTS (Surplus)/Deficit	($67,604)	($60,074)	($78,196)	($79,220)	($79,924)	($79,575)
Interest, Depriciation and Capital Charge						
Interest						
Interest Income	($1,882)	($1,839)	($1,170)	($1,570)	($1,619)	($1,668)
Interest Expenses	$8,814	$4,899	$198	$199	$201	$202
Total Interest	$6,932	$3,060	($972)	($1,371)	($1,418)	($1,466)
Capital Charge	$18,124	$15,188	$37,123	$37,494	$36,244	$32,969
Depriciation	$38,560	$40,216	$52,039	$53,192	$55,396	$58,575
Total IDCC	$63,615	$58,464	$88,191	$89,315	$90,222	$90,078
TOTAL COMPREHENSIVE INCOME	($3,988)	($1,610)	$9,995	$10,095	$10,297	$10,503

DHB Consolidated Statement of Financial Position 2015-16 to 2020-21

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Current Assets						
Petty Cash	$16	$16	$15	$15	$15	$15
Investments	$5,467	$7,020	$9,563	$7,369	$7,884	$8,411
Debtors	$39,660	$38,120	$60,521	$47,188	$47,518	$47,850
Inventory / Stock	$9,977	$10,384	$11,006	$10,862	$10,938	$11,015
Current Assets Total	**$55,120**	**$55,540**	**$81,105**	**$65,434**	**$66,355**	**$67,292**
Non Current Assets						
Fixed Assets	$573,369	$551,156	$710,913	$1,078,879	$1,075,884	$1,072,889
Work in Progress	$7,129	$10,007	$18,453	$18,453	$18,453	$18,453
Investment in Associates and Subsidiaries	$7,266	$7,254	$7,252	$7,252	$7,252	$7,252
Other Investments (Loans)	$0	$0	$0	$0	$0	$0
Non Current Assets Total	**$587,763**	**$568,417**	**$736,618**	**$1,104,584**	**$1,101,589**	**$1,098,594**
Current Liabilities						
Bank Account & Term Loans	($8,928)	$0	$0	($4)	($105)	($407)
Accounts Payables and Accruals	($67,946)	($56,453)	($68,505)	($53,151)	($53,521)	($53,896)
Payroll Creditors	($98,760)	($98,529)	($105,488)	($107,418)	($111,457)	($115,328)
Current Liabilities Total	**($175,633)**	**($154,982)**	**($173,993)**	**($160,573)**	**($165,083)**	**($169,631)**
WORKING CAPITAL	**($120,514)**	**($99,442)**	**($92,888)**	**($95,139)**	**($98,728)**	**($102,339)**
NET FUNDS EMPLOYED	**$467,250**	**$468,975**	**$643,731**	**$1,009,445**	**$1,002,861**	**$996,255**
Non-Current Liabilities						
Employee - Other Entitlements	($14,076)	($14,637)	($13,505)	($13,774)	($13,870)	($13,967)
Term Loans - Private (non-current portion)	($299)	($199)	($510)	($13,294)	($11,964)	($10,768)
Term Loans - Crown (non-current portion)	($212,036)	($211,932)	($169)	($76)	($15)	$0
Other Loans	($5,980)	($6,098)	($6,870)	($7,266)	($7,769)	($8,283)
Non-Current Liabilities Total	**($232,391)**	**($232,866)**	**($21,053)**	**($34,410)**	**($33,619)**	**($33,018)**
Crown Equity						
Crown Equity	($81,662)	($79,467)	($77,273)	($286,737)	($284,543)	($289,349)
Capital Injections	$0	$0	($211,659)	$0	($7,000)	($7,000)
Other Movements	$1,856	$2,400	$2,591	$2,310	$2,313	$2,311
Revaluation Reserve (Sum of 9926 -9929)	($83,411)	($84,951)	($261,187)	($626,131)	($626,131)	($626,131)
Retained Earnings	($71,643)	($74,091)	($75,150)	($64,476)	($53,881)	($43,068)
Crown Equity Total	**($234,859)**	**($236,109)**	**($622,677)**	**($975,034)**	**($969,242)**	**($963,237)**
NET FUNDS EMPLOYED	**($467,250)**	**($468,975)**	**($643,730)**	**($1,009,444)**	**($1,002,861)**	**($996,255)**

DHB Consolidated Statement of Cashflows 2015-16 to 2020-21						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Operating Activities						
Government and Crown Agency Revenue Receive	$1,250,302	$1,307,304	$1,375,876	$1,414,839	$1,459,104	$1,504,648
Other Revenue Received	$49,313	$27,046	$47,064	$48,235	$49,434	$50,659
Total Receipts	**$1,299,615**	**$1,334,351**	**$1,422,941**	**$1,463,074**	**$1,508,538**	**$1,555,307**
Payments for Personnel	($515,665)	($531,215)	($576,053)	($592,637)	($611,953)	($631,861)
Payments for Supplies	($268,882)	($284,967)	($283,472)	($266,131)	($252,039)	($237,887)
Capital Charge Paid	($18,124)	($15,188)	($37,123)	($37,494)	($36,244)	($32,969)
Payments to Providers	($457,396)	($462,542)	($484,296)	($520,379)	($560,077)	($601,557)
Total Payments	**($1,260,067)**	**($1,293,912)**	**($1,380,944)**	**($1,416,640)**	**($1,460,312)**	**($1,504,273)**
Net Cashflow from Operating	**$39,548**	**$40,439**	**$41,997**	**$46,433**	**$48,225**	**$51,033**
Investing Activities						
Interest receipts 3rd Party	$2,004	$1,839	$1,170	$1,570	$1,619	$1,668
Sale of Fixed Assets	$0	$40	$0	$0	$0	$0
Total Capital Expenditure	($19,226)	($32,178)	($55,061)	($50,198)	($52,401)	($55,580)
Increase in Investments and Restricted & Trust Fur	$12	$1	$1	$0	$0	$0
Net Cashflow from Investing	**($17,210)**	**($30,297)**	**($53,890)**	**($48,628)**	**($50,782)**	**($53,912)**
Financing Activities						
Equity Injections - Capital	$0	$211,659	$0	$7,000	$7,000	$7,000
Equity Injections - Deficit Support	$0	$0	($5)	$0	$0	$0
Interest Paid	($9,413)	($5,488)	($805)	($810)	($816)	($821)
Private Sector	($51)	$187	$12,792	($1,328)	($1,193)	($1,073)
Crown Debt	($199)	($211,763)	($93)	($60)	($14)	$1
Other Equity Movement	($2,194)	($2,194)	($2,194)	($2,194)	($2,194)	($2,194)
Net Cashflow from Financing	**($11,857)**	**($7,599)**	**$9,696**	**$2,609**	**$2,782**	**$2,912**
Net Cashflow						
Plus: Cash (Opening)	($3,445)	$7,036	$9,578	$7,380	$7,795	$8,020
Net cash movements	$10,481	$2,542	($2,198)	$414	$226	$33
Cash (Closing)	$7,036	$9,579	$7,380	$7,795	$8,020	$8,054

Presentations

No presentations this month.

Papers for Information

MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 9.1

HEALTH TARGETS REPORT – IMMUNISATION

Purpose	For information.

This update on the Immunisation Health Target has been provided noting the concerns in relation to continued under-performance highlighted at the October 2017 meeting. Of particular concern is the deterioration of the result for children identifying as Maori.

Health Target Results - Summary Table

Description	Target	Previous Qtr Official	Latest Qtr Offical (provisional)	Target Achieved Y/N?	DHB Ranking (provisional)	Local Data latest result
Increased Immunisation	95%	89%	88%	N	15th	89.4%

Target: Increased immunisations for 8 months

Table 2 – 8mnth Miulestone Immunisation Results by Quarter

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

Data for this target is reported on a three month rolling basis. Graph 4 shows our most recent result of 89% for the three month period from 1 Aug 2017 to 31 Oct 2017.

As noted at the October meeting increasing coverage for Māori infants is a key priority and there is concern in relation to the significant reduction reported. We have been advised that the trend in reduction of immunisation rates for Maori has occurred in other DHBs to a lesser extent with the national average for Maori babies reducing from 90.37% in Q3 2016/17 to 87.05% in Q1 2017/18. This national 3.32% reduction compares with the 7% reduction experienced in Waikato over this period.

The Ministry of Health is carrying out work to identify how the current downward trends for Māori babies, can be addressed. The Ministry aims to work alongside all DHBs to develop solutions.

There is currently a 2% difference in performance between our two large PHOs (Midlands Health Network (92% coverage and Hauraki PHO 90% from August to October) however neither PHO is meeting the national target of 95%. Given that the unenrolled population have had significantly lower immunisation rates the PHO populations would need to exceed 95% in order for the target to be achieved.

The decline/opt off rate for the Waikato district at 6.1%% is 2.1% higher than this time last year. The negative publicity around vaccination may have had an impact of this result. The Ministry has provided promotion material on positive immunisation messages and a communication tool kit specifically for the Waikato district which has been sent out to all stakeholders to adapt and use.

Waikato DHBs continued non achievement of the immunisation target and need for "Remediating our Immunisation Performance" was a key item discussed at the Inter-Alliance forum in October alongside the reporting around the Waikato Child Co-ordination service. The key overall question asked of Inter-Alliance members is *"Are our current structures effective and what changes we might consider to address performance?".* A copy of the presentation from the child health co-ordination service is attached as Appendix one.

Further opportunities identified to improve immunisation have been to:

- Increase the focus on opportunistic immunisation wherever a child may present. It was noted that there were very few situations which should present an immunisation being given but that this was not always understood.
- Increasing engagement with other provider such as family Start noting that it can be a challenge to local families where there have moved.

In line with previous reports, delays in enrolment in primary care have also been a concern. The report from the Waikato Child Co-ordination service gives additional visibility to this.

Options to improve immunisation will be further explored at the Waikato Child and Youth Health Network meeting on 16 November 2017 and discussed further at the Health Strategy Committee meeting in December 2017.

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

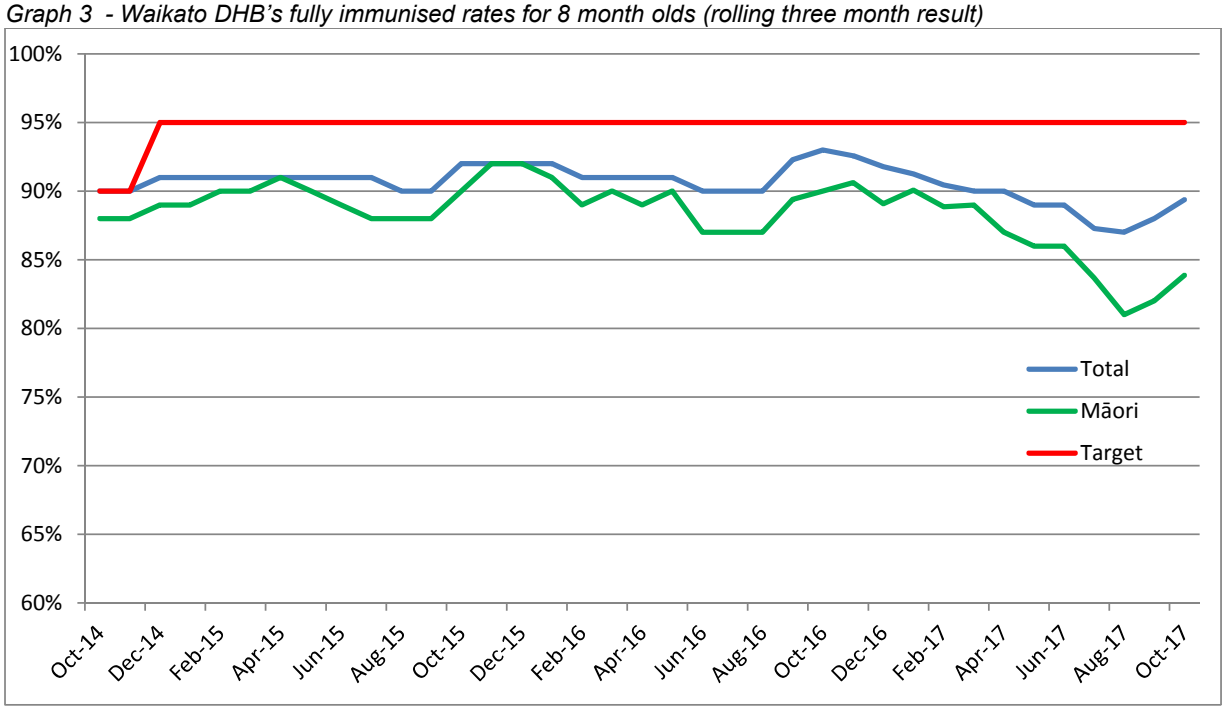


Table 8 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 85 additional children needed to be immunised to meet the 95% target.

Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from August 2017 to October 2017

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	518	472	91%	21
Māori	539	452	84%	61
Pacific	53	51	96%	0
Asian	170	166	98%	0
Other	103	95	92%	3
Total across ethnicities				85
Total	1,383	1,236	89%	78

Whilst the 84% result for Maori is concerning it does show a minor improvement from the 82% reported for the three month period ending in September 2017.

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

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

	Total population			Maori population		
PHO	No eligible population	No fully immunised population	Percent immunised	No eligible population	No fully immunised population	Percent immunised
Hauraki PHO	484	434	90%	227	194	85%
Midlands Health Network – Waikato	791	726	92%	252	215	85%
National Hauora Coalition	38	35	92%	19	17	89%
Enrolled with a PHO outside of Waikato	21	19	90%	9	8	89%
Unenrolled Waikato population	49	22	45%	32	18	56%
DHB Total	1,383	1,236	89%	539	452	84%

Recommendation
THAT
The Board receives this report.

JULIE WILSON
EXECUTIVE DIRECTOR STRATEGY AND FUNDING

MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 9.2

PROVIDER ARM KEY PERFORMANCE MONITORING – RED FLAGS

Purpose	For information.

Community and Clinical Support

Radiology
The pressures on the Radiology service have been reported to the Performance Monitoring Committee throughout 2016/17 and 2017/18. The issue is the ongoing rate of vacancy amongst Radiologists, coupled with sustained increases in demand. The service has mitigated those risks largely by outsourcing work and undertaking additional weekend/evening sessions.

Other DHB's, such as Bay of Plenty, have assisted when they have been able to. However, most of those options rely on extra work by the Radiologists to report the images. After 18 months of a reduced complement the ability to sustain this additional work is limited. The retirement of the department's workhorse for the reading of plain film x-ray next year will exacerbate the current situation further. Recruitment in an extremely competitive Australasian market is difficult.

The issues at a glance are:

1) The service has traditionally been resourced significantly below the norm for other DHBs. That has given it a reputation as a 'workhorse' department in the sector.
2) There are 2.9 FTE Radiologist vacant out of a total of 13. 2.4 of these FTE will be replaced by April if all the current locum offers are accepted. That is five months away, however, and other resignations are expected due to retirements.
3) The interventional radiology team has been depleted by half for most of 2017; the team will be at full strength by December.
4) There are 5.3 FTE (8 roster positions) Medical Radiation Technologist (MRT) vacancies at present. Only five students graduate in December.
5) The vacancies are reflected in (i) increased outsourcing and (ii) delayed reporting of images. It is the second of these two issues that is the primary concern.
6) Demand is increasing. Year to date CT referrals are up by 6%, MRI by 12% and x-ray by 7.5% compared to the prior year.

Mental Health and Addictions Service

No red flags to report.

Waikato Hospital Service

No red flags to report.

Recommendation
THAT
The Board notes the report.

MARK SPITTAL **EXECUTIVE DIRECTOR** **COMMUNITY &** **CLINICAL SUPPORT**	**VICKI AITKEN** **EXECUTIVE DIRECTOR** **MENTAL HEALTH** **(ACTING)**	**BRETT PARADINE** **EXECUTIVE DIRECTOR** **WAIKATO HOSPITAL** **SERVICES**

MEMORANDUM TO THE BOARD
22 NOVEMBER 2017

AGENDA ITEM 9.3

VERY LOW COST ACCESS PRACTICE OPTION IN CAMBRIDGE

Purpose	For information.

This paper is provided to update Board members on concerns raised at the Hamilton Community Health Forum in relation to loss of the only very low cost access (VLCA) practice option in Cambridge.

Background
Very low cost access (VLCA) practices were established as part of the national PHO arrangements and were designed to ensure that primary care services could be made more affordable in high needs areas. VLCA payments provide:

- extra funding in return for PHOs and general practices agreeing to maintain fees within the fees thresholds
- recognition of the extra effort involved in providing services to high need populations, and keeping fees low for the people who can least afford primary health care and improving health outcomes for those most likely to have the worst health.

From October 2009, eligibility for the Very Low Cost Access payment is limited to PHOs and contracted general practices meeting the eligibility criteria of 50% high needs population (defined as Māori, Pacific or New Zealand Deprivation Index quintile 5), and currently charging or prepared to reduce their fees to:

- zero fees for children 0–12 years. (note: this is in place for all practices not just VLCA)
- $12 maximum for children 13–17 years
- $18.00 maximum for adults 18 years and over.

Prior to this date practices could opt to be VLCA without meeting the high needs criteria and were able to remain funded as VLCA as long as fees were within the above thresholds. Where new practices are established or practices merge they must be able to demonstrate that they meet the requirement of 50% high needs population.

Nationally there has been voiced concern around the VLCA funding arrangements with key concerns being that the mechanism is based on the total enrolled population for the practice rather than addressing the needs for low cost access based in the needs of individual clients.

Practice merger
The Drs Pearson and Nyce practice in Cambridge had been eligible for VLCA through grand parenting with only 8% of the enrolled population (1,535 total patients) being defined as high needs. The practice was purchased by Cambridge Medical Centre and patient registers were merged from 1 Oct 2017. Patients were advised prior to that about the merger and given opportunity to opt out of the merge and seek an alternative practice if desired.

Cambridge Medical Centre (10,250 total population pre-merger) also has only 8% meeting the high needs threshold. Therefore the merged practice did not meet the requirements in order to retain VLCA funding.

Comment
This merger has meant that there is currently no VLCA practice in Cambridge. As noted above however, only 8% of the enrolled patients in Drs Pearson and Nyce met the high needs population criteria so it would be difficult to argue that this should be treated outside the national guidelines.

With media announcements from the new government in relation to primary care we would anticipate that a number of changes are likely to occur over the next 12 months including reduced charges for community services card holders in addition to enrolees with VLCA practices.

Recommendation
THAT
The Board receives the report.

JULIE WILSON
EXECUTIVE DIRECTOR STRATEGY AND FUNDING

Next Board Meeting: 28 February 2018.