DISTRIBUTION

Board Members (1 copy each)

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

Executive Management Team

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

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

Next Meeting Date: 22 March 2017

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

WAIKATO DISTRICT HEALTH BOARD

Agenda

Board

Date: **22 February 2017**

Time: **1.30pm**

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

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Meeting of the Waikato District Health Board

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

AGENDA

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

Item

1. Apologies

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

3. **MINUTES AND BOARD MATTERS**
- 3.1 Board Minutes: 14 December 2016
- 3.2 Committees Minutes: No meetings held
- 3.3 Committee Structure and Appointments
- 3.4 Committee Membership 2017
- 3.5 Board Code of Conduct

4. **CHIEF EXECUTIVE REPORT**

5. **FINANCE**
- 5.1 Finance Report

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

7. **PLANNING**
- 7.1 Investor Confidence Rating and Long Term Investment Plan Update
- 7.2 Waikato DHB Annual Plan 2017/18 Update

8. **WAIKATO DHB POSITION STATEMENTS AND POLICIES**
- 8.1 Serious Event Review Process
- 8.2 Fluoridation Submission

9. **PAPERS FOR INFORMATION**
- 9.1 Women's Health Transformation Programme
- 9.2 Elective Services Improvement Commissioner Progress Report

10. **NEXT MEETING**
- 10.1 22 March 2017

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

THAT:

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

Item 11: Minutes – Various
- **(i) Waikato District Health Board for confirmation: Wednesday 14 December 2016 (Items taken with the public excluded)**
- **(ii) Midland Regional Governance Group – to be received: Friday 3 February 2017 (All items)**

Item 12: Risk Register – Public Excluded
Item 13: Employment Negotiations with Junior Doctors – Public Excluded
Item 14: Patient Flow Manager Business Case – Public Excluded
Item 15: Replacement General Computerised Tomography (CT) Scanner – Public Excluded
Item 16: Sustainability and Enhancement of Primary Level Services in the Waikato, Progress Update – Public Excluded

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 11(i-ii): Minutes	Items to be adopted / confirmed / received were taken with the public excluded
Item 12: Risk Register	Avoid inhibiting staff advice about organisational risks
Item 13: Verbal update on employment negotiations with RDA	Negotiations with Union are occurring
Item 14: Patient Flow Manager business case	Negotiations will be required
Item 15: Replacement of Computerised Tomography Scanner	Negotiations will be required
Item 16: Primary care update	Negotiations will be required

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

Item 11: As shown on resolution to exclude the public in minutes.

Item 12: Section 9(2)(c) of the Official Information Act 1982 – To avoid prejudice to measures protecting the health or safety of members of the public.

Item 13-16: **Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

Item

11. MINUTES – PUBLIC EXCLUDED

11.1 Waikato District Health Board: 14 December 2016
To be confirmed: Items taken with the public excluded

11.2 Midland Regional Governance Group: 3 February 2017
To be received: All items

12. RISK REGISTER – PUBLIC EXCLUDED

13. EMPLOYMENT NEGOTIATIONS WITH JUNIOR DOCTORS – PUBLIC EXCLUDED

14. PATIENT FLOW MANAGER BUSINESS CASE – PUBLIC EXCLUDED

15. REPLACEMENT GENERAL COMPUTERISED TOMOGRAPHY (CT) SCANNER – PUBLIC EXCLUDED

16. SUSTAINABILITY AND ENHANCEMENT OF PRIMARY LEVEL SERVICES IN THE WAIKATO, PROGRESS UPDATE – PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

THAT:

(1) The Public Be Re-Admitted.

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

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO FEBRUARY 2017

Bob Simcock

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Chairman, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chairman, Orchestras	TBA	TBA	
Member, Waikato Regional Council	Pecuniary	Perceived	
Director, Rotoroa LLC	TBA	TBA	
Director, Simcock Industries Ltd	TBA	TBA	
Trustee, RM & AI Simcock Family Trust	TBA	TBA	
Wife is CEO of Child Matters, Trustee of Life Unlimited which holds contracts with the DHB, Member of Governance Group for National Child Health Information Programme, Member of Waikato Child and Youth Mortality Review Group	Pecuniary	Potential	

Sally Webb

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Deputy Chair and Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Bay of Plenty DHB	TBA	TBA	
Member, Health Workforce NZ	TBA	TBA	
Member, Capital Investment Committee	TBA	TBA	
Director, SallyW Ltd	TBA	TBA	

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
Partner, employee of Workwise	Pecuniary	Potential	

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
Director, Bridger Beavis & Associates Ltd, management consultancy	Non-Pecuniary	None	
Director, Strategic Lighting Partnership Ltd, management consultancy	Non-Pecuniary	None	
Life member, Diabetes Youth NZ Inc	Non-Pecuniary	Perceived	
Trustee, several Family Trusts	Non-Pecuniary	None	
Employee, Waikato District Council	Pecuniary	None	

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, Hamilton City Council	Pecuniary	Perceived	
Board member Parent to Parent NZ (Inc), also provider of the Altogether Autism service	Pecuniary	Potential	
Trustee, Waikato Community Broadcasters Charitable Trust	Non-Pecuniary	Perceived	
Alternate Member, Waikato Spatial Plan Joint Committee	Non-Pecuniary	Perceived	
Wife employed by Selwyn Foundation (contracts with Waikato DHB)	Pecuniary	Potential	

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
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	

Note 1: Interests listed in every agenda.

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

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
Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived	
Director/Shareholder, Asher Group Ltd	Pecuniary	Perceived	
Director, Hautu-Rangipo Whenua Ltd	Pecuniary	Perceived	
Owner, Chartered Accountant in Public Practice	Pecuniary	Perceived	
Daughter is an employee of Puna Chambers Law Firm, Hamilton	Non-Pecuniary	Potential	
Daughters are employees of Deloitte, Hamilton	Non-Pecuniary	Potential	

Clyde Wade

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
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	

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
Iwi: Ngati Pahauwera, Ngati Ranginui, Ngati Haua, Tuwharetoa, Maniapoto	Non-Pecuniary	Perceived	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	
Trustee/Shareholder, Whanau.com Trust	Pecuniary	None	
Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None	
Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None	
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None	
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None	
Justice of the Peace	Non-Pecuniary	None	

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
Employee, Life Unlimited	Pecuniary	Perceived	
Son is an employee of Hongkong and Shanghai Banking Corp Ltd (NZ)	Non-Pecuniary		

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

Note 1: Interests listed in every agenda.

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

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Board Meeting held on Wednesday 14 December 2016 commencing at 1.30 pm in the Kotahitanga Room on Level 9 of the KPMG Building, Alexandra Street, Hamilton

Present:
Mr B Simcock (Chair)
Ms C Beavis
Ms S Christie
Ms S Mariu
Dr C Wade
Mrs P Mahood
Ms M A Gill
Mr D Macpherson
Mr M Gallagher (part of the meeting)

In Attendance:
Dr N Murray (Chief Executive)
Mr N Hablous (Chief of Staff)
Mr B Paradine (Executive Director, Waikato Hospital Services)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Mr D Wright (Executive Director, Mental Health and Addictions Service)
Mr M Spittal (Executive Director, Community and Clinical Support)
Mr A McCurdie (Chief Financial Officer)
Ms T Maloney (Commissioner, Women's Health Transformation Taskforce)
Ms M Neville (Director, Quality and Patient Safety)
Mrs J Wilson (Executive Director, Strategy and Funding)
Mrs S Haywood (Director Nursing and Midwifery)
Mr D Hackett (Executive Director, Virtual Care and Innovation)
Mr C Cardwell (Executive Director, Facilities and Business)
Mr I Wolstencroft (Executive Director, Strategic Projects)
Mr M ter Beek, (Executive Director, Operations and Performance)
Mrs M Chrystal (Executive Director Corporate Services)

ITEM 1: APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms T Hodges and Ms S Webb.
Apologies for lateness from Mr M Gallagher – arrived 3.00 pm.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interest were noted at the meeting.

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

Minutes of the Waikato District Health Board Meeting held on 23 November 2016

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 23 November 2016 taken with the public present were confirmed as a true and accurate record subject to an amendment to Item 4 Chief Executive Report amended to read:
"Update on Priority Programme Plans for the Strategy Implementation".

ITEM 4: CHIEF EXECUTIVE REPORT

The Chief Executive welcomed the new Board members to their first meeting and explained that the agenda for the meeting was light due to it taking place earlier than normal in the month and some of the standard reports were not available.

Orientation for Board members

It was noted that there would be three levels of orientation provided to board members: national, regional and local.

The national orientation on 9 February 2017 in Wellington. The dates for the regional and local orientation were still to be notified.

It was acknowledged that the two new Board members had not been provided with any orientation prior to attending this Board meeting.

Arrangements would be made for the two new Board members to meet with the Executive Directors.

Resolved
THAT
The Board received the report.

ITEM 5: FINANCE REPORT

The Chief Financial Officer asked that his financial summary for the month to 30 November 2016 be taken as read highlighting the following:

- Breakeven was achieved for the month of November.
- Work was still to be done for the balance for the year to bring it back on track.

- IDF was the most significant aspect counter to trend for November – being validated the extent to which this is a trend or a spike.
- Some progress has been made in managing nursing and watches costs.
- Executive directors acknowledge that pressure has been building and the challenge was how to respond to that pressure.
- Outsourced costs remained high. A range of contributing factors was being assessed to see how it could be turned around. New orthopaedic staff coming on board February/April next year would make a difference but the DHB would always need to outsource these services.
- Full financial reports would be made available to Board members for each month between now and February.

Resolved
THAT
The financial summary of the Waikato DHB for the month to 30 November 2016 was received.

ITEM 6: PERFORMANCE REPORTING

There were no reports this month.

ITEM 7: PLANNING

There were no items this month.

ITEM 8: WAIKATO DHB POSITION STATEMENT AND POLICIES

There were no items this month.

ITEM 9: PAPERS FOR INFORMATION

9.1 Quality Account

This report submitted to the Board explained that Quality accounts were 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.

Significant areas had been aligned with strategic priorities and were similar to those identified last year.

The Quality Account would be sent to the Ministry of Health and HQSC and also made available on the DHB's website and staff intranet.

Quarterly progress reports would be made to the Audit and Risk Committee.

Resolved
THAT
1) The Board received the report.
2) The Board supported the proposed priority areas.

9.2 Suicide Prevention/Postvention Report

This report outlined the work undertaken to date with the Waikato DHB's Suicide Prevention and Postvention Action Plan 2014-17. It included the formation of the Suicide Prevention and Postvention Health Advisory Group (SPPHAG) and set out their Terms of Reference.

The work plan for the following 12 months was noted in the report as being:

- Prevention
- Emergency Department including an ACC supported pilot
- Bereavement support

Resolved
THAT
The Board received the report.

ITEM 10: NEXT MEETING

Date of Next Meeting

The next meeting to be held on Wednesday 22 February 2017, commencing at 1.30 pm.

BOARD MINUTES OF 14 DECEMBER 2016

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

THAT:

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

Item 11: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 23 November 2016 (Items taken with the public excluded)**
- **(ii) Audit and Risk Management Committee: Wednesday 23 November 2016 – (All Items)**

Item 12: Southern Rural Primary Maternity Services – Public Excluded
Item 13: Chief Executive Report – Public Excluded
Item 14: Presentation: Suicide Prevention/Postvention – Public Excluded
Item 15: Woman's Health Transformation Programme – Public Excluded
Item 16: Presentation: Creating our Futures – Public Excluded
Item 17: Committee Structure and Appointments – Public Excluded

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 11 (i-ii): Minutes		Items to be adopted/ confirmed/ received were taken with the public excluded
Item: 12	Southern Rural Primary Maternity Services	Negotiations will be required
Item 13:	Chief Executive Report	Discussions will be required
Item 14:	Presentation: Suicide Prevention/Postvention	Avoid inhibiting staff advice about organisaitonal risks
Item 15:	Women's Health Transformation Programme Update	Negotiations will be required
Item 16:	Mental Health & Addictions Services Presentation: Creating our Futures	Negotiations will be required
Item 16:	DHB Committee Structure and Appointments	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.

Items 12,13, 15 -17	**Section 9(2)(j) of the Official Information Act 1982 – to enable the Waikato DHB to carry on negotiations without prejudice or disadvantage negotiations.**
Item: 14	**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.**

ACTION LIST

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

	ACTION	BY	WHEN
1.	Provide board members with list of full list policies and dates for review		22 March 2017

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 3.3

COMMITTEE STRUCTURE AND APPOINTMENTS

Purpose	For information.

Note

An earlier version of this report was put to the Board in December. The Board suggested changes but agreed that I should proceed as if it were adopted in the interim. It is now submitted for adoption. It was circulated early in the New Year.

Introduction

It is necessary following the election/appointment of a new Board to review the committee structure and committee membership. This paper has been prepared to provide the context for that debate and to put before the Board my recommendations on the subject.

It is not intended to make decisions about who will serve on which committees at this meeting. Rather, it is suggested that the committee structure and membership (by way of numbers) should be agreed.

The time between the present meeting and the February meeting would then be used to continue the discussions I have already commenced with members as to their preferences for committee membership, and any conflicts of interest they may have which may preclude appointment to particular committees. I am envisaging that at the February meeting I would recommend the membership of the committees.

Legislative Context

The New Zealand Public Health and Disability Act requires the establishment of three committees. These are the Community and Public Health Advisory Committee, the Disability Support Advisory Committee, and the Hospital Advisory Committee (in our case currently called the Health Waikato Advisory Committee).

The statutory terms of reference for these committees are attached as Appendix 1.

Terms of Reference for Committees Required by Statute

It is not permissible to ignore the legislation by creating terms of reference for the three statutory committees which do not meet the legislative requirements. It is however possible to supplement the legislative requirements with additional responsibilities.

It is my suggestion that we broaden the monitoring and assessment role of the Health Waikato Advisory Committee to include monitoring and assessment of providers outside the Waikato DHB including primary care.

This would require regular reporting to the Committee through the Strategy and Funding Division on the status, performance and challenges of key providers. It should also involve scheduled meetings with providers at which they would be invited to speak on what's working for them, what's not working for them, and what the solutions are.

I understand that in the early days of the Waikato DHB such meetings with providers were held on a regular basis so it is not a novel idea for Waikato DHB.

Meetings with providers would be managed through a forward schedule that ensures discussions are related to matters of current interest.

Re-worked terms of reference for the Heath Waikato Advisory Committee are attached as Appendix 2.

In regard to the Community and Public Health Advisory Committee it is suggested that its role in prioritising health funding is broadened to include:

- monitoring of programmes by which new initiatives with significant costs (e.g. our virtual health and eSPACE programmes) are established;
- monitoring of programmes by which significant change to service models (e.g. proposed changes to rural services and mental health) is implemented; and
- consideration of priority programme plans arising from the refresh of the strategy undertaken in 2015, and monitoring of them as they are implemented.

I would envisage that staff would recommend a schedule of significant programmes that would fall within the monitoring scope of the committee.

Re-worked terms of reference for the Community and Public Health Advisory Committee are attached as Appendix 3.

Under this model the Board would retain its strategic focus with monitoring of the early implementation stages of significant initiatives sitting with the Community and Public Health Advisory Committee and the monitoring of "business as usual" both within Waikato DHB and outside Waikato DHB sitting with the Health Waikato Advisory Committee.

One implication of this amended approach is that the assumption by which the Executive Director: Strategy and Funding works to the Community and Public Health Advisory Committee and the Executive Director: Mental Health, Executive Director: Waikato Hospital Services, and Executive Director: Community and Clinical Support work to the Health Waikato Advisory Committee, will break down. There will be a need for reporting to both committees on the part of these staff.

I am not proposing any change to the terms of reference of the Disability Support Advisory Committee which would be as in legislation. These are attached at Appendix 4.

However, I do think that the Community and Public Health Advisory Committee and Disability Support Advisory Committee can to all intents and purposes be merged. This would in practical terms mean the following:

- The combined committee would have the short-hand title agreed for the Community and Public Health Advisory Committee but we would all understand that its scope will include the statutory scope of the Disability Support Advisory Committee;
- There would be one meeting;
- The membership and chair would be the same irrespective of the mode in which the committee would be operating;
- There would be one meeting fee payable; and
- There would be one agenda and items would not need to be separately identified as pertaining to one committee or the other.

This would not constitute a reduction in focus on matters currently within the scope of the Disability Support Advisory Committee. The legislative role of the Disability Support Advisory Committee will be conducted through the Community and Public Health Advisory Committee. Moreover, monitoring the effectiveness of delivery of services to people with disabilities will be part of the work of the amended Health Waikato Advisory Committee.

Primary Care and Committees

For a variety of reasons Waikato DHB currently faces challenges in regard to alignment with primary care including the ability to effect change through that important part of the sector. The above model will allow greater involvement with primary care through better monitoring of its performance and by providing opportunities for direct engagement with the Board.

Audit and Risk Management Committee

The Audit and Risk Management Committee is not a requirement of statute. However, we are aware that most (if not all) district health boards have a committee of this type.

Its current scope covers the following:

- Quality and patient safety indicators;
- Formal inquiries by outside agencies (Ombudsman etc.) that have reached the point of becoming essentially legal in nature;
- Treasury and Financial Position
- IT work programme;
- Internal audits;
- Audit programmes addressing external providers;
- External financial audit;
- Supply chain performance indicators;
- Post-implementation reviews.

There is no clear boundary between “monitoring” and “auditing” and it is apparent that some of the above (e.g. quality and patient safety indicators) could just as readily go to the Health Waikato Advisory Committee.

It is also noteworthy that the Board decided some time ago that despite the committee’s name the risk register should go to the Board and not this committee.

It is suggested that the committee should be renamed the Audit and Corporate Risk Management Committee with a particular focus on detailed review of corporate activity by audit or otherwise. A pragmatic approach will need to be maintained with respect to scope since both internal audits and post-implementation reviews are as

often clinical as they are corporate while formal legal processes with external agencies are invariably clinical in content.

As a consequence of this change the quality and patient safety indicators and the audits of external providers should transfer to the Health Waikato Advisory Committee.

New terms of reference are attached as Appendix 5.

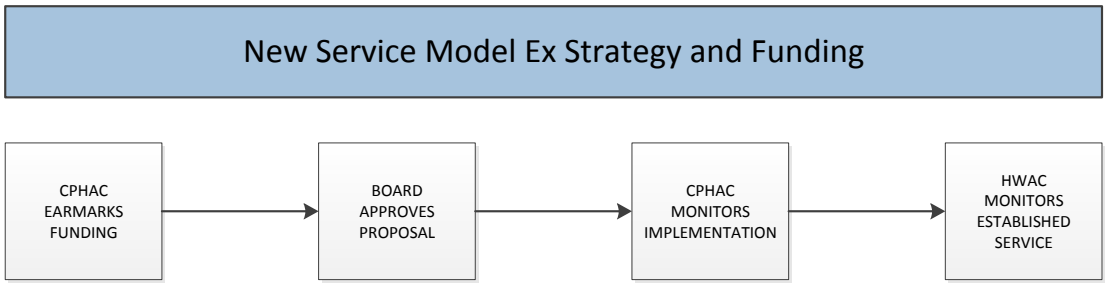
Process Flow for Core Committees

One of the complexities of the Waikato DHB is that significant organisational initiatives can arise from three different sources. They can be:

- The result of new models for delivering services (especially multi-provider services) proposed through the strategy and funding arm;
- The result of Waikato DHB as provider within its current funding seeking a new way of delivering existing services to the public; and
- The result of Waikato DHB as provider within its current funding seeking a new way of organising its own corporate support functions.

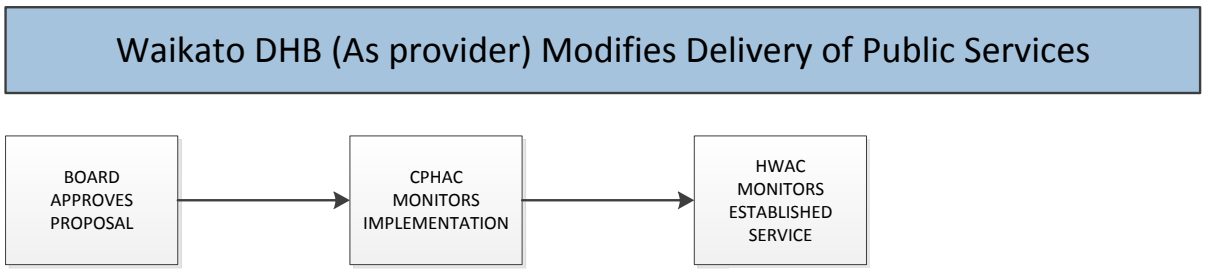
In terms of the proposed model for the committees this would translate into the following approach.

New Service Model (Esp Multi-Provider) Ex Strategy and Funding



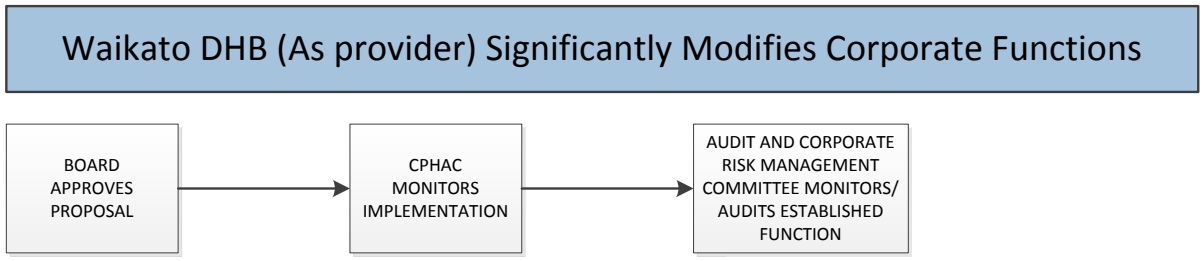
Eg:MENTAL HEALTH SERVICE MODEL

Waikato DHB as Provider Significantly Modifies its Delivery of Services



Eg: RURAL SERVICES
VIRTUAL HEALTH (both a service and a corporate function?)

Waikato DHB as Provider Significantly Modifies Corporate Functions



Eg: eSPACE
VIRTUAL HEALTH (both a service and a corporate function?)

Remuneration Committee

The Remuneration Committee is the means by which the performance and remuneration of the Chief Executive are monitored in an appropriately focussed and confidential manner. It is suggested that the value of such a committee is self-evident and that a remuneration committee should be maintained.

Terms of reference are attached as Appendix 6.

Sustainability Advisory Committee

The Sustainability Advisory Committee of the Board was originally set up in response to developing financial pressures which necessitated significant project work concerned with reducing costs and improving efficiency.

The committee provided the opportunity for the Executive to explain in a little more detail precisely what was occurring to improve financial performance.

Initially the committee met monthly.

I appreciated the opportunity to have more focussed discussions on the financial performance of the organisation.

I am not convinced however that regular meetings of such a committee are required at present.

My suggestion is that we establish the committee on the assumption that meetings will occur “as required” following discussion between the chair of the committee and the chair of the Board.

Terms of reference are attached as Appendix 7.

Payment of Committee Members

Members receive payment for attending meetings of the three statutory committees, and the Audit and Risk Management Committee but not for the Sustainability Committee and the Remuneration Committee. The Minister of Health is required to

approve payment for attendance at committee meetings and based on previous experience it is unlikely that such would be forthcoming for the Remuneration Committee, the Sustainability Advisory Committee or any other committee established subsequently. A request for payment for attendance at the Sustainability Advisory Committee was made in 2014 and was unsuccessful.

Membership of Committees

I think it is wise that the Chair and Deputy Chair are on all the committees to ensure they understand the business of the Board.

We have previously set up cross-DHB membership on the three statutory committees with Lakes DHB and Bay of Plenty DHB. The chairs have agreed that this should continue through the next term of the Boards.

The Board has historically had a member on each of the statutory committees appointed on the recommendation of the Iwi Maori Council. I support this approach as aligning with our broader obligations as a district health board and with the Memorandum of Understanding the Waikato DHB has with Maori.

In its last term the Board appointed four external members to the three statutory committees who were identified through a public process.

In my view the statutory committees have become unwieldy with significant non-Board membership. It is therefore my recommendation that the process of appointing external members should be discontinued.

However, as the Waikato DHB has recently approved the establishment of a consumer council it is my suggestion that one member of the statutory committees is appointed upon recommendation of the consumer council. That person would be a member of the council.

Following this logic the suggested membership of the committees is as follows:

Health Waikato Advisory Committee

- Chair
- Deputy Chair
- One member upon recommendation of IMC
- One member upon recommendation of the Consumer Council
- One member upon recommendation of Bay of Plenty DHB
- One member upon recommendation of Lakes DHB
- Five other Board members

Community and Public Health Advisory Committee

- Chair
- Deputy Chair
- One member upon recommendation of IMC
- One member upon recommendation of the Consumer Council
- One member upon recommendation of Bay of Plenty DHB
- One member upon recommendation of Lakes DHB
- Five other Board members

Disability Support Advisory Committee

- As for Community and Public Health Advisory Committee

Audit and Risk Management Committee

- Chair
- Deputy Chair
- Four other Board members

Sustainability Advisory Committee

- Chair
- Deputy Chair
- Four other Board members

Remuneration Committee

- Chair
- Deputy Chair
- Three other Board members

Delegations to Committees

At the present time there are no delegations to committees. This means that any decisions proposed by a committee do not become "live" until such time as the recommendations are approved by the Board.

It is my recommendation that this continues. Under the legislation the committees are identified as "advisory" and the current approach works well with the chairs briefly justifying their decisions before the Board at the time that recommendations are to be approved.

Other Subsidiary Entities

In addition to committees the Board has previously had representation on the Waikato Health Trust.

The Trust was established to hold donations and bequests provided to the organisation and also funds generated by research. The responsibilities of a trustee are not onerous.

It is suggested that Board representation should continue for the simple reason that staff obtain some comfort from this link. For reasons arising from the history of the organisation some staff are fearful that the trust funds will be diverted for general purposes and having a Board member on the Trust assists in dispelling this concern.

The Board has over the last three years had two members attending the Board of Clinical Governance. This is the Waikato DHB's forum for monitoring clinical standards and quality. In my view this should continue. Attendance has been unpaid.

Meeting Schedule

A draft meeting schedule has been circulated previously. We have modified that to commence the formal cycle of meetings in April. Meetings scheduled for February

will not be able to occur because appointments will not have been made at that point. However it is suggested that ad hoc meetings are held in March for the committees to get started.

A re-worked meeting schedule is attached as Appendix 8.

Timing of meetings and especially their duration will need to be flexible, if regular engagement with external parties is to occur. Therefore expected duration is set at three and a half hours.

Committee Titles

What we call the Health Waikato Advisory Committee is in the legislation called the Hospital Advisory Committee. Neither of these titles fits with the full role of the committee as envisaged in this paper. The title Community and Public Health Advisory Committee does not fit with the full role envisaged for this committee either.

It is suggested therefore that while establishing these committees in accordance with the legislation we call them the Performance Monitoring Committee (ex HWAC) Hospital, and Health Strategy Committee (ex CPHAC)

Recommendations
THAT:

1. The Board establishes as per legislation a Hospital Advisory Committee, Community and Public Health Advisory Committee and Disability Support Advisory Committee with terms of reference as attached.

2. The Board also establishes an Audit and Corporate Risk Management Committee, Sustainability Advisory Committee and Remuneration Committee with terms of reference as attached.

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

4. The Disability Support Advisory Committee functions under the umbrella of the Health Strategy Committee as set out in this paper.

5. Membership of the committees is as described within this paper.

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

7. The external committee members of the existing statutory committees are advised with thanks that:

    a. A decision has been made to discontinue appointing external members once the consumer council is able to propose members for committees;

    b. Present arrangements will with the current external members consent, be maintained until the consumer council is up and running.

    c. A farewell function will be arranged for an appropriate time.

8. The board policy 0301 Appointment of External Members to Board Committees is withdrawn

9. Meeting scheduling is generally as follows:

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

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

    c. Sustainability Advisory Committee and Remuneration Committee as required.

10. The attached meeting schedule is adopted.

BOB SIMCOCK
CHAIR

Functions of community and public health advisory committees

2 Functions of community and public health advisory committees

(1)

The functions of the community and public health advisory committee of the board of a DHB are to give the board advice on—

(a)

the needs, and any factors that the committee believes may adversely affect the health status, of the resident population of the DHB; and

(b)

priorities for use of the health funding provided.

(2)

The aim of a community and public health advisory committee's advice must be to ensure that the following maximise the overall health gain for the population the committee serves:

(a)

all service interventions the DHB has provided or funded or could provide or fund for that population:

(b)

all policies the DHB has adopted or could adopt for that population.

(3)

A community and public health advisory committee's advice may not be inconsistent with the New Zealand health strategy.

Functions of disability support advisory committees

3 Functions of disability support advisory committees

(1)

The functions of the disability support advisory committee of the board of a DHB are to give the board advice on—

(a) the disability support needs of the resident population of the DHB; and

(b)

priorities for use of the disability support funding provided.

(2)

The aim of a disability support advisory committee's advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population:

(a)

the kinds of disability support services the DHB has provided or funded or could provide or fund for those people:

(b)

all policies the DHB has adopted or could adopt for those people.

(3)

A disability support advisory committee's advice may not be inconsistent with the New Zealand disability strategy.

Functions of hospital advisory committees

4 Functions of hospital advisory committees

The functions of the hospital advisory committee of the board of a DHB are to—

(a)

monitor the financial and operational performance of the hospitals (and related services) of the DHB; and

(b)

assess strategic issues relating to the provision of hospital services by or through the DHB; and

(c)

give the board advice and recommendations on that monitoring and that assessment.

Appendix 2

PERFORMANCE MONITORING COMMITTEE TERMS OF REFERENCE

1) In accordance with the NZ Public Health and Disability Act, the Board shall establish a Hospital Advisory Committee to be called the Performance Monitoring Committee whose members and chairperson shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Performance Monitoring Committee shall be to examine in depth, issues associated with:

    a) the financial and operational performance of the services directly provided by Waikato DHB

    b) The financial and operational performance of the services funded by Waikato DHB including NGOs and primary care

    c) The effectiveness of the delivery of services to people with disabilities

    d) Regional or national service initiatives.

4) The issues to be examined by the Committee shall be identified:

    a) at the Committee's initiative

    b) at the Executive's initiative

    c) at the request of the Board.

5) Where current issues necessitate discussions with providers, meetings with the committee will be arranged and occur in accordance with a schedule maintained by the Strategy and Funding division.

6) The Performance Monitoring Committee shall hold meetings as frequently as the Board considers necessary. Six meetings are normally held annually.

Appendix 3

HEALTH STRATEGY COMMITTEE TERMS OF REFERENCE

1) In accordance with the NZ Public Health and Disability Act, the Board shall establish a Community and Public Health Advisory Committee to be called the Health Strategy Committee, whose members and chairperson shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The functions of the Health Strategy Committee shall be to

   a) Examine in depth, issues associated with:

      I. the needs, and any factors that the Committee believes may adversely affect the health status of the resident population of the Waikato DHB

      II. priorities for use of the health funding provided.

   b) Monitor:

      I. Programmes by which significant service models are established or amended; and

      II. Programmes by which new initiatives with significant costs are implemented.

   c) Consider priority programme plans arising from the refresh of the strategy undertaken in 2016 and monitor them as they are implemented.

4) The issues to be examined by the Committee shall be identified:

   a) at the Committee's initiative

   b) at the Executive's initiative

   c) at the request of the Board.

5) The Committee's advice may not be inconsistent with the New Zealand health strategy.

6) The executive group of Waikato DHB shall develop and have approved by the committee a rolling schedule of programmes to be monitored by the committee.

7) The Health Strategy Committee shall hold meetings as frequently as the Board considers necessary. Six meetings are normally held annually.

Appendix 4

DISABILITY SUPPORT ADVISORY COMMITTEE TERMS OF REFERENCE

1) In accordance with the NZ Public Health and Disability Act, the Board shall establish a Disability Support Advisory Committee to function through the Health Strategy Committee, whose members and chair person shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Disability Support Advisory Committee shall be:

   a) to examine in depth, issues associated with:

      - the disability support needs and any factors that the Committee believes may adversely affect the health status of the resident population of the Waikato DHB
      - priorities for use of the disability support funding provided.

   b) to promote the inclusion and participation in society for people with disabilities for the resident population of the Waikato DHB

4) The issues to be examined by the Committee shall be identified:

   a) at the Committee's initiative

   b) at the Executive's initiative

   c) at the request of the Board.

5) The Committee's advice may not be inconsistent with the New Zealand disability strategy.

6) The Disability Support Advisory Committee shall hold meetings as frequently as the Board considers necessary. Four meetings are normally held annually.

Appendix 5

AUDIT AND RISK MANAGEMENT COMMITTEE TERMS OF REFERENCE

1) In accordance with sound business practice, the Board shall establish an Audit and Risk Management Committee whose members and chair person shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The functions of the Audit and Risk Management Committee shall be:

   a) Internal Audit and Control:

      i) to evaluate whether management is setting the appropriate "control culture" by communicating the importance of internal control and the management of risk and by ensuring that all employees have an understanding of their roles and responsibilities

      iii) to ensure that risks are appropriately identified and mitigated throughout the organisation

      iv) to monitor at a high level the quality of Waikato DHB services from the perspective of risk

      v) to monitor the security of computer systems and applications and the contingency plans for processing information in the event of a systems break down

      vi) to monitor the implementation by management of recommendations made by internal auditors

      vii) to ensure that both fraud and sensitive expenditure are adequately addressed by relevant policy and control processes.

   b) Financial Reporting:

      i) to gain an understanding of the current areas of greatest financial risk and how management is managing those effectively

      ii) to review with the internal and external auditors any fraud, illegal acts, deficiencies in internal control or other similar issues

      iii) to review significant accounting and reporting issues, including recent professional and regulatory pronouncements, and understand their impact on the financial statements

      iv) to review any legal matters which could significantly impact the financial statements

      v) to review the financial statements and the result of the audit.

   c) External Audit:

      i) to make recommendations to the Board regarding the reappointment of the external auditors

      ii) to meet separately with external audit to discuss any matters that the Committee or auditors believe should be discussed privately

iii) to monitor the implementation by management of recommendations made by external auditors.

e) Compliance:

i) to review the findings of any examination by regulatory agencies where these are not clinically-focussed and, as such, within the scope of the Health Waikato Advisory Committee

ii) to review the Draft Annual Plan and Draft Annual Report.

e) State Sector Code of Conduct:

iii) to evaluate whether management is setting the appropriate tone relative to the applicable state sector code of conduct

iv) to review processes for monitoring compliance with the code of conduct.

4) The Audit and Risk Management Committee shall hold meetings as frequently as the Board considers necessary. Four meetings are normally held annually.

Appendix 6

REMUNERATION COMMITTEE TERMS OF REFERENCE

1) In accordance with sound business practice, the Board shall establish a Remuneration Committee whose members and chairperson shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Remuneration Committee shall be:

   a) to provide advice to the Board on employment issues relative to the organisation's CEO, including recruitment, conditions of employment, annual review

   b) to undertake the CEO performance review process on behalf of the Board and make recommendations regarding any resultant issues

   c) to report regularly to the Board on the Committee's findings (generally the minutes of each meeting will be placed on the agenda of the next Board Meeting).

4) The Remuneration Committee shall hold meetings as frequently as the Board considers necessary. Meetings are held as required.

Appendix 7

SUSTAINABILITY ADVISORY COMMITTEE

1) In accordance with sound business practice and as a means of ensuring the financial sustainability of the Waikato DHB, the Board shall establish a Sustainability Advisory Committee whose members and chair person shall be as determined by the Board from time to time.

2) This Committee of the Board does not have delegated authority. It advises the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Sustainability Advisory Committee shall be to:-

   a) Monitor the development, implementation and success of existing projects intended to ensure the financial sustainability of the Waikato DHB.

   b) Monitor the financial performance of the Waikato DHB with a view to advising the Board on the urgency to be given to initiatives to ensure the sustainability of the Waikato DHB.

   c) Ensure the Board is kept informed of the activities coming within the scope of the Committee and their success or otherwise;

   d) Assess any new proposals intended to ensure the financial sustainability of the Waikato DHB.

   e) Prioritise proposals/projects intended to ensure the financial sustainability of the Waikato DHB.

4) The matters to be examined by the Committee shall be identified:

   a) at the Committee's initiative;

   b) at the Executive's initiative;

   c) at the request of the Board.

5) The Sustainability Advisory Committee shall hold meetings as frequently as the Board considers it necessary. Meetings are held as required.

Appendix 8

2017 Waikato District Health Board, Committees and Iwi Maori Council Meeting Schedule

Iwi Maori Council Monthly 9.30am	SAC Monthly 8.30am As required – on Board days	Board Monthly 1.30pm Board only session 1pm-1.30pm	Audit & Risk 3 monthly 10am – 12pm	Performance Monitoring Committee 2 Monthly 8.30am – Noon	Health Strategy Committee 2 Monthly 12.30pm – 4pm	Waikato Health Trust Bi Annual 4.00pm
		22 Feb				
2 Mar						
				8 Mar	8 Mar	
		22 Mar	22 Mar			
6 Apr						
				12 Apr	12 Apr	12 Apr
		26 Apr **Taumarunui – timing TBC**				
4 May*						
		24 May	24 May			
1 Jun						
				14 Jun	14 Jun	
		28 Jun				
6 Jul						
		26 Jul **Tokoroa – timing TBC**				
3 Aug						
				9 Aug	9 Aug	
		23 Aug	23 Aug			
7 Sep						
		27 Sep				
5 Oct*						
				11 Oct	11 Oct	11 Oct
		25 Oct				
2 Nov						
		22 Nov	22 Nov			
				13 Dec	13 Dec	

** IMC/Board joint meeting (9:30am to 3pm)*

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 3.4

COMMITTEE MEMBERSHIP 2017

Purpose	For consideration.

In accordance with the decisions reached at the December Board meeting I have sought the views of all board members regarding the makeup of the board's committees. In making the following recommendation both the interests and aspirations of individuals and the need to balance workload have been taken into account.

I have written to the current external members of the committees advising them that the Board has decided to seek nominations from the Consumer Council for the Performance Monitoring Committee and the Health Strategy Committee but inviting them to stay on until the council has been established. This is reflected in the membership that follows.

My recommendations to the Board are as follows:

HWAC operating as Performance Monitoring Committee

Ms Sally Christie (Chair)
Ms Crystal Beavis (Deputy Chair)
Mr Bob Simcock
Ms Sally Webb
Mr Martin Gallagher
Mrs Mary Anne Gill
Mr Dave Macpherson
Dr P Malpass (until new recommendation from Consumer Council)
Mr K Price (until new recommendation from Consumer Council)
Iwi Maori Council representative
Lakes DHB representative
Bay of Plenty representative
Recommendation from Consumer Council, once established

CPHAC and DSAC operating as Health Strategy Committee

Dr Clyde Wade (Chair)
Ms Tania Hodges (Deputy Chair)
Mr Bob Simcock
Ms Sally Webb
Ms Sharon Mariu
Mrs Pippa Mahood
Ms Crystal Beavis
Mr F Mhlanga (until new recommendation from Consumer Council)
Mr J McIntosh (until new recommendation from Consumer Council)
Mr D Slone (until new recommendation from Consumer Council)

Iwi Maori Council representative
Bay of Plenty representative
Lakes DHB representative
Recommendation from Consumer Council, once established

Audit and Risk Management Committee

Ms Sharon Mariu (Chair)
Dr Clyde Wade (Deputy Chair)
Mr Bob Simcock
Ms Sally Webb
Mr Martin Gallagher
Mr Dave Macpherson

Sustainability Advisory Committee

Ms Tania Hodges (Chair)
Ms Sharon Mariu (Deputy Chair)
Mr Bob Simcock
Ms Sally Webb
Dr Clyde Wade
Mrs Mary Anne Gill

Remuneration Committee

Mr Bob Simcock (Chair)
Ms Sally Webb (Deputy Chair)
Ms Sally Christie
Ms Tania Hodges
Ms Crystal Beavis

Two Members to Attend Iwi Maori Council

Ms Tania Hodges
Mrs Pippa Mahood

Two Members to Attend Board of Clinical Governance

Mr Bob Simcock
Dr Clyde Wade

One Member to Chair Waikato Health Trust

Mrs Pippa Mahood

Recommendation
THAT
The membership of the committees of the Waikato DHB and other representation by Board members, is as outlined above.

BOB SIMCOCK
CHAIRMAN

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 3.5

BOARD CODE OF CONDUCT

Background/Information

Please find attached the Waikato DHB Code of Conduct for Board members. This was adopted in 2016. With the commencement of a new Board it is appropriate to affirm this Code for the present three year term.

Recommendation
THAT
The Waikato DHB Code of Conduct for Board Members is adopted for the present three year term of the Board.

BOB SIMCOCK
CHAIRMAN

Code of Conduct for Board Members

Policy Responsibilities and Authorisation

Department Responsible for Policy	Waikato DHB Board
Position Responsible for Policy	Chief of Staff
Document Owner Name	Neville Hablous
Sponsor Title	Chief of Staff
Sponsor Name	Neville Hablous
Target Audience	Waikato DHB Board members
Committee Approved	
Date Approved	
Committee Endorsed	Waikato DHB Board
Date Endorsed	22 February 2017

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Waikato District Health Board
Code of Conduct for Members

Introduction

This code of conduct provides guidance on the standards of behaviour that are expected from the chair and members of the Waikato District Health Board. The code applies to members in their dealings with:

- each other
- the Chief Executive
- all staff employed by the Chief Executive on behalf of the board
- the general public

The code of conduct that follows is based on the following general principles of good governance:

Public Interest

Members must serve only the interests of the community as a whole and must never improperly confer an advantage or disadvantage on any one person, or group of persons

Honesty and integrity

Members must not place themselves in situations where their honesty and integrity may be questioned, must not behave improperly and must on all occasions avoid the appearance of such behaviour

Objectivity

Members must make decisions on merit including making appointments, and awarding contracts

Personal judgment

Members must take account of the views of others, but should reach their own conclusions on the issues before them, and act in accordance with those conclusions

Respect for others

Members must remember the respect and dignity of their office in their dealings with each other, management and the public

Members must treat people with respect, regardless of their race, age, religion, gender, sexual orientation, or disability, and must not unlawfully discriminate against any person or group of persons.

Duty to uphold the law

Members must uphold the law

Stewardship

Members must ensure that the Waikato DHB uses resources prudently and for lawful purposes.

Relationships and Behaviours

Relationships with Other Members

Members must conduct their dealings with other members in ways that:

- maintain public confidence in the office which they hold
- are open and honest
- focus on issues rather than personalities
- avoid aggressive, offensive or abusive conduct.

Relationships with Chief Executive and Staff

The effective performance of Waikato DHB requires a high level of cooperation and mutual respect between members and staff. To ensure that level of cooperation and trust is maintained, members must:

- recognise that the Chief Executive is the employer (on behalf of the board) of all employees, and as such only the Chief Executive or his or her delegated appointee may hire, dismiss or instruct or censure an employee
- treat all employees with courtesy and respect (including the avoidance of aggressive, offensive or abusive conduct towards employees)
- observe any guidelines that the Chief Executive puts in place regarding contact with employees
- not do anything which compromises, or could be seen as compromising, the impartiality of an employee
- avoid publicly criticising any employee in any way, but especially in ways that reflect on the competence and integrity of the employee
- raise concerns about employees only with the Chief Executive, and concerns about the Chief Executive only with the Chair
- not seek to improperly influence staff in the normal course of their duties.

Members should be aware that failure to observe this portion of the code of conduct may compromise the Board's obligations to act as a good employer and may expose the Board to civil litigation.

Confidential Information

In the course of their duties members will receive information that they need to treat as confidential. Confidential information includes information that officers have judged there is good reason to withhold under the Official Information Act. This will often be information that is either commercially sensitive or is the subject of negotiations.

Members should be aware that failure to observe confidentiality will impede the performance of the Board by inhibiting information flows and undermining public confidence in the Board. Failure to observe these provisions may also expose the Board to penalties under the Privacy Act 1993 and/or civil litigation.

Ethics

Waikato DHB seeks to promote the highest standards of ethical conduct amongst its members. Accordingly, members must:

- claim only for legitimate expenses
- not influence, or attempt to influence, any employee to take actions that may benefit the member, or the member's family or business interests
- not use Waikato DHB resources for personal business (including campaigning)
- not abuse the advantages of their official position for personal gain, or solicit or accept gifts, entertainment, rewards or benefits that might compromise their integrity.

Process

Breaches of Code

Any alleged breach by a member of the provisions of the code for which there is not a process and penalty provided elsewhere must be reported in a timely manner to the Chair in the first instance. The Chair, in concert with the Chief Executive (where appropriate), must consider each allegation in a manner that is fair to all parties involved in the allegation, including ensuring that due process is respected. This will include ensuring that members named in an allegation are given an opportunity to consider and respond to that allegation. If following the opportunity to respond to the allegation, it is considered that an allegation of a breach of the code is well-founded, the Chair must inform the member concerned and take any appropriate lawful action.

Any alleged breach by the Chair must be reported in a timely manner to the Deputy Chair, who shall consider and deal with the allegation, seeking advice as appropriate. The Deputy Chair must consider each allegation in a manner that is fair to all parties involved in the allegation, including ensuring that due process is respected. That will include ensuring that the Chair is given an opportunity to consider and respond to that allegation.

If an alleged breach is considered to be of a serious enough nature, or if there is an allegation of repeated breaches of the code, the Chair (or in the case of an alleged breach by the Chair, the Deputy Chair) may instead refer the matter to the Board. The Board will be asked to consider and determine whether a breach of the code has occurred and, if so, what consequences for the member should arise from that breach. In completing a report to the Board, fairness to all parties involved, and due process, will be respected, including ensuring the member named in the allegation is advised of the allegation and given an opportunity to consider and respond to it before the matter is considered by the Board. The Board's consideration of the matter must comply with statutory requirements relating to matters such as personal privacy, or confidentiality of information.

Actions open to the Chair and Board in response to breaches include:

1. Formal confidential censure of the member;
2. Formal public censure of the member;
3. Formal censure accompanied by formal advice to the Minister of Health;
4. Removal of a member from Board committees; and
5. Other options available by law

Review

Once adopted, this code of conduct will continue in force until amended by the Board.

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Chief Executive Report

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 4

CHIEF EXECUTIVE REPORT

Purpose	For information.

Movement of Staff

As advised to the Board in August 2016 members of the executive and their teams occupying the Chief Executive's wing of the third floor of the Hockin Building were temporarily relocated to the KPMG Tower downtown, in December and January. This was to enable the third floor of the Hockin building to be refurbished.

The open plan at KPMG has been very successful.

It is therefore proposed to do further work (in addition to the Chief Executive's wing) on the remainder of the third floor of Hockin to refurbish the premises and allow for more open-space working. To cater for this, staff elsewhere on the third floor of Hockin will be decanted into the Chief Executive's wing.

As a consequence only myself and Donna will move back to third floor Hockin in the near future. Inevitably our time will be divided between the two sites as we will use KPMG to hold meetings with DHB staff and our many community-based stakeholders.

Ultimately the space in the KPMG Tower will be used for:

1. Meeting space available to DHB staff and community stakeholders;
2. Decanting space when staff need to be shifted out of existing premises as is currently the case with part of the HealthShare team;
3. "Docking" space for staff as necessary;
4. Board meetings and functions.

Board members may wish to visit the third floor of Hockin to see the work that has been completed there.

Waikato DHB Strategy

Attached for new Board members is the refresh of the Waikato DHB strategy which was completed in 2016.

Priority programme plans will be prepared for each of the priorities over the coming year or so and submitted to the Health Strategy Committee.

The priority programme plans are the means by which we "operationalise" the strategy and link it to day-to-day activity. The preparation of each is overseen by a member of the Executive. We expect the preparation of these plans to take at least a year with implementation taking at least five years after that.

Official Information Act Requests

Board members have asked for advice as to how we deal with requests under the Official Information Act.

Such requests fall into a number of categories. At the risk of oversimplification these include:

1. Requests from the media and political parties relating to current or potential issues of significance.
2. Requests from the media of a routine nature (e.g. how much equipment goes missing).
3. Requests from individuals relating to research or other matters of personal interest.

A growing number of inquirers seek their own or their loved ones medical records. These are dealt with separately.

In 2014/15 we had 234 requests under the Official Information Act and in 2015/16 we had 162.

This calendar year we would expect the number to increase as the election draws near.

Where a request is likely to be of strong media interest we generally advise the Board by email through the Executive Director: Public and Organisational Affairs (Lydia) of the essence of the request and our response. We do not do this in all cases because many of the requests (as noted above) are of limited interest/significance. Determining what is of significance is of course a matter of judgement. We do sometimes get it wrong by failing to predict what angle will be taken by the media or because we are not aware what other information the media holds to supplement what we have provided.

In keeping with our general obligation of “no surprises” we keep the Ministry of Health and Minister’s Office informed of requests as necessary.

It has been suggested that we should publish on our website all requests and our resulting replies. We have no difficulty with that and will implement this approach. It’s a good incentive for staff to treat all requests with respect. We are upgrading our website in April so will make the change at that time.

At this stage our thinking is that we would not include either the requestor’s identity or the responder’s identity. However, we will make the change and see how it runs.

Recommendation
THAT
The report be received.

DR NIGEL MURRAY
CHIEF EXECUTIVE

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

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

- Te Puea Herangi

JULY 2016

Healthy People Excellent Care

WAIKATO DISTRICT HEALTH BOARD STRATEGY

Vision:

Healthy people. Excellent care

Mission:

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

This Strategy document was published in July 2016 by the Waikato DHB, New Zealand.

For more information on the Waikato DHB's Strategy go to:
www.waikatodhb.health.nz/strategy

Waikato District Health Board
Pembroke Street
Private Bag 3200
Hamilton 3240
NEW ZEALAND

Email info@waikatodhb.health.nz
Waikato DHB (Board, Corporate, Strategy and Funding enquiries) - **Phone** (07) 839 4679

mihi

Ka tū whera te tatau pounamu o te Ao
E takoto te whāriki o te Atua ki mua i a tātou
He hōnore, he korōria ki te Atua
He maungārongo ki te whenua
He whakaaro pai ki ngā tāngata katoa
Ka huri te kei o te waka ki te Kīngi a Tūheitia
Me te whare Kāhui Ariki whānau whānui tonu
Mā te Atua e tiaki, e manaaki i a rātou
Me ngā whakaaro tonu ki ngā mate o te wā
Takoto mai, moe mai koutou, haere, haere, haere
Kāti rātou ki a rātou, tātou ki a tātou
Nō reira, he korowai rau whero o te whare Waiora o Waikato
Haere mai, Haere mai
Nau mai.

The green stone door to the world opens
The whariki of God is laid before us
All honour and glory be to God
May there be peace on Earth
And good will to all people
The keel of our waka turns to King Tuheitia
And the house hold of the Kahui Ariki
May God care and bless them
Our thoughts turn to those who have passed on recently
Rest in peace sleep in peace depart journey on
Let the dead be separated from us the living
Therefore to our distinguished guests gathered here
Welcome, welcome,
Welcome.

foreword

BOARD CHAIR AND CHIEF EXECUTIVE

What does our vision, "Healthy People. Excellent Care", mean?

It means we will support people to stay fit and healthy in their community. However, if people do need health and care services, we treat them quickly, expertly and in a caring and fair way.

Waikato DHB needs to change dramatically. Our people are getting older and they have long-term illnesses like diabetes and heart disease. This means we will not be able to provide the health service our people need unless we do things in a different way, while of course, still living within our means.

We service a district where 23 percent of our population is Māori and over 60 percent of our population is rural. Yet rural people and Māori have poor access to services – they get sick and end up even sicker. This is not acceptable.

Bob Simcock
Chair

Dr. Nigel Murray
Chief Executive

We need to

- Do things in a much smarter and more innovative way and make the most of new technology. Not just for diagnosing and treating disease but for treating and keeping people healthy at home.
- Break down the barriers that stop Māori, those living in poverty, people in rural communities and those with disabilities from keeping well. *How* we deliver our services to Māori is just as important as *what* we deliver. Everyone must have the same fair opportunity for a healthy life no matter who they are or where they live.
- Drive healthy life choices, such as not smoking, and intervene early to stop people getting sicker. However, we need to do this in different ways for different people.
- Make sure that when people do come into hospital or need treatment, they get the most effective and efficient care in the safest environment.
- Attract the best staff to the Waikato by offering high quality training and research, and make sure everyone who works for us is up to date with the latest advances in healthcare.
- Stop doing things that do not make a positive difference in people's lives.

But we can't do this alone – we need to work with our partners who are caring for people in the community from birth through to the end of their life - like GPs, midwives, residential care homes, pharmacies, and charities, so we can all have a profound impact on people's health and wellbeing.

In closing we would like to acknowledge King Tuheitia who endorses the good work of Waikato DHB.

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

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

- Te Puea Herangi

Bob Simcock
Chair

Dr Nigel Murray
Chief Executive Officer

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glossary

Culture	• The beliefs, customs, arts, etc. of a particular society, group, place, or time; • A particular society that has its own beliefs, ways of life, art, etc; • A way of thinking, behaving, or working that exists in a place or organisation (such as a business).
Cultural safety	Cultural safety can be defined as the effective practice of a person or family from another culture that is determined by that person or family. Its origins are in nursing education. A culture can range anywhere from age or generation, gender, sexual orientation, occupation, religious beliefs, or even disabilities. An unsafe cultural practice is an action that demeans the cultural identity of a particular person or family.
Cultural Competence	A set of congruent behaviours, attitudes and policies that come together as a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations. Cultural competence is a developmental process that evolves over an extended period. Both individuals and organisations are at various levels of awareness, knowledge and skills along the cultural competence continuum.
Centre (a centre of excellence)	The term centre is used to identify the Waikato as the centre and not any one place or physical location in the Waikato.
Disability	Disability is not something that individuals have, individuals have impairments. These impairments might be long-term or short-term and can be sensory, physical, neurological, psychiatric/psychological, or intellectual. Disability is the process which happens when one group creates barriers by designing a world only for their way of living and not taking account of others abilities or impairments.
Engagement	A participatory process where stakeholders are involved in dialogue about their views on a topic.
Health inequality and inequity – *As defined by the World Health Organisation*	Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequality and inequity in health. Some health inequalities are attributable to biological variations or choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case, it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health.
Innovation	Innovation is the creation of significant positive change that is sustainable over the mid to long-term. The innovative change can be generated from people, process or technology that once it is agreed to, must then be implemented across people, process and technology to be successful.
Inter-alliance	Refers to a Waikato group containing membership from the alliance leadership teams in the district. Membership is made up of representatives from Hauraki Primary Health Organisation, Midlands Health Network, National Hauora Coalition, Midlands Community Pharmacy Group and Waikato DHB.
Organisation	An entity comprising multiple people, such as an institution or an association, that has a collective goal and is linked to an external environment.
Mission	A written declaration of an organisation's core purpose and communicates a sense of intended direction to the entire organisation, which normally remains unchanged over time. A mission is different from a vision in that the former is the cause and the latter is the effect.
Primary Care	Is often defined by the following characteristics: the first point of contact, comprehensive care, coordinated care, continuity of care, and often located in the community.
Primary Health Care	In the context of this strategy, primary health care relates to the professional health care provided in the community, usually from a general practitioner, practice nurse, pharmacist or other health professional working within a general practice. Primary health care covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention and screening.

Priorities	Areas of work that will be the focus for the DHB. These are not the only priorities, as we have policy priorities that we deliver on as required by the Ministry of Health and Central Government. Each of the priorities will have a priority programme plan.
Programme plan	A suite of activities that will be carried out to fulfill the priorities. We will use objectives to guide delivery of the priority programme plans. There will be a clear logic flow between the objectives and achievement of the priorities. Objectives must be specific, measurable, accurate, realistic and time-bound.
Provider	A provider is an agency that the DHB pays to delivers services under a specific agreement.
Provider-arm	Provider-arm services are services that are directly delivered by the DHB, these are not contracted services.
Quality	The United States Institute of Medicine (IoM) definition states that quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[1] The IoM has identified six dimensions through which quality is expressed: • Safety - *avoiding harm to patients from care that is intended to help them* • Effectiveness - *providing services based on scientific knowledge and which produces clear benefit* • Patient centeredness – *providing care that is respectful or responsive to individual needs and values* • Timeliness – *reduced waits and sometimes harmful delays* • Efficiency – *avoiding waste* • Equity – *providing care that does not vary in quality because of a person's characteristics*
Refresh of a strategy	Refreshing a strategy is most viable when aspects of how the strategy is realised need to be revisited, but the overarching spirit does not.
Stakeholder	Person, group or organisation that has interest or concern in an organisation. Stakeholders can affect or be affected by the organisation's actions, objectives and policies. Some examples of key stakeholders in this context are providers, employees, government (central and local), professional agencies, iwi, hapu, primary care alliance partners, service users, patients and communities.
Strategic imperative	These are a declaration of Waikato DHB's critical areas of focus, which will remain unchanged over the medium term. The strategic imperatives communicate a sense of intended direction to the entire organisation.
Strategy	A strategy is a tool to guide you forward. It provides a high-level guide that is not too vague but also not so specific that adapting to a changing environment becomes impossible. A strategy is often widely communicated using a strategic framework that fits on one page. A strategy usually includes a vision, a mission statement, values, and priorities.
Values	Important and lasting beliefs or ideals shared by the members of a culture or group about what is good or bad and desirable or undesirable. Values have major influence on a person's behaviour and attitude and serve as broad guidelines in all situations.
Vision	A vision statement describes what the organisation aspires to achieve in the longer-term future. It indicates what the organisation wants to become and defines the direction for its development. It serves as a clear guide for choosing current and future courses of action.
Waikato DHB	Waikato DHB is based in Hamilton, and covers an area from the Coromandel in the north down to near Mt Ruapehu in the south. As a DHB we: • Plan in partnership with key stakeholders such as our primary care alliance partners, the strategic direction for health and disability services; • Plan regional and national work in collaboration with the National Health Board and other DHBs; • Fund the provision of the majority of the public health and disability services in our district, through the agreements we have with providers and the provider-arm; • Provide hospital, community based, and specialist services primarily for our population and also for people referred from other DHBs; • Promote, protect and improve our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives.

[1] Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington DC: National Academy Press, 1990, p244.

introduction

TO THE WAIKATO DHB STRATEGY

WHAT IS THIS STRATEGY ABOUT?

This strategy is about change. Not the tinkering around the edges kind of change nor the doing more of the same thing kind of change. This strategy is about transformative innovation causing significant change.

Waikato DHB is part of a wider health system and a strong health system is fundamental for improving the health of our population and eliminating health inequities. There is a need to move away from silo based thinking to systems based thinking which frames challenges and opportunities in the context of a wider dynamic health system. In order to work more effectively with our health and social partners we first need to get 'our own house in order'. There are many aspects of this strategy which focus on the changes Waikato DHB needs to make so we can 'be the change we want to see in the health system'. This strategy is not a hospital strategy; it is about all the functions Waikato DHB is responsible for delivering.

The thinking that the hospital is the most important part of the health system is outdated and needs to be updated. Our hospitals are a vital component of the health system and they will continue to be supported to deliver safe, high quality services but wherever possible people should be receiving the interventions they need in their homes and in their communities.

To implement this strategy successfully we must work in partnership with Māori communities in the planning, delivery, monitoring, and evaluation of health services and care. We must work to ensure that Māori have at least the same level of health as non-Māori, and to safeguard Māori cultural concepts, values, and practices.

Waikato DHB needs to be open to new technologies and new models that will threaten the status quo but will ultimately raise the quality and accessibility of health care. The DHB needs to be prepared to identify potential opportunities, take risks in investing in innovations and play an active role in driving, implementing, monitoring, and evaluating activity. This will help us create a more evidence based health system.

This strategy is about doing what is in the best interests of the people it serves, with them at the centre. This strategy is not about treating a broken arm or heart attack or depression or tooth decay or gout or bronchitis. It is about treating the whole person and keeping them well. It recognises that people are part of families/whānau, they are part of communities and they are a key part of implementing this strategy.

WHY DOES THIS STRATEGY MATTER?

Health care demand is intensifying as the population ages; population risk factors have tended to receive only limited attention. We propose a shift of emphasis to promote healthy life choices, early intervention to reduce disability, and preventing ill health from getting worse. To get there, a number of substantial challenges must be faced including:

- Failure to provide services well for all of the populations;
- Inequalities and inequities in the system;
- Increasing demands on the system as our population ages;
- Long-term conditions rather than illnesses (which can be dealt with using a one-off cure) are now in the majority;
- New Zealand, like most countries will continue to experience budget pressures;
- Changing personal preferences where many people wish to be more informed and involved with their own care;
- Technology is transforming our ability to predict, diagnose and treat disease;
- Integrating further and more rapidly with the other parts of the health sector and with the social sector.

We believe that a whole host of transformative innovations, small and large, will improve the health system and assist in responding to current and future health demands. We want to be part of a future where we work in partnership to build a new health system that is characterised by greater convenience, better outcomes, higher quality, better value, and greater performance than could ever be achieved under the old system.

WHAT WILL IMPLEMENTING THIS STRATEGY LOOK LIKE?

Transformative innovation happens across the health system. It happens in the community, it happens in public health, it happens in primary care, it happens in hospital environments and it happens in those functions that support health care service delivery. It is through viewing these component parts as a whole; and recognising they are tightly connected and highly sensitive to change elsewhere in the system that we stand the best chance of achieving the vision, the mission, and the strategic imperatives presented in this strategy.

The gains we expect to derive from this strategy are not simply a function of reallocating resources and utilising new technology. Effective system change will require us all to shift the way things are done; our staff, our primary health care partners, our health and social partners, our communities, and service users will need to adapt to the changes that will come from implementing this strategy but we cannot successfully implement this strategy without them.

Implementing this strategy will require working outside traditional health sector boundaries. This means working in partnership with agencies across sectors to address the determinants of health and the requirements of high-need populations.

The more often and more comprehensively the components of the system can talk to each other from within an integrated framework – communicating, sharing, problem solving – the better chance any intervention has to positively impact on shared outcomes. Essentially, multiple organisations can achieve more by working together and the health system needs to reflect that rather than creating fragmentation, encouraging ‘siloed’ approaches and stifling transformative innovation.

Performance and accountabilities need to reflect a system wide approach to health and health related outcomes. The performance management of the sector should be based on this foundation – an approach that aligns strongly with the drive to improve the quality, safety and individual patient experience of care, improve health and eliminate inequity, and ensure best value for public health system resources.

background

TO DEVELOPING THE WAIKATO DHB STRATEGY

The purpose of the strategy refresh is to ensure the Waikato DHB's values and priorities reflect a Waikato DHB strategic direction and align to day-to-day operations. The organisation needs to have a strategic direction that supports the parts of the organisation to work as a collective whole for a common purpose.

A refresh, rather than a 're-do', was decided because the spirit of the 2006 strategy was still relevant but there was a need to update the high-level strategic goals and specify key priorities for the next few years.

A draft strategy was developed and taken out for engagement with people in the Waikato. Engagement ran for six weeks, starting 1 March 2016 and ending 15 April 2016. Feedback from the engagement has been included in this final strategy or in the priority programme work stream. No feedback was discarded.

Waikato DHB in context

Waikato DHB was formed in 2001 and is one of 20 district health boards established to plan, fund, and provide health and disability services for their populations. This includes funding for primary care, hospital services, public health services, aged care services, and services provided by other non-government health providers including Māori and Pacific providers.

Te Tiriti o Waitangi (The Treaty of Waitangi) is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Waikato DHB values the Treaty. Central to te Tiriti o Waitangi relationship and implementation of te Tiriti o Waitangi principles is a shared understanding that health is a 'taonga' (treasure). The principles of Partnership, Participation and Protection[1] will continue to underpin the special relationship between Waikato DHB and iwi, and are threaded throughout our strategy.

The New Zealand health and disability system's statutory framework is made up of over 20 pieces of legislation. The most significant are the:

- New Zealand Public Health and Disability Act 2000;
- Health Act 1956;
- Crown Entities Act 2004.

[1] Derived from the Royal Commission on Social Policy

We collaborate with other health and disability organisations, stakeholders and our communities to identify what health and disability services are needed and how best to use the funding we receive from Government. Through this collaboration, we ensure that services are well coordinated and cover the full continuum of care, with the patient and/or whānau at the centre.

As at 30 June 2015, the Waikato DHB had 6,566 employees with 5,480 full time equivalents. These employees are central to the DHBs ability to plan, fund, and deliver health services to Waikato communities.

Our Board is responsible to the Minister of Health and comprises 11 members of which seven are elected and four are appointed by the Minister of Health.

The Waikato – Geography and Demography

Waikato DHB covers over eight percent of New Zealand's population, from Northern Coromandel to close to Mt Ruapehu in the South, and from Raglan on the West Coast to Waihi on the East. It takes in the city of Hamilton and towns such as Thames, Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngaruawahia, Te Kuiti, Tokoroa and Taumarunui.

Key demographics:

- For 2015/2016, our population was 394,340;
- Our population is getting proportionately older;
- The Māori population (estimated to be 23 percent of our population for 2015/2016) is growing;
- Pacific people represent almost 3 percent of our population;
- Approximately 60 percent of our population live outside the main urban areas;
- We have a larger proportion of people living in areas of high deprivation than in areas of low deprivation.

Mapping the Waikato DHB Strategy to the New Zealand Health Strategy

The New Zealand Health Strategy: Future Direction outlines the high-level direction for New Zealand's health system over the 10 years from 2016 to 2026. It lays out some of the challenges and opportunities the system faces; describes the future we want, including the culture and values that will underpin this future; and identifies five strategic themes for the changes that will take us toward this future.

During the development of the Waikato DHB Strategy, we assessed alignment with other government, non-government, provider, and partner agency strategies. The refresh of the New Zealand Health Strategy was occurring at the time of the early development of the Waikato DHB strategy refresh so we kept up-to-date on its progress to ensure alignment where appropriate.

Mapping the Waikato DHB Strategy to other agencies

Ensuring the Waikato DHB Strategy could be aligned to other agencies' strategies will help us to achieve our goals and help the other agencies to achieve theirs.

To align the Waikato DHB Strategy with others, we examined the strategies (or equivalent) for our social and health care partners to ensure their priorities, where appropriate, were aligned with our strategic imperatives or priorities.

IMPLEMENTING THE
strategy

The first pre-requisite to the success of this strategy will be strong and unambiguous leadership. Whether that be from the Board, the Chief Executive, the Senior Executive team or others, the opportunities identified in this strategy invites people to lead and take responsibility. Health care demand is intensifying as our population changes and grows. These changes and growth are and will continue to present the health and social systems with challenges, some of which have not been encountered before. In order to respond to these challenges we must become more innovative and we must get comfortable with change. Turning this strategy into action will mean making changes; some changes will see more investment in some areas and some changes will mean disinvestment. Whatever the changes, they will be done by using robust decision-making and in partnership with others to ensure we are delivering excellent health services and care.

Priority programme plans

To connect strategy with day-to-day activity, priority plans will be developed. These plans will detail the transformative innovation needed to create the health system that works best for the Waikato. A priority programme plan is created to:

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

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

Monitoring the strategy

We will monitor delivery of the strategy by assigning performance and progress measures to each priority programme plan. The progress for each priority will be a factor when reviewing the priorities every three years. When a priority has been achieved, it will move out of the strategy's priority section and into a maintenance schedule. This will make room for new priorities to be included in the strategy when required.

Progress measures will be assigned to each of the strategic imperatives, which will be reported on in the Waikato DHB's Annual Report. Progress of the strategic imperatives will provide an indication for how we are working in line with our mission and towards obtaining our vision.

Accountability for results

In the end, the success of this strategy will be measured by the results that will be achieved. Every strategic imperative and associated priority will be monitored and the objectives required under the contracts of the people charged with delivering those results. In this way, by being accountable for what we say we are going to do, we will give confidence to everyone that we mean what we say.

EXPLAINING THE WAIKATO DHB'S

strategy

Our vision

The vision for the organisation is our aspirational, long-term desired goal that all staff employed by the Waikato DHB can relate to and are working towards. The vision will be reviewed every five years to check whether it is still appropriate.

Our mission

The mission statement is a written declaration of our core purpose and focus, which communicates a sense of intended direction to the entire organisation. To ensure the mission statement stays relevant it will be reviewed every five years along with the vision.

Our strategic imperatives

The strategic imperatives are our long-term goals, which will be reviewed after five years along with the vision and mission.

Each strategic imperative is explained by illustrating what we mean, why each strategic imperative matters, and what our focus on each strategic imperative will look like. Under each strategic imperative are priorities, which have been developed for the operational level of the Waikato DHB.

Our priorities

The priorities are how we will action the strategic imperatives, and as a result the whole strategy through operational activities. The priorities will be reviewed every three years with the achieved priorities moving into a maintenance focus and those not yet achieved continuing to be priorities. During the three-year review, new priorities will be added where appropriate.

Under each strategic imperative four priorities have been allocated. Each priority is explained to illustrate what we mean, why it matters to have this priority, what the priority will look like when delivered, and how the priority will be actioned.

Our values

Our values lie at the core of what we do. Values are important and lasting beliefs or ideals shared by the members of a culture or organisation. They speak to us about what is good or bad and desirable or undesirable and serve as broad guidelines in all situations. Values have major influence on our attitudes and behaviours. When the vision and mission are reviewed, the values will be checked to ensure they are still appropriate.

Our Objectives

The objectives this strategy will achieve are not included in the detail of this document, however they are what will guide our actions to deliver on the priorities. Our objectives cross priorities, this will help reduce duplication, strengthen decision-making, and break silos. The objectives will be required under the contracts of the people charged with delivering those results to show accountability for doing what we say we are going to do.

STRATEGIC
framework

OUR priorities

- Radical improvement in Māori health outcomes by eliminating health inequities for Māori
- Eliminate health inequities for people in rural communities
- Remove barriers for people experiencing disabilities
- Enable a workforce to deliver culturally appropriate services

- Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement, and innovation
- Prioritise fit-for-purpose care environments
- Early intervention for services in need
- Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives

- Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services
- Provide care and services that are respectful and responsive to individual and whānau needs and values
- Enable a culture of professional cooperation to deliver services
- Promote health services and information to our diverse population to increase health literacy

- Live within our means
- Achieve and maintain a sustainable workforce
- Redesign services to be effective and efficient without compromising the care delivered
- Enable a culture of innovation to achieve excellence in health and care services

- Build close and enduring relationships with local, national, and international education providers
- Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research
- Cultivate a culture of innovation, research, learning, and training across the organisation
- Foster a research environment that is responsive to the needs of our population

- Incorporate te Tiriti o Waitangi in everything we do
- Authentic collaboration with partner agencies and communities
- Focus on effective community interventions using community development and prevention strategies
- Work towards integration between health and social care services

OUR values

People at heart
Te iwi Ngakaunui

Give and earn respect – *Whakamana*
- Be courteous and considerate
- Own what you do
- Value everyone's contribution
- Accept differences and diversity
- Put yourself in the shoes of others

Listen to me; talk to me – *Whakarongo*
- Listen to and hear others
- Open and safe sharing
- Kept in the loop and informed
- Direction and expectations clear

Fair play – *Mauri Pai*
- Create opportunities for inclusive decision-making
- Share the work, do your share
- Equal recognition for all
- Clear and transparent processes

Growing the good – *Whakapakari*
- Acknowledge and appreciate me
- Create opportunities to learn and grow
- Give support, praise and feedback
- Provide experiences to maximise potential
- Share learning(s); create change

Stronger together – *Kotahitanga*
- Be kind and helpful to each other
- Foster a supportive safe work place
- Celebrate and share success
- Collaborate to achieve known outcomes

“I like the focus on higher order concerns (such as reducing inequity) rather than specific service level issues such as closer to home, cardiac vs medicine, children vs elderly etc. Reducing inequity is a core principle that should be retained in the strategy”

Response to the survey question asking what people liked about the draft strategy

STRATEGIC IMPERATIVE

health equity for high-need populations

TE HUA RAUTAKI – ***oranga***

WHAT DO WE MEAN?

Waikato DHB in conjunction with Iwi Māori Council, will provide the leadership to ensure we are committed to achieving health outcomes and equity across high-need population groups. Health outcomes are described as the effect the process has had on the people targeted by it. These might include, for example, changes in their self-perceived health status or changes in the distribution of health determinants, or factors that are known to affect their health, wellbeing, and quality of life. Health inequities are described as 'differences which are unnecessary and avoidable, and are unfair and unjust'. While we have identified priority high-need populations, this does not mean we will not support other populations experiencing inequities.

WHY DOES THIS MATTER?

As a DHB, we have a specific remit to lead, promote, protect, and improve our population's health and wellbeing through accountability for our results. When we focus on achieving health outcomes and equity for our populations everyone benefits because we are ensuring the right type of health services and care are delivered at the right time (earlier rather than later) and in the right place (at home, closer to home, or if required at hospital).

WHAT WILL THIS LOOK LIKE?

There is an expectation that the DHB and all contracted providers will be responsible and accountable for contributing to this imperative. This signals a significant change that services will be more responsive and accountable for health outcomes for high-need populations. It is expected that existing services that are not meeting the needs of high-needs populations will be reconfigured; development and implementation of new service models and funding will be prioritised for these populations.

We will use the equity tools available to us in all service planning. The tools will be used to identify the most effective intervention for achieving health equity. We will take account of particular needs within the communities served, to ensure access to services and communication is effective and responsive, and that services are safe and culturally appropriate.

Focusing on the determinants of health is crucial if health inequities are to be eliminated. This requires a multi-agency approach; therefore, we will be continuing to work in partnership with organisations in some areas and growing partnerships in others.

Developing health services by, with, and for specific populations has shown to be effective in reducing inequities. We will work with all our high-need populations to improve health outcomes and achieve health equity. We will work with our providers, partners, and communities to ensure they are empowered to deliver services and care that suit the needs of the Waikato population.

WHAT ARE THE PRIORITIES FOR THIS STRATEGIC IMPERATIVE?

- Radical improvement in Māori health outcomes by eliminating health inequities for Māori
- Eliminate health inequities for people in rural communities
- Remove barriers for people experiencing disabilities
- Enable a workforce to deliver culturally appropriate services

implementing
THE PRIORITIES

1. Radical improvement in Māori health outcomes by eliminating health inequities for Māori

WHAT DO WE MEAN?

We will provide the leadership and action that is necessary to radically improve Māori health outcomes and eliminate health inequities. We expect radical and demonstrable improvements to Māori health. We expect every provider and employee that receives DHB funding will actively contribute and be accountable for achieving this priority. Collectively (and in conjunction with others), we will improve Māori health and eliminate health inequities.

WHY DOES THIS MATTER?

Māori in the Waikato, on average are poorer, sicker, and die earlier than their pākehā counterparts. This is unacceptable and there is no justifiable reason why we should continue to tolerate this imbalance. We need to ensure that Māori, along with everyone else, have the capacity and opportunity to realise their full potential for wellbeing.

WHAT WILL THIS LOOK LIKE?

Providing effective services for Māori is normal. Healthy Māori are normal.

2. Eliminate health inequities for people in rural communities

WHAT DO WE MEAN?

We are planning for sustainability in rural health services and exploring opportunities to get the workforce better joined up to ensure rural peoples are not experiencing inequity in health services and care.

WHY DOES THIS MATTER?

The Waikato DHB serves a range of communities 60 percent of which are rural. Many of these communities have poor access to health services and care and poorer health outcomes. It is becoming increasingly important that our rural areas are supported to sustain themselves as communities. This includes ensuring appropriate access to services to arrest depopulation and improving health outcomes for Māori living in rural communities.

WHAT WILL THIS LOOK LIKE?

The rural communities in Waikato will have equity of access to health services and care through the use of technology (where appropriate), service delivery closer to home, and support when travelling for health care or services.

The rural healthcare project for the Waikato will be one of the key guides used to action this priority. The rural healthcare project will provide those who are responsible for actioning this priority with a map for robust decision-making. The decision making will be informed by providers and communities by way of co-development of plans. Other activities will include those we are tasked with by central government and activities that the DHB has committed to in collaboration with other agencies.

3. Remove barriers for people experiencing disabilities

WHAT DO WE MEAN?

"Disability is not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual or other impairments... Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have..."[2] The DHB has the ability to achieve health equity for people living with disabilities by collaborating with those experiencing barriers to DHB services to make improvements.

WHY DOES THIS MATTER?

One in four people in the Waikato are living with disability. Living with a disability increases with age. Multiple impairments occur in over half of people living with disability. The Ministry of Health has tasked us to "promote the inclusion and participation in society and the independence of people with disabilities".

WHAT WILL THIS LOOK LIKE?

People living with disabilities will have equity of access to quality and timely health services and care through our increased collaboration with them on the design of services and care. There will be a focus on working with those who are advocating at a local, regional, and national level for a less disabling society. We will use best practice approaches rather than aiming for just compliance. One of the avenues that will be used to achieve this priority will be the Waikato DHB Disability Support Advisory Committee. A priority programme plan will be developed; this will include the development of a Waikato DHB Disability Action Plan. Engaging with our disability communities will help to identify the activities that will be included in the priority programme plan.

4. Enable a workforce to deliver culturally appropriate services

WHAT DO WE MEAN?

The Waikato DHB employs around 6,000 staff across the district, from diverse backgrounds and across a wide range of disciplines. All these people are working toward better health for the people of Waikato and beyond and their efforts need to be culturally appropriate. This means doing things in a different way for different people.

WHY DOES THIS MATTER?

The majority of Waikato DHB staff interact with patients, their family/whānau, other health providers, social and health agencies, or Waikato communities. We need to ensure that as a workforce, we are providing services in a way that meets the needs of those we interact with. By this means we will improve access and satisfaction.

WHAT WILL THIS LOOK LIKE?

The Waikato DHB staff/workforce will reflect the population it serves. A one-size fits all approach will not work. The Waikato DHB is a large complex organisation with a wide variety of activities and areas of work and each area will need to ensure that their service delivery caters to the particular community being served.

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[2] Minister for Disability Issues. (2001). New Zealand Disability Strategy. Wellington: Ministry of Health

“Become the leaders for the region - to provide/purchase/facilitate quality services for all of the Waikato DHB population, including Māori, rural and high-need populations in ways that make a difference to their wellbeing...doing whatever it takes with whoever is needed to make the difference. No more saying it’s not my / health’s job!”

Response from a joint workshop when asked about opportunities Waikato DHB should consider over the next few years

STRATEGIC IMPERATIVE

safe, quality health services for all

TE HUA RAUTAKI – ***haumaru***

WHAT DO WE MEAN?

Safe services means that services are consistently person (or whānau) centred, and clinically and culturally effective and safe, for all people, all the time. The United States Institute of Medicine definition states that quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[1]

WHY DOES THIS MATTER?

Unless we reshape care delivery, harness technology, and drive down variations in the delivery of quality, safety and timely care, then the changing needs of the individual and population will go unmet, people will be harmed who could have been cured, and unacceptable variations in outcomes will persist.

WHAT WILL THIS LOOK LIKE?

We will be accountable for the delivery of the highest quality healthcare services, at all the various stages of life, to people in the Waikato. Our goal is to have the highest quality health services and care in New Zealand.

We will have a culture that is safe, accountable, and committed to learning and continuous organisational development, which will enable us to deliver demonstrable improvements in patient care. We will embed continuous quality improvement, high quality safe patient care, compliance with regulatory frameworks within the organisation, and will empower our staff and providers to continuously raise the standard and improve quality and safety.

WHAT ARE THE PRIORITIES FOR THIS STRATEGIC IMPERATIVE?

- Deliver high quality, timely safe care based on a culture of accountability, responsibility, continuous improvement, and innovation
- Prioritise fit-for-purpose care environments
- Early intervention for services in need
- Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives

[1] Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington DC: National Academy Press, 1990, p244.

implementing
THE PRIORITIES

1. Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement, and innovation

WHAT DO WE MEAN?

The focus will be on delivering services in which quality is seen as an integral part of a whole system approach to improving standards and protecting our public from undue/unnecessary harm (including death).

WHY DOES THIS MATTER?

Our population demands and deserves safe care. It would be wrong to aspire to anything else.

WHAT WILL THIS LOOK LIKE?

As a DHB, we will lead, set, and maintain standards for our staff, so they can continue to deliver quality, timely, and safe care and services to their patients and communities. By setting standards for ourselves we will ensure and expect alignment with our providers and our health and social service partners.

There will be assurance that we will excel and lead in the areas of quality and safety that we are required to meet under legislation. We will work with others who are exemplars in the various areas of health care and service to learn and adapt to meet the needs of our population. All our systems and processes will ensure that the quality of care meets the expectations of the population we serve and that people are safe, with no avoidable injury or harm from the health care they receive.

2. Prioritise fit-for-purpose care environments

WHAT DO WE MEAN?

Environments where people receive care and services that are appropriate for their needs including cultural responsiveness. Hospitals and health care facilities are a key focus for this priority, however this priority is not limited to hospital and health care facilities. We will ensure mobile services, virtual care, and health service offices are available and of high quality, as well as accessible and designed to meet the needs of users.

WHY DOES THIS MATTER?

Fit-for-purpose environments are important to deliver safe, quality health services and care. For example hospital theatres need to be sterile and facilities need to be accessible. Ensuring the Waikato has fit-for-purpose environments also means that services can be delivered to our rural populations and to those in their homes (where appropriate) through innovative approaches like virtual health. Reducing (where safe and appropriate) the need for people to travel and wait in a healthcare facility frees up space for emergency cases, reduces the costs and impacts of travelling, reduces the spread of infection, and offers convenience to patients.

WHAT WILL THIS LOOK LIKE?

With the wide range of care and services that the Waikato DHB delivers, it is vital that environments are co-designed with our health and social service partners and providers. We will use knowledge from others who excel at providing fit-for-purpose care and services and adapt to suit our diverse populations (including our high-need populations). Our facilities will meet or exceed relevant compliance standards.

3. Early intervention for services in need

WHAT DO WE MEAN?

Services experiencing challenges will be prioritised to ensure people's care is not compromised. This includes health services delivered to patients as well as oganisational services.

WHY DOES THIS MATTER?

Services can come under challenge for a variety of reasons, including increase in demand, changes in other sectors, government policy changes, and as a result of our own decisions. When services are under challenge we are all impacted; staff are stressed, patient care may not be of the highest quality, and our providers and health and social care partners can also be affected. These impacts may be as minor as an annoyance or as severe as serious harm or death. It is not acceptable for people's care to be compromised when we have the power and ability to prevent these impacts.

WHAT WILL THIS LOOK LIKE?

Services that are delivered to providers, health and social service agencies, communities, and staff will be responsive to potential and actual challenges to ensure our populations' care and services are safe and of a high quality. We will ensure early responses are implemented and preventative strategies employed to avoid negative impacts on our service users including patients, whānau, staff, providers, health and social service agencies, and those we are accountable to. We will partner with others, learn from them, and be proactive when alerted to potential challenges for services.

4. Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives

WHAT DO WE MEAN?

This priority is about making sure we are investing in the right services for our populations at every stage of life. We will stop funding services that are not meeting the needs of our populations and invest in services that can make a positive difference to people's lives.

WHY DOES THIS MATTER?

People of the Waikato have differing needs from birth to the end of their lives and we need to meet their needs at every point. Health services and care are not just about bricks and mortar. While hospitals are vital we must also provide preventative services to keep people healthy and well.

WHAT WILL THIS LOOK LIKE?

We will take a holistic approach using care and services to treat the whole person or whānau not just the illness or problem. We will listen to what our populations need at every point in life's journey. We will learn and adapt what others do well, and continuously improve the way we work.

"I like the people centred priority – I hope it works in practice. Over the years in health we have talked about this but we only achieve it in limited manner"

Response to the survey question asking what people liked about the draft strategy

STRATEGIC IMPERATIVE

people centred services

TE HUA RAUTAKI – ***manaaki***

WHAT DO WE MEAN?

Providing people centred services means empowering people to take much more control over their own care and treatment. We recognise that patients, their families and carers are often 'experts by experience'. This imperative is focused on putting people at the centre of all services and interactions.

WHY DOES THIS MATTER?

We need to move away from 'one size fits all' care models and create a person centred approach to provision, which ensures that everyone gets the service they require, when they need it, where they need it and with their input. Increased health consumer knowledge and autonomy is associated with improved outcomes. Staff, health providers, and health systems need to be engaging with people wherever they are located. More broadly, we need to engage with communities and people in new ways, involving them directly in decisions about the future of health and care services.

WHAT WILL THIS LOOK LIKE?

We will do more to support people to stay healthy, make informed treatment choices, manage their conditions and avoid complications.

We will provide people and families with the necessary information and resources, and assist them to develop skills to engage with health services and be a part of managing their own health needs. We know that different people or groups will require different approaches so we will listen to, involve and empower our patients and service users in their own health care.

We will make more use of the opportunities digital technologies offer and strengthen our virtual care approach.

We will maintain processes to enable Māori to participate in, and contribute to, strategies designed to improve the health of Māori. These processes include the development of effective relationships with iwi and Māori, and consultation with Māori. They also include improving service delivery, reducing health inequities, monitoring health outcomes and being accountable for the results achieved. We will maintain and grow mechanisms to ensure other groups with high-needs are able to participate in, and contribute to, strategies designed to improve their health.

WHAT ARE THE PRIORITIES FOR THIS STRATEGIC IMPERATIVE?

- Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services
- Provide care and services that are respectful and responsive to individual and whānau needs and values
- Enable a culture of professional cooperation to deliver services
- Promote health services and information to our diverse population to increase health literacy

implementing
THE PRIORITIES

1. Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services

WHAT DO WE MEAN?

People who regularly interact with or work within the health system have a wealth of knowledge due to their personal and professional experience with health care, services, and systems. This expertise needs to be utilised for the design of health services and care to ensure they are appropriate for people's needs.

WHY DOES THIS MATTER?

Health services and care are about more than treating illness; people's health and wellbeing is improved when services are designed in a way that is appropriate to their cultural and socio-economic needs. We need to ensure we are working in the best way possible for our diverse population so they can stay well, get well, or manage with support and comfort that suits their needs. The Waikato has a diverse population with varying health needs and we need to ensure that we do not apply a one-size fits all approach.

It is equally important to use the knowledge of those who are responsible for delivering the care and services as they hold expertise in how systems and processes function. Their knowledge can be used to ensure there is safe practice, efficient service, and care for colleagues who are impacted by the work they do.

WHAT WILL THIS LOOK LIKE?

We will examine and use best practice to grow our ability to engage with the people of the Waikato and involve them in service design. Through this, we will ensure that people and groups who have not traditionally had a voice are given the ability to participate.

Our engagement will include our own staff, specialists, providers, and health and social agencies. We will learn and adapt what others do well and continuously improve the way we work.

2. Provide care and services that are respectful and responsive to individual and whānau needs and values

WHAT DO WE MEAN?

This is about putting the person at the centre when providing care and services, it is about always being respectful to others and acknowledging their values and beliefs by being adaptable and responsive to their needs.

WHY DOES THIS MATTER?

Waikato is a diverse district and often what is appropriate for one person, group, community, family, or whānau may not be appropriate for another. People need different things out of health care or services and as a DHB we must be able to adapt and respond to each person's needs. When we do this, people will have more confidence in the care and services they receive because they know they are not seen as a statistic.

WHAT WILL THIS LOOK LIKE?

This priority is focused on people who will receive health services and care, however it also applies to the other areas of the DHB which may not interact with people needing care but perhaps work with those who provide care. We will prioritise and expect our staff to be culturally competent, including those who do not work directly with people receiving care and services.

3. Enable a culture of professional cooperation to deliver services

WHAT DO WE MEAN?

Waikato DHB staff work in a variety of areas and represent various disciplines. We will cooperate with each other through clear communication and by using the different skills and knowledge colleagues have to provide timely, quality care and service for the population.

WHY DOES THIS MATTER?

Delivering people centred services is about recognising people's need to receive care and services that are appropriate to them. Different professional groups have different perspectives. By ensuring all view points are recognised in service design and delivery we are more likely to achieve people centre care.

WHAT WILL THIS LOOK LIKE?

Staff will work together to ensure care and services are respectful, responsive, and appropriate. We will drive clear communication between all health professionals, to enable cooperation to be achieved.

4. Promote health services and information to our diverse population to increase health literacy

WHAT DO WE MEAN?

This priority is about how we provide people with information; people vary in the ways they access and understand information and we need to be sure that we are communicating in ways that are appropriate and effective for our diverse population.

WHY DOES THIS MATTER?

In order for people to understand how to stay healthy, improve their health and access services we need to communicate in a way that is appropriate and relevant to them. In Waikato we have a diverse audience and we need to adapt how we communicate so the information is understood, and so people can make informed decisions about their health and wellbeing.

WHAT WILL THIS LOOK LIKE?

We will focus on building better health literacy working with the Ministry of Health to share effective techniques. We will use a range of methods for informing people about ways to get healthy and stay healthy. We will use appropriate language and technology. We will ensure information is clear and consistent. Cultural competence will be prioritised in our staff so we can better communicate with Māori, Pacific peoples, and our migrant populations.

“Let’s not stop innovation and let’s take advantage of the capability and capacity of what’s happening in the environment”

A participant’s view expressed at a public meeting on the draft strategy

STRATEGIC IMPERATIVE

effective and efficient care and services

TE HUA RAUTAKI – ***ratonga a iwi***

WHAT DO WE MEAN?

Effective and efficient services means at all levels health services and care will meet the needs of our populations. This means we need to ensure our foundations are strong, we are financially sustainable, we have a high quality and sustainable workforce, and the best available information to inform decision-making. It also means that we will have the courage to make the difficult decisions to either invest or disinvest in services in order to meet the needs of the populations we serve.

WHY DOES THIS MATTER?

This matters because everything we do has a consequence and ineffective quality, care, or services may cause unnecessary suffering. By "getting it right" the first time, we also avoid unnecessary costs to patients' health and government spending. There are more claims on the budget than can be afforded so we need to organise the system in the best way possible to meet current and future demand. We also need to work smarter to meet demands and excel in health services and care.

WHAT WILL THIS LOOK LIKE?

In order to deliver the necessary change we will invest in our current and future workforce. We will learn from the best examples, not just from within New Zealand but internationally. We will evaluate new care models to establish which produce the best experience for patients and the best value for money. We will exploit the information revolution to deliver more effective care.

We will be part of a future that no longer sees expertise locked into hospital buildings and fragmented services. It will be a future where the system is organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. We see a future that dissolves long-standing and artificial divides between general practice and hospitals; physical and mental health and addiction; health and social care; and prevention and treatment.

WHAT ARE THE PRIORITIES FOR THIS STRATEGIC IMPERATIVE?

- Live within our means
- Achieve and maintain a sustainable workforce
- Redesign services to be effective and efficient without compromising the care delivered
- Enable a culture of innovation to achieve excellence in health and care services

implementing
THE PRIORITIES

1. Live within our means

WHAT DO WE MEAN?

Maintaining financial stability is about ensuring we are spending wisely, working smarter, ensuring value for money, and that there is transparency and accountability for the health budget allocated to the Waikato.

WHY DOES THIS MATTER?

Health has continued to receive a significant portion of the government's expenditure and we are accountable to the government and to the taxpayers for how we spend it. On present projections health costs will go up and funding will not keep pace. We need to extract better value from every dollar we spend.

WHAT WILL THIS LOOK LIKE?

We need to be better at preventing poor health, ensuring people with conditions receive early and appropriate care and services to prevent deterioration, and providing whole-of-person care and services. This will require us to change the way we work and change the way we contract for the delivery of services (in collaboration with providers) so providers can continue to deliver to the Waikato population.

If we want to secure health and wellbeing for future generations then we must be prudent in the way we work and spend health dollars. This requires collective action and a fundamental change to ensure that all our services are efficient as they can be.

2. Achieve and maintain a sustainable workforce

WHAT DO WE MEAN?

Achieving a sustainable workforce is about ensuring the right people are in the right positions and proactively engaged. It is also about filling positions being vacated so there is no discontinuity of service. This may also extend to staff employed by contracted providers and other service agencies in order to implement the priorities in this strategy.

WHY DOES THIS MATTER?

A sustainable health workforce is fundamental to the delivery of excellent health services and care to the Waikato population. Training new staff is expensive and time consuming as is keeping people employed in roles they are not passionate about. As a DHB, we need to strive to be a place where people love to come to work because highly engaged staff are more efficient and effective in their work.

WHAT WILL THIS LOOK LIKE?

We will streamline our recruitment. We will anticipate where our future shortages will be and act swiftly to address them. We will be flexible in our approach to roles and staffing. We will grow our leadership capability and give those leaders appropriate support. We will ensure staff are fully engaged in their work and understand the vision and their role in delivering it.

3. Redesign services to be effective and efficient without compromising the care delivered

WHAT DO WE MEAN?

This priority is about changing the way we do things to ensure effective and efficient care and services for the Waikato population.

WHY DOES THIS MATTER?

If we continue to do what we have always done, then we will likely continue to get the same results and remain where we are. As a DHB, we need to regularly evaluate what we do to ensure we are continually improving our care and services to meet the populations' growing and complex needs. By this means we will also derive better value from every dollar we spend.

WHAT WILL THIS LOOK LIKE?

We will continue to evaluate services to find where improvements can be made and to confirm what is working well. We will also need to partner with our providers and other health and social service agencies to ensure the right type of services are being delivered and to identify gaps. We will need to work across traditional boundaries, such as primary and secondary, and we will need stronger systems and relationships.

4. Enable a culture of innovation to achieve excellence in health and care services

WHAT DO WE MEAN?

This priority focuses on achieving a culture that inspires innovation from staff for the Waikato population. Innovation is a term often used to describe great new ideas, however, in the wrong environment innovation can be hampered. Innovation occurs when the setting is designed to allow it.

WHY DOES THIS MATTER?

In order to deliver the right services, in the right way, at the right time the DHB needs to embed an organisational culture that inspires people to suggest new ways of working. Staff have a unique perspective and some great ideas and we need to encourage them to feel comfortable expressing these ideas.

WHAT WILL THIS LOOK LIKE?

Encouraging innovation from staff is an area of organisational development with many best practice examples. We will explore how others have achieved workplaces with a culture of innovation, and how that could be implemented here.

“We want Waikato DHB to become a centre of excellence, achieving this would raise Waikato’s profile nationally and internationally and lead to attracting high quality staff and improving our quality of patient care”

Response to the survey question asking what priorities should be in the strategy

STRATEGIC IMPERATIVE

a centre of excellence in learning, training, research, and innovation

TE HUA RAUTAKI – ***pae taumata***

WHAT DO WE MEAN?

Learning, training, research, and innovation are vital to ensure health professionals deliver services in a way that best meets the needs of patients and whānau. Becoming a centre of excellence means we aim to achieve the highest standards; anything less than exceptional is unacceptable. This will include developing the non-regulated workforce and other health professionals that evolve as service reconfigurations and models are implemented.

WHY DOES THIS MATTER?

We are responsible for making decisions that will affect the health and wellbeing of Waikato people; by using research we can ensure those decisions are based on strong evidence. The Waikato health system's ability to provide quality health services to the community now, and into the future, requires investment in training.

Trends show there are limited numbers of health professionals trained in New Zealand who remain here and our migrant health workforce is increasing. Often the Māori workforce tends to remain in New Zealand and if they go overseas, they are likely to return. That is why investing in recruitment, development and retention of Māori staff is a great return on investment.

When we take a principled approach to professional development and training, our staff will continually be focused on best practice for our high-need populations and our Waikato communities. We must ensure our workforce is trained to work within the diverse cultural environment that exists in the Waikato. We must ensure New Zealand trained health professionals are able to learn from the expertise that our migrant health workers bring with them.

WHAT WILL THIS LOOK LIKE?

We see a future where our innovative approach to learning, training and research will attract the best people who will come to learn, teach, and choose to stay within the Waikato. More qualified health professionals will be needed to meet the demand for health services as the Waikato grows. By offering the best training for students, opportunities for health professionals to teach others, and cutting edge research we will become a centre of excellence that health professionals are drawn to.

Our facilities and processes will provide staff and students with a great environment in which to learn and grow. People make employment decisions in part because of the quality of teaching and we need to offer and lead our students in the best training to encourage the best students to come to the Waikato for their careers.

WHAT ARE THE PRIORITIES FOR THIS STRATEGIC IMPERATIVE?

- Build close and enduring relationships with local, national, and international education providers
- Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research
- Cultivate a culture of innovation, research, learning, and training across the organisation
- Foster a research environment that is responsive to the needs of our population

implementing
THE PRIORITIES

1. Build close and enduring relationships with local, national and international education providers

WHAT DO WE MEAN?

Relationships with other education providers enhance the quality of education delivered to those who want to work in the health sector. This includes mātauranga Māori, Waikato based providers, New Zealand providers, and education providers overseas.

WHY DOES THIS MATTER?

There are many examples of excellence in learning, training, and research. Some of these examples are local to the Waikato and some are outside the Waikato. It is important that we build strong relationships with education providers so we can learn what is available and share the expertise and opportunities that Waikato DHB has. Joint arrangements will help us share the expertise others have developed.

WHAT WILL THIS LOOK LIKE?

Many staff at the DHB have received their education or have taught in institutions in New Zealand and around the world. Strengthening and formalising those networks and developing new forums for networking will help build and enhance relationships. Building the Waikato DHB's profile through better communicating the work that is occurring will be beneficial for education providers who might have students or specialists who could contribute. Partnering with the local and national providers will be crucial.

2. Attract doctors, nurses and allied health staff to the Waikato through high quality training and research

WHAT DO WE MEAN?

We want Waikato DHB to reflect the population we serve and be a workplace that health professionals are eager to work in because of the interesting research being conducted and for the excellent opportunities to give and receive training.

WHY DOES THIS MATTER?

When Waikato DHB employs the best, our populations get the best. We are able to employ the best health professionals when high-quality training and research is available to them.

WHAT WILL THIS LOOK LIKE?

As a DHB, we need to become braver in sharing the work we do and the research we conduct and are involved in. We need to do this using a variety of forums so our presence is visible to a wide audience. We will collaborate with other agencies to deliver on their research goals and activities, such as the first New Zealand Research Strategy. Opportunities to conduct research and to share our research will be better advertised within the DHB and to our health and social agency partners. We will develop our training to a consistently high standard that attracts staff including the non-regulated workforce.

3. Cultivate a culture of innovation, research, learning, and training across the organisation

WHAT DO WE MEAN?

Innovation, research, learning, and training are not just something most people do. They need to be fostered and nurtured to create a culture where staff are encouraged to be innovative, research is valued, learning is prioritised, and training is respected.

WHY DOES THIS MATTER?

A culture of innovation, research, learning, and training will help us to attract and keep the best staff. It will enable us to grow the staff we have. It will enable to DHB to be at the cutting edge of the latest advances in healthcare.

WHAT WILL THIS LOOK LIKE?

Staff will inspire each other and the DHB will become an organisation where innovative ideas from staff, providers, health and social partners, education providers, and communities are encouraged. Research will be used to support innovative ideas to turn them into reality, and an environment of continual learning and training will be nurtured.

4. Foster a research environment that is responsive to the needs of our population

WHAT DO WE MEAN?

The Waikato DHB will be an organisation that conducts research that will be valuable to our population and contributes to the wider research community. Research must prioritise and be inclusive of our high-needs populations. Decision-making will occur with the use of the most appropriate and robust research.

WHY DOES THIS MATTER?

Research which is responsive to the needs of our population is the springboard for improving services and care. Therefore, we must foster an environment from which exactly that kind of research emerges.

This priority is not only about being a contributor to research communities but also using research conducted internally and externally to the DHB for decision-making.

WHAT WILL THIS LOOK LIKE?

We will focus on research that is of value in the delivery and services especially to high-need populations. We will work closely with our partners to identify areas of research.

"Productive partnerships is something that will always require work…people change, situations change, so you need to keep the conversation going. There are old hurts but we can work through these when we keep the partnerships alive through communication"

A participant's view expressed at a public meeting on the draft strategy

STRATEGIC IMPERATIVE

productive partnerships

*TE HUA RAUTAKI – **whaneketanga***

WHAT DO WE MEAN?

Authentic partnerships are those in which collaborative sharing of knowledge, wisdom and experience with health, social, and community agencies occurs. The end goal is improving the health and wellbeing of the people of the Waikato.

WHY DOES THIS MATTER?

It is recognised internationally that integrating health and social care across public, private, non-government organisations, and professional agencies is critical to a safe and sustainable health service.

The challenges communities are facing cannot be addressed with the limited tools that hospitals and doctors in the medical system have. It is through a partnership approach that health services, social services and the broader community can share the responsibility of improving people's wellbeing to enable them to reach their full health and social potential. A partnership approach strengthens collective efforts.

WHAT WILL THIS LOOK LIKE?

We are uniquely placed to combine our clinical expertise, our roots in the community and our system leadership role to work in partnership across the health and social care systems to achieve health equity and improve wellbeing. This will require a new perspective where leaders look beyond their individual organisation's interests and towards the future development of the whole health care system – and are rewarded for doing so. It will require a new type of partnership between national bodies and local leaders. We cannot do everything that is needed by ourselves. That is why we will lead where possible, support when necessary and advocate when appropriate, a range of new approaches to improving health and wellbeing.

We will work to further develop an integrated health system in the Waikato. We will also be working with our social care partners to integrate with them. We will have an environment that is flexible and enables us to take the opportunities where we find them. We will build our communities' trust in us through effective community interventions. We will work with professional bodies of practitioners, thinkers, theorists, researchers, and communities who are working towards health and wellbeing, to use their expertise and diverse knowledge and skills.

WHAT ARE THE PRIORITIES FOR THIS STRATEGIC IMPERATIVE?

- Incorporate te Tiriti o Waitangi in everything we do
- Authentic collaboration with partner agencies and communities
- Focus on effective community interventions using community development and prevention strategies
- Work towards integration between health and social care services

implementing
THE PRIORITIES

1. Incorporate Te Tiriti o Waitangi in everything we do

WHAT DO WE MEAN?

This involves health and care agencies working together with Māori towards the mutual aim of improving health outcomes and achieving health equity for Māori.

WHY DOES THIS MATTER?

Waikato DHB values the importance of te Tiriti o Waitangi; the government affirms that Māori hold a unique place as tangata whenua and that te Tiriti o Waitangi is the nation's founding document. To improve Māori health and wellbeing it is vital that te Tiriti o Waitangi is a foundational guide in the health sector. Working with a common guide will set us all on the same page when understanding authentic partnerships. Central to partnerships that incorporate te Tiriti o Waitangi is a shared understanding that health is a 'taonga' (treasure) and we will work to protect it.

WHAT WILL THIS LOOK LIKE?

Acting in good faith as Tiriti o Waitangi partners. Working with an agreed common purpose, interest, and cooperation to achieve positive health outcomes. Not acting in isolation or unilaterally in assessment, decision-making, and planning of health and social care and services. Ensuring the integrity and wellbeing of both partners is preserved.

2. Authentic collaboration with partner agencies and communities

WHAT DO WE MEAN?

Collaboration is the process where two or more agencies or communities work together towards a shared goal or outcome. Collaboration is the direct opposite of competition. When we collaborate authentically with others, we are working to realise better health and wellbeing for our populations.

WHY DOES THIS MATTER?

The Waikato DHB holds a lot of power and control because we are responsible for delivering and funding for Waikato's health, this, however does not make us the experts in community interventions and we must work with and be inclusive of those who are the experts.

WHAT WILL THIS LOOK LIKE?

There are already some great examples of the Waikato DHB working in collaboration with other agencies to enhance the populations' wellbeing, such as the Peoples Project and the Well-child project. These projects work because there is no competition, the approach is person/whānau centred, and the overall aim of the projects is improving health and wellbeing through collaboration between agencies that have different but equally important skills and strengths. Models such as these will be used by others and adapted to suit the projects' requirements.

3. Focus on effective community interventions using community development and prevention strategies

WHAT DO WE MEAN?

Community development is about working with local groups and organisations (who represent people at a local level) towards structural interventions that give communities the opportunity to have greater control and participation in matters that affect their lives. Preventing poor health and wellbeing is always better than trying to cure it.

WHY DOES THIS MATTER?

Community development is about people's active involvement in their health, if we want people to be more responsible for their health then we need to enable a system to allow that to occur. Institutions are a key factor in community development being effective, as they will hold knowledge and power at a policy, funding, and decision-making level. If we fail to get serious about prevention then the recent progress in healthy life expectancies will stall, the unnecessary differences will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend our budgets on reducing the impact of wholly avoidable conditions. If we can work with those who are delivering effective community interventions then we can hopefully enhance the many community interventions and prevention strategies being delivered and create new effective approaches to enhance the health and wellbeing of our population.

WHAT WILL THIS LOOK LIKE?

This is about the community leading with the support of the DHB to achieve health and wellbeing. There are many opportunities for the Waikato DHB to become more involved in the community development approaches occurring throughout the Waikato and this can be done by firstly achieving the priority of authentic collaboration with other agencies. There are examples where this is done very well, such as the public health unit where community development and prevention strategies are core to the work they do. All Waikato DHB staff need to work closer with the public health unit and with the other health and social care agencies in the Waikato.

4. Work towards integration between health and social care services

WHAT DO WE MEAN?

The Waikato DHB is only one part of delivering effective health services and care. When there is integration between health and social agencies, we become a whole health system.

WHY DOES THIS MATTER?

A whole health system is stronger, more effective, and efficient than any single service. Sharing knowledge and learnings will enhance each other's areas of specialty, which will allow health and social services to deliver care and services that will be relevant and appropriate for our populations in the Waikato.

WHAT WILL THIS LOOK LIKE?

We cannot work in isolation from each other and the Waikato DHB must trust others to deliver services and care when they are the most appropriate and effective provider or agency to do so. We will continue to be active contributors to interagency groups and will lead where appropriate.

Waikato DHB Board 2016

Crystal Beavis

Andrew Buckley

Sally Christie (Deputy Chair)

Martin Gallagher

Tania Hodges

Pippa Mahood

Sharon Mariu

Gay Shirley

Bob Simcock (Chair)

Clyde Wade

Ewan Wilson

JULY 2016

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Finance

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 5.1

FINANCE REPORT

Purpose	For information.

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

Recommendation
THAT
The report be received.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Result for January 2017	Year to Date			Budget
	Actual $m	Budget $m	Variance $m	Jun-17 $m
Funder	34.5	23.4	11.1 F	42.9
Governance	(0.4)	(0.4)	0.0 F	(0.3)
Provider	(28.4)	(13.3)	(15.1) U	(38.1)
DHB Surplus/(Deficit)	**5.7**	**9.7**	**(4.0) U**	**4.5**

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

FINANCIAL PERFORMANCE MONTHLY COMMENT:

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

For January 2017 YTD we are unfavourable to budget by $4.0m. This is due in part to phasing particularly with regard to cost reduction plans. However, specific areas are of concern and are being focused on in order to develop comfort in how we will meet our forecast results for the year. Clearly there are risks to manage in this regard and we are very actively managing such risks, with improved bottom up forecasting processes being a key tool.

Forecast:

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

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

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

1. Unbudgeted costs
2. The impact of the required outsourcing to meet key targets
3. The achievement of the budgeted savings or alternate savings
4. Our ability to extract favourable variances through the balance of the year to counter the current unfavourable YTD variance

Negative

Provider:

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

1. Revenue unfavourable to budget $6.5m (1.3%) due to lower than planned Provider volumes.
2. Employed personnel costs unfavourable to budget $3.4m, the dominant negative variance being within nursing and a smaller positive offset by medical personnel.
3. Outsourced Personnel costs unfavourable to budget $7.4m, the dominant variances relate to medical locums ($2.5m), Nursing ($0.9m) and admin/management contractors for the National Oracle Solution (NOS) project ($3.7m) which has an offset in Other Revenue of ($2.9m).
4. Outsourced Services favourable to budget $1.8m.
5. Clinical supplies unfavourable to budget $0.8m.
6. Infrastructure & Non Clinical supplies are unfavourable to budget $1.6m.
7. Interest, depreciation and capital charge favourable to budget $2.8m

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

- Acute cases, excluding ED: episodes 2.0% above plan; case-weights 5.6% above plan
- Elective cases: episodes 16.2% below plan; case-weights 22.6% below plan
- Overall 2.9% below plan for cases and 3.1% below plan for case-weights
- ED attends: YTD ED attends are 1.7% higher than the same period last year.

Please note that analysis is being done to ensure that the volume differences are understood and the impacts managed.

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

RECOMMENDATION(S):

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

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD

YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$3.0 F**	Neutral
CFA Revenue		
Favourable to budget mainly due to: ● 15/16 elective surgery wash-up $1.5m received ● additional funding received which is offset by cost in External Provider Payments: Palliative Care $0.4m Rheumatic fever $0.2m Healthy Homes initiative $0.4m ● PHO Care Plus wash-up & VLCA $0.5m Offset by unfavourable variances relating to: ● Reduction in revenue received relating to the change in rate for the capital charge $1.4m. This reduction is offset by a reduction in capital charge paid. ● In between travel wash up relating to 2016/17 $0.6m (offset by reduced cost in External Provider payments) and to 2015/16 $0.3m.	$0.8 F	Favourable
Crown Side-Arm Revenue		
Side-arm contracts revenue favourable due mainly to funds received for the 2015/16 Colonoscopy project $0.3m and a contract variation on the main Public health contract $0.2m.	$0.6 F	Favourable
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is $1.3m favourable mainly due to: ● Reimbursement of costs associated with the implementation of NOS $2.9m favourable (offset in Outsourced Personnel) ● Catch up invoicing for outreach clinics at Bay of Plenty and Lakes DHBs $0.6m Offset by: ● ACC unfavourable $0.5m due to non acute rehab contract running lower than planned due to less discharges and the focus on Elective Service Performance Indicators meaning the elective surgical treatments contract patients are being delayed. ● Inter District Flows (IDF) in which is $1.8m unfavourable due to reduced IDF inflow when compared with Ministry of Health budget file.	$1.3 F	Neutral
Other Revenue		
Other revenue is favourable primarily due to higher sales in the Café than expected $0.4m and the favourable revenue washup from Urology Services Limited relating to 2015/16 of $0.2m. This is offset by lower than budget volumes of non resident patients $0.1m unfavourable and other revenue $0.2m unfavourable.	$0.3 F	Favourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($7.0) U**	Unfavourable
Personnel (employees and outsourced personnel total)	**($10.8) U**	
Employed personnel are unfavourable to budget mainly due to:	($3.4) U	Unfavourable
• Medical costs are favourable by $1.5m. Senior Medical Officers (SMO's): SMO costs are $1.7m favourable mainly due to: - paid FTE costs favourable $0.9m arising from vacancies, - favourable course and conference costs which is as a result of reduced accrual for CME costs following SMO resignations $0.4m, - annual leave movement $0.3m favourable due to less leave earned offset by less leave taken Resident Medical Officers (RMO's) RMO costs are $0.2m unfavourable due to vacancies offset by annual leave taken running lower than budgeted. The net financial YTD impact of the RMO strike in October 2016 on personnel costs is currently $0.2m: SMO claims to date to cover RMO shifts $0.3m Savings on payments to RMO's $0.1m The net financial impact of the RMO strike in January 2017 on personnel costs is not known as SMO claims are still being received and processed. • Nursing costs are unfavourable to budget by $4.5m. Paid FTE (Full Time Equivalent employee) cost is $1.5m unfavourable due to budgeted vacancy savings not being achieved. In addition to this the annual leave movement is running $3m unfavourable. • Allied Health costs are unfavourable to budget by $0.7m. Base costs are $0.3m favourable offset by unfavourable overtime $0.3m due to vacancies. In addition annual leave taken unfavourable to budget $0.7m. • Other favourable variances, largely in Management, Administration and Support $0.3m		
Outsourced personnel are unfavourable mainly due to:		
• Higher than planned use of locums within medical personnel to cover vacancies $2.9m. Nursing is $0.8m unfavourable due to external agency costs to fill roster gaps and watches.	($3.7) U	Unfavourable
• Higher than planned use of contractors in management/admin $3.7m primarily due to contractors working on the NOS implementation. Costs recovered in Other Government Revenue - $2.9m.	($3.7) U	Neutral

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$1.8 F**	
Outsourced corporate services $1.2m favourable primarily due to reduced spend on Clinical Work Station - budget set on business case but expected spend has been revised and is lower due to reduced costs over the first months of the year. In additional the actual calculation of Health Share Limited (HSL) operating costs has come in lower than budget for the first half of the financial year. In addition, outsourced clinical service costs are favourable to budget $0.6m due to lower than planned outsourcing of electives.	$1.8 F	Neutral
Clinical Supplies	**($0.9) U**	
Instruments & equipment are $0.4m favourable primarily due to favourable service contract costs.	$0.4 F	Favourable
Implants & prosthesis are $1.9m favourable due to underspends on spinal plates and screws and implants and prosthesis due to a combination of outsourcing to private providers and lower than planned orthopaedic volumes.	$1.9 F	Neutral
Treatment disposables unfavourable due to savings allocation of $3.9m offset by favourable variances across a range of areas such as dressings, staples, tubes/drainage/suction, IV fluids and rebates.	($2.2) U	Unfavourable
Pharmaceuticals $0.8m unfavourable primarily due to cytotoxic drug costs running higher than budgeted. This in part due to the newly approved melanoma treatment.	($0.8) U	Unfavourable
Diagnostic Supplies & Other Clinical Supplies - close to budget.	($0.2) U	Neutral
Infrastructure and non-clinical supplies	**($1.6) U**	
Infrastructure and non-clinical supplies are $1.6m unfavourable primarily due to: ● Savings allocation unfavourable by $1.4m, ● Cost of Goods Sold (COGS) is $1.1m unfavourable as a result of higher sales by Pharmacy on Meade resulting in higher cost of goods sold. Offset in Non Government Organisations (NGO) provider payments ($1.1m) ● IT costs $0.5m unfavourable due to minor hardware purchases and telecommunication costs for Virtual Health ● Offset by favourable facilities variance $0.9m due to delayed start of maintenance programme and Hilda Ross House demolition and cleaning costs running favourably by $0.5m due to a focus on this contract.	($1.6) U	Neutral

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$1.7 F**	
IDF out unfavourable by $1.3m due to increased outflow to Counties Manukau DHB due to a change in boundary lines and two high cost patients who have gone to Counties Manukau for treatment.	($1.3) U	Unfavourable
External Provider payments are favourable largely due to: ● a revised PHARMAC forecast $2.3m favourable. However this is offset in clinical supplies (Pharmaceutical costs - oncology drugs $0.8m) and Infrastructure costs (Retail Pharmacy COGS $1.1m). ● PHO Quality Indicator pool - prior year over accrual $0.6m ● Dental FSS volumes favourable to budget $0.5m ● Reduction in costs for in between travel (offset by reduced revenue) $0.6m ● post acute convalescent care $0.5m favourable as the cost is being reflected in Outsourced Services ($0.2m) ● Other favourable variance across MH, DSS FFS, Urology and residential care $0.8m This offset by Unfavourable variances arising mainly from additional costs relating to additional funding (Healthy Homes Initiative, Palliative Care, Rheumatic Fever).	$3.0 F	Neutral
Interest, depreciation and capital charge	**$2.8 F**	
Interest charge is close to budget	$0.3 F	Favourable
Capital charge is favourable to budget as a result of the reduction in the rate from 8% to 7%. Offset in CFA revenue	$1.3 F	Neutral
Non Cash Depreciation favourable mainly due to: ● Timing of capitalisation of IS projects.	$1.2 F	Favourable

TREASURY

Opinion on Result:	
Cash flows are favourable to budget	Favourable

YTD Actuals Jan-16 $'000	Waikato DHB Cash flows for year to January 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				
758,649	Operating inflows	787,528	782,959	4,569	1,345,020
(732,450)	Operating outflows	(753,572)	(738,529)	(15,043)	(1,285,884)
26,199	**Net cash from operating activities**	**33,956**	**44,430**	**(10,474)**	**59,136**
	Cash flow from investing activities				
1,011	Interest income and proceeds on disposal of assets	961	735	226	1,260
(14,477)	Purchase of assets	(13,018)	(39,669)	26,651	(68,003)
(13,466)	**Net cash from investing activities**	**(12,057)**	**(38,934)**	**26,877**	**(66,743)**
	Cash flow from financing activities				
1	Equity repayment	0	0	0	(2,194)
(5,602)	Interest Paid	(5,031)	(5,087)	56	(8,645)
(150)	Net change in loans	(110)	(109)	(1)	(198)
(5,751)	**Net cash from financing activities**	**(5,141)**	**(5,196)**	**55**	**(11,037)**
6,982	**Net increase/**(decrease) in cash	**16,758**	**300**	**16,458**	**(18,644)**
(8,948)	Opening cash balance	856	856	(0)	856
(1,966)	**Closing cash balance**	**17,614**	**1,156**	**16,458**	**(17,788)**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($10.4) U**	
• **Operating inflows**	**$4.6 F**	
Revenue favourable primarily as a result of: - Prior year elective funding washup received $1.5m - Additional care and other initiatives funding $1.5m - Washups in various areas (PHO, VCLA, IBT) during the period (both over and under) resulting in a net $0.1m cash impact - Reimbursement of costs associated with the implementation of NOS $2.9m Favourable inflow offset by reduction in revenue received relating to the change in rate for the capital charge $1.4m	$4.6 F	
• **Operating outflows**	**($15.0) U**	
○ Personnel cost variances are favourable mainly due to timing of pay runs and IRD payments.	$3.1 F	
○ Operating cash outflows for non-payroll costs are unfavourable as a result of: - Higher prepayments than budgeted $7.3m primarily as a result of timing of payments for IS related costs - the remaining unfavourable variance includes Unfavourable P&L expenditure variances.	($21.2) U	
○ GST cash movement is favourable due to timing variances on GST transacted.	$3.1 F	

Cash flow variances resulted from:	Variance $m	Impact on forecast
Net cash flow from Investing Activities	**$26.9 F**	
○ Interest received is favourable due to a slightly higher than expected funds with NZHPL.	$0.2 F	
○ Capital spend is slower than planned for the year to January - refer to capital expenditure report for further details.	$26.7 F	
Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Net cash flow from Financing Activities	**$0.1 F**	
○ Cash flow from financing activities is in alignment with P&L.	$0.1 F	

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

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

WAIKATO DISTRICT HEALTH BOARD
CASHFLOW FORECAST (GST INCLUSIVE)

As at 31-Jan-17	Jan-17 Actual	Feb-17 Forecast	Mar-17 Forecast	Apr-17 Forecast	May-17 Forecast	Jun-17 Forecast	Jul-17 Forecast	Aug-17 Forecast	Sep-17 Forecast	Oct-17 Forecast	Nov-17 Forecast	Dec-17 Forecast	Jan-18 Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	1,673	4,080	4,520	7,580	4,520	4,300	5,969	4,564	4,228	4,448	4,452	4,116	4,340
Funder inflow (MoH, IDF, etc)	120,436	119,190	124,965	118,565	118,565	124,965	124,542	124,523	121,878	121,680	124,523	130,923	124,523
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	3,949	2,185	2,645	2,300	2,645	2,415	2,415	2,645	2,415	2,530	2,530	2,400	2,415
Rents, ACC, & Sector Services	2,282	2,507	2,826	2,397	2,749	2,634	2,622	2,753	2,546	2,601	2,689	2,584	2,584
	128,341	127,962	134,956	130,842	128,479	134,314	135,549	134,486	131,067	131,259	134,194	140,023	133,862
Cash was applied to:													
Personnel Costs (incl PAYE)	(41,339)	(41,295)	(50,385)	(41,696)	(45,155)	(40,844)	(40,790)	(50,082)	(41,714)	(40,696)	(46,055)	(41,354)	(49,870)
Other Operating Costs	(27,978)	(29,850)	(33,800)	(32,128)	(29,300)	(32,200)	(34,460)	(31,300)	(32,000)	(31,000)	(31,200)	(24,560)	(25,700)
Funder outflow	(43,245)	(43,350)	(48,218)	(42,807)	(44,863)	(43,782)	(52,846)	(45,569)	(48,557)	(45,128)	(45,238)	(44,245)	(44,908)
Interest and Finance Costs	0	(2,141)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
Capital Charge	0	0	0	0	0	(8,251)	0	0	0	0	0	(15,721)	0
GST Payments	(13,588)	(7,000)	(7,000)	0	(14,000)	(7,000)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(14,420)
	(126,150)	(123,636)	(139,408)	(116,636)	(133,323)	(132,083)	(135,313)	(134,168)	(129,487)	(124,040)	(129,709)	(125,886)	(134,903)
OPERATING ACTIVITES	**2,191**	**4,326**	**(4,452)**	**14,205**	**(4,844)**	**2,231**	**236**	**318**	**1,580**	**7,219**	**4,485**	**14,137**	**(1,041)**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	327	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
	327	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(1,161)	(1,150)	(1,200)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
Investment in NZHPL (Finance project)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(1,161)	(1,150)	(1,200)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)	(2,300)
INVESTING ACTIVITIES	**(834)**	**(1,075)**	**(1,125)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**	**(2,225)**
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from NZHPL	98,971	0	5,578	0	7,080	2,188	1,989	1,918	645	0	0	0	3,266
MoH loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	98,971	0	5,578	0	7,080	2,188	1,989	1,918	645	0	0	0	3,266
Cash was applied to:													
Capital Repayment	0	0	0	0	0	(2,194)	0	0	0	0	0	0	0
Transfer to NZHPL	(100,328)	(3,240)	0	(11,981)	0	0	0	0	0	(4,995)	(2,250)	(11,912)	0
MoH loan repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	(11)	0	0	(11)	0	0	(11)	0	0	(11)	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	(100,328)	(3,251)	0	(11,981)	(11)	(2,194)	0	(11)	0	(4,995)	(2,260)	(11,912)	0
FINANCING ACTIVITIES	(1,357)	(3,251)	5,578	(11,981)	7,069	(6)	1,989	1,907	645	(4,995)	(2,260)	(11,912)	3,266
Opening cash balance	0	0	0	0	0	0	(0)	0	0	0	0	0	0
Overall increase/(decrease) in cash	0	(0)	0	(0)	(0)	(0)	0	0	(0)	(0)	(0)	0	(0)
CLOSING CASH BALANCE	0	0	0	0	0	(0)	0	0	0	0	0	0	(0)
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	0	0	(0)	0	0	0	0	0	0	(0)
Funder Account	0	0	0	0			0	0	0	0	0	0	0
Investment funds/(loan)													
NZ Health Partnerships Ltd (NZHPL)	17,564	20,803	15,226	27,207	20,126	17,938	15,949	14,031	13,386	18,380	20,630	32,542	29,275
Long-term Loans													
Ministry of Health	(211,659)	0	0	0	0	0	0	0	0	0	0	0	0
EECA Loan	(325)	(314)	(314)	(314)	(303)	(303)	(303)	(292)	(292)	(292)	(281)	(281)	(281)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(194,420)	20,490	14,913	26,893	19,823	17,635	15,646	13,739	13,094	18,088	20,348	32,261	28,994
LOANS AVAILABLE													
MoH loans	(211,659)	0	0	0	0	0	0	0	0	0	0	0	0
Working capital facility (NZHPL)	(64,367)	(64,367)	(64,367)	(64,367)	(64,367)	(64,367)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(276,026)	(64,367)	(64,367)	(64,367)	(64,367)	(64,367)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)

This cash flow forecast has been completed on the assumption that the debt to equity conversion will take place for all Crown debt on 15 February 2017.

BALANCE SHEET

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

Prior Year Jan-16 $'000	Waikato DHB Financial Position	As at January 2017 Actual $'000	Budget $'000	Variance $'000	Budget Jun-17 $'000
49,321	Total current assets	82,957	52,336	30,621 F	50,193
(154,967)	Total current liabilities	(173,761)	(163,921)	(9,840) U	(198,229)
(105,647)	**Net working capital**	**(90,804)**	**(111,585)**	**20,781 F**	**(148,036)**
568,417	Term assets	558,618	584,087	(25,469) U	611,664
(227,011)	Term liabilities	(226,297)	(226,962)	665 F	(226,771)
341,406	**Net term assets**	**332,321**	**357,125**	**(24,804) U**	**384,893**
235,759	**Net assets employed**	**241,517**	**245,540**	**(4,023) U**	**236,857**
235,759	**Total Equity**	**241,517**	**245,540**	**(4,023) U**	**236,857**

Prior Year Jan-16 $'000	Waikato DHB Ratios	As at January 2017 Actual $'000	Budget $'000	Achieved	Trend	Budget Jun-17 $'000
54,467	Borrowing facilities available at month end	64,146	64,146	✓	⇔	46,394
0.9	Debt to Equity ratio	0.9	0.9	✓	⇔	1.0
0.5	Debt to Debt + Equity	0.6	0.6	✓	⇔	0.6
0.3	Current ratio	0.5	0.3	✓	⇔	0.3
38.2%	Equity to total assets	37.6%	38.6%	✓	⇩	35.8%
1.3%	Return on equity	2.4%	4.0%	✓	⇔	1.9%
5.87	Interest covered ratio	7.45	8.11	✓	⇔	6.96

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital		
Net working capital is favourable against budget mainly due to: - Cash held with New Zealand Health Partnerships Limited is higher than planned by $16.4m, mainly due to lower than budgeted capital spend. - Prepayments are higher than planned by $7.3m due to the timing of annual IS spend. - Total accounts receivable and accrued debtors is higher than planned by $6.9m largely due to the actual timing of cash received compared to budget assumptions. - Payroll liabilities are $9.5m unfavourable, mainly due to the timing of pay runs and IRD payments resulting in higher month end accruals - Liabilities other is higher than planned by $0.4m mainly due to higher than planned spend compared to budget.	**$20.8 F**	
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $26.7m and favourable YTD depreciation $1.2m. Please see attached for latest forecast of capital spend for the year for further detail.	**($25.5) U**	
Non Current Liabilities:		
Close to budget	**$0.7 F**	
Equity		
Driven from variance in overall result.	**($4.0) U**	

CAPITAL EXPENDITURE AT 31 January 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 31 Jan-17 (J)	Approved Forecast Expenditure from 1st Feb 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
Total Under $50K Projects:	2,300		-	2,300		-	2,300	1,201	-	1,099	-		2,300	0
CLINICAL EQUIPMENT				-										
SUB TOTAL CLINICAL	12,455	27,218	210	39,883		2,031	23,350	3,758	3,280	16,312	14,096		39,477	406
INFORMATION SYSTEMS														
SUB TOTAL INFORMATION SYSTEMS	30,660	38,198	-244	68,614		8,323	32,721	3,663	9,221	19,838	26,237		67,281	1,333
PROPERTY & INFRASTRUCTURE - PLANT														
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	1,493	4,601	-	6,094		1,369	4,052	379	690	2,983	731		6,152	58
PROPERTY PROJECT SERVICES								-						0
SUB TOTAL PROPERTY PROJECT SERVICES	21,188	8,370	-175	29,383		10,173	16,080	2,760	6,879	6,441	3,317		29,570	-187
VEHICLES								-						0
SUB TOTAL VEHICLES	950	700	47	1,697		235	1,233	3	-	1,230	220		1,688	9
STRATEGIC PROJECT OFFICE								-						0
SUB TOTAL STRATEGIC PROJECTS	25,077	60,992	0	86,069		0	577	10	67	500	85,333		85,910	159
CORPORATE								-						0
SUB TOTAL CORPORATE PROJECTS	8,000	800	-691	8,109		1	5,480	149	354	4,977	1,470		6,950	1,159
MOH Projects (funded externally)							-	-						
SUB TOTAL MOH PROJECTS	426	-	-	426		197	230	104	126	-	-		427	1
Trust Funded Projects (funded externally)							-	-						0
SUB TOTAL TRUST FUNDED PROJECTS	-		-	-		333	263	263	-	-	-		596	(596)
PROJECT SAVINGS				-			(19,641)			(19,641)			19,641	19,641
CAPITALISED COMPLETED PROJECTS	4,189		275	4,464		3,150	1,358	1,358					4,508	(44)
TOTALS	106,738	140,879	-578	247,039		25,812	68,001	13,649	20,615	33,737	131,404		225,217	21,821

CAPITAL EXPENDITURE AT 31 January 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 31 Jan-17 (J)	Approved Forecast Expenditure from 1st Feb 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
Total Under $50K Projects:	**2,300**		-	**2,300**		-	**2,300**	**1,201**	**-**	**1,099**	-		**2,300**	**0**
CLINICAL EQUIPMENT				-										
Urology - Equipment	-	300	-	300		-	200	-	-	200	-		200	100
Heart Lung machines - Cardiac surgery	-	680	-	680		-	680	-	-	680	-		680	0
Heater Cooler units	-	156	-	156		-	156	-	156		-		156	0
Echo vivid - Cardiology - portable	-	400	-	400		-	150	-	-	150	250		400	0
Trans-Oesophageal Echo (Toe)		329		329		-	-	-	-	-	250		250	79
Cardiac output machines (critical care) EV1000	90	-		90			90	-	-	90			90	0
Radiation Dispenser manual - Oncology	-	90	-	90		-	90	-	-	90	-		90	0
Supra laser - Opthalmology	-	170	-58	112		-	112	-	-	112	-		112	0
Retinal Camera Head	-	-	58	58			58	58	-	-			58	(0)
Ultrasound Replacement (Endoscope, Operating Table & EMG System)	-	100	-	100		-	100	-	-	100	-		100	0
Cytogenics Incubators NICU	25	-	-	25		-	-	-	-	-			0	25
Endoscopy scope cleaning equipment	-	174		174		-	193	193	-	-	-		193	(19)
Endoscopes 16/17		1,040	-	1,040		-	414	-	-	414	626		1,040	0
Theatre Instruments	300	-	-	300		-	150	-	-	150	-		150	150
Transeosophageal Echo machine (Philips IE33)	-	226		226			226	-	-	226			226	0
Equipment and Supply Washer	50	-	-	50		-	-	-	-	-	50		50	0
Washer/Disinfector (Thames)	125	-	-92	33		-	-	-	-	-			0	33
Washer Decontaminator for Thames Sterile Services	-	-	92	92		-	92	-	92	-			92	0
Il Machine (Thames)	120	-	-	120		-	-	-	-	-	120		120	0
Transport Monitors (Critical Care)	75	-	-	75		-	-	-	-	-	75		75	0
Endoscope Camera (Thames)	103	-	-	103		-	-	-	-	-	103		103	0
ENT Zeiss S21 (Theatres)	50	50	-	100		-	50	-	-	50			50	50
X-ray Specimen (Theatres) Faxitron	85	-	-	85		-	-	-	-	-	85		85	0
Gynae Urodynamics	55	-	-	55		-	-	-	-	-	55		55	0
GP Pumps (Biomed)	450	-	-	450			450	-	-	450			450	0
Bed Replacement Programme	800	-	-330	470			470	-	-	470	-		470	0
Bed Replacement	-	-	330	330			354	354	-	-			354	(24)
Gamma Camera (Nuclear Med Imaging Scanner)	1,200	-	-	1,200		-	1,200	880	320				1,200	(0)
Home Haemo Dialysis Replacement 16/17	-	62	-	62			62	-	-	62	-		62	0
Haematology Main Analyser (to be approved for hA negotiationing for all hospital	715	-	-	715		-	715	40	553	122	-		715	(0)
Bio Chemistry Lab - Mass Spectrometer	500	-	-	500		-	500	-	-	500	-		500	0
Linear Accelerator (approved by BRRG Nov-15)	4,000	-	-	4,000		2,031	2,190	2,190	-		-		4,221	(221)
-Rapid ARC Licences (Oncology)	123	-	-	123		-	123	-	123	-	-		123	0
PCA Pumps (Biomed)	500	-	-	500		-	500	-	-	500	-		500	0
Treon Plus Stealth station OE9823	-	450		450			-	-		-	450		450	0
Haemodialysis (Incentre)	650	-	-	650		-	527	-	-	527	-		527	123
Eyese Heidelberg - Theatres	200			200			-	-		-	200		200	0
CT Replacement - Thames (to be approved)	1,500	-	-	1,500		-	1,500	-	-	1,500	-		1,500	0
Non-Invasive Ventilator	-	-	-	-		-	-	-	-	-	-		0	0
Oversize Operating theatre table RX500	-	83	-	83		-	83	-	-	83	-		83	0
Bipap Respironics (CCD x 4) - Respiratory	-	120	-	120		-	120	-	-	120	-		120	0
Bronchosopes (CCD x $) - Respiratory	-	70	-	70		-	70	-	67	3	-		70	0
Scopes - eBus - Respiratory	-	120	-	120		-	120	-	-	120	-		120	0
Trolley Washer - SSU	-	276	-	276		-	276	-	-	276	-		276	0
Telemetry	-	800	-	800		-	200	-	-	200	600		800	0
Cordless Driver (incl wore collect) - Theatres	-	69	-	69		-	69	-	-	69	-		69	0
IMM4 Anaesthethic Monitoring system	-	114	-	114		-	114	-	-	114	-		114	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No1	-	93		93			-	-	-	-	93		93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No2	-	93		93			-	-	-	-	93		93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No3	-	93		93			-	-	-	-	93		93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No4	-	93		93			-	-	-	-	93		93	0
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No5	-	93		93			-	-	-	-	93		93	0
MONITOR IMM4 FM FLEXIBLE MONITOR & LIC E13191	-	60	-	60		-	60	-	-	60	-		60	0
Replacement of Task Operating Theatre Lighting in OT7 & OT8	-	-	70	70		-	70	14	56	-	-		70	(0)
Replacement of Task Operating Theatre Lighting in OT 9 - 12	-	-	140	140		-	140	28	112	-	-		140	(0)
Orthopeadic Cordless Driver 4300 sets x 7	-	141	-	141		-	141	-	-	141	-		141	0
Orthopeadic system - 6 rotary sets x 2	-	63	-	63		-	63	-	-	63	-		63	0
System 6 dual Trigger Rotary Hand Piece	-	65	-	65		-	65	-	-	65	-		65	0

CAPITAL EXPENDITURE AT 31 January 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 31 Jan-17 (J)	Approved Forecast Expenditure from 1st Feb 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
System 6 Sag Saw	-	65	-	65		-	65	-	-	65	-		65	0
Ultrasound - diagnostic E14773	-	224	-	224		-	224	-	-	224	-		224	0
Cardotokograph	-	510	-	510		-	170	-	-	170	340		510	0
Colposcope	-	66	-	66		-	22	-	-	22	-		22	44
Dinamap	-	150	-	150		-	60	-	-	60	-		60	90
Echocadiograph (Wakids)	-	272	-	272		-	272	-	-	272	-		272	0
Foetal heart detector	-	100	-	100		-	60	-	-	60	40		100	0
Foetal monitor, CTG	170	-	-	170		-	170	-	-	170	-		170	0
Humidifier	-	150	-	150		-	69	-	-	69	81		150	0
Infusion pumps (Thames)	-	408	-	408		-	212	-	-	212	196		408	0
Intellivue physiologic monitor	-	352	-	352		-	192	-	-	192	160		352	0
Immunology - Molecular Micro Array	50	-	-	50			-	-		-	-		0	50
Monitor cardiac , multi parameter	-	320	-	320		-	80	-	-	80	240		320	0
Scanner, ultrasonic	-	300	-	300		-	150	-	-	150	150		300	0
Scanner, ultrasonic ob/gyn	-	320	-	320		-	320	-	-	320	-		320	0
Warmer, radiant, infant IW930	-	72	-	72		-	72	-	-	72	-		72	0
Cathlabs	-	2,500	-	2,500		-	1,000	-	-	1,000	1,500		2,500	0
Incubator	400	1,440	-	1,840		-	880	-	-	880	960		1,840	0
Haematology Flow Cytometry Robotics system	-	200	-	200		-	200	-	-	200	-		200	0
Histology Pathvision Radiographic system	-	400	-	400		-	400	-	-	400	-		400	0
Building Refurnishment - free up space	-	77		77			77	-		77			77	0
Biochemistry LC Tandom Mass Spectrometer	-	500	-	500		-	500	-	-	500	-		500	0
Cytogenetics Digital Imaging system	-	800		800			300	-		300	500		800	0
Scanner 3D Cone Beam (maxFac)	-	150	-	150		-	150	-	-	150	-		150	0
Med - Dispense Units	-	900	-	900		-	100	-	-	100	800		900	0
Licensing (breast screening)	-	52	-	52		-	52	-	-	52	-		52	0
CT Scanner	-	5,200	-	5,200		-	1,600	-	-	1,600	3,600		5,200	0
Digital Mobile X - ray	-	1,500	-470	1,030		-	130	-	-	130	900		1,030	0
Fluro Room units	-	750	-619	131		-	131	-	-	131	-		131	0
Combi Diagnost Fluoroscopy Unit			619	619		-	619	-	589	30	-		619	0
Mobile Image Intensifier - Waikato	-	1,500	-550	950		-	50	-	-	50	900		950	0
X-ray machines and Image Intensifiers	-	-	1,020	1,020		-	1,020	-	1,020	-	-		1,020	0
Ultasound (medical Photography / imaging)	-	200	-	200		-	200	-	-	200	-		200	0
Infusion pumps (Thames)	-	67	-	67		-	67	-	-	67	-		67	0
Steriliser Autoclave (Thames)	-	200	-	200		-	200	-	-	200	-		200	0
Blood gas analysers	-	800	-	800		-	400	-	-	400	400		800	0
CEP - Pool - 2016/17	119			119		-	192	-	192	-	-		192	(73)
SUB TOTAL CLINICAL	**12,455**	**27,218**	**210**	**39,883**		**2,031**	**23,350**	**3,758**	**3,280**	**16,312**	**14,096**		**39,477**	**406**
INFORMATION SYSTEMS														
PLATFORM							-	-						
ISSP - Decommission Galen 15/16	300	-	15	315		53	261	52	210		-		314	1
ISSP - Decommission Galen 16/17	-	251	-	251			159	-	-	159			159	92
ISSP - File Server -(profile , home drive, appv)rearchitecture	-	150	-	150		-	150	-	-	150	-		150	0
NIPS - Local Capacity Augments	-	700	-	700		-	400	-	-	400	300		700	0
ISSP - Lifecycle - Infrastructure Application Workplan 16/17	-	1,000	-	1,000		-	249	22	228		750		999	1
ISSP - Lifecycle - Infrastrucure 15/16	300		-	300		232	67	49	18		-		299	1
ISSP - Clinical and Corporate Platform		500		500			500	-	-	500			500	0
ISSP - Clinical and corporate Platform SQL Server consolidation	475		-	475		99	265	65	200		-		363	112
ISSP - Disaster Recovery Solution 15_16	1,150		-	1,150		2	221	23	148	50	900		1,123	27
ISSP - Backup Capacity Augment	200		-	200		0	199	46	4	150	-		200	0
ISSP - Contingency (IS)	100		-64	36		-	36	-	36	-	-		36	0
ISSP - Windows Server Migration 2003-2008 (DIA)	491		-221	270		-	270	-	-	270	-		270	0
STORAGE & REPORTING							-	-						0
ISSP - Clinical PhotographyImage Management	-	300	-	300		-	300	-	-	300	-		300	0
ISSP - DataWarehouse Phase 2 - after 16/17	-	400	-200	200		-	200	-	-	200	-		200	0
ISSP - Enterprise Reporting Content remediation -after 16/17	-	250	-	250		-	250	-	-	250	-		250	0
ISSP - Data Analyst Toolset Implementation (16/17)	-	700	-	700		-	350	-	-	350	350		700	0

CAPITAL EXPENDITURE AT 31 January 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (A)	New Approvals FY16/17 (B)	Transfers (C)	Total Board Approved Capital Plans (D) = A+B+C	1	Prior year expenditure for active Projects (H)	Expenditure FY 16/17 (Actual + Forecast) (I) = J+k+L	Actual Expenditure YTD from 1 Jul-16 to 31 Jan-17 (J)	Approved Forecast Expenditure from 1st Feb 17 to 30 Jun-17 (K)	To Be Approved Forecast Expenditure from 1 Jul -16 to 30-Jun -17 (L)	Board Approved Forecast Subsequent Years (M)	1	Total Planned Expenditure (Actual + Forecast to Project completion) (N) =H+I+M	Total Planned Expenditure Versus Total Board Approved (O) =D - N
ISSP - Lifecycle - Sharepoint Workplan (e.g. replace fileshares, online sharepoint)		1,100		1,100			200	-		200	900		1,100	0
ISSP - San Controller		322		322			-	-		-	322		322	0
ISSP - SharePoint (Doc Management Pilot)	700		-	700		237	117	10	107	-	346		699	1
ISSP - Data Warehouse Phase 1	400		-	400		175	225	72	153	-	-		400	1
ISSP - Data Warehouse Phase 2			200	200		-	199	5	195	-	-		199	1
NETWORK & COMMUNICATIONS				-			-	-						0
ISSP - Paging System Replacement	-	350	-	350		-	350	-	-	350	-		350	0
ISSP - Unified Comms Phase 4 (16/17)	-	174	-112	62		-	62	-	-	62	-		62	0
ISSP - Jabber Instant Messaging and Guest			201	201		-	201	-	-	201	-		201	0
ISSP - Lifecycle - 1-2 Communication Tools Workplan	-	400	-	400		-	100	-	100	-	300		400	0
ISSP - WiFi Rollout	-	1,000	-	1,000		-	500	305	195	-	500		1,000	(0)
ISSP - Network Remediation Work Package 2015/2016	400			400		262	138	0	138	-	-		400	0
ISSP - Network Remediation Lifecycle Work Plan 16/17	300			300		-	299	196	87	17	-		299	1
ISSP - Comms Rooms remediation 2015/2016	230		-	230		44	186	33	153	-	-		230	0
ISSP - Unified Comms Phase 4	147		-	147		35	55	55	-	-	-		89	58
ISSP - Hylafax replacement	96			96		-	95	6	90	-	-		95	0
DEVICES				-			-	-						0
ISSP - Telehealth- replacement schedule	-	1,800	-	1,800		-	200	-	-	200	1,600		1,800	0
ISSP - Telehealth- Expansion		200	-27	173		-	173	-	-	173	-		173	0
ISSP - Southern Rural Outpatient Video Units			27	27			27	1	26	-	-		27	0
ISSP - Tablets to enable mobile workforce	-	500	-	500		-	300	-	-	300	200		500	0
ISSP - Touch screens	-	300	-	300		-	150	-	-	150	150		300	0
ISSP - Desktop - increase coverage		200		200			100	-		100	100		200	0
ISSP - Desktop upgrade from windows 7 to windows 10		2,000		2,000			-	-		-	2,000		2,000	0
ISSP - Desktop environment replacement >$2k	100		-	100		-	100	-	-	100	-		100	0
ISSP - Mobile device management	90		-54	36		-	90	-	-	90	-		90	(54)
ISSP - iPads for Virtual Health	745		-	745		-	745	-	-	745	-		745	0
ISSP - Hardware Solution - Medication Room	20		-	20		-	9	9	-	-	-		9	11
ENTERPRISE SERVICE BUSINESS / RULES ENGINE				-			-	-						0
ISSP - Clinical Business Rules	-	250	-	250		-	250	-	-	250	-		250	0
ISSP - Web Applications -S_Web_Services Infra_Mess Standards	-	500	-	500		-	500	-	-	500	-		500	0
ISSP - Web Applications -S_Web_Services Infra_Solution Select_Impl	-	500	-	500		-	500	-	-	500	-		500	0
TOOLS				-			-	-	-	-				0
ISSP - PVS Citrix	39	-	-	39		-	15	15	-	-	-		15	24
ISSP - Citrix Sharefile	150	150	-150	150		98	43	34	9	-	-		141	9
ISSP - Archiving Tool	-	380	-	380		4	356	7	-	349	-		360	20
ISSP - TQUAL Reporting	50	50	-	100		1	54	9	45	-	-		55	45
ISSP - Toolsets (after 16/17 refer to Lifecycle plan line items)		452		452			19	-	-	19	433		452	0
ISSP - Toolsets (IS Toolsets 15/16)	563		-	563		178	384	170	215	-	-		562	1
ISSP - Toolsets (14/15)	130		-	130		72	60	30	30	-	-		131	(1)
ISSP - Toolsets (13/14)	471	-	-	471		474	5	5	-	-			479	(8)
ISSP - Citrix Netscaler10.5 upgrade	-	150	-	150		-	141	-	-	141	-		141	9
ISSP - Rapid Logon	-	700	-	700		-	500	-	-	500	200		700	0
ISSP - e2e Clinical Docs		499		499			46	-		46	453		499	0
ISSP - EMRAM compliance to lvl 6 - upgrade / implementation	-	700	-	700		-	700	-	-	700	-		700	0
ISSP - Lifecycle integration Tools workplan - Rhapsody etc	-	1,000	-	1,000		-	250	-	-	250	750		1,000	0
ISSP - Anivirus / Malware - Toolset upgrade / replacement	-	150	-	150		-	150	-	-	150	-		150	0
ISSP - Lifecycle - Desktop Workplan (Outlook, Flexplus, etc)	-	1,200	-	1,200		-	300	-	-	300	900		1,200	0
ISSP - Lifecycle - Development tools (Visual studio, Kendo etc)	-	200	-	200		-	50	-	-	50	150		200	0
ISSP - Team foundation Server - Source Code management	-	250	-	250		-	250	-	-	250	-		250	0
ISSP - LIS Reporting Development	200		-	200		83	116	13	104		-		199	1
SECURITY				-			-	-					0	0
ISSP - Perimeter Redesign		598	-89	509			260	-	-	260	249		509	0
ISSP - Lifecycle - 1-2 Security tools Workplan (cardex, etc)		600	-	600		-	150	-	-	150	450		600	0
ISSP - Perimeter Redesign	150		-	150		33	49	49	-	-	-		81	69
ISSP - Security Defence in depth	500		-122	378		29	348	29	83	236	-		377	1
LICENSING				-			-	-					0	0
ISSP - MS Licensing True-Up (16/17)	300		-	300		-	300	-	-	300	-		300	0
ISSP - Other Licensing True-Up (16/17)	300		-	300		-	300	-	-	300	-		300	0
ISSP - Other Licensing True-Up	300		-251	49		49	16	16	-	-	-		65	(16)
ISSP - MS Licensing True-Up	300		-124	176		129	47	-	47		-		176	0
CLINICAL SYSTEMS							-	-					0	0
ISSP - Lifecycle: LIS Workplan	150			150			150	-	-	150			150	0

CAPITAL EXPENDITURE AT 31 January 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
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ISSP - Healthviews DC Uploader replacement		150	-150	-			-	-	-	-			0	0
ISSP - Clinical Workstation Core Component Workplan	-	-	480	480			479	114	366				479	1
ISSP - NCAMP. 3M, MKR	250	250	-250	250		78	171	63	108		-		249	1
ISSP - NCAMP 2017			250	250		-	250	-	250		-		250	0
ISSP - Workflow eData	250	-	-	250		3	247	96	151		-		250	(0)
ISSP - Workflow eData		2,100		2,100		-	1,500	-	-	1,500	600		2,100	0
ISSP - Database Replacements		300	-	300		2	297	15	283		-		299	1
ISSP - Oral Health system		1,000	-	1,000		165	835	369	425	41	-		999	1
ISSP - eTasks	-	230	-	230		-	100	2	98	-	130		230	0
ISSP - Cardiac Dendrite Phase 3	200	200	-116	284		-	84	-		84	200		284	0
ISSP - Surgical Services Audit Systems			116	116		-	116	3	113				116	0
ISSP - eProgesa replacement impacts - NZ Blood Service	-	150	-	150		-	150	-	-	150	-		150	0
ISSP - Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense		250		250			80	-		80	150		230	20
ISSP - Life cycle - cat 1-2 Medical Records Workplan (eg Kofax)	-	600	-	600		-	150	-	-	150	450		600	0
ISSP - Life cycle - cat 1-5 In house Apps Workplan(eg Whitboards)	-	1,400	-350	1,050		-	-	-	-	-	1,050		1,050	0
ISSP - Cat1-5 In-House Developed Applications Work Plan	-	-	350	350		-	350	41	309	-	-		350	0
ISSP - Life cycle - cat 2 Clinical Apps Workplan(eg NHI Gateway)	-	600	-150	450		-	-	-	-		450		450	0
ISSP - Cat 2 Off-the-shelf Applications Work Plan	-	-	150	150		-	150	3	147	-	-		150	0
ISSP - Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	-	1,400	-	1,400		-	350	44	306		1,050		1,400	0
ISSP - Life cycle - CWS / Healthviews Workplan	-	1,000	-654	346		-	176	-	-	176	170		346	0
ISSP - Software Upgrades (Apps Lifecycle 15/16)	250		-	250		149	101	61	40		-		250	0
ISSP - Master Data Implementation- after 16/17	-	100	-	100		-	100	-	-	100	-		100	0
ISSP - Laboratory Information Systems June 2016 GA upgrade	-	400	-	400		-	400	-	-	400	-		400	0
ISSP - Lab Analysers	-	600	-	600		-	150	-	-	150	450		600	0
ISSP - HealthViews - External eReferrals	-	300	-	300		-	222	2	-	220	-		222	78
ISSP - Clinical workstations - Document Tree search	-	100	79	179		-	101	1	-	100	-		101	78
ISSP - Access to community pharmacy	-	100	-100	-		-	-	-	-	-	-		0	0
ISSP - Data collection	-	100	-	100		-	50	-	-	50	-		50	50
ISSP - Procedure based Booking / Scheduling	-	1,250	-	1,250		-	250	-	-	250	1,000		1,250	0
ISSP - Structured programme - scanned history	-	200	-	200		-	100	-	-	100	100		200	0
ISSP - Cardiology - Xcelera to ISCV	-	100	-	100		-	100	-	-	100	-		100	0
ISSP - ipm upgrade to V10 - after 16/17	-	450	-	450		-	450	87	363		-		450	0
ISSP - SSU re-engineering	-	666	-	666		-	466	-	-	466	200		666	0
ISSP - eCWB Infrastructure	-	739	-	739		-	611	-	-	611	128		739	0
ISSP - Maternity (CleverMed)	760		-	760		12	740	-	740	-	-		752	8
ISSP - LIS Lifecycle upgrade (LIS Drop 6)	200		-	200		218	60	60	-	-	-		279	(79)
ISSP - HealthViews access to Primary Encounters (GP to Workstations)	300		-	300		69	231	214	17	-	-		300	(0)
ISSP - LIS Print solution	80		-	80		-	-	-	-	-	80		80	0
ISSP - HealthViews Internal eReferrals	300		-300	-		-	-	-	-	-	-		0	0
ISSP - Internal eReferrals			499	499		-	505	19	486				505	(6)
ISSP - eOrders	350		-	350		3	197	0	197		150		350	0
ISSP - Radiology - PACS/RIS Upgrade 16/17	500	200	-	700		-	653	-	-	653	-		653	47
ISSP - RIS Upgrade (Project split) (PACS Upgrade 15)	223		-	223		93	135	74	61		-		228	(5)
ISSP - RIS Upgrade 2016	124		-	124		1	122	0	122		-		124	0
ISSP - Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense	250		-	250		-	150	-	-	150	-		150	100
ISSP - Laboratory Phlebotomy (Te Kuiti)	40		-	40			40	-	-	40			40	0
ISSP - HealthViews - e2e Clinical Documents	350		-	350		53	297	139	158	-	-		350	0
ISSP - Clinical Workstation Metadata Scoping			50	50		1	49	2	-	48	-		51	(1)
ISSP - Speech Recognition			100	100		1	99	-	99		-		100	0
ISSP - Clinical Workflow Integration Work Plan			430	430		-	429	33	397		-		429	1
ISSP - Provation Host Tairawhiti	27		-	27		-	27	-	27		-		27	0
ISSP - e-Discharge Summaries	100		-100	-		-	-	-	-		-		0	0
CORPORATE SYSTEMS & PROCESSES				-			-	-	-				0	0
ISSP - Costpro Upgrade		103		103			26	-	-	26	77		103	0
ISSP - Costpro Tactical Improvements & Upgrade	400		-	400		238	162	1	161		-		400	0
ISSP - HRIS Lifecycle Upgrade 15_16		400	-	400		4	396	26	370		-		400	(0)
ISSP - Lifecycle HRIS / Peoplesoft Workplan		950		950		-	150	-	-	150	800		950	0
ISSP - HRIS Self Service implementation - payroll improvement	400	-	-	400		-	400	-	-	400	-		400	0
ISSP - Attendants System - enhancements or replacement	-	100	-	100		-	100	-	-	100	-		100	0
ISSP - Hockin Conversion	21		-	21		12	9	4	5		-		21	0
REGIONAL							-	-	-				0	0
RSSP - Regional Netscaler Reconfiguration	-	33	-	33		-	33	-	-	33	-		33	0
RSSP - Regioanl Microsoft Reporting Services	-	225	-	225		-	131	-	-	131	94		225	0

CAPITAL EXPENDITURE AT 31 January 2017 ($000s)

CAPITAL PLANS						CASHFLOW FORECAST							FULL PROJECT FORECAST	
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RSSP - SEEMAIL	-	26	-14	12		-	12	-	-	12	-		12	0
RISSP - HSL - File sharing technology	42			42		-	-	-	-		42		42	0
RISSP - HSL - ANZAC - Q1	40		-	40		-	-	-	-		40		40	0
RISSP - HSL - Core Intrastructure	644			644		-	-	-	-		644		644	0
RISSP - HSL - Enhanced Identity Management	46		-	46		-	-	-	-		46		46	0
RISSP - HSL - Enhanced Regional Integration	502		-	502		-	-	-	-		502		502	0
RISSP - HSL - e Space Clinical Workstation	7,831		-	7,831		-	2,500	-	-	2,500	5,331		7,831	0
RISSP - Risk Management Solution (Regional)	369		-	369		306	63	-	63		-		369	0
MRISSP - Pharmacy System Phase II – Implementation	2,462		-	2,462		2,356	106	-	106		-		2,462	0
RISSP - Midland Regional Platform Project	409		-	409		245	164	-	164		-		409	0
RISSP - Clinical Workstation - Phase II (License)	500	500	-	1,000		500	500	500	-		-		1,000	0
ISSP - Netscaler Infrastructure			343	343		1	342	222	120		-		342	1
OTHER PROJECTS				-			-	-					0	0
ISSP - FMIS Replacement - Phase I	792		-	792		499	-	-	-		-		499	293
ISSP - Clinical whiteboard - eCWB Infrastructure	442		-	442		128	82	82	-		-		210	232
ISSP - Portfolio Resource Management Upgrade	130		-	130		85	10	10	-		-		95	35
ISSP - Printer Architecture Upgrade	130		-	130		9	120	4	116	-	-		130	0
ISSP - Application Lifecycle 2014/15 WorkPlan	470			470		454	4	4	-		-		458	12
ISSP - Baseline - Infrastructure Lifecycle Management	465		-	465		318	151	23	128		-		469	(4)
ISSP - Windows 10 COE (Part deduction see below for balance of deduction	45		-	45		27	18	18	-		-		45	0
ISSP - Cobas IT 1000	120		-	120		2	118	0	118		-		120	0
ISSP - Spark Consultancy Services			64	64		-	6	6	-	-	-		6	58
SUB TOTAL INFORMATION SYSTEMS	**30,660**	**38,198**	**-244**	**68,614**		**8,323**	**32,721**	**3,663**	**9,221**	**19,838**	**26,237**		**67,281**	**1,333**
PROPERTY & INFRASTRUCTURE - PLANT														
Waikato Waiora Chillers	643		-	643		626	2	2	-	-	-		628	15
Waikato Distribution Board stuff 11/12	250		-	250		196	54	16	38	-	-		250	0
Waikato Switchboards - Menzies,Kemp,Waiora & ERB	-	600	-	600		-	600	-	-	600	-		600	0
Theatre - Air conditioning upgrades	-	400	-250	150		-	150	-	-	150	-		150	0
Kempthorne Plantroom Upgrade	-	-	250	250		-	252	169	83	-	-		252	(2)
Thames - Air conditioning inpatient unit upgrade	-	200	-	200		-	200	-	-	200	-		200	0
Carpark Lighting - Upgrade	-	50	-	50		-	50	-	37	13	-		50	0
HV System - upgrade- SCADA to BMS	-	160	-	160		-	160	-	-	160	-		160	0
Ward 32 - Air conditioning	-	45	-	45		-	45	-	-	45	-		45	0
Hockin sewage system	-	65	-	65		-	65	-	-	65	-		65	0
Marsh Insurance Items	-	150	-	150		-	150	-	-	150	-		150	0
Mothercraft Fire Panel - upgrade	-	20	-	20		-	20	-	-	20	-		20	0
NICU ERM's to 4 x 4 upgrade	-	36	-	36		-	36	-	-	36	-		36	0
Tunnel lighting	-	30	-	30		-	30	-	-	30	-		30	0
Maternity Refurb / Electrical	-	44	-	44		-	44	-	-	44	-		44	0
EWIS communications solution	-	170	-	170		-	170	-	-	170	-		170	0
Lift car upgrades	-	72	-	72		-	72	-	-	72	-		72	0
ERB chilled water buffer tank installation	-	20	-	20		-	20	-	-	20	-		20	0
ERB Fire panel upgrade	-	200	-	200		-	200	-	-	200	-		200	0
Menzies Fire panel upgrade	-	200	-	200		-	200	-	-	200	-		200	0
Avigilon DVR's in all building x9	-	117	-	117		-	39	-	-	39	78		117	0
Carpark CCTV	-	300	-	300		-	100	-	-	100	200		300	0
Convert CCTV from analogue to IP	-	60	-	60		-	30	-	-	30	30		60	0
Develop Web based payment for Multicash	-	150	-	150		-	150	-	-	150			150	0
Change Readers X 125	-	60	-	60		-	30	-	-	30	30		60	0
Gallagher door controllers - upgrade to 6000 model	-	300	-	300		-	100	-	-	100	200		300	0
Virtual controller for Monitoring stations	-	80	-	80		-	80	-	-	80	-		80	0
Intercoms at all barrier arms	-	110	-	110		-	55	-	-	55	55		110	0
CCTV for Hockin building	-	80	-	80		-	80	-	-	80	-		80	0
Master key - Waikato buildings (2 x bldgs)	-	112	-	112		-	54	-	-	54	58		112	0
Ward - standard install	-	120	-	120		-	40	-	-	40	80		120	0
Monitoring centre (setup, 24/7 manning)	-	50	-	50		-	50	-	-	50	-		50	0
Infrastructure Replacement Pool (15/16)	600			600		547	191	191	-	-			738	(138)
Infrastructure Replacement Pool (16/17)		600		600		-	533	-	533		-		533	67
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	**1,493**	**4,601**	**-**	**6,094**		**1,369**	**4,052**	**379**	**690**	**2,983**	**731**		**6,152**	**58**
PROPERTY PROJECT SERVICES								-						0
Priority Roading Works		565		565		-	565	-	-	565	-		565	0
MCC - Edge roof protection		30		30		-	30	-	-	30	-		30	0
OPRS - Roof access		30		30		-	30	-	-	30	-		30	0

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ERB improvements (counter cold & wind)		150		150			150	-		150			150	0
Greening Programme	875	-	-280	595			-	-			595		595	0
Concept Design- Oncology/Haematology Facility	300	-	-	300		62	238	19	219				300	0
Virtual Care Office	46	-		46		57	35	35					92	(46)
Boiler House Upgrade	1,833	-	-	1,833		1,833	33	33	-				1,866	(33)
Hilda Ross - Remediation	3,403	-	280	3,683		0	3,684	972	1,462	1,250			3,684	(0)
Lift Upgrade	1,835	-	-	1,835		1,610	225	-	-	225			1,835	0
Electrical Systems Improvement	6,889	-	-175	6,714		5,789	947	121		826			6,736	(22)
Consolidation of CBD facilities	-	5,557	-	5,557		-	5,557	838	4,720	-	-		5,557	(0)
Office Relocations	2,000	-	-95	1,905		-	405	-		405	1,500		1,905	0
Hockin - Open planning/ Modernisation of Level 3 Executive Wing			95	95		-	95	5	90				95	0
Seismic Remediation	3,207	-		3,207		123	2,044	728	254	1,062	1,222		3,389	(182)
Internal Reconfiguration - Gallaghers	-	863	-	863		-	863	-		863			863	0
Internal Reconfiguration - Room Pressure	-	210	-	210		-	210	-		210			210	0
Internal Reconfiguration - Pain Clinic - L3 Menzies	-	100	-	100		-	100	-		100			100	0
Internal Reconfiguration - Coffee outlet L1 MCC	-	75	-	75		-	75	-		75			75	0
Internal Reconfiguration - Refurb - Waiora L2	-	200	-	200		-	200	-		200			200	0
Outdoor staff facility- Rest & Recovery off red Corridor	-	100	-	100		-	100	-		100			100	0
Ward Block A & environs	-	300	-	300		-	300	-		300			300	0
Landscape Ward Block A		50		50		-	50	-	-	50			50	0
Tokoroa / Te kuiti / Rhoda Road / Matariki Refurb	-	140	-140	-		-	-	-			-		0	0
Combining Matariki and Princess Street Bases			140	140		-	140	5	135				140	0
Legacy SCR - Still Required - decanting	800		-	800		700	4	4	-	-	-		704	96
SUB TOTAL PROPERTY PROJECT SERVICES	**21,188**	**8,370**	**-175**	**29,383**		**10,173**	**16,080**	**2,760**	**6,879**	**6,441**	**3,317**		**29,570**	**-187**
VEHICLES								-						0
Vision Hearing Truck (Moblie Ear Clinic)	**200**		47	247		235	3	3			-		238	9
Mobile Dental Unit Replacements level 1		700		700			700	-		700			700	0
Mobile Dental Unit Replacements level 2	**750**		-	750		-	530	-	-	530	220		750	0
SUB TOTAL VEHICLES	**950**	**700**	**47**	**1,697**		**235**	**1,233**	**3**	**-**	**1,230**	**220**		**1,688**	**9**
STRATEGIC PROJECT OFFICE								-						0
Education; Research and supporting amenities	25,000	-		25,000			-	-			25000		25,000	0
Mental Health Facility - scoping	77	-	-	77		-	77	10	67		-		77	0
Mental Health Facility	-	60,992	-	60,992		-	500	-		500	60,333		60,833	159
SUB TOTAL STRATEGIC PROJECTS	**25,077**	**60,992**	**0**	**86,069**		**0**	**577**	**10**	**67**	**500**	**85,333**		**85,910**	**159**
CORPORATE								-						0
COS - Contingency (was CFO)	1,000		-492	508		-	508	-		508			508	0
Catalyst Initiatives	2,500		-574	1,926		-	356	-		356	1,470		1,826	100
Service & Capacity Planning Tool			98	98		-	98	-	98				98	0
BPAC eReferral Phase 2			247	247		-	247	-	247	-			247	0
Production & Meal ordering S/W	-	300	-	300		-	300	-		300			300	0
Positive NPV Projects	1,000		-	1,000		-	1,000	-		1,000			1,000	1
Oracle - Mop ups and Budgeting solution	-	500	-	500		-	500	-		500			500	1
Taleo - Transition module			30	30		-	30	21	9				30	0
Project Elevate-Upgrade to NOS			118	118		1	129	129					129	(11)
Transition to National Oracle System	3,500		-118	3,382		-	2,314	-		2,314			2,314	1,069
SUB TOTAL CORPORATE PROJECTS	**8,000**	**800**	**-691**	**8,109**		**1**	**5,480**	**149**	**354**	**4,977**	**1,470**		**6,950**	**1,159**
MOH Projects (funded externally)							-	-						
National Patient Flow-Phase 2	177		-	177		174	2	2			-		177	0
National Patient Flow Phase 3	249			249		23	228	102	126		-		251	(2)
Telestroke Pilot	-	-	-	-		-	39	39	-	-	-		39	(39)
SUB TOTAL MOH PROJECTS	**426**	**-**	**-**	**426**		**197**	**230**	**104**	**126**	**-**	**-**		**427**	**1**
Trust Funded Projects (funded externally)							-	-						0
15/16 Trust Account	-			-		250	226	226			-		476	(476)
16/17 Trust Account				-		-	31	31			-		31	(31)
15/16 Other Donated Assets				-		84	5	5					89	(89)
SUB TOTAL TRUST FUNDED PROJECTS	**-**		**-**	-		**333**	**263**	**263**	**-**	**-**	**-**		596	(596)
PROJECT SAVINGS				-			**(19,641)**			**(19,641)**			**19,641**	**19,641**
CAPITALISED COMPLETED PROJECTS	4,189		275	4,464		3,150	1,358	1,358					**4,508**	**(44)**
TOTALS	**106,738**	**140,879**	**-578**	**247,039**		**25,812**	**68,001**	**13,649**	**20,615**	**33,737**	**131,404**		**225,217**	**21,821**

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Performance Reporting

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 6.1

HEALTH TARGETS REPORT

Purpose	For information.

Most recent results

Table 1 shows a summary of performance for Waikato DHB's health target results including 2016/17 quarter one results. DHB comparison rankings for 16/17 quarter two performance are not yet available, but the most recent results in the last column give the most up to date picture of performance.

Table 1- Health targets performance summary

HEALTH TARGETS		2014/15 Q4 results & ranking	15/16 Target	2015/16 Q1 results & ranking	2015/16 Q2 results & ranking	2015/16 Q3 results & ranking	2015/16 Q4 results & ranking	16/17 Target	2016/17 Q1 results & ranking	2016/17 Q2 results	Target achieved	2016/17 Most recent result
Shorter stays in emergency departments		94.0% 16th ✗	**95%**	89% 18th ✗	92% 16th ✗	90% 19th ✗	**91% 18th** ✗	**95%**	89.3% 19th ✗	87.6% no ranking available	X	88.8% Jan 17
Improved access to elective surgery		115.0% 3rd ★	**100%**	119% 4th ★	120% 2nd ★	120% 2nd ★	**119% 2nd** ★	**100%**	108.2% 7th ★	101.6% no ranking available	√	101.6% Jan 17 YTD
Faster Cancer Treatment (FCT)	Achievement	55.9% 17th ✗	**85%**	57% 17th ✗	68% 17th ✗	**73% 13th**	77% 10th ●	**85%**	81.1% 5th ★	86.1% 5th prelim result	√	86.1% Dec 16 6 mth rolling (provisional)
Better Help for Smokers to quit	Primary Care	84% 10th ●	**90%**	84% 12th ●	88% 7th ★	**89% 8th**	88% 6th ★	**90%**	87.0% 7th ★	87.0% prelim result	X	86.7% 16/17 prelim Q2 result (rank 12th)
	Maternity	91.2% 14th= ✗	**90%**	91% 16th ✗	89% 15th ✗	**95% 13th**	97% 8th ●	**90%**	92.9% 12th ●	No result or ranking	√	92.9% 16/17 Q1 result
Increased immunisation (8 months)		90.7% 15th ✗	**95%**	90% 17th ✗	92% 13th ●	91% 15th ✗	**90% 17th** ✗	**95%**	92.3% 13th ●	92.0% no ranking available	X	91.2% Jan 17 3 mth rolling
Raising Healthy Kids[1]				9%	18%	19%	31%	**95%[1]**	47.0%[2] Rk TBC	82.0% no ranking available	X	79% 16/17 Q2 result (Jun-Nov16 data)

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

[1] Target by Dec 2017

[2] Q1 data is for the six months to the end of August 2016

Target: Shorter stays in Emergency Departments (ED)

DHB quarter results 2017

DHB Q4 result 12/13	DHB Q4 result 13/14	DHB Q4 result 14/15	**DHB Target 15/16**	DHB Q1 result 15/16	DHB Q2 result 15/16	DHB Q3 result 15/16	**DHB Q4 result 15/16**	**Q1 2016/17**	**Q2 2016/17**
88.4% 18th ranking	93.0% 16th ranking	94.0% 16th ranking	**95%**	89.5% 18th ranking	91.9% 16th ranking	90.5% 19th ranking	**91%**	**89.3% 19th Ranking**	**87.6%**

Table 2 –2017 ED results for January

Quarterly Results – by DHB total population			
	Numerator: The number of ED presentations with a length of stay of less than six hours	Denominator: Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	24046	27439	87.6%
Waikato	15668	18672	83.9%
Taumarunui	1483	1549	95.7%
Thames	4052	4282	94.6%
Tokoroa	2843	2936	96.8%

Table 2 shows all Health Waikato hospitals emergency department performance up to the latest result of 88.8% for YTD January 2017.

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

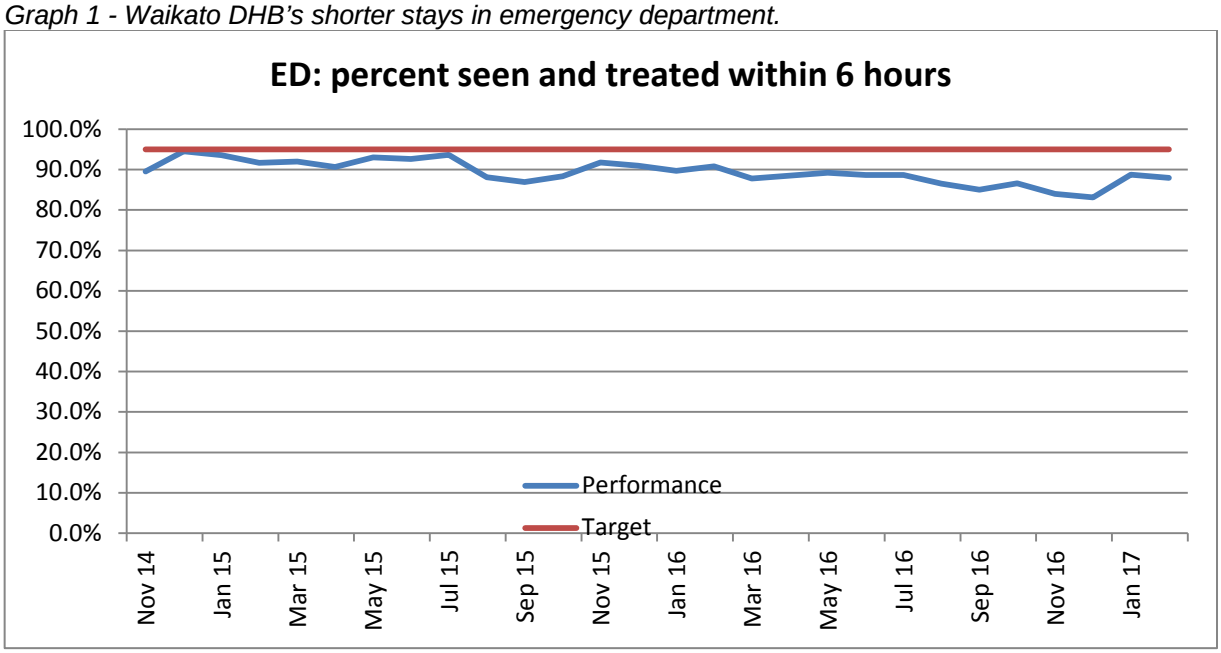


Table 3 - Emergency Department January 2017 results by site and by clinical unit

	Clinical Unit	Month: Jan-2017		Year To Date	
		Departures	%	Departures	%
By Specialty/Division (Waikato Hospital Only)	General & Specialty Surgery	825	78.1%	5682	79.4%
	Cardiology	237	70.9%	1806	57.3%
	Cardiothoracic Surgery	11	100.0%	49	89.8%
	Critical Care	0		0	
	Paediatrics	310	91.9%	3057	88.9%
	Emergency Department	3453	94.5%	24581	93.2%
	Internal Medicine	801	81.0%	5830	72.1%
	Womens Care	105	78.1%	772	79.8%
	Oncology	68	82.4%	504	78.3%
	Orthopaedics	285	80.1%	1808	75.9%
	Renal	53	77.4%	333	80.5%
	Vascular Surgery	33	90.9%	246	91.4%
	Allied health	0		0	
	Community Services	0		0	
	Older Persons	2	100.0%	3	100.0%
	Mental Health	111	90.1%	623	88.5%
By Site	Waikato Hospital	6294	88.2%	45294	85.5%
	Thames Hospital	1742	94.7%	10185	94.8%
	Tokoroa Hospital	1027	97.1%	7045	97.2%
	Taumarunui Hospital	570	95.4%	3713	96.7%
	Total Health Waikato	**9633**	**90.7%**	**66237**	**88.8%**

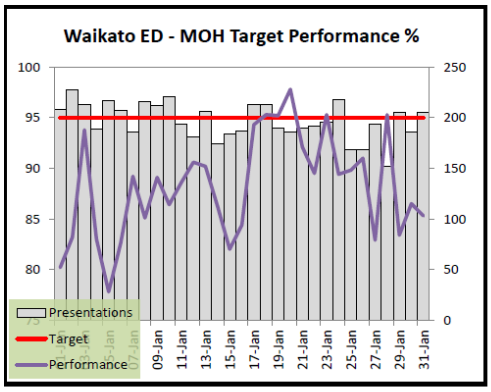
To manage within the overall 6 hour target for emergency department patients the 6 hours is broken down for operational purposes into:

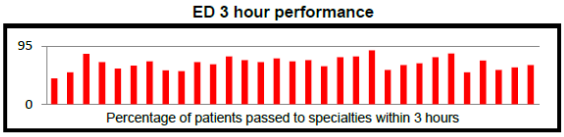
- 3 hours for the emergency department to complete the initial assessment and investigation of patients, including a decision if the patient needs to be referred to a speciality; and
- 2 hours for the specialty to review the patient and to make a decision if they need to be admitted; and
- 1 hour to secure a bed and transfer the patient for those who do need to be admitted.

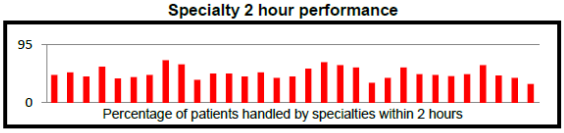
The dash board below has started to be utilised at the ED operational meeting, with a focus on the initial 3 hours and the non-admitted patients. Discussion with the ED medical senior staff consistently occurs to focus the team to manage patients through the 3-2-1 model.

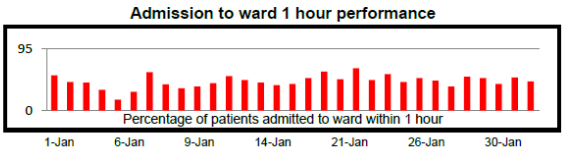
Waikato Acute Flow Dashboard - Monthly

Month Performance	88.17%



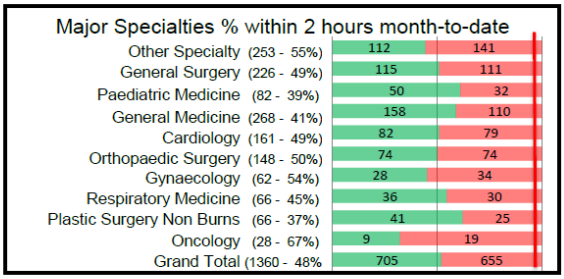






Month: Jan 2017

	Admitted	Not Admitted	Total
Totals	**2270**	**3827**	**6097**
Breaches	**471**	**250**	**721**
Met Target	**79%**	**93%**	**88.17%**



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

Recruitment following approval of the ED business case is underway and a panel is in place to interview a number of SMO applications mid-February. The nursing component is underway for the Registered Nurse and Health Care Assistant components.

The performance of the admitted patient pathway has not changed, and continues to be the most significant area of challenge in terms of both delivery and performance. As the table above demonstrates, all clinical units are currently failing to achieve the target and we are consistently not achieving any of the 3-2-1 performance targets. Interestingly, the target was consistently delivered during the Junior Doctor strike, when there was sufficient bed capacity for acute admissions, combined with senior medical presence at the front door. That emphasises the importance of the recently revised specialty referral guidelines and the patient flow project to release bed capacity without creating new beds.

During January change team members have undertaken a number of observations and have begun to identify short, medium and long term opportunities to improve flow within and out of the Emergency Department. These are currently being reviewed and the change team will have a dedicated session with the Emergency Department SMOs in mid-February to discuss prioritisation of the potential initiatives.

A planning session with the Emergency Department SMO team was held on 14 February including a focused workshop on the 3 hr commitment of the ED team within the the 3-2-1 model of care.

The current actions to reduce acute demand are:

GP unenrolled patients:

- A proposal for the management of the unenrolled patients who are currently 11% of the attendance has been supported at the Demand Management Group (DMAG) and will progress over the next quarter.

Chronic Obstructive Pulmonary Disease:

- A care model pilot proposal for COPD in Hamilton will also be presented to DMAG at the February meeting. The proposal is based on the efficiencies delivered in Canterbury and Hawkes Bay DHBs, backed up by a clinical research project in the Waikato. The principle gain anticipated from the pilot would be a saving of 1,000 bed days, combined with improved education and case management with primary care and St John Ambulance. If supported funding options will be considered.

Advance Care Planning

- The Advance Care Planning project that commenced in 2016 is progressing and should increase the proportion of advanced care plans available with designated groups.

Acute Patient Governance group

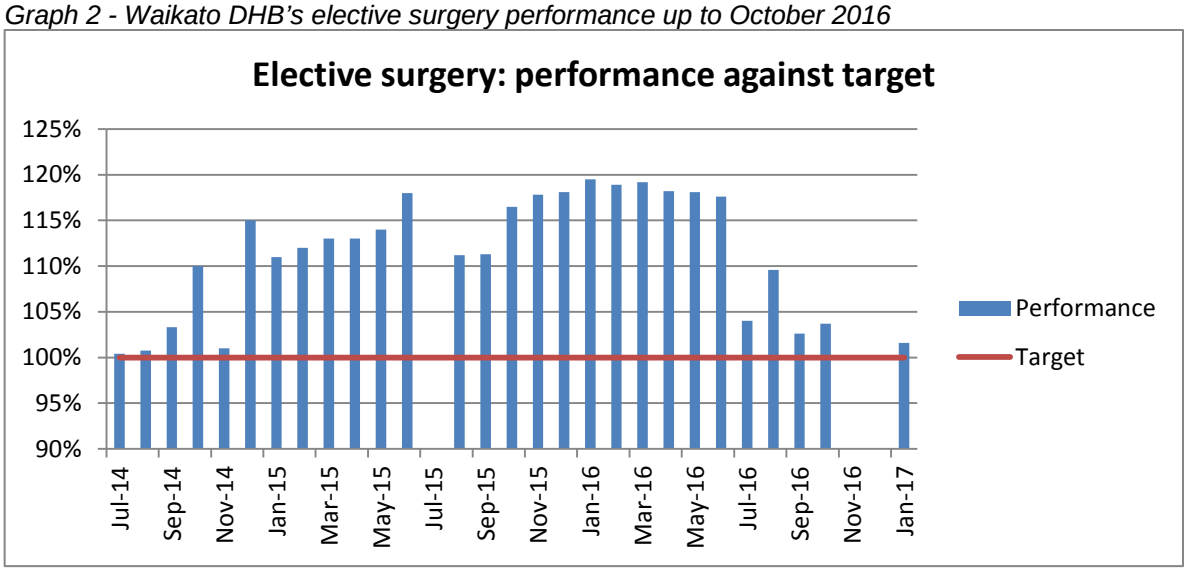
- The Chair of the Acute Patient Governance group held an additional meeting on 14th February. The focus of this meeting was to consider how activity overseen by the group might be better targeted. It was agreed that as a cross-specialty governance group the particul focus would now be on the processes of specialty acceptance and transfer to wards of Emergency Department patients requiring admission.

Target: Elective Surgery

DHB Q4 result 13/14	DHB Q4 result 14/15	DHB Q4 result 15/16	**DHB Target 16/17**	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	**DHB Q1 result 16/17**	**Most recent result**
111.0 % YTD 5th ranking (target 13,231 discharges)*	115.5% YTD 3rd ranking (target 13,583 discharges)	119% YTD (target 15,858 discharges)	**100%** **(target 16,805 discharges)**	120% YTD 2nd ranking (target 7,858 discharges)	120% YTD 2nd ranking (target 11,546 discharges)	119% YTD (target 15,858 discharges)	**108% YTD 7th ranking** **(target 15,858 discharges)**	**101.6% YTD January 17** **(target 10,065 discharges)**

The 2016/17 target is 16,805 discharges. Graph two provides the most recent result of 102%, a total of 10,231 actual discharges for the period from 1 July 2016 to 31 January 2017. Our official ranking result for Q2 has not yet been released.

Graph 2 - Waikato DHB's elective surgery performance up to October 2016



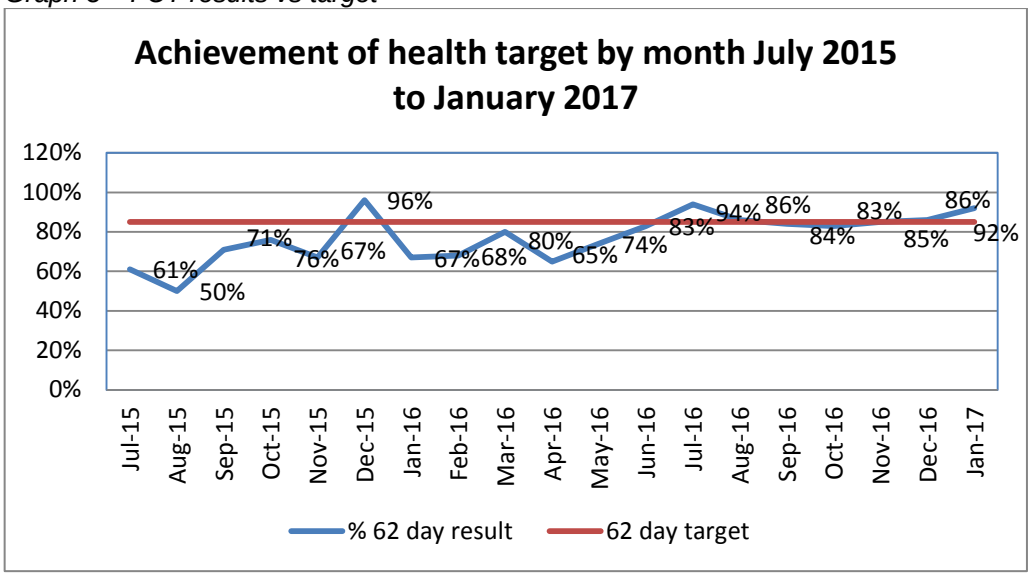
Target: Faster Cancer Treatment (FCT)

FCT 62 DAY HEALTH TARGET								
DHB Target by July 2017	**DHB Current Target**	DHB Q1 Result 15/16*	DHB Q2 Result 15/16	DHB Q3 Result 15/16	DHB Q4 Result 15/16	DHB Q1 Result 16/17	**DHB Q2 Result 16/17**	**Most recent six monthly result**
90.00%	**85%**	57.0% 17th ranking	68.0% 17th ranking	76.5% 10th ranking	72.6% 14th ranking	81.4% 5th ranking	**86.1%** 5th ranking (provisional)	**86.1%** **Dec-16 (provisional)**
FCT VOLUME TARGET								
DHB Target by July 2017	**DHB Current Target**	DHB Q1 Result 15/16*	DHB Q2 Result 15/16	DHB Q3 Result 15/16	DHB Q4 Result 15/16	DHB Q1 Result 16/17	**DHB Q2 Result 16/17**	**Most recent six monthly result**
25.00%	**15%**	17% 11th ranking	16% 14th ranking	14% 15th ranking	14%	17%	**19%**	**19%** **Dec-16 (provisional)**

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

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

Graph 3 – FCT results vs target



Waikato DHB has achieved the 85% target for the last three months, with January's provisional result of 92% not included in the Q2 6 month rolling average data detailed above.

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

It needs to be recognised that the numbers of patients being treated on the 62 day pathway are relatively small and one or two breaches can have a substantial impact on the DHB's overall percentage performance. Currently there are risks with the pressures on the Gynaecology service, with a number of breaches in December and January and a few predicted for February which will impact on the DHB's Q3 performance and the 6 month rolling average. This is being followed up directly with the service.

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

- Business manager and nurse tracker working very closely with cancer care coordinators and CNS's monitoring the patient pathway from initial date of referral;
- Business manager working closely with gynaecology team in Waikato and Auckland to ensure patients receive their surgery in Auckland in timely manner;
- New gynaecologist with special interest in gynaecological cancers commenced January 2017;
- Early notification to oncology booking clerks highlighting patients on the 62 day pathway being referred for first treatment.

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

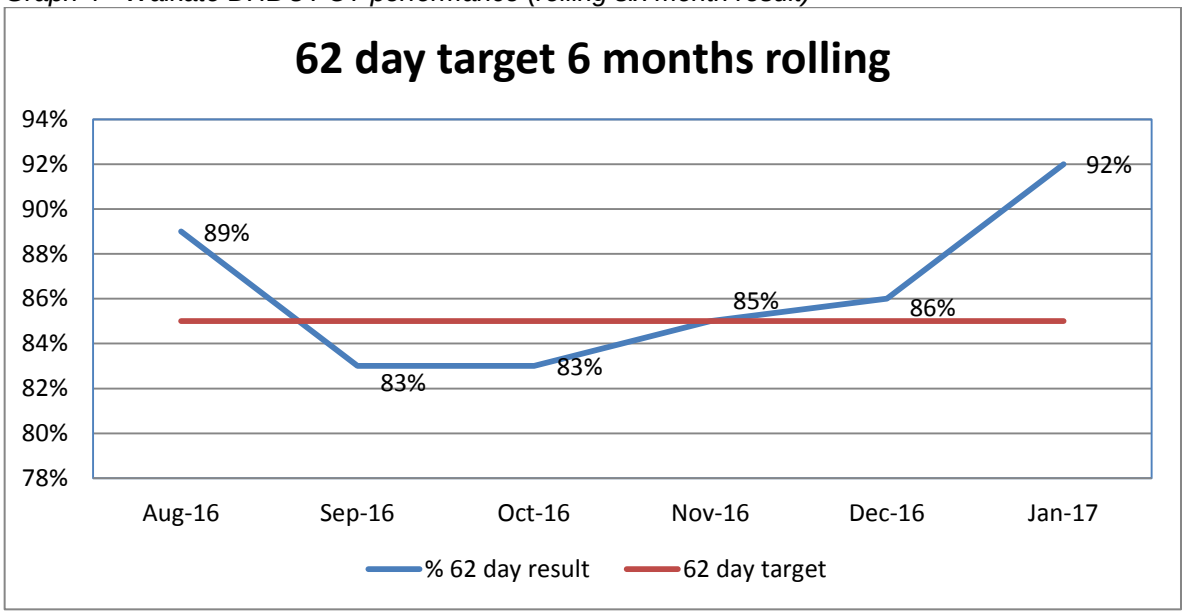


Table 4 - Latest six month data for 62-day FCT cohort, by month of first treatment

Local FCT Database	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Total
Number of records submitted	36	29	23	34	42	24	188
Number of records within 62 days	32	24	19	29	36	22	162
% 62 day Target Met (85%)	89%	83%	83%	85%	86%	92%	86%
% Volume Target Met (15%)	22%	18%	14%	21%	26%	15%	19%

Result for the volume measure of 15% of cancer registrations identified as high suspicion of cancer is also included in the table above. This is a check that the referrals that should be identified as high suspicion of cancers are being captured against this measure. Our latest six month volume result is 19%, which is also a marked improvement on previous quarters.

Target: Increased immunisations for 8 months

DHB Q4 result 13/14	DHB Q4 result 14/15	DHB Q4 result 15/16	**DHB Target 16/17**	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	**DHB Q2 Result 16/17**	**Most recent 3 monthly result**
89% 17th ranking	91% 15th ranking	89% 17th ranking	**95%**	92% 13th ranking	91% 15th ranking	89% 17th ranking	92% 13th ranking	**92% Rank not yet available**	**91% Jan 17**

Data for this target is reported on a three month rolling basis. Graph 5 shows our most recent result of 91% for the three month period from 1 Nov 2016 to 31 Jan 2016. This is a slight decrease from quarter 2, however delivery against this target over the Christmas break is often low.

We still have not yet met the target of 95%. An Immunisation Resolution Plan was developed prior to Christmas in conjuction with the Immunisation Steering Group members capturing all current and planned activity. The Ministry has agreed the detailed actions outlined to improve immunisation performance. This resolution plan is led by the Immunisation Steering group which has delegated representative's from PHOs, Strategy and Funding, Population Health and the NIR.

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

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

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

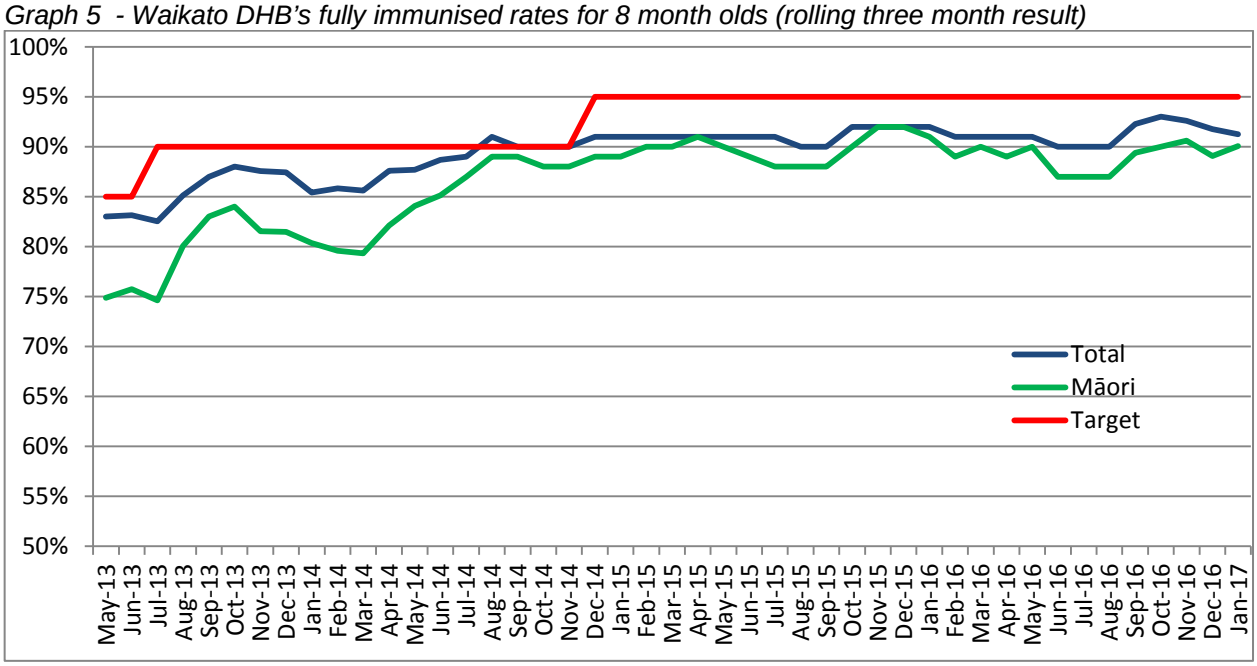


Table 5 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 52 additional children need to be immunised to meet the 95% target.

Table 5 - Waikato DHB 8 month old immunisations ethnicity breakdown from Nov 16 to Jan 17

Ethnicity	**Number Eligible**	**Fully immunised**	**Result**	**Increase needed to meet the target (95%)**
Asian	154	145	94%	2
Māori	533	480	90%	27
NZ European	509	467	92%	17
Other	129	112	87%	11
Pacific	56	56	100%	0
Total across ethnicities				57
Total	**1,381**	**1,260**	**91%**	**52**
Opt off			11	
Declined			69 (5%)	

Table 6 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 6 - Waikato DHB's PHO level results for 8 month old immunisation from Nov 16 to Jan 17

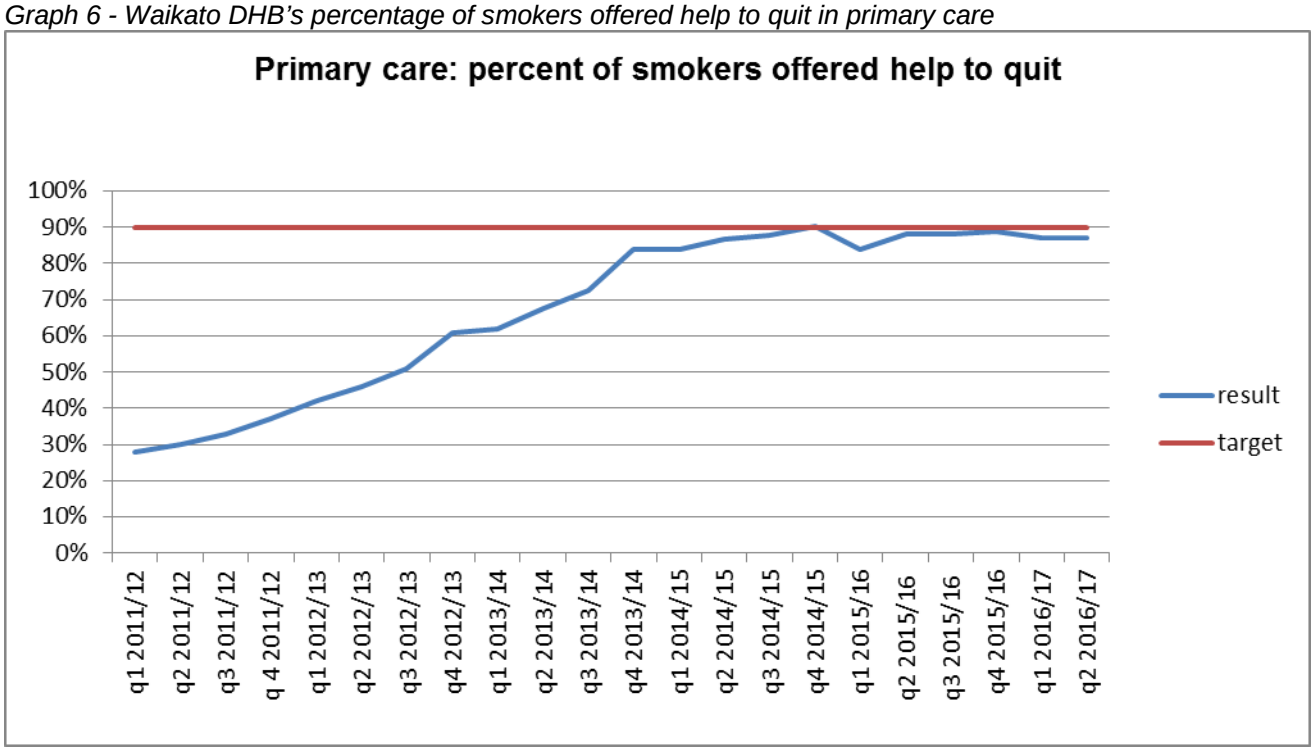
PHO	**Total population**			**Maori population**		
	No eligible population	*No fully immunised population*	*Percent immunised*	*No eligible population*	*No fully immunised population*	*Percent immunised*
Hauraki PHO	522	485	93%	271	247	91%
Midlands Health Network – Waikato	786	725	92%	234	215	92%
National Hauora Coalition	22	20	91%	9	7	78%
Not Enrolled with a Waikato DHB based PHO	51	30	59%	19	11	58%
DHB Total	1,381	1,260	**91%**	533	480	90%

Target: Better help for smokers to quit - primary care

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

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

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



Activities underway as part of the Ministry contract with Midlands Health Network for tobacco cessation support across the district will help improve this result moving forwards. The Ministry has also signalled a possible increase in funding in 17/18 for the DHB tobacco control programme. Planningis underway with the sector on how best to utilise this resource to support smoking cessation

Table 7 shows a breakdown of primary care smoking results by PHOs for 2016/17 quarter two.

Table 7 – 2016/17 Q2 primary care smoking preliminary results by PHOs (target 90%)

PHOs	**Tobacco Numerator**	**Tobacco Denominator**	**2016/17 Q2 result**	**2016/17 Q1 result**	**2015/16 Q4 result**	**2015/16 Q3 result**	**2015/16 Q2 result**
Midlands Health Network	25,815	29,507	88%	88%	88%	87%	87%
Hauraki PHO	20,067	23,411	86%	86%	86%	90%	89%
National Hauora Coalition	1,168	1,365	86%	87%	92%	84%	84%
Total	47,050	54,283	**87%**	**87%**	**89%**	**88%**	**88%**

Target: Better help for smokers to quit - maternity

DHB Q4 result 13/14	DHB Q4 result 14/15	DHB Q4 result 15/16	**DHB Target 16/17**	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	**DHB Q1 result 16/17**	**Most recent result**
95.3% 10th ranking	91.2% 14th= ranking	95% 13th ranking	**90%**	89% 15th ranking	97% 8th ranking	95% 13th ranking	**93% Rk TBC**	**93% Q1 result**

Graph 7 quarter one result of 93% shows we continue to met this target although this has dropped from the previous quarter.

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

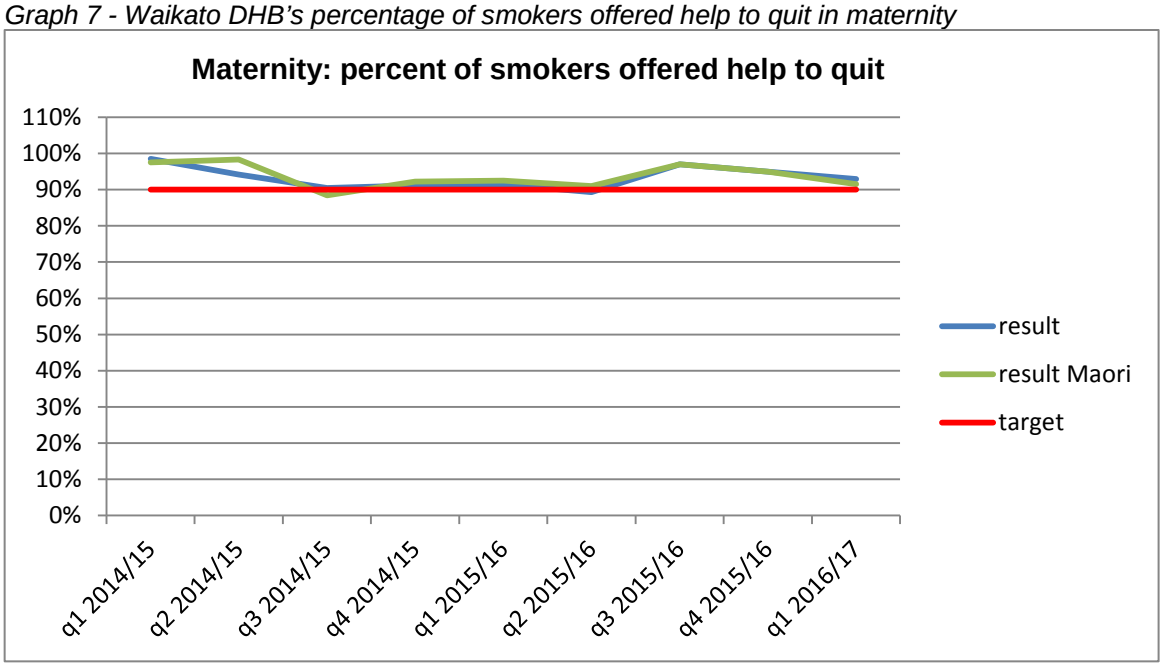


Table 8 shows our quarter one results provided by the Ministry for our total and Maori population.

Table 8 – 2016/17 Q1 maternity smoking status and advice results (target 90%)

	No. women registered *	No. of women identified as smokers	No. people given advice	Smoking prevalence	Percent of smokers offered advice
Maori	199	82	75	41.2%	91.5%
Total	748	112	104	14.9%	92.9%

**Data comes from three sources: Midwifery and Maternity Providers Organisations (MMPOs), Lead Maternity Carers Services (LMCs) and from DHB employed midwives (if available)*[3]

Target: Raising healthy kids

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

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

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

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

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

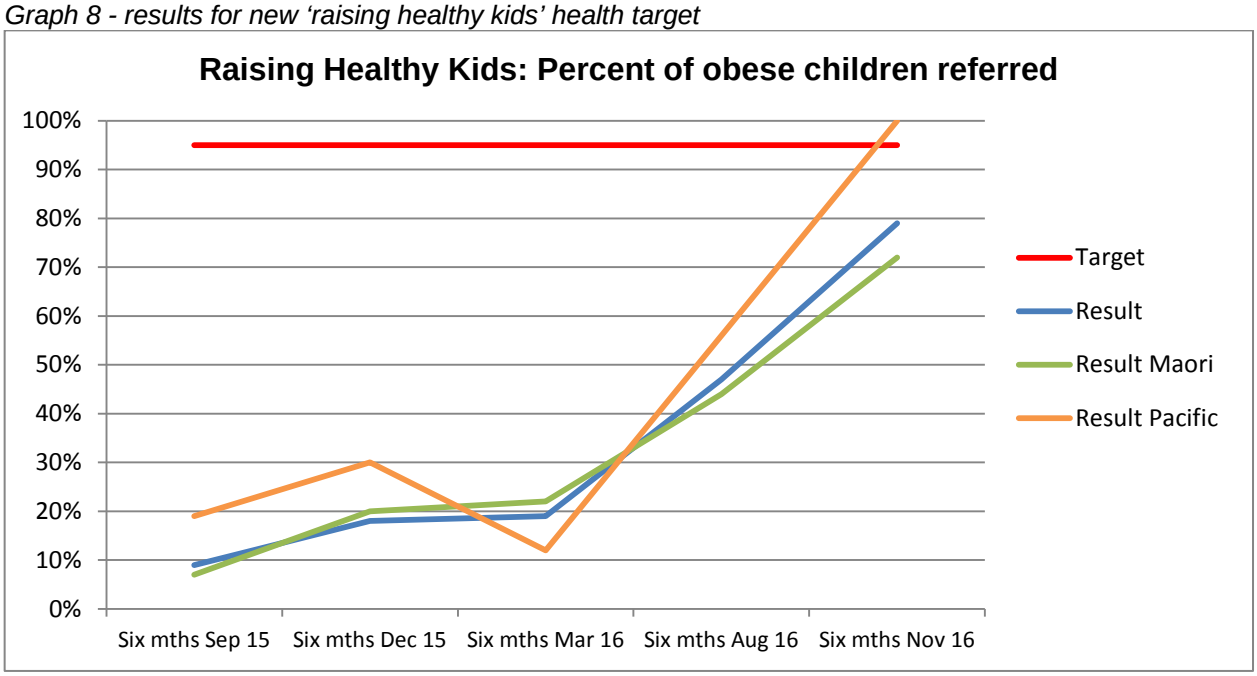
Locally the introduction of the target is led out by the Waikato Child Health Network chaired by our primary care clinical lead and GP Child health liaison doctor. The health target is just one part of both a national and district wide multifaceted approach to tackle child hood obesity including amongst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

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

Table 9 – 2016/17 Q1 Raising Healthy Kids Results (target 95%)

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

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



Data for a 6 month rolling period up to Nov 2016

Recommendation
THAT
The Board receives this report.

BRETT PARADINE
EXECUTIVE DIRECTOR
WAIKATO HOSPITAL SERVICES

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY & FUNDING

SUE HAYWARD
DIRECTOR
NURSING AND MIDWIFERY

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY AND CLINICAL SUPPORT

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 6.2

PROVIDER ARM KEY PERFORMANCE DASHBOARD

Purpose	For information.

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

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

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

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

Recommendation
THAT
The Board notes the report.

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY &
CLINICAL SUPPORT

DEREK WRIGHT
EXECUTIVE DIRECTOR
MENTAL HEALTH

BRETT PARADINE
EXECUTIVE DIRECTOR
WAIKATO HOSPITAL
SERVICES

Key Performance Dashboard

Community & Clinical Support

January 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	95.5	95.0	0.5	95.9	95.0	0.9		
Number of long wait patients on outpatient waiting lists	# > 4 mths	0	0	0	0	0	0		
Number of long wait patients on inpatient waiting lists	# > 4 mths	0	0	0	0	0	0		
CTs reported within 6 weeks of referral	%	83.9	90.0	(6.1)	94.5	90.0	4.5		
MRIs reported within 6 weeks of referral	%	84.2	85.0	(0.8)	89.5	85.0	4.5		

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department - Number relative to Target growth of 4% p.a.	Numbers	Rolling 12 month measure			33,961	33,616	(345)		
Elective Surgery Volumes vs Elective Health Target	% of target	Under development - see separate Elective Health Target Report							
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			84.0	86.9	(2.9)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			94.1	99.4	(5.3)		2
Laboratory – Histology specimens reported within 7 days of receipt	% for Dec YTD	28.0	80.0	(52.0)	47.4	80.0	(32.6)		3
Pharmacy - Chart turnaround times, % within 2.5 hours	%	94.1	80.0	14.1	93.0	80.0	13.0		
Pharmacy on Meade script turnaround time in minutes	minutes	6.8	10.0	3.2	7.0	10.0	3.1		
Outpatient DNA Rate	%	10.6	10.0	(0.6)	10.8	10.0	(0.8)		4
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	97.9	100.0	(2.1)	93.5	100.0	(6.5)		5
Output Delivery Against Plan - Inpatient Number of Episodes	%	95.5	100.0	(4.5)	93.9	100.0	(6.1)		6
Output Delivery Against Plan - Inpatient CWD Volumes	%	83.0	100.0	(17.0)	92.6	100.0	(7.4)		7
District Nurse Contacts (DHB Purchased)	Numbers	9,056	-	-	69,274				
District Nurse Contacts (ACC Purchased)	Numbers	1,796	-	-	13,929				
School Dental Service - Clients assessed and treated	Numbers	Under development							
Radiology - total imaging events	Numbers	Under development							
Lab - total tests	Numbers	Under development							
pharmacy - scripts processed	Numbers	Under development							
pharmacy - medications reconciled	Numbers	Under development							

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			3.59	3.78	0.19		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			0.98	0.96	(0.02)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			1.05	1.08	0.03		
DOM101 Avg Length of Stay	Days	Under development							

Quality and Patient Safety KPI measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	96.3	95.0	1.3	92.8	95.0	(2.2)		

Quality Indicators - Patient Safety

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Breast screening Total volumes - Waikato DHB	Numbers	2,569	3,000	(431)	22,875	24,000	(1125)		
Breast screening Maori volumes - Waikato DHB	Numbers	166	155	11	1,482	1,817	(335)		8
Hospital Acquired MRSA (Department)	Numbers	0	0.0	0	0.0	0.0	0		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers	13	8	(5)	83	57	(26)		9
Complaints resolved within 20 wd (1 month lag)	% for Dec-16	86	70	16	59	70	(11)		10
Falls Resulting in Harm	Numbers	5		(5)	28		(28)		
All Falls	Numbers	18	9	(9)	92	66	(26)		11
Patient Feedback	*Not yet collected - in Development*								

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	9,887	9,777	110	73,827	73,550	277		
Actual Expenditure vs Budget ($000s)	$000s	12,189	12,103	(86)	90,255	87,969	(2,285)		
Actual Contribution vs Budget ($000s)	$000s	(2,302)	(2,326)	24	(16,428)	(14,419)	(2,008)		12
Actual FTEs vs Budget	FTEs	1,001.1	1,007.5	6.4	1,000.4	996.8	(3.6)		
Sick Leave	% of paid hours	1.6	1.6	(0.0)	3.0	2.9	(0.1)		
Overtime $'s	$000s	199	136	(63)	1,225	949	(276)		13
Annual Leave Taken	% of Budget	Rolling 12 month measure			93.4	100.0	(6.6)		14

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

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

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

KPI Report: Community & Clinical Support

The interim KPI report for the division is appended to this report. This interim report is deficient in that the KPI do not reflect the core activities of the Community & clinical Support services.

An indication of some of the new KPIs that might be reported on in the future is shown below. The KPIs are grouped into the tripartite framework of efficiency/ effectiveness, safety/ quality and equity. It would be helpful at this juncture to receive feedback from the board about whether that tripartite framework will meet their expectations. Obviously the example below covers the clinical support services only and context relevant measures will be provided for rural, population, screening and community services as well. These measures are a subset of a much larger set that are monitored at service level. Finding the right balance between span and detail of reporting will be challenge for a diverse group of services such as those in this part of the Board's operation.

Measure	Target	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Laboratory							
Efficiency and Effectiveness							
Biochemistry: ED urgent Biochemistry profile TAT within 90 min of collect	≥90%	96%	94%	95%	92%	97%	94%
Histology specimens reported within 7 calendar days of receipt.	≥80%	48%	42%	58%	54%	58%	
Microbiology: ED Urine TAT's within 45 minutes	≥90%	89%	87%	87%	92%	92%	90%
Haematology ED Hb TAT within 60 mins	≥90%	95%	94%	95%	93%	95%	94%
Number of requested RTP's unable to be returned due to Laboratory error	0%	0					
Quality and Patient Safety							
Phlebotomy Hand hygiene audits	100%	90%	93%	93%	88%	85	100%
Blood Sciences amended results for error correction per test number	<0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Microbiology amended results for error correction per specimen	<0.5%	0.10%	0.18%	0.06	0.08%	0.20%	0.15%
POCT amended results for error correction	<5	7	4	7	2	6	9
Phlebotomy specimen and labelling errors	<0.08%	0.10%	0.04%	0.15%	0.03%	0.00%	0.10%
Equity							
TAT Breast biopsies within 7 days	90.00%	98%	99%	100%	99%	100%	
TAT Prostate biopsies within 7 days	90.00%		48%	44%	94%	47%	
Customer satisfaction - % of complaints re cultural appropriateness of mortuary (Under development)		0%					
Radiology							
Efficiency and Effectiveness							
Outpatient CT's completed within 6 weeks of request	≥90%	92%	95%	96%	98%	97%	99%
Outpatient MRIs completed within 6 weeks if request	≥85%	91%	91%	90%	89%	91%	90%
All inpatients scanned within 24 hours	≥90%	87%	86%	89%	88%	88%	91%
All inpatients scanned within 48 hours	≥95%	96%	95%	96%	95%	96%	97%
Emergency Department patients CT scanned within 6 hours	100%		100%	100%	99.5%	99.8%	99.7%
Emergency Department patients General X-Ray scanned within 30 min	100%	77%	69%	70%	69%	77%	78%
Orthopaedic department patients scanned within 4 hours	100%	100%	100%	100%	100%	100%	100%
Quality and Patient Safety							
Wrong side scans reported by the referrer - GP/Nurse/clinic	0	1	1	0	0	8	4
Wrong side scanned by the MRT	0	0	1	1	0	7	3
Wrong side reported by the Radiologist	0	0	0	0	0	17	17
Equity							
Patients who did not attend (By ethnicity)% of population % of DNA							
European	<74%	35%	48%	41%	38%	44%	40%
Maori	<14.9%	41%	39%	39%	49%	40%	40%
Asian (South East Asian, Indian, Other Asian)	<11.8%	2.3%	4.10%	3.7%	2.8%	4.60%	6.7%
Pacific Peoples (Cook Island, Fijian, Niuean, Samoan, Other Pacific Peoples)	<7.4%	5.6%	3.10%	4.2%	2.0%	2.30%	3.6%

Pharmacy							
Efficiency and Effectiveness							
Chart turnaround times within 2.5 hours	≥80%	89.7%	92.95	92.4	90	97	94.9
Pharmacy on Meade script turnaround time in minutes	< 10 m				7.1	6.8	7.1
Enquiries answered within an agreed time frame	≥90%	92%	97%	86%	85%	74%	92%
Quality and Patient Safety							
Good catches	<2	0	1	0	0	1	
Medication charts reviewed	≥60%	54%	56%	60%	57%	59%	54%
Equity							
Number of clients given smoking cessation advice	≤4	1	1			5	1
Blood Management							
PBM: Pre-operative anaemia patients screened with intervention	≥16	15	16	17	17	11	18

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

Note	Indicator	Commentary
1	Emergency Department - number relative to target growth of 4% p.a.	In January significantly more patients have attended the emergency departments at Thames (+2.2%), Tokoroa (+4.4%) and Taumarunui (+9.8%) than in the prior year. This reflects an ongoing trend all year, except at Te Kuiti. The increased attendances are by low urgency patients suited to a general practice setting.
2	Elective and Arranged Day of Surgery Admissions	Phenomenally good performance in Australasian terms. The KPI target requires resetting.
3	Laboratory – Histology specimens reported within 7 days of receipt	Actual specimens are triaged on the basis of clinical risk. Significant work has been done to successfully improve histology turnaround times. No concerns of significance are noted. The KPI target requires resetting to measure time critical histology only.
4	Outpatient DNA rate	No concerns of note.
5	Output delivery against plan FSA/ F/up etc	The non-delivery of visiting clinics by Waikato hospital services due to other service pressures is influencing this variance. Shifts in community and Thames hospital service delivery to reduce attendances and deliver care in different ways (e.g. phone triage in General Surgery rather than FSA).
6	Output delivery against plan – inpatient episodes	Lower than planned demand in general surgery and general medicine. This reflects (i) a deliberate service change to reduce acute surgical admissions (utilising Waikato instead) and (ii) the lack of influenza in the community in winter.
7	Output delivery against plan – inpatient cwd	Refer above. The average cwd per case for both acute and elective is consistent with the plan. The difference is due to the reduced volume not altered case-mix.
8	Breast Screening – Māori volumes	The KPI was met for January. This KPI and as well as increasing overall coverage by reducing unutilised appointment slots is being intensively managed by the service.
10	Complaints	An above average number of complaints received in relation to Emergency Department services at Thames as well as Thames theatres. Staff attitudes and clinical treatment (inferior pain management) are the main themes. Each is being investigated more fully.
11	Complaints resolved within 20 wd (1 month lag)	The KPI reflects performance in prior periods. The most recent result indicates that the corrective actions are proving effective.

12	All falls	Falls have increased at Thames Hospital. Evidence suggests good use of prevention technologies has occurred; each case is being reviewed in greater detail to look for other causative factors to reverse this decline. Reducing falls is now a renewed focus for the services at Thames.
13	Actual Contribution vs Budget ($000s)	Unable to reconcile the differing numbers in this KPI report and the numbers in financial reports at the time of submitting this commentary. Blood savings are tracking lower than budget but considerably higher than in prior years due to volumes of a single blood product (IVIG). Reducing costs in Community & Southern Rural and Thames & Coromandel are the key areas of focus. Overall, the C&CS group reduced its budget by $7m compare to the prior year's budget prior to savings target allocations. Achieving a net reduction of $10m against prior year budget is not an insignificant achievement. That said the goal is to lift that reduction to $12m which, whilst a significant challenge, remains imperative.
14	Overtime $'s	No particular concerns are evident that have not been reported in prior periods.
15	Annual leave taken	No particular concerns are evident that have not been reported in prior periods. A rate of 93.4% is an exemplary result by national standards across all industries.

Key Performance Dashboard

Mental Health

January 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	88.4	95.0	(6.6)	89.7	95.0	(5.3)		1

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health seclusion hours	Hours	377	371	(6)	7,552	2,595	(4957)		2
Mental health treatment plans	% Cases	90.6	95.0	(4.4)	91.9	95.0	(3.1)		
Mental health HoNos matched pairs	% Cases	98.5	95.0	3.5	98.6	95.0	3.6		
Mental health inpatient bed occupancy	%	85.7	87.1	1.4	92.4	87.1	(5.3)		3
Mental health GP methadone cases	Cases	95.0	76.0	19.0	92.9	76.0	16.9		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health post discharge follow up - % seen in 7 days	%	91.2	90.0	1.2	92.7	90.0	2.7		
Mental health follow up - numbers seen in 7 days	Number of Cases	52	51.3	0.7	430	417.6	12.4		
Mental health community contract positions filled	% FTEs	99.8	95.0	4.8	96.6	95.0	1.6		
Mental health 28 day readmission rate	%	11.6	15.0	3.4	12.3	15.0	2.7		

Quality and Patient Safety KPI measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	100.0	95.0	5.0	98.5	95.0	3.5		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers	4	8	4	43	54	11		
Complaints resolved within 20 wd (1 month lag)	% for Dec-16	50	70	(20)	26	70	(44)		4
Falls Resulting in Harm	Numbers	1		(1)	20		(20)		

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	7,032	7,213	(181)	48,776	50,569	(1,793)		
Actual Expenditure vs Budget ($000s)	$000s	5,988	6,295	307	42,442	42,261	(181)		
Actual Contribution vs Budget ($000s)	$000s	1,043	918	125	6,334	8,308	(1,974)		5
Actual FTEs vs Budget	FTEs	747.8	724.8	(22.9)	736.7	732.5	(4.2)		
Sick Leave	% of paid hours	2.3	1.7	(0.6)	3.3	3.0	(0.3)		6
Overtime $'s	$000s	69	76	7	561	529	(33)		7
Annual Leave Taken	% of Budget	Rolling 12 month measure			88.8	100.0	(11.2)		8

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

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

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

KPI Report: Mental Health & Addictions Services January 2017

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

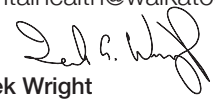
Note	Indicator	Commentary
1	Emergency Hours <6 hours	Monthly audits have been occurring on all ED presentations not seen within the allocated time since April 2016. In the January data set 10 people not seen. Presentations included - overdose, suicidal ideation, paranoia, drug seeking, anxiety, and bizarre behavior. 6 breaches resulted where ED medical clearance was the first priority and resulted in delays for MH assessment. 3 breached with less than 30 mins and 1 with less than an hour. 3 breaches occurred as a result of MH service delay due to either staff shortages, or staff being involved in other assessments. being busy with other presentations. Since tracking the data in 2016, we know that: • 30% of MH ED presentations are admitted to HRBC after assessment • 10% of all MH ED presentations breach the 6 hr target • Analysing the 10% of breaches shows that 56% of those presentations presented with either an overdose, suicidality or self-harm From April – Dec 2016: a total of 770 presentations of which 75 people breached the target.
2	Seclusion	Overall seclusion hours were 377 with a target of 371. 14 individuals were secluded during the month of January, 12 within Adult wards and 2 within Forensic wards. 10 of the 14 users were Maori (8 adult, 2 forensic). Maori accounted for 78% of the time spent in seclusion. The longest seclusion episode lasted for 110 hours, the shortest ~8 hours. Total hours spent in seclusion for the adult service was 337 hours (monthly target ~233). Total hours spent in seclusion for the Forensic service was 40.25 hours (monthly target ~138). For the adult service January saw the lowest seclusion numbers, in terms of time, since May 2016. No patient was secluded more than once, the last time this happened was May 2016.

		The average number of hours spent in seclusion for the 14 individuals was 26.94 hours, the average per incident being the same this represents the lowest average time by users and incidents since Dec 2015. As part of the National KPI project, Seclusion reduction is the key indicator that is being focused on nationally. In addition to the work that we are carrying out in the Seclusion Minimisation Steering Group, there are a number of additional actions for consideration: • Establishing accountability measures across management and clinical leadership that focus on a whole of service approach to both prevention and review. • Setting a KPI around Advanced Directives, where alternatives to seclusion are incorporated. • Inclusion of expectation's around no seclusion where service users are asleep. • Looking at the rationale for seclusion only being imminent risk of violence. • Implementing nurse led seclusion completions.
3	Occupancy	Occupancy for January had a welcome reprieve from a YTD actual of 92% to 85.7 % in January. The Low Stimulus Area (LSA) was also closed for a short period in January.
4	Complaints	Two complaints were open in January. One was closed on 3 February. The other still open has a meeting scheduled week 13 February 2017 for resolution and closure.
5,6, & 7	Contribution	Good performance to budget for January and increasing contribution to budget against target. As our FTE position continues to improve our ability to meet budged contribution remains unachievable. Sick leave was at 2.3% in January, down from a ytd actual of 3.3% Overtime was also below budget reflecting more manageable occupancy for the month.
8	Annual Leave Taken	The extensive annual leave planning is showing dividends with annual leave used against annual leave earnt beginning to align. This is a promising picture for the service and demonstrates the importance of year long leave planning within teams. The service did not implement a service reduction plan for Christmas this year, however it is expected that the leave planning that extends beyond this period will continue to provide a positive contribution to the services financial picture.

Waikato DHB Mental Health • How we're doing

ISSUE 4

Waikato Mental Health & Addictions Service is keen to get better at keeping our community informed about what we do.
This is the fourth Mental Health & Addictions Report Card that helps us share stories and news with you. We will provide an updated report card every three months, comparing the results against the previous quarter.
If you have any feedback about what you'd like to see reported here or any questions about our services, please email us at - mentalhealth@waikatodhb.health.nz



Derek Wright
Executive Director,
Mental Health and Addiction Service

Rees Tapsell
Director of Clinical Services,
Mental Health and Addiction Service

Report card

	Current Quarter October - December 2016	Total Appointments
Number of service users seen during period	4,960	40,150
Number of inpatient admissions during period	370	

Key Performance Indicators	October - December 2016	July – September 2016
AWOLs with adverse outcome *	0	1
Crisis contacts	3,068	3,472
Complaints by category:		
Admission/Discharge	3	4
Clinical Treatment	2	2
Staff Attitude	7	8
Personal information	3	6
Environmental issue	2	3
TOTAL	**17**	**23**

* Absent without Official Leave (AWOL) refers to clients who have left the inpatient unit without permission. However the inpatient unit is a health facility and not a prison. A number of clients will be in the inpatient unit but not under the Mental Health Act. This means they can leave the unit at any time, however if they leave without seeking permission, they will be classed as being AWOL. For our report card we will report on AWOLs where there was an adverse outcome, e.g. harm to the person or to someone else.

ALL FEEDBACK is important

While it's great to hear when we get things right, it is equally, if not more, important for us to know things could have gone better. From this feedback, we can learn and work to improve how we do our business.

Across the Waikato DHB, we have worked to make the process of giving feedback, good or bad, as simple as possible and to ensure that:

- Anyone is able to make a complaint in a way that is easiest for them. This could be verbally, in person, by phone, in writing in a letter, fax or email.
- Care and treatment will never be influenced by whether a person has made a complaint in the past.
- Anyone making a complaint can expect that if the issue can be resolved simply, or straight away, it is.
- If not, you can expect a formal response within three working days of receipt, telling you what is going to happen and importantly, what to do if you are not satisfied with the outcome.
- Any complaint that cannot be resolved and dealt with immediately has to be investigated. Depending on the nature of the issue, this might be simple or could take some time and might involve meeting with you and family/ whanau. Either way, you should expect an outcome or an update, within 20 working days.

We acknowledge that things don't always go as we would want them to. If we can learn from someone's experience and so improve what we do for others, you can expect to hear what we found when we investigated and what we are going to do about it.

If you receive Mental Health and Addictions Services from Waikato DHB and have feedback, good or bad, please take a moment to let us know.

We would welcome any feedback, questions or comments you might have and you can contact us at Mentalhealth@waikatodhb.health.nz

creating OUR futures

WHAT'S HAPPENING IN MENTAL HEALTH

Mental health services in New Zealand need to change and improve.

Late last year Waikato Mental Health and Addictions Service launched a programme of work called **'Creating our futures'** as part of a larger Waikato DHB mental health and addictions services continuous quality improvement programme. This work is to help us meet contemporary best practice standards and deliver a continuum of safe, quality mental health services for the Waikato community.

The work includes developing a service strategy for the next five years, developing new Models of Care to guide us with our service planning and help us to plan and organise our facilities for the future. We have been talking with staff, consumers, families/whānau, providers, community services providers and primary health organisations.

All of these activities will prepare us well for the future so that

- Consumers will have an improved and more streamlined service experience – one care plan where they join up as a single service. They will know where to go, what their care will involve, and who will be looking after them.
- Staff will have good support, systems and processes in place to help them do their job better
- We see ourselves as one part of a much wider community supporting the wellbeing of the population of the Waikato.

Public can become involved and have their say about how we can improve services for people with experience of mental health and addictions and their families/whānau.

If you want to be involved contact:
creatingourfutures@waikatodhb.health.nz

Key Performance Dashboard

Waikato Hospital Services

January 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	88.1	95.0	(6.9)	85.5	95.0	(9.5)		1
Faster Cancer Treatment - Referral received to first treatment <= 62 days	% of patients	95.7	85.0	10.7	86.7	85.0	1.7		
Chemotherapy treatment < 4 Weeks Wait	% of patients	100.0	100.0	0.0	100.0	100.0	0.0		
Radiotherapy < 4 Weeks Wait	% of patients	100.0	100.0	0.0	100.0	100.0	0.0		
Number of long wait patients on outpatient waiting lists	# > 4 mths	308	0	(308)	2,131	0	(2131)		2
Number of long wait patients on OPRS outpatient waiting lists	Patients	0	0	0	0	0	0		
Number of long wait patients on inpatient waiting lists	# > 4 mths	254	0	(254)	565	0	(565)		3

Theatre Productivity

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Theatre Utilisation - Elective Sessions	%	71.2	85	(13.8)	75.6	85.0	(9.4)		4
Hospital initiated elective theatre cancellations	%	6.1	2.5	(3.6)	6.0	2.5	(3.5)		5
Waiting Time for acute theatre < 24 hrs	%	73.1	80	(6.9)	74.0	80.0	(6.0)		6
Waiting Time for acute theatre < 48 hrs	%	87.7	100	(12.3)	87.9	100.0	(12.1)		7

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Elective Services Standardised Intervention Rates (SIRs)	Discharges per 10,000 pop	Rolling 12 month measure			207.5		207.5		
Elective Surgery Volumes vs Elective Health Target	% of target	Under development - see separate Elective Health Target Report							
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			49.2	49.9	(0.7)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			74.8	81.2	(6.5)		8
Number of long stay patients (>20 days length of stay)	Discharges	55	47	(8)	436	349	(87)		9
Number of long stay patient bed days (>20 days los)	Bed Days	2,108	1,389	(719)	15,105	11,888	(3217)		10
Outpatient DNA Rate	%	10.7	10.0	(0.7)	9.9	10.0	0.1		
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	96.4	100.0	(3.6)	97.3	100.0	(2.7)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	96.2	100.0	(3.8)	97.4	100.0	(2.6)		
Output Delivery Against Plan - Inpatient CWD Volumes	%	90.9	100.0	(9.1)	97.2	100.0	(2.8)		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Presentation to ED < 14 Days after discharge as an Acute InPatient	%	Under development							
Acute Readmissions to Hospital	%	Rolling 12 month measure			8.8	8.5	(0.3)		
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			4.14	4.01	(0.13)		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			2.04	1.99	(0.04)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			1.63	1.60	(0.03)		

Quality and Patient Safety KPI measures

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

Organisational Quality Safety Markers

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Patients assessed as being at risk have an individualised care plan which addresses their falls risk.	% for Dec-16	88.6	90.0	(1.4)	94.9	90.0	4.9		
Compliance with good hand hygiene practice (WDHB Rate)	%	85.4	80.0	5.4	86.1	80	6.1		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers	67	67	(0)	504	467	(37)		11
Complaints resolved within 20 wd (1 month lag)	% for Dec-16	25	70	(45)	49	70	(21)		12
Falls Resulting in Harm	Numbers	20		(20)	172		(172)		

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	41,219	44,376	(3,157)	340,303	349,743	(9,441)		
Actual Expenditure vs Budget ($000s)	$000s	36,720	37,208	488	261,283	251,859	(9,424)		
Actual FTEs vs Budget	FTEs	3,076.4	3,181.1	104.8	3,095.0	3,098.9	3.9		
Sick Leave	% of paid hours	1.2	2.7	1.5	3.0	3.0	0.0		
Overtime $'s	$000s	489	353	(137)	3,097	1,881	(1,216)		13
Annual Leave Taken	% of Budget	Rolling 12 month measure			88.3	100.0	(11.7)		14

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

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

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

Waikato Hospital Services KPI Dashboard

Notes re Operational Plan Items – January 2017

Note	Indicator	Commentary
1	Emergency Department < 6 hours	This target continues to remain challenging for the DHB. January saw an improved performance, principally due to strong performance during the Junior Doctor's strike when there was sufficient bed capacity for acute admissions, combined with senior medical presence at the front door. It is interesting to note that this is one of the few times that we have been able to deliver >95% performance. A recruitment panel for mid-February has been established for additional ED SMOs and recruitment to additional registered nurse posts is being progressed. A Full Capacity Protocol has been introduced to assist with additional temporary bed provision during times of pressure. There remains some operational issues with implementing this protocol, but once successfully embedded it should assist.
2	Long wait patients on outpatient waiting lists	Red status will be reported for January. A key driver has been our constrained spinal and foot & ankle orthopaedic capacity. To assist with managing this there has been successful implementation of a temporary increase in threshold for referrals in those subspecialties. A new spinal surgeon started the week beginning 13 February and a foot & ankle surgeon will start in April. That has been factored into production planning. Some spinal outpatient consultations have also been successfully outsourced to address the backlog. Further work is occurring and an orthopaedic recovery plan is in place to meet compliance by April. Medicine and Oncology have undertaken additional clinics to ensure the outpatient long waiters have been seen in time. The RMO strike had a negative impact on the volumes delivered in the month, which will continue to impact a number of services beyond January. Funding is not at risk as long as we achieve compliance for orthopaedic services by April and for all other specialties from February. While that is challenging we are on track to achieve those targets.
3	Number of long wait patients on inpatient waiting lists	We achieved compliance in October and November, but not in December or January, and won't in February. Again the issues are primarily restricted to orthopaedics subspecialties. This target continues to be hampered by significantly reduced elective operating theatre capacity as a result of an extended Christmas theatre closure (until 16 January 2017), RDA RMO strike (17–19 January 2017), anaesthetic RMO vacancies and demand increase putting pressure on anaesthetic SMO numbers. In addition the difficulty in recruiting subspecialist orthopaedic surgeons (spinal and foot & ankle) has further restricted the ability to operate on the range and volume of patients required in these areas. New orthopaedic surgeons have been recruited as previously noted, planning is underway on right sizing anaesthetic capacity and in the meantime we have been accessing outsourced capacity and facility lists across a number of specialities and recruiting an SMO locum to mitigate these issues.
4	Theatre Utilisation – Elective Sessions	Elective session utilisation remains below target due to the cancellation of lists as a result of RMO anaesthetist vacancies and unmet growth in demand for SMO anaesthetist resource. By June 2017 will have a full complement of RMOs.
5	Hospital Initiated elective theatre cancellations	This KPI is currently impacted by acute demands, causing theatre overruns. The Pre-Hospital Preparedness project aims to better prepare patients for their day of surgery and is expected to reduce day of surgery cancellations. Work is taking place to improve data collection of the 'reasons' for cancellations to understand where further improvement can be gained. Stage 3 Orthopaedics was successfully implemented. Stage 4 implementation is scheduled for 20 February 2017 for Plastics, and Ophthalmology and Endoscopy to follow. This

Note	Indicator	Commentary
		project could be presented to a Board sub-committee if that would be helpful.
6	Waiting time for acute theatre less than 24 hours	Work continues to determine the reason for the upward trend of this KPI so positive actions can be implemented. As part of this, it has been identified that the system to record this KPI does not, as intended, "stop the clock" for delays that are clinically required. This means that actual performance is better than is reflected in this KPI. Work is underway to assess options to improve reporting.
7	Waiting time for acute theatre less than 48 hours	There has been a slight upward trend in this KPI. Theatre CapPlan will further inform actions in this area as will adjustment of the theatre capacity for orthopaedics when this is fully staffed.
8	Elective and arranged day of surgery admissions	Every case bought in prior to surgery is reviewed to ensure, where possible, admission occurs on the day of surgery. This measure will be enhanced as rollout of the Pre-Hospital Preparedness Project continues and more services are brought on board.
9	Number of long stay patients (> 20 days length of stay)	A DHB-wide discharge initiative is being planned, led by the Executive Director Operations and Performance with involvement from the Director of Medicine, Oncology, ED and Ambulatory Care and the Director of Older Persons, Rehabilitation and Allied Health. This programme includes emphasis on long stay patients, which has been enhanced with weekly reporting to the capacity and demand management forum and higher scrutiny of long stay reasons. There has been some improvement in recent months, however, YTD still higher than target. Resourcing and staffing of regular audits of long stay patients are being considered as part of the patient flow programme, to supplement the weekly nursing audit of reasons for long stay.
10	Number of long stay patient bed days	As per item 9. A DHB-wide discharge initiative is being planned, led by the Executive Director Operations and Performance with involvement from the Director Internal Medicine, Oncology, ED & Ambulatory Care and the Director Older Persons, Rehabilitation and Allied Health.
11	Complaints	While the trend over the last 12 months has shown a reduction in complaint volumes, the lower target for this financial year has not yet been met. A theme within this area is patients either unclear about communications regarding reasons for not being able to access elective surgery, or unhappy at not being put onto the orthopaedic surgical waitlist because they do not meet the required threshold due to capacity constraints. Standard communication letters have been revised to address the communication issue and as previously described measures are in place to address our orthopaedic capacity as soon as possible.
12	Complaints resolved within 20 working days	Performance on resolving complaints over the Christmas/New Year period was poor. Improving on this will be a focus of planning for the next December/January period. Subsequently there has been significant effort to resolve outstanding complaints by the surgery and CCTVS team (one of the areas with the largest volume of complaints). As at 7 February only 14% of their complaints are >20 days.
13	Overtime $'s	Overtime for the month was significantly lower than the year to date trend. Within that however overtime was slightly higher than usual for the Ambulatory, Medical and Emergency Services cluster due to the operational pressures within the Emergency Department and Internal Medicine. Surgical and Critical Care also continues to experience pressure on overtime which is being closely monitored. A large majority of the costs are associated with theatre where escalation lists are used to clear acute load. A number of services also continue to have vacancies requiring others to work additional shifts.
14	Annual leave taken	While the ambitious target of 100% of annual leave being taken within year was not met, there was as planned a high level of leave taken over the December/January period. That helped to produce the year to date result of 88.3%, which is very high by historical standards.

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 6.3

STRATEGY & FUNDING KPI DASHBOARD

Purpose	1) For information

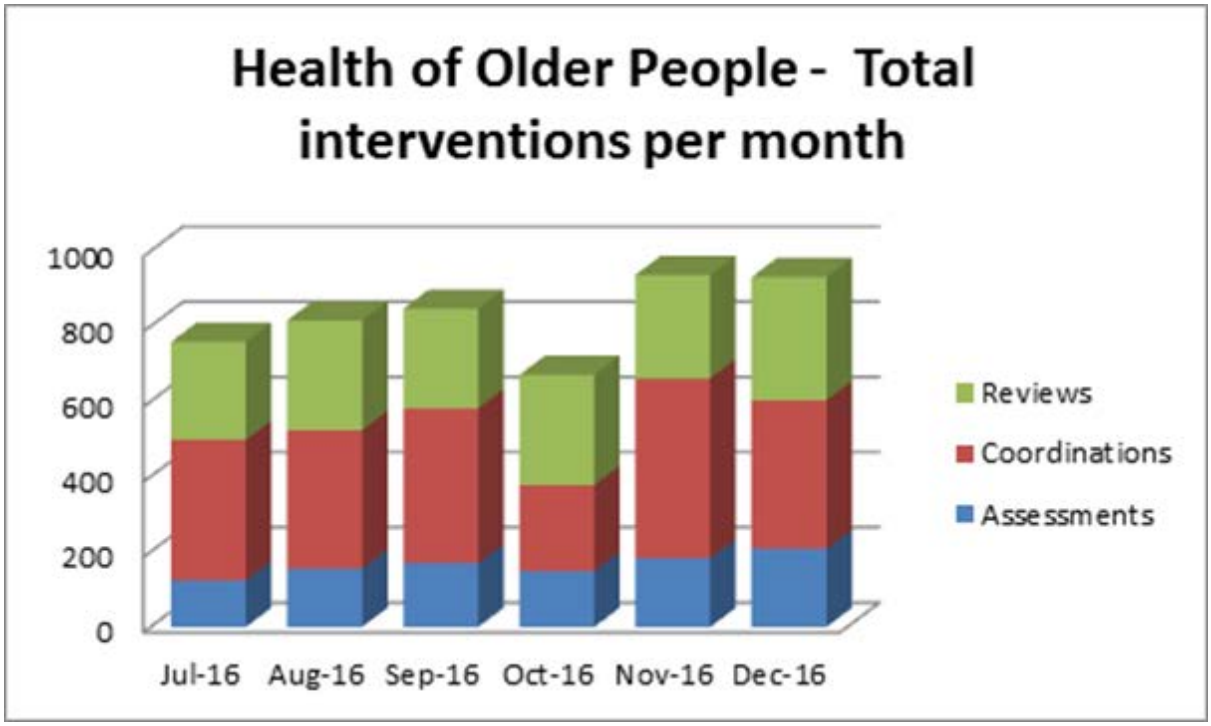
The Strategy & Funding KPI dashboard is attached as Appendix A. Items updated are noted on the dashboard and items noted as having negative variances have a commentary provided excluding items already reported on within the health target report.

Recommendation
THAT
The report be received.

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY & FUNDING

Strategy and Funding KPI Dashboard

Note	Indicator	Commentary
1	IDF estimates	The IDF inflows for the period July 2016 to December 2017 show an under-delivery of case weighted discharges of $2.2m compared to the planned YTD budget. IDF flows are inherently susceptible to fluctuations over the year and do not perfectly align with monthly revenue of equal twelfths of the total IDF budget, however a large negative year-end result is indicated. IDF discharges and caseweights in General Surgery, Orthopaedics and Cardiothoracic Surgery continue to be less than the budget. Health Waikato, Finance, and Strategy and Funding continue to monitor the inflows and work with the services to review their IDF components.
2	AOD Waiting times (% of new clients seen within 3 weeks of referral	Wait times at 3 weeks for adults in AOD services continues to lag behind the target. While data collection and systems continue to be improved, a key challenge for services will be to look at processes to engage the population and the factors which may lead to patients choosing not to attend initial assessments. Work is underway in this area however it will take some time for any changes to be reflected in these results.
3	Proportion of older people waiting greater than 20 days for assessments or reassessment	Whilst there has been significant work undertaken in this area this has largely been focussed on improving timeliness of more urgent referrals and slowly addressing the backlog. During October, new staff were being trained and all external assessments were brought in-house. As the new staff are coordinating from the assessment, there is no need for the coordinator to review the assessment and so there is no delay in services going in. This is achieving an expected efficiency gain and reducing the time people wait for services to begin following assessment. However, during training in October, the number of completed assessments dipped, creating a backlog that was addressed during November and December. As a result more people than usual waited more than 20 days for assessment during the quarter. Staff that started in October have now all qualified as interRAI assessors and their performance is improving going forward. The table below demonstrates the overall increase in assessments now being undertaken



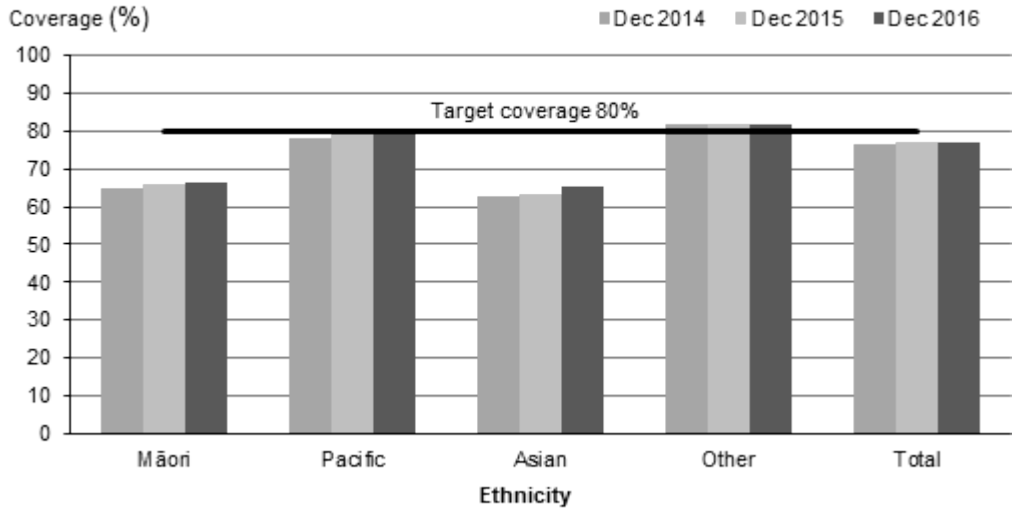
Note	Indicator	Commentary
4	Breast screening - total eligible population (target 70%)	Quarterly indicator. Latest results to the end of Dec-16 show this indicator remaining fairly consistent at 67% (66% in prior quarter). This measure is a component of system level measures and we would expect this, along with the new Ministry contracts for services to support access should improve results in subsequent quarters. The Ministry contracts are split between Pinnacle and Hauraki on a 50/50 basis with the provider working collaboratively around development of services enhancements and an overall plan.
5	Cervical Screening	Update information on high needs is not yet available. Information from the national screening programme has however been released based on ethnicity and shows small but consistent improvements over the last few years.

NCSP coverage (%) in the three years ending 31 December 2016 by ethnicity, women aged 25–69 years, Total Coverage

Ethnicity	Population	Women screened in last 3 years	3-year coverage	Additional screens to reach target*
Māori	19,851	13,156	66.30%	2,724
Pacific	2,448	1,931	78.90%	27
Asian	9,612	6,282	65.40%	1,407
Other	67,212	55,024	81.90%	
Total	**99,123**	**76,393**	**77.10%**	**2,905**

**For the total population the number of additional screens is the number required to move from the total population coverage to 80%. This may not be the same as the sum of additional screens required for each ethnic group to reach 80%.*

NCSP coverage (%) of women aged 25–69 years in the three years ending 31 December 2016 by ethnicity, Total Coverage



Note	Indicator	Commentary
		As noted above under Breast screening, the new Ministry contracts for services to support access should improve results in subsequent quarters
6	2 year old immunisations	Latest 24 month coverage result is 92% (target 95%) which is the same as reported last quarter. The 3% point gap represents 52 children not immunised on time. For children aged 24 months, this quarter the highest coverage was for Asian children (97%) and lowest for Other (not Maori, Pacific, NZ European, Asian) (86%). Our latest results also show little disparity between NZ European and Maori for this cohort by 24 months (Maori at 92%). This measure is a contributory measure in the recently signed off Service Level Measure for ASH rates for 0-4 year olds.

Appendix A **Strategy and Funding KPI RESULTS**

Strategy and Funding - Key Performance Dashboard

January 2017

Health Targets

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

Finance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Month Actual	Target	Variance		YTD Actual	Target	Variance		Trend
IDF inflow estimate	$		Jan YTD	Yes	9,931	10,993	-1,062	✗	75,122	76,951	-1,829	!	
IDF outflow estimate	$		Jan YTD	Yes	5,205	4,559	646	✗	33,185	31,913	1,272	!	

Other Performance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Period Actual	Target	Variance		Trend
AOD waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Oct 16	Yes	77%	80%	-3%	!	77%	80%	-3%	!	
MH waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Oct 16	Yes	81%	80%	1%	✓	82%	80%	1%	✓	
AOD waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Oct 16	Yes	94%	95%	-1%	!	94%	95%	-1%	!	
MH waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Oct 16	Yes	94%	95%	-1%	!	94%	95%	-1%	!	
Proportion of Health of Older people initial needs assessments Waiting greater than 20 days	%	↓	Oct-Dec 16	Yes	38%	0%	-38%	✗	29%	0%	-29%	✗	
Proportion of health of older people need re-assessments Waiting greater than 20 days	%	↓	Oct-Dec 16	Yes	8%	0%	-8%	✗	8%	0%	-8%	✗	
Proportion of older person funding in community based services	%	↑	Dec YTD	Yes	26%	25%	1%	✓	27%	25%	2%	✓	
Pharmacy Items claimed	Items		Dec-16	Yes	555,101	N/A			547,304	N/A			
Laboratory turnaround tmes	%	↑	Jul-Sep16	Yes	100%	97%	3%	✓	100%	97%	3%	✓	
Primary options referrals	Referrals				These areas will be reported in the future once expected volumes are seasonalised/targets set								
	%												
Breast Screening (total eligible population)	%	↑	Dec-16	Yes	67%	70%	-3%	!	66%	70%	-4%	✗	
Cervical screening (total eligible population)	%	↑	Jul-Sep16	No	76%	75%	1%	✓	76%	75%	1%	✓	
Cervical screening (High Need)	%	↑	Jul-Sep16	Yes	69%	75%	-6%	✗	67%	75%	-8%	✗	
2 year old immunisations (total population)	%	↑	Rolling 3 months	Yes	92%	95%	-3%	!	91%	95%	-4%	!	
2 year old immunisations (Maori)	%	↑	Rolling 3 months	Yes	92%	95%	-3%	!	91%	95%	-4%	!	
Green Prescriptions	%	↑	Oct - Dec 16	Yes	1,404	1,675	-271	✗	1,708	1,675	33	✓	

Ambulatory Sensitive Admissions - Rates per 100,000 Population

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

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

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Planning

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 7.1

INVESTOR CONFIDENCE RATING AND LONG-TERM INVESTMENT PLAN UPDATE

Purpose	1) For information

Background
In 2015, the Cabinet approved a new approach to long term investment in public services. They asked the Treasury to assess how well all major public agencies and Departments manage their investments. To do this, Treasury has now introduced an Investor Confidence Rating process. This process will assess the DHB's ability to effectively manage and realise outcomes and benefits through the commitment of public funds.

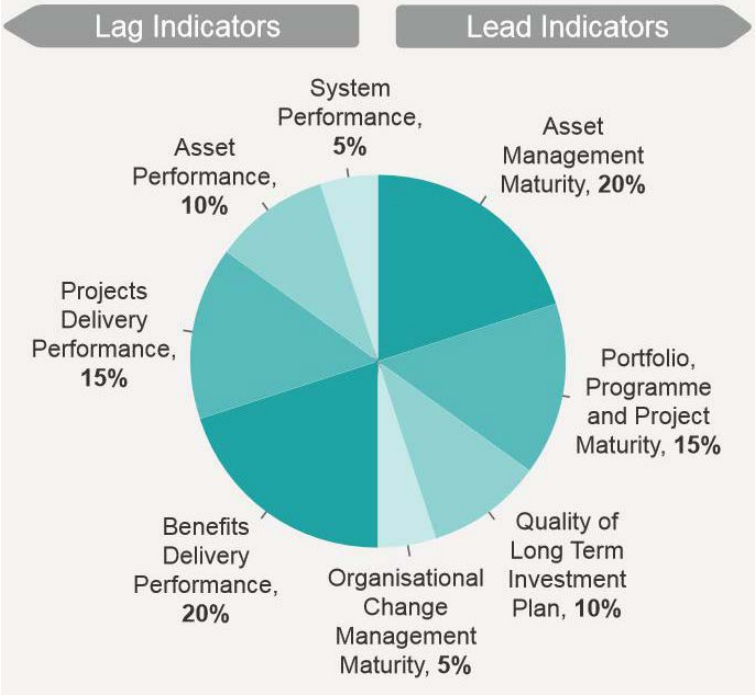
The rating which the DHB is given will influence the level of financial delegation and autonomy and the level of monitoring and reporting we are given.

The assessment will be based on eight elements:

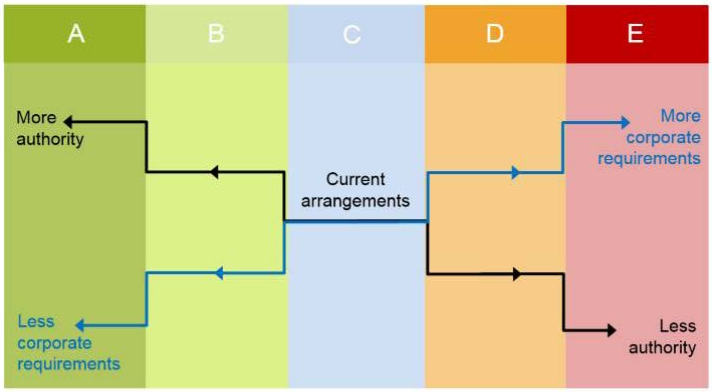
1. Asset management maturity
2. Portfolio, Programme and Project (P3M3) maturity
3. Quality of Long Term Investment Plan
4. Organisational change management maturity
5. Benefits delivery performance
6. Project delivery performance
7. Asset performance
8. System performance (compliance)

The eight elements are weighted, as shown in the diagram below, showing the emphasis which is placed on the delivery of expected benefits (20%) and asset management (20%). The Long Term Investment Plan is one of the lead indicators - that is, it indicates future performance. While it only contributes 10% to the overall weighting, the value of the Long Term Investment Plan for health sector agencies such as Waikato DHB should be much greater as it will provide the context and logic for future investments.

The elements of the Investor Confidence Rating assessment are:



Based on the assessment of these indicators, the Investor Confidence Rating uses a rating scale from 'A' to 'E'. 'A' signals the highest level of performance, while 'E' indicates that significant assistance may be required. Through an initial indicative self-assessment, our view is that Waikato DHB's current rating is a high 'C". The aim will be to improve on this and to obtain a 'B' rating from Treasury, following the assessment in July 2017.



Assessment approach

The Investor Confidence Rating will be conducted for all investment intensive agencies across the State sector, every two years. Treasury is conducting the first Investor Confidence Rating assessments in four tranches and tranche one is now complete. Waikato DHB is one of the tranche two agencies, whose assessments will be conducted in July 2017, with the exact dates to be agreed between the DHB and Treasury in the near future.

A mid-cycle view of an agency's investment management performance will also be conducted. This is to provide both a rating and a relevant outlook as an indicator of

whether the agency is on track to improve its investment and asset performance by the time of the next scheduled Investor Confidence Rating.

The Investor Confidence Rating process will therefore be an ongoing commitment for the DHB and it will be important to ensure that the rating is favourable, so as to allow early approval of any major developments and to reduce the level of monitoring which the Treasury will require.

It should be noted that the assessment made by the Treasury will be presented to Cabinet in the autumn and the Investor Confidence Rating will then be confirmed.

Long Term Investment Plan
The overall deadline for the Investor Confidence Rating assessment is 31 July 2017; however the deadline for submitting the Long Term Investment Plan is 31 May 2017. It should be noted that we have already submitted a Long Term Investment Plan to the Ministry of Health (in November 2016) but we recognised that it had a large number of gaps. The requirement is to deliver a revised Long Term Investment Plan to Treasury by the end of May 2017. Treasury will have a very different focus on the Long Term Investment Plan than the Ministry of Health – our perception is that the Ministry is most interested in the quantum of our investment needs, whilst Treasury is a lot more interested in the confidence in our "story" and strategic direction and how these translate into pragmatic plans and investments over time.

To create the Long Term Investment Plan, we will first model future demand and investment in a 'base case' scenario. We will then get input from relevant sources to inform the scenarios and assumptions we will be making about investments. A first workshop using the Investment Logic Mapping methodology has been held and will be followed up shortly by a second workshop. A relatively robust engagement plan is being developed to ensure that a good cross section of management and clinical leaders are involved in the process of the Long Term Investment Plan development. The scenario modelling will be driven off and validated through these engagements. A key aspect of engagement required is a Board workshop to update the Board on the scenarios modelled and the assumed impacts of such scenarios. During March and early April, the scenarios will be refined before the Plan is drafted and brought to the Board for such suggested workshop, in April and thereafter for approval at the May Board meeting.

An updated Long Term Investment Plan will be required by July 2019. Treasury may also ask for a letter from the Chief Executive during 2018, outlining the DHB's progress in addressing any gaps in capability which the Investor Confidence Rating assessment process has found.

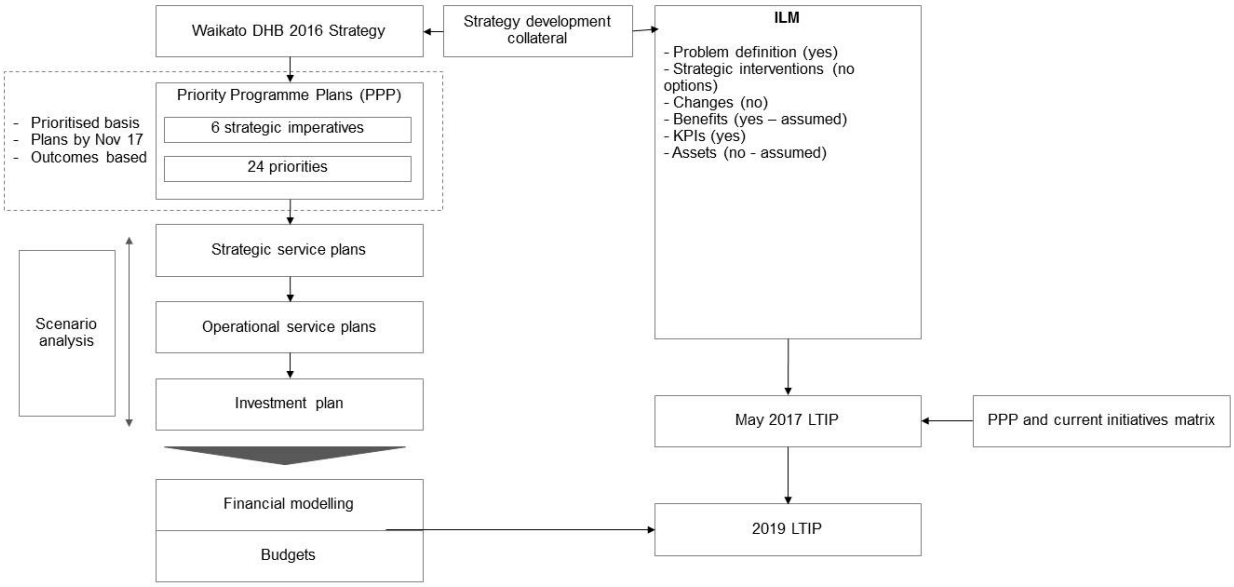
Alignment of the Long Term Investment Plan and DHB Strategy implementation
A key question is "How does this Long Term Investment Plan process link to the DHB Strategy work under way and the Priority programme plans (PPPs) that are being developed through 2017, to support more detailed planning of the Waikato DHB strategy's 24 priorities."

The key is to develop the two aspects in parallel in order to meet both deliverables, minimising rework and avoiding conflicts and/or perceptions of being pre-emptive.

The Priority Programme Plan and Long Term Investment Plan processes are thus to be aligned following the principles:

- Collateral from the development of the 2016 strategy is to be used to inform the Long Term Investment Plan

- No disruption to the priority programme plan process
- No prescription or pre-empting of the priority programmes which are still to be developed through the priority programme plan process
- The Long Term Investment Plan framework may be useful for those developing Priority programme plans, but will not determine their content.



We anticipate that the 2019 Long Term Investment Plan will leverage off and be totally aligned to the Priority programme plans.

Recommendation
THAT

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

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY & FUNDING

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 7.2

WAIKATO DHB ANNUAL PLAN 2017/18 UPDATE

Purpose	1) For information

Overview of the Annual Plan, Statement of Performance Expectations (SPE) and Statement of Intent (SOI)

Each District Health Board (DHB) has a statutory responsibility to prepare:

- An Annual Plan for approval by the Minister of Health (Section 38 of the New Zealand Public Health and Disability Act 2000 (NZPHD) – providing accountability to the Minister of Health
- A SPE (Section 149C of the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013) – providing financial accountability to Parliament and the public annually
- A SOI (Section 139 of the Crown Entities (CE) Act 2004) – providing accountability to Parliament and the New Zealand public.

These documents are pulled together in one document for submission on an annual basis.

The SOI needs to be prepared and tabled in Parliament every three years.

National Requirements
The Ministry of Health issues planning guidelines that detail what the Ministry expects to see in a DHB's AP. Last year, the Ministry completed a refresh of the New Zealand Health Strategy (NZHS) setting out a clear view of the future for the health system over the next 10 years to ensure All New Zealanders live well, stay well, get well. DHB's must be sure to reflect the direction of this strategy in their APs.

Letter of Expectations
The Minister of Health issues a Letter of Expectations to DHBs each year that sets out the Minister's priorities for APs. As outlined in the December 2016 CEOs report, the Minister's Letter of Expectations has been received. The Minister expects the following to be reflected in Annual Plans for 2017/18:

- Alignment to the refreshed NZ Health Strategy including a strong focus on providing care in the community and for services to be provided closer to home, especially for the management of long-term conditions
- Budgeting and operating to be within allocated funding with clear plans to improve year-on-year financial performance

- Working closely with the NZ Health Partnerships Ltd on ensuring the delivery of their current work programmes and services
- Working across social sector agencies to achieve cross-sector goals in relation to the Government's Better Public Services initiatives
- Focusing on achieving and improving performance against all six national health targets
- Streamlining annual plans so that they are focused on the Minister's key expectations
- Considering longer-term strategic planning as a way to deliver on the vision of the NZ Health Strategy, and considering this in a regional context.

Concluding comments emphasise the need for clinician engagement and clinical leadership.

A copy of the letter of expectations is included as Appendix A

Regional Requirements
In the midland region, planners and analysts from each of the five DHBs have regular meetings by teleconference, with a view to ensuring more regionally consistent APs. Overall, the structure, subject headings and a reasonable amount of the body of the document are agreed regionally with local actions where appropriate.

Local Requirements
While much of the AP is prescribed by the Ministry, the AP is still very much a local plan and needs to reflect the focus that is occurring within Waikato DHB and to maximum extent possible the new Waikato DHB strategy. Delivering on priorities with the plan will therefore be a mix of local priorities and national Government priorities (refer Ministers priorities below).

Revised Structure of the Annual Plan

The 2017/18 year sees a significant change in the approach by the Ministry of Health with regard to the Annual Plan development process. One key change is the size of the plan being requested which is to be around 30-33 pages long plus appendices. This compares to the 2016/17 Waikato AP where the main body of the plan was 163 pages. The second key change is that the Ministry of Health are no longer requiring Maori Health Plans to be submitted and are instead expecting that addressing Maori health equity to be incorporated within annual plan.

The revised 2017/18 AP structure is provided in table 1

Table 1: 2017/18 Annual Plan structure

SECTION 1: OVERVIEW OF STRATEGIC PRIORITIES *(suggested three pages long)*
1.1 Strategic Intentions/Priorities **1.2 Message from the Chair and Chief Executive** **1.3 Signature Page**
SECTION 2: DELIVERING ON PRIORITIES *(suggested ten to twelve pages long)*
2.1 Government Planning Priorities
SECTION 3 : SERVICE CONFIGURATION *(suggested two pages long)*
3.1 Service Coverage **3.2 Service Change**
SECTION 4: STEWARDSHIP *(suggested two pages long)*
4.1 Managing our Business **4.2 Building Capability**
SECTION 5: PERFORMANCE MEASURES *(suggested four pages long)*
5.1 2017/18 Performance Measures
APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS including FINANCIAL PERFORMANCE *(for tabling as SPE)*
Statement of Performance Expectations (SPE) Output classes **Financial Performance**
APPENDIX B: SYSTEM LEVEL MEASURES IMPROVEMENT PLAN
Guidance TBC.

Whilst significant components have been released in the DHB Planning Package and the Minister's Letter of Expectation in mid-December 2016, we are expecting further expectations from the Ministry of Health on the following priority areas to be released in February 2017:

- Prime Ministers Youth Mental Health Project;
- Supporting Vulnerable Children BPS Target (target may change and further advice will be provided as decisions are made);
- System Level Outcome Measures (Youth measure);
- Mental Health;
- Child Health;

We are maintaining ongoing contact with the Ministry of Health about the items yet to be released. As soon as these expectations are received work will commence on assessing the impact on the organisation, development of responses to the new expectations and further developing and refining the content of our plan. Once the impact of the new expectations has been assessed, pertinent issues will be raised with the Board as appropriate.

2017/18 Ministers Priorities

Planning priorities are as follows:

- Prime Minister's Youth Mental Health Project
- Reducing Unintended Teenage Pregnancy - Better Public Service Target
- Supporting Vulnerable Children - Better Public Service Target
- Reducing Rheumatic Fever - Better Public Service Target
- Increased Immunisation - Better Public Service and Health Target
- Shorter Stays in Emergency Departments - Health Target
- Improved Access to Elective Surgery - Health Target
- Faster Cancer Treatment - Health Target
- Better Help to Smokers to Quit - Health Target
- Raising Healthy Kids - Health Target
- Bowel Screening
- Mental Health
- Healthy Ageing
- Living Well with Diabetes
- Childhood Obesity Plan
- Child Health
- Disability Support Services
- Primary Care Integration
- Pharmacy Action Plan
- Improving Quality
- Living Within our Means
- Information Technology
- Workforce.

2017/18 Funding Envelope

Funding Envelope (FE) advice has not been received. Instead an indicative signal has been provided for 2017/18 of a national increase of $400 million. This is the same nominal increase as in 2016/17.

Updated advice and funding parameters will be issued in May this year following confirmation of Budget 2017. DHBs have been told to assume they will receive same equivalent share of the $400 million as last year, according to population size and make-up, called PBF. For Waikato DHB, the PBF share is 8.97% so assuming this share of the national increase remains constant the increase is expected to be in the vicinity of $35.87M. This increase would be less than the actual increase received in both 2015/16 and 2016/17 and will create significant financial pressure for the DHB.

The PBF formula includes population numbers in different age groups, adjusted for sex, ethnicity and deprivation. Information on our population forecast has been received, however this does not contain sufficient information to enable an estimate of our demographic growth in line with the PBF formula compared with national growth.

Without certainty regarding the Funding Envelope, preparation of a meaningful budget by the 3 March 2017 deadline will be difficult and will be based on a number of assumptions which may not be clarified till budget announcements are made. This position differs to all prior years where a funding envelope has been received prior to Christmas.

The first draft of the Budget will be submitted to the Ministry of Health on the 3rd of March, recognising that this version will require a great deal more detailed work without changing the net result other than for late adjustments due to possible funding envelope changes. The draft Annual Plan will then be submitted to the Ministry of Health on Friday the 31st of March 2017. The second and final draft of the budget will be submitted to the Ministry of Health on the 25th of May 2017 and the second and final draft of the Annual Plan will be submitted to the Ministry of Health on Tuesday 30th of May 2017. These submissions will need to be consistent with the first year of the Long Term Investment Plan due for submission to Treasury by the 31st of May 2017.

Key Board Considerations

Key points to bring to the Board's attention;

- It is important to note is that the actions in the AP are expected to help achieve health equity for all populations, including Māori. This includes a requirement to clearly identify actions that are specifically designed to help reduce health equity gaps by coding them "EOA" (Equitable Outcomes Action). There is an expectation that every priority will have an equity focus. The Māori Health Plan indicators are included in APs now and there will be no separate Māori Health Plan developed.
- We are running behind schedule for the production of the first draft of the AP which would normally be with the Board in February. This is predominantly due to the delay in the FE advice and the significant changes in the structure of the document.
- The DHB will be submitting a 'top down' AP budget for 2017/18 based on a number of high level assumptions to meet the AP timetables noting this is being completed in the absence of specific revenue information.
- At this stage, without the budget announcement, no new or significantly different Government priorities in the 2017/18 year have been factored into the plan

Annual Plan Timeline

The following table sets out key dates for the Annual Planning process for 2017/18:

Activity	**Date**
DHBs submit draft Annual Plan financial templates to the Ministry.	Friday 3 March 2017
DHBs submit Production Plans to the Ministry.	Monday 13 March 2017
DHBs submit draft Annual Plans (including Statements of Performance Expectations), Regional Service Plans, and Public Health Unit Annual Plans to the Ministry.	Friday 31 March 2017
Ministry facilitates feedback on DHBs draft Annual Plans, Regional Service Plans and, Public Health Unit Annual Plans.	Week beginning Monday 1 May 2017
Budget announcements	Thursday 25 May 2017
Funding envelope and advice around budget announcements	Shortly after 25 May
QUEEN'S BIRTHDAY	Monday 5 June

Activity	Date
	2017
Ministry feedback on DHBs final draft Annual Plans, Regional Service Plans, and Public Health Unit Annual Plans. And ongoing resolution of issues expected to occur in June but may be impacted by funding advice and budget announcements	June 2017
DHBs publish their Annual Plans, Statements of Intent and Statements of Performance Expectations as soon as practicable after they have been presented.	As soon as practicable

Ministry advice has been sought in relation to the date for submissions of the second budget submission as original dates had required this to be submitted prior to receiving the Funding Envelope.

Recommendation
THAT
The Board:

1) Note the first draft of the Annual Plan will be provided for the March 2017 Board meeting;
2) Note that DHBs are yet to receive 2017/18 Funding Envelope advice from the Ministry of Health making completion of the draft Annual Plan and budgeting process challenging;
3) Note that the Ministry of Health requires Maori Health Plans to be integrated into DHBs Annual Plans in 2017/18.

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation

Member of Parliament for Northcote

16 DEC 2016

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

chairman@waikatodhb.health.nz

Dear Mr Simcock

Letter of Expectations for DHBs and Subsidiary Entities 2017/18
The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2016 Vote Health received an additional $568 million, the largest increase in seven years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy
The refreshed New Zealand Health Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to ensure that all New Zealanders live well, stay well and get well.

The DHB annual plans are the primary document for demonstrating DHB delivery of the Strategy, and your 2017/18 annual plan is expected to clearly demonstrate the linkages between the five themes of the Strategy and your DHB's performance story, activities and outcomes, while also maintaining a focus on Māori health outcomes and health equity.

In particular I want to see a strong focus on providing care in the community and for services to be provided closer to home, especially for the management of long-term conditions.

Finally, I want your Board to very carefully consider how any new local initiatives fit within the context of the Strategy.

Living Within our Means
While the global economic environment continues to be challenging, DHB funding has continued to be increased year on year. DHBs need to budget and operate within allocated funding and must have clear plans to improve year-on-year financial performance. Your DHB's financial performance is currently unfavourable to your agreed budget for 2016/17. I expect that you will improve this position throughout the year and will continue to make efficiency gains to ensure better performance in 2017/18. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. In particular your Board must work closely with NZ Health Partnerships Ltd on ensuring the delivery of their current work programmes and services.

Working Across Government
I expect DHBs to continue supporting cross-agency work to support vulnerable families and progress outcomes for children and young people, including working with the new Ministry for Vulnerable Children, Oranga Tamariki once this has been established.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

All DHBs must continue to work closely with other social sector organisations to achieve cross-sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as the Prime Minister's Youth Mental Health Project, the Childhood Obesity Plan and the *Living Well with Diabetes* Plan.

Locally, I expect Waikato DHB will continue working with other agencies to sustain its reduction in rheumatic fever through the delivery of its rheumatic fever prevention plan, increase immunisation coverage rates to target levels and improve outcomes for children not enrolled with a PHO, and reduce the use of seclusion in inpatient mental health services.

National Health Targets

All of the national health targets are very important for driving overall performance, and have resulted in major improvements in the health outcomes of New Zealanders. I expect DHBs to remain focussed on achieving and improving performance against all six health targets. The *faster cancer treatment* target remains a top priority for service delivery for DHBs and further progress is expected during 2017/18.

The first national result for the *raising healthy kids* health target is 49 percent. I expect results for all DHBs to improve considerably each quarter as referral processes and clinical pathways are fully implemented.

Locally, Waikato DHB has shown good performance in relation to the *improved access to elective surgery* health target. However, performance in relation to the other health targets needs to be improved, particularly for the *shorter stays in emergency departments* and *increased immunisation* health targets. Please ensure delivery of these health targets is a priority for your DHB.

Streamlining of DHB Annual Planning

In order to ensure that the Health Strategy is informing DHB planning, DHB annual plans will be streamlined in 2017/18 so that they are focussed on my key expectations for your DHB. Your DHB should also be considering longer-term strategic planning (ten-year horizon) as a way to deliver on the vision of the Health Strategy, and I expect that in the future you will be able to demonstrate this planning.

Working regionally also continues to be important, and I expect that when you are considering your long-term strategic planning you are also considering this in a regional context.

There are a number of key planning priorities for 2017/18 that DHBs will need to clearly respond to in their annual plans. These planning priorities have been selected in order to progress the key Government expectations outlined above, and also to progress other key health initiatives, such as Bowel Screening, implementation of the Healthy Ageing Strategy and continued integration of health care in order to better prevent and manage long term conditions, and provide services and care in the best ways to meet local needs. This will require ongoing engagement with your primary and community partners, including implementation of the System Level Measures.

The full list of my planning priorities for 2017/18 is attached for your information. I have asked the Ministry to provide separate advice about how each of these should be reflected in your plan.

Concluding comments

In implementing your annual plan it is important that clinicians are engaged and involved throughout; clinical leadership is fundamental in delivering high-quality health services.

Please note that I am not requiring DHBs to refresh their statements of intent (SOIs) for tabling in 2017/18. However, please ensure you review your SOI produced in 2016/17 to confirm that there are no significant changes. The statements of performance expectations will still need to be produced and tabled.

Keep in mind that the Budget 2017 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available, including information on planning priorities.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2017/18.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

2017/18 DHB Annual Planning Priorities

Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target
Supporting Vulnerable Children Better Public Service Target
Reducing Rheumatic Fever Better Public Service Target
Increased Immunisation Better Public Service and Health Target
Shorter Stays in Emergency Departments Health Target
Improved Access to Elective Surgery Health Target
Faster Cancer Treatment Health Target
Better Help for Smokers to Quit Health Target
Raising Healthy Kids Health Target
Bowel Screening
Mental Health
Healthy Ageing
Living Well with Diabetes
Childhood Obesity Plan
Child Health
Disability Support Services
Primary Care Integration
Pharmacy Action Plan
Improving Quality
Living Within our Means
Information Technology
Workforce.

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Waikato DHB Policies and Position Statements

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 8.1

SERIOUS EVENT REVIEW PROCESS

Purpose	1) For information.

- Outlines the evolution of the serious event review process since Protected Quality Assurance Activity (PQAA) was removed in November 2014.
- The serious event review process is in place to facilitate learning and quality improvement from the reporting and reviewing of adverse events. The aim is to ensure safer systems and a reduction in adverse events.
- The focus of all serious event reviews is to find out what happened, how it happened and recommend what systems or processes should be put in place to prevent further incidents using a human factors approach.
- Highlights areas where the process has changed over the last two years since protection was removed.
- Notes areas that are and will continue to evolve as new national policy and international best practice is adopted, particularly around better patient / family involvement, wider sharing of reports / learning.
- Notes the challenges with capacity and governance and the need to strive for an open and informed culture.

Recommendation
THAT
The report be received.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

Serious Event Review process

"Even apparently simple human errors almost always have multiple causes, many beyond the control of the individual who makes the mistake. Therefore, it makes no sense at all to punish a person who makes an error, still less to criminalise it. The same is true of system failures that derive from the same kind of multiple unintentional mistakes. Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe, such that all can learn from them."
"The best way to reduce harm ... is to embrace wholeheartedly a culture of learning."

A promise to learn – a commitment to act, The National Advisory Group on the Safety of Patients in England, chaired by Don Berwick, August 2013

1.0 Background

The serious event review process is evolving as the culture in the organisation shifts toward a positive safety culture that is open, just and informed, in which reporting and learning from error is the norm. Up until November 2014, all serious event reviews were under Protected Quality Assurance Activity (PQAA). This legislation protects the confidentiality of information which becomes known **solely** as a result of such activities and affords immunity from civil liability to health practitioners engaging in Protected Quality Assurance Activities (PQAAs) in good faith. This means that information about a health practitioner which becomes known *solely* as result of a PQAA cannot be used against that practitioner in a civil case e.g. Coroner's court, Health and Disability Commissioner investigation.

This meant that learning from the reviews was difficult to share amongst wider teams and therefore improvements in DHB wide systems more difficult to achieve. Removing this protection was a necessary step towards becoming a learning organisation, but it has not been (is not) a quick or easy transition for some staff.

The DHB (and health) is a complex system and adverse events will occur. Each of these events should be regarded as an opportunity to learn and to improve in order to increase the safety of our care system for everyone. We are on a journey to become an open and transparent organisation, aiming to provide high quality care that is safe, effective and person-centered. The serious event process will need to continue to evolve and improve as national and international best practice emerges.

2.0 Purpose of the Serious Event Review Process

The serious event review process is in place to facilitate learning and quality improvement from reporting and reviewing adverse events, and to enable analysis of contributory factors / trends over a cluster of events or time. The aim is to ensure safer systems and a reduction in adverse events.

The process is not about apportioning blame. Reviews seek to understand what happened, how and why it happened and recommends what systems or processes should be put in place to prevent future occurrence using a human factors approach.

An event being subject to a serious event review does not automatically indicate a causal link between care or service delivery and the outcome, or that the event was avoidable. It reflects the perceived need to review the event in detail to establish the facts of what happened to determine any links between the care delivery and the outcome or that there is potential for learning to inform system/service improvement

3.0 Serious event review process

The Quality and Patient Safety teams' role is to support all Waikato DHB staff to manage and learn from adverse events. The serious event review process is part of the incident management policy but we have further developed the serious event review process, to ensure consistency of approach by the team leaders. This has included having a single approach across the DHB which includes mental health and non-clinical issues if appropriate such as privacy breaches.

The approach seeks to ensure that no matter where an adverse event occurs in the DHB:

- The affected person receives the same high quality response
- Any staff involved are treated in a consistent manner
- The event is reviewed in a similar way, and
- Learning is shared and implemented across the organisation and more widely to improve the quality of services.

The DHB follows the national reportable events policy 2012 and the national matrix, which is currently under review and we are actively contributing to this process, being seen by HQSC as a proactive DHB in this space.

Table 2: Guide to levels of review ***(****There is a national matrix published by the HQSC that assists in the categorising of incidents).*

Severity Assessment Category (SAC)	**Suggested minimum level of review**	**Review team**	**Reporting of findings and learning**	**Guidance timescale**
SAC 1 (including mental health)	Quality and Patient Safety team - Serious event review. Use of validated analysis tools to comprehensively examine the chronology, care delivery problems and contributory factors. (RCA, London Protocol) or evidence of screening / triaging and clear rationale for any not progressing to analysis.	Full review team: • Director QPS to agree review lead • Executive Director to agree clinical technical expert/s • The review team should be sufficiently removed from the event, and have no conflict of interest, to be able to provide an objective view. • External experts may be required • Consumers may be included in the team	Via Serious Event Review Panel / governance structures Findings and recommendations signed off by the appropriate Executive Via division/service governance structures with evidence of improvement plans as required. The development of the improvement plan should sit within the team/department where the adverse event took place. Report may be sent to Coroner / HDC / Ministry	Commence review within 1 week and complete within 70 working days Extensions can be obtained from Director QPS / HQSC
SAC 2	Local management team review with Quality and Patient Safety overview Use of validated analysis tools (including falls and pressure injuries templates)	Service manager with multidisciplinary team input.	Via Serious Event Review Panel Via local governance structures with evidence of improvement plans as required. Report may be sent to Coroner / HDC / Ministry	Commence review within 1 week and complete within 70 working days

SAC 3 and 4	Local review by line manager in discussion with staff.	Managers/staff locally. If further review required then local management review process.	Via aggregated reports and learning points to management and governance structures.	Adverse event approved and closed within 2 weeks of being reported.

A human factors approach is critical to undertaking a review. Awareness of human factors can help to:

- understand why staff make errors and, in particular, which 'systems factors' threaten safety
- improve the safety culture of teams and organisations
- enhance teamwork and improve communication between care staff
- improve the design of care systems and equipment
- identify 'what went wrong' and predict 'what could go wrong', and
- appreciate how certain tools can help to lessen the likelihood of harm.

3.1 Review outcomes

Where service or care delivery problems have been identified, recommendations are developed and actions agreed. Not all adverse events reviews will identify system failures. A review may conclude that the care delivered was appropriate and an event was unavoidable. The potential for learning in these cases are still recognised and areas of good practice shared appropriately.

3.2 Links with disciplinary process

Whilst it is extremely rare, there may be an occasion where there is evidence that a member of staff has committed a negligent or criminal act. In such situations, the DHB invokes the disciplinary process. The Decision Incident Tree is used to support the decision-making process to move to disciplinary procedures (see Appendix 2).

If at any stage in the serious event review process it is deemed that disciplinary processes are required, the HR department is informed so that the disciplinary process can begin; this should not be part of the serious event review.

4.0 Sharing learning

The full serious event review report is discussed at the serious event review panel chaired by the Chief Medical Officer. The findings and recommendations are approved by this panel.

The DHB has fledgling arrangements in place to share learning and improvements from adverse event reviews across services, the wider organisation and nationally as appropriate. Although it is our aim for adverse serious event review reports to be written in a way that can be shared and others can learn from the event, a brief learning summary is likely to be a better way to share key learning points to ensure anonymity for patients and staff. During 2016, a one-page template was developed to summarise what happened, what went well, what if anything could be improved and what has been learned. These summaries are now shared with the executive group and placed on the intranet.

Reports relating to thematic learning are collated over specific timeframes to assist and inform wider service and organisation patient safety / improvement programmes of work e.g. deteriorating patient project that encompasses sepsis and family escalation has come about because of recurring themes in the serious events and complaints during 2015 / 16. Datix has improved our ability in this area.

There has been some high level reporting of serious events (numbers, general themes) to the Audit and Risk Committee during the past 2 years.

5.0 Key points in process that have changed / improved over the last 2 years

PQAA – Protected quality assurance activity removed November 2014	→	Frequent HQSC 'Open Book' contributor DHB learning summaries on Intranet / shared with executive group and DHB staff SER panel reviewing trends / learning /completion of actions on a quarterly basis
Reporting to the HQSC in terms of Reportable Events Brief (REB) A (15 days) and Reportable Events Brief (REB) B (70 days) reports – Timescales not met and wide variation	→	100% compliance with REB A reports within 15 days of incident being reported >90 % compliance with REB B reports – reviews completed on time and HQSC informed. If known issue, extension requested by Risk Manager. All serious events (inc. mental health) reported though QPS
Root Cause Analysis (RCA) only method utilised	→	London Protocol that includes human factors / service / delivery issues and contributory factors
Open Disclosure not consistently undertaken	→	SER information leaflet outlining process Open Communication (2 way process) Patient / family outlining concerns that are included in the TOR and scope
Patient / family / consumer involvement unusual apart from mental health	→	Contact with family at set points in the process to keep them up to date with progress Sharing final report with family Independent consumer equal member of review team *Aim* o *Consumer on all SAC1 reviews* o *sharing draft report and recommendations with family for comment before the SER panel* o *Keeping family informed when recommendations completed / changes made*
Closing the loop seldom achieved	→	Action plans monitored for completion through the SER panel and BoCG (evaluation method increasingly through clinical audit) but still not robust *Aim* o *Suite of reports to be developed to monitor performance and effectiveness of process*
Risk register – no links	→	Risks of similar incidents occurring remain until the recommendations have been fully implemented – risks are discussed at the SER panel and added to the risk register as appropriate

6.0 Areas that are evolving

- Reporting to the Board
    - It has not been usual practice to share final reports at the DHB Board but it is acknowledged that if a serious incident is seen as 'high risk' for the DHB (large number of patients / services involved, high media interest), then it would be appropriate for the findings and recommendations to be presented at the Board – this could be in the public section if patient / family consent has been obtained for wider sharing of the report, otherwise these findings would need to be presented in the public excluded section of the Board meeting.
- Coroner and Health and Disability Commission (HDC) expectations
    - Increasingly use the final DHB serious event review reports to support their investigations
- OIA requests for release of reports and the privacy interests / coroners process (links to s18(c)(i) and s9(2)(a)of OIA
- National Reportable Events Policy 2012 discussion document (Nov 16-Feb 17) outlines some future expectations that will be encouraged but not mandated
    - Increase focus on consumers / patients
    - Increase focus on learning and action
    - Increase focus on supporting staff
- Independent consumer representatives in review team for SAC 1 reviews
    - Safe space, confidentiality, conflict of interest, protection
- Whole sector / multi organisation / cross community reviews (GP, NGO,LMC, other DHB providers) and shared learning
- Increased reviewing of 'near misses'
- Debrief process for staff (multiple department) / second victim support
- Sharing learning summaries across DHB / web site
- Sharing learning across the region through Datix.
- Promoting and supporting the elements of a safety culture (see appendix 1).

7.0 Challenges

There remain a number of challenges with the management, monitoring and sharing of learning from serious event reviews.

Media – trying to balance the media / public need to identify who to blame with the need for openness and a just culture

Capacity – Clinical (or other) commitments can result in delays and having sufficiently trained staff in critical review and analysis, interview techniques and human factors as well as report writing. There is a need to ensure sufficient staff in the services with improvement methodology knowledge.

Links – ensuring learning from mortality reviews, global trigger tools and other safety information is used to ensure focus of improvement work is on the identified priority areas.

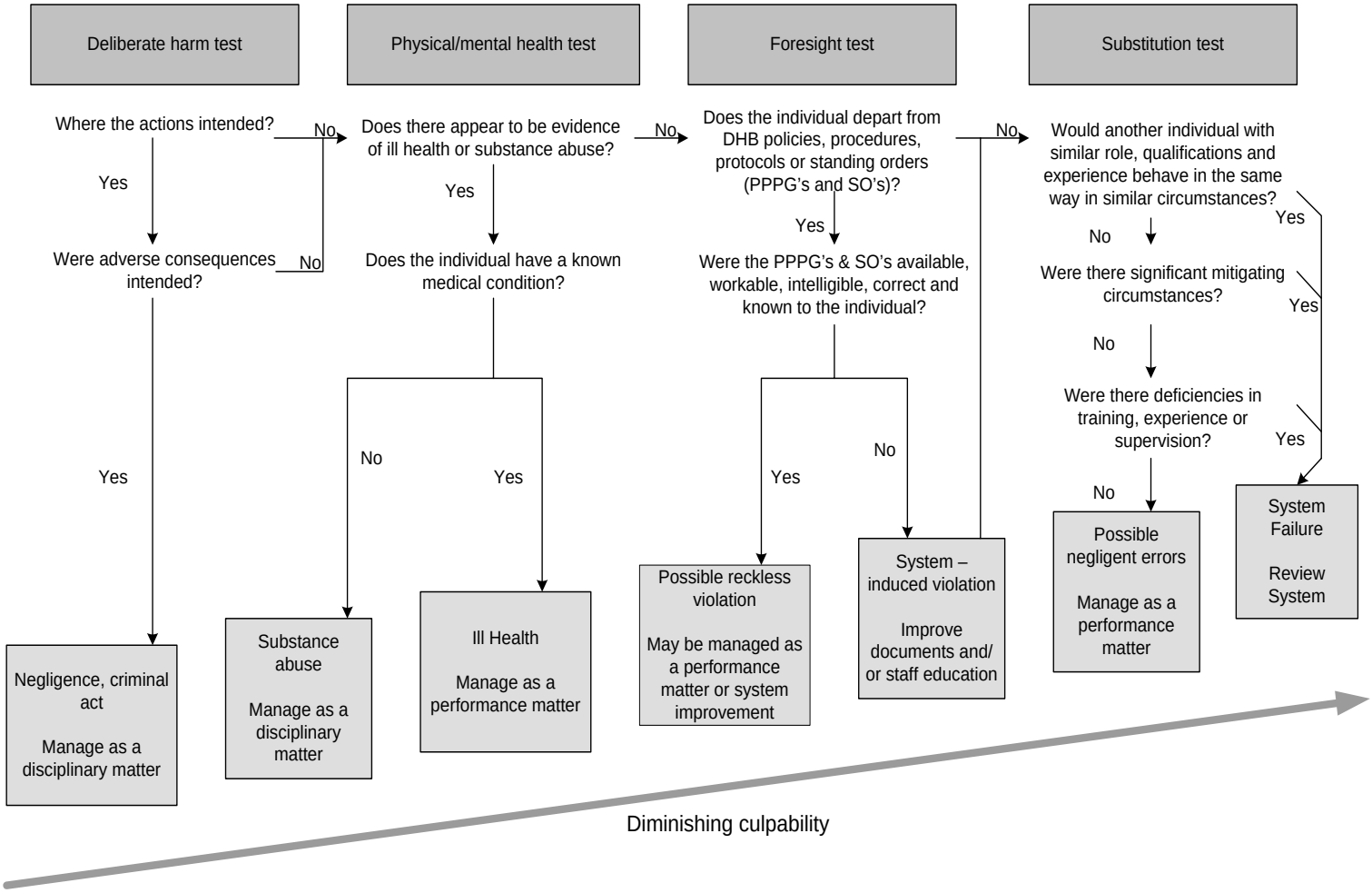
Governance – capacity to monitor actions arising from the serious event review process and ensuring actions are taken. Capacity to evaluate whether the actions taken following a serious event review, results in changes that are improvements

Elements of a safety culture

Open culture	Staff feel comfortable discussing adverse events and raising safety issues with both colleagues and senior managers
Just culture	Staff, patients, service users and carers are treated fairly, with empathy and consideration when they have been involved in an adverse event or have raised a safety issue
Reporting culture	Staff have confidence in the local adverse event reporting system and use it to notify managers of adverse events that are occurring, including near misses. Barriers to adverse event reporting have been identified and removed: • staff are not blamed and punished when they report adverse events • staff receive constructive timely communication and feedback after submitting an adverse event report, and • the reporting process is easy • staff will be directly involved in reviews
Learning culture	The organisation: • is committed to learn safety lessons • communicates learning outcomes to colleagues • remembers them over time • shares key learning points more widely
Informed culture	The organisation has learned from past experience and has the ability to identify and mitigate future adverse events because it: • learns from events that have already happened (for example, adverse event reviews, and shares key learning points) • undertakes trend analysis and develops appropriate action plans • uses learning from adverse events to promote a positive safety culture

Waikato DHB Incident Decision Tree*

***Based on James Reason's Culpability Model**



MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 8.2

FLUORIDATION SUBMISSION

Purpose	1) For consideration.

In August 2016 the Board adopted a Position Statement on the Fluoridation of Drinking Water.

Over the December/ January period the Health Select Committee sought submissions on the Health (Fluoridation of Drinking Water) Amendment Bill. Due to timing the submission was circulated to Board members but there was no opportunity for verbal discussion prior to it being submitted. The submission makes that clear and allows for subsequent comment to be made once the Board itself has had an opportunity to discuss the matter. The submission is, of course, consistent with the principles of the Position Statement.

In summary the Bill proposes the following changes to the status quo:

1. that the responsibility for deciding on whether community water supplies should be fluoridated should transfer from local government to District Health Boards.
2. that single set of national criteria should be established against which DHBs should evaluate the scientific evidence related to population health status and the efficacy of fluoridation of community water supplies as a public health measure.
3. that DHBs will be responsible for operationalising the legislation both within their local jurisdiction and also between DHBs where the flow of water supplies requires it.

The Bill, as written, does not anticpate that the decision making and public consultation processes that were previously followed by local athorities will be adopted by DHBs. The expensive, time intensive, and sectionally polarised nature of the historic processes is arguably something that the Bill, as drafted, is intending to avoid. This is particular issue in the Waikato given the unusually high number discrete networked water supplies to be considered (seventy) across an unusually high number of territorial local authorities (ten).

Any decision making process by the officers or Directors of a DHB is subject to the prospect of Judical Review. Processes of Judicial Review are intended to be a safeguard of the public interest. A DHB ought to take considerable care that it does not create more onerous or complicated internal processes than those required by legislation and, equally, that due care is taken when exercising legislative authority. That unusual complexity of the Waikato situation (numbers of supplies and authorities) suggests that the Board would sensibly be careful not to create a rod of its own regret once the final requirements of the legislation are known. The future challenge will be to find the balance of the public interest as the DHB works to improve the health and wellbieng of the community at large.

Recommendation
THAT:
The Board notes and discusses the Fluoridation submission.

MARK SPITTAL
EXECUTIVE DIRECTOR – COMMUNITY & CLINICAL SUPPORT

SUBMISSION ON:
Health (Fluoridation of Drinking Water) Amendment Bill
January 2016

1. Introduction

The following submission presents the views of Waikato District Health Board (DHB). The Waikato DHB is part of a wider health system and network and has a strong focus on improving the health of the population and improving health equity. DHBs have a statutory mandate[1] to improve, promote and protect the health of people and communities and to reduce health outcome disparities between various population groups.

Community Water Fluoridation (CWF) is one of many oral health interventions and is recommended in addition to other services and advice already provided by the Waikato DHB. No single intervention is promoted at the expense of the others.

2. Recommendations

The Waikato DHB **welcomes** and **strongly supports** the Bill as drafted as a significant improvement on the status quo.

The Waikato District Health Board recommends that:

1. Decision making on Community Water Fluoridation shift from local government sector to the health sector. Our Board unequivocally supports that change. That said, national decision making undertaken via the auspices of the Ministry of Health is our first preference, noting that while decision making by individual District Health Boards is an option it is a more complex one and is therefore less preferred. Consequently the Waikato DHB supports the Bill, but would more strongly support it if decision making was retained at a national level.

2. Should decision making on the fluoridation of drinking water be transferred from local authorities to District Health Boards there must be clear national guidance for consistency, efficiency and transparency.

3. Objective scientific method should underpin the decision making process and as community consultation is not relevant to that approach it should not therefore be a requirement. The judicial review process to which any decision can be subjected (whether by the Ministry of Health or by DHBs) will sufficiently protect public interest.

4. Ethical and legal issues have already been extensively considered at a national level, consequently these issues should not be required to be further considered, and especially not as part of the particulars of individual DHB decision making should decisions on the fluoridation of drinking water be delegated to that level in the legislation.

[1] New Zealand Public Health and Disability Act 2000 and Health Act 1956

DRAFT

3. Acknowledgement

Thank you for the opportunity to comment on the **Health (Fluoridation of Drinking Water) Amendment Bill** (the Bill).

Waikato DHB has considerable expertise and experience in oral health and health improvement services due to the specialist workforce it employs, its evidence based approach, and CWF decision making within its district in the last several years. It is from this knowledge base that the following comments and recommendations are made.

Waikato DHB believes that the decision making should ideally be vested within the Ministry of Health. This would both reflect the national nature of the issue and also remove the need for subsidiary complexities such as several DHBs having to agree. The Waikato DHB believes and supports the important shift in decision making from local authorities into the health sector on this oral health and equity improving intervention. Vesting the decision making powers in DHBs within a national framework to ensure consistency is a secondary option that the Waikato DHB supports if a national process is unable to be progressed.

The Waikato DHB recognises that fluoridation has become an increasingly contentious and costly issue for local authorities and acknowledges the difficulty local authorities have in weighing and assessing conflicting advice about the usefulness and safety of fluoridation. Transferring the decision-making on the fluoridation of drinking-water supplies from local authorities to DHBs places this decision making responsibility within the health sector, where people elected and appointed to improve and protect the health of a district's population will discharge this responsibility. DHBs are responsible for making decisions that will improve oral health outcomes and reduce disparities between groups and communities. This amendment thus puts the decision making powers within the elected authority that also has access to health expertise and ethical decision making for population based health interventions.

4. Background

The Bill provides an opportunity for the Waikato DHB to decide on the fluoridation of local government drinking water supplies throughout the greater Waikato region based on criteria set by government, namely the scientific evidence and the costs and benefits of CWF. The Bill, as drafted, does not require DHBs to consult when considering whether to require local authorities to implement or retain CWF for drinking-water supplies. The public interest is, however, protected by enabling the board's decision-making to be subjected to judicial review.

5. The role of DHBs

Waikato DHB's conclusions from recent local government decision making related to CWF, including "public"[2] consultations has demonstrated that councils are poorly equipped to hold responsibility for introducing or continuing CWF. In the past, lobbying and pressure have confused the debate and succeeded in obfuscating the overwhelming base of scientific evidence about the benefit and safety of CWF. Despite this, populations and communities in the Waikato District Health Board region, and in other

[2] During recent consultations in Hamilton City Council main substantive submitters were co-ordinated by, and in some cases represented by, international lobby organisations.

regions, have shown strong support for fluoridation of water supplies as evidenced in referenda in recent years[3]. Local government does not want to retain this decision making responsibility.

The New Zealand Public Health and Disability Act, 2000, established DHBs with responsibility to improve, promote, and protect the health of people and communities.[4] DHBs are therefore the right place for decisions to be made about health improvement measures at a population level, including CWF.

6. Community consultation and evidence base

DHBs are not required to undertake community consultation as a routine part of decision making. Indeed, it would be time consuming, wasteful and inappropriate for each DHB to consult regarding the effectiveness and cost benefit of CWD each time it considers requiring fluoridation of a local government drinking water supply when "The science of fluoride in water is effectively settled"[5]. The draft legislation already clearly sets out the particulars that need to be taken into account when deciding on this health improvement service. We note in passing that the DHB has ten territorial authorities within its boundaries which would make consultation particularly onerous.

Waikato DHB recognises it is important to be able to address the regional community health priorities and to be able to weigh the benefits of fluoridation for each community; therefore, we support the provisions of section 69ZJA in the Bill.

7. Ethical considerations

Ethically it is sound and fair to apply universal measures like CWF to communities. In particular, people living in areas of high deprivation will significantly benefit from CWF, thus improving equity. Several legal challenges to local government decisions to introduce or retain CWF have been unsuccessful. Judgements have consistently found that CWF does not contravene individual rights, ie *New Health NZ Inc v South Taranaki District Council* [2016] NZCA 462 / [2017] 2 NZLR 13. National and local government frequently decides on and implements population level measures, whether it is in the health sector such as free universal secondary health care; screening programmes; restriction of infectious food handlers, or in any other areas of government responsibility such as taxation; rates; education, and seat belts. The application of population level measures to improve oral health has a sound ethical basis, especially when considered in the light of the evidence of the considerable health benefits that result.

8. Concluding comments

The Waikato DHB welcomes and supports the Bill as drafted notwithstanding that it would be our preference that the Ministry of Health had a nationwide decision making function for simplicity. The Bill is cognisant of public policy and human rights. District

[3] Referenda results are Hamilton 2013 66% in favour; Thames 2015 73% in favour, South Taranaki 2012 81% in favour; Whakatane 2013 66% in favour; Ohope 2013 70% in favour.

[4] Section 22 of the New Zealand Public Health and Disability Act 2000

[5] http://www.pmcsa.org.nz/blog/what-is-in-the-water/

Health Boards are well placed to find the balance between cost benefit, community input and scientific research with the overall improvement of health outcomes and health equity pre-eminent in their decision-making.

A transfer in decision-making to DHBs will improve oral health and reduce disparities between groups and communities.

Please note that due to the deadline for submissions, this submission has been prepared by the DHB's management and the Board has not had the opportunity to meet and formally consider the submission. The Waikato DHB therefore wishes to retain the right to add to the submission after the Board itself has had time to consider it.

The Waikato DHB does wish to be heard.

9. Contact address

Comments on this submission or requests for further information should be addressed to:

Dr Felicity Dumble
Medical Officer of Health/Public Health Physician
Waikato DHB Population Health
Private Bag 3200
Hamilton 3400
E: felicity.dumble@waikatodhb.health.nz

Submitter information

The Waikato District Health Board (Waikato DHB) serves a population of more than 360,270 people within 10 territorial authorities and two regional councils, stretching from the northern tip of Coromandel Peninsula to south of National Park and from Raglan and Awakino in the west to Waihi in the east.

The Waikato DHB has five hospitals and two continuing care facilities; community services, older persons and rehabilitation service, population health service and mental health and addiction services (collectively known as its provider arm Health Waikato). It directly employs around 6083 doctors, nurses, allied health professionals and support staff.

The Waikato DHB also funds and monitors (through contracts) a large number of other health and disability services that are delivered by independent providers such as GPs and practice nurses, rest homes, community laboratories, dentists, iwi health services, Pacific peoples' health services, and many other non-government organisations and agencies.

The Waikato DHB is extensively engaged in providing services in the region both directly through the provider wing of the organisation and indirectly through other providers. These include personal health services and public health or population based health services

Population Health is focused on providing early intervention and prevention services that improve, promote and protect the health of population groups within the Waikato DHB region. It works to help ensure all people in the Waikato have opportunities to access services and make choices that enable them to live long and healthy lives.

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Papers for Information

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 9.1

WOMEN'S HEALTH TRANSFORMATION PROGRAMME

Purpose	1) For information.

1. OVERVIEW

The focus over the last two months has been on the following:

- Progressing the changes to the model of care for elective caesareans, the women's assessment unit and outpatients day assessment unit,
- Recruitment of midwives, SMOs and registrars,
- Development of a recruitment and retention plan for midwives,
- Review of midwifery rostering process

The first Taskforce meeting for 2017 was held in late January. The Taskforce reported being pleased with the progress made over the last couple of months. The Taskforce has been meeting face-to-face, monthly, for a full day over the last year; the decision was made to reduce the meeting frequency to bimonthly for the next six months, at which time we will determine the frequency and need for future meetings.

2. PROGRESS

Clinical Unit Leader

The recruitment of the Clinical Unit Leader is currently one of the highest priorities for the service. A medical recruitment agency (Wavelength) has been engaged to undertake a specialist search and commenced preliminary work prior to Christmas. The formal campaign was launched late January. We expect to make an appointment by the end of March 2017.

Director, Women's and Children's Health

Following advice from the Taskforce, the decision was made to remove Women's and Children's Health Services from the wider Waikato Hospital restructure. This has provided more certainty with respect to the ongoing need for a Director for Women's and Children's Health; thus, recruitment to the Director position commenced in late January 2017. We expect to make an appointment to the position in March 2017.

Model of Care

Work has progressed on the changes to the model of care with the most signifciant developments as follows:

- Reconfiguration of the gynaecology, antenatal and postnatal wards: The data is being mined and analysed in order to determine the volume of patients with a view to creating one maternity ward, for antenatal and postnatal women and a separate ward for gynaecology inpatients. A discussion paper will be finalised once the volumes are confirmed.
- Refining the scope of the Women's Acute Assessment Unit (WAU), and reducing the volume of non-acute women being seen in WAU.
- Further development of the outpatients' clinics including the development of a Day Assessment Unit with midwife led clinics. Midwives have been appointed and the unit will commence operation in late March.
- Changes to the provision of elective caesareans. The plan for the development of a second theatre in Delivery Suite is well underway. The plan includes other changes that will support critical changes to the model of care, such as the development of rooms within the Delivery Suite for inductions of labour. The business case is well underway and will be presented for DHB approval in April. An interim arrangement was implemented on 22 December 2016, involving elective caesareans being provided in main theatre, 3 days per week (half day sessions). This arrangement has been well received although it is difficult to provide the midwifery staffing for this list with the current vacancies. External (LMC) midwives have been contracted for some of this work.

Workforce

The recruitment of registrars and midwives continues to be one of the highest priorites for the service.

SMOs and Registrars

As reported in November 2016, the vacancies in the registrar workforce and the very junior workforce have hindered progress on changes critical to regaining RANZCOG accreditation, including full implementation of the newly agreed team structure, registrar experience in the full range of clinical activities and appropriate protected teaching time. However, there has been significant progress with registrar appointments over the last couple of months. The number of vacancies for registrars will reduce to 2.0 FTE by March and 1.0FTE by May 2017 (out of a total of 12 FTE positions).

Midwives

The vacancy status for midwives is improving over the next four months with six midwives (4.9FTE commencing in February and three midwives (2.6 FTE) commencing in March. Although the total number of vacancies remains relatively high, this is mitigated by the fixed term appointment of registered nurses into vacant midwife positions on a fixed term contract to cover the gaps. In addition to the nurses and casual midwives, we have engaged 9 LMCs to cover shifts on a contract basis as needed.

The leadership team are working with MERAS and NZNO to explore options for recruiting and retaining midwives. Amongst other strategies, we are targeting the current part time and casual workforce to ascertain what the service would need to change to encourage a further commitment (that is, increased hours or change from casual to permanent) from these midwives. Other changes

to the rostering approach are also being implemented to support the permanent workforce, and potentially encourage casuals to seek permanent employment.

Registrar teaching, education and support

A new advanced trainee has taken on the responsibility for leading the registrar teaching programme, and is providing significant leadership in this area. The registrar teaching programme will be reestablished under her leadership from late February.

3. PROGRAMME RISKS

Risk	Status	Comment
Inadequate RMO resource to provide services		RMO vacancies continue to put pressure on the SMOs to work without registrars and/or work additional shifts.
Inadequate SMO resource to provide services		Whilst there are not significant SMO vacancies, the SMOs are very stretched with supporting junior registrars and covering registrar vacancies.
Inadequate Midwifery resource to safely provide services		This risk remains high despite considerable improvement this month. The risk is partially mitigated by fixed term RN appointments, casual MWs and LMC contract midwives.
Failure to provide safe and effective *acute* services		It remains very challenging to cover the acute roster due to registrar vacancies.
Failure to provide adequate *elective* services and meet KPIs (incl ESPI targets)		Elective services continue to be reduced due to registrar vacancies and SMOs being rostered onto acute services in evenings and nights. The service continues to use locums and the outsourcing of some services.
Resistance to change		There is strong interest in change and improvement, particularly when compared with the resistance early in 2016.
Potential adverse employment relations		There is no imminent risk.
RANZCOG accreditation not afforded in time for 2017 core trainees		The slow rate of (net) progress with recruitment of registrars continues to present a risk to implementation of changes required for RANZCOG accreditation.
Status key:		
 **= Urgent attention required**  **= Some concerns exist**  **= Risk is well mitigated**		

4. CONCLUSION

It is of note that whilst the service is still under considerable pressure due to workforce vacancies, we have made considerable progress with appointments over the last two months. We continue to diversify our recruitment strategies and explore changes that will attract more registrars and midwives and retain our current workforce.

The transformation priorities for the next few months are:

- Appointment of the Clinical Unit Leader
- Appointment of a Director
- Complete a proposal for change to the 'middle' management and leadership group (in follow up to the withdrawal of Women's and Children's Services from the Waikato Hospital Leadership restructure)
- Progress the changes to the model of care, particularly
    - Changes to the management of induction of labour and post epidural women
    - Complete the business case for the second D/S theatre
    - Complete the proposal for the change for the antenatal, postnatal and gynaecology wards
- Enhance the retention and recruitment strategy for midwives.

Recommendation
THAT
The report be received.

TANYA MALONEY
COMMISSIONER, WOMEN'S HEALTH TRANSFORMATION

MEMORANDUM TO THE BOARD
22 FEBRUARY 2017

AGENDA ITEM 9.2

ELECTIVE SERVICES IMPROVEMENT COMMISSIONER PROGRESS REPORT

Purpose	For information.

Introduction
This report provides an update on the work undertaken in the area of elective services improvement over the last three months, since the commencement of the elective services improvement commissioner role. It is based around the five key areas of work, identified both in the initial report into elective services issues and in the Action Plan agreed for the commissioner role.

Key Focus Areas

Wait list management and ESPI Compliance
Slow progress is being made in the overall management of wait lists. A number of services are still overly focused on the patients who will breach ESPI compliance, instead of managing the total patient group. ESPI results to end December (the most recent available from the Ministry of Health) are at Appendix 1.

ESPI 2 (Outpatients waiting more than four months for assessment)
We breached ESPI 2 for the fourth month in January. This would normally result in financial penalties. However, the Ministry has acknowledged the work we have been doing and that the issues are confined to two subspecialties within orthopaedics (spinal and foot and ankle), so have given the DHB a dispensation until April. This has a number of caveats, which we are comfortable with at this point in time. A large number of spinal assessments have been outsourced, but with additional resource arriving within the next three months in both subspecialties, we should meet the April compliance target.

ESPI 5 (Inpatients waiting more than four months for treatment)
We achieved compliance in October and November, but not in December or January, and won't in February. Again the issues are primarily restricted to orthopaedics and the spinal and paediatric subspecialties.

The dispensation letter referred to above made it clear that there would be no further dispensations for ESPI 5. Given the anaesthetic resource issue currently evident in theatres, achieving compliance in March will be difficult (a locum anaesthetist is scheduled to commence in March). This is exacerbated by the fact that the DHB has already contracted the available capacity at external facilities and a large percentage of the subspecialty patients are not appropriate to be outsourced.

Delivery of elective volumes
As per Appendix 2, we are well behind on our anticipated year to date caseweights in several specialties. We do have the ability to move funding between inpatients and non-

inpatients, outside of the agreed orthopaedic and general surgery volumes. While we have planned to outsource surgery for over 500 orthopaedic patients before the end of the year, the planned internal delivery volumes remain below what we need. We will arrange service delivery to provide service to as many patients as possible and also to maximise the level of revenue earned.

We have started to look at the delivery options for the next financial year and are considering how best to maximise both internal and external capacity on a more planned basis.

Systems and Processes

A full set of reports is now available to manage both ESPI compliance and elective delivery. With the DHB having always achieved Health Target volumes, there were effectively no reports that allowed us to monitor the procedures within the Health Target where we are the DHB of service (but not of domicile), such as cardiac surgery and bariatric surgery.

Initial work has been undertaken on production capacity and planning, but there is still a lot of work to do before we can be confident in the information.

A series of resource documents has been developed and these are linked through the electives intranet page, together with the two elective services reports to the DHB. Updates will be posted there and we will also provide links to other resources, such as the Ministry of Health and Medical Council documents.

We have reviewed all the relevant inpatient letters to patients and drafted updates. We have made some significant changes to a few and these are going through iPM (patient management system) testing, before they are all uploaded to replace current versions. This will help improve the clarity of how we communicate with patients about our elective services.

Clinical decisions

To date only ad hoc discussions have taken place with clinicians around subjects such as prioritisation of patients, medico-legal responsibilities, balancing of first versus follow-up outpatient assessments, and intervention rate data to inform future resourcing decisions.

A framework for assessing the relative priority of first and follow-up outpatient assessments has been drafted and is to be trialled with one specialty, with a view to rolling it out to all services.

Information on orthopaedic activity and resourcing has been requested from four other large DHBs, so that a long term plan can be developed that identifies resourcing needs for the department.

Project governance and operational oversight

The Electives Taskforce meets for the first time on 15th February and will focus initially on progress against the agreed Action Plan, together with ESPI compliance.

The internal Action Group has met twice and meets again on the 14th February. A key agenda item is to assess where we may be able to shift volumes to ensure that we provide the most funded services possible.

I am in the process of reviewing the focus and attendees at a range of internal meetings that exist, to ensure that issues are being addressed in the most appropriate forum.

Recommendation
THAT
The Board notes the report.

BRENDA WILLS
ELECTIVE SERVICES IMPROVEMENT COMMISSIONER

Appendix 1: ESPI results to December 2016 (per MoH)

Summary of Patient Flow Indicator (ESPI) results for each DHB

DHB Name: Waikato

	2016 Jan			2016 Feb			2016 Mar			2016 Apr			2016 May			2016 Jun			2016 Jul			2016 Aug			2016 Sep			2016 Oct			2016 Nov			2016 Dec		
	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.
1. DHB services that appropriately acknowledge and process patient referrals within required timeframe.	26 of 26	100.0%	0	26 of 26	100.0%	0	22 of 26	84.6%	4	20 of 26	76.9%	6	24 of 26	92.3%	2	25 of 26	96.2%	1	22 of 26	84.6%	4	21 of 26	80.8%	5	18 of 26	69.2%	8	18 of 26	69.2%	8	3 of 26	11.5%	23	6 of 26	23.1%	20
2. Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	55	0.8%	-55	55	0.8%	-55	192	2.0%	-192	168	1.8%	-168	24	0.3%	-24	262	2.7%	-262	585	6.4%	-585	464	4.5%	-464	30	0.3%	-30	140	1.4%	-140	393	3.7%	-393	406	4.0%	-406
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	9	0.1%	-9	6	0.0%	-6	10	0.1%	-10	9	0.1%	-9	43	0.3%	-43	95	0.6%	-95	84	0.5%	-84	62	0.4%	-62	45	0.3%	-45	44	0.3%	-44	17	0.1%	-17	12	0.1%	-12
6.Patients given a commitment to treatment but not treated within the required timeframe.	235	5.3%	-235	301	6.8%	-301	197	4.4%	-197	256	5.8%	-256	202	4.8%	-202	39	1.0%	-39	47	1.3%	-47	45	1.3%	-45	48	1.4%	-48	33	0.9%	-33	42	1.0%	-42	79	1.7%	-79
8. Patients in active review who have not received a clinical assessment within the last six months.	0	0.0%	0	1	10.0%	-1	1	7.7%	-1	2	12.5%	-2	4	8.0%	-4	4	3.9%	-4	4	4.4%	-4	1	1.5%	-1	5	10.2%	-5	22	48.8%	-22	5	26.3%	-5	3	13.6%	-3
8. The proportion of patients who were prioritised using approved nationally recognised processes or tools.	1008	99.7%	3	1131	99.7%	3	1333	100.0%	0	1075	100.0%	0	1144	99.7%	3	1119	99.8%	2	916	93.2%	67	1187	93.5%	83	1086	93.8%	72	968	90.4%	103	1426	94.1%	90	942	90.2%	102

Data Warehouse Refresh Date: 07/Feb/2017

Report Run Date: 08/Feb/2017

Appendix 2: Electives Initiative delivery to 31/01/17 (based on internal data)

as at **31/01/2017**

Waikato - 2016/17 Electives Initiative

Purchase Unit Group	Purchase Unit Code and Name	YTD Base Planned CWD Volume	YTD Additional Planned CWD Volume	YTD Total Planned CWD Volume	Actual CWD Delivery	Base Plan to Actual Variance	Total to Actual CWD Variance	% YTD CWD Volume Delivery	2016/17 Base Planned CWD Volume	2016/17 Additional Planned CWD Volume	2016/17 Total Planned CWD Volume
Other	D01.01 Inpatient Dental	154.5	74.3	228.8	253.2	98.64	24.35	**110.6%**	262.9	126.4	**389**
	M10.01 Cardiology	270.9	183.0	453.9	762.9	491.99	308.97	**168.1%**	460.9	311.4	**772**
Other	**Other PUCs Total:**	**425.4**	**257.3**	**682.7**	**1,016.1**	**590.63**	**333.32**	**148.8%**	**723.8**	**437.8**	**1,162**
Surgical	S00.01 General Surgery	1,374.1	408.3	1,782.4	1,887.7	513.57	105.27	**105.9%**	2,337.9	694.7	**3,033**
	S05.01 Anaesthesia	12.2	4.1	16.3	26.6	14.37	10.25	**162.7%**	20.8	7.0	**28**
	S15.01 Cardiothoracic	445.0	251.0	696.0	546.6	101.56	(149.43)	**78.5%**	757.1	427.0	**1,184**
	S25.01 ENT	722.4	0.0	722.4	591.0	(131.47)	(131.47)	**81.8%**	1,229.1	0.0	**1,229**
	S30.01 Gynaecology	662.4	174.4	836.9	566.1	(96.34)	(270.78)	**67.6%**	1,127.1	296.8	**1,424**
	S35.01 Neurosurgery	203.4	134.2	337.6	336.8	133.35	(0.83)	**99.8%**	346.1	228.3	**574**
	S40.01 Ophthalmology	577.8	56.7	634.5	501.0	(76.77)	(133.49)	**79.0%**	983.0	96.5	**1,080**
	S40007 Intraocular injections	0.0	27.8	27.8	67.0	66.99	39.16	**240.7%**	0.0	47.3	**47**
	S45.01 Orthopaedics	1,456.7	1,403.5	2,860.2	1,499.3	42.61	(1,360.88)	**52.4%**	2,478.5	2,387.9	**4,866**
	S55.01 Paed Surgical	185.3	88.5	273.7	243.4	58.15	(30.31)	**88.9%**	315.2	150.5	**466**
	S60.01 Plastics	582.7	235.3	818.1	818.3	235.57	0.22	**100.0%**	991.5	400.4	**1,392**
	S70.01 Urology	573.5	0.0	573.5	402.5	(170.96)	(170.96)	**70.2%**	975.8	0.0	**976**
	S75.01 Vascular	364.0	212.6	576.5	559.9	195.98	(16.59)	**97.1%**	619.2	361.7	**981**
Surgical	**Surgical PUCs Total:**	**7,159.6**	**2,996.4**	**10,156.0**	**8,046.2**	**886.60**	**(2,109.83)**	**79.2%**	**12,181.3**	**5,098.1**	**17,279**
	MS02016 Skin Lesion Removal	104.5	64.2	168.7	278.6	174.11	109.94	**165.2%**	177.8	109.2	**287**
	PUCs Total:	**104.5**	**64.2**	**168.7**	**278.6**	**174.11**	**109.94**	**165.2%**	**177.8**	**109.2**	**287**
	Total CWD Volume:	**7,689.6**	**3,317.9**	**11,007.5**	**9,340.9**	**1,651.34**	**(1,666.57)**	**84.9%**	**13,082.9**	**5,645.1**	**18,728**