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 L Elliott, Executive Director, Maori Health
- Dr T Watson, Chief Medical Advisor
- Mr I Wolstencroft, Executive Director, Strategic Projects
- Ms J Wilson, Executive Director, Strategy and Funding
- Dr D Tomic, Clinical Director, Primary and Integrated Care
- 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: 23 August 2017

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

A g e n d a

Board

Date: **26 July 2017**

Time: **10.30am**

Place: **Conference Room/Library**
Tokoroa Hospital
Maraetai Road
TOKOROA

Meeting of the Waikato District Health Board

to be held on Wednesday 26 July 2017
commencing at 10.30am at Tokoroa Hospital

AGENDA

Note: Board members only session will be held at 9.30am
Board members/Chief Executive session will be held at 10am

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: 28 June 2017
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 6 July 2017
  - 3.2.2 Maori Strategic Committee: 21 June 2017
  - 3.2.3 Maori Strategic Committee (verbal update): 19 July 2017

4. **CHIEF EXECUTIVE REPORT**

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

6. **DECISION REPORTS**
- 6.1 Waikato DHB Fraud Policy

7. **FINANCE MONITORING**
- 7.1 Finance Report
- 7.2 Year End Matters

8. **PRESENTATION**
No presentations this month

9. **PAPERS FOR INFORMATION**
- 9.1 Health Targets
- 9.2 Provider Arm Key Performance Dashboard
- 9.3 Strategy and Funding Key Performance Dashboard
- 9.4 Mental Health and Addictions Service S99 Inspection Action Plan Update

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

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

THAT:

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

Item 12: Minutes – Various
- **(i) Waikato District Health Board for confirmation: Wednesday 28 June 2017 (Items taken with the public excluded)**
- **(ii) Sustainability Advisory Committee – to be adopted: Wednesday 28 June 2017 (All items)**

Item 13: Risk Register – Public Excluded
Item 14: Chief Executive's Report – Public Excluded
Item 15: CBD Accommodation Projects – Public Excluded

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 12(i-ii): Minutes		Items to be adopted / confirmed / received were taken with the public excluded
Item 13:	Risk Register	Avoid inhibiting staff advice about organisational risks
Item 14:	Chief Executive's report – Anglesea Clinic	Negotiation will be required
Item 15:	CBD accommodation request for additional capital	Negotiation will be required

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

Item 12:	**As shown on resolution to exclude the public in minutes.**
Item 13:	**Section 9(2)(c) of the Official Information Act 1982 – To avoid prejudice to measures protecting the health or safety of members of the public.**
Item 14-15:	**Section 9(2)(j) of the Official Information Act 1982 – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

Item

12. MINUTES – PUBLIC EXCLUDED

12.1 Waikato District Health Board: 28 June 2017
To be confirmed: Items taken with the public excluded

12.2 Sustainability Advisory Committee: 28 June 2017
To be adopted: All items

13. RISK REGISTER – PUBLIC EXCLUDED

14. CHIEF EXECUTIVE REPORT –– PUBLIC EXCLUDED

15. CBD ACCOMMODATION PROJECTS –– PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

THAT:

(1) The Public Be Re-Admitted.

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

Waikato District Health Board

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO AUGUST 2017

Bob Simcock

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

Sally Webb

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

Note 1: Interests listed in every agenda.

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

Crystal Beavis

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

Sally Christie

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

Martin Gallagher

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

Note 1: Interests listed in every agenda.

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

Mary Anne Gill

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

Tania Hodges

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

Dave Macpherson

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

Note 1: Interests listed in every agenda.

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

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

Pippa Mahood

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

Sharon Mariu

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

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

Clyde Wade

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

Note 1: Interests listed in every agenda.

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

Waikato District Health Board

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 28 June 2017 commencing at 2.00 pm in the Board Room, Hockin Building, Waikato Hospital Campus

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

In Attendance:
Dr N Murray (Chief Executive)
Mr B Paradine (Executive Director, Waikato Hospital Services)
Ms M Chrystall (Executive Director, Corporate Services)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Mr M Spittal (Executive Director, Community and Clinical Support)
Mrs J Wilson (Executive Director, Strategy and Funding)
Ms L Elliott (Executive Director, Maori Health)
Mr C Cardwell (Executive Director, Facilities and Business)
Mr D Wright (Executive Director, Mental Health and Addictions Service)
Mr A McCurdie (Chief Financial Officer)
Dr D Tomic (Clinical Director, Primary and Integrated Care)
Ms T Maloney (Commissioner, Women's Transformation Taskforce)
Mrs S Hayward (Director of Nursing and Midwifery)

ITEM 1: APOLOGIES FOR ABSENCE

There were no apologies for absence.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

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

DRAFT

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 24 May 2017

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 24 May 2017 taken with the public present were confirmed as a true and accurate record.

3.2 Committee Meeting Minutes

3.2.1 Iwi Maori Council: 1 June 2017

Resolved
THAT
The Board noted the minutes of this meeting.

3.2.2 Performance Monitoring Committee: 14 June 2017

Resolved
THAT
The Board adopted the minutes of this meeting.

3.2.3 Health Strategy Committee: 14 June 2017

Resolved
THAT
The Board adopted the minutes of this meeting.

3.2.4 Maori Strategic Committee: 21 June 2017

Resolved
THAT
The Board adopted the minutes of this meeting.

ITEM 4: CHIEF EXECUTIVE REPORT

The report was taken as read. The Chief Executive highlighted:

4.1 Format of the Agenda

Changes to the format of the Board agenda were agreed. The proposed list of suggested headings that would be reported on each month was accepted subject to one further addition – Primary and Community Care.

DRAFT

4.2 2017/18 Budget

A key aspect was that it reflected a deficit of $38m. This would prove challenging for the DHB.

4.3 ED Performance and Acute Flow

The Chief Executive reported that the number of presentations to ED for the previous few days had been the highest the DHB had known. 285 presentations were noted in one day. 45 of those were within 2 hours.

4.4 Theatre Performance and ESPIs

Work was continuing to refine and streamline overall performance of the surgical division.

4.5 SmartHealth

The rollout of SmartHealth continued. The integration with HealthLine was completed on 6 June. This had resulted in several referrals to the virtual after hours doctor service.

4.6 Waikato Medical School

The final business case was submitted to the Government on 31 May 2017.

4.7 Fieldays

There had been strong interest in the proposed Waikato Medical School at Fieldays.

The Board thanked Lydia Aydon and her team for the hard work they had put into making the DHB's stand at Fieldays a success.

4.8 Influenza Vaccination Update

The influenza season had been declared as the number of swabs returned positive for influenza had passed the threshold to declare the influenza season open. The DHB's Vaccination for Health Care Workers Policy was now effective. The press had been notified.

Unvaccinated visitors would be asked to wear a mask when visiting the hospitals.

Board members expressed their disappointment at the low vaccination number within some staff groups.

Resolved
THAT
1. The Board received the report.

DRAFT

2. Approved that the members of the Maori Health Committee, who are not members of the Board, be paid at the rate of $250 per meeting with mileage reimbursement for attendance as necessary.

ITEM 5: QUALITY AND SAFETY REPORT

There was no report this month.

ITEM 6: DECISION REPORTS

6.1 2017/2020 Midland Regional Services Plan

Andrew Campbell Stokes and Suzanne Andrew from HealthShare attended for this item.

The 2017/2020 Midland Regional Services Plan, Strategic Directions, Initiatives and Activities were attached for the Board member's approval.

Resolved
THAT
The Board approved the report.

6.2 Waikato DHB Annual Plan 2017/18 Submission

Julie Wilson and Kathryn Hugill attended for this item.

A new template with more focus on activities and measures was used to draft the Annual Plan. It was noted that there were a number of areas still awaiting final advice from the Ministry. Any changes resulting from feedback from the Ministry of Health would be brought to the July or August Board meeting.

Resolved
THAT
The Board approved the draft Annual Plan being submitted to the Ministry of Health.

6.3 Waikato DHB Draft Annual Plan 2017/18 Update

Julie Wilson and Kathryn Hugill attended for this item.

The paper was taken as read.

Resolved
THAT
The Board received the update.

6.4 Memorandum of Understanding and terms of reference between the Waikato DHB and Iwi Maori Council

The Board considered the Memorandum of Understanding and Terms of Reference between the Waikato DHB and Iwi Maori Council.

DRAFT

An amendment was suggested on page 5 – 7.2.2 (i) insert the word 'to' between 'committees' and 'be' to read:

The Council will:

(i) Nominate representatives for appointment to the statutory advisory committees to be rotated every three years.

Resolved
THAT
The Board approved the Memorandum of Understanding and Terms of Reference between the Waikato DHB and Iwi Maori Council.

ITEM 7: FINANCE REPORT

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

- The DHB were forecasting break even at year end noting that there were still a range of year-end adjustments to be made.

- The provider was unfavourable to budget to 31 May 2017:

    1. Revenue favourable to budget $7.3m.
    2. Employed personnel costs were unfavourable to budget $5.7m the dominant negative variances being within nursing.
    3. Outsourced personnel were unfavourable to budget $13.3m – the dominant variance related to medical locums ($4.8m), nursing ($1.3) and admin/management contractors for the National Oracle Solution (NOS) project ($6.7m) which had an offset in other revenue (3.6m).
    4. Outsourced services were unfavourable at $5.1m.
    5. Clinical supplies were unfavourable at $0.2m.
    6. Infrastructure and non-clinical supplies were unfavourable to budget at $0.5m.
    7. Interest depreciation and capital charges were favourable to budget $9.0m.

    It was noted that:
    - Acute cases excluding ED: episodes 3.2% above plan; case-weights 7.2% above plan
    - Elective cases: episodes 11.3% below plan; case-weights 18.9% below plan
    - Overall 0.8% below plan for cases and 1.0% below plan for case weights
    - ED attends: YTD ED attends are 3.6% higher than the same period last year
    - The result for the Funder was favourable due to favourable External Provider payment costs
    - The result for Governance was close to budget.

DRAFT

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

ITEM 8: PRESENTATIONS

There were no presentations this month.

ITEM 9: PAPERS FOR INFORMATION

9.1 Health Targets

The Health Targets Report was presented to the Board for their information.

Resolved
THAT
The Board received the report.

9.2 Provider Arm Key Performance Dashboard

The Provider Arm Key Performance Dashboard was presented to the Board for their information.

Resolved
THAT
The Board received the report

9.3 Strategy and Funding Key Performance Dashboard

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

Resolved
THAT
The Board received the report.

The Board were updated on the progress made to establish a Consumer Council for Waikato DHB.

The draft terms of reference and expression of interest process were considered.

Resolved
THAT
The Board received the report.

ITEM 10: NEXT MEETING

Date of Next Meeting

The next meeting to be held on Wednesday 26 July 2017, commencing at 10.30am at Tokoroa Hospital, Maraetai Road, Tokoroa.

DRAFT

BOARD MINUTES OF 28 JUNE 2017

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

THAT:

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

Item 12: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 24 May 2017 (Items taken with the public excluded)**
- **(ii) Sustainability Advisory Committee – Wednesday 24 May 2017 To be adopted (All Items)**
- **(iii) Sustainability Advisory Committee – Wednesday 28 June 2017 Verbal Update (All Items)**
- **(iv) Audit and Corporate Risk Management Committee – Wednesday 24 May 2017 to be adopted (All Items)**
- **(v) Performance Monitoring Committee – 14 June 2017 – to be adopted (Items 7-8)**
- **(vi) Midland Regional Governance Group – to be received Wednesday 2 June 2017 (All Items)**

Item 13: Risk Register – Public Excluded
Item 14: Chief Executive Report – Public Excluded
Item 15: Audit Reports – Public Excluded
Item 16: FY17/18 Operating Budget and Capital Plan – Public Excluded
Item 17: Gallagher Drive Warehouse and Community and Southern Rural Health Facility Capital Investment – Public Excluded
Item 18: Waikato DHB System Level Measures Plan 2017/18 – Public Excluded
Item 19: Care and Support Workers (Pay Equity) Settlement Agreement Update – Public Excluded
Item 20: Funding Advice – Public Excluded

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 12 (i-vi): Minutes		Items to be adopted/ confirmed/ received were taken with the public excluded
Item 13:	Risk Register	Avoid inhibiting staff advice about organisational risks
Item 14:	Chief Executive Report	Negotiations will be required
Item 15:	Operating budget and capital plan 2017/18	Negotiations will be required
Item 16:	Gallagher Drive Warehouse and Southern Rural Health Facility capital investment request	Negotiations will be required

DRAFT

Item 18:	**System Level Measures Plan**	**Negotiations will be required**
Item 19:	**Pay equity settlement update**	**Negotiations will be required**
Item 20:	**Funding Advice**	**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 12:	**As shown on resolution to exclude the public in minutes.**
Item 13:	**Section 9(2)(c) of the Official Information Act 1982 – to avoid prejudice to measures protecting the health or safety of members of the public.**
Item 14 - 20	**Section(9)(2)(j) of the Official Information Act 1982 – to enable the Waikato DHB to carry on negotiations without prejudice or disadvantage.**

DRAFT

ACTION LIST

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

	ACTION	BY	WHEN
1	Agenda item 4 – Format of Agenda and additional heading to be added to the bulleted point list – Primary and Community Care	Nigel Murray	July meeting
2	Agenda Item 6.2 – PP25 – Provide a report.	Julie Wilson	October meeting
3	Agenda Item 13 – The requested another expanded Risk Report for those risks rated 20 or above again next month	Mo Neville	July meeting

DRAFT

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Maori Council

Held on Thursday 6th July 2017 at 9.30am

Present:

Mr H Mikaere (Chair)	Hauraki Māori Trust Board
Mr G Tupuhi	Hauraki Māori Trust Board
Mr T Sewell	Te Rūnanga o Kirikiriroa
Dr K McClintock	Waikato Tainui Te Whakakitenga o Waikato Inc
Ms T Thompson-Evans	Waikato Tainui Te Whakakitenga o Waikato Inc

In Attendance:

Ms L Elliott	(Executive Director of Māori Health)
Mr B Simcock	(Chair Waikato DHB Board)
Matua H Curtis	(Pou Herenga Te Puna Oranga)
Ms G Roberts	(Kaumātua Kaunihera)
Ms P Mahood	(WDHB Board member)
Ms T Hodges	(WDHB Board member)
Mrs N Barrett	(Minute taker)

In attendance: Ms E McKenzie-Norton, Ms A Barnett, Mr D Tomic, Mr W Skipage, Ms J Wilson, Mr R Lawrenson

(Following items are in order of appearance)

Karakia: Mr H Mikaere

Mihi: Mr H Mikaere

Apologies

Ms K Grosman
Ms T Moxon
Ms F Chase
Ms K Hodge
Mr B Bryan

Received by: Dr K. McClintock
Seconded by: Mr T. Bell

Minutes of last meeting

Changes need to be made:

- Apologies received by P. Mahood
- Correct Tania Hodges name spelling

Action list-

1. ***Dr McClintock summary on Performance and Monitoring Committee***

Suicide Prevention Plan

- No ethnic data breakdown which meant I was not able to provide cultural expertise.
- The pathway from secondary services to primary care, hospital pathway great but statistics not broken for Māori.
- Been in contact with Reese Tapsil and Claire Simcock regarding their presentation on Suicide prevention plan lacks Māori voice, youth voice.

Smoking

- Smoking prevention data was not broken down for Māori so cannot determine whether strategy is impacting on data?
- Smoking- should we be measuring people who get advice or people who get cessation support? Does giving information have an impact?
- Māori providers lost Smoking contracts and given to PHO and the threshold have been

lowered- this was given from Ministry of Health.

- At the Committee meeting there was no report information of this intervention.
- Reiterate no breakdown of ethnicity data therefore cannot provide.
- IMC should have been advised about the process of strategy from the beginning, we know the community.

Ministry of Health

- Approximately 90% of Primary Care funding is bypassed the DHB.
- Need to strengthen present, ability, relationship with Ministry- Mr Mikaere to write a letter to Chai Chuah: Director-General of Health and Chief Executive at Ministry of Health.

IMC

- In our sphere of influence- IMC should be consulted much earlier, we were consulted too far in the process where protocols were already in place- this has been exampled in the Suicide prevention plan. Internal DHB decisions are made and IMC are being bypassed. Suicide prevention should sit in the community.
- IMC role at strategic role not who should get the contract but it questions should be asked and what the skills should be?
- Who should be involved in answering these questions, i.e. should this be contestable, if it is then who should be involved in deciding, criteria for the scope.

3- ToR and MOU

- Changes have been made and ready to be signed
- Send to IMC members
- Set up a time and invitation to all Board and IMC and KK to be present for signing process- must have Chair of Board and IMC as well as Chairs for respective representatives.

Actions:

1. Mrs Barrett to make changes to previous IMC minutes.

2. Mr Mikaere to write a letter to Chai Chuah: Director-General of Health and Chief Executive at Ministry of Health.

3. L. Elliott to email ToR and MOU to IMC members.

4. L. Elliott to send tentative dates to all Board members, IMC representative Chairs and members, and Kaumātua and Kaunihera members to be present for signing of ToR and MOU.

Alison Barnett-

Presentation in Agenda booklet.

Update on the Consumer Council

- Ms Barnett in role part time capacity for 1 year now
- Draft Terms of reference drawn up
- Went into the community hui in Hamilton staff, Board members, PHO representatives, community
- Went into rural communities- 6x rural locations that hospital currently works in
- Recruitment of members, selection rather than election.
- Compiled all people into a database who have been communicated on progress
- Hoped to come to IMC hui in April but postponed
- Board sign off
- Engaging Māori-
    - Current contact with already establish relationships
    - Support from Te Puna Oranga (Māori Health Service)
    - Seek guidance from IMC

An opportunity for stakeholders to shape what the DHB do and play a role in meeting the strategic priorities.
Reports to the Boards (IMC) via the CEO

Purpose? Page 19
How will recruitment and selection take place? Page 21-23.
How will members be supported? page25-26
What we're asking of Iwi Māori Council: (page 28).

Questions from IMC

1. Kaumātua Kaunihera what have they said? Haven't spoken to the group about the Consumer Council.
2. Have you done a cost benefit analysis? My team leader has and will be presenting to CEO. Great benefit to the community and support the goal of reducing ER waiting times etc.

Kaumātua and Kaunihera group have not yet been consulted or contacted on mahi related to Consumer Council. Ms Roberts expressed concern that they would rather be given a small amount of information than no information.

Action:

5. Ms Barnett to request a presentation to Kaumātua and Kaunihera group on Consumer Council kaupapa.

Dr Ross Lawrenson:
Ms Millie Berryman has been the Te Puna Oranga representative working alongside this project, and meeting with Ms Loraine Elliott tomorrow.

Presentation in Agenda booklet.

Characteristics:
Ethnicity- Māori
Age
Gender
Locality

Questions from IMC:

1. Māori males have lower life expectancy how does that impact on rates?
2. Dot point two, why? One will be driven from hospital service and the other from GP services. Issue around low socio deprivation and access to services in different localities. Issues of treatment and doses based on the prescriber's point of view.
3. The trend is still the same, what are we going to do about it? Have four working parties revamping the models of care by the end of year.
4. How is this going to impact on new mental health facility? It is going to make a difference. Youth review done 2 years ago now doing an evaluation to see the impact? There are parallels with this project, i.e. Henry Bennett centre need to change and adapt to
5. Relationship between primary care and primary services.
6. In Māori world there is no such thing as psychotic but a Māori issue that needs to be addressed by Māori. Needs to be acknowledged to be addressed. Need to change currently Māori model of care.

Action:

6. L. Elliott to send invitation to be sent to Ross Lawrenson to bring back the reports on the 4x working parties at the end of the year.

Ms Esmae McKenzie-Norton

Paper Submitted in Agenda booklet.

A proposed process for Priority Programme Plan reporting to IMC (page 12).

Questions/statements from IMC:

1. Is there opportunity for IMC to feed into each of the PPPs before the plans are drafted and developed?
    - Ms McKenzie-Norton to take this back to project owners.
2. The DHB will benefit from Māori capacity and capability early before plans and structures are put in place.
3. What is the role of the Māori Strategic Committee? To focus and pick up any grey areas those are missed at IMC level and deal with the process.
4. IMC to ensure paper trailing from IMC to get onto Māori Strategic Committee agenda.
5. Visual perspective dashboard helpful however IMC should be part of the beginning process.
6. What is the process and what can IMC do to get the process going?
    - Develop a high level plan all 24 plans will be developed by the end of the year but implementation will occur next year. We need IMC to provide information about each of the priorities. We want to know what we are currently doing and what the gaps are.

Ms. Eketone cannot support the current process of IMC receiving a PPP once the plan is already drafted. IMC should be at the front end of the conversation/s. Open to what a workshop will look like however as the current process is now, cannot support.

How can IMC be active participants in these plans? IMC should be in the know and not have other staff feeding back on the plans to IMC.

Lack of communication between different projects, focuses of the PPP's. Ms L. Elliott- ***"If we focused on Priority 1.1, 1.2, and 1.3 then the other priorities will fall out of these 3"***.

Actions:

7. Ms McKenzie-Norton to follow up with project owners to determine how IMC can feed into plans early.

8. IMC and Ms McKenzie-Norton to coordinate a way forward to ensure IMC are included early in the development process of the strategic plans.

Mr Wayne Skipage, Dr Damian Tomic and Ms Julie Wilson

Presentation: Not released for distribution yet by authors.

Purpose: Overview of Primary Care sector and Alliancing space. Current problems/issues, how to make Primary Care more responsive to Māori.

Mr Wayne Skipage, Dr Damian Tomic and Ms Julie Wilson approaching IMC as the first port of call before PHO and other parties.

GP Practices: rural defined as outside Hamilton, Cambridge, Te Awamutu and Ngaruawahia.

Alliances 2010- to improve health outcomes for our populations. Challenges WDHB part of 3 Alliances. Creates challenges when we try and work with one Alliance and then not involved in another Alliance.

Inter-Alliance bringing together the 3 Alliances.

MURIAL includes all Midland DHBs and PHOs.

Move to having:

- One Waikato wide sector Alliance
- Exiting current Alliance arrangements
- Continuing with Midland Regional Alliance
- Independent Chair
- Clinically Leadership and consumer focussed.
- General concerns:
- Inequity of access, quality and outcomes, particularly Māori
- Provider centric model- 9 to 5 face to face
- Capitation model hasn't led to the intended focus
- ED being regularly used for Primary Care provided services
- 8% of Māori are not enrolled, and they are high users of ED and hospital services
- We have to do things differently to turn the tide on Māori health inequity in this district.

IMC response:

- The Terms of Reference must hold true to the Treaty of Waitangi
- Question was discussed, "why do our whanau come to ED?" Do they know under 5 services are free? An ambulance can provide free transport.
- Services should be taken out of hospital services and given into the community, primary care and secondary services.
- Support the need for a united front but some narratives and discussion of processes need to be continued.
- We say we want to make change but are holding onto things- can't do both.
- The united approach is needed but change for Māori needs to be immediately done not in 20 years' time having the same conversation.

Concerns:
The local voice could get lost being bundled in as one group, however this could support local groups.

Formal Alliance as one. If you lump Māori in with Mainstream and Māori there is risks of 1) dilution of Māori voice in wider forum, 2) ability for non-Māori providers to gain in roads into Māori provider contracts. *I understand the angst with this. At the moment there is no one forum for all providers a lot of silos. Having 6x of the same conversations.*

I am all for having one alignment however I am reluctant to come on board without the detail.

Tuhoe as part of their settlement they have stipulated that they will sit at the governance board of the region to ensure funding is distributed fairly.

Do not want to instil the philosophy of 'one size fits all'

Why a Waikato DHB region Alliance as opposed to community based approach?

Next steps:
Alliance- An estimated 7 month process to contact PHO's and advise of 6 month change.

If we were looking at a model that would improve Māori health what would that look like? IMC should workshop that.

The need to change is now while the Board, IMC and CEO are all on board, we have 2 years to

make this happen.

Break

Suicide strategy Tio-

Suicide through media has an increased profile. What is our repose locally to suicide? Dr Kahu was reassured that TPO will be around the table for this. Te Puna Oranga (Māori Health Service) should be accountable for being involved in the Waikato DHB suicide strategy. There should be strong community involvement also. Kaitakawaenga have been given an FTE.

In Tokoroa there were 8 youth suicides and the only involvement was police involvement. Therefore it must be ensured the Waikato DHB Suicide Strategy has ground level support in place.

Equity for IMC members

Reserved parking for Board members yet IMC members must pay for parking ($1.50). Board members have guest access to Wifi whilst IMC members must use Public intermittent wifi.

Action:

8. L. Elliott to follow up on obtaining the same parking rights and Wifi ability whilst on DHB campus as Board members

Te Puna Oranga (Māori Health Service) 6monthly updates:

- IMC request 6 monthly report be a presentation

Action:

9. L. Elliott to arrange for IMC to present the 6 monthly report at next August IMC hui.

Moved by: Dr Kahu
Seconded by: Mr G. Tupuhi

General Business

Add Kaumātua Kaunihera Minutes to IMC agenda

Add Māori Strategic Committee minutes to IMC agenda

Ms T. Hodges

As Ms Hodges is no longer an IMC committee member she requests the ability to step into IMC hui pending on her availability- Granted.

Mr Mikaere

Reaffirm that in the August IMC hui there will be the process of electing a new Chair

Hub in Waiora Waikato

KK have put forth the name Piki-Ora for the Hub. It is a Waikato name and is appropriate for what it is going to be used for.

Dr K. McClintock

Will find out on Saturday whether she is the representative for Waikato-Tainui and will remain on Iwi Māori Council.

Action:

10. L. Elliott to ensure KK minutes and Māori Strategy Committee minutes are added as a regular agenda item to future IMC meetings.

Moved by: Mr G. Tupuhi
Seconded by: Ms P. Mahood

Hui Closed: Matua Hemi Curtis

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Maori Strategic Committee held on Wednesday 21 June 2017 commencing at 9.30am at Waikato Hospital

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

In Attendance:
Dr N Murray (Chief Executive)
Ms L Elliott (Executive Director Maori Health)
Mr H Curtis (Pou Herenga)
Ms R Walker (Minutes)

KARAKIA

ITEM 1: APOLOGIES

Apologies were received from Ms T Moxon, and Mr D Macpherson,

ITEM 2: WHAKAWHANAUNGATANGA

Tania welcomed members to the inaugural meeting. Members each gave a brief whanaungatanga and the reasons why they had agreed to be part of this committee which included the following comments:

- The desire to see the radical improvement in Maori health outcomes with Maori working together.
- A suggestion that the Committee work on one or two focus areas.
- The importance of being open minded to new frameworks, and to put aside any existing presumptions to ensure the acceleration of Maori health.
- How to involve people that currently do not see Maori health as their issue.

ITEM 3: TERMS OF REFERENCE MAORI STRATEGIC COMMITTEE

3.1 Maori Health Strategic Committee Terms of Reference

Confirmation was still to be received on whether Iwi Maori Council members would be paid a meeting fee to attend the Maori Strategic Committee

It was agreed to include a review of the terms of reference as necessary.

Resolved
THAT

1. That the Board establish a committee to undertake the tasks set out in point 2 below.
2. The terms of reference of the committee are:
    a. To oversee the development of the Priority Programme Plan to radically improve Maori health outcomes by eliminating health for Maori noting that the Plan will be developed by staff in conjunction with a working group including representation from outside Waikato DHB.
    b. To oversee the implementation of the Priority Programme Plan to radically improve Maori health outcomes by eliminating health inequities for Maori.
    c. To identify and consider other areas of the Waikato DHB that could contribute towards radical improvements in Maori health outcomes by eliminating health inequalities for Maori.
    d. To consider the version of the Memorandum of Understanding proposed by the Iwi Maori Council and recommend to the Iwi Maori Council and Board any changes considered necessary; and
    e. To recommend the name of the new committee.
3. The Board does not delegate authority to the committee but adopts the principles outlined above in the section headed “Delegation”.
4. The committee meets every month, and otherwise as needed.
5. The committee comprises eight members, four of whom are from the Board and four of whom are appointed on recommendation from the Iwi Maori Council.
6. The Board appoints the chair of the committee.
   The Board seeks approval to pay the members of the committee on the same basis as payment is made to other Board members.
7. The committee comprises eight members, four of whom are from the Board and four of whom are appointed on recommendation from the Iwi Maori Council.
8. The Board appoints the chair of the committee.
   The Board seeks approval to pay the members of the committee on the same basis as payment is made to other Board members.

ITEM 4: TERMS OF REFERENCE AND MEMORANDUM OF UNDERSTANDING BETWEEN WAIKATO DHB AND IWI WITHIN ITS DISTRICT

4.1 Final draft terms of reference

The draft terms of reference were discussed with the following points noted:

- Discussion occurred around the intent of item 6.2 “Ensure the growth of sustainable Kaupapa Maori health services”. It was highlighted that that whilst Kaupapa Maori services needed to play a role, Kaupapa services may not be Maori providers as these services were not necessarily for Maori by Maori. However, these services needed to result in “whanau Ora”. Background information on the original intent of whanau ora would be circulated to members. It was agreed that in this context sustainable referred

to being effective and efficient with robustness. It was agreed to include the word "philosophy" to clarify the intent of this statement.

- It was agreed to add the word "significant" to items 7.2.1(a) (b) and(c).
- The reference to provider contracts in item 7.2.1(d) should be read in context with the opening statement "moving towards ensuring..".
- Mr B Simcock highlighted that item 8.1 Nga Hui/Joint Meetings represented 14 separate meetings, which was a significant number and whilst he would attempt to attend scheduled meetings, he sought understanding from members that it was likely he would not be able to attend all meetings.
- The frequency of Iwi Maori Council meetings was raised, but agreed that this was an Iwi decision.
- It was agreed that Item 7.2.2(i) "Nominate representatives for appointment to the statutory advisory committees .." referred to the three statutory committees required by DHBs.

Resolved
THAT

1. The report be received.
2. That the terms of reference be updated with the changes outlined above, and presented to the 28 June 2017 Board meeting, and subsequently Iwi Maori Council on 6 July 2017.

ITEM 5: WORKSHOP – WHAT SHOULD WE FOCUS ON

Committee members were asked to provide suggestions on areas the Committee should initially focus on to achieve radical improvement in Maori Health. Discussion ensued based on diagram 1 below.

Impact

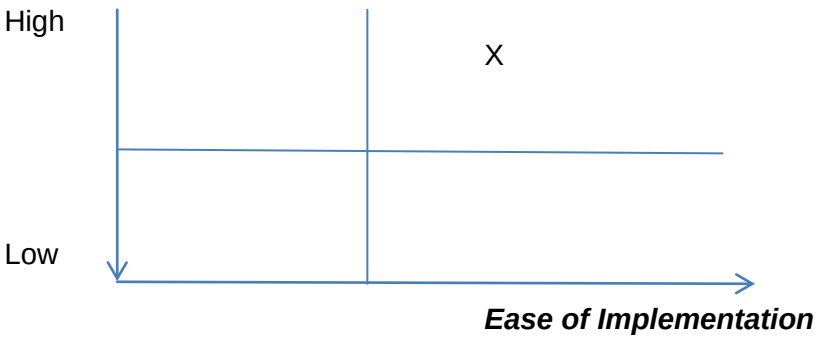


Diagram 1

A list of potential topics to be considered at point "x" of Diagram 1 were suggested:

- Teeth
- Cancel (bowel screening)
- Smoking cessation of pregnant women
- 0-5 years
- Diabetes
- Cardiovascular

It was suggested a focus community geographical area could be used as a pilot. It was agreed to invite Ms Nina Scott (Te Puna Oranga Advisor) to the

July Maori Strategic Committee meeting to provide the latest information on Maori Health status which would help inform which priorities the Committee should focus on. NGOs and PHO representatives would also be invited to attend a future committee meeting. It was suggested that consideration should be given to declaring Maori Health was in a state of emergency.

Resolved
THAT
The report be received.

ITEM 6: PRIORITY PROGRAMME PLANS

This would be a standard agenda item with a full update to be provided at the next meeting.

Resolved
THAT
The report be received.

ITEM 7: GENERAL BUSINESS

No discussion held.

ITEM 8: NEXT MEETING

8.1 Date of Next Meeting

Wednesday 19 July 2017

KARAKIA WHAKAMUTUNGA

Chairperson: _____

Date: _____

Waikato District Health Board

Chief Executive Report

MEMORANDUM TO THE BOARD
26 JULY 2017

AGENDA ITEM 4

CHIEF EXECUTIVE'S REPORT

Purpose	For consideration and information.

Format of Agenda

It was suggested that Quality and Safety would become a regular feature of Board reporting, as per the current agenda format. Given the extensive reporting on quality and safety elsewhere can I confirm that this is indeed the intention?

Budget for 2017/18

We have not yet submitted the Board approved budget to the Ministry of Health. We have presented our view of the drivers of the 2017/18 budget to the Ministry and continue to have discussions with them, as well as reviewing and assessing the consequential impact of options to bring the budget closer to the 2016/17 result. We will be meeting with the Ministry on 20 July and will verbally update the Board on those discussions.

ED performance and acute flow

Unprecedented demand for the services of our emergency department continues. This is an issue that is being seen across a number of DHBs and is a pressure that is also being keenly felt by our partners in the St John's Ambulance service and in general practices across the district. Details of the pressures and responses is included in the "Shorter stays in the emergency department" section of the Health Targets report, later in this agenda.

Theatre performance and ESPIs

ESPI compliance has been an area of intense focus with 2016/17 initiatives continuing into 2017/18 across the range of service elements and associated variables that influence satisfactory elective patient flow.

To achieve stable elective service compliance more work is required in 2017/18 although it may be noted that there is growing knowledge and 'ownership' within the services on elective patient flow that informs the ESPI results each month.

We achieved ESPI 2 compliance (amber result) in April and May in official Ministry reporting. Our internal assessment is that we also achieved amber compliance in June. This is the first time in the past 12 months that we have achieved three consecutive months of 'amber' compliance. Achieving three months of compliance is a success that will be celebrated with all the teams specialities involved.

ESPI 5 was not compliant in May due to elective operating theatre capacity being less than planned and required for the number of patients given certainty. This was due to anaesthetist SMO vacancies and high acute demand. We do however expect to be compliant for June 2017. As a consequence both ESPI 2 and 5 will be amber compliant in June. At this point in time, July results will be close to compliance for ESPI 5, but there is no certainty that this will be achieved.

Electives funding
There is a proposal with the Ministry in respect of the allocation of the $30m electives funding, which will allow the DHB additional flexibility across the 'wash-up' provisions. Based on current production planning across internal and external delivery, our Electives Commissioner is confident that the DHB has minimised the revenue risk around this funding for the 17/18 year. Significant funding has been allocated within the current budget for the outsourcing of cases to achieve the relevant volume targets.

The surgical service group ended the financial year with significant work underway to maximise utilisation of the theatre suite. This work continues to be hampered by a short fall of anaesthetist FTE to resource. Anaesthetist recruitment has however progressed well, with four new anaesthetists expected to be in place by year end.

The waiting time for acute theatre access is consistently below the internal 24hr and 48 hr targets, which were set to ensure quality patient outcomes.

#	Target	16/17 YTD	June	Comments
1	80% within 24 hours	73%	74%	Best month: 77% in July, August and May
2	100% within 48% hours	88%	88%	Best month: 93% January

Work underway to "right size" the acute theatre schedule is expected to materially improve this performance.

As a summary at the end of the 2016/17 year;

- The acute theatre throughput increased 12% from 15/16
- The full year result acute timeliness deteriorated from the previous year (in 2015/16 Target 1 was met and target 2 was not met at 90%).

Theatre performance remains one of the key issues facing us and I am currently exploring whether external assistance is required to assist us in this area.

Cardiac waiting list

As previously reported a recovery plan over a 10 week period was initiated in April to address this waiting list. This plan comprised short term support from Auckland DHB and local outsourcing. We have commenced regular teleconferences with the Ministry of Health to provide updates on this recovery plan. The number of people waiting in April was 91 compared to the guideline of 65 (maximum) patients waiting. At the time of this report the number of patients waiting had reduced to 82. Of this number, 13 already have a procedure date, six are not ready for surgery and two are scheduled for personalised external aortic root support (PEARS) procedures. We are now working through plans to ensure we achieve the target in the next financial year.

The situation in respect of cardiac intervention has been complicated by a high number of trans-catheter aortic valve implantation (TAVI) referrals. All patients have been identified and are being case managed by the service to ensure they are given appropriate treatment. In addition a number of Central Region patients have been repatriated back to Capital & Coast DHB, which has now commenced a TAVI programme. The Clinical Unit Leader is working with the service to ensure there is a single point of entry for all patients requiring intervention for aortic valve disease.

Current financial status for 2016/17

We achieved the break-even result we have been forecasting in the latter half of the year – the result was a surplus of $50,536. It should be noted that this result is provisional and still subject to finalisation of the inter district flow wash-up, finalisation of Pharmac rebates, finalisation of elective services revenue and finalisation of other national accruals.

SmartHealth

Within the national health line team, 75% have been trained with the use of SmartHealth SOS to give instant access to the virtual out of hours doctor services.

Following engagement with Bupa, a patient group at Eventhorpe residential home connected last week to the SmartHealth out of hours doctor service. The residents at Eventhorpe residential home will now start "virtually" attending outpatient appointments as the clinical services provided by Waikato Hospital are enabled for SmartHealth.

The inpatient trial for Maori patients has been completed. The findings will be worked through with Te Puna Oranga to ensure a culturally appropriate way of engaging and supporting patients.

Work with DHB's Mental Health and Addictions service and with Allied Health and Community services to utilise SmartHealth for outpatient appointments is continuing with the first patients now using SmartHealth.

SmartHealth consultations are now 'business as usual' activity in Renal. This service is also utilising the technology outside outpatient consultations and looking to lead out how virtualisation can support change in clinical services. The Renal service has been a significant reason for the progress we are now seeing in SmartHealth and virtualisation of health care and I would request that the Board formally acknowledges the excellent work they have been doing.

The redirection of patients in ED at Tokoroa into the SmartHealth booth went live on 19 June. We are also working with several community groups in Tokoroa to promote SmartHealth, encouraging them to sign up to the service and utilise the SmartHealth booth. There is a focus on high needs groups in the community and on supplementing current community services.

SmartHealth outpatient service change activity is to commence in Waikato Hospital from August. This will result in approximately 40% of services using SmartHealth to deliver outpatient appointments by the end of the year. The work in Renal has provided the foundation for the successful rollout of the services. One of the services in Waikato Hospital has identified that their outreach staff, once fully virtualised, may vacate several of its current offices. Instead of leasing dedicated office space in the

community they will take advantage of “hot-desk” options from a variety of locations when required.

As part of the ongoing work to create leadership in the use of virtual care the DHB is sponsoring a Virtual Care Symposium on 5 August. This will provide an opportunity for further engagement and discussion with various clinical leaders and patients on moving quickly and safely to virtual care being and for this to become the standard custom and practice in delivering care to patients in New Zealand.

The outline of the day is below.

Attached for the Board’s information is a copy of the virtual health newsletter. This newsletter is produced and distributed monthly to DHB staff and primary care GPs.

Waikato Medical School

Positive publicity from the media continues with regard to Waikato DHB and the University of Waikato’s third medical school proposal. We have also had approaches

from Victoria University and Massey University exploring ways that their respective institutions might work with the proposed medical school.

We await Government's response to this proposal.

Primary and Community Care Workshop

A meeting is being held with local primary and community care parties on 24 August as part of developing a Waikato district primary and community care plan. This meeting is being facilitated by Graham Scott and will be an opportunity to get open dialogue to inform the development of a primary and community care strategy for Waikato DHB.

Board members have been forward the details for this forum should they wish to attend.

Approach to Alliancing

A review has commenced of the current primary care Alliances, of which Waikato DHB is a member, to look for opportunities to improve effectiveness for the Waikato population.

Feedback has been sought on a proposal for Waikato DHB to transform existing arrangements (membership of the Midlands Health Regional Network, Hauraki PHO Alliance, National Hauora Coalition Alliance and the Waikato Inter-alliance Forum) and move to an inclusive Waikato DHB Alliance arrangement focussed on improving the outcomes of the Waikato population.

Alliance partners including PHOs and other DHBs involved with the Midlands Health Regional Network and National Hauora Coalition have been sent the proposal paper with feedback requested in August.

Once feedback has been received a paper will be prepared for Board consideration.

Memorandum of Understanding and Terms of Reference

Board members would have received a diary placeholder, with an official invitation to follow, for the signing of the Memorandum of Understanding with Terms of Reference, between Waikato DHB and Iwi Maori Council. This will take place on Wednesday 27 September 2017 from 11am to 12.30pm, in the Board room, leel 1, Hockin building, Waikato Hospital.

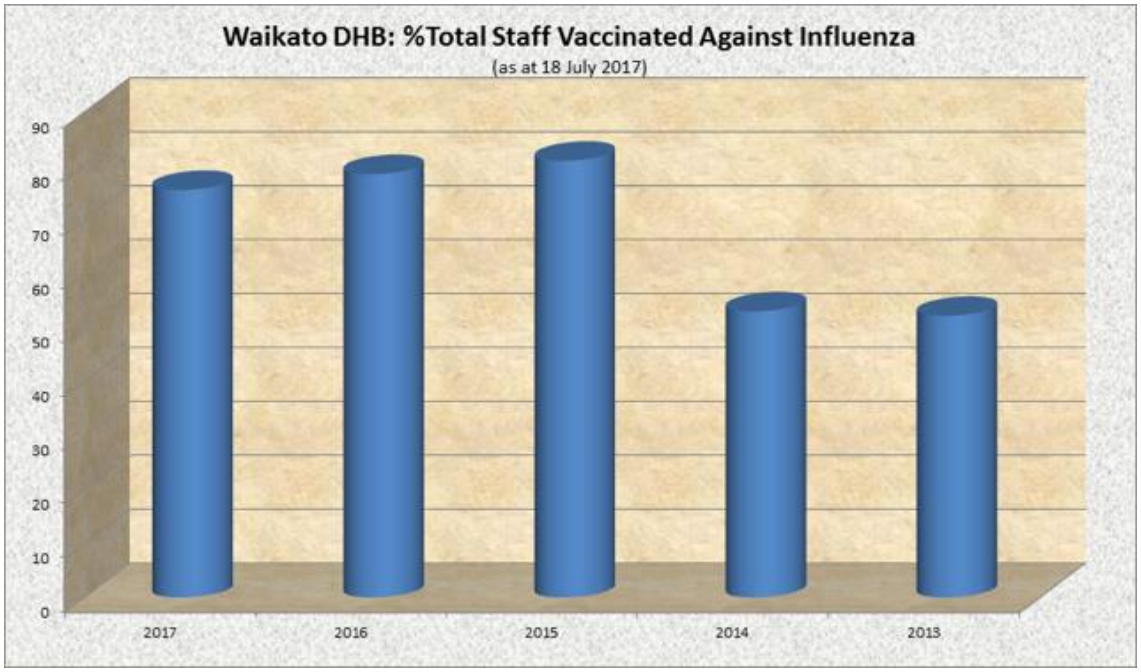
Iwi chairpersons will be present to sign the Memorandum of Understanding, which will also be signed by Waikato DHB's chairman Bob Simcock. It is also likely that Kingi Tuhetia will be in attendance.

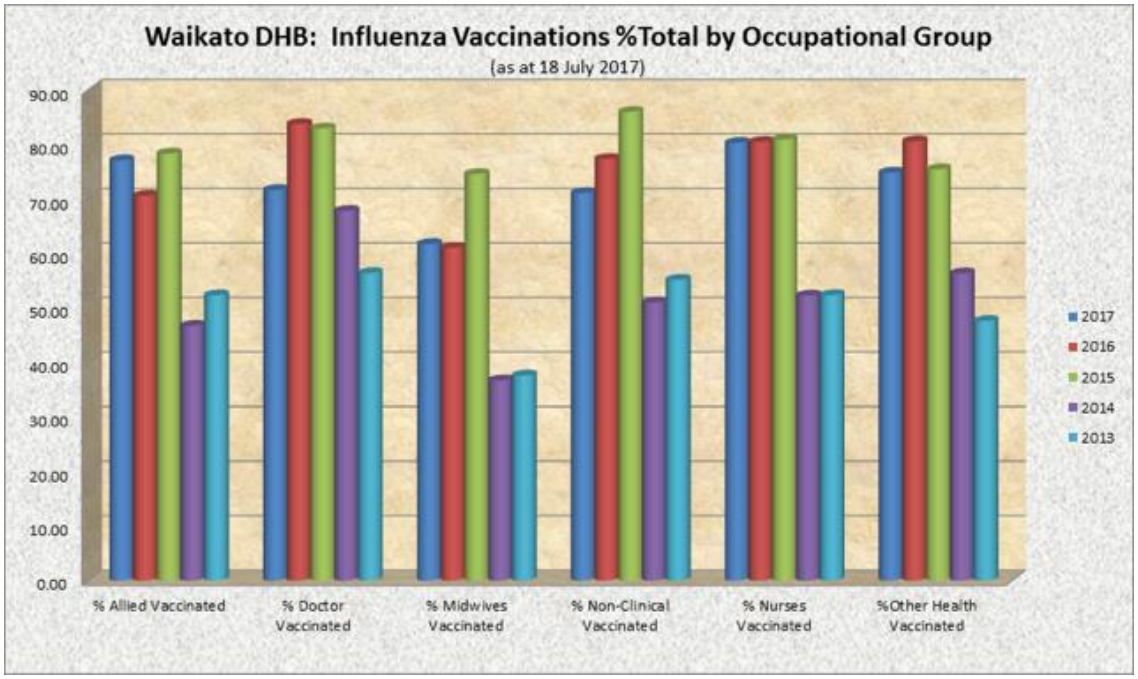
Influenza Vaccination Update

The Waikato DHB's Medical Officer of Health has now declared the start of the flu season. This declaration has triggered the DHB's immunise or mask policy for staff and visitors to the DHB's hospitals. This means that visitors will be asked to help protect sick and vulnerable patients this flu season by making sure they have had the influenza vaccine. Visitors will be asked to wear a mask if they have not been vaccinated.

The best protection for our vulnerable patients and their families is for staff and visitors to get vaccinated, but if they can't, then wearing a mask helps to reduce the risk of transmission of the virus.

The latest staff influenza vaccination statistics (as at 18 July 2017) are shown in the following graphs.





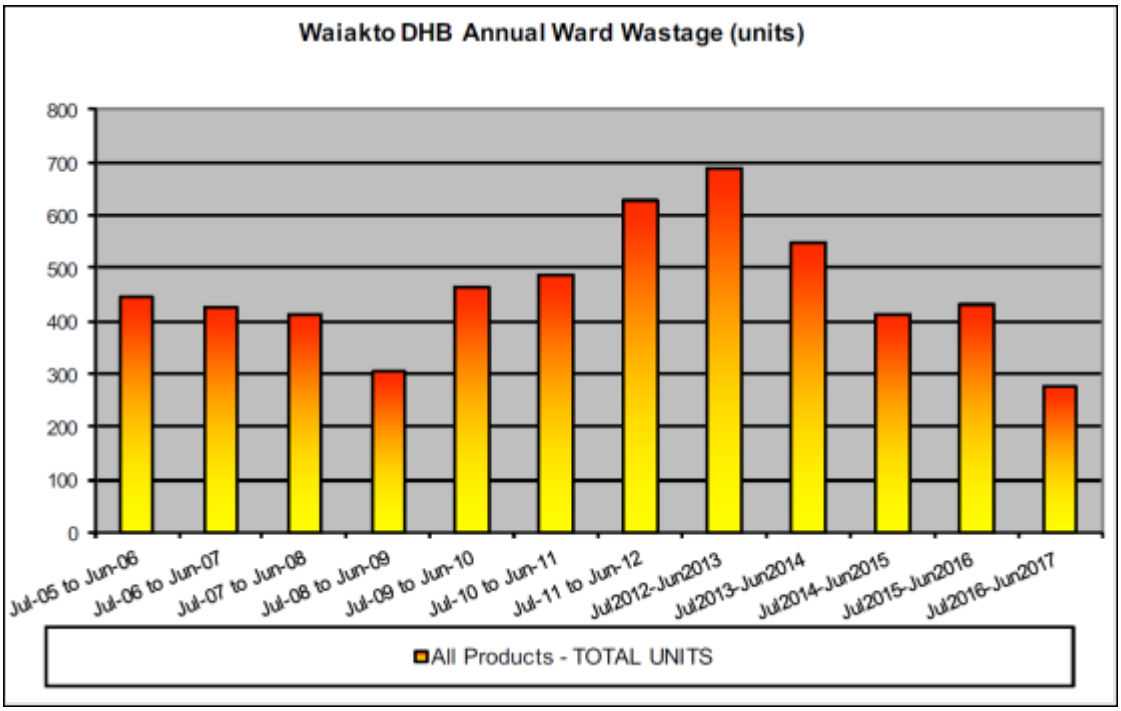
Work to vaccinate greater numbers is still occurring. We would like to at least reach last year's totals.

Blood Products

This year Waikato DHB has wasted fewer blood products than ever before since records began. The reduced wastage is both for red blood and for blood products of all types.

The DHB's Patient Blood Management team, who have led the way in introducing a range of improvements in how we order, store and use blood and blood products are justified in celebrating this success, and how as a whole hospital community we have achieved it together.

The official statistics are:



This improvement is great for patient care; it improves quality, reduces risk, and frees up money for other things that benefit patients. It is a fantastic result and one of which everyone who uses blood and blood products can be justifiably proud.

I wish to acknowledge the great efforts of the Patient Blood Management team and the many clinical staff across the organisation and to also thank Mark Spittal, Executive Director Community and Clinical Support, for his leadership.

Recommendation
THAT
The Board:

1) Receives the report.
2) Acknowledges the work undertaken by the DHB's Renal service with regard to SmartHealth.
3) Acknowledges the work by DHB staff to reduce wastage of blood products.

DR NIGEL MURRAY
CHIEF EXECUTIVE

VHug

Your virtual hug!

Welcome to the July edition of VHug, bringing you the latest news and information in Virtual Health

SmartHealth at the Fieldays

Waikato DHB partnered with local healthcare services at the Fieldays Health Hub at Mystery Creek from 14-17 June.

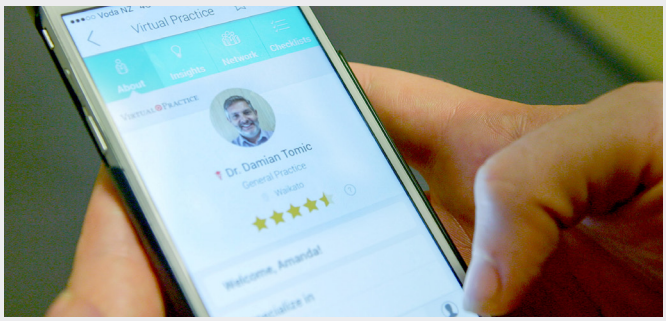
Thousands of people visited the hub, which demonstrated innovative and lifesaving technologies and gave people the opportunity to practice CPR, learn about rural health and wellbeing, and show their support for Waikato Medical School.

Around 180 people signed up for SmartHealth while they were there, and hundreds of pamphlets were handed out. SmartHealth administrator Poppy Taylor-Moore says people were very positive about SmartHealth. "They could see how it would help them access health services without a long trip in to town. It was also a good opportunity for people already using SmartHealth to give us their feedback."

HealthTap sign ups at a glance

2,791 clinicians on board

7,501 patients / consumers



Tips and updates

Clarification on verifying patient ID during sign up

If your patient doesn't have primary ID you can still sign them up to SmartHealth by **viewing their secondary ID and verifying their identity**. To do this, you need to have known the patient for at least 12 months and ensure you sign the associated declaration form during the sign up process, while the patient is on site.

Booking SmartHealth training sessions

Training sessions in the SmartHealth Learning Hub can be arranged as needed by emailing training@waikatodhb.health.nz with your training and learning requests.

SmartHealth highlights the benefits of being mobile

When tropical Cyclone Cook loomed in April 2017, schools and roads were closed and the Coromandel Peninsula was declared to be in a state of emergency. Community mental health nurse Dana Nash hunkered down at home with her family and got to work on her iPad.

Dana knows the critical importance of staying in touch with her patients. Based in Whitianga, her caseload includes home visits with vulnerable people experiencing a range of mental health concerns. Some were feeling suicidal and had a safety plan in place to help keep them safe.

Dana had recently received training and an iPad to get started using SmartHealth. "During the storm I really put it to good use," says Dana. "Because of all the closures, I had to be at home with my family. But I also had people to take care of. I was able to sit on the couch and continue on with my day. I checked in with everyone on my list by phone, talked through all the things we'd usually talk about face to face, and entered patient notes."

"Only a small percentage of my patients have signed up for SmartHealth right now, but I've been leaving SmartHealth brochures behind when I visit and talking to them about it. After Cyclone Cook I told them, if you were signed up, I could have talked to you by video that day and it would have been even better. People just need to understand what it means for them personally."

"As a clinician, SmartHealth gives me options. More importantly, it gives my patients continuity of care. It's about people getting the care they need, when they need it, and I'm right behind it."

Waikato DHB teams up with Healthline to increase access to after hours care

Healthline is supporting the SmartHealth online doctor service to expand the support it offers patients.

Free health advice when you need it
Healthline
0800 611 116
www.healthline.govt.nz

When someone from the Waikato DHB catchment area calls the nurse-led Healthline service for advice on an evening or weekend, and the nurse deems it clinically appropriate, they will be offered the opportunity to talk to a SmartHealth online doctor.

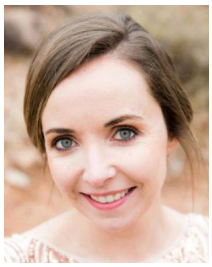
The SmartHealth doctor can provide the patient with self-management advice; prescribe medication in certain situations and fax the prescription to their local pharmacy; advise whether they need to visit a hospital Emergency Department, urgent care clinic or general practice out of hours service; or refer them to their GP the next day.

Patients don't need to already be signed up to SmartHealth to access the online doctor service through Healthline. The Healthline team will text a link to callers who meet the clinical criteria, so they can sign up straight away and speak to a doctor then and there. Healthline has integrated Waikato DHB's clinical criteria for referring patients to online doctor consultation services.

"Healthline is delivered in partnership with DHBs and we are pleased to be able to support this local Waikato initiative to connect appropriate patients with a doctor," says Andrew Slater, CEO of Healthline.

Dr Damian Tomic, Clinical Director of Primary and Integrated Care for Waikato DHB, says "We are really pleased to join forces with Healthline as it improves access for all our Waikato residents to get good medical advice and can hopefully, in some cases, prevent that person attending the hospital Emergency Department unnecessarily."

HealthTap opens Asia-Pacific hub office in Hamilton



HealthTap, the US-based provider of the software that powers SmartHealth, has opened an Asia-Pacific hub office in Hamilton.

General manager Anita Hogan will hire a local team to work in collaboration with US-based HealthTap engineers, designers, and customer success teams.

A local presence will strengthen HealthTap's innovative partnership with Waikato District Health Board and contribute to the ongoing development of SmartHealth, connecting people with the care they need, when they need it

Tokoroa SmartHealth booth trial

A new SmartHealth booth initiative is being trialled in the Tokoroa Hospital Emergency Department, aimed at helping prevent lengthy waits for some patients.

Out of hours patients who do not need a physical examination, tests, or x-rays as part of diagnosis are being given the option of connecting with a SmartHealth online doctor from the booth next to the Emergency Department waiting room. The booth contains all the technology required for a patient to sign up to SmartHealth, if they haven't already, and have an online consultation via video or text.

Within the first few weeks of opening, approximately 20% of patients waiting in the Emergency Department have been suitable and willing to use the SmartHealth booth to talk to an online doctor.

The Tokoroa SmartHealth booth is available to appropriate patients between 6pm to 11pm week days, and 8am to 8pm Saturdays, Sundays and public holidays. The initiative follows the success of the SmartHealth online doctor service in evenings and weekends, which has been running for several months and proven successful with patients needing to connect with a doctor outside of normal health clinic operating hours.

Tokoroa administrator Kyra Creigh-Smith (left) and ED nurse Marlese Weaver in the SmartHealth booth. Both Kyra and Marlese have been outstanding in promoting SmartHealth and supporting appropriate patients to use the booth.

Waikato District Health Board

Quality and Safety

Waikato District Health Board

Decision Reports

MEMORANDUM TO THE BOARD
26 JULY 2017

AGENDA ITEM 6.1

FRAUD POLICY

Purpose	For consideration and approval.

Introduction

The Fraud policy was reviewed by the Audit and Corporate Risk Management Committee (ACRMC) at their last quarterly meeting on 24 May 2017. ACRMC requested the Fraud policy come to the full Board meeting for approval.

ACRMC commented that "Management was asked to satisfy themselves that there is adequate provision in the fraud policy (and other DHB policies) that covers increased clinical risk to patients and staff as a result of a fraud incident."

In response to this, the fraud policy states:

- Managers shall implement all recommendations and preventable actions listed in any fraud investigation report.
- The manager of the department where the fraud occurred shall complete a Datix incident report for any proven case of fraud.

This ensures that the relevant manager is delegate to implement recommendations, which includes working with other relevant departments as appropriate, and logging the incident through the Datix risk management system.

Background (as presented to ACRMC)

The Fraud Policy was substantially reviewed in the last iteration (May 2014), making reference to a December 2013 comparative review of DHB fraud policies undertaken by the Assurance division of the Ministry of Health. Changes included:

1) Clause added to preserve evidence during investigation by requirement of the investigator to obtain and secure all documentary evidence as early as possible.
2) Additions to the responsibility section regarding position specific responsibilities.

This iteration of the Fraud Policy has been updated for the following changes:

1) New policy format.
2) Changes in position titles.

3) Changes in anonymous fraud phone line and email details (to the Health Integrity phone line and crimestoppers website for anonymous written disclosures).
4) Update incident form to Datix incident report in the process flow chart.
5) Policy exclusion added for special circumstances.
6) Define “fraud of a serious nature”.
7) Recognise the ability of a manager with Level 4 delegation or above to determine the Lead Investigator.

Recommendation
THAT
The Board approve the Waikato DHB’s fraud policy.

MAUREEN CHRYSTALL
EXECUTIVE DIRECTOR – CORPORATE SERVICES

Fraud

Policy Responsibilities and Authorisation

Department Responsible for Policy	Finance
Position Responsible for Policy	Director Finance Operations
Document Owner Name	Rowan Cramond
Sponsor Title	Executive Director Corporate Services
Sponsor Name	Maureen Chrystall
Target Audience	All staff
Committee Approved	Policy Committee
Date Approved	
Committee Endorsed	
Date Endorsed	

Disclaimer: This document has been developed by Waikato District Health Board specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Waikato District Health Board assumes no responsibility whatsoever.

Policy Review History

Version	Updated by	Date Updated	Summary of Changes
5	Rowan Cramond	10 March 2017	• New policy format • Changes in position titles • Changes in anonymous fraud phone line and email details • Update incident form to Datix incident report in the process flow chart • Policy exclusion added for special circumstances • Define “fraud of a serious nature” • Recognise the ability of a manager with Level 4 delegation or above to determine the Lead Investigator

Fraud

Contents

1. Introduction

1.1 Purpose

The purpose of the Waikato District Health Board (DHB) Fraud policy is to ensure that all instances of fraud are dealt with appropriately and in an equitable and consistent manner.

1.2 Scope

This policy seeks to facilitate the prevention and detection of fraud as well as outline the appropriate steps to be taken if fraud is detected, thus demonstrating that fraud is not tolerated at Waikato DHB.

The policy applies to the following people:

- Current or former employees of Waikato DHB
- Volunteers of Waikato DHB
- Board members of Waikato DHB
- Individuals seconded to Waikato DHB
- Individuals and organisations acting as agents for, engaged with or contracted to Waikato DHB

If members of the public are involved in defrauding Waikato DHB the principles of this policy outlined in section 2 apply to them.

1.3 Exclusions

This policy excludes any investigative process regarding a member of the Case Management Team or Chief Executive. For a member of the Case Management Team, the manager of the person concerned is to consult with the Chief of Staff and agree any appropriate action and identify the people required to undertake any investigative process. For the Chief Executive, the Chair of the Board or the Chair of the Audit and Corporate Risk Management Committee is to consult with the Chief of Staff and agree any appropriate action and investigative process.

2. Definitions

Fraud	Fraud is any deliberate action or omission designed to deceive so as to derive some direct or indirect personal gain, benefit or advantage. Examples of fraud may include but are not limited to: • Forgery or alteration of cheques, EFTPOS payments, direct credit payments or other documents • Misappropriation or theft of funds, intellectual property, assets or supplies (including any consumable, pharmaceutical or piece of equipment purchased and or owned by the DHB) • Irregularity in the handling or reporting of money • Manipulation of information or documents • Omission or fraudulent treatment of accounting records • Misrepresentation of timesheets and expense claims • Abuse of a conflict of interest • Trading on confidential or inside information • Accepting or granting of a kickback or bribe

	• Involvement in the rigging of a bid or price fixing • Hacking or other security breaches • Information Systems related fraud such as manipulation of data, equipment, programmes, or substituting records • Duplicate billing or attempting to procure payment by sending false invoices as a phantom vendor • Inappropriate use of Waikato DHB assets including motor vehicles • Falsification of employment credentials The above examples are indicative only and may also fall within the coverage of other policies or legislation.
Fraud of serious nature	Consideration of if fraud is of a serious nature includes one or more of the following: • the nature and consequences of the alleged fraud, such as whether a large number of people have been impacted by the alleged offending and if it has had a significant impact on a victim or victims; and/or • the scale of the alleged fraud, including whether the alleged offending is likely to undermine public confidence in the integrity of Waikato DHB; and/or • the factual, financial or legal complexity of the alleged fraud, including whether an investigation is beyond the resources of an HR Consultant or internal resources identified by CMT; and/or • the nature of the public interest in the alleged fraud.
Case Management Team (CMT)	Team consisting of one HealthShare employee and two Waikato DHB employees, being the HealthShare Internal Audit Manager, Property Security Manager and Director of People & Performance or delegate. Others may be seconded as appropriate.
Investigator	Person assigned by the CMT or Manager to lead any formal investigation into cases of suspected fraud. The Investigator can be a member of the CMT.
Internal Audit	Waikato DHB appointed Internal Audit department.
Manager	Refers to a Manager holding a minimum level four delegation

3. Policy Statements

The Waikato DHB policy for fraud is that:

- Fraud is not tolerated at Waikato DHB.
- Any suspected fraud perpetrated against Waikato DHB must be reported.
- All incidents of suspected fraud of a serious nature must be reviewed, and unless there are reasonable grounds not to the suspected fraud must be investigated.
- All incidents of suspected fraud must be reported to the Case Management Team (CMT) as soon as practicable.
- All suspected misconduct by employees relating to fraudulent activity must be managed in accordance with the Waikato DHB Performance Management and Discipline Policy.
- Referral to the police for prosecution and/or dismissal may result.

- All established cases of fraud shall be recorded in the Waikato DHB Fraud Database.
- Waikato DHB will seek recovery of all losses arising from fraud where viable.
- Managers shall include fraud risk assessment and mitigation in their risk management processes.
- The CMT will have an operational oversight of investigations into suspected fraud

4. Policy Processes

4.1 Reporting of fraud

- Fraud is any deliberate action or omission designed to deceive so as to derive some direct or indirect personal gain, benefit or advantage (refer Appendix B1 for examples). A fraud therefore will typically have three elements; intent, deceit and gain.
- In the interests and welfare of the organisation, any person suspecting fraud must report it immediately to one of the following:
    - Level 3 Executive Director
    - Level 4 Director/Manager
    - HealthShare Internal Audit Manager, Property Security Manager or Employee Relations Manager
    - Chief Executive Officer
    - Contact the Ministry of Health – Health Integrity Line (or equivalent) by freephone 0800 424 888 or email anonymously online at www.crimestoppers-nz.org
- An independently operated Health Integrity Line is available as a reporting option for both members of the public or employees. This option allows for greater anonymity of disclosure of suspected fraud.
- The person above receiving the report on suspected fraud must then promptly inform the Case Management Team (CMT). The CMT consists of the HealthShare Internal Audit Manager, Property Security Manager and Director of People and Performance (or nominee).
- Where a person who reports suspected fraud invokes the protection provided by the Protected Disclosures Act 2000, they must be afforded the degree of confidentiality required by section 9 of that Act. (See Waikato DHB Protected Disclosure policy).

4.2 Referral

- The CMT shall discuss all suspected fraud brought to its attention and may separately determine if a formal investigation is to be conducted. An important determinant is if the suspected fraud is of a serious nature which is considered on a case-by-case basis.
- Nothing in the paragraph above shall prevent, a Manager initiating their own investigation. Such investigations will be assisted by Internal Audit, People & Performance directorate, or Property Security Manager as appropriate. CMT must be notified of the formal investigation into suspected fraud to be conducted.
- The CMT or Manager (as appropriate) shall notify the Chief Executive of any investigations of a serious nature that are to be undertaken.
- If an investigation not regarding an employee is to take place, the CMT or Manager will determine if the investigation will be undertaken by internal resources and/or by a relevant external party.
- Any other person may be informed of the suspected fraud at the discretion of the Chief Executive or CMT, such as the Chairperson of the Audit & Risk Management Committee, the Chairperson of the Board, Level 3 Managers or the Manager of the service affected.
- Under the terms of the ACC Partnership Programme, Waikato DHB Health and Safety

must inform ACC of all suspected work-related ACC fraud.

- Depending on the circumstances of the case and in accordance with People & Performance policies, strict confidentiality may be required while investigating any suspected fraud.

4.3 Investigation

- If it is suspected that an employee of Waikato DHB is involved in fraud, the investigation process must comply with the Waikato DHB Performance Management and Discipline Policy.
- Where CMT or Manager decides on an external investigator, the Investigator will agree the terms of reference of the investigation with the CMT or Manager prior to the commencement of the investigation.
- The Investigator's plan for the investigation must include determining the necessary steps for obtaining, securing and safeguarding evidence, the possible prevention of further fraud, the timeframe for the investigation, and the need to ensure process does not compromise any subsequent action taken against perpetrator whether in a criminal or civil jurisdiction.
- The Investigator must obtain and secure all documentary evidence as early as possible in the investigation in order to preserve the evidence.
- The Investigator may recommend to the CMT that external specialists be engaged to assist in the investigation.
- The Investigator will review the relevant systems and procedures and advise on any improvements necessary to prevent recurrence of the fraud or similar acts in the future.
- The Investigator will report the results of the investigation to the Manager and CMT.
- Investigations into external health providers managed by the Strategy and Funding department are conducted by HealthShare Limited and the Audit and Compliance Unit of the Ministry of Health. The results are reported to the Executive Director Strategy and Funding and to the Chief Executive of Waikato DHB.
- Investigations that occur outside the process stipulated above, may be subsequently validated by the CMT or Manager as appropriate.

4.4 Remedial action

- On receiving the results of an investigation carried out under section 3, or after determining that a suspected fraud is not of a serious nature and therefore does not require investigation under section 2, the CMT must determine the appropriate remedial action, if any, to be taken.
- If an investigation has concluded that fraud has taken place, the CMT or Manager must advise the Chief Executive of this.
- If an investigation has concluded that fraud has taken place, the CMT or Manager must (in determining the remedial action to be taken) consult with either the Chief of Staff or Executive Director Corporate Services. Action may include:
  - Dismissal (in the case of an employee)
  - End of contract (in the case of a supplier/contractor/volunteer)
  - Referral to the Police for prosecution unless there are specific mitigating circumstances.
- Where an investigation identifies misconduct relating to fraudulent activity of a current employee, the offender will be managed in accordance with the Waikato DHB Performance Management and Discipline policy.
- Recovery of all losses will be sought if financially viable.
- All proven incidents of fraud and the remedial action taken must be recorded by Internal

Audit on their Fraud Database. The Fraud Database is a requirement of a statement from the Auditor General "AG-206: Auditor-General's Statement of the Auditor's Responsibility to Consider Fraud in an Audit of a Financial Report" which stipulates that the database must contain information of the fraud including the nature of the fraud, the name and position of the person involved and the estimated dollar value of the fraud.

- The Audit & Corporate Risk Management Committee and the external auditor for Waikato DHB will be informed via written report prepared by Internal Audit, in the Audit Committee agenda, of all proven instances of fraud and the remedial action taken in each case as recorded on the Fraud Database.
- The Audit & Corporate Risk Management Committee will recommend to the Board if the matter is to be referred to the Serious Fraud Office.
- An employment reference shall not be provided by Waikato DHB to any employee dismissed for fraud. It is noted that an employment reference is different from a statement of service.

4.5 Responsibilities

- Managers are to have fraud risk assessment and mitigation in their risk management processes. This can include ensuring segregation of duties in processes (e.g. ensuring that staff responsible for the custodianship of assets are not also responsible for the record keeping) and providing fraud awareness training for staff.
- Managers are to ensure due diligence assessments are undertaken prior to entering into high risk, high value or complex procurement contracts with third party providers in accordance with the Procurement and Contracts Policy.
- Managers are to ensure employees provide verified copies of any qualifications and certification essential to the position in accordance with the Recruitment and Selection Policy.
- Recruitment coordinators are responsible for ensuring Police vetting or Ministry of Justice criminal conviction checks are completed (as applicable to the position) for new employees in accordance with the Recruitment and Selection Policy..
- The Executive Director Public Affairs is responsible for all external statements to the media regarding fraud.
- Managers shall implement all recommendations and preventable actions listed in any fraud investigation report.
- The manager of the department where the fraud occurred shall complete a Datix incident report for any proven case of fraud.
- Internal Audit is responsible for maintaining a fraud database.
- Internal Audit is responsible for evaluating the design and operating effectiveness of fraud controls.
- Internal Audit is responsible for reporting to the Audit & Corporate Risk Management Committee on internal control and fraud risk assessments, audits and fraud investigations.

4.6 Fraud process flow chart

In the interests and welfare of the organisation, any person suspecting fraud must report it immediately to one of the following:
- Level 3 Manager (Direct report to the Chief Executive)
- Level 4 Manager (Direct reports to Level 3 Manager)
- Internal Audit Manager, Property Security Manager or Director of People and Performance
- Chief Executive Officer
- Fraud Hotline.

↓

The person receiving the information about a suspected fraud must promptly report the suspected fraud to a member of the CMT or Manager .

↓

Where necessary the CMT or Manager will determine an Investigator to investigate the suspected fraud and inform any person as deemed necessary of the suspected fraud.

↓

The Investigator investigates the suspected fraud and reports the findings to the CMT and Manager as appropriate

↓

Proven incidents of fraud are:
- Recorded on the Internal Audit Fraud Database
- Reported to the Audit & Corporate Risk Management Committee and Waikato DHB external auditors
- Documented in a Datix Incident Report by the appropriate Manager
- Subject to remedial action. Action may include dismissal and referral to the Police for prosecution unless there are specific mitigating circumstances

5. Audit

5.1 Success Indicators

- All episodes of reported suspected fraud of a serious nature shall be investigated.
- All proven cases of fraud shall be entered on the Fraud Database.
- Managers shall include fraud risk assessment and mitigation in their risk management processes.

6. Legislative Requirements

6.1 Legislation

Waikato DHB must comply with the following legislation (this list is not exclusive):

- Employment Relations Act 2000
- Securities Act 1978
- Secret Commissions Act 1910
- New Zealand Bill of Rights Act 1990
- Fair Trading Act 1986
- Crimes Act 1961

7. Associated Documents

- Waikato DHB Incident Management Policy (0104)
- Waikato DHB Procurement & Contracts Policy (0170)
- Waikato DHB Receiving and Giving of Gifts Policy (1829)
- Waikato DHB Financial Accounting Policy (1813)
- Waikato DHB Performance Management and Discipline Policy (5250)
- Waikato DHB Conflict of Interest Policy (0006)
- Waikato DHB Information Security Policy (3153)
- Waikato DHB Protected Disclosure (Whistleblower) Policy (5151)
- Waikato DHB Risk Management Policy (0118)
- Waikato DHB Surveillance Policy (0124)
- Waikato DHB Media and Communications Policy (1816)
- Waikato DHB Treasury Management Policy (0042)
- Waikato DHB Delegations of Authority Policy (2175)
- Waikato DHB Recruitment and Selection Policy (0021)
- Waikato DHB Medication Security Procedure (0003)
- AG-206: Auditor-General's Statement of the Auditor's Responsibility to Consider Fraud in an Audit of a Financial Report

Waikato District Health Board

Finance Monitoring

MEMORANDUM TO THE BOARD
26 JULY 2017

AGENDA ITEM 7.1

FINANCE REPORT

Purpose	For information.

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

Recommendation
THAT
The report be received.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Result for June 2017	Year to Date			Group Budget
	Actual $m	Group Budget $m	Variance $m	Jun-17 $m
Funder	35.4	42.9	(7.5) U	42.9
Governance	(0.4)	(0.3)	(0.1) U	(0.3)
Provider	(35.7)	(38.1)	2.4 F	(38.1)
Waikato Health Trust	0.7	0.1	0.6 F	0.1
DHB Surplus/(Deficit)	**(0.0)**	**4.6**	**(4.6) U**	**4.6**
Note: $ F = favourable variance; ($) U = unfavourable variance				

FINANCIAL PERFORMANCE MONTHLY COMMENT:

This report includes commentary on current year to date performance for the Waikato DHB Group compared to the budget for the year. In June 2017 the result for the Waikato Health Trust has been consolidated with Waikato DHB to provide a group view. The actual result was a surplus of $50,536.

For June 2017 YTD we are unfavourable to budget by $4.6m. Unfavourable variance arises mainly from higher outsourced elective costs, nursing personnel annual leave costs and outsourced personnel costs.

Provider:

The Provider is favourable to budget for June 2017, variances include:

1. Revenue favourable to budget $12.9m mainly as a result of favourable IDF In and Sector Services revenue and unbudgeted NOS reimbursement. This offset by lower revenue as a result of under delivery of mainly orthopaedic volumes.
2. Employed personnel costs unfavourable to budget $1.7m, the dominant negative variance being within nursing.
3. Outsourced Personnel costs unfavourable to budget $12.3m, the dominant variances relate to medical locums ($6.5m), Nursing ($1.4m) and admin/management contractors for the National Oracle Solution (NOS) project ($3.8m) which has an offset in Other Revenue of ($3.8m).
4. Outsourced Services unfavourable to budget $6.1m mainly due to higher outsourcing of electives.
5. Clinical supplies favourable to budget $1.0m.
6. Infrastructure & Non Clinical supplies are unfavourable to budget $1.9m.
7. Interest, depreciation and capital charge favourable to budget $10.5m mainly due to decrease in capital charge rate, reduction in interest charge after debt/equity swap and favourable depreciation cost.

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

- Acute cases, excluding ED: episodes 3.8% above plan; case-weights 8.3% above plan
- Elective cases: episodes 11.0% below plan; case-weights 18.5% below plan
- Overall 0.3% below plan for cases and 0.2% below plan for case-weights
- ED attends: YTD ED attends are 4.1% higher than the same period last year.

Funder and Governance:

The result for the Funder is unfavourable to budget mainly due to unfavourable revenue variances arising from reduction in funding for reduced capital charge, debt/equity swap and IDF in . Governance is close to budget.

Waikato Health Trust

The result for the Waikato Health Trust is favourable to budget mainly due to favourable revenue variances arising from increased donated funds.

RECOMMENDATION(S):

That this report for the year ended June 2017 be received.

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD

YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$2.1 F**	
CFA Revenue		
Unfavourable to budget mainly due to: ● Reduction in revenue received relating to the change in rate for the capital charge $3.4m. This reduction is offset by a reduction in capital charge paid. ● In between travel wash up relating to 2016/17 $1.2m (offset by reduced cost in External Provider payments) and to 2015/16 $0.4m. ● Reduction in revenue as a result of debt to equity conversion $3.0m (offset in reduction of interest payable). Offset by favourable variances relating to: ● 15/16 elective surgery wash-up $1.5m received, ● additional funding received which is offset by cost in External Provider Payments: Palliative Care $0.8m Rheumatic fever $0.2m ● PHO Care Plus wash-up & VLCA $1.1m, ● Non exchange revenue year end accrual $1.2m higher than prior year due mainly to new Healthy Homes contract ● Other favourable variances $0.8m.	($2.4) U	N/A
Crown Side-Arm Revenue		
Side-arm contracts revenue favourable due mainly to: ● Funds received for the 2015/16 Colonoscopy project $0.3m ● A contract variation on the main Public health contract $0.1m (offset by costs) ● Breast screening running ahead of contract volumes $0.2m ● Gynae colps catch up on contract volumes $0.2m (offset by costs)	$0.8 F	N/A
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is $1.9m favourable mainly due to: ● Reimbursement of costs associated with the implementation of NOS $3.8m favourable (offset in Outsourced Personnel), ● Catch up invoicing for outreach clinics at Bay of Plenty and Lakes DHBs $0.4m, ● Catch up invoicing to HWNZ $0.6m. ● Other favourable variances including haemophilia $0.9m. Offset by: ● ACC unfavourable $0.9m due to non acute rehab contract running lower than planned due to less discharges and the focus on Elective Service Performance Indicators meaning the elective surgical treatments contract patients are being delayed. ● Inter District Flows (IDF) in which is $2.9m unfavourable due to reduced IDF inflow when compared with Ministry of Health budget file.	$1.9 F	N/A

<table>
<tr><th>The Waikato DHB YTD Variance resulted from:</th><th>Variance
$m</th><th>Impact on forecast</th></tr>
<tr><td colspan="3">Other Revenue</td></tr>
<tr><td>Other revenue is favourable primarily due to:
● Higher sales in the Café than expected $0.8m
● Favourable revenue washup from Urology Services Limited relating to 2015/16 of $0.2m
● Higher than budgeted interest received of $0.4m as funds held with NZHPL throughout the year were higher than budgeted
● Waikato Health Trust revenue favourable to budget $0.5m as the Trust budget is based on conservative estimates.</td><td>$1.8 F</td><td>N/A</td></tr>
<tr><td>Operating expenditure including IDCC</td><td>($6.7) U</td><td></td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Personnel (employees and outsourced personnel total)</td><td>($14.1) U</td><td></td></tr>
<tr><td>Employed personnel are unfavourable to budget mainly due to:
● Medical costs are favourable by $3.9m.
<u>Senior Medical Officers (SMO's):</u>
SMO costs are $4.4m favourable mainly due to:
- paid FTE costs favourable $5.6m arising from vacancies, favourable course and conference costs which is as a result of reduced accrual for CME costs following SMO resignations $0.8m and CME rate revaluation $2m,
- annual leave movement $1.0m unfavourable due to less leave earned offset by less leave taken,
- professional membership fees $0.2m unfavourable.

<u>Resident Medical Officers (RMO's)</u>
RMO costs are $0.5m unfavourable due to vacancies offset by annual leave taken running lower than budgeted.

The net direct financial YTD impact of the RMO strikes on personnel costs is currently:
<table><tr><th></th><th><u>October 2016</u></th><th><u>January 2017</u></th></tr><tr><td>SMO claims cover RMO shifts</td><td>$0.3m</td><td>$0.5m</td></tr><tr><td>Savings on payments to RMO's</td><td>$0.1m</td><td>$0.2m</td></tr><tr><td>Net impact</td><td>$0.2m</td><td>$0.3m</td></tr></table>
The far greater cost of the strikes is the impact on volume delivery.
● Nursing costs are unfavourable to budget by $5.7m. Paid FTE cost is $0.8m unfavourable due to budgeted vacancy savings not being achieved. In addition to this the annual leave movement is running $5.5m unfavourable. Course conference fees and payment on return from maternity leave are running favourable by $0.6m.
● Allied Health costs are $0.5m unfavourable to budget mainly due to:
- base costs are $1.0m favourable due to vacancies
- this is offset by unfavourable overtime $0.5m, penals $0.2m and allowances $0.2m.
- In addition annual leave taken unfavourable to budget $0.5m.
● Other favourable variances, largely in Management, Administration and Support $0.5m.</td><td>($1.7) U</td><td>N/A</td></tr>
</table>

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced personnel are unfavourable mainly due to:		
● Higher than planned use of locums within medical personnel to cover vacancies $6.5m, ● Nursing is $1.4m unfavourable due to external agency costs to fill roster gaps and watches.	($7.9) U	N/A
● Higher than planned use of contractors in management/admin $4.5m primarily due to contractors working on the NOS implementation. Costs recovered in Other Government Revenue - $3.8m. The remaining $0.7m unfavourable variance is spread over a number of areas.	($4.5) U	N/A
Outsourced services	**($6.1) U**	
Outsourced services are unfavourable primarily due to: ● Outsourced clinical service costs are unfavourable to budget $9.2m due to higher than planned outsourcing of electives and unmet savings. ● Off set by outsourced corporate services $1.9m favourable primarily due to reduced spend on Clinical Work Station - budget set on business case but expected spend has been revised and is lower due to reduced costs over the first months of the year. In addition the actual calculation of Health Share Limited (HSL) operating costs has come in lower than budget. ● Smart Health outsourced services are favourable $1.2m as costs have been charged to Infrastructure (offset in infrastructure and non-clinical supplies)	($6.1) U	N/A
Clinical Supplies	**$1.0 F**	
Instruments & equipment are $0.4m favourable primarily due to favourable service contract costs.	$0.4 F	N/A
Implants & prosthesis are $2.9m 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.	$2.9 F	N/A
Treatment disposables unfavourable due to savings allocation of $4.5m offset by favourable variances across a range of areas such as dressings, staples, tubes/drainage/suction, IV fluids and rebates.	($2.1) U	N/A
Pharmaceuticals $0.1m favourable primarily due to: ● The favourable Hospital Pharmacy rebate $2.6m offset by: ● Drug costs running higher than budgeted $2.5m - this mainly being cytotoxic drugs in part due to the newly approved melanoma treatment.	$0.1 F	N/A
Diagnostic Supplies & Other Clinical Supplies - close to budget.	($0.3) U	N/A

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Infrastructure and non-clinical supplies	**($1.9) U**	
Infrastructure and non-clinical supplies are $1.9m unfavourable primarily due to: ● IT costs $1.0m favourable due to favourable variances for mobile phones and software maintenance charges. The movement from an unfavourable April YTD variance to favourable in June is as a result of capitalisation of pooled assets largely in the virtual health area. ● Facilities favourable variance of $1.8m due to deferred start of maintenance programme and Hilda Ross House demolition ● Hotel services costs are $0.8m favourable due to cleaning and laundry costs running lower than budgeted. Offset by: ● Savings allocation unfavourable by $1.8m, ● IT costs associated with Smart Health programme unfavourable $1.2m - the budget for this spend is in outsourced services (offset in Outsourced Services) ● Cost of Goods Sold (COGS) is $2.4m 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 ($2.4m),	($1.9) U	N/A
NGO Payments	**$3.9 F**	
IDF out unfavourable by $1.9m due to increased outflow to Counties Manukau DHB due to timing of a GP practice PHO change not aligning with budget assumption. In addition, two high cost patients who have gone to Counties Manukau for treatment.	($1.9) U	N/A
External Provider payments are favourable largely due to: ● A revised PHARMAC forecast $4.5m favourable. However this is offset in clinical supplies (Pharmaceutical costs - oncology drugs $0.9m) and Infrastructure costs (Retail Pharmacy COGS $2.4m), ● PHO Quality Indicator pool - prior year over accrual $0.6m, ● Dental FSS volumes favourable to budget $1.0m, ● Reduction in costs for in between travel (offset by reduced revenue) $1.1m, ● Post acute convalescent care $0.6m favourable as the cost is being reflected in Outsourced Services ($0.2m), Offset by ● Other unfavourable variances arising mainly from: - Unbudgeted increase in non exchange expense accrual $2m as a result of Project Energise - Additional costs relating to additional funding (Healthy Homes Initiative, Palliative Care, Rheumatic Fever), offset by favourable variances across MH, DSS FFS, Urology and residential care.	$5.8 F	N/A
Interest, depreciation and capital charge	**$10.5 F**	
Interest charge favourable mainly due to interest costs on the Ministry of Health loan ceasing after the debt equity swap in March. Largely offset in CFA Revenue.	$3.3 F	N/A
Capital charge is favourable to budget as a result of the reduction in the rate from 8% to 6%. Offset in CFA revenue.	$3.3 F	N/A
Non Cash Depreciation favourable mainly due to: ● Timing of capitalisation of IS projects and slower than expected spend on Clinical Equipment.	$3.9 F	N/A

TREASURY

Opinion on Result:	
Cash flows are favourable to budget	N/A

YTD Actuals Jun-16 $'000	Waikato DHB Cash flows for year to June 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				
1,298,369	Operating inflows	1,348,419	1,355,380	(6,961)	1,355,380
(1,267,391)	Operating outflows	(1,306,852)	(1,296,258)	(10,594)	(1,296,258)
30,978	**Net cash from operating activities**	**41,567**	**59,122**	**(17,555)**	**59,122**
	Cash flow from investing activities				
1,817	Interest income and proceeds on disposal of assets	1,839	1,405	434	1,405
(11,083)	Purchase of assets	(32,212)	(68,004)	35,792	(68,004)
(9,266)	**Net cash from investing activities**	**(30,372)**	**(66,599)**	**36,227**	**(66,599)**
	Cash flow from financing activities				
0	Equity repayment	(2,193)	(2,194)	1	(2,194)
(11,610)	Interest Paid	(6,810)	(8,644)	1,834	(8,644)
(300)	Net change in loans	6,531	5,417	1,114	5,417
(11,909)	**Net cash from financing activities**	**(2,473)**	**(5,421)**	**2,948**	**(5,421)**
9,803	**Net increase/**(decrease) in cash	**8,721**	**(12,898)**	**21,620**	**(12,898)**
(8,948)	Opening cash balance	856	856	(0)	856
856	**Closing cash balance**	**9,577**	**(12,042)**	**21,620**	**(12,042)**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($17.6) U**	
• **Operating inflows**	**($7.0) U**	
Revenue received unfavourable primarily as a result of: - Revenue reduction relating to the change in rate for the capital charge $3.4m, - Reduction in CFA revenue relating to the debt equity swap $3m, - Interdistrict flows unfavourable by $2.9, - ACC revenue unfavourable $0.9m, - Reduction in revenue relating to the unfavourable washup of In Between Travel $1.6m, - Increase in accrued debtors $8.5m arising mainly from a higher than budgeted balance owing by MoH $8m. Unfavourable inflow offset by: - Prior year elective funding washup received $1.5m, - Additional care and other initiatives funding $4.1m, - Reimbursement of costs associated with the implementation of NOS $3.8m, - Crown side arm revenue favourable $0.8m, - Catch up Invoicing $1.0m - Other favourable variances $2.1m as a result off timing of receipts not corresponding with budget assumptions.	($7.0) U	N/A

Cash flow variances resulted from:	Variance $m	Impact on forecast
• **Operating outflows**	**($10.6) U**	
○ Personnel cost variances are favourable against budget due to the timing of fortnightly pay runs.	$2.3 F	N/A
○ Operating cash outflows for non-payroll costs are unfavourable as a result of: - Higher prepayments than budgeted $9.7m primarily as a result of timing of payments for IS related costs, - The remaining unfavourable variance includes unfavourable P&L expenditure variances together with differences between timing of budgeted and actual payments.	($14.1) U	N/A
○ GST cash movement is favourable due to timing variances on GST transacted.	$1.2 F	N/A
Net cash flow from Investing Activities	**$36.2 F**	
○ Interest received is favourable due to slightly higher than expected funds with NZHPL.	$0.4 F	N/A
○ Capital spend is slower than planned for the year to June - refer to capital expenditure report for further details.	$35.8 F	N/A
Net cash flow from Financing Activities	**$2.9 F**	
○ Cash flow from financing activities is favourable mainly due to interest no longer being payable on the long term loan as a result of the debt equity swap.	$2.9 F	N/A

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 30-Jun-17	Jun-17 Actual	Jul-17 Forecast	Aug-17 Forecast	Sep-17 Forecast	Oct-17 Forecast	Nov-17 Forecast	Dec-17 Forecast	Jan-18 Forecast	Feb-18 Forecast	Mar-18 Forecast	Apr-18 Forecast	May-18 Forecast	Jun-18 Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	3,358	5,240	4,564	4,228	4,448	4,452	4,116	4,340	4,116	4,340	4,116	4,564	4,228
Funder inflow (MoH, IDF, etc)	128,866	124,542	124,523	126,378	123,052	127,766	130,576	125,896	125,896	130,011	125,331	125,331	130,011
Donations and Bequests	0	0	0	0	0	0	0	0	115	0	0	0	0
Other Income (excluding interest)	2,720	2,415	2,645	2,415	2,530	2,530	2,400	2,415	2,070	2,415	2,185	2,645	2,300
Rents, ACC, & Sector Services	3,441	2,971	3,112	2,375	2,608	2,695	2,584	2,592	2,504	2,681	2,514	2,761	2,651
	138,385	135,168	134,844	135,396	132,639	137,443	139,676	135,243	134,701	139,447	134,146	135,301	139,189
Cash was applied to:													
Personnel Costs (incl PAYE)	(43,517)	(42,034)	(51,461)	(45,868)	(41,974)	(49,832)	(42,064)	(51,243)	(45,808)	(42,094)	(41,974)	(47,452)	(43,944)
Other Operating Costs	(35,917)	(34,760)	(34,200)	(34,900)	(33,900)	(34,100)	(27,160)	(28,300)	(28,100)	(35,700)	(30,700)	(30,000)	(31,600)
Funder outflow	(50,295)	(47,122)	(47,792)	(50,843)	(47,354)	(47,457)	(46,452)	(47,122)	(46,452)	(50,843)	(46,684)	(47,726)	(46,787)
Interest and Finance Costs	(7)	(6)	(6)	(31)	(31)	(31)	(31)	(31)	(31)	(31)	(31)	(31)	(31)
Capital Charge	(7,073)	0	0	0	0	0	(7,073)	0	0	0	0	0	(15,721)
GST Payments	(6,370)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(14,420)	(9,000)	(7,210)	0	(13,710)	(7,210)
	(143,179)	(131,132)	(140,668)	(138,852)	(130,469)	(138,630)	(122,780)	(141,116)	(129,391)	(135,878)	(119,389)	(138,919)	(145,292)
OPERATING ACTIVITES	**(4,795)**	**4,036**	**(5,824)**	**(3,455)**	**2,170**	**(1,187)**	**16,896**	**(5,873)**	**5,310**	**3,569**	**14,757**	**(3,618)**	**(6,103)**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	152	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
	152	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(6,309)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)
Investment in NZHPL (Finance project)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(6,309)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)
INVESTING ACTIVITIES	**(6,156)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**	**(3,425)**
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from NZHPL	134,119	0	9,275	6,880	1,255	4,638	0	9,298	0	0	0	7,069	9,528
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
	134,119	0	9,275	6,880	1,255	4,638	0	9,298	0	0	0	7,069	9,528
Cash was applied to:													
Capital Repayment	(2,194)	0	0	0	0	0	0	0	0	0	0	0	0
Transfer to NZHPL	(120,973)	(611)	0	0	0	0	(13,471)	0	(1,859)	(144)	(11,332)	0	0
MoH loan repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	(123,168)	(611)	(26)	0	0	(26)	(13,471)	0	(1,885)	(144)	(11,332)	(26)	0
FINANCING ACTIVITIES	10,951	(611)	9,249	6,880	1,255	4,612	(13,471)	9,298	(1,885)	(144)	(11,332)	7,043	9,528
Opening cash balance	0	0	0	0	(0)	(0)	(0)	0	0	0	0	0	0
Overall increase/(decrease) in cash	0	0	(0)	(0)	(0)	(0)	0	(0)	(0)	0	0	(0)	(0)
CLOSING CASH BALANCE	0	0	0	(0)	(0)	(0)	0	0	0	0	0	0	0
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	(0)	(0)	(0)	0	0	0	0	0	0	0
Funder Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Investment funds/(loan)													
NZ Health Partnerships Ltd (NZHPL)	2,503	3,114	(6,161)	(13,041)	(14,296)	(18,935)	(5,464)	(14,761)	(12,903)	(12,759)	(1,426)	(8,495)	(18,023)
Long-term Loans													
Ministry of Health	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA Loan	(273)	(273)	(247)	(247)	(247)	(221)	(221)	(221)	(195)	(195)	(195)	(169)	(169)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	2,231	2,842	(6,407)	(13,288)	(14,543)	(19,156)	(5,684)	(14,982)	(13,097)	(12,953)	(1,621)	(8,664)	(18,192)
LOANS AVAILABLE													
MoH loans	0	0	0	0	0	0	0	0	0	0	0	0	0
Working capital facility (NZHPL)	(64,367)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(64,367)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)

BALANCE SHEET

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

Prior Year Jun-16 $'000	Waikato DHB Financial Position	As at June 2017 Actual $'000	Budget $'000	Variance $'000	Budget Jun-17 $'000
49,321	Total current assets	81,105	54,608	26,497 F	54,608
(154,967)	Total current liabilities	(176,252)	(176,878)	626 F	(176,878)
(105,647)	**Net working capital**	**(95,147)**	**(122,270)**	**27,123 F**	**(122,270)**
568,417	Term assets	737,316	592,997	144,319 F	592,997
(227,011)	Term liabilities	(21,053)	(232,312)	211,259 F	(232,312)
341,406	**Net term assets**	**716,264**	**360,685**	**355,579 F**	**360,685**
235,759	**Net assets employed**	**621,117**	**238,415**	**382,702 F**	**238,415**
235,759	**Total Equity**	**621,117**	**238,415**	**382,702 F**	**238,415**

Prior Year Jun-16 $'000	Waikato DHB Ratios	As at June 2017 Actual $'000	Budget $'000	Achieved	Trend	Budget Jun-17 $'000
54,491	Borrowing facilities available at month end	64,198	46,394	✓	⇧	46,394
0.9	Debt to Equity ratio	0.0	1.0	✓	⇩	1.0
0.5	Debt to Debt + Equity	0.2	0.6	✓	⇩	0.6
0.3	Current ratio	0.5	0.3	✓	⇔	0.3
38.2%	Equity to total assets	75.9%	36.8%	✓	⇧	36.8%
1.5%	Return on equity	0.0%	-1.8%	✓	⇧	-1.8%
5.62	Interest covered ratio	9.39	5.86	✓	⇧	5.86

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital		
Net working capital is favourable against budget mainly due to: Current Assets: - Cash held with New Zealand Health Partnerships Limited is higher than planned by $2.5m, mainly due to lower than budgeted capital spend, - Prepayments are higher than planned by $9.7m mainly due to the timing of annual IS spend, which includes $2.6m for e-Space and $3.4 for Smart Health, and $3.4 funding received from MoH relating to Pay Equity wage increases effective 1 July. - Unbudgeted accrual of Non Exchange Revenue at year end $3.5m - Total accounts receivable and accrued debtors is higher than planned by $9.0m largely due to the timing of cash received compared to budget assumptions. - Other favourable variances $1.8m	**$26.5 F**	N/A

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital (continued)		
Current Liabilities: - Payroll liabilities are $5.3m unfavourable to budget mainly due to the timing of pay runs and IRD payments resulting in higher month end accruals, - Unbudgeted Non Exchange expense accrual at year end $3.6m, - Income in Advance $3.7m higher that budgeted mainly due to pay equity settlement funds received, - GST $1.2m higher that budgeted partly due to Income in Advance being higher, - Other Current Liabilities are $3.4m unfavourable, which includes an unbudgeted $2m accrual for e-Space, - Bank overdraft liability $17.8m favourable to budget as bank was not overdrawn. Budgeted overdraft based on high capital spend which has not eventuated.	**$0.6 F**	N/A
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $35.8m and favourable YTD depreciation $3.9m. Revaluation of assets $176.2m. Please see attached for latest forecast of capital spend for the year for further detail.	**$144.3 F**	N/A
Non Current Liabilities:		
Favourable variance mainly due to the unbudgeted Debt to Equity swap for MOH loans which was transacted in February 2017.	**$211.3 F**	N/A
Equity		
Variance mainly due to : - Debt to Equity swap for MOH loans transacted February 2017 - $211.6m - Unfavourable variance in overall result against budget $4.6m - Revaluation of Assets $176.2m.	**$382.7 F**	N/A
The MoH debt to equity swap also resulted in the movement in financial ratios relating to return on equity and equity to total assets: Equity to Total Assets: Budgeted 36.8%, Actual 75.9% Return on Equity: Budgeted -1.8%, Actual 0.0%		N/A

CAPITAL EXPENDITURE AT 30 JUNE 2017 ($000s)

Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Jun-17 (M)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
	CAPITAL PLANS				CASHFLOW FORECAST				FULL PROJECT FORECAST	
Total Under $50K Projects:	**2,300**		-	**2,300**	-	**2,930**	**2,930**		**2,930**	**-630**
CLINICAL EQUIPMENT				-						
Supra laser - Opthalmology	-	170	-58	112	-	-	-	112	112	0
SUB TOTAL CLINICAL	**13,769**	**27,393**	**1,402**	**42,564**	**519**	**9,912**	**9,912**	**30,067**	**40,499**	**2,065**
INFORMATION SYSTEMS										
SUB TOTAL INFORMATION SYSTEMS	**30,128**	**38,568**	**2,316**	**71,012**	**6,775**	**11,040**	**11,040**	**51,617**	**69,432**	**1,580**
PROPERTY & INFRASTRUCTURE - PLANT										
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	**1,493**	**4,601**	**-**	**6,094**	**1,180**	**955**	**955**	**3,958**	**6,093**	**1**
PROPERTY PROJECT SERVICES										0
SUB TOTAL PROPERTY PROJECT SERVICES	**21,188**	**8,370**	**-175**	**32,184**	**12,803**	**5,242**	**5,242**	**14,009**	**32,054**	**130**
VEHICLES										0
SUB TOTAL VEHICLES	**950**	**700**	**47**	**1,697**	**235**	**3**	**3**	**1,450**	**1,688**	**9**
STRATEGIC PROJECT OFFICE										0
SUB TOTAL STRATEGIC PROJECTS	**25,077**	**60,992**	**0**	**86,069**	**0**	**124**	**124**	**85,833**	**85,957**	**112**
CORPORATE										0
SUB TOTAL CORPORATE PROJECTS	**8,000**	**800**	**-791**	**8,009**	**1**	**1,990**	**1,990**	**6,079**	**8,069**	**-60**
MOH Projects (funded externally)						-				
SUB TOTAL MOH PROJECTS	**426**	**42**	**-**	**468**	**197**	**231**	**231**	**40**	**469**	**-1**
Trust Funded Projects (funded externally)						-				0
SUB TOTAL TRUST FUNDED PROJECTS	**-**		**797**	797	**333**	**464**	**464**	**-**	797	**0**
TOTAL CAPITAL EXPENDITURE	**103,332**	**141,466**	**3,596**	**251,194**	**22,044**	**32,891**	**32,891**	**193,053**	**247,988**	**3,206**
REPORT TOTALS	**103,332**	**141,466**	**3,596**	**251,194**	**22,044**	**32,891**	**32,891**	**193,053**	**247,988**	**3,206**

CAPITAL EXPENDITURE AT 30 JUNE 2017 ($000s)

	CAPITAL PLANS				CASHFLOW FORECAST				FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Jun-17 (M)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
Total Under $50K Projects:	**2,300**		-	**2,300**	-	**2,930**	**2,930**		**2,930**	**-630**
CLINICAL EQUIPMENT				-						
Urology - Equipment	-	300	-	300	-	-	-	200	200	100
Heart Lung machines - Cardiac surgery	-	680	-	680	-	-	-	680	680	0
Heater Cooler units	-	156	-	156	-	159	159		159	(3)
Sorin Heater Cooler Units (funded from refund Heater cooler units above)	-	-	-	-	-	-	-	150	150	(150)
Echo vivid - Cardiology - portable	-	400	-	400	-	-	-	400	400	0
Trans-Oesophageal Echo (Toe)		329		329	-	-	-	250	250	79
Cardiac output machines (critical care) EV1000	90	-		90		-	-	90	90	0
Radiation Dispenser manual - Oncology	-	90	-	90	-	-	-	90	90	0
Supra laser - Opthalmology	-	170	-58	112	-	-	-	112	112	0
Ultrasound Replacement (Endoscope, Operating Table & EMG System)	-	100	-	100	-	83	83	17	100	0
Cytogenics Incubators NICU	25	-	-	25	-	-	-		0	25
Endoscopes 16/17		1,040	-604	436	-	-	-	436	436	0
Endoscopy scope replacement			604	604	-	604	604		604	0
Ultrasound scanner replacement		175		175	-	158	158	17	175	0
Theatre Instruments	300	-	-	300	-	-	-	150	150	150
Transeosophageal Echo machine (Philips IE33)	-	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	-	141	141		141	(38)
ENT Zeiss S21 (Theatres)	50	50	-	100	-	-	-	50	50	50
Gynae Urodynamics	55	-	-	55	-	-	-	55	55	0
GP Pumps (Biomed)	450	-	-	450		-	-	450	450	0
Bed Replacement Programme	800	-	-330	470		-	-	470	470	0
Gamma Camera (Nuclear Med Imaging Scanner)	1,200	-	-	1,200	-	880	880	320	1,200	(0)
Home Haemo Dialysis Replacement 16/17	-	62	-	62		-	-	62	62	0
Haematology Main Analyser (to be approved for hA negotiationing for all hospital	715	-	-	715	-	535	535	-	535	180
Bio Chemistry Lab - Mass Spectrometer	500	-	-	500	-	-	-	500	500	0
-Rapid ARC Licences (Oncology)	123	-	-	123	-	-	-	123	123	0
PCA Pumps (Biomed)	500	-	-	500	-	421	421	79	500	0
Treon Plus Stealth station OE9823	-	450		450		-	-	450	450	0
Haemodialysis (Incentre)	650	-	-	650	-	-	-	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	0
Non-Invasive Ventilator	-	-	-	-	-	-	-	-	0	0
Oversize Operating theatre table RX500	-	83	-	83	-	-	-	83	83	0
Bipap Respironics (CCD x 4) - Respiratory	-	120	-	120	-	-	-	120	120	0
Scopes - eBus - Respiratory	-	120	-	120	-	-	-	120	120	0
Trolley Washer - SSU	-	276	-	276	-	-	-	276	276	0
Telemetry	-	800	-	800	-	-	-	800	800	0
Cordless Driver (incl wore collect) - Theatres	-	69	-	69	-	-	-	69	69	0
IMM4 Anaesthethic Monitoring system	-	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

CAPITAL PLANS					CASHFLOW FORECAST				FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Jun-17 (M)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
LAPAROSCOPIC TOWER WITH WIRELESS SLAVE MONITORS E15750 No5	-	93		93	-	-	-	93	93	0
MONITOR IMM4 FM FLEXIBLE MONITOR & LIC E13191	-	60	-	60	-	-	-	60	60	0
Orthopeadic Cordless Driver 4300 sets x 7	-	141	-	141	-	-	-	141	141	0
Orthopeadic system - 6 rotary sets x 2	-	63	-	63	-	-	-	63	63	0
System 6 dual Trigger Rotary Hand Piece	-	65	-	65	-	-	-	65	65	0
System 6 Sag Saw	-	65	-	65	-	-	-	65	65	0
Ultrasound - diagnostic E14773	-	224	-	224	-	-	-	224	224	0
Cardotokograph	-	510	-	510	-	-	-	510	510	0
Colposcope	-	66	-	66	-	-	-	22	22	44
Dinamap	-	150	-	150	-	-	-	60	60	90
Echocadiograph (Wakids)	-	272	-	272	-	-	-	272	272	0
Foetal heart detector	-	100	-	100	-	-	-	100	100	0
Foetal monitor, CTG	170	-	-	170	-	-	-	170	170	0
Humidifier	-	150	-	150	-	-	-	150	150	0
Infusion pumps (Thames)	-	408	-	408	-	-	-	408	408	0
Intellivue physiologic monitor	-	352	-	352	-	-	-	352	352	0
Immunology - Molecular Micro Array	50	-	-	50		-	-	-	0	50
Monitor cardiac , multi parameter	-	320	-	320	-	-	-	320	320	0
Scanner, ultrasonic	-	300	-	300	-	-	-	300	300	0
Scanner, ultrasonic ob/gyn	-	320	-	320	-	-	-	320	320	0
Warmer, radiant, infant IW930	-	72	-	72	-	-	-	72	72	0
Cathlabs	-	2,500	-	2,500	-	-	-	2,500	2,500	0
Incubator	400	1,440	-	1,840	-	-	-	1,840	1,840	0
Haematology Flow Cytometry Robotics system	-	200	-	200	-	-	-	200	200	0
Histology Pathvision Radiographic system	-	400	-	400	-	-	-	400	400	0
Building Refurnishment - free up space	-	77		77		-	-	77	77	0
Biochemistry LC Tandom Mass Spectrometer	-	500	-	500	-	-	-	500	500	0
Cytogenetics Digital Imaging system	-	800		800		28	28	772	800	0
Scanner 3D Cone Beam (maxFac)	-	150	-	150	-	-	-	150	150	0
Med - Dispense Units	-	900	-	900	-	-	-	900	900	0
Licensing (breast screening)	-	52	-	52	-	-	-	52	52	0
CT Scanner	-	5,200	-	5,200	-	-	-	5,200	5,200	0
Digital Mobile X - ray	-	1,500	-470	1,030	-	-	-	1,030	1,030	0
Fluro Room units	-	750	-619	131	-	-	-	131	131	0
Combi Diagnost Fluoroscopy Unit			619	619	-	186	186	433	619	0
Mobile Image Intensifier - Waikato	-	1,500	-550	950	-	-	-	950	950	0
Ultrasound (medical Photography / imaging)	-	200	-97	103	-	-	-	103	103	0
Infusion pumps (Thames)	-	67	-	67	-	-	-	67	67	0
Steriliser Autoclave (Thames)	-	200	-	200	-	-	-	200	200	0
Blood gas analysers	-	800	-50	750	-	-	-	750	750	0
Blood Gas Analyser - Critical Care			50	50		-	-	50	50	0
Echo Ultrasound Machine Replacement				-		-	-		0	0
Kay Pentax Stroboscopy System			100	100		100	100		100	0
BD MGIT 960 Automated TB Growth Analyser						-	-		0	0
CEP - Pool - 2016/17	119		81	200	-	-	-	192	192	8
Capitalised items	5,399	244	2,726	8,369	519	6,527	6,527		7,047	1,322
SUB TOTAL CLINICAL	**13,769**	**27,393**	**1,402**	**42,564**	**519**	**9,912**	**9,912**	**30,067**	**40,499**	**2,065**
INFORMATION SYSTEMS										
PLATFORM						-	-			

CAPITAL PLANS					CASHFLOW FORECAST				FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Jun-17 (M)	Forecast Subsequent Years (P)	Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
ISSP - Decommission Galen 15/16	300	-	15	315	53	62	62	6	121	194
ISSP - Decommission Galen 16/17	-	251	-	251		-	-	159	159	92
ISSP - File Server -(profile , home drive, appv)rearchitecture	-	150	-	150	-	-	-	150	150	0
NIPS - Local Capacity Augments	-	700	-	700	-	-	-	700	700	0
ISSP - Lifecycle - Infrastructure Application Workplan 16/17	-	1,000	-	1,000	-	69	69	930	999	1
ISSP - Clinical and Corporate Platform		500		500		-	-	500	500	0
ISSP - Clinical and corporate Platform SQL Server consolidation	475		-	475	99	87	87	177	362	113
ISSP - Disaster Recovery Solution 15_16	1,150		-	1,150	2	55	55	1,066	1,124	26
ISSP - Backup Capacity Augment	200		-	200	0	46	46	154	200	(0)
ISSP - Contingency (IS)	100		-64	36	-	-	-	-	0	36
ISSP - Windows Server Migration 2003-2008 (DIA)	491		-221	270	-	-	-	270	270	0
STORAGE & REPORTING				-		-	-		0	0
ISSP - Clinical PhotographyImage Management	-	300	-300	-	-	-	-		0	0
ISSP- Clinical Photography and Image Management			397	397		7	7		7	390
ISSP - DataWarehouse Phase 2 - after 16/17	-	400	-200	200	-	-	-	200	200	0
ISSP - Enterprise Reporting Content remediation -after 16/17	-	250	-250	-	-	-	-	-	0	0
ISSP - Enterprise Reporting 16-17			250	250	-	5	5	196	201	49
ISSP - Data Analyst Toolset Implementation (16/17)	-	700	-350	350	-	-	-	350	350	0
ISSP - Enterprise Business Intelligence Tool			350	350	-	92	92	258	350	(0)
ISSP - Lifecycle - Sharepoint Workplan (e.g. replace fileshares, online sharepoint)		1,100	-200	900	-	-	-	900	900	0
ISSP - San Controller		322		322	-	-	-	322	322	0
ISSP - SharePoint (Doc Management Pilot)	700		-	700	230	13	13	442	685	15
ISSP - Data Warehouse Upgrade	400		-	400	175	79	79	145	398	2
ISSP - Data Warehouse Phase 2 15_16			200	200	-	13	13	187	200	(0)
ISSP - Business Intelligence Data and Reporting 16_17				-		1	1	-	1	(1)
ISSP- Phlebotomy Bedside Labelling Discovery				-		0	0	-	0	(0)
NETWORK & COMMUNICATIONS				-		-	-		0	0
ISSP - Paging System Replacement	-	350	-	350	-	88	88	285	373	(23)
ISSP - Unified Comms Phase 4 (16/17)	-	174	-174	-	-	-	-	62	62	(62)
ISSP - Unified Communications Lifecycle			62	62		21	21		21	41
ISSP - Jabber Instant Messaging and Guest			201	201	-	61	61	147	208	(7)
ISSP - Lifecycle - 1-2 Communication Tools Workplan	-	400	-	400	-	35	35	364	399	1
ISSP - WiFi Rollout	-	1,000	-	1,000	-	381	381	619	1,000	0
ISSP - Network Remediation Work Package 2015/2016	400			400	262	0	0	138	400	(0)
ISSP - Network Remediation Lifecycle Work Plan 16/17	300			300	-	243	243	74	317	(17)
ISSP - Communication Room Remediation Lifecyle		370		370		4	4	366	370	0
ISSP - Comms Rooms remediation 2015/2016	230		-	230	44	45	45	141	230	(0)
ISSP - Unified Comms Phase 4	147		-	147	35	62	62	-	97	50
ISSP - Hylafax replacement	96			96	-	25	25	72	96	(1)
ISSP - IaaS Implementation				-		164	164		164	(164)
DEVICES				-		-	-		0	0
ISSP - Telehealth- replacement schedule	-	1,800	-	1,800	-	-	-	1,800	1,800	0
ISSP - Telehealth- Expansion		200	-27	173	-	-	-	173	173	0
ISSP - Southern Rural Outpatient Video Units			27	27		25	25	2	27	0
ISSP - Tablets to enable mobile workforce	-	500	-242	258	-	-	-	258	258	0
ISSP - Touch screens	-	300	-150	150	-	-	-	150	150	0
ISSP - Mobile office Productivity & Management			392	392		4	4	388	392	(0)
ISSP - Desktop - increase coverage		200		200		-	-	200	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	0
ISSP - Mobile device management	90		-54	36	-	-	-	36	36	0
ISSP - Hardware Solution - Medication Room	20		-	20	-	9	9	-	9	11
IS Pool - clearing				-		5	5		5	(5)
ENTERPRISE SERVICE BUSINESS / RULES ENGINE				-		-	-		0	0
ISSP - Clinical Business Rules	-	250	-	250	-	-	-	250	250	0

CAPITAL PLANS					CASHFLOW FORECAST				FULL PROJECT FORECAST	
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ISSP - Web Applications -S_Web_Services Infra_Mess Standards	-	500	-100	400	-	-	-	400	400	0
ISSP - Enterprise Service Bus (ESB)			100	100		5	5		5	95
ISSP - Web Applications -S_Web_Services Infra_Solution Select_Impl	-	500	-	500	-	-	-	500	500	0
TOOLS				-		-	-		0	0
ISSP - PVS Citrix	39	-	-	39	-	15	15	-	15	24
ISSP - Archiving Tool	-	380	-	380	4	9	9	348	361	19
ISSP - TQUAL Reporting	50	50	-	100	1	36	36	18	56	44
ISSP - Toolsets (after 16/17 refer to Lifecycle plan line items)		452		452		-	-	452	452	0
ISSP - Toolsets (IS Toolsets 15/16)	563		-	563	178	295	295	89	563	0
ISSP - Toolsets (14/15)	130		-	130	72	42	42	13	127	3
ISSP - Citrix Netscaler10.5 upgrade	-	150	-	150	-	-	-	-	0	150
ISSP - Rapid Logon	-	700	-	700	-	5	5	700	705	(5)
ISSP - e2e Clinical Docs		499		499		-	-	499	499	0
ISSP - EMRAM compliance to lvl 6 - upgrade / implementation	-	700	-	700	-	-	-	700	700	0
ISSP - Lifecycle integration Tools workplan - Rhapsody etc	-	1,000	-90	910	-	-	-	910	910	0
ISSP - Mobile device management			90	90		3	3	87	90	(0)
ISSP - Anivirus / Malware - Toolset upgrade / replacement	-	150	-	150	-	-	-	150	150	0
ISSP - Lifecycle - Desktop Workplan (Outlook, Flexplus, etc)	-	1,200	-292	908	-	-	-	908	908	0
ISSP - Desktop Work Plan 16/17	-	-	292	292	-	4	4	288	292	0
ISSP - Lifecycle - Development tools (Visual studio, Kendo etc)	-	200	-	200	-	-	-	200	200	0
ISSP - Team foundation Server - Source Code management	-	250	-250	-	-	-	-	-	0	0
ISSP - SharePoint Work Pan 16-17	-	-	450	450	-	4	4	448	452	(2)
ISSP - LIS Reporting Development	200		-	200	83	58	58	55	196	4
SECURITY				-		-	-		0	0
ISSP - Perimeter Redesign		598	-262	336		-	-	336	336	0
ISSP - Perimeter Remediation Work Plan 16/17			173	173	-	17	17	156	173	0
ISSP - Lifecycle - 1-2 Security tools Workplan (cardex, etc)		600	-	600	-	-	-	600	600	0
ISSP - Security Defence in depth	500		-122	378	29	41	41	307	377	1
LICENSING				-		-	-		0	0
ISSP - MS Licensing True-Up (16/17)	300		-	300	-	-	-	300	300	0
ISSP - Other Licensing True-Up (16/17)	300		-29	271	-	-	-	271	271	0
ISSP - Other True-Up Winscribe	-	-	29	29	-	23	23	6	29	0
ISSP - Other Licensing True-Up	300		-251	49	49	16	16	-	65	(16)
ISSP - MS Licensing True-Up	300		-124	176	129	-	-	35	164	12
CLINICAL SYSTEMS				-		-	-		0	0
ISSP - Lifecycle: LIS Workplan	150		-79	71		-	-	71	71	0
ISSP - Healthviews DC Uploader replacement		150	-150	-		-	-		0	0
ISSP - Clinical Workstation Core Component Workplan	-	-	480	480		234	234	245	479	1
ISSP - NCAMP. 3M, MKR	250	250	-250	250	78	94	94	78	250	(0)
ISSP - NCAMP 2017			250	250	-	23	23	226	249	1
ISSP - Workflow eData	250	-	-	250	3	135	135	112	250	0
ISSP - Workflow eData		2,100		2,100	-	-	-	2,100	2,100	0
ISSP - Database Replacements		300	-	300	2	26	26	271	299	1
ISSP - Oral Health system		1,000	-	1,000	165	621	621	214	1,000	(0)
ISSP - eTasks	-	230	-	230	-	3	3	229	231	(1)
ISSP - Cardiac Dendrite Phase 3	200	200	-116	284	-	-	-	284	284	0
ISSP - Surgical Services Audit Systems			116	116	-	42	42	75	116	(0)
ISSP - eProgesa replacement impacts - NZ Blood Service	-	150	-	150	-	-	-	-	0	150
ISSP - Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense		250	-150	100		-	-	80	80	20
ISSP - LIS Drop 8			150	150	-	1	1	150	151	(1)
ISSP - Life cycle - cat 1-2 Medical Records Workplan (eg Kofax)	-	600	-	600	-	-	-	600	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	-	128	128	222	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	-	22	22	128	150	0
ISSP - Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	-	1,400	-	1,400	-	97	97	1,301	1,398	2

CAPITAL PLANS						CASHFLOW FORECAST					FULL PROJECT FORECAST	
Activity	Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H		Prior year expenditure for active Projects (K)	Total Expenditure Forecast FY 16/17 (Actual + Planned) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Jun-17 (M)	Forecast Subsequent Years (P)		Total Planned Expenditure (Actual + Forecast to Project completion) (R) =K+L+P	Total Planned Expenditure Versus Total Board Approved (S) =I-R
ISSP - Life cycle - CWS / Healthviews Workplan	-	1,000	-654	346		-	-	-	346		346	(0)
ISSP - Software Upgrades (Apps Lifecycle 15/16)	250		-	250		149	79	79	21		249	1
ISSP - Master Data Implementation- after 16/17	-	100	-	100		-	-	-	100		100	0
ISSP - Laboratory Information Systems June 2016 GA upgrade	-	400	-	400		-	-	-	400		400	0
ISSP - Lab Analysers	-	600	-	600		-	-	-	600		600	0
ISSP - HealthViews - External eReferrals	-	300	-	300		-	8	8	216		224	76
ISSP - Clinical workstations - Document Tree search	-	100	79	179		-	5	5	195		200	(21)
ISSP - Access to community pharmacy	-	100	-100	-		-	-	-	-		0	0
ISSP - Data collection	-	100	-	100		-	-	-	50		50	50
ISSP - Procedure based Booking / Scheduling	-	1,250	-	1,250		-	-	-	1,250		1,250	0
ISSP - Structured programme - scanned history	-	200	-	200		-	-	-	200		200	0
ISSP - Cardiology - Xcelera to ISCV	-	100	-	100		-	-	-	-		0	100
ISSP - ipm upgrade to V10 - after 16/17	-	450	-	450		-	215	215	234		449	1
ISSP - SSU re-engineering	-	666	-	666		-	-	-	666		666	0
ISSP - eCWB Infrastructure	-	739	-	739		-	-	-	739		739	0
ISSP - Maternity (CleverMed)	760		-	760		12	-	-	740		752	8
ISSP - HealthViews access to Primary Encounters (GP to Workstations)	300		-	300		69	219	219	12		300	(0)
ISSP - LIS Print solution	80		-	80		-	-	-	80		80	0
ISSP - HealthViews Internal eReferrals	300		-300	-		-	-	-	-		0	0
ISSP - Internal eReferrals			499	499		-	99	99	405		504	(5)
ISSP - eOrders	350		-	350		3	0	0	347		350	(0)
ISSP - Radiology - PACS/RIS Upgrade 16/17	500	200	-350	350		-	-	-	350		350	0
ISSP - RIS Release 5			150	150			0	0	150		150	(0)
ISSP - PACS Release 5			200	200			5	5	195		200	(0)
ISSP - RIS Upgrade (Project split) (PACS Upgrade 15)	223		-	223		93	78	78	57		228	(5)
ISSP - RIS Upgrade 2016	124		-	124		1	33	33	89		123	1
ISSP - Lifecycle - cat 1 Clinical Apps Workplan e.g. Dendrite, Med Dispense	250		-	250		-	-	-	150		150	100
ISSP - Laboratory Phlebotomy (Te Kuiti)	40		-	40			-	-	40		40	0
ISSP - HealthViews - e2e Clinical Documents	350		-	350		53	432	432	-		485	(135)
ISSP - Clinical Workstation Metadata Scoping			50	50		1	8	8	41		50	0
ISSP - Speech Recognition			100	100		1	1	1	98		101	(1)
ISSP - Clinical Workflow Integration Work Plan			430	430		-	52	52	382		434	(4)
ISSP - Provation Host Tairawhiti	27		-	27		-	-	-	27		27	0
ISSP - Waikato Hauora iHub	-	-	-	-			18	18			18	(18)
ISSP - e-Discharge Summaries	100		-100	-		-	-	-	-		0	0
CORPORATE SYSTEMS & PROCESSES				-			-	-			0	0
ISSP - Smarthealth - System implementation costs			500	500			-	-	500		500	0
ISSP - Costpro Upgrade		103		103			-	-	103		103	0
ISSP - Costpro Upgrade	400		-	400		238	1	1	161		400	(0)
ISSP - HRIS Lifecycle Upgrade 15_16		400	-	400		4	48	48	348		399	1
ISSP - Lifecycle HRIS / Peoplesoft Workplan		950	-200	750		-	-	-	750		750	0
ISSP - HRIS PeopleSoft WorkPlan AWE Calculation Pay Rules			200	200		-	2	2	198		200	(0)
ISSP - HRIS Self Service implementation - payroll improvement	400	-	1,200	1,600		-	1,608	1,608			1,608	(8)
ISSP - Attendants System - enhancements or replacement	-	100	-	100		-	-	-	100		100	0
ISSP - Hockin Conversion	21		-	21		12	4	4	5		21	(0)
REGIONAL				-			-	-			0	0
RSSP - Regional Netscaler Reconfiguration	-	33	-	33		-	-	-	33		33	0
RSSP - Regioanl Microsoft Reporting Services	-	225	-	225		-	-	-	225		225	0
RSSP - SEEMAIL	-	26	-14	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 - Risk Management Solution (Regional)	369		-	369		306	-	-	63		369	0
RISSP - Clinical Workstation - Phase II (License)	500	500	-	1,000		500	500	500	-		1,000	0

CAPITAL PLANS					CASHFLOW FORECAST				FULL PROJECT FORECAST	
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ISSP - Netscaler Infrastructure			343	343	1	275	275	66	342	1
eSPACE				-			-		0	0
RISSP - HSL - e Space Clinical Workstation	7,831		-	7,831	-	-	-	7,831	7,831	0
OTHER PROJECTS				-		-	-		0	0
ISSP - Printer Architecture Upgrade	130		-	130	9	18	18	102	130	0
ISSP - Baseline - Infrastructure Lifecycle Management	465		-	465	318	32	32	119	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	1	1	117	120	0
ISSP - Spark Consultancy Services			64	64	-	32	32	32	64	0
Capitalised items	6,189	150	692	7,031	3,282	3,551	3,551		6,833	198
SUB TOTAL INFORMATION SYSTEMS	**30,128**	**38,568**	**2,316**	**71,012**	**6,775**	**11,040**	**11,040**	**51,617**	**69,432**	**1,580**
PROPERTY & INFRASTRUCTURE - PLANT										
Waikato Waiora Chillers	643		-	643	626	2	2	-	628	15
Waikato Distribution Board stuff 11/12	250		-	250	196	16	16	38	250	(0)
Waikato Switchboards - Menzies,Kemp,Waiora & ERB	-	600	-	600	-	-	-	600	600	0
Theatre - Air conditioning upgrades	-	400	-250	150	-	-	-	150	150	0
Kempthorne Plantroom Upgrade	-	-	250	250	-	246	246	6	252	(2)
Thames - Air conditioning inpatient unit upgrade	-	200	-	200	-	-	-	200	200	0
Carpark Lighting - Upgrade	-	50	-	50	-	45	45	5	50	(0)
HV System - upgrade- SCADA to BMS	-	160	-	160	-	-	-	160	160	0
Ward 32 - Air conditioning	-	45	-	45	-	-	-	45	45	0
Hockin sewage system	-	65	-20	45	-	-	-	45	45	0
Hockin Sewer Pumping Stations and Heating Controls	-	-	20	20	-	18	18	2	20	0
Marsh Insurance Items	-	150	-	150	-	-	-	150	150	0
Mothercraft Fire Panel - upgrade	-	20	-	20	-	-	-	20	20	0
NICU ERM's to 4 x 4 upgrade	-	36	-18	18	-	-	-	18	18	0
Extension to Current ERM Manifolds for NICU	-	-	18	18	-	-	-	18	18	0
Tunnel lighting	-	30	-	30	-	-	-	30	30	0
Maternity Refurb / Electrical	-	44	-	44	-	-	-	44	44	0
EWIS communications solution	-	170	-	170	-	-	-	170	170	0
Lift car upgrades	-	72	-	72	-	-	-	72	72	0
ERB chilled water buffer tank installation	-	20	-	20	-	-	-	20	20	0
ERB Fire panel upgrade	-	200	-	200	-	-	-	200	200	0
Menzies Fire panel upgrade	-	200	-	200	-	-	-	200	200	0
Avigilon DVR's in all building x9	-	117	-	117	-	32	32	84	116	1
Carpark CCTV	-	300	-87	213	-	-	-	213	213	0
Pembroke Street Car Park CCTV			87	87		13	13	74	87	(0)
Convert CCTV from analogue to IP	-	60	-	60	-	-	-	60	60	0
Develop Web based payment for Multicash	-	150	-48	102	-	17	17	85	102	(1)
Change Readers X 125	-	60	-	60	-	27	27	33	60	(0)
Gallagher door controllers - upgrade to 6000 model	-	300	-	300	-	90	90	210	300	(0)
Virtual controller for Monitoring stations	-	80	-	80	-	-	-	80	80	0
Intercoms at all barrier arms	-	110	-	110	-	-	-	110	110	0
CCTV for Hockin building	-	80	-54	26	-	-	-	26	26	0
CCTV Installations	-	-	54	54		51	51	3	54	(0)
Master key - Waikato buildings (2 x bldgs)	-	112	-	112	-	-	-	112	112	0
Ward - standard install	-	120	48	168	-	-	-	168	168	0
Monitoring centre (setup, 24/7 manning)	-	50	-	50	-	-	-	50	50	0
Infrastructure Replacement Pool (15/16)	600			600	358	321	321		679	(79)
Infrastructure Replacement Pool (16/17)		600		600	-	76	76	457	533	67
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	**1,493**	**4,601**	**-**	**6,094**	**1,180**	**955**	**955**	**3,958**	**6,093**	**1**
PROPERTY PROJECT SERVICES										0
Priority Roading Works		565		565	-	-	-	565	565	0
MCC - Edge roof protection		30		30	-	28	28	2	30	0
OPRS - Roof access		30		30	-	-	-	30	30	0
ERB improvements (counter cold & wind)		150		150		-	-	150	150	0

CAPITAL PLANS						CASHFLOW FORECAST					FULL PROJECT FORECAST	
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Greening Programme	875	-	-280	595			-	-	595		595	0
Concept Design- Oncology/Haematology Facility	300	-	-	300		62	43	43	194		299	1
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		-	1,557	1,557	2,154		3,711	(28)
Lift Upgrade	1,835	-	-	1,835		1,610	235	235			1,845	(10)
Electrical Systems Improvement	6,889	-	-175	6,714		5,789	166	166	779		6,734	(20)
Consolidation of CBD facilities	-	5,557	-	5,557		-	1,171	1,171	4,386		5,557	(0)
Office Relocations	2,000	-	-95	1,905		-	-	-	1,905		1,905	0
Hockin - Open planning/ Modernisation of Level 3 Executive Wing			95	95		-	119	119			119	(24)
Seismic Remediation	3,207	-		3,207		123	1,469	1,469	1,633		3,225	(18)
Internal Reconfiguration - Gallaghers	-	863	-	863		-	-	-	791		791	72
Internal Reconfiguration - Room Pressure	-	210	-	210		-	240	240			240	(30)
Internal Reconfiguration - Pain Clinic - L3 Menzies	-	100	-	100		-	-	-	100		100	0
Internal Reconfiguration - Coffee outlet L1 MCC	-	75	-	75		-	-	-	75		75	0
Internal Reconfiguration - Refurb - Waiora L2	-	200	-	200		-	-	-	200		200	0
Outdoor staff facility- Rest & Recovery off red Corridor	-	100	-	100		-	-	-	100		100	0
Ward Block A & environs	-	300	-	300		-	-	-	300		300	0
Landscape Ward Block A		50		50		-	-	-	50		50	0
Tokoroa / Te kuiti / Rhoda Road / Matariki Refurb	-	140	-140	-		-	-	-	-		0	0
Combining Matariki and Princess Street Bases			140	140		-	141	141			141	(1)
Legacy SCR - Still Required - decanting	800		-	800		700	4	4	-		704	96
Capitalised items	2,626		175	2,801		2,630					2,630	171
SUB TOTAL PROPERTY PROJECT SERVICES	**21,188**	**8,370**	**-175**	**32,184**		**12,803**	**5,242**	**5,242**	**14,009**		**32,054**	**130**
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	0
Mobile Dental Unit Replacements level 2	**750**		-	750		-	-	-	750		750	0
SUB TOTAL VEHICLES	**950**	**700**	**47**	**1,697**		**235**	**3**	**3**	**1,450**		**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		-	106	106	-		106	(29)
Mental Health Facility	-	60,992	-	60,992		-	-	-	60,833		60,833	159
Gallagher Building - Med Store & CSES Clinic				-			-	-			0	0
Gallagher Building - Racking System				-			-	-			0	0
Gallagher Building - Converyor System				-			-	-			0	0
Clinical Skills, Simulation and Research Centre							18	18			18	(18)
SUB TOTAL STRATEGIC PROJECTS	**25,077**	**60,992**	**0**	**86,069**		**0**	**124**	**124**	**85,833**		**85,957**	**112**
CORPORATE												0
COS - Contingency (was CFO)	1,000		-592	408		-	-	-	408		408	0
Catalyst Initiatives	2,500		-574	1,926		-	-	-	1,826		1,826	100
Service & Capacity Planning Tool			98	98		-	-	-	98		98	0
BPAC eReferral Phase 2			247	247		-	-	-	247		247	0
Production & Meal ordering S/W	-	300	-	300		-	-	-	300		300	0
Positive NPV Projects	1,000		-	1,000		-	-	-	1,000		1,000	0
Oracle - Mop ups and Budgeting solution	-	500	-	500		-	-	-	500		500	0
Taleo - Transition module			30	30		-	24	24	6		30	(0)
Project Elevate-Upgrade to NOS			1,759	1,759		1	1,758	1,758			1,759	0
Audio Visual Equipment							160	160	-		160	(160)
Transition to National Oracle System	3,500		-1,759	1,741		-	47	47	1,694		1,741	0
SUB TOTAL CORPORATE PROJECTS	**8,000**	**800**	**-791**	**8,009**		**1**	**1,990**	**1,990**	**6,079**		**8,069**	**-60**
MOH Projects (funded externally)							-					
National Patient Flow-Phase 2	177		-	177		174	2	2	-		177	0
National Patient Flow Phase 3	249			249		23	187	187	40		250	(1)
Telestroke Pilot	-	42		42		-	42	42	-		42	0
SUB TOTAL MOH PROJECTS	**426**	**42**	**-**	**468**		**197**	**231**	**231**	**40**		**469**	**-1**

CAPITAL PLANS					CASHFLOW FORECAST				FULL PROJECT FORECAST	
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Trust Funded Projects (funded externally)						-				0
15/16 Trust Account	-		476	476	250	226	226	-	476	0
16/17 Trust Account			112	112	-	112	112	-	112	(0)
15/16 Other Donated Assets			89	89	84	5	5		89	0
16/17 Other Donated Assets			120	120	-	120	120		120	(0)
SUB TOTAL TRUST FUNDED PROJECTS	**-**		**797**	797	**333**	**464**	**464**	**-**	797	**0**
TOTAL CAPITAL EXPENDITURE	**103,332**	**141,466**	**3,596**	**251,194**	**22,044**	**32,891**	**32,891**	**193,053**	**247,988**	**3,206**
REPORT TOTALS	**103,332**	**141,466**	**3,596**	**251,194**	**22,044**	**32,891**	**32,891**	**193,053**	**247,988**	**3,206**

MEMORANDUM TO THE BOARD
26 JULY 2017

AGENDA ITEM 7.2

YEAR END MATTERS

Purpose	For consideration and approval prior to being signed by the Chair and Deputy Chair.

The following list has been compiled to give an overview of year end matters.

Potential changes to provisional result

The provisional consolidated result for year to 30 June 2017 is $50k surplus but the following are not yet finalised and could affect result:

Item	Reason not yet incorporated
Inter district flow wash-up	National information available late August
Pharmac rebates	National information not yet finalised
Elective services revenue	Agreement with Ministry not yet finalised
Other national accruals	National information available late August

Estimates have been made for all the above items. In addition other items may be identified in final audit.

Timetable for finalisation of Annual report

Due Date	Action	Comment
24-Jul-17	Unaudited CFIS templates files sent to Ministry and auditors	
31-Jul-17	AuditNZ on site for CFIS audit	
31-Jul-17	Draft financial statements for Annual Report sent to auditors	
14-Aug-17	CFIS template agreed with DHB auditor	
14-Aug-17	Joint Statement of Representation sent to Ministry (to agree to CFIS)	Further detail below
14-Aug-17	Audited CFIS template filed with Ministry	
21-Aug-17	Request for letter of Comfort submitted to Ministry	Not required for Waikato DHB
Late August-17	Final wash-up of IDFs, PCT and ARC amounts provided to DHBs by Ministry	

Late Sept-17	Last date for annual report submission to auditors	
16-Oct-17	Verbal audit clearance given - last date for completion of audits	
18-Oct-17	Last date for submission of audited monthly template to MoH	
25-Oct-17	Annual report and audit representation letter to be signed. Audit opinion issued	Further detail below

Annual Report

The draft annual report for Waikato DHB is planned to be presented at the September 2017 board meeting.

Letter of Representation

The letters of representation (template) relating to the CFIS template submission and the annual report are to be signed off by the Board Chair, a second board member, the Chief Executive and the Chief Financial Officer and filed in accordance with the CFIS audit timeline.

Capital Review

As part of our year end process we review project costs for expenditure that has resulted in the creation of an asset when the project is complete. We've dealt with project costs that will lead to creation of an asset during the year so there are no material issues in the expenses.

Revaluation Reserve

Waikato DHB is required to complete a full revaluation exercise (as opposed to a desktop revaluation exercise) at least every three years for its land and buildings assets. The results are required to be reflected in the annual accounts. The value of land and buildings has increased by $176 million. This reflects an increase in accounting value, and a change in valuation assumptions due to a change in external valuer used following a procurement process completed last year. The CFO is comfortable with the new assumptions used.

Waikato Health Trust

The DHB has the right to appoint and remove trustees so substantially has control over the trust. Because of this we have been advised by our auditors that the trust meets the definition of a subsidiary in FRS-37 and therefore will be consolidated into the Board's financial statements. This treatment is consistent with other DHBs.

Recommendation
THAT
The Board:

1) Receives this report.
2) Nominates Bob Simcock, Sally Webb, Nigel Murray and Andrew McCurdie to sign the finance letters of representation in relation to the CFIS template and annual report.
3) Nominates Bob Simcock and Sally Webb to sign the annual report.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

Waikato District Health Board

Presentations

Waikato District Health Board

Papers for Information

MEMORANDUM TO THE BOARD
26 JULY 2017

AGENDA ITEM 9.1

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 three results. DHB comparison rankings for 2016/17 quarter three performance are included where available. 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		15/16 Target	2015/16 Q3 results & ranking	2015/16 Q4 results & ranking	16/17 Target	2016/17 Q1 results & ranking	2016/17 Q2 results	2016/17 Q3 results	2016/17 Q4 results	Target achieved	2016/17 Most recent result
Shorter stays in emergency departments		**95%**	90% 19th ✗	**91% 18th** ✗	**95%**	89.3% 19th ✗	87.6% 20th ✗	88.4% 20th ✗	85.8% (provisional)	X	85.8% June 17 YTD
Improved access to elective surgery		**100%**	120% 2nd ★	**119% 2nd** ★	**100%**	108% 7th ★	106% 10th ●	110% 3rd ★	111.8% (provisional)	√	111.8% June 17 YTD
Faster Cancer Treatment (FCT)	Achievement	**85%**	**73%** 13th ●	77% 10th ●	**85%**	81.4% 5th ★	85.9% 4th ★	86.1% 5th ★	86.7% (provisional)	√	86.7% Q4 16/17 (provisional) 3rd
Better Help for Smokers to quit	Primary Care	**90%**	**89%** 8th ●	88% 6th ★	**90%**	87% 12th ●	86% 13th ●	87% 12th ●	Not yet available	X	86% 16/17 Q3 result
	Maternity	**90%**	**95%** 13th ●	97% 8th ●	**90%**	93% 12th ●	96%	98% 4th ★	Not yet available	√	96% 16/17 Q3 result
Increased immunisation (8 months)		**95%**	91% 15th ✗	**90% 17th** ✗	**95%**	92.3% 13th ●	92% 15th ✗	90% 16th ✗	89% (provisional)	X	89% Jun 17 3 mth rolling
Raising Healthy Kids[1]			19%	31%	**95%**[1]	47% 11th ●	79% 6th ★	84% 9th ●	Not yet available	X	84% 16/17 Q3 result (6mths to Feb-17 data)

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

[1] Target by Dec 2017

Target: Shorter stays in Emergency Departments (ED)

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

Table 2 – 2017 ED results for June

Quarter: 4 - 2017

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:	24585	28639	85.8%
Waikato	16277	19824	82.1%
Taumarunui	1472	1542	95.5%
Thames	3825	4173	91.7%
Tokoroa	3011	3100	97.1%

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

	Clinical Unit	Mth Attendances	Jun'17 %	YTD Attendances	YTD %
By Specialty/Division (Waikato Hospital Only)	General & Specialty Surgery	837	78.3%	10055	77.6%
	Cardiology	324	55.9%	3468	60.1%
	Cardiothoracic Surgery	18	88.9%	157	84.7%
	Critical Care	5	80.0%	91	98.8%
	Paediatrics	644	82.1%	5490	88.2%
	Emergency Department	3595	88.1%	40669	92.4%
	Internal Medicine	1121	65.1%	11003	72.0%
	Womens Care	147	76.2%	1683	77.4%
	Oncology	114	61.9%	1065	75.3%
	Orthopaedics	241	77.6%	3105	76.2%
	Renal	65	63.1%	691	78.1%
	Vascular Surgery	46	75.6%	505	84.5%
	Allied Health	0	0.0%	13	92.3%
	Community Services	0	0.0%	3	0.0%
	Older Persons	2	50.0%	16	87.5%
	Mental Health	63	86.7%	992	87.9%
By Site	Waikato Hospital	7223	79.7%	79009	84.3%
	Tokoroa Hospital	1097	96.5%	12308	97.3%
	Thames Hospital	1457	92.0%	17444	93.5%
	Taumarunui Hospital	545	97.0%	6272	96.1%
	Total Health Waikato	**10322**	**84.2%**	**115033**	**87.7%**

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

* By specialty for Waikato Hospital Only

ED performance and acute flow

For June 2017, Waikato Hospital continued to struggle with performance on the 6 hour target, ending the month on 79.7% within 6 hours. Thames Hospital experienced a busy month and did not meet the 6 hr target either, with performance dropping from 93.8% to 92% within six hours. Tokoroa and Taumarunui were the only two hospitals to exceed the target. Combined for the DHB, performance was 84.2% for June.

Presentations to ED in Waikato Hospital for the month of June were an unprecedented 16% higher than the previous year, and YTD June presentations were 4.8% higher than last year. Highest daily patient presentations of 283 on Monday 26 June were exceeded by a record 297 presentations on Monday 10 July. Thames presentations in June were 12% higher than last June and have increased by 5% for the full year compared to last year. Highest annual growth occurred in Tokoroa where annual presentations increased by 12.5% since last year. Te Kuiti was the only hospital which experienced a decline in annual ED presentations, being 6.5%.

For Waikato Hospital, 'main delay' phases for patient breaches in June were most commonly ED assessment (47%), specialist assessment (35%), and bed allocation (18%). The increase in delays in ED is concerning and relates to a large extent to increased presentation numbers. Conversion rates to inpatient admission have remained stable at 36%, which means the admissions to wards from ED are also exceeding expectations.

Increasing demand has been experienced across the country, with a number of hospitals reporting operational difficulties. Advice from St John Ambulance is that there has been a 7% increase in ambulance conveyances nationally. The highest growth has been experienced in Auckland and Waikato, with Waikato ambulances reporting significant increases on last year, with a 14% increase in May and 12.8% in June. St John has managed to mitigate the impact in Auckland to a certain degree, due to being able to convey patients to three centres to make the most of any available

capacity, an opportunity which is not available for Waikato, which is also the busiest trauma centre in the country.

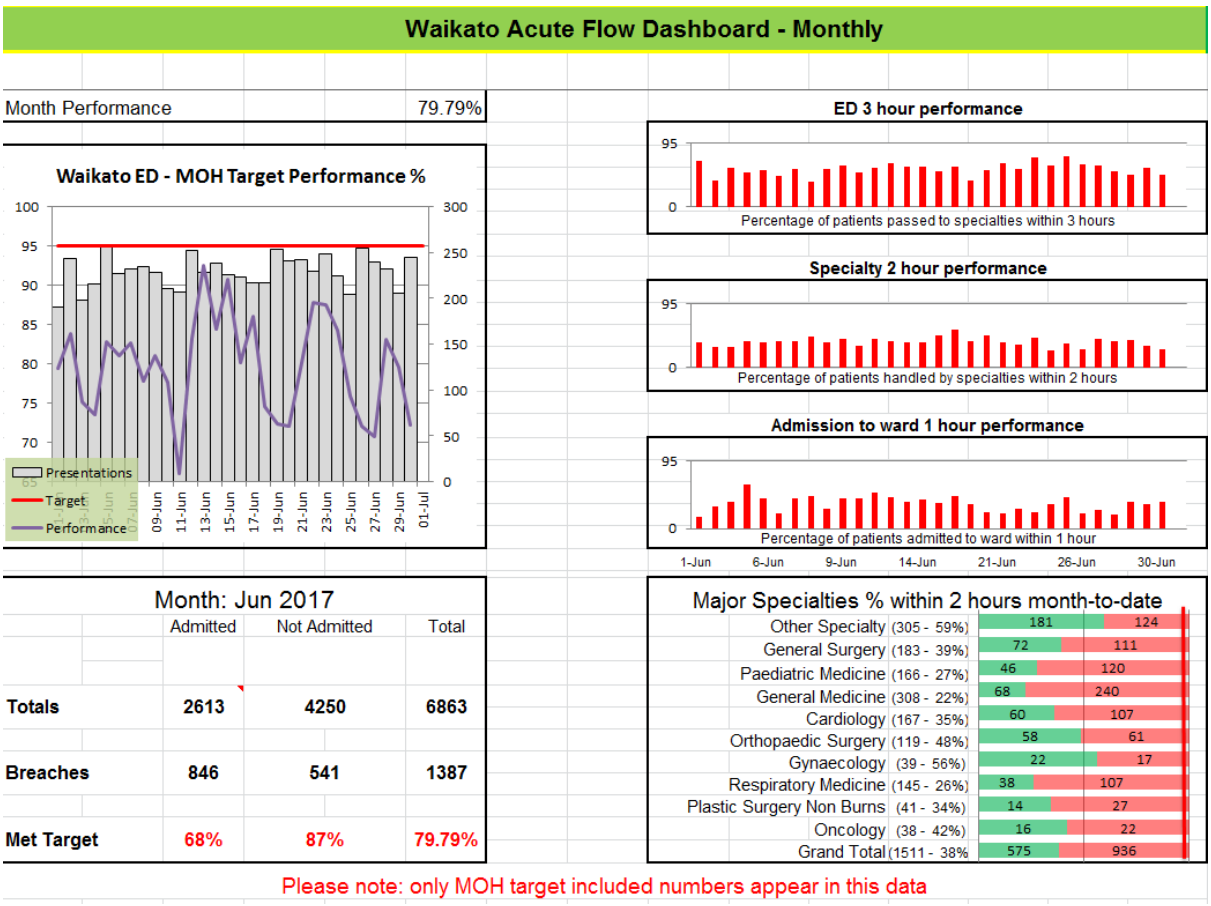
St John advise that many primary care practices have been turning away ambulances with patients who have conditions that do not require ED attendance due to the high demand in the practices, full clinics and consequent long waiting times they are experiencing. The Accident & Medical centres in town have also been turning away ambulances as they have been at capacity with the result in both cases that the ambulances are going to ED as the highest-cost but default provider for primary care. Anglesea Clinic has notified Waikato Hospital emergency department that they will not accept re-directed patients from ED when they have a 4 hour wait. This has contributed to excess demand on the Waikato Hospital emergency department.

The reason for the increased demand is uncertain. Some may be due to winter ailments – for instance there have been many admissions for respiratory conditions. Other influences may be population growth on top of the pre-existing issue of a significant number of patients not registering with a primary care provider, instead seeking primary care from the ED. Patients are consequently being encouraged by the Emergency Department to enrol with a primary care provider and to register with SmartHealth.

Pressure on beds in Waikato Hospital remains a concern particularly after weekends, with the hospital having to invoke an incident management response to address the hospital being overloaded on 21 June. Interventions put in place to address the bed shortage in Internal Medicine during the day helped to address the bed shortage without significant disruption (4 elective cancellations).

The related pressure on nursing resource on the wards is a recent concern with increased sick leave being experienced in early July. This caused some bed closures and high workloads for remaining staff on the wards. Key interventions to address the pressure are progressing with new nursing positions for OPR5, with nursing staff who can start before the September opening available to supplement staffing on other wards. Furthermore, short term interventions to bolster the clinical nursing staff on the floor (eg. non-clinical nurses temporarily adopting clinical roles) have been implemented and are being monitored through the weekly demand and capacity forum. Longer term solutions to access a larger flexible nursing resource pool are being explored as well, to address the persistent gaps on the nursing roster.

Other positive news is that transfers to rural hospitals have been increasing in recent weeks, with occupancy in Tokoroa and Thames now at higher levels than previously seen. The launch of the SAFER bundle project unfortunately has been delayed to 6 September due to an unforeseen IS dependency. Project activity is progressing with implementation of criteria based discharges and usage of estimated discharge dates now becoming more common.

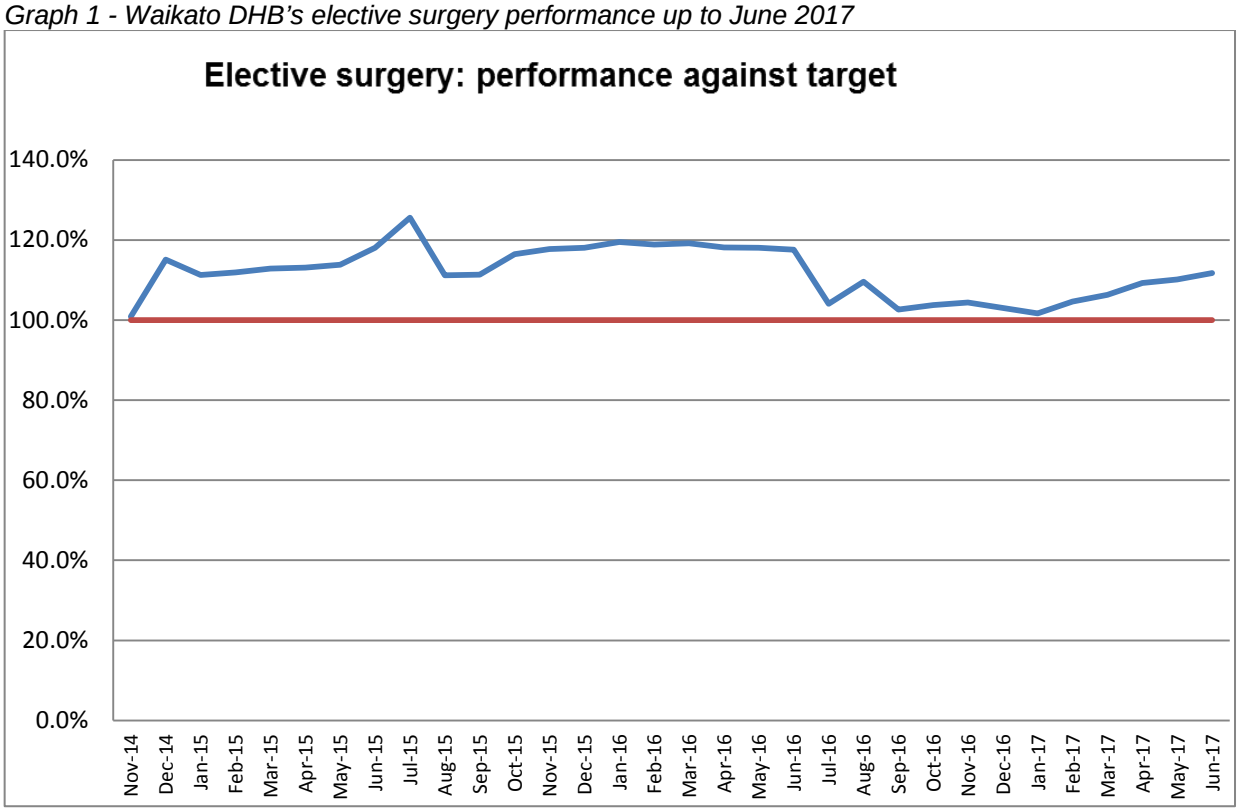


Target: Elective Surgery

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	**DHB Q3 result 16/17**	**Most recent result**
119% YTD (target 15,858 discharges)	**100%** **(target 16,805 discharges)**	120% YTD 2nd ranking (target 7,858 discharges)	120% YTD 2nd ranking (target 11,546 discharges)	119% YTD (target 15,858 discharges)	108% YTD 7th ranking (target 4,651 discharges)	106% YTD 10th ranking (target 8,966 discharges)	**110.1% YTD 3rd** **(target 12,619 discharges)**	**111.8% YTD June 17** **(target 19,141 discharges)**

The 2016/17 target is 17,114 discharges. Graph 1 below provides the most recent result of 112%, a total of 19,141 actual discharges for the period from 1 July 2016 to 30 June 2017. Our official ranking result for Q3 had Waikato ranked 3rd.

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



Target: Faster Cancer Treatment (FCT)

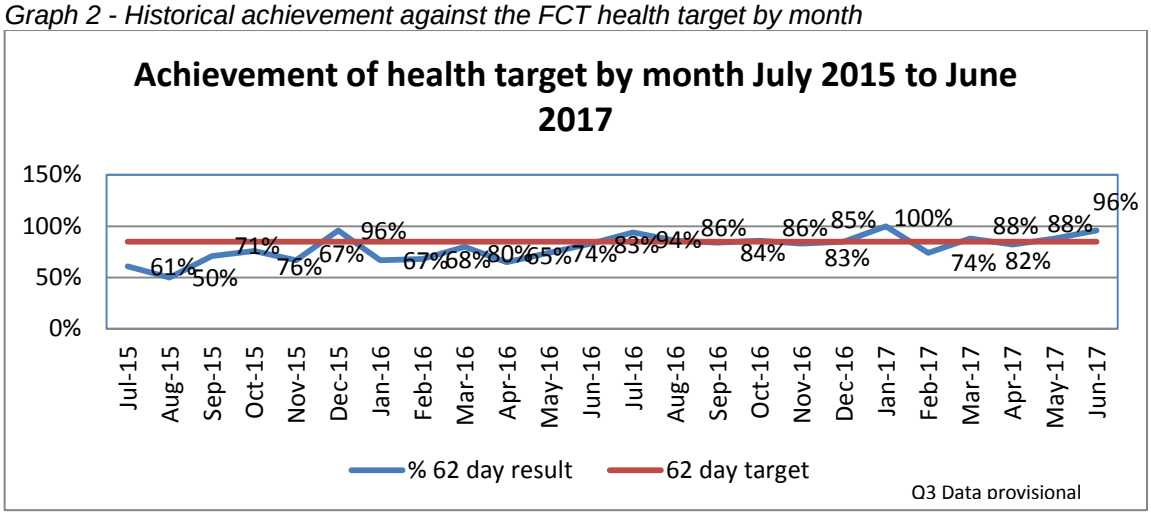
Table 4 - Summary of achievement against the FCT health target from July 2015 to June 2017

FCT 62 DAY HEALTH TARGET									
DHB Target from 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	DHB Q3 Result 16/17	**DHB Q4 Result 16/17**
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	85.9% 4th ranking	**86.7%** 3rd ranking
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	DHB Q3 Result 16/17	**DHB Q4 Result 16/17**
25.00%	**15%**	17%	16%	14%	14%	17%	19%	19%	**17%**

The 2016/17 provisional quarter 4 result at 86.7% (for the six months January to June 2017) shows that Waikato has sustained achievement against the 85% health target. Quarter 2 was the first quarter we delivered the 85% target making Waikato DHB one of the first DHBs in the country to achieve >85% for a full quarter. In Q3 Waikato was at 86% and again in Q4, while also increasing the number of patients reported in the 62 day cohort.

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

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



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

- FCT Business Manager and FCT Nurse Tracker are working very closely with cancer care coordinators and clinical nurse specialists monitoring patient pathways from initial date of referral
- improving the timeliness of gynaecology triaging and first specialist appointment
- weekly coordinated meeting with gynaecology clinical nurse specialist and cancer care coordinator to discuss individual patients and tracking pathways to ensure patients are discussed at Auckland multi-disciplinary meetings in a timely manner
- Midland Cancer Network is collaborating with Northern Cancer Network and Auckland DHB to map the pathways for those patients who have breached to identify all the reasons contributing to those breaches
- outpatient clinic commencing late June/early July which will enable patients who are eligible to have hysteroscopy under local anaesthetic, thus freeing up theatre time and improving patient pathways
- ongoing monitoring of respiratory triaging and time to FSA
- weekly coordinated meeting with upper gastro-intestinal surgeons and upper gastro-intestinal cancer nurse coordinator to discuss and track individual patients to ensure patients proceed along the pathway in a timely manner.
- liaison with interventional radiologists to ensure patients receive their CT biopsy in a timely manner.
- weekly urology waitlist meeting to discuss any patients triaged onto 62 day pathway.

Graph 3 - Faster Cancer Treatment health target performance for Q4 2016-17 by month

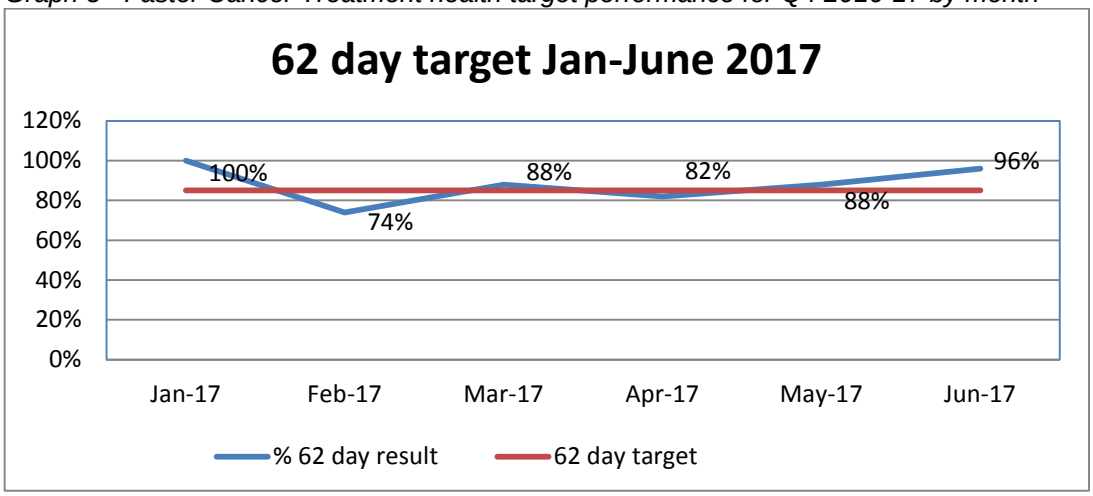


Table 5 - Faster Cancer Treatment health target performance for Q4 2016-17 by month

Local FCT Database	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Total
Number of records submitted	20	30	42	31	39	23	185
Number of records within 62 days	20	23	37	25	34	22	161
% 62 day Target Met (85%)	100%	77%	88%	81%	87%	96%	87%
% Volume Target Met (15%)	12%	19%	26%	19%	24%	14%	19%

Changes to the FCT health target in 2017-18

The Minister has confirmed that the FCT health target will increase to 90% from 1 July 2017.

From 1 July 2017 all FCT breaches of the health target including patient reason or clinical consideration will continue to be reported to the Ministry, but not included in DHBs FCT result.

In non-financial quarterly reporting DHBs will report a brief summary of all breaches to the MoH.

Target: Increased immunisations for 8 months

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	**DHB Q3 Result 16/17**	**Most recent 3 monthly result**
89% 17th ranking	**95%**	92% 13th ranking	91% 15th ranking	89% 17th ranking	92% 13th ranking	92% 15th ranking	**90% 16th ranking**	**89% June 17**

Data for this target is reported on a three month rolling basis. Graph 4 shows our most recent result of 89% for the three month period from 1 April 2017 to 30 June 2017.

Waikato DHB has still not met this target despite a range of well-established additional services such as outreach immunisation and the child health coordination services which have been in place for the last five years. Our approach is similar to other funders nationally and internationally taken to address missed immunisation events.

Current activities in this area include

- Focused activity on early enrolment of new-borns in primary care is a high priority for Waikato Child Health coordination Service and all PHOs. In trial is a generic new born enrolment form for use by Outreach Immunisation Service (OIS) providers
- New agreements are in place with PHOs which include free consultations for unenrolled mothers of new-borns to ensure their babies are enrolled which should assist immunisation.
- Outreach Immunisation Services (OIS) – working with Hauraki PHO to amalgamate subcontracted OIS providers to the PHO to reduce fragmentation and overheads and have one team focusing on hard to reach babies. Hauraki has appointed an administrator to support the OIS team.
- 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 is maintained
- Reduced declines - Annual training for health professionals with best practice embedded has been continued with a focus on reducing delays due to non-related medical concerns where delay to a vaccination is NOT contraindicated. Meeting held with Plunket to discuss ongoing health education with all females and whanau is respect to improving immunisation

coverage. NIR team leader contacts all general practices which decline new-borns with view to get them enrolled or refer to another practice. These new born are referred to OIS if not enrolled at 7 Weeks

- Waikato Child Health Co-ordination Service - a key service/contractual change means the provider (Midlands Health Network) has sufficient FTE resource in place to provide a comprehensive missing event's service and KPIs and outputs agreed between the DHB and all PHOs jointly monitored. There are 4 FTE fully funded clinical and non-clinical FTEs delivering this service
- Agreement in place for national Immunisation Monitoring and Advisory Group (IMAC) to run 6 hours immunisation training session for Lead Maternity Carers (LMCs) at no cost to LMC
- In depth analysis of immunisation events data by NHO underway to determine areas of low coverage and determinants of babies who miss immunisation with this information brought the attention of the Immunisation Steering Group to advise solutions

Further discussion has commenced in relation to the declines and whether alternative approaches to communicating with new mums around immunisation may impact on the decline rates.

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

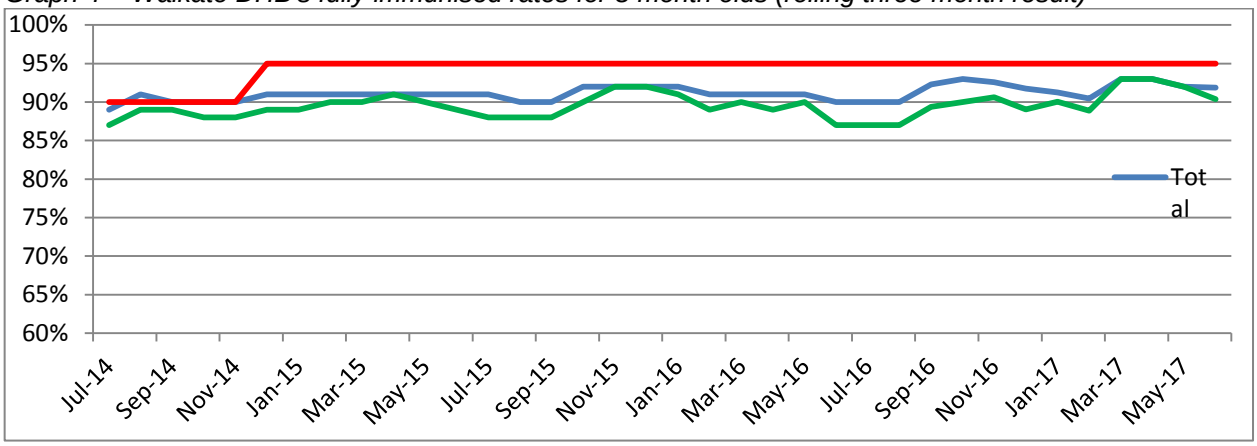


Table 6 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 90 additional children needed to be immunised to meet the 95% target.

Table 6 - Waikato DHB 8 month old immunisations ethnicity breakdown from Apr 2016 to June 2017

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
Asian	173	170	98%	0
Māori	533	457	86%	50
NZ European	521	465	89%	30
Other	127	107	84%	14
Pacific	51	46	90%	3
Total across ethnicities	0	0	0%	97
Total	1405	1245	89%	90

Table 7 below shows the latest immunisation rates for the eight month population for Waikato DHB by PHO and the population not fully enrolled with a Waikato based PHO.

Table 7 - Waikato DHB's PHO level results for 8 month old immunisation from Apr 2017 to June 2017

	Total population			Maori population		
PHO	No eligible population	No fully immunised population	Percent immunised	No eligible population	No fully immunised population	Percent immunised
Hauraki PHO	462	425	92%	216	192	89%
Midlands Health Network – Waikato	798	727	91%	238	211	89%
National Hauora Coalition *	21	17	81%	12	9	75%
Enrolled with a PHO outside of Waikato	38	31	82%	17	15	88%
Not enrolled	86	45	52%	50	30	60%
DHB Total	1405	1245	89%	533	457	86%

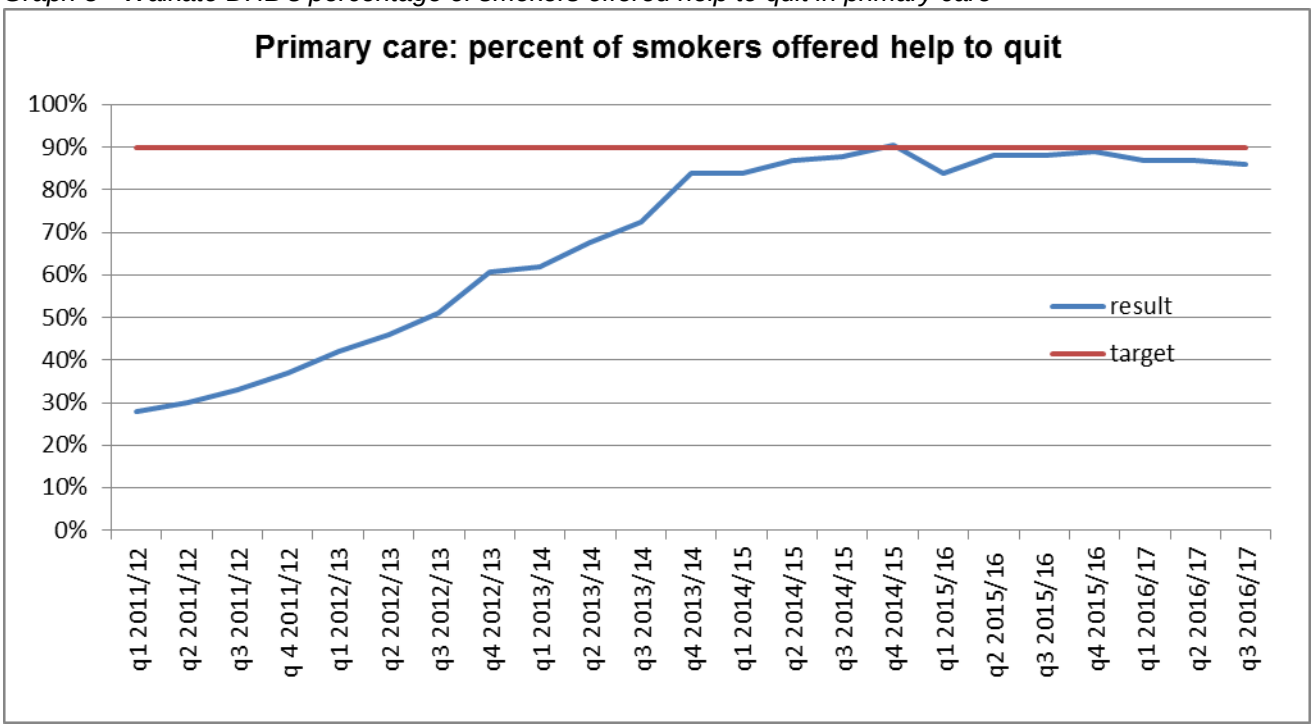
*Note – NHC data not yet available due to technical issues with the national reporting system so this data is for the 3 months ending March17.

Target: Better help for smokers to quit - primary care

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

Graph 5 of the quarter three final result of 86.0% shows Waikato DHB has dropped slightly from the previous quarter.

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



Following a recent discussion at the Waikato inter-alliance forum we are aware that approaches are occurring in relation to both improving achievement against this target and improving primary care referrals for cessation. Information for quarter 4 is not yet available to identify if this has resulted in an increase.

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

Table 8 – 2016/17 Q3 primary care smoking results by PHOs (target 90%)

PHOs	**Tobacco Numerator**	**Tobacco Denominator**	**2016/17 Q3 result**	**2016/17 Q2 result**	**2016/17 Q1 result**	**2015/16 Q4 result**
Midlands Health Network	25,815	29,507	88%	88%	88%	88%
Hauraki PHO	20,067	23,411	86%	86%	86%	86%
National Hauora Coalition	1,182	1,366	87%	86%	87%	92%
Total	46,791	54,204	**86%**	**87%**	**87%**	**89%**

Target: Better help for smokers to quit - maternity

DHB Q4 result 14/15	DHB Q4 result 15/16	DHB Q2 result 15/16	DHB Q3 result 15/16	DHB Q4 result 15/16	DHB Q1 result 16/17	DHB Q2 16/17	**Most recent result Q3 16/17**
91.2% 14th= ranking	95% 13th ranking	89% 15th ranking	97% 8th ranking	95% 13th ranking	93% 12th Ranking	98% Q2 result 4th Ranking	**96% Q3 result**

Graph 6 quarter two result of 96% shows we continue to met this target. Quarter three ranking is not yet available.

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

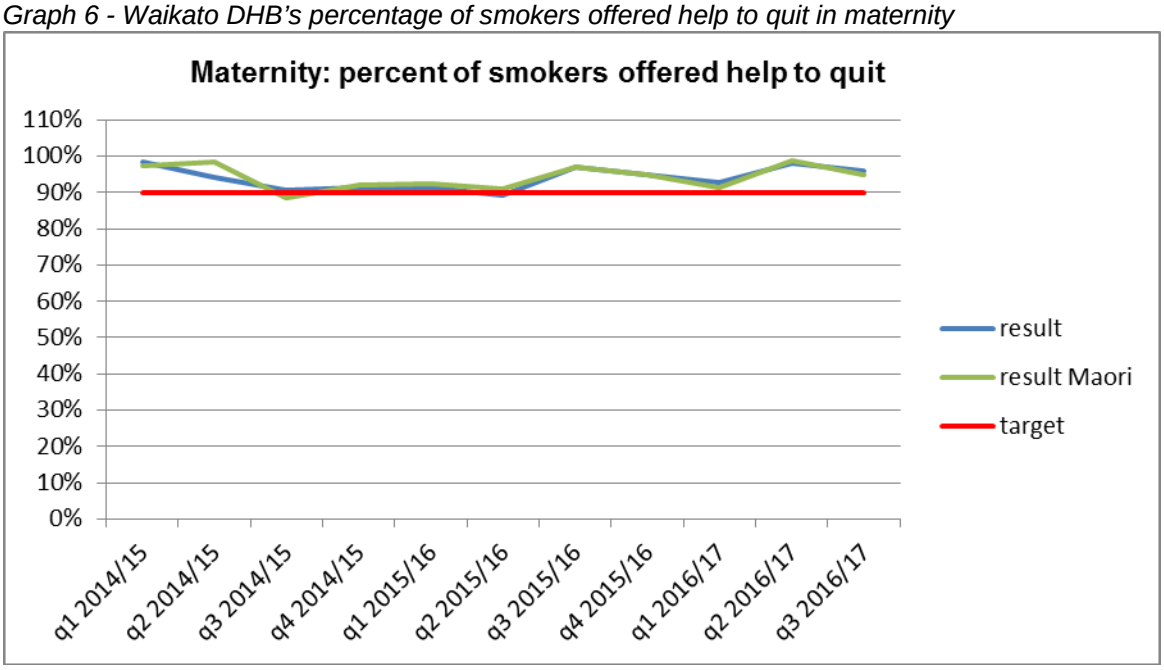


Table 9 shows our quarter three results provided by the Ministry for our total and Maori population.

Table 9 – 2016/17 Q3 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	150	78	74	52%	94.9%
Total	610	121	116	19.8%	95.9%

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

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

Target: Raising healthy kids

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

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

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

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

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

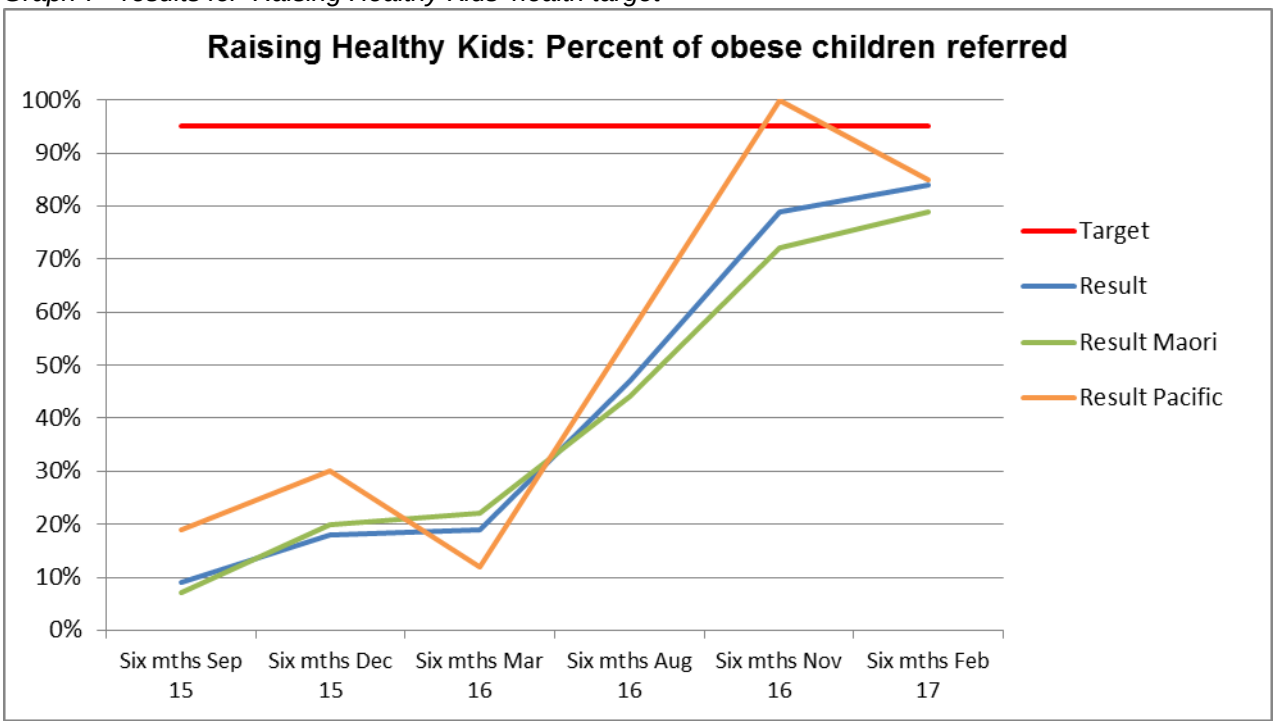
Table 10 – 2016/17 Q2 Raising Healthy Kids Results (target 95%)

		Waikato DHB						**National**
		2015/16 Q2	**2015/16 Q3**	**2015/16 Q4**	**2016/17 Q1**	**2016/17 Q2**	**2016/17 Q3**	**2016/17 Q3**
		Six mths Sep 15	**Six mths Dec 15**	**Six mths Mar 16**	**Six mths Aug 16**	**Six mths Nov 16**	**Six mths Feb 17**	**Six mths Feb 17**
Total	Referral Sent	13%	18%	23%	50%	82% (141)	86% (133)	89%
	Referral Sent and Acknowledged	**9%**	**18%**	**19%**	**47%**	**79% (135)**	**84% (127)**	**86%**
Maori	Referral Sent	12%	21%	30%	49%	76% (63)	82% (65)	86%
	Referral Sent and Acknowledged	**7%**	**20%**	**22%**	**44%**	**72% (58)**	**79% (61)**	**83%**
Pacific	Referral Sent	26%	30%	12%	56%	100% (11)	90% (9)	94%
	Referral Sent and Acknowledged	**19%**	**30%**	**12%**	**56%**	**100% (11)**	**85% (8)**	**92%**

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

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

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



Data for a 6 month rolling period up to Feb 2017

Recommendation
THAT
The Board receives this report.

BRETT PARADINE
EXECUTIVE DIRECTOR
WAIKATO HOSPITAL SERVICES

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

SUE HAYWARD
DIRECTOR
NURSING AND MIDWIFERY

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY AND CLINICAL SUPPORT

MEMORANDUM TO THE BOARD
26 JULY 2017

AGENDA ITEM 9.2

PROVIDER ARM KEY PERFORMANCE DASHBOARD

Purpose	For information.

The high level provider arm key performance dashboards for June 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

June 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	94.5	95.0	(0.5)	95.3	95.0	0		
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	%	89.7	90.0	(0.3)	92.1	90.0	2.1		
MRIs reported within 6 weeks of referral	%	83.9	85.0	(1.1)	88.0	85.0	3.0		

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department - Number relative to Target growth of 4% p.a.	Numbers	Rolling 12 month measure			34,481	34,170	(311)		
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			79.6	85.5	(5.8)		1
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			94.2	99.4	(5.1)		2
Laboratory – Histology specimens reported within 7 days of receipt	% for May YTD	75.0	80.0	(5.0)	50.3	80.0	(29.7)		3
Pharmacy - Chart turnaround times, % within 2.5 hours	%	92.0	80.0	12.0	91.8	80.0	11.8		
Pharmacy on Meade script turnaround time in minutes	minutes	8.7	10.0	1.3	7.5	10.0	2.5		
Outpatient DNA Rate	%	9.5	10.0	0.5	10.7	10.0	(0.7)		4
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	97.2	100.0	(2.8)	96.2	100.0	(3.8)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	98.9	100.0	(1.1)	93.6	100.0	(6.4)		5
Output Delivery Against Plan - Inpatient CWD Volumes	%	98.7	100.0	(1.3)	93.2	100.0	(6.8)		6
District Nurse Contacts (DHB Purchased)	Numbers	10,411	-		118,858				
District Nurse Contacts (ACC Purchased)	Numbers	1,885	-		26,007				

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			3.34	3.80	0.46		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			1.09	0.96	(0.12)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			0.32	0.41	0.09		

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	100.0	95.0	5.0		

Quality Indicators - Patient Safety

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Breast screening Total volumes - Waikato DHB	Numbers	3,602	3,500	102	41,718	41,000	718		
Breast screening Maori volumes - Waikato DHB	Numbers	209	331	(122)	2,542	3,465	(923)		7
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 (All)	9	8	(1)	163	94	(69)		8
Complaints resolved within 20 wd (1 month lag)	% for May-17	82	70	12	68	70	(2)		
Falls Resulting in Harm	Numbers	0			22				
Pressure Injuries - Total	Numbers	0	2	2	22	49	27		
Patient Feedback	*Not yet collected - in Development*								

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	2,794	2,532	263	32,179	29,542	2,637		
Actual Expenditure vs Budget ($000s)	$000s	12,588	12,687	99	151,249	147,608	(3,641)		
Actual Contribution vs Budget ($000s)	$000s	(9,794)	(10,156)	362	(119,070)	(118,067)	(1,004)		
Actual FTEs vs Budget	FTEs	1,000.6	1,003.6	3.1	999.5	997.9	(1.6)		
Sick Leave	% of paid hours	4.0	2.8	(1.2)	3.0	2.9	(0.2)		9
Overtime $'s	$000s	198	141	(58)	2,144	1,682	(463)		10
Annual Leave Taken	% of Budget	Rolling 12 month measure			87.9	100.0	(12.1)		11

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

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

Note	Indicator	Commentary
1	Elective and Arranged Day Surgery Percentage	Phenomenally good performance in Australasian terms. The mix of same day vs overnight surgery is changing. The KPI target requires resetting.
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 – inpatient episodes	Seasonal demand is now evident.
6	Output delivery against plan – inpatient cwd	Refer above.
7	Breast Screening – Māori volumes	As was forecast this target was not met for the year. The change in Support to Screening providers effectively reduced activity for 5-6 months. All of the new Support to Screening providers are now fully operational and the rate of Maori women now being referred to be booked is showing improvement.
8	Complaints	Complaint numbers have been brought into line with expectations.
9	Sick leave	No concerns of note.
10	Overtime $'s	No particular concerns are evident that have not been reported in prior periods.
11	Annual leave taken	No particular concerns are evident that have not been reported in prior periods.

Key Performance Dashboard

Mental Health

June 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	86.7	95.0	(8.3)	87.8	95.0	(7)		1

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health seclusion hours	Hours	478	371	(108)	11,039	4,449	(6590)		2
Mental health treatment plans	% Cases	82.6	95.0	(12.4)	89.2	95.0	(5.8)		3
Mental health HoNos matched pairs	% Cases	95.0	95.0	(0.0)	98.3	95.0	3.3		
Mental health inpatient bed occupancy	%	94.2	87.1	(7.1)	93.6	87.1	(6.5)		4
Mental health GP methadone cases	Cases	92.0	76.0	16.0	93.5	76.0	17.5		

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	%	89.2	90.0	(0.8)	91.0	90.0	1.0		
Mental health follow up - numbers seen in 7 days	Number of Cases	66	66.6	(0.6)	735	727.2	7.8		
Mental health community contract positions filled	% FTEs	98.6	95.0	3.6	96.9	95.0	1.9		
Mental health 28 day readmission rate	%	11.7	15.0	3.3	11.8	15.0	3.2		

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	98.3	95.0	3.3	98.1	95.0	3.1		

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 (All)	6	7	1	89	86	(4)		
Complaints resolved within 20 wd (1 month lag)	% for May-17	13	70	(58)	35	70	(35)		5
Falls Resulting in Harm	Numbers	4			18				

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	249	202	47	2,544	2,573	(29)		
Actual Expenditure vs Budget ($000s)	$000s	6,431	6,094	(337)	73,789	72,257	(1,531)		
Actual Contribution vs Budget ($000s)	$000s	(6,182)	(5,892)	(290)	(71,245)	(69,685)	(1,560)		
Actual FTEs vs Budget	FTEs	743.3	734.1	(9.3)	739.8	732.5	(7.3)		
Sick Leave	% of paid hours	4.2	3.0	(1.3)	3.4	3.0	(0.4)		6
Overtime $'s	$000s	118	76	(41)	1,054	910	(143)		7
Annual Leave Taken	% of Budget	Rolling 12 month measure			89.4	100.0	(10.6)		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 June 2017

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

Note	Indicator	Commentary
	Emergency Hours <6 hours	64 MH Presentations for June versus 88 presentations for May • 76% of the MH related presentations arrived in ED after hours • 8 Breached presentations included: ▪ 3 overdose ▪ 2 suicidal ▪ 1 psychotic episode ▪ 1 delusional / visual hallucinations ▪ Unclear "mental health issues" There were less presentations to ED in June, half the number of breaches, however the numbers arriving after hours increased from 58% to 76%
1	Seclusion	• Total hours spent in seclusion for Adult was 312.19 for June compared to 852.73 hours in May (monthly target ~233) • Total hours spent in seclusion for Forensic was 166.25 for June compared to 232.74 hours in May (monthly target ~138) • Sixteen individuals were secluded during June 2017, 14 of those within the Adult wards and 2 within the Forensic wards. • The Longest episode in the adult facility was 71.6 hours long and the shortest 3.18 hours long • The Longest episode in the Forensic facility was 112.75 hours long and shortest 53.5 hours • Of the sixteen individuals secluded during June 6 identified as Maori • There were 19 seclusion events during June; Maori accounted for 9 of the events and NZ Euro/Other 10 events. The service has arranged for a peer review to look at our performance around seclusion. Anne Brebner, Nurse Director Counties Manukau and Dr Mike Ang, Clinical Director, Waitemata have agreed to look at our strategy, meet with staff, and help identify any further improvements we might make to reduce our levels of seclusion.
2	Treatment Plans	All services dropped their treatment plan completion percentages slightly in June, which is disappointing given the efforts which are

		being employed to ensure they are kept up to date. A sustained effort to improve this is being undertaken.
3	Occupancy	Over occupancy of the HRBC continues to be challenging and additional beds were again temporarily opened for 24 hours in a previously used ward, to support individuals who were due to be discharged the following day. Whilst there is flow out of the adult inpatient beds, there continues to be a steady number of individuals requiring acute admission. All services including older persons (15 beds) and Forensic (50) beds are generally 100% full, further adding to the overall mental health bed occupancy being maintained above 85%. There is beginning to be pressure on both older adult and forensic beds, with individuals identified as needing admission prior to a bed becoming available. Work is currently being developed to report data and narrative around individuals who are in the HRBC for extended periods due to an inability to find a suitable community placement. As previously reported this is a sustained problem for the service, with a number of individuals with complex presentations, usually related to intellectual disability or level of cognitive functioning and a lack of suitable community options for the level of complexity in their presentation. While we feel an obligation not to discharge these people without suitable community care, the unintended consequences are high occupancy, untenable patient mix and a deteriorating mental state for those who are spending extended periods in an acute unit.
	Post discharge 7 day follow up (not required to be reported upon)	A total of 74 people seen and 8 not seen in the timeframe. Total of 8 people not seen within the post 7 day timeframe were a mix of those who declined to be followed up, difficulty trying to engage individuals for follow up or DNA to planned appointments. One service user was not seen due to staff sickness, which could have been allocated to another staff member to undertake. Overall percentage seen is 89.19% which is including post discharge follow up for alcohol or any other drug detox admissions.
4	Complaints	A total of 8 complaints were received in May 2017 – 6 of which have been closed. 2 of these were closed within the timeframe, 4 were overdue

		>10 days with 1 still outstanding from May. This is a complex situation in MHSOP where the family member has requested an independent review of care received. Professor Mellsop has agreed to complete this review. 2 were about patient property 4 about clinical treatment 2 other (appointments being moved & CADS input at Springhill)
5	Falls	Two falls with harm are reported although four falls have been reported in Datix for June. Current action in relation to falls within the service: OPR1 are implementing the falls module as part of the Releasing Time to Care module. Incident 1: Harm reported – graze on back. Immediate actions: vital signs, physical assessment. CNM review No corrective action indicated. Incident 2: patient sustained small 1cm scratch on back of the head. Immediate actions taken: observations, assisted back to bed, area on head cleansed, Dr. notified. CNM follow up – no corrective action indicated Incident 3: painful right knee. Duty House Officer examined. No corrective action indicated Incident 4: Query fractured Rib. CNM follow up: No corrective action indicated. No serious injury from this fall
6	Contribution	With the savings targets which were identified for mental health and addictions the service was not able to meet these, despite making a significant contribution to the organisation. This is largely due to better than expected recruitment to community positions, which in previous years has proved challenging and meant to the service could meet increased budget savings placed upon it.
	Sick Leave	Sick leave, whilst ahead of target appears to follow the usual seasonal trend for mental health. The target is 3.9% which for winter months is a reasonably low target. 4.2% actual sick leave is not concerning for this time of year.
7	Annual Leave	Active annual leave management across the year is encouraged. Teams have yearly leave plans and it is rare that leave is declined. 83.5% of annual leave earned was used in the year that is was earned.

Key Performance Dashboard

Waikato Hospital Services

June 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	79.7	95.0	(15.3)	84.3	95.0	(11)		1
Faster Cancer Treatment - Referral received to first treatment <= 62 days	% of patients	95.7	85.0	10.7	86.2	85.0	1.2		
Chemotherapy treatment < 4 Weeks Wait	% of patients	100.0	100.0	0.0	100.0	100.0	0.0		
Radiotherapy < 4 Weeks Wait	% of patients	100.0	100.0	0.0	100.0	100.0	0.0		
Number of long wait patients on outpatient waiting lists	# > 4 mths	33	0	(33)	2,506	0	(2506)		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	39	0	(39)	1,018	0	(1018)		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	%	87.3	85	2.3	77.0	85.0	(8.0)		4
Hospital initiated elective theatre cancellations	%	6.4	2.5	(3.9)	5.8	2.5	(3.3)		5
Waiting Time for acute theatre < 24 hrs	%	74.5	80	(5.5)	73.1	80.0	(6.9)		6
Waiting Time for acute theatre < 48 hrs	%	88.4	100	(11.6)	87.3	100.0	(12.7)		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			250.3				
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			51.2	51.9	(0.7)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			75.7	81.2	(5.5)		8
Outpatient DNA Rate	%	9.5	10.0	0.5	9.9	10.0	0.1		
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	94.1	100.0	(5.9)	98.6	100.0	(1.4)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	109.6	100.0	9.6	100.4	100.0	0.4		
Output Delivery Against Plan - Inpatient CWD Volumes	%	104.6	100.0	4.6	100.3	100.0	0.3		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Number of long stay patients (>20 days length of stay)	Discharges	49	59	10	737	624	(113)		9
Number of long stay patient bed days (>20 days los)	Bed Days	1,474	1,786	312	24,690	20,618	(4072)		10
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			4.13	4.01	(0.12)		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			2.18	2.00	(0.18)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			1.02	1.14	0.12		

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	93.3	95.0	(1.7)	95.1	95.0	0.1		

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 May-17	83.1	90.0	(6.9)	94.4	90.0	4.4		
Compliance with good hand hygiene practice (Cluster Rate)	%	85.7	85.0	0.7	85.8	80	5.8		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers (All)	51	63	12	676	753	77		
Complaints resolved within 20 wd (1 month lag)	% for May-17	64	70	(6)	57	70	(13)		11
Falls Resulting in Harm	Numbers	16			127				

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	11,120	9,486	1,634	120,044	113,663	6,382		
Actual Expenditure vs Budget ($000s)	$000s	41,795	38,191	(3,605)	455,322	433,198	(22,124)		12
Actual FTEs vs Budget	FTEs	3,155.8	3,067.2	(88.6)	3,113.3	3,091.8	(21.4)		
Sick Leave	% of paid hours	3.6	2.7	(0.8)	3.0	2.9	(0.1)		
Overtime $'s	$000s	543	312	(231)	5,629	3,308	(2,321)		13
Annual Leave Taken	% of Budget	Rolling 12 month measure			86.7	100.0	(13.3)		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 – June 2017

Note	Indicator	Commentary
1.	Emergency Department < 6 hours	This target remains challenging as outlined in the recent presentation to the Performance Monitoring Committee by the Executive Director Operations & Performance and the Director Medicine, Oncology and Emergency services. Waikato Hospital is continuing to experience pressure from increased attendances (+16% when compared to June 2016) and pressure on beds, with the hospital invoking an incident management response to address the hospital being overloaded on one occasion in the month. June saw the greatest volume of Waikato ED attendances on a single day on record, with 283 presentations on 26th June, against a staffing matrix for circa 210. This has had a negative impact on performance for both the non-admitted, or ED only patients, (which reduced to 87%) and for the admitted pathway which deteriorated to 68%. Plans to open an additional ward in OPR5 are progressing with urgency, alongside a redoubled focus on specialties responding promptly to surges in their ED patient numbers. Additional work is planned at a service leadership group level on improving discharges and expediting discharges to the T hospitals for patients who could be treated in more local facilities. Internal Medicine has proactively been ensuring the medical teams attend ED and have started to attend the regular ED meetings at both a nursing and medical leadership level. This has helped reduce the 'silo working' that has traditionally existed and is expected to be one of the benefits of the new Service Leadership Group model created through the Waikato Hospital Leadership restructure which put ED and Internal Medicine under the same leadership.
2.	Long wait patients on outpatient waiting lists	Work continues on this on a daily basis with a number of specialities against the MOH ESPI 2 target. With initiatives in managing inflows, recruitment and implementation of the orthopaedic action plan we achieved ESPI 2 compliance in April and May and provisional result of amber compliance for ESPI 2 in June. Amber compliance in June will be the first time that we have achieved three months of amber compliance in succession for ESPI 2 since the recently filled orthopaedic surgery vacancies occurred.
3.	Number of long wait patients on inpatient waiting lists	A provisional result of amber compliance for ESPI 5 in June is the first month for ESPI 5 and ESPI 2 compliance coinciding for some time. This will become more common as our ESPI management process and production planning continue to mature. At this point in time, July results will be close to compliance. The outlook for ESPI 5 beyond July is improving at this early stage.
4.	Theatre Utilisation – Elective Sessions	In June the target was met – 87.5%, although from the YTD result this indicator remains an area for attention. The deficit in budgeted anaesthetic resource will continue to adversely affect this marker in the short term however recruitment is underway with the current expectation being that we will have an additional 4 SMO anaesthetists arriving between October and December. In the meantime there is robust weekly management of this resource to maximise elective theatre session utilisation.

Note	Indicator	Commentary
5	Hospital Initiated elective theatre cancellations	An audit of reasons for cancellations is being analysed. The results will be included in the project evaluation of the pre hospital preparedness project which is due for completion during July.
6.	Waiting time for acute theatre less than 24 hours	This KPI is monitored via our Theatre and Interventional Governance Group (TIGG). TIGG has identified a gap in weekend acute capacity, with the principal bottlenecks being weekend anaesthetist and MRT numbers. Planning to utilise the additional anaesthetist FTE referred to above will include allocation to enhance weekend acute capacity. In the meantime escalation (additional session) processes are being used to secure additional weekend capacity. Work is happening alongside this to secure commensurate MRT resource.
7.	Waiting time for acute theatre less than 48 hours	As per item 6.
8.	Elective and arranged day of surgery admissions	Although our day stay rates compare favourably there is room for improvement in both day stay and DOSA. Our TIGG has initiated investigation to address this and identified clinical leads to initiate process change across services starting with those procedures identified as being suitable for day stay but where those procedures have incurred an overnight stay. This will be monitored via TIGG.
9.	Number of long stay patients (> 20 days length of stay)	A DHB wide discharge initiative is being launched in September now, led by the Executive Director Operations and Performance with involvement from the Director of Medicine, Oncology, ED and Ambulatory Care and the Director of OPR and Allied Health. This programme includes emphasis on long stay patients, which has been enhanced with weekly reporting to the capacity and demand management forum and higher scrutiny of long stay reasons. There has been some improvement in recent months, however, YTD still higher than target.
10.	Number of long stay patient bed days	As per item 9
11.	Complaints resolved within 20 working days	The result of 64% for May is a significant improvement on the YTD result of 57%, reflecting ongoing work to achieve this target.
12.	Actual Expenditure vs Budget	The year end result is as per forecast, including the impact of initiatives including increased elective outsourcing and ED staffing.
13.	Overtime $'s	This has remained steady as a result of regular levels of escalation lists required to support acute service delivery particularly at weekends. This links to # 6. Also an exceptionally busy acute month in the Child Health service within the service resulted in additional staff being rostered after hours/weekends to provide safe staffing to meet demand. Ongoing high vacancies have resulted in the requirements for increased

Note	Indicator	Commentary
		overtime throughout the Womens Health service. Overtime up slightly due to sick leave and high presentations and occupancy for OPR & AH.
14.	Annual leave taken	Year to date performance against this indicator remains very good.

MEMORANDUM TO THE BOARD
26 JULY 2017

AGENDA ITEM 9.3

STRATEGY & FUNDING KPI DASHBOARD

Purpose	For information.

The Strategy and 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.

As discussed at the June Board meeting a revised approach to reporting had been considered at the June Performance Monitoring Committee meeting. This would include additional reporting on key areas on a rolling schedule throughout the year. This approach is intended to give a more depth view of key areas and reflecting that the majority of items reported are available on a quarterly basis only and often move only gradually over time.

The report for the August committee will focus on the child and youth suite of indicators. The reporting will focus on equity as well as performance against targets (where available) and national rates.

At the August Performance Monitoring Committee meeting a schedule of future items will be agreed however it is expected that the next few workshops will include items such as services for older people and mental health and addictions. Following introduction of this new approach consideration will be given to whether there is value in continuing this dashboard except for specific items.

Recommendation
THAT
The report be received.

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

Strategy and Funding KPI Dashboard

Note	Indicator	Commentary
1	Proportion of older people waiting greater than 20 days for initial assessment or reassessment	Data shows most recent quarter. This indicator continues to improve and the service is managing the issues previously identified. This has indicated significant improvement over the last 2 years reducing from 46% of initial assessments being outside of 20 days in the quarter ending June 2015 to 8% in the quarter ended June 2017. Waiting time targets are also managed at different triage levels to ensure high needs clients are prioritised.
3	2 year old immunisations	Latest 2 year old coverage result is 92% (target 95%). The 3% point gap represents 111 children not immunised on time. For children aged 2 years, this quarter the highest coverage was for Asian children (98%) and lowest for Other (none Maori, Pacific, NZ European, Asian) (84%). Our latest results also show NZ European 3% ahead of Maori for this cohort by 2 years. This measure is a contributory measure in the 16/17 and upcoming 17/18 Service Level Measure Improvement Plan for ASH rates for 0-4 year olds. In line with the approach taken in under 8 month immunisations an initial focus will be on addressing enrolment status of any children not enrolled and identifying reasons for declines.
4	Ambulatory sensitive hospitalisations	Quarterly indicator – Information has recently been received but is yet to be analysed / discussed at the demand management forum. The data shows pleasing improvements in the rates for 0-4 years but have deteriorated for the 45-64 year old age group for both Maori and other ethnicities.

Appendix A **Strategy and Funding KPI RESULTS**

Strategy and Funding - Key Performance Dashboard

June	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	89%	95%	-6%	✗	89%	95%	-6%	✗	
Better help for smokers to quit (primary care)	%	↑	Mar-17	No	86%	90%	-4%	!	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	$		Jun YTD	Yes	10,418	10,993	-575	✗	129,030	131,921	-2,891	!	
IDF outflow estimate	$		Jun YTD	Yes	4,325	4,559	-234	✓	56,643	54,714	1,929	!	

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 Feb 17	No	74%	80%	-6%	✗	75%	80%	-5%	✗	
MH waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Mar 17	Yes	79%	80%	-1%	!	79%	80%	-1%	!	
AOD waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Feb 17	No	94%	95%	-1%	!	94%	95%	-1%	!	
MH waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Mar 17	Yes	92%	95%	-3%	!	92%	95%	-3%	!	
Proportion of Health of Older people initial needs assessments Waiting greater than 20 days	%	↓	Apr - Jun 17	Yes	8%	0%	-8%	✗	11%	0%	-11%	✗	
Proportion of health of older people need re-assessments Waiting greater than 20 days	%	↓	Apr - Jun 17	Yes	7%	0%	-7%	✗	4%	0%	-4%	✗	
Proportion of older person funding in community based services	%	↑	Jun YTD	Yes	27%	25%	2%	✓	28%	25%	3%	✓	
Pharmacy Items claimed	Items		May-17	Yes	580,814	N/A			477,283	N/A			
Laboratory turnaround tmes	%	↑	Oct-Dec16	No	100%	97%	3%	✓	100%	97%	3%	✓	
Primary options referrals	Referrals				These areas will be reported in the future once expected volumes are seasonalised/targets set								
	%												
Breast Screening (total eligible population)	%	↑	Mar-17	No	67%	70%	-3%	!	67%	70%	-3%	!	
Cervical screening (total eligible population)	%	↑	Mar-17	No	77%	75%	2%	✓	77%	75%	2%	✓	
Cervical screening (High Need)	%	↑	Mar-17	No	68%	75%	-7%	✗	68%	75%	-7%	✗	
2 year old immunisations (total population)	%	↑	Rolling 3 months	Yes	92%	95%	-3%	!	92%	95%	-3%	!	
2 year old immunisations (Maori)	%	↑	Rolling 3 months	Yes	90%	95%	-5%	✗	92%	95%	-3%	!	
Green Prescriptions	%	↑	Apr - Jun 17	Yes	1,537	1,675	-138	✗	1,656	1,675	-19	!	

Ambulatory Sensitive Admissions - Rates per 100,000 Population

Indicator	Unit	⇵	Data period	Updated from prior report	YT Mar 2017				YT Dec 2016				
Ambulatory sensitive admissions 0-4	rate	↓	YT Mar 2017	y	7172	7298	126	✓	7473	7298	-175	!	New ASH Definitions
Ambulatory sensitive admissions 0-4 (Maori)	rate	↓	YT Mar 2017	y	8015	7936	-79	!	8224	7936	-288	!	New ASH Definitions
Ambulatory sensitive admissions 45-64	rate	↓	YT Mar 2017	y	4243	3936	-307	✗	4167	3936	-231	✗	New ASH Definitions
Ambulatory sensitive admissions 45-64 (Maori)	rate	↓	YT Mar 2017	y	8303	5838	-2465	✗	7926	5838	-2088	✗	New ASH Definitions

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

S&F Primary Care KPIs

Data updated to end of: Jun-17

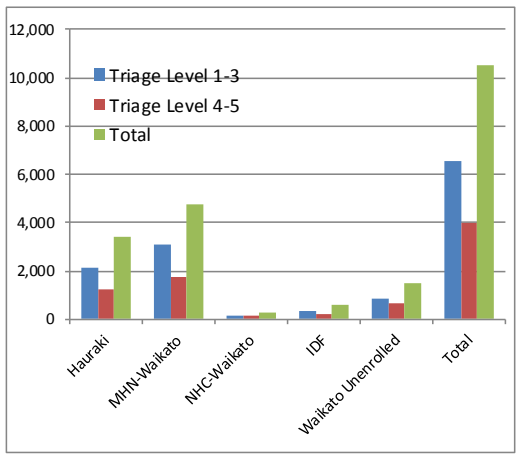
Emergency Department Presentations

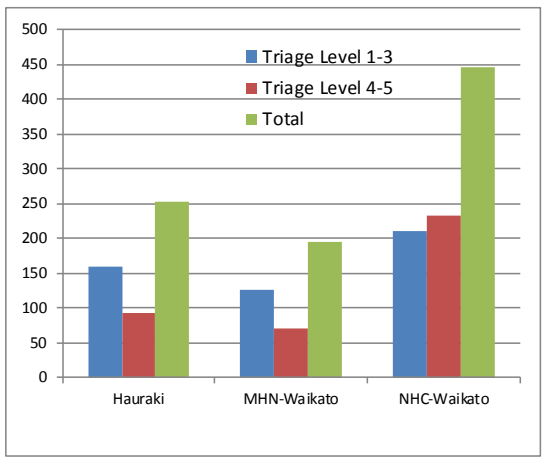
Monthly data for June-17

Total - All Ethnicities

	Volumes			Rates per 10,000 people		
	Triage Level			Triage Level		
PHO	1-3	4-5	Total	1-3	4-5	Total
Hauraki	2,156	1,251	3,407	160	93	253
MHN-Waikato	3,061	1,724	4,785	126	71	196
NHC-Waikato	124	137	261	212	234	446
IDF	360	222	582			
Waikato Unenrolled	842	641	1,483			
Total	**6,543**	**3,975**	**10,518**			

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*

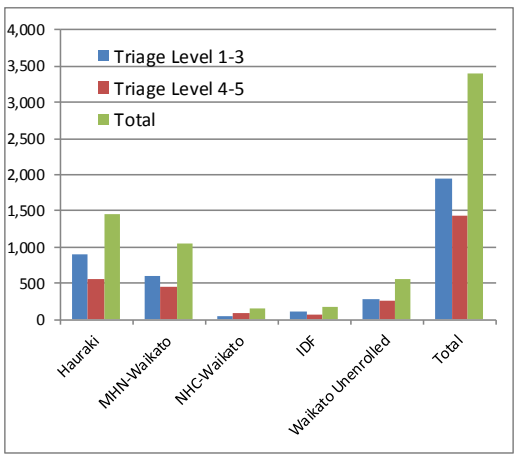


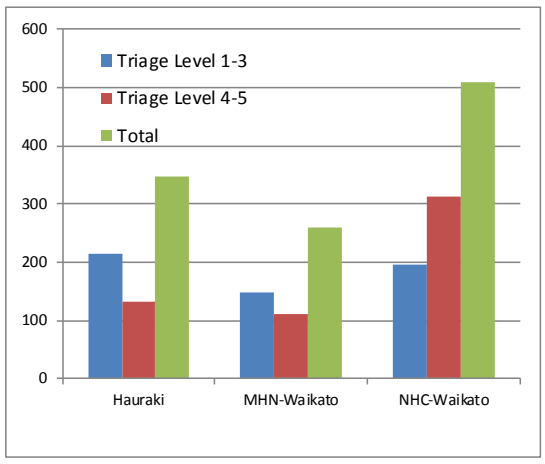


Maori

	Volumes - Maori			Rates per 10,000 people		
	Triage Level			Triage Level		
PHO	1-3	4-5	Total	1-3	4-5	Total
Hauraki	903	556	1,459	215	132	347
MHN-Waikato	596	446	1,042	148	111	259
NHC-Waikato	58	93	151	195	313	509
IDF	106	80	186			
Waikato Unenrolled	294	257	551			
Total	**1,957**	**1,432**	**3,389**			

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*



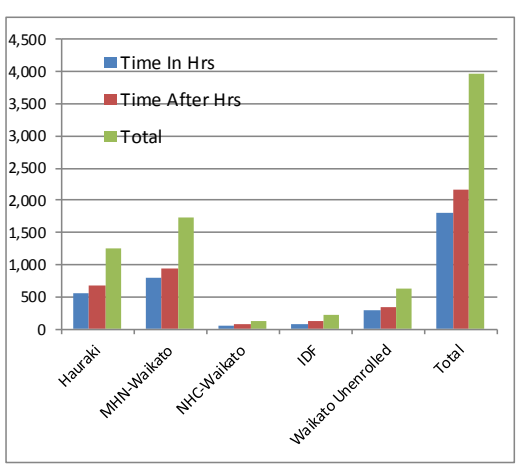


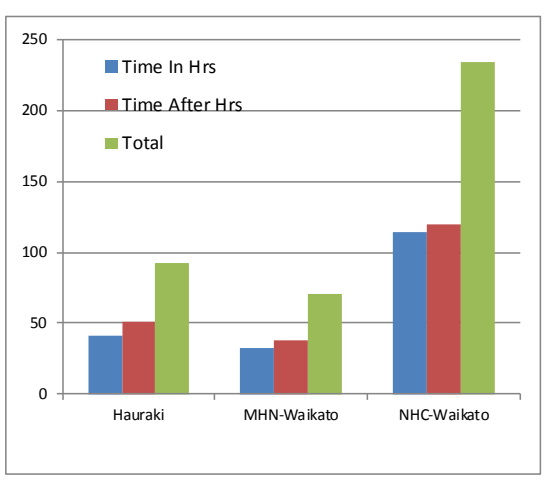
In Hours vs After Hours (Triage 4-5 only)

In Hours = 8am to 5pm Mon-Fri exc public holidays

	Volumes			Rates per 10,000 people		
	Time			Time		
PHO	In Hrs	After Hrs	Total	In Hrs	After Hrs	Total
Hauraki	562	689	1,251	42	51	93
MHN-Waikato	789	935	1,724	32	38	71
NHC-Waikato	67	70	137	114	120	234
IDF	84	138	222			
Waikato Unenrolled	297	344	641			
Total	**1,799**	**2,176**	**3,975**			

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*





Ambulatory Sensitive Hospitalisations (ASH) Jun-17 (Utilising the new ASH Definitions)

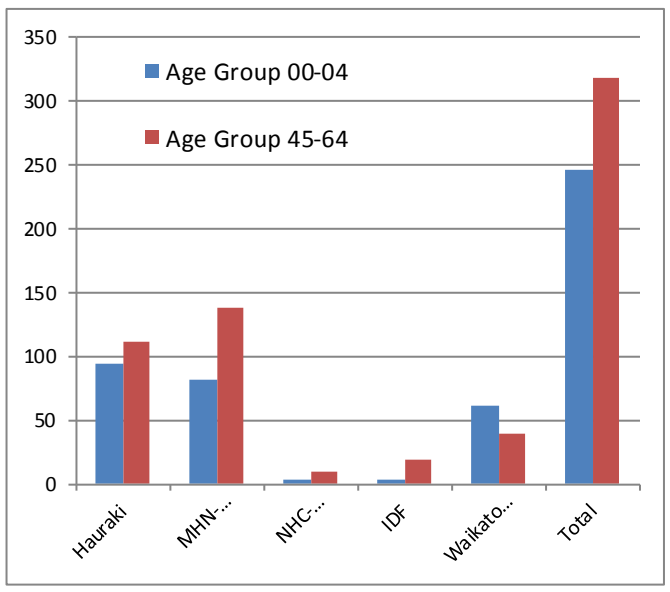
Total - All Ethnicities Monthly data for June-17

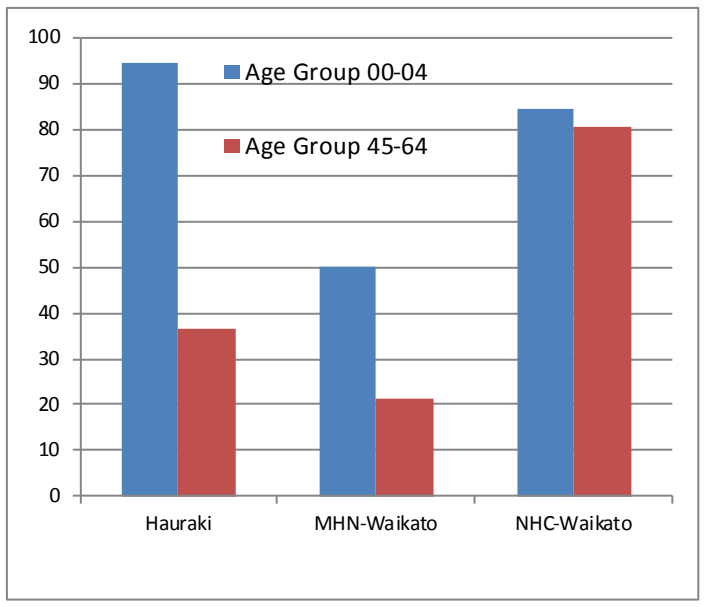
	Volumes - Apr17	
	Age Group	
PHO	00-04	45-64
Hauraki	95	111
MHN-Waikato	82	138
NHC-Waikato	4	10
IDF	4	20
Waikato Unenrolled	62	40
Total	**247**	**319**

Rates per 10,000	
Age Group	
00-04	45-64
95	37
50	21
84	80

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*

** Not Enrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs or from outside the area (i.e. an IDF patient)*





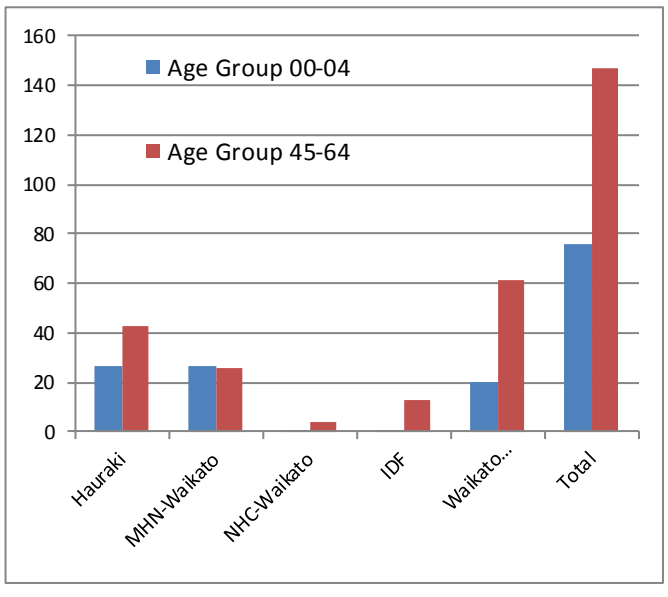
Maori Monthly data for June-17

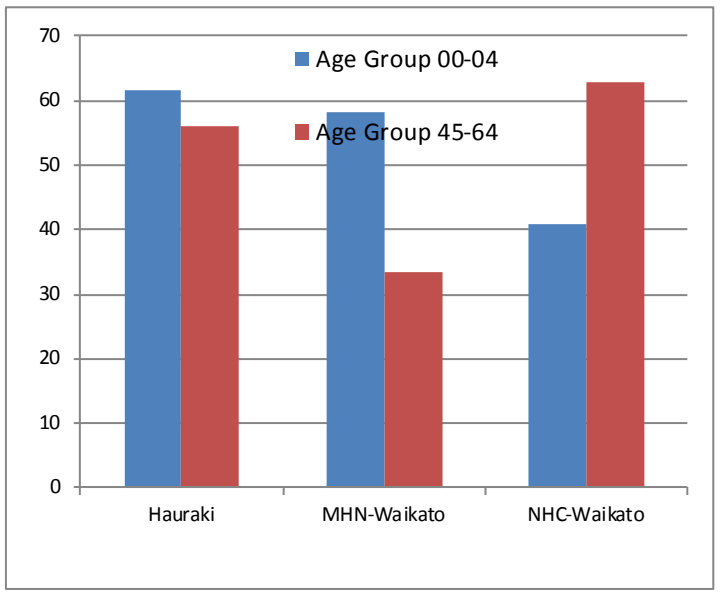
	Volumes - Maori	
	Age Group	
PHO	00-04	45-64
Hauraki	27	43
MHN-Waikato	27	26
NHC-Waikato	1	4
IDF	1	13
Waikato Unenrolled	20	61
Total	**76**	**147**

Rates per 10,000	
Age Group	
00-04	45-64
62	56
58	34
41	63

**unenrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs*

** Not Enrolled = living inside Waikato DHB area and not enrolled with one of the 3 PHOs or from outside the area (i.e. an IDF patient)*





MEMORANDUM TO THE BOARD
26 JULY 2017

AGENDA ITEM 9.4

MENTAL HEALTH & ADDICTIONS SERVICE S99 INSPECTION ACTION PLAN UPDATE

Purpose	For information.

An update on actions arising from the s99 Mental Health (CAT) Act Inspection (2015) is attached for the Board's information.

Recommendation
THAT
The report be received.

DEREK WRIGHT
EXECUTIVE DIRECTOR, MENTAL HEALTH AND ADDICTIONS SERVICE

WAIKATO DHB MENTAL HEALTH & ADDICTIONS SERVICE

S99 (Mental Health Act) Inspection Report Action Plan

Recommendation 1: There needs to be an immediate appointment to the role of Executive Director, to enable the Director of Clinical Services to concentrate on leading clinical changes. The DHB needs to give careful consideration to appointing someone who is the right fit for this service given its transformational change and operational challenges.			
Appointment of Executive Director.	Feb 2016	Complete	Derek Wright appointed as Executive Director.
Recommendation 2: There needs to be a clear strategy on positive clinical risk management that ensures appropriate human rights while at the same time educating and assuring the public.			
Models of care and staff education support "positive risk taking"	Dec 2016	Partially Complete	Training in positive risk training was implemented in June 2016 and continues. Phase 1 on the Model of Care development is currently underway as this aligns to the development of the business case for the new inpatient and rather than rush to completion, a consultative process, including Investment Logic Mapping and community, family and cross sector engagement is underway.
Current framework of audit and evaluation of inpatient services to continue	April 2016	Complete and ongoing	A specific audit framework and evaluation plan has been developed and audits are reported quarterly to the MHAS Clinical Governance Forum on an ongoing basis.
Communication strategy and communications plan for internal and external stakeholders	April 2016	Complete and ongoing	A communications strategy which includes increased engagement and communication with the wider community has been developed and implemented.

			The Waikato DHB Board receives bi-monthly updates on progress against the implementation action plan for the S99 report, along with continued reporting of MHAS service development. Mental Health and Addictions Services publishes a "Community Report Card" on a quarterly basis in regional and local press. In addition, Mental Health and Addictions Services have linked with Waikato DHB's Suicide Prevention and Rural Health Teams to deliver presentations and seminars to a number of community focus groups, at Field Days and at rural mental health sites. We plan to continue and grow all of these initiatives on an ongoing basis, making our services more transparent to the wider Waikato community.
Recommendation 3: *The DHB needs to devote attention to some immediate staffing relief in critical areas (especially in some of the community teams) to reduce staff burn-out and churn, fill vacancies and improve staff retention.*			
Increase inpatient staffing levels	July 2016	Complete	An additional 6 Full Time Equivalent (FTE) registered nursing staff have been employed in the inpatient services.
Right sizing of budget/staff ratios	July 2017	Incomplete	Whilst work continued on the safe rostering project and implementation of right-size roster models for inpatient

			services, it is acknowledged this piece of work will take longer than initially anticipated due to the requirement for ongoing union discussion and the national issues relating to rosters.
Improved staff recruitment and retention	July 2016	Complete	A specific Mental Health and Addictions Service recruitment and retention strategy has been developed and implemented across the service.
Particular areas/teams of concern to be identified and strategies developed to attract and retain staff to those areas	July 2016	Complete	This issue has been partially addressed with the implementation of the strategy noted above. In addition, specific areas such as the challenges facing inpatient psychiatrists, have been identified as requiring specific focus.
Capacity within PVS (Price Volume Schedule) to consider deployment of staff to respond to demand	July 2016	Complete	Planning and Funding have agreed to increase inpatient pricing to national pricing. There is also agreement around increased ability to offset between services within the Price Volume Schedule (PVS) to best meet demand .
Recommendation 4: *Because of the magnitude of the change agenda, the MHAS needs strong engagement and support from the wider DHB at all levels.*			
Needs Assessment and Service Reconfiguration review	July 2017	Partially complete	The mental health & addiction first stage of the needs analysis has been completed. The second stage will be gathering feedback from communities and focus groups on their communities

			as part of the working Groups under Te Pae Tawhiti mental health and addictions programme of work. These are being set up, with adult addictions and adult mental health in place and working on their models of care and outcome frameworks This programme is looking at the whole continuum from prevention and primary care through to secondary care and is working closely with Creating our Futures, the Provider Arm acute model of care outlined below.
Development of the business case for the new build.	July 2017	Incomplete	The Draft Model of Care for Adult Acute has been developed and the Investment Logic Mapping Exercise has been undertaken. The Stakeholder Working Group, that includes DHB staff, consumers, family, NGO staff & Primary Care will reconvene and review the draft Model of Care The Business Case is in development and we are working closely with the MOH & Treasury. Good progress is being made
Increased change management capacity for implementation of ICP project	July 2016	Complete	Review of the ICP project and the need for further planned change has resulted in the addition of specific project resource, in addition to a planned programme of change (Creating Our

			Futures), which will see significant change delivered over the next 5 years.
Recommendation 5: *The strategic direction is one of system change in the district; therefore, a systems-wide change process is needed that includes the MHAS, its strategic NGO partners, primary care services, iwi, consumers and family/whānau.*			
Mental Health and Addictions Service Needs Assessment Review of the Waikato Region 2016 - 2026			See update at Recommendation 4
Strategic Plan For MHAS Service Delivery 2016 – 2020	August 2016	Complete	
Recommendation 6: *Integrated clinical and operational governance that includes planning and funding is necessary across this continuum.*			
Development of an operational governance structure across all elements of the MHA sector with clear reporting through to the CEO and Board.	August 2016	Partially complete	A steering group for the overall programme of work has been developed which includes representation from the DHBs mental health and addiction services along with NGOs from the sector, consumer representative and Strategy and funding. Approaches to clinical governance across the mental health sector will be considered as part of this overall programme of work
Recommendation 7: *The service should report progress to the DHB Board and the Director of Mental Health.*			
	May 2016 July 2016 Sept 2016	Complete and ongoing.	

	Nov 2016		
Recommendation 8: *The current direction of travel is appropriate and necessary. The agenda for transformational change cannot be discarded. However, to give effect to change of this magnitude, the following are required:* *a. There needs to be appropriate shared leadership, supported by a change team with experience in embedding transformational change.* *b. There needs to be adequate resourcing for the change (including fiscal resources and staffing resources).* *c. There needs to be support for embedding practice change at the front line/consumer level, with effective feedback loops.* *d. Industrial relationships need resetting to ensure partnership in change.* *e. Professional leads need time to participate in and develop support for change (including service and clinical leads).* *f. The renewed strengthened nursing and allied leadership model needs ongoing monitoring and support.* *g. The MHAS needs to build up a sufficient group of 'in-service leads and champions' to support change within teams.* *h. There needs to be a clear and detailed communication and engagement strategy at all levels. The strategy needs to include the DHB's strategic partners, the people using the service and the community. The strategy should have a clearly articulated narrative that supports the transformational change agenda.*			
All transformational change in MHAS is brought under one programme of change and delivered via a Project Methodology Programme management resource as #4 The development of a Consumer advisory board to ensure effective feedback loops Executive Directors has met with unions and agreed "how we work together". We have agreed to develop a Joint		Complete Complete Complete Complete	

Consultative Committee that will meet quarterly Prof leads to be brought into workforce development group chaired by DCS Exec Director meets regularly with professional leads of all disciplines reporting against agreed workplans With the ICP development group we will develop service champions/user groups to head the various work projects. Implementation of the MHAS communication strategy.		Complete Complete Complete Complete	
Recommendation 9: *The ICP, while appropriate as a high-level organising principle, needs to be customised to fit local circumstances. This would effectively complement the existing level of co-design and increase future levels of acceptance among service users.*			
Defined Programme of Change Plan for ICP implementation.		Complete	Please see update on recommendation 4 – Creating Our Futures, Programme of Change.
Recommendation10: *Good cultural practice must be embedded, effective and consistent*			
Full implementation of the Culturally Responsive Services Review Recommendations		Incomplete	Whilst there has been some delay in implementation of all of the recommendation from the review of Culturally Appropriate Services, MHAS continues to work closely with Te Puna Oranga, to ensure all elements of the change programme are culturally appropriate.
Recommendation11: *Planning must incorporate realistic timeframes, based on best practice and how to embed change.*			

Planning will incorporate realistic timeframes, based on best practice and how to embed change.		Complete	
Recommendation 12: *The service needs to galvanise community relationships to support and protect the change.*			
Community and sector engagement is clear in service planning and delivery		Complete	Whilst there is always an opportunity for wider community involvement, the actions detailed in recommendations 2 and 5 continue to demonstrate increasing engagement with the community both in terms of how we deliver services currently, what issues we face and planning processes for future development.
Community are aware and informed of Mental Health and Addictions Services in the Waikato		Complete	