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: 28 June 2017

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

Agenda

Board

Date: **24 May 2017**

Time: **1.30pm**

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

Meeting of the Waikato District Health Board

to be held on Wednesday 24 May 2017
commencing at 1.30pm at Waikato Hospital

AGENDA

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

Item

1. Apologies

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

3. **MINUTES AND BOARD MATTERS**
- 3.1 Board Minutes: 26 April 2017
- 3.2 Committees Minutes: No meetings held
- 3.3 Establishment of Maori Health Strategic Committee
- 3.4 Appointments to Midland DHB Statutory Committees

4. **CHIEF EXECUTIVE REPORT**

5. **FINANCE**
- 5.1 Finance Report
- 5.2 Banking Services Supplier Change

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

7. **PLANNING**
- 7.1 Southern Rural Primary Maternity Services

8. **WAIKATO DHB POSITION STATEMENTS AND POLICIES**

No items

9. **PRESENTATION**
- 9.1 A Consumer Council for Waikato District Health Board
  Presentation by Wendy Entwistle at 3pm

10. **PAPERS FOR INFORMATION**
- 10.1 Mental Health & Addictions Service S99 (Mental Health (CAT) Act 1992) Inspection Report Action Plan
- 10.2 A Strategy to Prevent Suicide in New Zealand

11. **NEXT MEETING**
- 11.1 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 26 April 2017 (Items taken with the public excluded)**
- **(ii) Sustainability Advisory Committee – verbal update to be received: Wednesday 24 May 2017 (All items)**
- **(iii) Audit and Corporate Risk Management Committee – verbal update to be received: Wednesday 24 May 2017 (All items)**
- **(iv) Midland Regional Governance Group – to be received – Friday 5 May 2017**

Item 13: Risk Register – Public Excluded

Item 14: Infrastructure as a Service Business Case – Public Excluded

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 12(i-iv): Minutes		Items to be adopted / confirmed / received were taken with the public excluded
Item 13:	Risk Register	Avoid inhibiting staff advice about organisational risks
Item 14:	Infrastructure as a Service business case	Negotiation will be required

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

Item 12: As shown on resolution to exclude the public in minutes.

Item 13: Section 9(2)(c) of the Official Information Act 1982 – To avoid prejudice to measures protecting the health or safety of members of the public.

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

Item

12. MINUTES – PUBLIC EXCLUDED

12.1 Waikato District Health Board: 26 April 2017
To be confirmed: Items taken with the public excluded

12.2 Sustainability Advisory Committee: 24 May 2017
Verbal update: All items

12.3 Audit and Corporate Risk Management Committee: 24 May 2017
Verbal update: All items

12.4 Midland Regional Governance Group: 5 May 2017
To be received: All items

13. RISK REGISTER – PUBLIC EXCLUDED

14. INFRASTRUCTURE AS A SERVICE (IAAS) BUSINESS CASE –– 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 MAY 2017

Bob Simcock

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Chair, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Chairman, Orchestras	TBA	TBA	
Member, Waikato Regional Council	Pecuniary	Perceived	
Director, Rotoroa LLC	TBA	TBA	
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	

Note 1: Interests listed in every agenda.

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

Mary Anne Gill

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

Tania Hodges

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

Dave Macpherson

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Performance Monitoring Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Councillor, Hamilton City Council	Pecuniary	Perceived	
Deputy Chair, Western Community Centre, Inc	Non-pecuniary	Potential	
Partner is Chair of Ngaruawahia Community House, Inc	Non-pecuniary	Potential	
Member, Waikato Regional Transport Committee	Non-pecuniary	Potential	
Member, Waikato Water Study Governance Group	Non-pecuniary	None	
Member, Future Proof Joint Council Committee	Non-pecuniary	None	

Note 1: Interests listed in every agenda.

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

Pippa Mahood

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

Sharon Mariu

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

Clyde Wade

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Board of Clinical Governance, Waikato DHB	Non-Pecuniary	None	
Shareholder, Midland Cardiovascular Services	Pecuniary	Potential	
Trustee, Waikato Health Memorabilia Trust	Non-Pecuniary	Potential	
Trustee, Waikato Heart Trust	Non-Pecuniary	Potential	

Note 1: Interests listed in every agenda.

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

Trustee, Waikato Cardiology Charitable Trust	Non-Pecuniary	Potential	
Patron, Zipper Club of New Zealand	Non-Pecuniary	Potential	
Emeritus Consultant Cardiologist, Waikato DHB	Non-Pecuniary	Perceived	
Cardiology Advisor, Health & Disability Commission	Pecuniary	Potential	Will not be taking any cases involving Waikato DHB
Fellow Royal Australasian College of Physicians	Non-Pecuniary	Perceived	

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

Waikato District Health Board

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 26 April 2017 commencing at 1.30 pm in the Board Room, Hockin Building, Waikato Hospital Campus

Present:
Mr B Simcock (Chair)
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 N Hablous (Chief of Staff) – part of the meeting
Mr A McCurdie (Chief Financial Officer)
Mr B Paradine (Executive Director, Waikato Hospital 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)
Mr D Wright (Executive Director, Mental Health and Addictions Service)
Ms T Maloney (Commissioner, Women's Health Transformation Taskforce)
Professor R Lawrenson (Clinical Director, Strategy and Funding)
Mr I Wolstencroft (Executive Director, Strategic Projects) – part of the meeting

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ITEM 1: APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs S Webb and Ms T Hodges.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

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

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 22 March 2017

Resolved
THAT

The part of the minutes of a meeting of the Waikato District Health Board held on 22 March 2017 taken with the public present were confirmed as a true and accurate record.

3.2 Committees

3.3.1 Iwi Maori Council: No meeting held in April 2017

3.3.2 Performance Monitoring Committee: 12 April 2017
Resolved
THAT
The Board adopted the minutes of this meeting.

3.3.3 Health Strategy Committee: 12 April 2017
Resolved
THAT
The Board adopted the minutes of this meeting.

ITEM 4: CHIEF EXECUTIVE REPORT

The Chief Executive provided the Board with an update on:

4.1 Waikato Hospital restructure – The Executive Director, Waikato Hospital Services had completed a restructure of the services that report to him. The services were now managed by a clinical unit leader, service manager and clinical nurse director reporting directly to the Executive Director, Waikato Hospital Services.

4.2 Appointment of Executive Director, Maori Health – Ms Loraine Elliott had been appointed to this role commencing on 4 May 2017. A powhiri would take place on this day. This was the same day as the joint Board/IMC meeting.

The Board members acknowledged the excellent job Ms Millie Berryman had done acting in this role and asked for their thanks to be passed on to her. The Chair agreed to send a letter of thanks to Ms Berryman.

Resolved
THAT
The Board received the report.

ITEM 5: FINANCE REPORT

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

- The DHB continued on track and expected to break even at year end.
- The provider was unfavourable to budget for 31 March 2017:

1. Revenue favourable to budget $0.8% (0.1%).
2. Employed personnel costs were unfavourable to budget $4.3m the dominant negative variances being within nursing and a smaller variance in allied health personnel. Medical and administrative personnel had small favourable variances and support personnel were close to budget.

3. Outsourced personnel were unfavourable to budget $9.9m – this related to medical locums ($3.8m), nursing ($1.0) and admin/management contractors for the National Oracle Solution (NOS) project ($5.1m) which had an offset in other revenue (3.2m).
4. Outsourced services were unfavourable at $2.9m.
5. Clinical supplies were unfavourable at $0.7m.
6. Infrastructure and non-clinical supplies were unfavourable to budget at $1.3m.
7. Interest depreciation and capital charges were favourable to budget $5.9m.

It was noted that:

- Acute cases excluding ED: episodes 2.8% above plan; case-weights 6.7% above plan
- Elective cases: episodes 10.9% below plan; case-weights 6.7% below plan
- Overall 0.9% below plan for cases and 0.9% below plan for case weights
- ED attends: YTD ED attends are 1.7% higher than the same period last year
- The result for the Funder was favourable due to favourable Provider payment costs
- The result for Governance was on budget.

The Board members asked for the average cost per day to be included in future reports.

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

ITEM 6: PERFORMANCE REPORTING

6.1 Health Targets

The Health Targets report was submitted for information.

Management noted:

- **Shorter stays in the Emergency Department** – the most recent result was 83%. Recent medical recruitment panels had not been as successful as hoped. It was envisaged it would improve once the department was fully staffed.

  Difficulties in admitting patients into the hospital continued to affect performance.

- **Improved Access to Elective Surgery** – most recent result was 106.3%.

- **Faster Cancer Treatment** – preliminary results for quarter 3 showed a result of 88%.

- **Increased immunisation for 8 month olds** – despite capturing all current activity the result was disappointing at 90%.

- **Better help for smokers to quit** – maternity – quarter three information was incomplete. Quarter two result was 98%.

Resolved
THAT
The Board received the report.

6.2 Provider Arm Key Performance Dashboard

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

Clinical and Community Support

The report was taken as read and no changes noted.

The complaints response target had not been met.

Mental Health and Addictions Service

The report was taken as read. Management noted:

ED Presentations – There had been 94 presentations to ED. 56 had presented in ED after hours; 38 had arrived during business hours.

A pilot project that had the potential to dramatically affect the outcomes for individuals presenting in ED was planned with ACC. This project would improve access to mental health services by putting psychiatric resources directly into ED.

Waikato Hospital Services

Management noted:

Waiting time for acute theatres – in order to meet acute surgical demand, two regular additional acute theatres sessions had been running at weekends.

Resolved
THAT
The Board received the report.

6.3 Strategy and Funding Key Performance Dashboard

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

Management noted:

- **Proportion of older people waiting greater than 20 days for assessment or reassessment** – showed a result of 6% for the quarter.

- **AOD and mental health waiting times (% of new clients seen within 3 and 8 weeks of referral)** – significant areas where performance is not being met including DHB provider arm services

and a number of NGO adult services, half of which are not meeting the waiting time targets.

- **Ambulatory sensitive hospitalisations** – this target was based on MOH requirements which included specific targeted reductions for Maori.

  For the 45-64 population in the December results indicate little or no change for total population and a 3.4% reduction for Maori.

Resolved
THAT
The Board received the report.

ITEM 7: PLANNING

7.1 Health Care Home

Professor Ross Lawrenson attended for this item.

Professor Lawrenson explained that the Health Care Homes framework was a model of care developed by Pinnacle Midlands Health Network in response to changes in the way general practice is provided.

An independent evaluation of the Health Care Homes model of care had been carried out by Ernst and Young. The report incorporated findings of past evaluation work and identified future performance measure and potential future impacts of the model.

Professor Lawrenson summarised the review of the Ernst and Young evaluation and included his comments and outcome measures.

Resolved
THAT
The Board noted the contents of the report.

7.2 Creating Our Futures Programme Business Case – Strategic Assessment

Ian Wolstencroft and Derek Wright attended for this item.

Ian Wolstencroft explained the Better Business Cases process to the Board members.

The Creating our Futures Programme Strategic Assessment had been completed for Investment Ministers as part of the Better Business Case process.

The Strategic Assessment outlined the initial justification for the need to invest in change and support a recommendation to proceed to further business case development.

The key purpose of the Strategic Assessment included:

- Identifying the strategic context and fit of the proposed investment.

- Outlined the case for change and consider the need for investment
- Provided early opportunity for the service and key stakeholders to influence the direction and structure of the proposed programme.

Resolved
THAT
The Board:

1) Received the Creating Our Futures Programme Strategic Assessment
2) Approved the Creating Our Futures Programme
3) Approved submission of the Creating Our Futures Programme Strategic Assessment to NZ Treasury and the Ministry of Health for presenting to Investment Ministers
4) Supported the development of a Creating Our Futures Programme Business Case.

ITEM 8: WAIKATO DHB POSITION STATEMENT AND POLICIES

There were no items this month.

ITEM 9: PRESENTATION

There were no presentations this month.

ITEM 10: PAPERS FOR INFORMATION

There were no items this month.

ITEM 11: NEXT MEETING

Date of Next Meeting

The next meeting to be held on Wednesday 24 May 2017, commencing at 1.30 pm in the Board Room, Hockin Building, Waikato Hospital Campus.

BOARD MINUTES OF 26 APRIL 2017

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

THAT:

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

Item 12: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 22 March 2017 (Items taken with the public excluded)**
- **(ii) Audit and Corporate Risk Management Committee – Wednesday 22 March 2017 to be adopted (All Items)**
- **(iii) Performance Monitoring Committee to be adopted: Wednesday 12 April 2017 (Items 14-16)**
- **(iv) Midland Regional Governance Group – to be received Wednesday 3 March 2017**
- **(v) Midland Regional Governance Group – to be received Wednesday 31 March 2017**

Item 13: Risk Register – Public Excluded
Item 14: Chief Executive's Report – Public Excluded
Item 15: Taylors Linen and Laundry Contract – Public Excluded
Item 16: IWI Maori Representatives on Board Statutory Committees – 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-v): 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: MHN Mediation and Waikato Medical School	Negotiations will be required
Item 15:	Linen and Laundry Contract	Negotiation will be required
Item 16:	IMC nominations on the Board's statutory committees	Protect the privacy of natural persons

(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.**
Items 14 and 15:	**Section 9(2)(j) of the Official Information Act 1982 – to enable the Waikato DHB to carry on negotiations without prejudice or disadvantage negotiations.**
Item 16:	**Section 9(2)(a) of the Official Information Act 1982 – to protect the privacy of natural persons**

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 3.3

ESTABLISHMENT OF MAORI HEALTH STRATEGIC COMMITTEE

Purpose	For consideration and approval.

Introduction

At the joint meeting between the Board and Iwi Maori Council held on 4 May 2017 a paper was submitted by the Chair and Chief Executive that proposed the establishment of a committee of the Board to oversee the development and implementation of the priority programme plan concerned with radical improvement in Maori health outcomes by eliminating health inequities for Maori.

The paper is attached as Appendix 1.

This idea was well-received by the joint meeting and the Chair undertook to progress it at the Board's May meeting. This paper is intended to allow that to happen.

The paper to the joint meeting proposed four members from Waikato DHB and four nominated by the Iwi Maori Council with the chair appointed by the Board from one if its Maori members. The Iwi Maori Council undertook to advise Waikato DHB of four members for the committee as soon as possible.

Revised Memorandum of Understanding

The joint meeting also had before it a revised version of the Memorandum of Understanding between iwi and Waikato DHB which had established the Iwi Maori Council. It was agreed at the meeting that further consideration of the revised documents would be undertaken by the committee once it is established.

Terms of Reference

The paper submitted to the joint meeting included skeletal terms of reference. These seemed acceptable.

Taking the skeletal terms of reference and adding other consensus views and/or logic from the meeting results in terms of reference as follows:

1. To oversee the development of the Priority Programme Plan to radically improve Maori health outcomes by eliminating health inequities for Maori noting that the Plan will be developed by staff in conjunction with a working group including representation from outside Waikato DHB.
2. To oversee the implementation of the Priority Programme Plan to radically improve Maori health outcomes by eliminating health inequities for Maori.

3. To identify and consider other areas of the Waikato DHB that could contribute towards radical improvements in Maori health outcomes by eliminating health inequities for Maori.
4. 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.
5. To recommend the name of the new committee.

Delegation

The Board does not delegate authority to the new committee. However, the following principles will guide the operations of the committee:

1. The Board and Chief Executive confirm that they are committed to achieving the priority to radically improve Maori health outcomes by eliminating health inequities for Maori.
2. The Board values the committee as an important strategic driver to contribute towards the priority to radically improve Maori health outcomes by eliminating health inequities for Maori.
3. The Board recognises, in order to radically improve Maori health outcomes by eliminating health inequities for Maori, there may / will be a need to review and input into other parts of the organisation and region.
4. The Board also recognises that the committee will input into the other priority plans (at the committees discretion) to ensure alignment of the priority to radically improve Maori health outcomes by eliminating health inequities for Maori.
5. The Board and Chief Executive confirm that staff and resources as applicable will be provided to support the committee.

Payment of Members

Payment of the members of the committee is not within the discretion of the Waikato DHB. Approval for it needs to be given by the Minister of Health. Based on previous requests it is considered unlikely that such approval would be given.

Recommendation
THAT

1. The Board establishes 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 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 committees

BOB SIMCOCK
CHAIRMAN

MEMORANDUM TO THE BOARD AND IWI MAORI COUNCIL

4 MAY 2017

PROPOSAL FOR GOVERNANCE OVERSIGHT OF THE MAORI HEALTH STRATEGY

Purpose	For consideration and discussion.

Strategy Refresh and Way Forward

In 2016 the Waikato DHB in partnership with the Iwi Maori Council undertook a refresh of its strategy. The current strategy is bold in its aspirations to eliminate Maori health inequities.

That has caused the Waikato DHB to consider how best the implementation of the strategy can be supported by and engage with Maori.

The theoretical framework by which the strategy will be implemented involves the development of a Priority Programme Plan for each priority (in this case the elimination of Maori health inequities). That process would include the establishment of a working group involving representation from key stakeholders to guide the plan's development. But there is also a need for governance oversight to support and monitor the development and delivery of the Plan.

Accordingly we would like to discuss with the Iwi Maori Council the possibility of establishing a committee of the Board to be the mechanism by which Maori are involved in the development of the Priority Programme Plan to eliminate Maori health inequities.

Our early thinking suggests this might be a committee of eight with four appointed from the Board and four appointed from names proposed by the Iwi Maori Council. The Chair would be appointed by the Board and would be one of the Maori Board members.

The role of the committee would in the first instance be:

1. To oversee the development of the Priority Programme Plan to eliminate Maori health inequities noting that the Plan will be developed by staff in conjunction with a working group including representation from outside the Waikato DHB.
2. To oversee the implementation of the Priority Programme Plan to eliminate Maori health inequities.

This committee would have the same status as the existing "strategy committee" which currently has responsibility for the oversight of the DHB strategy.

MR BOB SIMCOCK
CHAIRMAN

DR NIGEL MURRAY
CHIEF EXECUTIVE

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 3.4

APPOINTMENTS TO MIDLAND DHB STATUTORY COMMITTEES

Purpose	For approval.

As Board members are aware, it has been agreed that the Waikato, Lakes and Bay of Plenty District Health Boards will appoint members to each other's statutory committees. As a consequence of that agreement this paper recommends the appointment of five Waikato DHB board members to the three statutory committees at Lakes District Health Board and the two statutory committees at Bay of Plenty District Health Board.

Recommendation
THAT
The following Board member appointments be approved:

1) Lakes District Health Board
   - Community and Public Health Advisory Committee: Mrs Pippa Mahood
   - Disability Support Advisory Committee: Mrs Pippa Mahood
   - Hospital Advisory Committee: Mr Martin Gallagher.
2) Bay of Plenty District Health Board
   - Hospital Advisory Committee: Dr Clyde Wade
   - Community and Public Health Advisory Committee/Disability Support Advisory Committee: Mrs Mary Anne Gill.

Recommendation
THAT
The report be received.

BOB SIMCOCK
CHAIRMAN

Waikato District Health Board

Chief Executive Report

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 4

CHIEF EXECUTIVE REPORT

Purpose	For consideration.

Waikato Medical School

There has been a significant amount of media on the Waikato Medical School. The Board will be familiar with these reports as they are forwarded each week to members through Fuseworks.

I thought it would be useful to distil down the clear problem statement and solution statement which highlights the core issues that we are trying to fix.

The Issue:

> Comparatively lower levels of healthcare quality, continuity, and accessibility in New Zealand provincial and rural communities is contributing to disparities in health outcomes. For these populations this means reducing health system effectiveness and efficiency. There is a key workforce issue contributing to this problem. We are not training enough doctors, nor the right doctors and also not distributing them to meet the needs of all New Zealanders.

The Solution:

> The Waikato proposal for a Community Engaged Graduate Entry Medical School will significantly improve quality and access to health care by increasing the number of GPs in primary care as well as general specialists in these provincial and rural communities. The new programme will generate a modern sustainable medical workforce that is committed and trained to work in higher needs communities. This will help reduce New Zealand's reliance on overseas trained doctors who are presently backstopping New Zealand's suboptimal production and deployment of primary care doctors and general specialists in these communities.

I will brief the Board on progress with the business case and the process evaluation by Government.

Ransomware Virus: WannaCry

WannaCry is the largest scale ransomware campaign seen to date, which infected private sector, government and healthcare organisations around the world (over 150 countries and 10,000 organisations have been impacted and over 230,000 computers infected). In the United Kingdom, 40 hospitals across 24 trusts have been impacted. Current reports indicate there have been four infections in Australia and three in New Zealand.

Key points to note:

1. Across the New Zealand health sector there have been no infections of the WannaCry ransomware reported.
2. Some organisation's operations have been adversely effected by precautionary shutdowns (eg. an eight hour shutdown at Lyttelton Port).
3. There have been no adverse impacts or precautionary shutdowns at Waikato DHB.

Unfortunately the economics with ransomware are compelling for the perpetrators. As predicted and expected by our IS team, there have been further variants. So far we have seen a further three email based malware variants, one of which appears to be targeting the NZNO membership database (which was leaked last year). There has also been a phone based variant whereby the perpetrators call and advise the computer user that they have ransomware installed and talked the user through how to remove the ransomware. However, the steps actually install ransomware.

Two lists have also recently been released ('Anti Public Combo' and 'Exploit.in') which contain circa 500 million email addresses and passwords which have been obtained through hacking online services, which are then leveraged by malware perpetrators. The IS team have obtained confirmation that there are 231 DHB email accounts and passwords within these lists and have contacted all effected staff to ensure they change their passwords on all online services which they use their DHB email account.

The team have enacted various precautionary measures to ensure that the DHB was not impacted by the ransomware, and have brought forward the deployment of additional protective toolsets, which are part of our Security in-depth programme of work. The Security in-depth programme includes policy, process, technology, and people control initiatives. Part of the people component includes a cyber security training program and cyber risk awareness campaign for staff.

The DHB's ransomware response plan has proved effective. Nationally the engagement across the health sector both to the Ministry and across the DHBs, and regionally across the Chief Information Officers from the five Midland DHBs, ensured an effective response was in place. Within the DHB we have had an active staff and executive team communication plan in place throughout the incident period.

2017/18 Budget

The draft budget for 2017/18 will be presented to the Board in June. This is the third budget that I have overseen at the Waikato DHB and is clearly the most challenging.

The impact of collective agreements and other cost pressures means that any increase in revenue is virtually accounted for prior to much else being considered. Acute growth across many of our services is intense and we have shortages in pivotal areas such as anaesthetics which constrain our ability to increase production. There is a strong case being made that more beds are required to meet the demands that are being placed on Waikato Hospital notwithstanding the universal perspective that greater effort needs to be placed on avoiding admissions.

We need to ensure that some funding is available to support the implementation of the Waikato DHB strategy and finding that is going to be difficult.

HDC Complaints

We have recently received communication from the Health and Disability Commissioner regarding their interest in trends complaints against Waikato DHB and our performance in a variety of areas which include orthopaedics, women's health, first specialist assessments and follow-up and staffing levels.

Last year I visited with the Health and Disability Commissioner to discuss these matters and also provided a full status report. The Commissioner has indicated that he would like to follow up again in July, which we will of course do. I am also going to update the Director-General of Health on our progress.

Regular updates are also provided to the Ministry of Health through the Monitoring and Intervention Framework process.

Primary and Community Health Strategy

A workshop will be held the morning of 28 June (prior to the Board meeting) for Board members to identify opportunities and challenges for primary and community health services that should be explored as part of a district wide plan. This will include opportunities for considering partnerships with providers and communities and identifying areas for further engagement. A facilitated workshop with primary care and other stakeholders is being organised at a date following the Board workshop.

Smoking Policy

Attached is an email from a Board member seeking discussion on some aspects of our smoking policy. The Chair has agreed it should initially be discussed. That discussion is not intended to give rise to a substantive decision on any aspect of the policy, but to frame questions that management might be asked to report on if the Board collectively wishes this to occur.

Recommendation
THAT
The report be received.

DR NIGEL MURRAY
CHIEF EXECUTIVE

From:	David Macpherson
To:	Nigel Murray; Bob Simcock
Cc:	Millie Berryman; Grant Berghan; Wade_CRC; Crystal; Crystal Beavis - 2; Martin Gallagher_HCC; Maryanne Gill_GMAIL; Pippa Mahood_GMAIL; Sally Christie; Sally Webb; Sharon; Tania_DIGITAL
Subject:	Request for Variation to Waikato DHB smoking policy - to allow secure outdoor smoking areas within Henry Bennett Centre
Date:	Friday, 12 May 2017 9:58:40

TO: Bob Simcock, Chair, Waikato DHB
Nigel Murray, CEO, Waikato DHB

Dear Bob and Nigel – I wish to have placed on the agenda of the next Waikato DHB Board meeting the following Item:

Request for Variation to Waikato DHB smoking policy

- to allow secure outdoor smoking areas within Henry Rongomau Bennett Centre
- to enable patients not in the Henry Bennett Centre's Forensic wards to smoke cigarettes while still within the precinct of the Waikato Hospital.

I wish to provide commentary and information relating to this request at the meeting.

I note that, as the father of a patient who had died as a result, in part, of this policy, I raised this issue with the Board some two years ago.

I note that the HRBC has at least 3 secure outdoor areas suitable for use for this purpose, and that these were used for patients to smoke, outdoors and away from staff, prior to the DHB bringing in its new policy.

I draw the Board's attention to the recent death of a patient in the Palmerston North Hospital's mental health unit, following her departure outside for a smoke: http://www.stuff.co.nz/manawatu-standard/news/92407431/Woman-who-went-missing-from-mental-health-ward-found-dead.

Please note I am not proposing to change the overall DHB policy on smoking, and support the smoking cessation programmes that the DHB is responsible for; I am seeking to change it in respect of the HRBC only.

Thanks

Dave Macpherson

Financial Report

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 5.1

FINANCE REPORT

Purpose	For information.

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

Recommendation
THAT
The report be received.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Result for April 2017	Year to Date			Budget
	Actual $m	Budget $m	Variance $m	Jun-17 $m
Funder	44.7	40.5	4.2 F	42.9
Governance	(0.4)	(0.3)	(0.1) U	(0.3)
Provider	(41.7)	(27.6)	(14.1) U	(38.1)
DHB Surplus/(Deficit)	**2.6**	**12.6**	**(10.0) U**	**4.5**
Note: $ F = favourable variance; ($) U = unfavourable variance				

FINANCIAL PERFORMANCE MONTHLY COMMENT:

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

For April 2017 YTD we are unfavourable to budget by $10.0m. Unfavourable variances such as those relating to outsourced elective and personnel costs and nursing annual leave costs continue to be challenging. Areas of concern continue to be focused on in order to strive to meet our forecast for the year. Clearly there are risks to manage in this regard and we are managing such risks, with improved bottom up forecasting processes continuing to be a key tool.

Forecast:

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

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

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

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

Negative

Provider:

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

1. Revenue favourable to budget $0.1m
2. Employed personnel costs unfavourable to budget $5.4m, the dominant negative variance being within nursing and a smaller unfavourable variance in allied health personnel. Medical personnel are favourable to budget $0.9m & administrative & support personnel have small favourable variances.
3. Outsourced Personnel costs unfavourable to budget $11.5m, the dominant variances relate to medical locums ($4.0m), Nursing ($1.1m) and admin/management contractors for the National Oracle Solution (NOS) project ($5.8m) which has an offset in Other Revenue of ($3.5m).
4. Outsourced Services unfavourable to budget $4.0m mainly due to higher outsourcing of electives.
5. Clinical supplies unfavourable to budget $0.1m.
6. Infrastructure & Non Clinical supplies are unfavourable to budget $0.8m.
7. Interest, depreciation and capital charge favourable to budget $7.6m 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 2.6% above plan; case-weights 6.3% above plan
- Elective cases: episodes 9.7% below plan; case-weights 17.3% below plan
- Overall 0.7% below plan for cases and 1.0% below plan for case-weights
- ED attends: YTD ED attends are 3.2% higher than the same period last year. This as a result of an increase for the month over last year in April 2017 8.5% and March 2017 9%. There is currently no single driver identified for the increase but trends will be closely monitored.

Funder and Governance:

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

RECOMMENDATION(S):

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

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**($0.7) U**	Neutral
CFA Revenue		
Favourable to budget mainly due to: ● 15/16 elective surgery wash-up $1.5m received, ● additional funding received which is offset by cost in External Provider Payments: Palliative Care $0.7m Rheumatic fever $0.2m ● PHO Care Plus wash-up & VLCA $0.8m, ● other favourable variances $0.6m. Offset by unfavourable variances relating to: ● Reduction in revenue received relating to the change in rate for the capital charge $2.4m. This reduction is offset by a reduction in capital charge paid. ● In between travel wash up relating to 2016/17 $0.9m (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 $1.6m (offset in reduction of interest payable).	($1.5) U	Neutral
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 $0.1m ● Gynae colps catch up on contract volumes $0.2m (offset by costs)	$0.7 F	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is $0.5m unfavourable mainly due to: ● ACC unfavourable $1.0m 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 $3.8m unfavourable due to reduced IDF inflow when compared with Ministry of Health budget file. Offset by: ● Reimbursement of costs associated with the implementation of NOS $3.7m favourable (offset in Outsourced Personnel), ● Catch up invoicing for outreach clinics at Bay of Plenty and Lakes DHBs $0.5m, ● Higher than budgeted invoicing for Blood and Laboratory $0.1m.	($0.5) U	Unfavourable
Other Revenue		
Other revenue is favourable primarily due to higher sales in the Café than expected $0.6m and the favourable revenue washup from Urology Services Limited relating to 2015/16 of $0.2m. This is offset by lower than budget volumes of non resident patients $0.1m unfavourable and other revenue $0.1m unfavourable.	$0.6 F	Favourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($9.3) U**	Unfavourable
Personnel (employees and outsourced personnel total)	**($16.9) U**	
Employed personnel are unfavourable to budget mainly due to:	($5.4) U	Unfavourable
• Medical costs are favourable by $0.9m. Senior Medical Officers (SMO's): SMO costs are $1.5m favourable mainly due to: - paid FTE costs favourable $2.0m arising from vacancies, - favourable course and conference costs which is as a result of reduced accrual for CME costs following SMO resignations $0.6m, - annual leave movement $0.9m unfavourable due to less leave earned offset by less leave taken, - professional membership fees $0.2m unfavourable. Resident Medical Officers (RMO's) RMO costs are $0.6m 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: October 2016 / January 2017 SMO claims cover RMO shifts: $0.3m / $0.5m Savings on payments to RMO's: $0.1m / $0.2m Net impact: $0.2m / $0.3m 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 $1.1m unfavourable due to budgeted vacancy savings not being achieved. In addition to this the annual leave movement is running $5.2m unfavourable. Course conference fees and payment on return from maternity leave are running favourable by $0.6m. • Allied Health costs are unfavourable to budget by $1.2m. Base costs are $0.5m favourable offset by unfavourable overtime $0.5m and penals $0.2m due to vacancies. In addition annual leave taken unfavourable to budget $0.9m. • Other favourable variances, largely in Management, Administration and Support $0.5m.		
Outsourced personnel are unfavourable mainly due to:		
• Higher than planned use of locums within medical personnel to cover vacancies $4.5m, • Nursing is $1.1m unfavourable due to external agency costs to fill roster gaps and watches.	($5.6) U	Unfavourable
• Higher than planned use of contractors in management/admin $5.9m primarily due to contractors working on the NOS implementation. Costs recovered in Other Government Revenue - $3.7m.	($5.9) U	Neutral

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**($4.0) U**	
Outsourced services are unfavourable primarily due to: ●Outsourced corporate services $1.4m favourable primarily due to reduced spend on Clinical Work Station - budget set on business case but expected spend has been revised and is lower due to reduced costs over the first months of the year. In addition the actual calculation of Health Share Limited (HSL) operating costs has come in lower than budget for the first half of the financial year. ●Outsourced clinical service costs are unfavourable to budget $5.4m due to higher than planned outsourcing of electives and unmet savings.	($4.0) U	Unfavourable
Clinical Supplies	**($0.1) U**	
Instruments & equipment are $0.3m favourable primarily due to favourable service contract costs.	$0.3 F	Favourable
Implants & prosthesis are $2.8m 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.	$2.8 F	Neutral
Treatment disposables unfavourable due to savings allocation of $4.3m offset by favourable variances across a range of areas such as dressings, staples, tubes/drainage/suction, IV fluids and rebates.	($1.9) U	Unfavourable
Pharmaceuticals $1.3m unfavourable primarily due to cytotoxic drug costs running higher than budgeted. This in part due to the newly approved melanoma treatment.	($1.3) U	Unfavourable
Diagnostic Supplies & Other Clinical Supplies - on budget.	$0.0 F	Neutral
Infrastructure and non-clinical supplies	**($0.8) U**	
Infrastructure and non-clinical supplies are $0.8m unfavourable primarily due to: ● Savings allocation unfavourable by $2.1m, ● Cost of Goods Sold (COGS) is $1.6m unfavourable as a result of higher sales by Pharmacy on Meade resulting in higher cost of goods sold. Offset in Non Government Organisations (NGO) provider payments ($1.6m), ● IT costs $1.0m unfavourable due to minor hardware purchases and telecommunication costs for SmartHealth and timing of planned replacement of laptops and PCs, ● Offset by favourable facilities variance $2.9m due to delayed start of maintenance programme and Hilda Ross House demolition and hotel services costs are $1.0m favourable due to cleaning and laundry costs running lower than budgeted.	($0.8) U	Unfavourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$4.9 F**	
IDF out unfavourable by $2.3m 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.	($2.3) U	Unfavourable
External Provider payments are favourable largely due to: ● a revised PHARMAC forecast $3.6m favourable. However this is offset in clinical supplies (Pharmaceutical costs - oncology drugs $0.8m) and Infrastructure costs (Retail Pharmacy COGS $1.6m). ● PHO Quality Indicator pool - prior year over accrual $0.6m, ● Dental FSS volumes favourable to budget $0.7m, ● Reduction in costs for in between travel (offset by reduced revenue) $0.7m, ● Post acute convalescent care $0.6m favourable as the cost is being reflected in Outsourced Services ($0.2m), ● Other favourable variances across MH, DSS FFS, Urology and residential care offset by unfavourable variances arising mainly from additional costs relating to additional funding (Healthy Homes Initiative, Palliative Care, Rheumatic Fever) $1.0m.	$7.2 F	Neutral
Interest, depreciation and capital charge	**$7.6 F**	
Interest charge favourable mainly due to interest costs on the Ministry of Health loan ceasing after the debt equity swap in March. Offset in CFA Revenue.	$2.0 F	Neutral
Capital charge is favourable to budget as a result of the reduction in the rate from 8% to 6%. Largely offset in CFA revenue.	$2.6 F	Neutral
Non Cash Depreciation favourable mainly due to: ● Timing of capitalisation of IS projects.	$3.0 F	Favourable

TREASURY

Opinion on Result:	
Cash flows are favourable to budget	Favourable

YTD Actuals Apr-16 $'000	Waikato DHB Cash flows for year to April 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				
1,086,337	Operating inflows	1,116,290	1,128,856	(12,566)	1,355,379
(1,037,926)	Operating outflows	(1,072,847)	(1,062,722)	(10,125)	(1,296,243)
48,411	**Net cash from operating activities**	**43,443**	**66,134**	**(22,691)**	**59,136**
	Cash flow from investing activities				
1,380	Interest income and proceeds on disposal of assets	1,320	1,050	270	1,260
(15,716)	Purchase of assets	(19,675)	(56,670)	36,995	(68,003)
(14,336)	**Net cash from investing activities**	**(18,355)**	**(55,620)**	**37,265**	**(66,743)**
	Cash flow from financing activities				
1	Equity repayment	0	0	0	(2,194)
(7,988)	Interest Paid	(6,718)	(7,198)	480	(8,645)
(229)	Net change in loans	(162)	(160)	(2)	(198)
(8,216)	**Net cash from financing activities**	**(6,880)**	**(7,358)**	**478**	**(11,037)**
25,860	**Net increase/**(decrease) in cash	**18,208**	**3,156**	**15,052**	**(18,644)**
(8,948)	Opening cash balance	856	856	(0)	856
16,913	**Closing cash balance**	**19,064**	**4,012**	**15,052**	**(17,788)**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($22.6) U**	
• **Operating inflows**	**($12.6) U**	
Revenue received unfavourable primarily as a result of: - revenue reduction relating to the change in rate for the capital charge $2.4m, - reduction in CFA revenue relating to the debt equity swap $1.6m, - Interdistrict flows unfavourable by $3.8, - ACC revenue unfavourable $1.0m, - reduction in revenue relating to the unfavourable washup of In Between Travel $1.3m, - Increase in accrued debtors $11.1m arising mainly from a higher than budgeted balance owing by MoH $8m and accrual of DSS<65 contract which will be invoiced in May - $3m. Unfavourable inflow offset by: - Prior year elective funding washup received $1.5m, - Additional care and other initiatives funding $2.3m, - Reimbursement of costs associated with the implementation of NOS $3.7m, - Crown side arm revenue favourable $0.7m, - Other favourable timing variances across various areas $0.4m.	($12.6) U	

Cash flow variances resulted from:	Variance $m	Impact on forecast
• **Operating outflows**	**($10.0) U**	
○ Personnel cost variances are unfavourable against budget due to the timing of fortnightly pay runs.	($0.8) U	
○ Operating cash outflows for non-payroll costs are unfavourable as a result of: - Higher prepayments than budgeted $2.8m 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.	($18.7) U	
○ GST cash movement is favourable due to March GST being payable in May 2017 and not April as budgeted - $6.9m.	$9.5 F	
Net cash flow from Investing Activities	**$37.4 F**	
○ Interest received is favourable due to slightly higher than expected funds with NZHPL.	$0.4 F	
○ Capital spend is slower than planned for the year to March - refer to capital expenditure report for further details.	$37.0 F	
Net cash flow from Financing Activities	**$0.5 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.	$0.5 F	

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

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

WAIKATO DISTRICT HEALTH BOARD
CASHFLOW FORECAST (GST INCLUSIVE)

As at 30-Apr-17	Apr-17 Actual	May-17 Forecast	Jun-17 Forecast	Jul-17 Forecast	Aug-17 Forecast	Sep-17 Forecast	Oct-17 Forecast	Nov-17 Forecast	Dec-17 Forecast	Jan-18 Forecast	Feb-18 Forecast	Mar-18 Forecast	Apr-18 Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	4,626	4,520	4,300	5,240	4,564	4,228	4,448	4,452	4,116	4,340	4,116	4,340	4,116
Funder inflow (MoH, IDF, etc)	120,080	121,280	123,065	124,542	124,523	126,378	121,680	124,523	129,203	124,523	124,523	128,638	123,958
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	115	0	0
Other Income (excluding interest)	1,982	2,645	2,415	2,415	2,645	2,415	2,530	2,530	2,400	2,415	2,070	2,415	2,185
Rents, ACC, & Sector Services	3,309	3,053	2,935	2,971	3,112	2,375	2,608	2,695	2,584	2,592	2,504	2,681	2,514
	129,997	131,498	132,716	135,168	134,844	135,396	131,266	134,200	138,304	133,870	133,328	138,074	132,773
Cash was applied to:													
Personnel Costs (incl PAYE)	(41,481)	(46,455)	(43,215)	(42,034)	(51,461)	(45,868)	(41,974)	(49,832)	(42,064)	(51,243)	(45,808)	(42,094)	(41,974)
Other Operating Costs	(29,603)	(29,100)	(29,900)	(33,260)	(32,700)	(33,400)	(32,400)	(32,600)	(27,160)	(28,300)	(28,100)	(35,700)	(30,700)
Funder outflow	(44,696)	(44,863)	(43,995)	(45,749)	(46,419)	(49,470)	(45,981)	(46,084)	(45,079)	(45,749)	(45,079)	(49,470)	(45,311)
Interest and Finance Costs	(7)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(21)	(6)	(31)	(31)	(31)
Capital Charge	0	0	(8,251)	0	0	0	0	0	(15,721)	0	0	0	0
GST Payments	0	(13,745)	(7,000)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(14,420)	(9,000)	(7,210)	0
	(115,787)	(134,168)	(132,366)	(128,259)	(137,796)	(135,954)	(127,571)	(135,732)	(130,045)	(139,718)	(128,018)	(134,505)	(118,016)
OPERATING ACTIVITES	**14,211**	**(2,670)**	**349**	**6,909**	**(2,951)**	**(558)**	**3,695**	**(1,532)**	**8,259**	**(5,848)**	**5,310**	**3,569**	**14,757**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	218	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
	218	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(2,065)	(2,500)	(4,600)	(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
	(2,065)	(2,500)	(4,600)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)
INVESTING ACTIVITIES	**(1,847)**	**(2,425)**	**(4,525)**	**(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	93,233	5,120	6,370	0	6,403	3,983	0	4,983	0	9,273	0	0	0
MoH loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	93,233	5,120	6,370	0	6,403	3,983	0	4,983	0	9,273	0	0	0
Cash was applied to:													
Capital Repayment	0	0	(2,194)	0	0	0	0	0	0	0	0	0	0
Transfer to NZHPL	(105,597)	0	0	(3,484)	0	0	(270)	0	(4,834)	0	(1,859)	(144)	(11,332)
MoH loan repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	(105,597)	(26)	(2,194)	(3,484)	(26)	0	(270)	(26)	(4,834)	0	(1,885)	(144)	(11,332)
FINANCING ACTIVITIES	(12,363)	5,094	4,176	(3,484)	6,377	3,983	(270)	4,957	(4,834)	9,273	(1,885)	(144)	(11,332)
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)	19,016	13,896	7,525	11,009	4,606	624	894	(4,090)	744	(8,529)	(6,670)	(6,526)	4,806
Long-term Loans													
Ministry of Health	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA Loan	(299)	(273)	(273)	(273)	(247)	(247)	(247)	(221)	(221)	(221)	(195)	(195)	(195)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	18,718	13,623	7,252	10,736	4,359	377	647	(4,310)	524	(8,749)	(6,864)	(6,720)	4,612
LOANS AVAILABLE													
MoH loans	0	0	0	0	0	0	0	0	0	0	0	0	0
Working capital facility (NZHPL)	(64,367)	(64,367)	(64,367)	(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)	(64,367)	(64,367)	(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.	On Target

Prior Year Apr-16 $'000	Waikato DHB Financial Position	As at April 2017 Actual $'000	Budget $'000	Variance $'000	Budget Jun-17 $'000
49,321	Total current assets	85,402	53,780	31,622 F	50,193
(154,967)	Total current liabilities	(176,736)	(168,145)	(8,591) U	(198,229)
(105,647)	**Net working capital**	**(91,334)**	**(114,365)**	**23,031 F**	**(148,036)**
568,417	Term assets	555,611	589,645	(34,034) U	611,664
(227,011)	Term liabilities	(14,281)	(226,937)	212,656 F	(226,771)
341,406	**Net term assets**	**541,330**	**362,708**	**178,622 F**	**384,893**
235,759	**Net assets employed**	**449,996**	**248,343**	**201,653 F**	**236,857**
235,759	**Total Equity**	**449,996**	**248,343**	**201,653 F**	**236,857**

Prior Year Apr-16 $'000	Waikato DHB Ratios	As at April 2017 Actual $'000	Budget $'000	Achieved	Trend	Budget Jun-17 $'000
54,520	Borrowing facilities available at month end	64,172	64,172	✓	⇔	46,394
0.9	Debt to Equity ratio	0.0	0.9	✓	⇩	1.0
0.5	Debt to Debt + Equity	0.3	0.6	✓	⇩	0.6
0.3	Current ratio	0.5	0.3	✓	⇔	0.3
38.2%	Equity to total assets	70.2%	38.6%	✓	⇧	35.8%
-5.7%	Return on equity	0.6%	5.1%	✓	⇩	1.9%
3.49	Interest covered ratio	8.45	8.17	✓	⇧	6.96

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital		
Net working capital is favourable against budget mainly due to: Current Assets: - Cash held with New Zealand Health Partnerships Limited is higher than planned by $15.1m, mainly due to lower than budgeted capital spend, - Prepayments are higher than planned by $2.8m due to the timing of annual IS spend, - Total accounts receivable and accrued debtors is higher than planned by $13.5m largely due to the accrual for MoH revenue being higher than budgeted $8m (across various areas) and a DSS contract which will be invoiced in May 2017 $3.5m.	**$23.0 F**	

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital (continued)		
Current Liabilities: - GST payable is $9.5m higher than budgeted as the March GST is payable in May and not April as budgeted, - Payroll liabilities are $6.5m higher than budgeted mainly due to the timing of pay runs and IRD payments resulting in higher month end accruals, - Accounts payable and other current liabilities are lower than budgeted $7.2m mainly as a result of lower accruals for capital charge and interest on term loans together with a difference in timing of payments against budget.		
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $37.0m and favourable YTD depreciation $3.0m. Please see attached for latest forecast of capital spend for the year for further detail.	**($34.0) U**	
Non Current Liabilities:		
The unbudgeted Debt to Equity swap for MOH loans was transacted in February 2017.	**$212.7 F**	
Equity		
Variance mainly due to : - Debt to Equity swap for MOH loans transacted February 2017 - $212m - Unfavourable variance in overall result against budget $10.0m	**$201.7 F**	
The MoH debt to equity swap also resulted in the movement in financial ratios relating to return on equity and equity to total assets: Equity to Total Assets: Budgeted 38.6%, Actual 70.2% Return on Equity: Budgeted 5.1%, Actual 0.6%		

CAPITAL EXPENDITURE AT 30 April 2017 ($000s)

Activity	CAPITAL PLANS: Prior year Board Approvals (F)	New Approvals FY16/17 (G)	Transfers (H)	Total Board Approved Capital Plans (I) = F+G+H	CASHFLOW FORECAST: Prior year expenditure for active Projects (K)	FY 16/17 Expenditure (Actual + Forecast) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Apr-17 (M)	Forecast Expenditure from 1st May 17 to 30 Jun-17 (N)	Forecast Subsequent Years (P)	FULL PROJECT FORECAST: 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	-	2,300	1,750	550	-	2,300	0
CLINICAL EQUIPMENT				-							
SUB TOTAL CLINICAL	12,455	27,393	210	40,058	2,031	6,082	5,451	630	31,168	39,281	777
INFORMATION SYSTEMS											
SUB TOTAL INFORMATION SYSTEMS	30,660	38,198	-244	68,614	8,316	7,711	5,118	2,594	50,798	66,825	1,789
PROPERTY & INFRASTRUCTURE - PLANT											
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	1,493	4,601	-	6,094	1,180	1,254	803	451	3,631	6,065	29
PROPERTY PROJECT SERVICES											0
SUB TOTAL PROPERTY PROJECT SERVICES	21,188	8,370	-175	29,383	10,173	6,423	4,267	2,155	12,809	29,405	(22)
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	77	10	67	85,833	85,910	159
CORPORATE											0
SUB TOTAL CORPORATE PROJECTS	8,000	800	-691	8,109	1	295	290	6	6,793	7,089	1,020
MOH Projects (funded externally)						-					
SUB TOTAL MOH PROJECTS	426	-	-	426	197	177	147	30	52	427	(1)
Trust Funded Projects (funded externally)						-					0
SUB TOTAL TRUST FUNDED PROJECTS	-		-	-	333	328	328	-	-	662	(662)
TOTAL CAPITAL EXPENDITURE						24,651	18,169	6,482	192,533	239,651	3,100
2016/17 PROJECTS NOT COMMENCED				-		41,895		41,895		41,895	(41,895)
CAPITALISED COMPLETED PROJECTS	4,189		275	4,464	3,150	1,455	1,455			4,605	(142)
REPORT TOTALS	106,738	141,054	-578	247,214	25,616	68,001	19,624	48,377	192,533	286,151	-38,936

CAPITAL EXPENDITURE AT 30 April 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)	FY 16/17 Expenditure (Actual + Forecast) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Apr-17 (M)	Forecast Expenditure from 1st May 17 to 30 Jun-17 (N)	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
Urology - Equipment	-	300	-	300	-	-	-	-	200	200	100
Heart Lung machines - Cardiac surgery	-	680	-	680	-	-	-	-	680	680	0
Heater Cooler units	-	156	-	156	-	-	-	-	156	156	0
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
Retinal Camera Head	-	-	58	58		58	58	-	-	58	(0)
Ultrasound Replacement (Endoscope, Operating Table & EMG System)	-	100	-	100	-	83	83	-	17	100	0
Cytogenics Incubators NICU	25	-	-	25	-	-	-	-		0	25
Endoscopy scope cleaning equipment	-	174		174	-	193	193	-	-	193	(19)
Endoscopes 16/17		1,040	-604	436	-	-	-	-	436	436	0
Endoscopy scope replacement			604	604	-	-	-	-	604	604	0
Ultrasound scanner replacement		175		175	-	-	-	-	175	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	85	7		92	0
Il Machine (Thames)	120	-	-	120	-	-	-	-	120	120	0
Transport Monitors (Critical Care)	75	-	-	75	-	-	-	-	75	75	0
Endoscope Camera (Thames)	103	-	-	103	-	-	-	-	103	103	0
ENT Zeiss S21 (Theatres)	50	50	-	100	-	-	-	-	50	50	50
X-ray Specimen (Theatres) Faxitron	85	-	-	85	-	89	89	-	-	89	(4)
Gynae Urodynamics	55	-	-	55	-	-	-	-	55	55	0
GP Pumps (Biomed)	450	-	-	450		-	-	-	450	450	0
Bed Replacement Programme	800	-	-330	470		-	-	-	470	470	0
Bed Replacement	-	-	330	330		354	354	-		354	(24)
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	-	200	78	122	-	200	515
Bio Chemistry Lab - Mass Spectrometer	500	-	-	500	-	-	-	-	500	500	0
Linear Accelerator (approved by BRRG Nov-15)	4,000	-	-	4,000	2,031	2,191	2,191	-	-	4,222	(222)
-Rapid ARC Licences (Oncology)	123	-	-	123	-	-	-	-	123	123	0
PCA Pumps (Biomed)	500	-	-	500	-	-	-	-	500	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
Bronchosopes (CCD x $) - Respiratory	-	70	-	70	-	70	61	9	-	70	(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
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

CAPITAL EXPENDITURE AT 30 April 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)	FY 16/17 Expenditure (Actual + Forecast) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Apr-17 (M)	Forecast Expenditure from 1st May 17 to 30 Jun-17 (N)	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
Replacement of Task Operating Theatre Lighting in OT7 & OT8	-	-	70	70	-	71	71	-	-	71	(1)
Replacement of Task Operating Theatre Lighting in OT 9 - 12	-	-	140	140	-	140	140	-	-	140	(0)
Orthopeadic Cordless Driver 4300 sets x 7	-	141	-	141	-	-	-	-	141	141	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		310	10	300	490	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	-	-	-		619	619	0
Mobile Image Intensifier - Waikato	-	1,500	-550	950	-	-	-	-	950	950	0
X-ray machines and Image Intensifiers	-	-	1,020	1,020	-	1,020	1,020	-	-	1,020	0
Ultrasound (medical Photography / imaging)	-	200	-	200	-	-	-	-	200	200	0
Infusion pumps (Thames)	-	67	-	67	-	-	-	-	67	67	0
Steriliser Autoclave (Thames)	-	200	-	200	-	-	-	-	200	200	0
Blood gas analysers	-	800	-	800	-	-	-	-	800	800	0
GE Logiq - 9 Vascular Ultrasound	-	-	-	-	-	138	138	-	-	138	(138)
CEP - Pool - 2016/17	119			119	-	192	-	192	-	192	(73)
SUB TOTAL CLINICAL	**12,455**	**27,393**	**210**	**40,058**	**2,031**	**6,082**	**5,451**	**630**	**31,168**	**39,281**	**777**
INFORMATION SYSTEMS											
PLATFORM						-	-	-			
ISSP - Decommission Galen 15/16	300	-	15	315	53	68	58	10	-	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	-	108	58	50	891	999	1

CAPITAL EXPENDITURE AT 30 April 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)	FY 16/17 Expenditure (Actual + Forecast) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Apr-17 (M)	Forecast Expenditure from 1st May 17 to 30 Jun-17 (N)	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 - Lifecycle - Infrastrucure 15/16	300		-	300	232	67	66	1	-	299	1
ISSP - Clinical and Corporate Platform		500		500		-	-	-	500	500	0
ISSP - Clinical and corporate Platform SQL Server consolidation	475		-	475	99	164	81	83	100	363	112
ISSP - Disaster Recovery Solution 15_16	1,150		-	1,150	2	94	44	50	1,027	1,123	27
ISSP - Backup Capacity Augment	200		-	200	0	50	46	4	150	200	(0)
ISSP - Contingency (IS)	100		-64	36	-	36	-	36	-	36	0
ISSP - Windows Server Migration 2003-2008 (DIA)	491		-221	270	-	-	-	-	270	270	0
STORAGE & REPORTING						-	-	-			0
ISSP - Clinical PhotographyImage Management	-	300	-	300	-	-	-	-	300	300	0
ISSP - DataWarehouse Phase 2 - after 16/17	-	400	-200	200	-	-	-	-	200	200	0
ISSP - Enterprise Reporting Content remediation -after 16/17	-	250	-	250	-	-	-	-	200	200	50
ISSP - Data Analyst Toolset Implementation (16/17)	-	700	-350	350	-	-	-	-	350	350	0
ISSP - Business Intelligence Toolset			350	350	-	87	87	-	263	350	(0)
ISSP - Lifecycle - Sharepoint Workplan (e.g. replace fileshares, online sharepoint)		1,100		1,100	-	-	-	-	1,100	1,100	0
ISSP - San Controller		322		322	-	-	-	-	322	322	0
ISSP - SharePoint (Doc Management Pilot)	700		-	700	230	-	-	-	455	685	15
ISSP - Data Warehouse Phase 1	400		-	400	175	145	74	71	80	400	1
ISSP - Data Warehouse Phase 2			200	200	-	7	7	-	193	200	(0)
NETWORK & COMMUNICATIONS				-		-	-	-			
ISSP - Paging System Replacement	-	350	-	350	-	171	32	139	180	351	(1)
ISSP - Unified Comms Phase 4 (16/17)	-	174	-112	62	-	-	-	-	62	62	0
ISSP - Jabber Instant Messaging and Guest			201	201	-	57	7	50	151	208	(7)
ISSP - Lifecycle - 1-2 Communication Tools Workplan	-	400	-	400	-	50	-	50	350	400	0
ISSP - WiFi Rollout	-	1,000	-	1,000	-	400	365	35	600	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	-	299	231	68	17	316	(16)
ISSP - Comms Rooms remediation 2015/2016	230		-	230	44	35	35	-	151	230	0
ISSP - Unified Comms Phase 4	147		-	147	35	60	60	-	-	95	52
ISSP - Hylafax replacement	96			96	-	30	10	20	65	95	1
DEVICES				-		-	-	-			
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		27	25	2	-	27	0
ISSP - Tablets to enable mobile workforce	-	500	-	500	-	-	-	-	500	500	0
ISSP - Touch screens	-	300	-	300	-	-	-	-	300	300	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 - iPads for Virtual Health	745		-	745	-	-	-	-	745	745	(0)
ISSP - Hardware Solution - Medication Room	20		-	20	-	9	9	-	-	9	11
ENTERPRISE SERVICE BUSINESS / RULES ENGINE				-		-	-	-			
ISSP - Clinical Business Rules	-	250	-	250	-	-	-	-	250	250	0
ISSP - Web Applications -S_Web_Services Infra_Mess Standards	-	500	-	500	-	-	-	-	500	500	0
ISSP - Web Applications -S_Web_Services Infra_Solution Select_Impl	-	500	-	500	-	-	-	-	500	500	0
TOOLS				-		-	-	-			
ISSP - PVS Citrix	39	-	-	39	-	15	15	-	-	15	24
ISSP - Citrix Sharefile	150	150	-150	150	98	51	51	-	-	149	1
ISSP - Archiving Tool	-	380	-	380	4	8	8	-	349	361	19
ISSP - TQUAL Reporting	50	50	-	100	1	54	21	33	-	55	45
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	284	239	45	100	562	1
ISSP - Toolsets (14/15)	130		-	130	72	60	39	20	-	131	(1)
ISSP - Toolsets (13/14)	471	-	-	471	474	5	5	-		479	(8)
ISSP - Citrix Netscaler10.5 upgrade	-	150	-	150	-	-	-	-	-	0	150
ISSP - Rapid Logon	-	700	-	700	-	-	-	-	700	700	0
ISSP - e2e Clinical Docs		499		499		-	-	-	499	499	0

CAPITAL EXPENDITURE AT 30 April 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)	FY 16/17 Expenditure (Actual + Forecast) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Apr-17 (M)	Forecast Expenditure from 1st May 17 to 30 Jun-17 (N)	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 - EMRAM compliance to lvl 6 - upgrade / implementation	-	700	-	700	-	-	-	-	700	700	0
ISSP - Lifecycle integration Tools workplan - Rhapsody etc	-	1,000	-	1,000	-	-	-	-	1,000	1,000	0
ISSP - Anivirus / Malware - Toolset upgrade / replacement	-	150	-	150	-	-	-	-	150	150	0
ISSP - Lifecycle - Desktop Workplan (Outlook, Flexplus, etc)	-	1,200	-	1,200	-	-	-	-	1,200	1,200	0
ISSP - Lifecycle - Development tools (Visual studio, Kendo etc)	-	200	-	200	-	-	-	-	200	200	0
ISSP - Team foundation Server - Source Code management	-	250	-	250	-	-	-	-	250	250	0
ISSP - LIS Reporting Development	200		-	200	83	66	24	42	50	199	1
SECURITY				-		-	-	-		0	0
ISSP - Perimeter Redesign		598	-262	336		-	-	-	336	336	0
ISSP - Perimeter Remediation Work Plan 16/17			173	173	-	73	1	72	100	173	(0)
ISSP - Lifecycle - 1-2 Security tools Workplan (cardex, etc)		600	-	600	-	-	-	-	600	600	0
ISSP - Perimeter Redesign	150		-	150	33	49	49	-	-	81	69
ISSP - Security Defence in depth	500		-122	378	29	112	37	75	236	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	-	15	15	-	14	29	(0)
ISSP - Other Licensing True-Up	300		-251	49	49	16	16	-	-	65	(16)
ISSP - MS Licensing True-Up	300		-124	176	129	47	-	47	-	176	0
CLINICAL SYSTEMS						-	-	-		0	0
ISSP - Lifecycle: LIS Workplan	150		-79	71		-	-	-	71	71	0
ISSP - Healthviews DC Uploader replacement		150	-150	-		-	-	-		0	0
ISSP - Clinical Workstation Core Component Workplan	-	-	480	480		209	181	28	270	479	1
ISSP - NCAMP. 3M, MKR	250	250	-250	250	78	124	84	40	47	249	1
ISSP - NCAMP 2017			250	250	-	66	6	60	184	250	0
ISSP - Workflow eData	250	-	-	250	3	247	120	128	-	250	(0)
ISSP - Workflow eData		2,100		2,100	-	-	-	-	2,100	2,100	0
ISSP - Database Replacements		300	-	300	2	97	23	74	200	299	1
ISSP - Oral Health system		1,000	-	1,000	165	594	547	47	241	999	1
ISSP - eTasks	-	230	-	230	-	100	2	98	130	230	0
ISSP - Cardiac Dendrite Phase 3	200	200	-116	284	-	-	-	-	284	284	0
ISSP - Surgical Services Audit Systems			116	116	-	116	39	77		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		250		-	-	-	230	230	20
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	-	130	90	40	220	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	-	80	10	70	70	150	0
ISSP - Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	-	1,400	-	1,400	-	181	70	111	1,217	1,398	2
ISSP - Life cycle - CWS / Healthviews Workplan	-	1,000	-654	346	-	-	-	-	346	346	(0)
ISSP - Software Upgrades (Apps Lifecycle 15/16)	250		-	250	149	101	73	27	-	250	0
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	-	7	7	-	217	224	76
ISSP - Clinical workstations - Document Tree search	-	100	79	179	-	101	3	98	99	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	-	221	181	40	229	450	0
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 - LIS Lifecycle upgrade (LIS Drop 6)	200		79	279	218	60	60	-	-	279	0

CAPITAL EXPENDITURE AT 30 April 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)	FY 16/17 Expenditure (Actual + Forecast) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Apr-17 (M)	Forecast Expenditure from 1st May 17 to 30 Jun-17 (N)	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 - HealthViews access to Primary Encounters (GP to Workstations)	300		-	300	69	231	230	1	-	300	(0)
ISSP - LIS Print solution	80		-	80	-	-	-	-	80	80	0
ISSP - HealthViews Internal eReferrals	300		-300	-	-	-	-	-	-	0	0
ISSP - Internal eReferrals			499	499	-	132	72	60	372	504	(5)
ISSP - eOrders	350		-	350	3	0	0	-	347	350	(0)
ISSP - Radiology - PACS/RIS Upgrade 16/17	500	200	-	700	-	-	-	-	653	653	47
ISSP - RIS Upgrade (Project split) (PACS Upgrade 15)	223		-	223	93	135	75	60	-	228	(5)
ISSP - RIS Upgrade 2016	124		-	124	1	122	17	105	-	124	0
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	408	408	-	-	461	(111)
ISSP - Clinical Workstation Metadata Scoping			50	50	1	5	5	-	46	53	(3)
ISSP - Speech Recognition			100	100	1	-	-	-	99	100	(0)
ISSP - Clinical Workflow Integration Work Plan			430	430	-	125	43	82	305	430	1
ISSP - Provation Host Tairawhiti	27		-	27	-	-	-	-	27	27	0
ISSP - Waikato Hauora iHub	-	-	-	-			-	-		0	0
ISSP - e-Discharge Summaries	100		-100	-	-	-	-	-	-	0	0
CORPORATE SYSTEMS & PROCESSES				-		-	-	-		0	0
ISSP - Costpro Upgrade		103		103		-	-	-	103	103	0
ISSP - Costpro Tactical Improvements & Upgrade	400		-	400	238	1	1	-	161	400	(0)
ISSP - HRIS Lifecycle Upgrade 15_16		400	-	400	4	50	39	11	346	400	0
ISSP - Lifecycle HRIS / Peoplesoft Workplan		950		950	-	-	-	-	950	950	0
ISSP - HRIS Self Service implementation - payroll improvement	400	-	-	400	-	-	-	-	400	400	0
ISSP - Attendants System - enhancements or replacement	-	100	-	100	-	-	-	-	100	100	0
ISSP - Hockin Conversion	21		-	21	12	9	4	5	-	21	0
REGIONAL						-	-	-		0	0
RSSP - Regional Netscaler Reconfiguration	-	33	-	33	-	-	-	-	33	33	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
MRISSP - Pharmacy System Phase II – Implementation	2,462		-	2,462	2,356	-	-		106	2,462	0
RISSP - Midland Regional Platform Project	409		-	409	245	-	-		164	409	0
RISSP - Clinical Workstation - Phase II (License)	500	500	-	1,000	500	500	500	-	-	1,000	0
ISSP - Netscaler Infrastructure			343	343	1	342	229	113	-	342	1
eSPACE											
RISSP - HSL - e Space Clinical Workstation	7,831		-	7,831	-	-	-	-	7,831	7,831	0
OTHER PROJECTS				-		-	-	-		0	0
ISSP - FMIS Replacement - Phase I	792		-	792	499	-	-	-	-	499	293
ISSP - Clinical whiteboard - eCWB Infrastructure	442		-	442	128	95	95	-	-	223	219
ISSP - Portfolio Resource Management Upgrade	130		-	130	85	10	10	-	-	95	35
ISSP - Printer Architecture Upgrade	130		-	130	9	60	4	56	60	130	0
ISSP - Application Lifecycle 2014/15 WorkPlan	470			470	454	4	4	-	-	458	12
ISSP - Baseline - Infrastructure Lifecycle Management	465		-	465	318	151	30	121	-	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	-	64	24	41	-	64	(0)
SUB TOTAL INFORMATION SYSTEMS	**30,660**	**38,198**	**-244**	**68,614**	**8,316**	**7,711**	**5,118**	**2,594**	**50,798**	**66,825**	**1,789**
PROPERTY & INFRASTRUCTURE - PLANT											
Waikato Waiora Chillers	643		-	643	626	2	2	-	-	628	15
Waikato Distribution Board stuff 11/12	250		-	250	196	54	16	38	-	250	0
Waikato Switchboards - Menzies,Kemp,Waiora & ERB	-	600	-	600	-	-	-	-	600	600	0
Theatre - Air conditioning upgrades	-	400	-250	150	-	-	-	-	150	150	0

CAPITAL EXPENDITURE AT 30 April 2017 ($000s)

CAPITAL PLANS					CASHFLOW FORECAST					FULL PROJECT FORECAST	
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Kempthorne Plantroom Upgrade	-	-	250	250	-	252	241	11	-	252	(2)
Thames - Air conditioning inpatient unit upgrade	-	200	-	200	-	-	-	-	200	200	0
Carpark Lighting - Upgrade	-	50	-	50	-	50	37	13	-	50	(0)
HV System - upgrade- SCADA to BMS	-	160	-	160	-	-	-	-	160	160	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	-	20	-	20	-	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	-	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		87	-	87	-	87	
Convert CCTV from analogue to IP	-	60	-	60	-	-	-	-	60	60	0
Develop Web based payment for Multicash	-	150	-48	102	-	-	-	-	102	102	(0)
Change Readers X 125	-	60	-	60	-	27	27	-	33	60	(0)
Gallagher door controllers - upgrade to 6000 model	-	300	-	300	-	100	90	10	200	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		-	-	-	54	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	293	293	-		651	(51)
Infrastructure Replacement Pool (16/17)		600		600	-	318	64	254	215	533	67
SUB TOTAL PROPERTY & INFRASTRUCTURE- PLANT	**1,493**	**4,601**	**-**	**6,094**	**1,180**	**1,254**	**803**	**451**	**3,631**	**6,065**	**29**
PROPERTY PROJECT SERVICES											0
Priority Roading Works		565		565	-	-	-	-	565	565	0
MCC - Edge roof protection		30		30	-	-	-	-	30	30	0
OPRS - Roof access		30		30	-	-	-	-	30	30	0
ERB improvements (counter cold & wind)		150		150		-	-	-	150	150	0
Greening Programme	875	-	-280	595		-	-	-	595	595	0
Concept Design- Oncology/Haematology Facility	300	-	-	300	62	238	19	219		300	0
Virtual Care Office	46	-		46	57	35	35	-		92	(46)
Boiler House Upgrade	1,833	-	-	1,833	1,833	33	33	-		1,866	(33)
Hilda Ross - Remediation	3,403	-	280	3,683	-	1,784	1,359	425	1,900	3,684	(1)
Lift Upgrade	1,835	-	-	1,835	1,610	-	-	-	225	1,835	(0)
Electrical Systems Improvement	6,889	-	-175	6,714	5,789	156	156	-	789	6,734	(20)
Consolidation of CBD facilities	-	5,557	-	5,557	-	1,388	1,092	296	4,169	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	-	96	96	-		96	(1)
Seismic Remediation	3,207	-		3,207	123	2,193	1,255	938	909	3,225	(18)
Internal Reconfiguration - Gallaghers	-	863	-	863	-	146	72	74	717	863	(0)
Internal Reconfiguration - Room Pressure	-	210	-	210	-	210	90	120		210	0
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

CAPITAL EXPENDITURE AT 30 April 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)	FY 16/17 Expenditure (Actual + Forecast) (L) = M+N	Actual Expenditure YTD from 1 Jul-16 to 30 Apr-17 (M)	Forecast Expenditure from 1st May 17 to 30 Jun-17 (N)	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
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	-	140	56	84		140	0
Legacy SCR - Still Required - decanting	800		-	800	700	4	4	-	-	704	96
SUB TOTAL PROPERTY PROJECT SERVICES	**21,188**	**8,370**	**-175**	**29,383**	**10,173**	**6,423**	**4,267**	**2,155**	**12,809**	**29,405**	**(22)**
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	-	77	10	67	-	77	0
Mental Health Facility	-	60,992	-	60,992	-	-	-	-	60,833	60,833	159
SUB TOTAL STRATEGIC PROJECTS	**25,077**	**60,992**	**0**	**86,069**	**0**	**77**	**10**	**67**	**85,833**	**85,910**	**159**
CORPORATE											0
COS - Contingency (was CFO)	1,000		-492	508	-	-	-	-	508	508	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	-	30	24	6		30	0
Project Elevate-Upgrade to NOS			118	118	1	207	207	-		208	(90)
Audio Visual Equipment						58	58	-	-	58	(58)
Transition to National Oracle System	3,500		-118	3,382	-	-	-	-	2,314	2,314	1,068
SUB TOTAL CORPORATE PROJECTS	**8,000**	**800**	**-691**	**8,109**	**1**	**295**	**290**	**6**	**6,793**	**7,089**	**1,020**
MOH Projects (funded externally)						-					
National Patient Flow-Phase 2	177		-	177	174	2	2	-	-	177	0
National Patient Flow Phase 3	249			249	23	175	145	30	52	250	(1)
Telestroke Pilot	-	-	-	-	-	42	42	-	-	42	(42)
SUB TOTAL MOH PROJECTS	**426**	**-**	**-**	**426**	**197**	**177**	**147**	**30**	**52**	**427**	**(1)**
Trust Funded Projects (funded externally)						-					0
15/16 Trust Account	-			-	250	226	226	-	-	476	(476)
16/17 Trust Account				-	-	97	97	-	-	97	(97)
15/16 Other Donated Assets				-	84	5	5	-		89	(89)
SUB TOTAL TRUST FUNDED PROJECTS	**-**		**-**	-	**333**	**328**	**328**	**-**	**-**	662	(662)
TOTAL CAPITAL EXPENDITURE						**24,651**	**18,169**	**6,482**	**192,533**	**239,651**	**3,100**
2016/17 PROJECTS NOT COMMENCED				-		41,895		41,895		**41,895**	**(41,895)**
CAPITALISED COMPLETED PROJECTS	4,189		275	4,464	3,150	1,455	1,455			**4,605**	**(142)**
REPORT TOTALS	**106,738**	**141,054**	**-578**	**247,214**	**25,616**	**68,001**	**19,624**	**48,377**	**192,533**	**286,151**	**-38,936**

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 5.2

BANKING SERVICES SUPPLIER CHANGE

Purpose	For approval.

New Zealand Health Partnerships Limited (NZHP) manage the master banking agreement with Westpac for delivery of banking services on behalf of all DHBs. Excess DHB funds are swept daily to NZHP for consolidating all DHB funds and investing this at optimal interest rates based on forecast cash balances provided by DHBs to NZHP.

The current banking arrangement for the DHB's for transactional banking services, including the current daily sweep, is due to expire with the incumbent supplier (Westpac) on 2 April 2017. Due to unsuccessful discussions with the incumbent to find further benefit for DHBs and extend the original contract, the Chief Financial Officers' (CFOs') forum endorsed the recommendation to go to market.

The attached NZHP "Banking and Treasury Services Supplier Recommendation Report" recommends a change for the sector in its banking services provider. The report has been endorsed by the Treasury Evaluation Group involved in the procurement process (of which the Treasurer of Waikato DHB was a member).

Waikato DHB support the recommendation to change banks noting the reliance on system changes to the National Oracle System will impact Waikato DHB's timeframe to be able to implement a change in banking service provider. The benefits and risks associated with this change were discussed at the Audit & Risk Management Committee meeting on 22nd March 2017.

Recommendation
THAT

1) The Board approves the Supplier Recommendation report.
2) The Board approves Waikato DHB changing its banking services provider from Westpac to BNZ, in conjunction with the Sector.

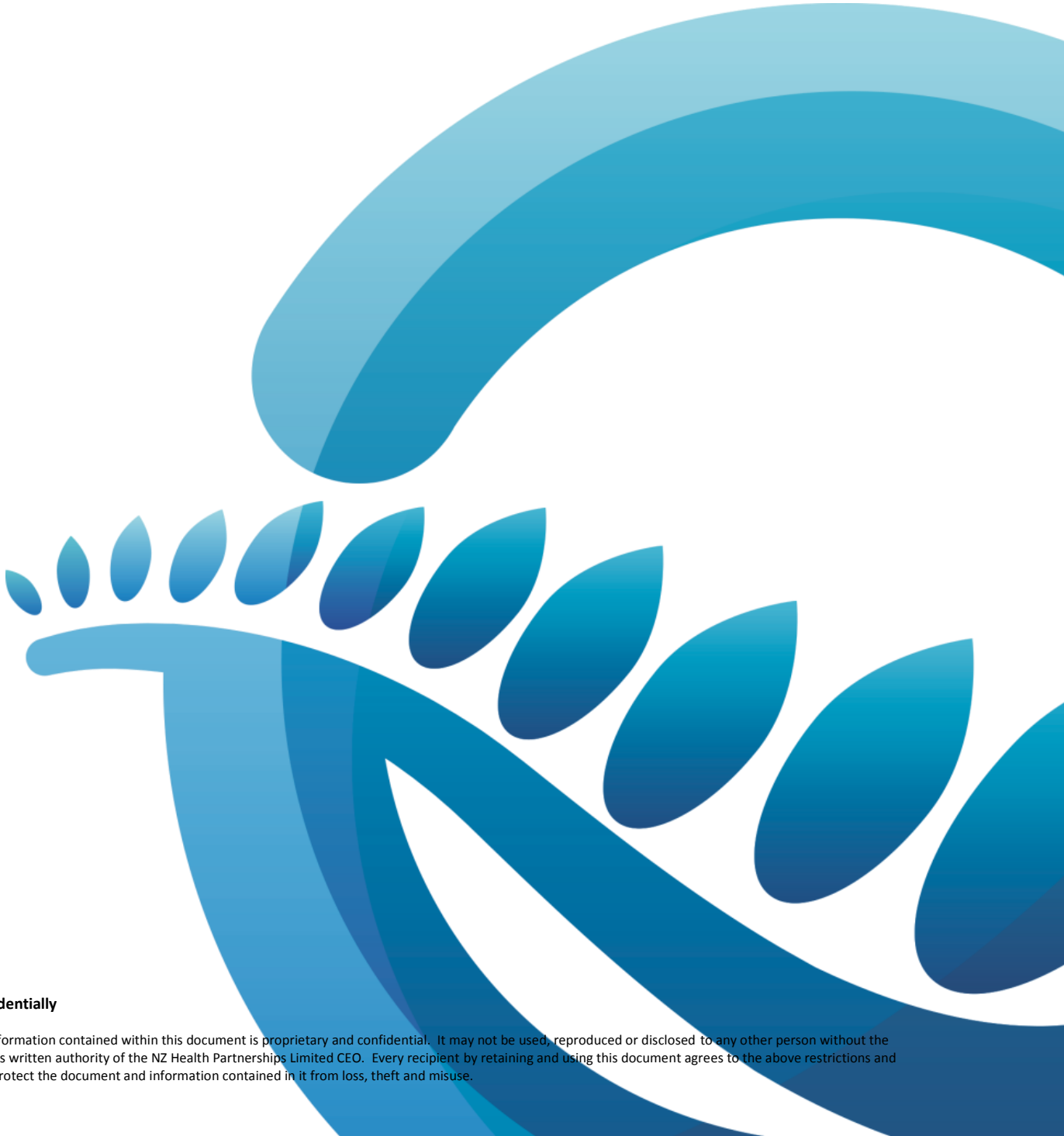
ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

NZ HEALTH PARTNERSHIPS

Supplier Recommendation

Banking & Treasury Services

23-Mar-17 Bart Signal



Contents

Figures

No table of figures entries found.

Document Control

Version Control		
Date	**Version**	**Created/Amended By and Provide Comments**
2-Mar-17	0.1	Bart Signal
2-Mar-17	0.2	Amended by Bart Signal following feedback from Govind Shaw
3-Mar-17	0.3	Amended by Bart Signal
3-Mar-17	0.4	Amended by Bart Signal following feedback from Govind Shaw and Geoff Goodwin
7-Mar-17	0.5	Incorporating feedback from Andrew McCurdie, Meng Cheong, Rowan Cramon, Brian Walden and Alan Mountfort
10-Mar-2017	0.6	Incorporating feedback from Megan Main and additional feedback from B&I TEG members
16-Mar-17	0.7	Incorporating feedback from CFO briefings

Contributors to this Document		
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	Govind Shaw	NZ Health Partnerships Limited, Treasury and Finance Manager
	Geoff Goodwin	NZ Health Partnerships Limited,

Distribution		
Date	**Name**	**Organisation and Title**
6-Mar-2017 8-Mar-2017	Banking and Insurance Tender Evaluation Group	
8-Mar-2017	Megan Main	NZ Health Partnerships Limited Chief Executive
10-Mar-2017	DHB Sector Chief Financial Officers'	
10-Mar-2017	NZ Health Partnerships Board	
	Sector DHB Chief Executives'/Board	(subject to DHB local delegation)

Approvals		
Date	**Name**	**Organisation and Title**
	DHB Sector Chief Financial Officers'	
	NZ Health Partnerships Board	
	Sector DHB Chief Executives'/Board	(subject to DHB local delegation)

1. Executive Summary

Overview

NZ Health Partnerships manages shared banking and treasury arrangements on behalf of District Health Boards (DHBs) and associated subsidiaries. DHBs derive benefits from streamlined transactional banking services, cash management and little or no working capital facility fees. Administration costs have been reduced and standardised fees and charges have been introduced. Our contract with the current provider (Westpac) is coming up for expiry on 2 April 2017 and the DHBs have tested the market to find innovative approaches and value-add services to create better value for DHBs.

Due to unsuccessful discussions with the incumbent bank to find further benefit for DHBs and extend the original contract, the Chief Financial Officers (CFOs) present a their June 2016 forum endorsed the recommendation to go to market. It was decided by NZ Health Partnerships, in conjunction with its DHB shareholders, to run a pre-qualification and Competitive Dialogue process with suitably rated (AA – minimum from S&P) New Zealand registered banks. As a result, we identified characteristics and capabilities of banks who NZ Health Partnerships and the DHBs, through representation by colleagues who sit on the Banking and Insurance Tender Evaluation Group (B&I TEG), invited to respond to a Request for Proposal (RFP). The purpose of the RFP was to invite suitably qualified and experienced suppliers to submit a proposal for the provision of banking and treasury services.

The procurement was also designed to extract a high level of service for each of the DHBs. Respondents were encouraged to propose options which will:

1. Reduce the costs of transactional banking
2. Minimise the cost of working capital and term borrowing facilities
3. Maximise returns from credit balances
4. Add value to the DHB business processes
5. Provide better individualised customer service for each of the DHBs

The B&I TEG, completed their procurement process which also included presentations by each of the participating banks. The outcome of this process has determined a likely outcome of changing banks away from the incumbent for transactional and treasury services. The scoring was very close among the top two participants with a point's difference of only 1.4. However, there was a gap of 8.7 points between the incumbent and the first place participant. On this basis the B&I TEG decided that a negotiation strategy focused on the preferred participant(s) would provide the most efficient and cost effective manner on a collective basis to DHBs.

The outcome from negotiations to date indicates that:

- Transitioning banking services from Westpac to the BNZ would result in a predicted financial benefit for the sector of $1.2m per annum or $7.3m benefit over the life of the contract.
- Keeping banking services with Westpac will not realise any new benefits and will reduce interest income for the sector for no cost reduction.
- BNZ will provide project management and training resource at no cost to NZHP and the DHBs
- DHB access to 33 BNZ Partner Centres throughout the country
- BNZ's structured finance expertise for infrastructure and procurement
- Dedicated and experienced BNZ team to facilitate a smooth transition

The table below compares the predicted revenue benefit, estimated implementation costs and predicted operational costs in year one for each option.

	Incumbent Westpac	Transition to BNZ
Annual predicted interest revenue benefit	Nil	$1,043k
Implementation costs – year one only	Nil	$198k
Annual operational cost (i.e. line and transaction fees)	$211k	$41k

Recommendation

The following recommendations are made for endorsement:

- That the sector changes its banking service provider from Westpac to BNZ effective 1 June 2017.
- That the new arrangement be for a term of three years with a further right of renewal for an additional three years, at NZHP's sole discretion (subject to approval of each DHB)

2. Introduction

2.1 Purpose

The purpose of this document is to seek approvals from the following bodies to change the sector's banking service provider from Westpac to BNZ in the sequence outlined below:

1. Banking and Insurance Tender Evaluation Group
2. DHB Sector Chief Financial Officers
3. NZ Health Partnerships' Board
4. Sector DHB Chief Executives'/Board approval (in line with each DHB's delegation of authority)

2.2 Background

The current banking arrangement for the DHBs for transactional banking services, including the current daily sweep, is due to expire with the incumbent supplier (Westpac) on 2 April 2017. Due to unsuccessful discussions with the incumbent to find further benefit for DHBs and extend the original contract, the Chief Financial Officers (CFOs) present a their June 2016 forum endorsed the recommendation to go to market. It was decided by NZ Health Partnerships, in conjunction with its DHB shareholders, to run a pre-qualification and Competitive Dialogue process with some New Zealand registered banks and invited them to respond to a Request for Proposal (RFP).

2.3 Scope of Procurement

The scope of this procurement included:

1. Transactional Banking services/accounts
2. Working capital requirements
3. A "Cash Sweep type" Solution or similar in order to meet requirements
4. Transition services
5. Other value add services/offerings

This procurement excluded All-of-Government banking Subcategories 2, 3, and 4 being:

- Foreign Exchange Services (low value foreign exchange transaction services)
- Payment Services (merchant acquiring service, online gateway services, over-the-counter services and remittance processing)
- Card Services (issuing of purchase and/or credit cards and expense management system services)

However the evaluation group was open to looking at any innovative ideas that would bring value to DHBs' businesses individually and collectively.

Refer to Appendix C for more detail on the scope of procurement.

2.4 Benefits sought

This procurement sought the following benefits for DHBs:

- reduce the costs of transactional banking;
- minimise the cost of working capital and term borrowing facilities;
- maximise returns from credit balances; and
- add value to the DHB business processes.
- better individualised customer service for each of the DHBs

3. Tender Evaluation and Negotiations

3.1 Banking and Insurance Tender Evaluation Group (B&I TEG)

The Banking and Insurance Service Performance group (B&I SPG) created a Tender Evaluation Group (B&I TEG) which consisted of their members plus additional sector representation and other advisors. The B&I TEG have been meeting to discuss Transactional Banking and Treasury Services for New Zealand DHBs since June 2016.

The Banking and Insurance Service Performance Group membership is below

Name	B&I SPG Role	Organisation	Position
Nigel Trainor	Chair and CE Sponsor	South Canterbury DHB	CEO
Ron Pearson	Northern Region representative	Counties Manukau DHB	Deputy CEO/Director of Corporate & Business Services
Alan Mountfort	Midland Region representative	Lakes DHB	CFO
Peter Kennedy	Central Region representative	Hawkes Bay DHB	Head of Finance
Justine White	Southern Region representative	Canterbury DHB and West Coast DHB	GM Finance and Corporate Services
Geoff Goodwin	Service Provider representative	NZ Health Partnerships	GM Corporate Services

Additional sector representation and other advisors included in B&I TEG is below

Name	Organisation	Position
Rowan Cramond	Waikato DHB	Director of Finance Operations
Meng Cheong	Northland DHB	GM, Finance, Funding & Commercial Services
Brian Walden	Whanganui DHB	GM Strategic and Corporate
Peter Blackwell	NZ Health Partnerships	Commercial Manager - Procurement

3.2 Negotiation Team

At the B&I TEG meeting on 7 December, the members unanimously agreed that the Negotiation team would consist of a subset of members:

- Rowan Cramond
- Justine White
- Geoff Goodwin

3.3 Evaluation of submissions

3.3.1 Procurement process

The process for this procurement was based on a multi-stage that included;

- Pre-qualification criteria
- Competitive Dialogue
- RFP
- Individual Bank presentations
- Evaluations (individual and group)
- Negotiations

Refer to Appendix D for more detail on the procurement processes.

3.3.2 Evaluation criteria

The evaluation criteria and weightings for the RFP are identified in the table below:

Evaluation Criteria	Weighting (%)
Functional Requirements	30%
Service Delivery	10%
Strategic fit	20%
Pricing	40%

3.3.3 Final Scoring Evaluation Team

Pricing Evaluation	Tender Sum	Pricing Score 40%	Non Pricing Score 60%	Total Score	Ranking
BNZ	69	20	42.3	62.3	1
ANZ	69	20	40.9	60.9	2
Westpac	73	17.7	35.9	53.6	3

3.4 Negotiations

At the B&I TEG meeting on 23 November it was unanimously agreed to progress into a negotiation phase and in the subsequent meeting on 7 December it was reported that 17 DHBs confirmed support for negotiating with 2 DHBs against and one no response. On this basis the B&I TEG members unanimously agreed that negotiations would only be with the top placed participant; in this case that was the BNZ.

However, there have been ongoing discussions with Westpac that have resulted in obtaining a 9 month extension at a revised rate under the existing terms. The extension with Westpac provides time to transition to BNZ if this is the final decision.

The outcomes (costs and benefits) from negotiations resulted in BNZ proposing to increase credit interest rate by 10 basis points. All other outcomes are outlined below in each option.

4. Option A: Transition to BNZ

4.1 Overview

The terms negotiated with the lead participant (BNZ) will reduce the operational cost of in-scope banking services and generate additional interest income.

4.1 Benefits

The annual predicted financial benefit for the sector once the in-scope banking services transitioned to BNZ for all DHBs is expected to be $1.2m per annum or $7.3m benefit over the life of the contract.

Financial Benefit	Annual Predicted Financial Benefit
Interest revenue Projected interest revenue in excess of proposed Westpac rates. Sensitivity analysis indicates the OCR fluctuations do not impact this benefit because BNZ and Westpac use OCR as a basis for their proposed rates.	$1,043k
Line fees The BNZ terms have no line fees so this is a cost avoidance benefit when compared with terms being quoted by Westpac.	$150k
Transaction fees The BNZ terms have lower transaction fees than the terms being quoted by Westpac. A cost reduction benefit based on modelling	$20k
Total annual financial benefit	**$1,213k**

A copy of modelling results and assumptions is provided in Appendix A.

It should be noted that the interest revenue benefit will reduce by $86k in year one for every month transition to the BNZ is delayed. Refer to Appendix B for each DHB's individual benefit erosion estimate.

Transitioning to BNZ for banking services will also realise indirect benefits such as:

- DHB access to 33 BNZ Partner Centres throughout the country
- BNZ's structured finance expertise for infrastructure and procurement
- Dedicated and experienced BNZ team to facilitate a smooth transition
- BNZ's plan to waive their project management costs during transition
- BNZ will provide project management and training resource at no cost to NZHP and the DHBs
- There is no ability for BNZ to alter the price unless there is a significant market change

4.1 Impact considerations

4.1.1 NOS Programme

The National Oracle Solution (NOS) specifications allow for only one banking provider as it has been assumed that all DHBs had and will continue to collectively agree to a use a single banking service provider. NOS will need to be modified to incorporate a transition of banking services from Westpac to BNZ. The NOS programme team estimates that these modifications will cost $98k as a one-off cost and this has been included in implementation costs. There has been no consideration (cost or schedule) of re-configuring NOS to allow DHBs to have multiple banking service providers.

The current NOS programme roll-out schedule will also constrain and NOS schedule changes could impact plans that transition banking services to BNZ. For example to mitigate risk and disruption the under current NOS go-live schedule[1], the HealthBiz DHBs (Bay of Plenty, Canterbury and Waikato) have requested that they are not transitioned to a new banking provider until their NOS implementation is stable (i.e. NOS Phase one is stable). These constraints have been incorporated into the indicative timeline below.

Non-HealthBiz DHBs can transition their banking services to BNZ from June 2017 (i.e. contract start) but NOS will need to be modified prior to their NOS go-live (possible future constraint on NOS programme). A transition of banking services to BNZ will need to be completed before the current Westpac contract extension or transitional arrangement expires. These constraints have been incorporated into the indicative timeline below.

The NOS and Share Banking programme will maintain an open dialogue to ensure that implications of changes from either programme are understood, validated and endorsed.

4.1.2 Other impact considerations

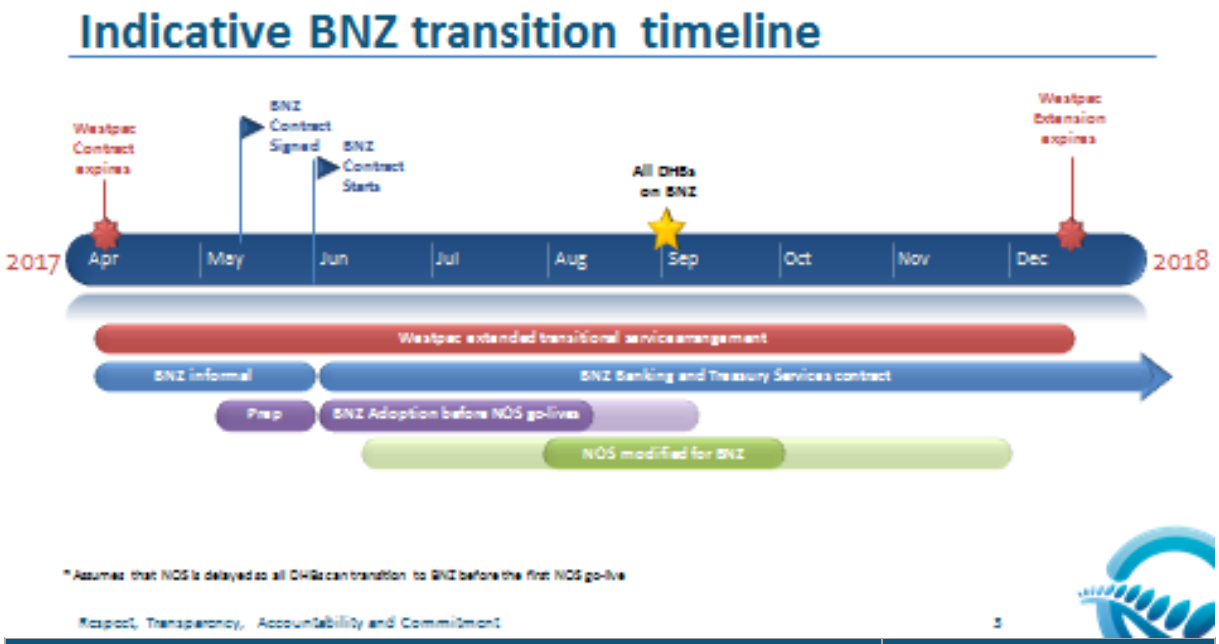
There has been no impact assessment of other programmes, DHB systems, DHB projects, processes or other banking products that are out-of-scope. However, each DHB should consider change impacts to such things as:

- Payroll systems
- Existing financial systems
- Eftpos and credit card payment services
- Foreign exchange providers
- Out-of-scope banking products (e.g. credit cards)
- Automated/electronic bank transactions (e.g. customer and DHB, DHB direct credits, customer, DHB automatic payments, IRD payments etc.)
- Documentation (e.g. pre-printed forms, policies etc.)

[1] NOS plans as at March have their Phase One go-live date a July 2017.

4.2 Transition timeline

The following is an indicative timeline for transitioning Shared Banking Services from Westpac to BNZ. It assumes that the NOS programme is delayed to such an extent that all DHBs can transition to the BNZ before their NOS go-live.



Milestone	Target date
Contract signed and awarded	19 May 2017
Contract start date	1 June 2017
Start transition to BNZ – All DHBs	June 2017
Transition to BNZ is complete	September 2017
Westpac extension expires	21 December 2017
Complete NOS modifications for BNZ banking services	Late 2017
NOS phase one go-live	TBC

4.3 Cost of transition

The following table is a summary estimated implementation costs and operational costs in year one for transitioning Shared Banking Services from Westpac to BNZ.

Description	Year One Cost
National Oracle Solution (NOS) impact The NOS team have advised that changing banks would result in a one-off cost of up to $98k to make the necessary configuration changes to core NOS system, as well as to the 4 DHBs that are already coded to the and modification to supporting documentation. This estimate assumes that all DHBs continue to use a single bank in NOS.	$98k
DHB Implementation costs An allowance for additional implementation costs not funded from DHB 'business as usual' resourcing, plans, programmes or projects.	$100k
Legal costs There is an agreement in place with BNZ that each party will bear their own legal costs. NZ Health Partnerships will fund legal costs related to contract negotiations with BNZ.	Nil
Line fees Operational cost in year one as per provided terms and modelling in Appendix A	Nil
Transaction fees Operational cost in year one as per provided terms and modelling in Appendix A	$41k
Implementation + first year's operational cost	**$239k**

It appears that the total cost in year one (i.e. implementation + operating costs) for transitioning to BNZ is similar to the annual operating cost of the incumbent supplier (refer below).

5. Option B: Continuing with Incumbent (Westpac)

5.1 Overview

The incumbent supplier (Westpac) has provided terms, should they be successful, that would reduce interest revenue for the same annual operational cost under the current contract.

5.2 Benefits

There are no apparent financial benefits for keeping banking services with Westpac as revised terms will keep operational costs at current levels but reduce interest revenue.

However, continuing with Westpac as the incumbent supplier can be seen as a lower risk option that:

- avoids impacts to National Oracle Solution (NOS) programme.
- avoids any local disruption to DHB personnel
- requires minimal implementation activities
- avoids impacts and costs to modifying other DHB systems and processes

5.1 Impact considerations

There are no apparent impacts to other programmes, systems or processes with continuing banking services with Westpac.

5.1 Implementation Timeline

The following is an indicative timeline for continuing Shared Banking Services with Westpac.

Milestone	Target date
Contract signed and awarded	TBC
Contract start date	TBC

5.1 Cost

The cost of implementation of revised banking services terms from Westpac is expected to be negligible because there is no expected system impact, no expected process impact and minimal implementation costs. The following table is a summary estimated costs in year one for continuing with the incumbent.

Description	Year One Cost
DHB Implementation costs	Nil
Line fees Operational cost in year one as per provided terms and modelling in Appendix A	$150k
Transaction fees Operational cost in year one as per provided terms and modelling in Appendix A	$61k
Implementation + first year's operational cost	**$211k**

It appears that the annual operating cost for continuing with Westpac is slightly less than total year one cost (i.e. implementation + operating costs) for transitioning to BNZ (refer above).

6. Recommendation and Next steps

6.1 Recommendation

The table below compares the predicted revenue benefit, estimated implementation costs and predicted operational costs in year one for each option.

	Incumbent Westpac	Transition to BNZ
Annual predicted interest revenue benefit	Nil	$1,043k
Implementation costs – year one only	Nil	$198k
Annual operational cost (i.e. line and transaction fees)	$211k	$41k

Note that in year one the above revenue benefit could erode by $86k per month should there be any transition delays. Refer to Appendix B for each DHBs' benefit erosion estimate.

On the balance of risk, cost and benefits, NZ Health Partnerships recommends that the sector changes its banking service provider from Westpac to BNZ to take advantage of the soft benefits and a $1.2m predicted annual financial benefit or $7.3m benefit over the six years of the contract.

6.2 Next steps

The next steps to complete procurement activities and initiate implementation plans are:

#		Status
1.	Circulate this Supplier Recommendation report to B&I TEG members for comment and feedback.	Complete
2.	Present and discuss Supplier Recommendation report at the B&I TEG meeting on 7 March. Reflecting on finalised contract negotiations, benefits, impacts, cost and a draft transition timeline.	Complete
3.	Circulate this Supplier Recommendation report to B&I TEG members and obtain their endorsement.	Complete
4.	Circulate this Supplier Recommendation report to DHB CFOs and obtain their approval by Friday, 17 March	In-progress
5.	Present this Supplier Recommendation report at NZHP Board on 30 March and obtain their approval by Friday, 17 March	In-progress
6.	Obtain DHBs approval of the Supplier Recommendation report, dependent on each DHB's delegation of authority. DHB approval is needed by Friday, 12 May.	
7.	Contract signed and awarded by Friday, 19 May	
8.	Start implementation of approved option in conjunction with contract start date on 1 June	

Appendix A – BNZ Benefit modelling

The following analysis is limited to the benefit gained by banking with BNZ over Westpac based on the interest rate and the line fees and has not considered any other factors such as transition costs, training costs, opportunity costs etc.

Analysis of the net benefit earned by banking with Westpac and BNZ

On cash excluding TDs and ASB on call account*

Summary	Interest	Line fees	Transaction fees	Net Benefit for 1 year	Net benefit for 6 years
Westpac	6,673,810	(150,000)	(60,780)	6,463,030	38,778,182
BNZ	7,716,593	-	(41,201)	7,675,391	46,052,349
Gain	**1,042,783**	**150,000**	**19,578**	**1,212,361**	**7,274,167**

* Avg Term Deposit balance maintained is $230m

* Avg ASB balance maintained is $226m

Assumptions

The above benefit analysis assumes:

1. Twelve month daily cash balance is made up of last 6 month actual balance and 6 months forecast balance (average of weekly high and low).
2. There are no Term Deposits are made during the period.
3. Official Cash Rate (OCR) is currently at 1.75%.
4. BNZ credit Interest rate of OCR + 0.10 as per proposals and negotiations
5. Westpac credit Interest rate of OCR – 0.15% as per proposals and negotiations. The rate used assumes that the following performance criterion proposed by Westpac are not achievable:
    - Funding deadline – performance and influence are outside the control of NZ Health Partnerships and DHBs.
    - Forecasting variation – historical forecasting variance indicates that this is always at risk.
    - Activity reporting – doesn't provide NZ Health Partnerships with sufficient latitude to make beneficial investment decisions

Appendix B – Benefit Erosion from implementation delays

The following table provide each DHB with an estimate of benefit erosion[3] of interest income for any delay after the start of the BNZ contract.

DHB	Annual Predicted Financial benefit[3] ($000's)	Benefit erosion per month
Northern region		
• Auckland	179.6	14,969
• Counties Manukau	118.2	9,850
• Northland	377	3,140
• Waitemata	110.1	9,175
Midlands region		
• Bay of Plenty	53.4	4,451
• Lakes	19.0	1,584
• Tairawhiti	2.7	221
• Taranaki	14.3	1,190
• Waikato	86.6	7,220
Central region		
• Capital and Coast	59.2	4,931
• Hawkes Bay	43.4	3,615
• Hutt Valley	28.1	2,342
• MidCentral	58.8	4,896
• Wairarapa	3.9	325
• Whanganui	16.6	1,383
Sothern region		
• Canterbury	96.6	8,046
• Nelson Marlborough	53.7	4,476
• South Canterbury	24.8	2,067
• Southern	17.1	1,421
• West Coast	19.1	1,594
	1,042.8	**86,896**

[3] Based on NZ Health Partnerships modelling assumptions and calculations used to support Appendix A.

Appendix C –Procurement Scope

The scope of this procurement included:

1. Transactional Banking services/accounts including:

- electronic banking services for processing and payment of accounts receivable and accounts payable, funds transfers between accounts, bank statement management and payroll processing;
- automatic payments and direct debits;
- processing of cheques received for accounts receivable and cheques issued for accounts payable;
- cheque cashing facilities to draw petty cash, cash handling and receipt of cash, and other facilities that may be required at branches including arrangements at branches other than the "home" branch to accommodate the needs of DHBs with multiple locations;
- account management including transactional statistics and management information.
- account/relationship management

2. Working capital requirements including the provision of:

- overnight, on call rates; and
- overdraft facilities;

3. A "Cash Sweep type" Solution or similar in order to meet requirements

- An automatic sweep of residual balances in accounts at the end of each business day is what we have now but NZ Health Partnerships and the DHBs are open to any process which would be more efficient and cost effective.

4. Transition Services

- Transition Services are likely going to be required whether it is to another service provider or to services offered that differ in scope or specification to that which are delivered today.

5. Other Value Add Services (examples only)

- Electronic banking for all staff, patients, visitors. Possibly including ATMs
- Payment solutions tailored to DHB requirements

This procurement did not include, All-of-Government banking Subcategories 2, 3, and 4 being:

- Foreign Exchange Services (low value foreign exchange transaction services)
- Payment Services (merchant acquiring service, online gateway services, over-the-counter services and remittance processing)
- Card Services (issuing of purchase and/or credit cards and expense management system services)

However, the evaluation group were open to looking at any innovative ideas that would bring value to the DHBs businesses individually and collectively.

For more information refer to the RFP documentation.

Appendix D – Evaluation process

The evaluation process for this procurement was based on a multi-stage processes that included;

6. **Pre-qualification Criteria**
   Service providers that were invited to participate must:

- have a minimum credit rating from Standards and Poors of "A+" or better
- be a registered bank in New Zealand and not be a bank which operates in New Zealand as branches of overseas-incorporated banks
- have a nationwide branch presence, with local branch services to be provided at all DHB head office locations
- be an existing transactional banking provider to large corporate groups in New Zealand.

7. **Competitive Dialogue**
   A dialogue with each of the pre-qualified participants to understand what they can and cannot deliver with regards to requirements. This also allows participants to understand our requirements so that they can introduce innovative thinking and respond to our procurement with very specific solutions and ideas.

8. **RFP**
   The RFP was issued to the pre-qualified participants through the Government Electronic Tendering Service (GETS) and was in the market for the requisite 20 working days.

9. **Individual Bank presentations**
   Each of the banks who responded to the RFP was asked to make a presentation to the evaluation members on their proposals. This allowed the evaluators to ask questions in order to increase their understanding of the proposals and evaluate with better insight.

10. **Evaluations (individual and group)**
    Each evaluator was asked to evaluate the non-price attributes of each of the proposals. The pricing was evaluated separately by NZ Health Partnerships. The individual scores were consolidated and agreed by the evaluation members to derive the final group score. Pricing was then added to create a ranking of preferred participants.

11. **Negotiations**
    It is proposed that the CFO forum endorses the recommendations of the B&I TEG. The recommendations are to negotiate with the top placed participant and to keep the second place participant close. That the third placed participant (the incumbent) is notified that they will not be taken further in the process as it stands. This recommendation is made with the goal of achieving overall best value for the sector as well as the individual DHBs.

Performance Reporting

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 6.1

HEALTH TARGETS REPORT

Purpose	For information.

Most recent results

Table 1 shows a summary of performance for Waikato DHB's health target results including some 2016/17 quarter three results. DHB comparison rankings for 2016/17 quarter three performance are not yet 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 Q2 results & ranking	2015/16 Q3 results & ranking	2015/16 Q4 results & ranking	16/17 Target	2016/17 Q1 results & ranking	2016/17 Q2 results	2016/17 Q3 results	Target achieved	2016/17 Most recent result
Shorter stays in emergency departments		**95%**	92% 16th ✗	90% 19th ✗	**91% 18th** ✗	**95%**	89.3% 19th ✗	87.6% 20th ✗	88.4%	X	88.2% Apr 17 YTD
Improved access to elective surgery		**100%**	120% 2nd ★	120% 2nd ★	**119% 2nd** ★	**100%**	108% 7th ★	106% 10th ●	110%	√	109.3% Apr 17 YTD
Faster Cancer Treatment (FCT)	Achievement	**85%**	68% 17th ✗	**73%** 13th ●	77% 10th ●	**85%**	81.4% 5th ★	86.1% 5th ★	89%	√	86% Apr 17
Better Help for Smokers to quit	Primary Care	**90%**	88% 7th ★	**89%** 8th ●	88% 6th ★	**90%**	87% 12th ●	87% 12th ●	86% 13th ●	X	86% 16/17 Q3 result
	Maternity	**90%**	89% 15th ✗	**95%** 13th ●	97% 8th ●	**90%**	93% 12th ●	98% 4th ★	96%	√	96% 16/17 Q3 result
Increased immunisation (8 months)		**95%**	92% 13th ●	91% 15th ✗	**90% 17th** ✗	**95%**	92.3% 13th ●	92% 15th ✗	90%	X	90% Apr 17 3 mth rolling
Raising Healthy Kids[1]			18%	19%	31%	**95%[1]**	47% 11th ●	79% 6th ★	84%	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)

Table 2 - DHB quarter results 2017

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

Table 3 – 2017 ED results for April

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:	24039	27201	88.4%
Waikato	15730	18458	85.2%
Taumarunui	1460	1533	95.2%
Thames	4101	4401	93.2%
Tokoroa	2748	2809	97.8%

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

	Clinical Unit	Mth Attendances	Apr'17 %	YTD Attendances	YTD %
By Specialty/Division (Waikato Hospital Only)	General & Specialty Surgery	845	72.5%	8314	78.1%
	Cardiology	283	57.9%	2803	60.8%
	Cardiothoracic Surgery	17	88.2%	125	84.8%
	Critical Care	11	100.0%	81	100.0%
	Paediatrics	393	89.2%	4313	89.0%
	Emergency Department	3460	92.2%	33667	92.8%
	Internal Medicine	895	73.0%	8853	73.2%
	Womens Care	129	76.7%	1388	77.5%
	Oncology	97	67.7%	854	76.9%
	Orthopaedics	264	79.1%	2586	76.5%
	Renal	55	87.3%	562	79.9%
	Vascular Surgery	40	85.0%	418	85.9%
	Allied Health	2	100.0%	13	92.3%
	Community Services	0	0.0%	3	0.0%
	Older Persons	0	0.0%	11	100.0%
	Mental Health	58	87.7%	843	88.5%
By Site	Waikato Hospital	6549	83.8%	64836	84.9%
	Tokoroa Hospital	1122	97.4%	10159	97.4%
	Thames Hospital	1488	89.3%	14525	93.7%
	Taumarunui Hospital	532	96.2%	5235	96.3%
	Total Health Waikato	**9691**	**86.9%**	**94755**	**88.2%**

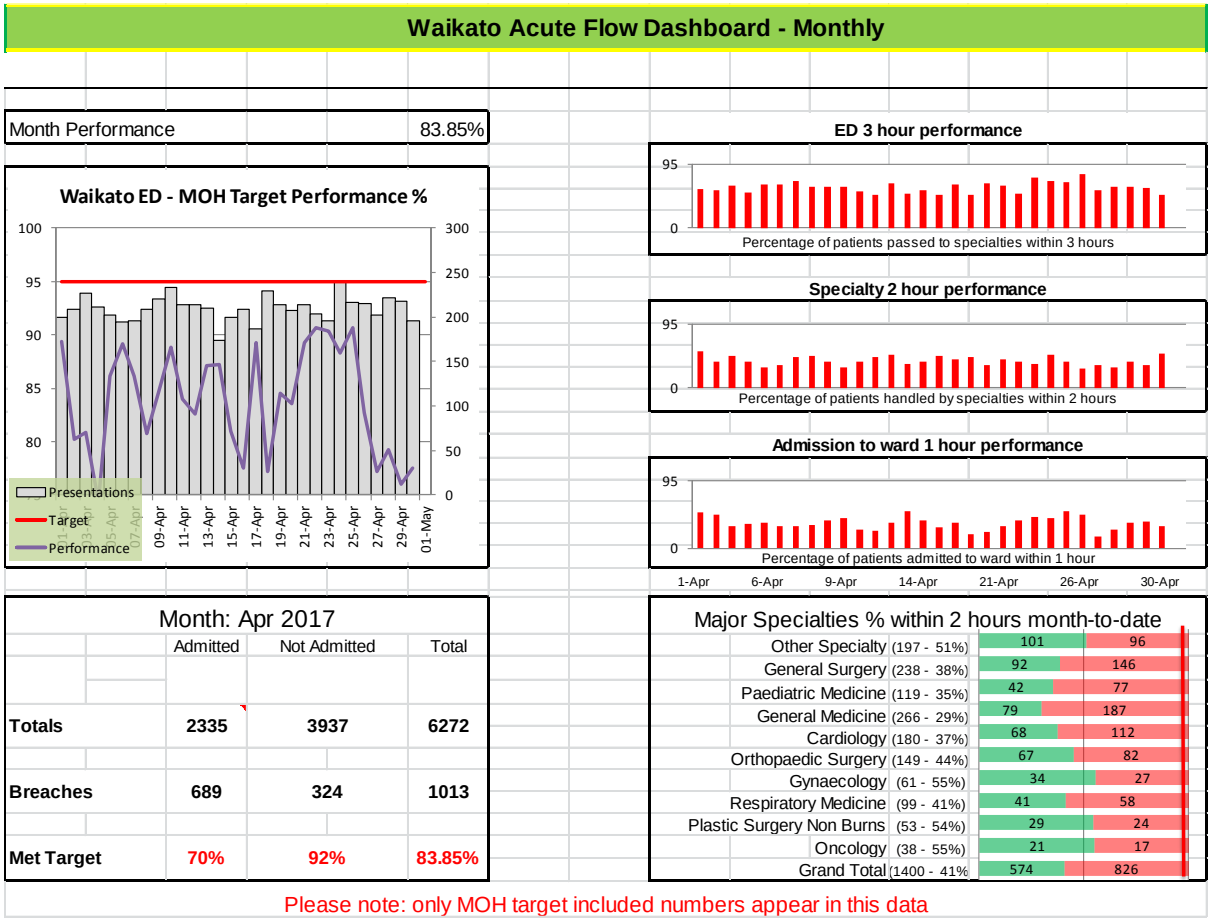
NB: From 1 July 2013 Tokoroa and Taumarunui EDs have been added to the calculation.

* By specialty for Waikato Hospital Only

Table 3 shows all Health Waikato hospitals emergency department performance up to the latest result of 88.4% for YTD April 2017.

As the table above indicates the principle challenge for Waikato Hospital remains the admitted pathway. Performance for non-admitted patients, or those treated in ED alone, is at 92%. The aim is to improve this to >95% once the department is fully staffed and through closer working with Medical teams, enabled by the new hospital restructure.

The principal risks therefore remains for admitted patients, which is likely to get worse unless we achieve effective measures to address the significant anticipated pressure on bed numbers from increased acute demand in the winter months.
At the most recent Acute Patient Governance Group cardiology and paediatric clinical directors demonstrated their use of the dash board and how they are using the background data to improve communications and understand the issues. Further Clinical Directors have agreed to undertake this approach and provide feedback at the next meeting.



Emergency Department medical recruitment is on-going. After several rounds of Senior Medical Officer interviews, we have managed to appoint to two substantive positions, who will join the department in September. We have also offered jobs to a Medical Officer and two Fellows, as part of the strategy to increase out of hours medical cover in the department.

The Department continues to experience sustained pressure, including increased staff sickness and high levels of nursing turnover. This has been compounded by changes to the senior leadership team, leaving three key positions being covered on an interim basis.

Covering for the loss of the Department's three principal key operational leaders has not been easy and has caused some operational uncertainty within the Department. The good news is that we

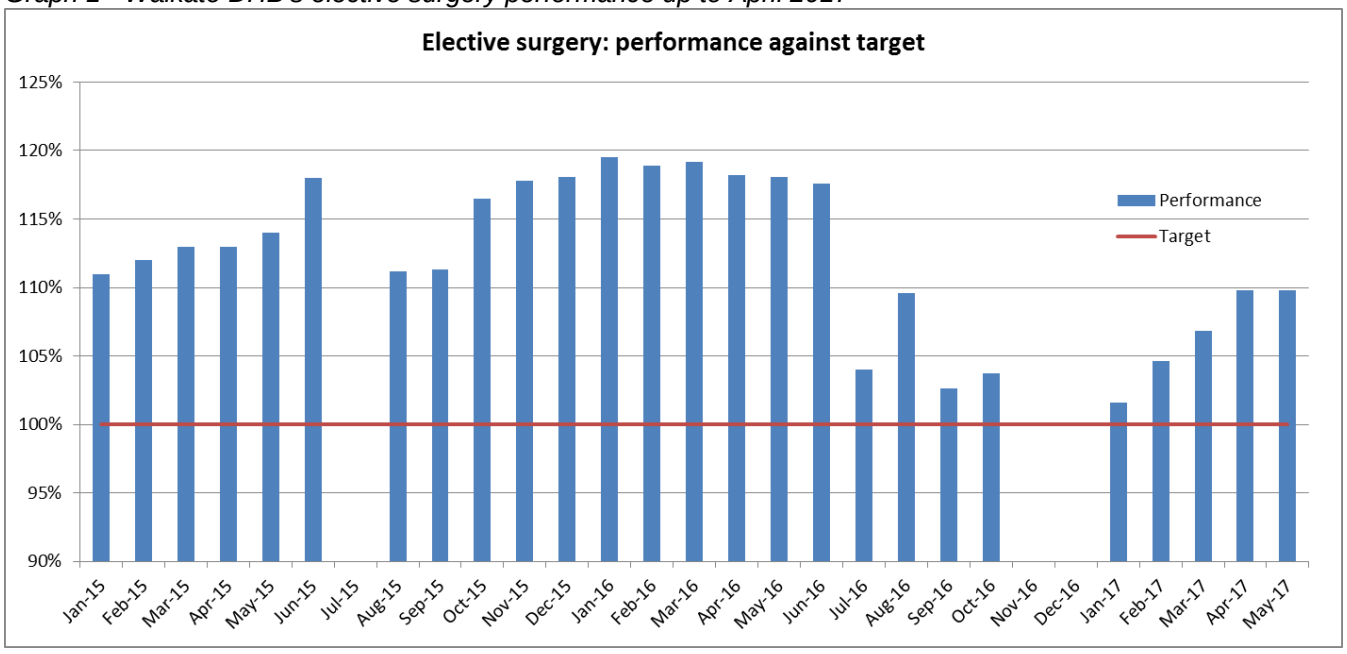
have successfully appointed a new Service Manager (starting 3 May) and a new Clinical Nurse Director (starting on 15 May) and put in place back-fill arrangements for the Charge Nurse Manager position. The principle priority for the new team will be recruiting to the nursing vacancies.

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** **(target 12,619 discharges)**	**109.3% YTD April 17** **(target 15,349 discharges)**

The 2016/17 target is 16,805 discharges. Graph 1 below provides the most recent result of 106%, a total of 13,663 actual discharges for the period from 1 July 2016 to 31 April 2017. Our official ranking result for Q2 had Waikato ranked 10th.

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



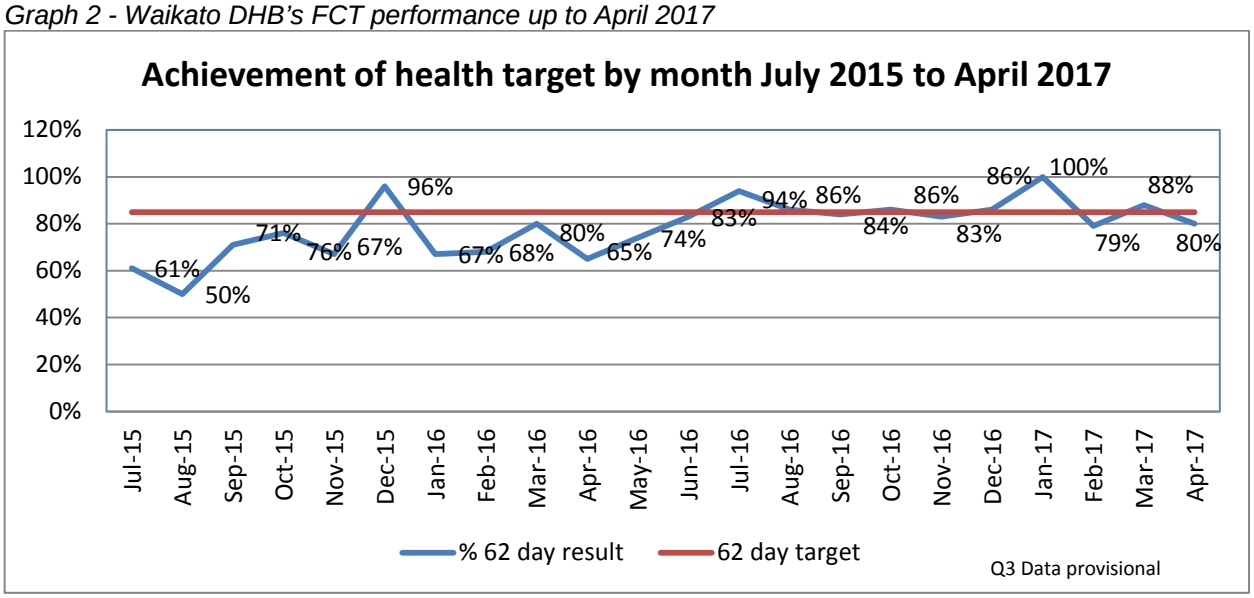
Target: Faster Cancer Treatment (FCT)

FCT 62 DAY HEALTH TARGET									
DHB Target by July 2017	**DHB Current Target**	DHB Q1 Result 15/16*	DHB Q2 Result 15/16	DHB Q3 Result 15/16	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	**DHB Q3 Result 16/17**	**Most recent six monthly result**
90.00%	**85%**	57.0% 17th ranking	68.0% 17th ranking	76.5% 10th ranking	72.6% 14th ranking	81.4% 5th ranking	86.1% 5th ranking	**89.0%**	**86%**
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**	**Most recent six monthly result**
25.00%	**15%**	17% 11th ranking	16% 14th ranking	14% 15th ranking	14%	17%	19%	**19%**	**19%** **Q3 provisional**

The 2016/17 quarter three result of 89% reflects a steady continued improvement in Waikato DHB's Faster Cancer Treatment performance.

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

Graph 2 - Waikato DHB's FCT performance up to April 2017



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

Q2 was the first financial quarter we delivered the 85% target for a full quarter, making Waikato DHB one of the first DHB's in the country to achieve >85% for a full quarter. This has been sustained in Q3, when we achieved a record high of 89%.

April is currently showing a provisional result of 80%. There are a number of reasons for these breaches:

- Delays are occurring discussing patients at Auckland gynaecology multi-disciplinary meetings, some weeks Multi-disciplinary meetings are at full capacity thus delaying the presentation of patients a week. This is being discussed through the Midlands Cancer Network, as all DHB's in the region are similarly affected.
- Patient choice.

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

- Business Manager and Nurse Tracker working very closely with cancer care coordinators and Clinical Nurse Specialist monitoring the patient pathway from initial date of referral.
- Improving the timeliness of gynaecology triaging and first specialist appointment.
- Midland Cancer Network has been involved in ongoing discussions regarding input into the Auckland gynaecology multi-disciplinary meetings to ensure patients are discussed at multi-disciplinary meetings in timely manner, as this is an issue that is impacting on all Midland DHBs.
- 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.
- Continue to monitor respiratory triaging and time to FSA.
- Weekly coordinated meeting with upper gastrointestinal surgeons and upper cancer nurse coordinator to discuss and track individual patients to ensure we proceed along pathway in a timely manner.
- Liaising with interventional radiologists to ensure patients receive their CT biopsy in a timely manner.
- Weekly urology waitlist meeting to discuss any patients triaged onto 62 day pathway. Urology service is transitioning to WDHB inpatient management system and implemented the high suspicion of cancer indicator when triaging.

Graph 3 - Waikato DHB's Faster Cancer Treatment performance (rolling six month result)

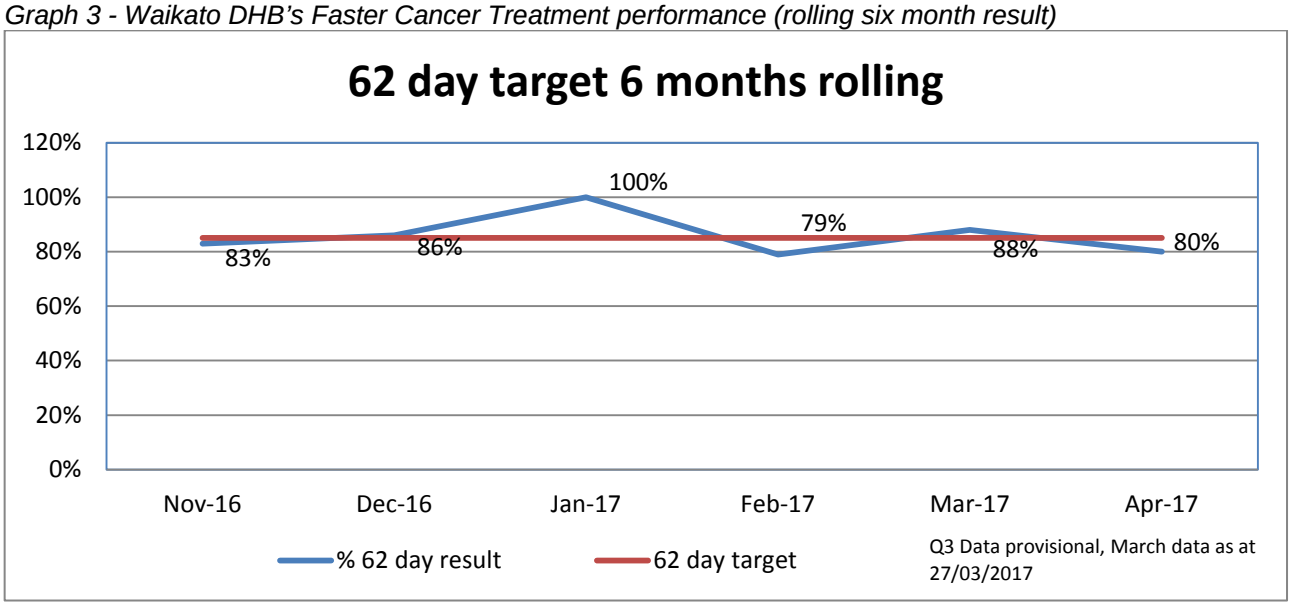


Table 5 – Latest six month data for 62-day Faster Cancer Treatment cohort, by month of first treatment

Local FCT Database	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Total
Number of records submitted	35	42	22	28	42	34	203
Number of records within 62 days	29	36	22	22	37	28	174
% 62 day Target Met (85%)	83%	86%	100%	79%	88%	82%	86%
% Volume Target Met (15%)	22%	26%	14%	17%	26%	21%	21%

Result for the volume measure of 15% of cancer registrations identified as high suspicion of cancer is also included in the table above. This is a check that the referrals that should be identified as high suspicion of cancer are being captured against this measure. Our latest provisional six month volume result is 21%.

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%**	**90% Apr 17**

Data for this target is reported on a three month rolling basis. Graph 4 shows our most recent result of 90% for the three month period from 1 February 2017 to 30 April 2017.

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

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

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

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

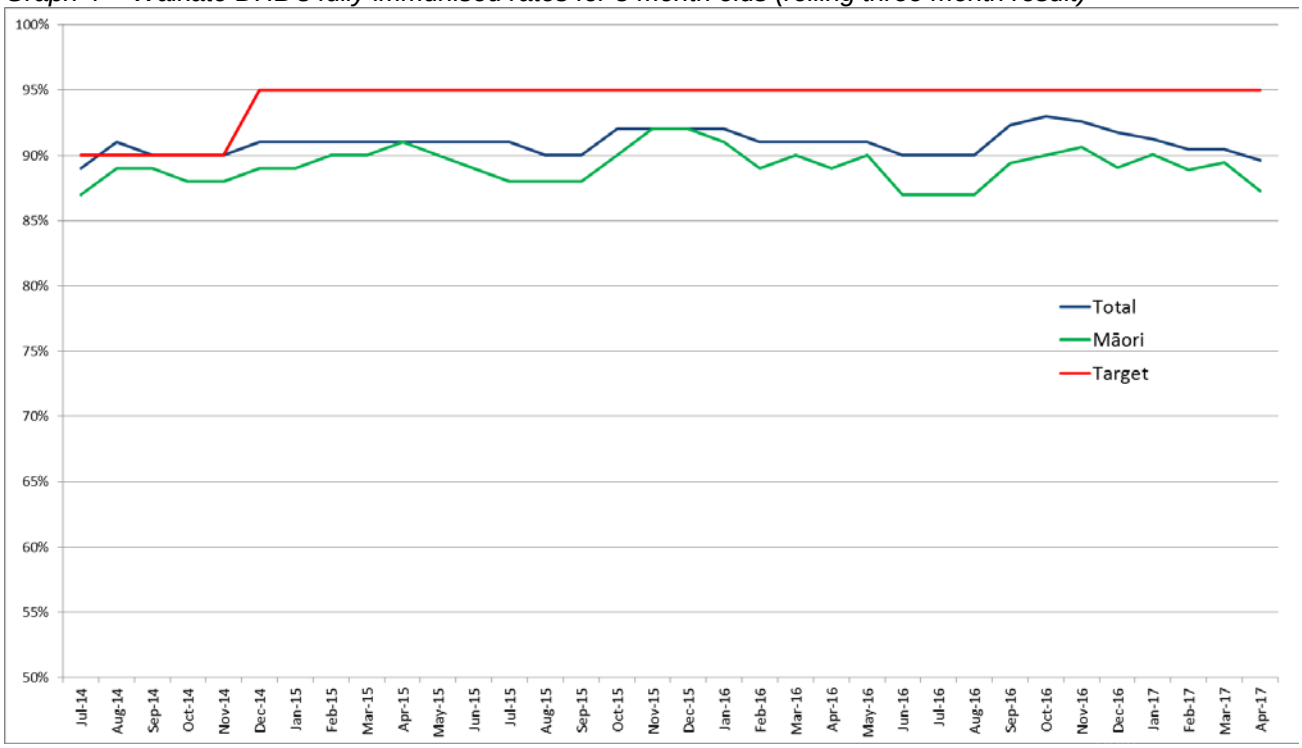


Table 6 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 64 additional children needed to be immunised to meet the 95% target.

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

Ethnicity	**Number Eligible**	**Fully immunised**	**Result**	**Increase needed to meet the target (95%)**
Asian	176	170	97%	
Māori	542	473	87%	42
NZ European	507	457	90%	25
Other	118	101	86%	12
Pacific	52	49	94%	1
Total across ethnicities				80
Total	**1395**	**1250**	**89.6%**	**76**
Opt off			7	
Declined			65 (4.7%)	

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 Feb 2017 to Apr 2017

PHO	Total population			Maori population		
	No eligible population	*No fully immunised population*	*Percent immunised*	*No eligible population*	*No fully immunised population*	*Percent immunised*
Hauraki PHO	524	478	91%	248	219	88%
Midlands Health Network – Waikato	785	717	91%	248	225	91%
National Hauora Coalition *	21	17	81%	12	9	75%
Enrolled with a PHO outside of Waikato	12	10	83%	34	20	59%
Not Fully Enrolled with PHO *	53	28	53%			
DHB Total	**1,395**	**1,250**	**90%**	**542**	**473**	**87%**

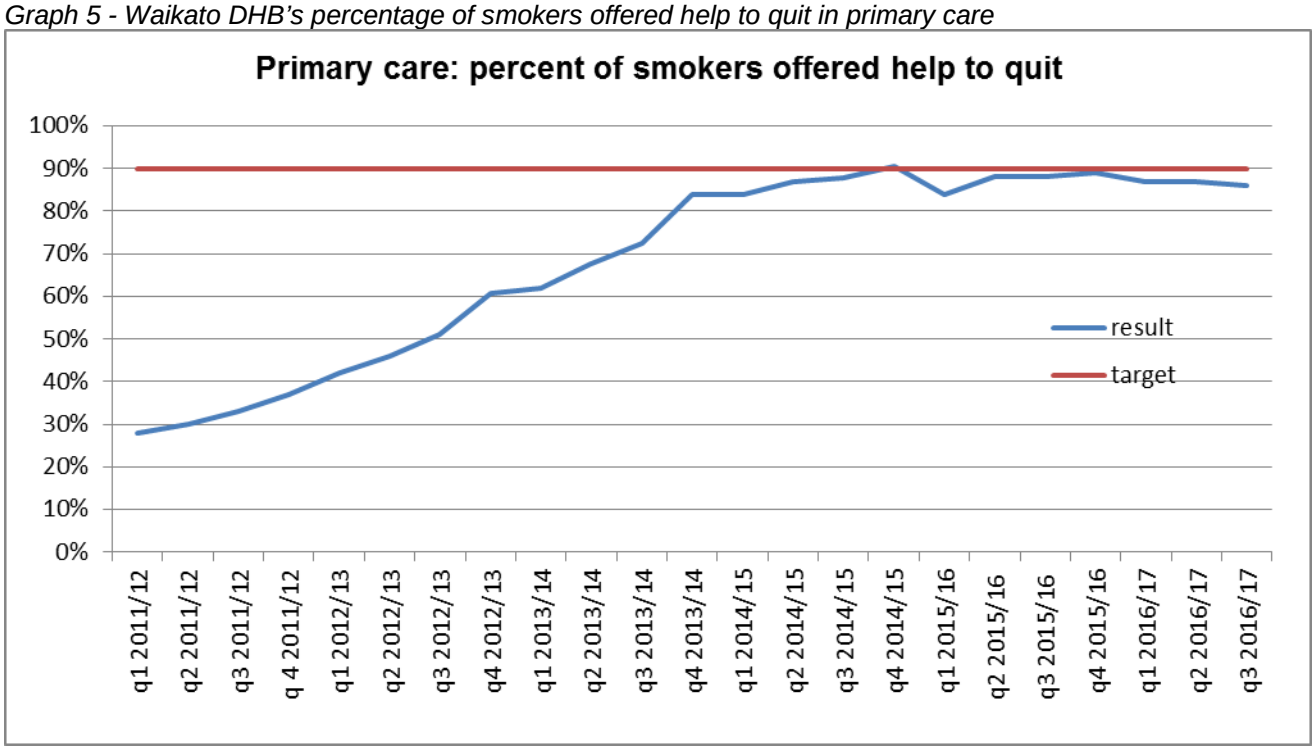
*Note – NHC data not available for end of April17 due to technical issues with the national reporting system so this data is for the 3 months ending March17.

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 (prelim)**

Graph 5 of the quarter two 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



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

Table 8 shows a breakdown of primary care smoking results by PHOs for 2016/17 quarter 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% Q2 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

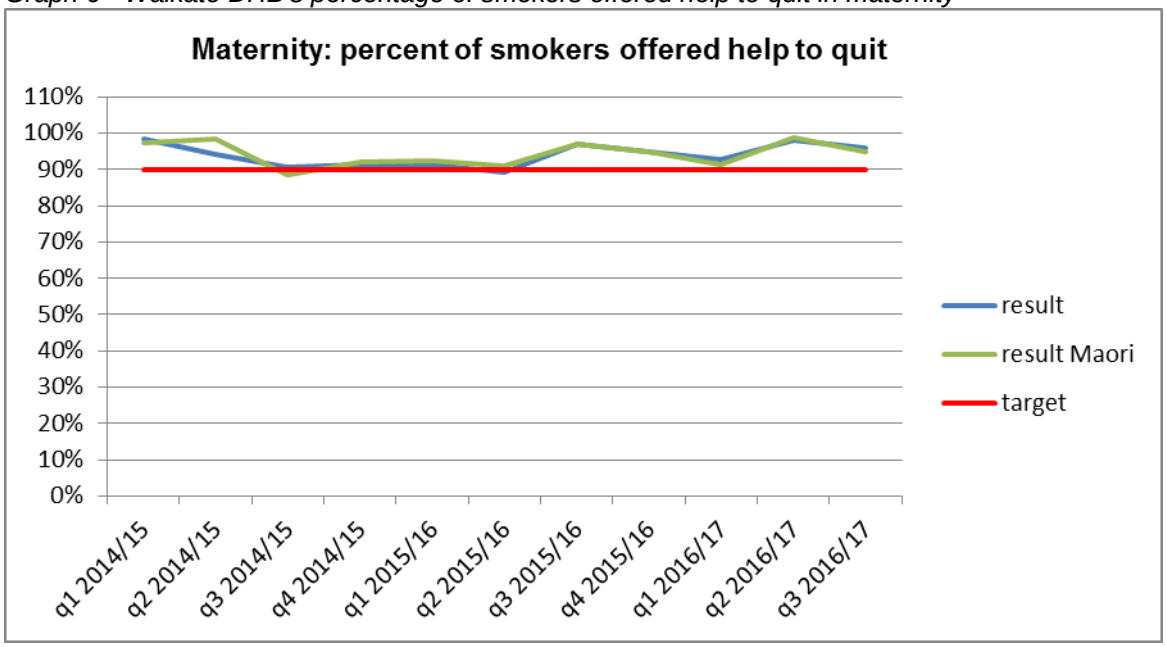


Table 9 shows our quarter three results provided by the Ministry for our total and Maori population.

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.

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.

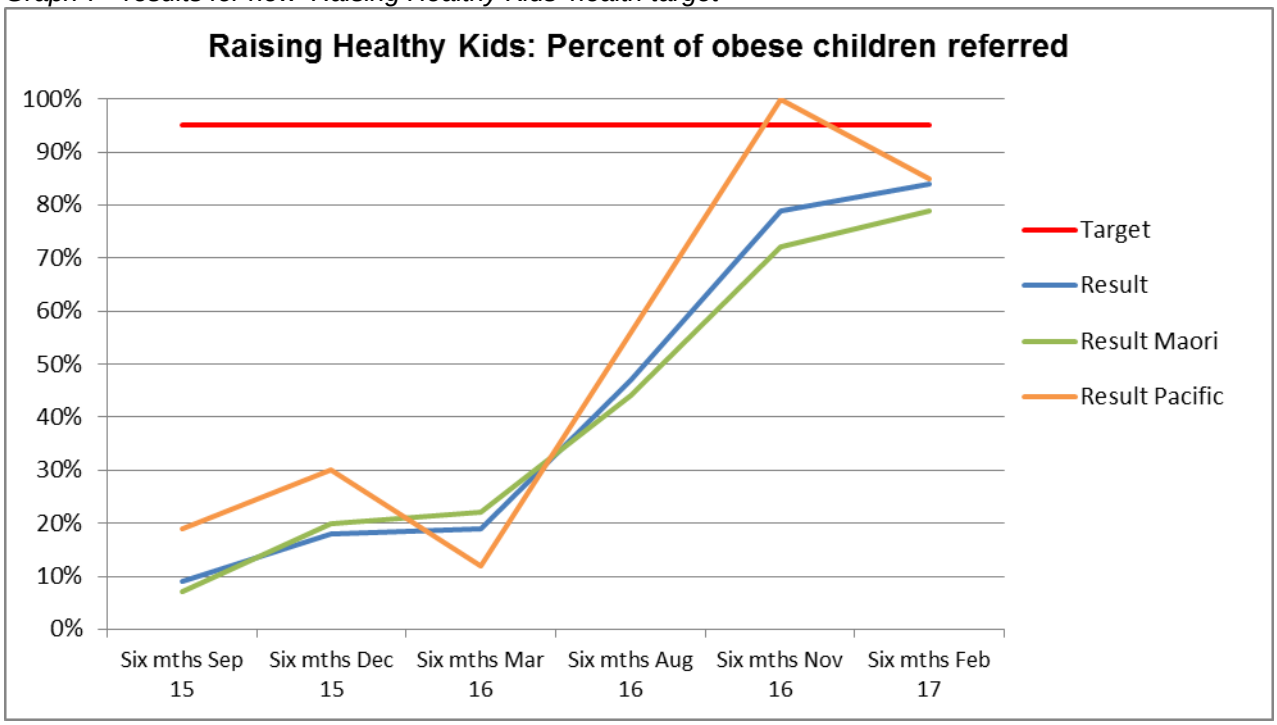
[2] Note, Waikato DHB has reported to the Ministry that the data shows significantly less first registrations with a midwife than expected in Waikato. The Ministry has informed us full activity is not reflected in the data for other DHBs also and they are working through the accuracy of information but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

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

Graph 7 - results for new '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
24 MAY 2017

AGENDA ITEM 6.2

PROVIDER ARM KEY PERFORMANCE DASHBOARD

Purpose	For information.

The high level provider arm key performance dashboards for April 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

April 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	93.4	95.0	(1.6)	95.4	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	%	87.7	90.0	(2.3)	93.6	90.0	3.6		
MRIs reported within 6 weeks of referral	%	87.9	85.0	2.9	88.9	85.0	3.9		

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			34,085	33,948	(137)		
Elective Surgery Volumes vs Elective Health Target	% of target	Under development - see separate Elective Health Target Report							
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			83.9	89.0	(5.2)		1
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			93.0	99.4	(6.4)		2
Laboratory – Histology specimens reported within 7 days of receipt	% for Mar YTD	0.0	80.0	(80.0)	44.0	80.0	(36.0)		3
Pharmacy - Chart turnaround times, % within 2.5 hours	%	88.0	80.0	8.0	92.4	80.0	12.4		
Pharmacy on Meade script turnaround time in minutes	minutes	8.1	10.0	1.9	7.2	10.0	2.8		
Outpatient DNA Rate	%	11.1	10.0	(1.1)	10.8	10.0	(0.8)		4
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	94.8	100.0	(5.2)	95.9	100.0	(4.1)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	94.1	100.0	(5.9)	92.9	100.0	(7.1)		5
Output Delivery Against Plan - Inpatient CWD Volumes	%	85.0	100.0	(15.0)	91.7	100.0	(8.3)		6
District Nurse Contacts (DHB Purchased)	Numbers	9,231	-		97,585				
District Nurse Contacts (ACC Purchased)	Numbers	1,846	-		21,005				
School Dental Service - Clients assessed and treated	Numbers	Under development							
Radiology - total imaging events	Numbers	Under development							
Lab - total tests	Numbers	Under development							
pharmacy - scripts processed	Numbers	Under development							
pharmacy - medications reconciled	Numbers	Under development							

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			3.48	3.79	0.31		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			0.98	0.96	(0.03)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			0.33	0.39	0.06		
DOM101 Avg Length of Stay	Days	Under development							

Quality and Patient Safety KPI measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	86.3	95.0	(8.7)	90.7	95.0	(4.3)		

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	3,040	3,500	(460)	33,913	34,000	(87)		
Breast screening Maori volumes - Waikato DHB	Numbers	176	309	(133)	2,065	2,797	(732)		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	15	8	(7)	133	78	(55)		8
Complaints resolved within 20 wd (1 month lag)	% for Mar-17	76	70	6	64	70	(6)		9
Falls Resulting in Harm	Numbers	0			19				
Pressure Injuries - Total	Numbers	15	11	(4)	119	139	20		
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	2,416	2,480	(64)	26,353	24,439	1,915		
Actual Expenditure vs Budget ($000s)	$000s	12,299	11,969	(330)	125,392	121,846	(3,546)		
Actual Contribution vs Budget ($000s)	$000s	(9,883)	(9,489)	(394)	(99,039)	(97,407)	(1,631)		
Actual FTEs vs Budget	FTEs	1,006.3	1,003.0	(3.3)	999.6	996.9	(2.7)		
Sick Leave	% of paid hours	2.3	3.2	0.9	2.9	2.9	(0.0)		
Overtime $'s	$000s	190	189	(0)	1,736	1,362	(374)		10
Annual Leave Taken	% of Budget	Rolling 12 month measure			92.2	100.0	(7.8)		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 Admissions	Phenomenally good performance in Australasian terms. The is suggesting 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. (Actual data is not available in this report. That data will be tabled at the Performance Committee meeting.)
4	Outpatient DNA rate	No concerns of note.
5	Output delivery against plan – inpatient episodes	Lower than planned demand in general surgery and general medicine. This reflects (i) a deliberate service change to reduce acute surgical admissions (utilising Waikato instead) and (ii) the lack of influenza in the community in winter.
6	Output delivery against plan – inpatient cwd	Refer above. The average cwd per case for both acute and elective is consistent with the plan. The difference is due to the reduced volume not altered case-mix.
7	Breast screening – Total volumes	The forecast is that breast screening volumes will be fully met by the end of the financial year, as planned. One service provider in Rotorua was adversely affected by a fire, but effective remedial and business continuity plans are in place.
8	Breast Screening – Māori volumes	This target will not be 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.
9	Complaints	Staff attitudes and clinical treatment are the main themes. Each is being investigated more fully.
10	Complaints resolved in 20 working days	Improving performance against this KPI has been a focus as discussed at the last Board. The April result is a positive sign, but as yet it is too early to conclude that the immediate lift in performance that has been achieved is secure for the long term.
11	Overtime $'s	No particular concerns are evident that have not been reported in prior periods.
12	Annual leave taken	No particular concerns are evident that have not been reported in prior periods. A rate of 92.2% is an exemplary result by national standards across all industries.

Key Performance Dashboard

Mental Health

April 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	87.7	95.0	(7.3)	88.6	95.0	(6)		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	1,121	371	(750)	9,475	3,707	(5768)		2
Mental health treatment plans	% Cases	82.8	95.0	(12.2)	90.3	95.0	(4.7)		
Mental health HoNos matched pairs	% Cases	98.9	95.0	3.9	98.8	95.0	3.8		
Mental health inpatient bed occupancy	%	95.6	87.1	(8.6)	93.2	87.1	(6.1)		3
Mental health GP methadone cases	Cases	95.0	76.0	19.0	93.7	76.0	17.7		

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	%	88.7	90.0	(1.3)	91.4	90.0	1.4		
Mental health follow up - numbers seen in 7 days	Number of Cases	63	63.9	(0.9)	602	593.1	8.9		
Mental health community contract positions filled	% FTEs	100.1	95.0	5.1	97.6	95.0	2.6		
Mental health 28 day readmission rate	%	14.0	15.0	1.0	12.1	15.0	2.9		

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	95.9	95.0	0.9	98.0	95.0	3.0		

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	6	7	1	75	69	(6)		4
Complaints resolved within 20 wd (1 month lag)	% for Mar-17	57	70	(13)	36	70	(34)		5
Falls Resulting in Harm	Numbers	0			12				

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	164	201	(37)	2,083	2,119	(36)		
Actual Expenditure vs Budget ($000s)	$000s	6,077	5,910	(167)	60,725	59,928	(797)		
Actual Contribution vs Budget ($000s)	$000s	(5,913)	(5,708)	(204)	(58,643)	(57,809)	(833)		
Actual FTEs vs Budget	FTEs	743.5	731.2	(12.3)	738.5	732.3	(6.2)		
Sick Leave	% of paid hours	2.9	3.2	0.2	3.3	3.0	(0.2)		6
Overtime $'s	$000s	91	76	(14)	842	758	(84)		7
Annual Leave Taken	% of Budget	Rolling 12 month measure			89.8	100.0	(10.2)		8

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

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

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

KPI Report: Mental Health & Addictions Services April 2017

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

Note	Indicator	Commentary
1	Emergency Hours <6 hours	• 58 MH presentations for April o 67% of the MH related presentations arrived in ED after hours • 7 Breaches o 5 of the 7 people who breached the target arrived in ED after hours ▪ 3 overdose related presentations ▪ 1 acute psychotic presentation ▪ 1 drug induced psychosis and 1 early symptoms of psychosis presentations ▪ 1 PTSD presentation
2	Seclusion	• Thirteen Individuals were secluded during April 2017, ten of those within the Adult wards and three within the Forensic wards. • Maori accounted for 71.21% (798.07 hours) of the hours spent in seclusion • Total hours spent in seclusion for Adult was 714.55 hours (monthly target ~233) • Total hours spent in seclusion for Forensic was 406.18 hours (monthly target ~138)
3	Occupancy	Actual 95.6, target 87.1 The HRBC inpatient unit has been at or over full capacity all year due to high and complex needs clients not being able to be moved out to supported accommodation. This occupancy does not account for individual service users who go on overnight leave where a bed is not kept for them. There are regularly temporary beds placed in interview or quiet rooms to accommodate for the admissions. There continue to be a growing number of people within the HRBC who have complex needs with no community options for transition. These are typically people who have come into MH due to behavioural concerns in the community. The majority do not have a mental illness and are often people with cognitive difficulties for whom disability support has been a feature for most of their childhood. We are having discussions with Strategy and Funding to determine a way forward for this growing population with needs that are not currently being met in the community.

4 & 5	Complaints	7 complaints received for the month of March (one month lag) • 3 x staff attitude / behaviour, • 1 x patient property / expenses, • 1 x staff competence, 1 x consent to treatment and • 1 shared with Anaesthetics re personal records. 2 with responses overdue by 1 week. These complaints were overdue as a result of difficulties in making appointments to speak with the relevant people involved. It is important that time is taken to respond to complaints thoroughly and sometimes this necessitates a delay. However all complaints are now closed.
6	Sick Leave	Sick leave is behind the target for the month and slightly above year to date. This is not something the service is concerned about as is following usual seasonal patterns. Despite pressure on services, this is not flowing onto spikes in sick leave.
7	Overtime	Whilst overtime had previously been tracking below budget, this month has again seen significant amounts of overtime to manage both the acuity and complexity of presentations to both the HRBC and to OPR1 (Mental health services older persons ward). In addition there are inpatient vacancies which are yet to be filled.
8	Annual Leave	Annual leave continues to track at the same rate as it did for recent months and is being actively managed by managers. It is however now proving increasingly difficult to push annual leave to be taken when the service is under such pressure.

Key Performance Dashboard

Waikato Hospital Services

April 2017

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	83.8	95.0	(11.2)	84.9	95.0	(10)		1
Faster Cancer Treatment - Referral received to first treatment <= 62 days	% of patients	82.4	85.0	(2.6)	86.0	85.0	1.0		
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	21	0	(21)	2,444	0	(2444)		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	144	0	(144)	893	0	(893)		3

Theatre Productivity

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Theatre Utilisation - Elective Sessions	%	77.3	85	(7.7)	76.1	85.0	(8.9)		4
Hospital initiated elective theatre cancellations	%	6.0	2.5	(3.5)	5.9	2.5	(3.4)		5
Waiting Time for acute theatre < 24 hrs	%	69.5	80	(10.5)	72.7	80.0	(7.3)		6
Waiting Time for acute theatre < 48 hrs	%	85.9	100	(14.1)	87.1	100.0	(12.9)		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			266.7				
Elective Surgery Volumes vs Elective Health Target	% of target	Under development - see separate Elective Health Target Report							
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			50.2	51.1	(0.9)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			75.7	81.2	(5.6)		8
Outpatient DNA Rate	%	10.9	10.0	(0.9)	10.0	10.0	0.0		
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	100.9	100.0	0.9	100.6	100.0	0.6		
Output Delivery Against Plan - Inpatient Number of Episodes	%	103.7	100.0	3.7	100.0	100.0	0.0		
Output Delivery Against Plan - Inpatient CWD Volumes	%	97.1	100.0	(2.9)	99.5	100.0	(0.5)		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Presentation to ED < 14 Days after discharge as an Acute InPatient	%	Under development							
Acute Readmissions to Hospital	%	Rolling 12 month measure			9.0	8.5	(0.5)		9
Number of long stay patients (>20 days length of stay)	Discharges	63	50	(13)	608	510	(98)		10
Number of long stay patient bed days (>20 days los)	Bed Days	2,069	1,529	(540)	20,856	17,045	(3811)		11
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			4.15	4.01	(0.14)		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			2.12	2.00	(0.12)		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			1.06	1.14	0.08		

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	90.3	95.0	(4.7)	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 Mar-17	95.8	90.0	5.8	97.0	90.0	7.0		
Compliance with good hand hygiene practice (WDHB Rate)	%	82.3	80.0	2.3	85.3	80	5.3		

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	70	69	(1)	735	687	(48)		12
Complaints resolved within 20 wd (1 month lag)	% for Mar-17	52	70	(18)	55	70	(15)		13
Falls Resulting in Harm	Numbers	23			172				

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	8,576	9,320	(744)	97,231	94,864	2,368		
Actual Expenditure vs Budget ($000s)	$000s	37,852	36,501	(1,351)	372,834	355,895	(16,939)		
Actual FTEs vs Budget	FTEs	3,165.5	3,108.7	(56.8)	3,106.7	3,096.2	(10.5)		
Sick Leave	% of paid hours	2.5	2.7	0.2	2.9	2.9	0.0		
Overtime $'s	$000s	453	315	(138)	4,496	2,706	(1,789)		14
Annual Leave Taken	% of Budget	Rolling 12 month measure			85.8	100.0	(14.2)		15

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 – April 2017

Note	Indicator	Commentary
1	Emergency Department < 6 hours	This target has deteriorated, with Waikato Hospital delivering only 83%. Performance for the non-admitted, or ED only patients, is currently performing at 93%. Although recent medical recruitment panels have not proved as successful as the department had hoped, it is envisaged that this will improve to >95% once fully staffed. Difficulties in admitting patients into the hospital continue on a daily basis, with performance for the admitted pathway at 71%. To achieve a sustained improvement in the 6 hour target, this is where the organisation would achieve the most gain. Now that the full capacity protocol has become fully operational, it has been used far more frequently in March. It is an effective tool when applied to reduce overload, but will not be sufficient to cope with the significant bed pressure forecast for the coming winter months. The patient flow programme that has been underway to reduce delayed discharge and long waiting patients is also on a timeframe that will not assist greatly over winter. Options to better match bed numbers with demand over the period are currently being reviewed to maintain safe and effective patient flow during winter.
2	Long wait patients on outpatient waiting lists	We are ESPI 2 compliant in April. The May projection is for compliance however there is some risk around this. Mitigation plans are currently in place.
3	Number of long wait patients on inpatient waiting lists	We projected ESPI 5 compliance for April however qualified this noting ongoing risk with continued reduced elective operating theatre due to anaesthetic RMO vacancies and demand increase made worse by the number of public holidays that occur in April. Regrettably these risks came to materialise, this has had a knock on impact to May which we are working hard to mitigate. We are working towards compliance in June.
4.	Theatre Utilisation – Elective Sessions	The high number of public holidays in April impacted on our elective utilisation.
5	Hospital Initiated elective theatre cancellations	The paper based audit of reasons for cancellations is still being analysed and the results will be included in the project evaluation of the pre hospital preparedness project due for completion by July.
6.	Waiting time for acute theatre less than 24 hours	We ran escalation lists over the Easter/Anzac Day holiday period. This KPI is monitored via our Theatre and Interventional Governance Group (TIGG). The piece of work to develop a business case with some options to address this is within the work plan of this group; currently under development is a plan to right size acute theatre capacity and will be presented to TIGG in May.
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 our Theatre and Interventional Governance Group (TIGG).

Note	Indicator	Commentary
9.	Acute Readmissions to hospital	Analysis of Health Round Table data shows that our acute readmission rates post-surgery and post myocardial infarction compare favourably with peers. The drivers for acute readmission in medicine are being investigated.
10.	Number of long stay patients (> 20 days length of stay)	A DHB wide discharge initiative is being planned, led by the Executive Director Operations and Performance with involvement from the Director of Medicine, Oncology, ED and Ambulatory Care and the Director of OPR and Allied Health. This programme includes emphasis on long stay patients, which has been enhanced with weekly reporting to the capacity and demand management forum and higher scrutiny of long stay reasons. There has been some improvement in recent months, however, YTD still higher than target. Resourcing and staffing of regular audits of long stay patients are being considered as part of the patient flow programme, to supplement weekly nursing audit of reasons for long stay. OP&R senior staff review all long stayers involving the multi-disciplinary team, as standard practise each week.
11	Number of long stay patient bed days	As per item 10 Within OPR the medical team aim for a target of 16.5 days. The senior medical team are of the view that the current average length of stay of 17.3 days is reasonable considering the multiple problems encountered clinically among our older and disabled patients.
12	Complaints	While the trend over the last 12 months has shown a reduction in complaint volumes, the lower target for this financial year has not yet been met. A theme within this area is patients being either unclear about communications regarding reasons for not being able to access elective surgery, or unhappy at not being put onto the orthopaedic surgical waitlist because they do not meet the required threshold. Standard communication letters have been revised to address the communication issue and as previously described measures are in place to address our orthopaedic capacity as soon as possible. New CD Obstetrics in place as of 11 April 2017 should assist in more timely responses.
13	Complaints resolved within 20 working days	The surgery and CCTVS team (one of the areas with the largest volume of complaints) have 51% of their complaints >20 days. There is considerable focus on resolving outstanding complaints by the service. OP&R and AH once again have a 100% record this month for complaints resolved within the 20 working days.
14	Overtime $'s	Surgical and Critical Care continues to experience pressure on overtime the large majority of the costs are associated with theatre where escalation lists are used to clear acute load. This was higher for the month of April due to escalation lists over the Easter/Anzac Day holiday period Women's - Ongoing Midwifery and Medical vacancies require overtime and additional duties. OPR&AH within target KPI this month.
15	Annual leave taken	The juxtaposition of the public holidays in April supported continuation of our annual leave planning. A challenging KPI to report on as not represented month on month but rather a rolling year average. On receipt of financial reports more specific service information will be accessible.

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 6.3

STRATEGY & FUNDING KPI DASHBOARD

Purpose	For information.

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

A revised indicator set is being prepared for discussion at the June Committee meetings along with recommendations around frequency of updates. This is expected to include additional reporting on key areas on a rolling schedule as the majority of items reported have been available on a quarterly basis only.

The proposed approach will be included for discussion on the June 2017 Board agenda.

Recommendation
THAT
The report be received.

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY & FUNDING

Strategy and Funding KPI Dashboard

Note	Indicator	Commentary
1	Proportion of older people waiting greater than 20 days for initial assessment or reassessment	Results from the Jan-Mar quarter show the expected efficiencies from restructuring are beginning to improve results with significant reductions in the number of patients waiting more than 20 days for initial assessment and reassessment. There are still a number of clients waiting more than 20 days however the majority of waits over 20 days have mitigating reasons such as START or Acute care still in place and therefore not clinically ready for assessment of family and client difficult to get hold of over the holiday period. Encouraging referrals for assessment to be made early in an acute episode (before the person is clinically ready for assessment) allows better planning but may result in an apparent delay.
2	AOD and mental health waiting times (% of new clients seen within 3 and 8weeks of referral	The MOH wait time definition is designed to describe the experience a new client has when interacting with any MH/AOD services for the first time. This can be either via a provider arm service or an NGO service. Wait Times measures the duration in days between the date a referral is accepted and the date of first face to face contact with the client. The wait times measure focuses only on clients NEW to ANY MH or AOD service in the country. i.e. brand new to any service OR has not been seen by any service anywhere in NZ for the past 12 months. Targets are set at 80% of new clients seen in three weeks (wait time of 21 days or less for first face to face activity; and 95% at 8 weeks (56 days or less waited for first face to face activity). As noted previously there have been concerns in relation to this target and the accuracy of information reported.. A Midland regional PRIMHD (the system from which waiting times are reported) workshop held in Hamilton on 10 May 2017 highlighted coding issues that may be contributing to some reported wait times and these are being investigated by the relevant providers.
3	2 year old immunisations	Latest 2 year old coverage result is 93% (target 95%) which is the same as the prior period. The 2% point gap represents 32 children not immunised on time. For children aged 2 years, this quarter the highest coverage was for Asian children (97%) and lowest for Other (not Maori, Pacific, NZ European, Asian) (85%). Our latest results also show little disparity between NZ European and Maori for this cohort by 2 years (Maori 0.44% ahead). This measure is a contributory measure in the 16/17 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.
4	Ambulatory sensitive hospitalisations	The targets for ambulatory sensitive hospitalisations were set based on MOH requirements which included specific targeted reductions for Maori

Baseline Equity Gap	Expected Improvement
DHB Māori ASH > 10% Above National Total Population Rate	Halve the equity gap
DHB Māori ASH 5-10% above National Total Population Rate	Eliminate the equity gap
DHB Māori ASH <5% Above National Total Population Rate (or less than National Total Population Rate)	Reduce DHB Māori and Pacific ASH rates to within 5% of DHB Total Population Rate (equity within the DHB)

This created targets that require significant reductions for Maori as can be seen within the table below.

	Y/E Jun16	2016/17 Target	Y/E Sep16	Y/E Dec16	Mid-point (Y/E June to target)
0-4 total	7,668	7,298	7,477	7,473	7,483
0-4 Maori	8,898	7,936	8,538	8,224	8,417
45-64 total	4,177	3,936	4,089	4,167	4,057
45-64 Maori	8,104	5,838	7,758	7,926	6,971

For the 0-4 population the results for both Maori and total population have shown positive reductions and after 6 months are below the midpoint between the baseline and new target.

For the 45-64 population the December results indicate little or no change for total population and a 2.2% reduction for Maori. Whilst any reduction is positive with the target requiring a 28% reduction and the length of lead in time to reduce hospitalisations in some specialties, it is unlikely that this target will be achieved.

Details of ASH rates for the top ten conditions for the 45-64 age group are shown in the table below. While the latest December results show reduction in the ASH rates for Maori for 4 of the 10 conditions (angina and chest pain, cellulitis, COPD and Kidney/ urinary infection), further work in needed to bring down the rates for the other conditions, particularly diabetes, congestive heart failure and stroke. The Demand Management Advisory Group has begun a workplan examining potential initiatives to address the adult ASH rates.

This item is scheduled for discussion at the Committee meetings.

Condition	Group	Y/E June16	Y/E Sept16	Y/E Dec16	Reduction % Y/E Dec compared to Y/E June
Angina and chest pain	45-64 Total	1137	1082	1107	2.6%
	45 -64 Maori	1674	1541	1601	4.4%
Cellulitis	45-64 Total	370	357	396	-7.0%
	45 -64 Maori	784	671	743	5.2%
COPD	45-64 Total	384	335	336	12.5%
	45 -64 Maori	1198	1043	989	17.4%
Gastroenteritis/ dehydration	45-64 Total	288	285	318	-10.4%
	45 -64 Maori	377	378	396	-5.0%
Pneumonia	45-64 Total	246	254	255	-3.7%
	45 -64 Maori	513	504	540	-5.3%
Myocardial infarction	45-64 Total	252	249	241	4.4%
	45 -64 Maori	290	330	312	-7.6%
Kidney/ urinary infection	45-64 Total	210	202	198	5.7%
	45 -64 Maori	408	366	354	13.2%
Diabetes	45-64 Total	182	180	181	0.5%
	45 -64 Maori	389	444	462	-18.8%
Congestive heart failure	45-64 Total	169	174	188	-11.2%
	45 -64 Maori	581	606	707	-21.7%
Stroke	45-64 Total	151	158	170	-12.6%
	45 -64 Maori	284	318	378	-33.1%

Appendix A **Strategy and Funding KPI RESULTS**

Strategy and Funding - Key Performance Dashboard

April	2017

Health Targets

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Quarter Actual	Target	Variance		Trend
CVD risk assessments	%	↑	Jul-Sep16	No	93%	90%	3%	✓	92%	90%	2%	✓	
8 month old immunisations	%	↑	Rolling 3 months	Yes	90%	95%	-5%	✗	90%	95%	-5%	✗	
Better help for smokers to quit (primary care)	%	↑	Mar-16	Yes	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	$		Apr YTD	Yes	9,388	10,993	-1,605	✗	106,056	98,937	7,119	✓	
IDF outflow estimate	$		Apr YTD	Yes	4,940	4,559	381	✗	47,847	41,031	6,816	✗	

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 Jan 17	Yes	75%	80%	-5%	✗	75%	80%	-5%	✗	
MH waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Jan 17	Yes	79%	80%	-1%	!	78%	80%	-2%	!	
AOD waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Jan 17	Yes	94%	95%	-1%	!	93%	95%	-2%	!	
MH waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Jan 17	Yes	93%	95%	-2%	!	92%	95%	-3%	!	
Proportion of Health of Older people initial needs assessments Waiting greater than 20 days	%	↓	Jan-Mar 17	Yes	11%	0%	-11%	✗	20%	0%	-20%	✗	
Proportion of health of older people need re-assessments Waiting greater than 20 days	%	↓	Jan-Mar 17	Yes	4%	0%	-4%	✗	7%	0%	-7%	✗	
Proportion of older person funding in community based services	%	↑	Dec YTD	No	28%	25%	3%	✓	27%	25%	2%	✓	
Pharmacy Items claimed	Items		Mar-17	yes	559,149	N/A			492,938	N/A			
Laboratory turnaround tmes	%	↑	Jul-Sep16	No	100%	97%	3%	✓	100%	97%	3%	✓	
Primary options referrals	Referrals				These areas will be reported in the future once expected volumes are seasonalised/targets set								
	%												
Breast Screening (total eligible population)	%	↑	Dec-16	No	67%	70%	-3%	!	66%	70%	-4%	✗	
Cervical screening (total eligible population)	%	↑	Oct - Dec 16	No	77%	75%	2%	✓	76%	75%	1%	✓	
Cervical screening (High Need)	%	↑	Oct - Dec 16	No	68%	75%	-7%	✗	69%	75%	-6%	✗	
2 year old immunisations (total population)	%	↑	Rolling 3 months	Yes	93%	95%	-2%	!	93%	95%	-2%	!	
2 year old immunisations (Maori)	%	↑	Rolling 3 months	Yes	93%	95%	-2%	!	93%	95%	-2%	!	
Green Prescriptions	%	↑	Jan - Mar 17	No	1,656	1,675	-19	!	1,404	1,675	-271	✗	

Ambulatory Sensitive Admissions - Rates per 100,000 Population

Indicator	Unit	⇵	Data period	Updated from prior report	YT Dec 2016				YT Sep 2016				
Ambulatory sensitive admissions 0-4	rate	↓	YT Dec 2016	Y	7473	7298	-175	!	7477	7298	-179	!	New ASH Definitions
Ambulatory sensitive admissions 0-4 (Maori)	rate	↓	YT Dec 2016	Y	8224	7936	-288	!	8538	7936	-602	✗	New ASH Definitions
Ambulatory sensitive admissions 45-64	rate	↓	YT Dec 2016	Y	4167	3936	-231	✗	4089	3936	-153	!	New ASH Definitions
Ambulatory sensitive admissions 45-64 (Maori)	rate	↓	YT Dec 2016	Y	7926	5838	-2088	✗	7758	5838	-1920	✗	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: Apr-17

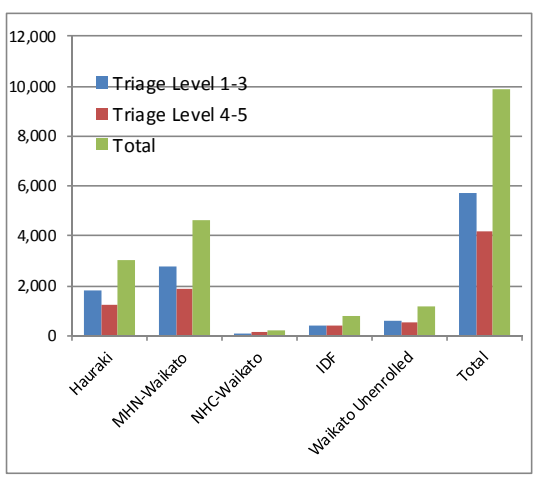
Emergency Department Presentations

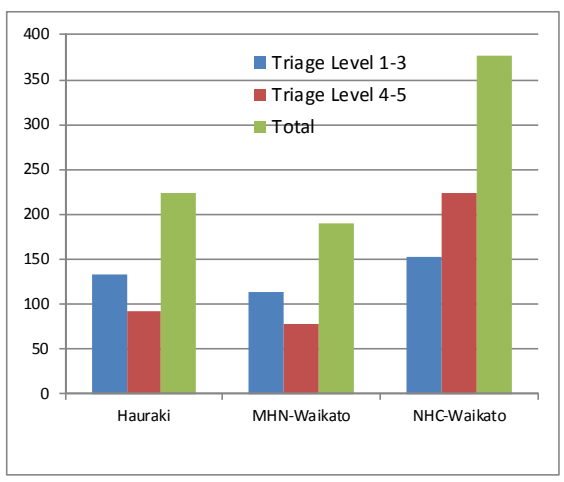
Monthly data for Apr-17

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	1,787	1,238	3,025	133	92	224
MHN-Waikato	2,761	1,883	4,644	113	77	191
NHC-Waikato	89	131	220	152	224	376
IDF	431	381	812			
Waikato Unenrolled	627	526	1,153			
Total	**5,695**	**4,159**	**9,854**			

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

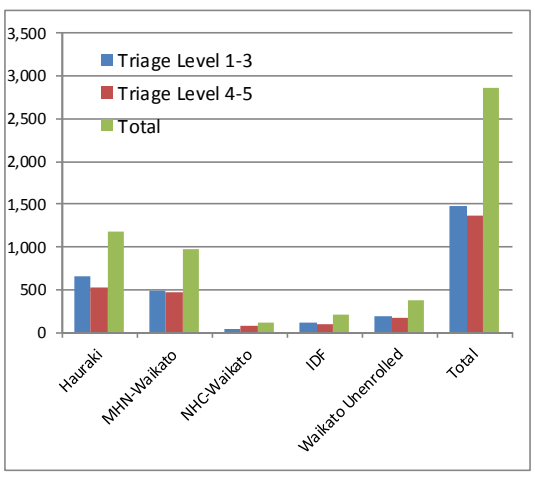


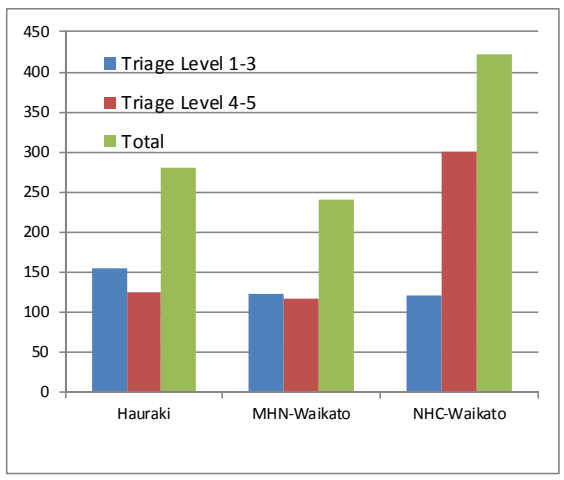


Maori

	Volumes - Maori			Rates per 10,000 people		
	Triage Level			Triage Level		
PHO	1-3	4-5	Total	1-3	4-5	Total
Hauraki	652	526	1,178	155	125	280
MHN-Waikato	493	476	969	122	118	241
NHC-Waikato	36	89	125	121	300	421
IDF	109	108	217			
Waikato Unenrolled	199	178	377			
Total	**1,489**	**1,377**	**2,866**			

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



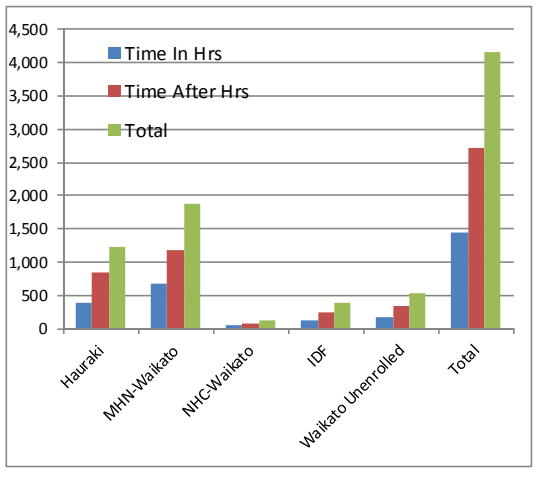


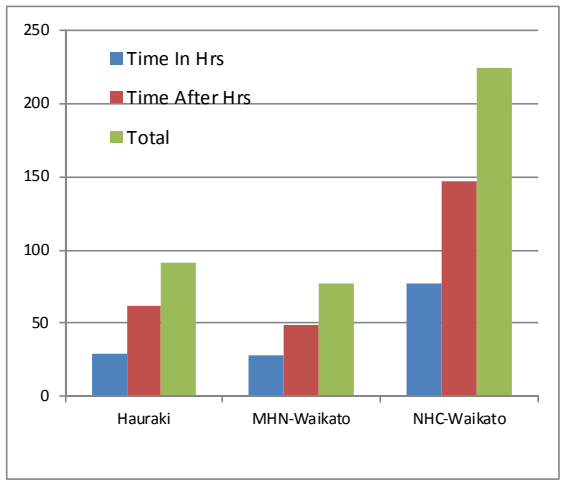
In Hours vs After Hours (Triage 4-5 only)

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	401	837	1,238	30	62	92
MHN-Waikato	688	1,195	1,883	28	49	77
NHC-Waikato	45	86	131	77	147	224
IDF	137	244	381			
Waikato Unenrolled	178	348	526			
Total	**1,449**	**2,710**	**4,159**			

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





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

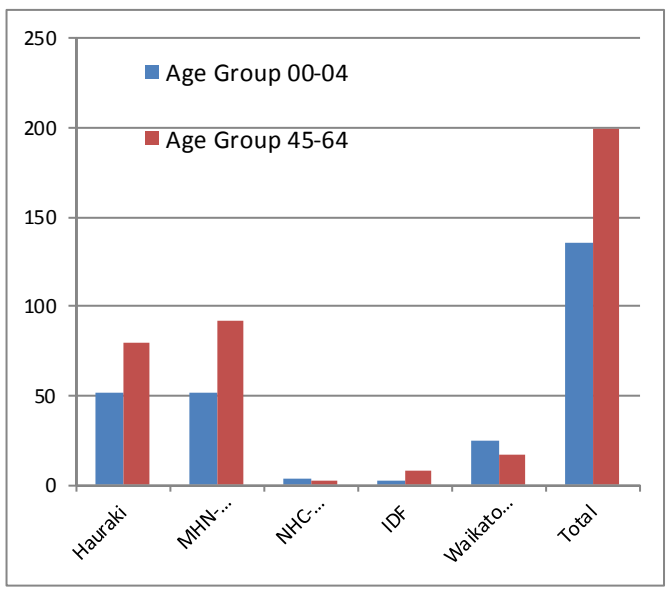
Total - All Ethnicities Monthly data for Apr-17

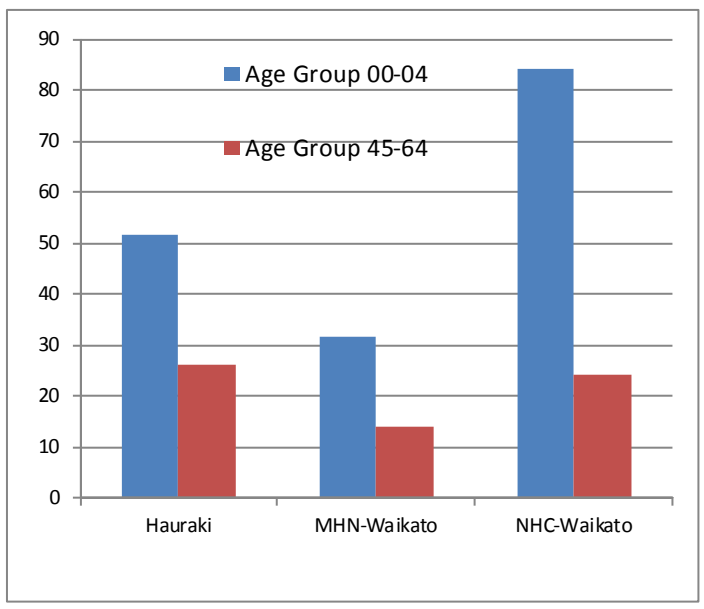
	Volumes - Apr17	
	Age Group	
PHO	00-04	45-64
Hauraki	52	80
MHN-Waikato	52	92
NHC-Waikato	4	3
IDF	3	8
Waikato Unenrolled	25	17
Total	**136**	**200**

Rates per 10,000	
Age Group	
00-04	45-64
52	26
32	14
84	24

**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)*





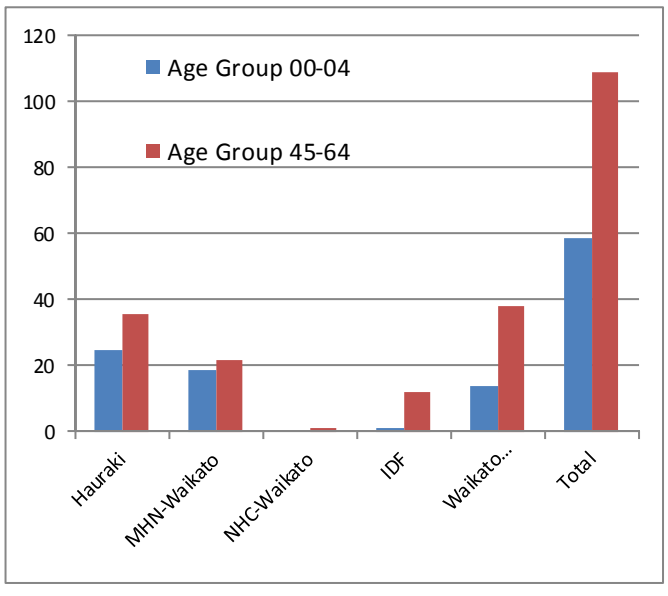
Maori Monthly data for Apr-17

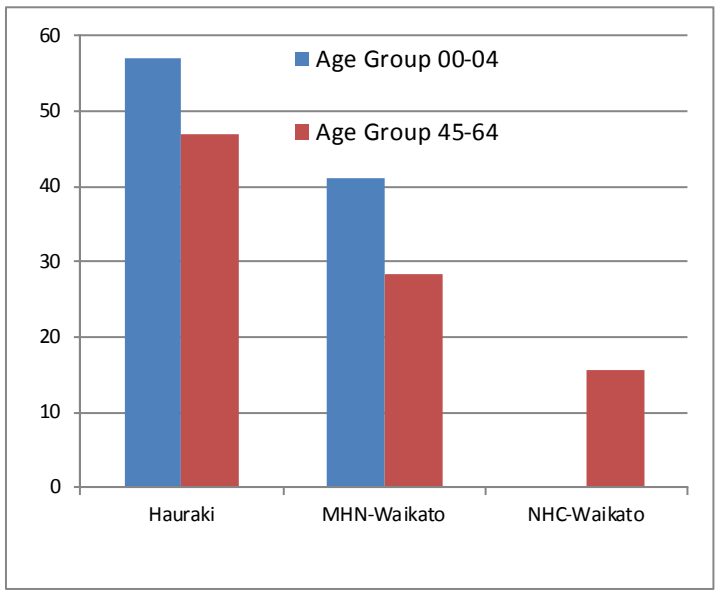
	Volumes - Maori	
	Age Group	
PHO	00-04	45-64
Hauraki	25	36
MHN-Waikato	19	22
NHC-Waikato	0	1
IDF	1	12
Waikato Unenrolled	14	38
Total	**59**	**109**

Rates per 10,000	
Age Group	
00-04	45-64
57	47
41	28
0	16

**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)*





Waikato District Health Board

Planning

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 7.1

SOUTHERN RURAL PRIMARY MATERNITY SERVICES

Purpose	For approval.

Determining the future service model for the primary maternity services that are delivered in the southern part of the DHB's catchment is one of the 2016/17 work streams agreed to as part of the Strategic Review of Rural Health Services.

In December 2016 the Board recognised the vulnerability of primary maternity services in the southern part of its catchment and as a result:

- endorsed the primary maternity hub service model for the delivery of primary maternity services in the southern DHB catchment in principle, subject to the outcome of consultation with the affected communities and providers; and
- agreed that the DHB Executive should undertake a process of consultation with the affected communities and providers early in the 2017 calendar year.

The purpose of this paper is to provide a final recommendation to the Board following the consultation process. A summary of the status quo, the proposed changes, and the consultation feedback, is provided in the attached paper.

In essence it is proposed to reform how primary maternity services are delivered by re-distributing the existing expenditure on these services in a way that better reflects the overall needs of the community across the whole of the southern rural area. A core component of the proposed model is the creation of three primary maternity hubs. These primary maternity hubs are designed to ensure that women and their babies are well connected to the wider health and social service system as early as possible utilising a 'navigator' rather than a 'refer' based way of working. It is proposed to enhance the availability of specialist services locally, such as lactation support and to make specialist obstetric and diabetes input more accessible through the use of modern technologies. It is proposed to move from a caseload midwife model to one in which lead maternity carers play an increased role supported by a local primary maternity services coordinator. Finally it is proposed to close the birthing unit at Te Kuiti. The very low number of births, the lack of latent demand in the community to enable the unit at Te Kuiti to grow sufficiently, and the close proximity of that location to desirable birthing facilities nearby, do not justify retaining that unit. The simple reality is that most women from the Te Kuiti area are already choosing to birth elsewhere, and the current investment in services could achieve far better health outcomes if it is re-allocated into a primary maternity hub service model and better support to the two other birthing units as is proposed.

Board members may wish to refer to the Southern Rural Primary Maternity Services paper in the December 2016 agenda for further background.

Having balanced all the relevant data, the feedback and the discussion outcomes, the final recommendation that is being put to the Board is as follows.

Recommendation
THAT
The Board:

1. Receives the report.
2. Agrees that Waikato DHB:
    a. implements the primary maternity hub service model as proposed.
    b. closes the Te Kuiti Birthing Unit.
    c. moves to a Lead Maternity Carer model for Te Kuiti and Tokoroa.
    d. offers an enhanced facility contract for the two birthing units in Tokoroa and Taumarunui.
    e. develops a physical primary maternity hub location in Te Kuiti, Tokoroa and Taumarunui.
    f. commences a co-design process which includes working with Strategy & Funding, Te Puna Oranga, key stakeholders and local service providers to develop enhanced access to services and a well-coordinated antenatal and postnatal service (ie) the operational underpinning of the primary maternity hub service model.

MARK SPITTAL
EXECUTIVE DIRECTOR, COMMUNITY & CLINICAL SUPPORT

Waikato District Health Board

Southern Rural Maternity Services

Consultation Process Report

Bernadette Doube Consulting Ltd

May 16th 2017

Contents

1. Executive Summary

Maternity services in rural New Zealand are recognised as being vulnerable and the Waikato DHB, with a population of 407,860, of whom 60% live rurally, is no exception. In March 2017, the Waikato District Health Board commenced a consultation process on a proposed model of care as part of a review of maternity services in Tokoroa, Te Kuiti and Taumarunui, to ensure that women and their whanau in the region can have a healthy birth and as healthy a baby as possible.

The 11 birthing facilities located across the Waikato managed approximately 5110 births in 2016. Nearly 3500 of these were in Waikato Hospital. Midwives at Tokoroa, Taumarunui and Te Kuiti hospitals delivered 144 babies in total in 2016 with 41 of those in Te Kuiti, 47 in Taumarunui and 56 in Tokoroa.

The more recent birthing numbers used in this report have been checked using an exhaustive process, both manual and electronic records have been scrutinised for accuracy and the figures have been verified. (The previous report to the Board used data from 2015, which has been updated to include 2016 and 2017 YTD information in this paper). All maternity data in this report is based on a calendar year and not a financial year.

The consultation process took place between March 6th and April 14th and included a series of public consultation meetings, an online survey and written submissions. Interviews were held with the press on request and some additional conversations were held with key stakeholders such as the College of Midwives, a Midwives ERAS organiser, the members of the Rural Health Advisory Group, the manager of the Te Awamutu birthing unit, Te Puna Oranga, the Te Kuiti GP practice and the Tokoroa hospital doctors plus interested individuals in the community occurred.

In order to reach the community and engage authentically, 10 public meetings were held across South Waikato, Ruapehu and Waitomo. The meetings occurred at various times of the day in a range of community venues. Communication regarding the consultation included word of mouth, electronic mail out, flyers in the high street, word of mouth via community organisations and media interviews and articles. In addition, an online survey was available and submissions in writing were invited.

117 people attended the consultation workshops, 61 survey monkey responses were completed and 14 written submissions were received.

The 90-minute consultation workshops were independently facilitated and were structured to allow the proposed model for maternity services to be presented (one-third) and time for comments, questions, participant-led discussion (two-thirds).

The NZ College of Midwives (the College) and Midwives Employee Representation and Advisory Services were informed of the consultation process and its purpose, a representative from these organisations attended meetings and the organisations made written submissions.

The process has uncovered some interesting information about the lack of service delivery in some parts of the rural maternity system, raised questions related to a “culture of care” and confirmed a strong interest and support for the proposed Hub model.

Key themes from the consultation process are:

- Constrained access to antenatal services, ultrasound, lactation and breastfeeding support, smoking cessation services and transport.
- The physical state of the three birthing units "Rugged" "Overheated" "Underwhelmed" and “not a very good stay.”
- Transport/logistics of access to secondary services for women who need that level of care at Waikato Hospital
- Usefulness of Telehealth from a local hub or rural hospital to access secondary obstetric appointments
- Fear of loss of local midwifery services. The College and MERAS do not support the closure of the birthing unit in Te Kuiti and expressed concern about the impact of this on retention of rural midwives and maternal wellbeing.
- Concern regarding the willingness of LMCs to service the rural locations and provide cover for the DHB birthing facilities
- Maori inequalities being addressed, services and service providers being culturally appropriate and “Let the Maori community have a voice to be heard”.

Having balanced all the relevant data, the feedback and the discussion outcomes, the recommendations are:

1. Implement the primary maternity hub service model as proposed
2. Close the Te Kuiti Birthing Unit
3. Move to a Lead Maternity Carer model for Te Kuiti and Tokoroa
4. Offer an enhanced facility contract for the two birthing units in Tokoroa and Taumarunui
5. Develop a physical primary maternity hub location in Te Kuiti, Tokoroa and Taumarunui
6. Commence a co-design process which includes working with Strategy & Funding, Te Puna Oranga, key stakeholders and local service providers to develop enhanced access to services and a well-coordinated antenatal and postnatal service.

2. Introduction

Following a decision by the Waikato District Health Board (DHB), taken at the December 2016 meeting, a consultation process on the proposed future service model for the Southern rural Waikato was undertaken between March 6th and April 14th, 2016.

> ITEM 12: SOUTHERN RURAL PRIMARY MATERNITY SERVICES – PUBLIC EXCLUDED
>
> A report setting out a future service model for the primary maternity services that are delivered in the southern part of the DHB's catchment area was tabled for consideration.
>
> Dr Chris Hendry attended for this item and gave a presentation to the Board that set out the options the options for Waikato DHB on the provision of maternity services in the South Waikato and King Country.
>
> Resolved THAT The Board:
>
> 1) Received the report.
>
> 2) Endorsed the recommended model for the delivery of primary maternity services in the southern DHB catchment in principle, subject to the outcome of consultation with the affected communities and providers.
>
> 3) Agreed that the DHB should undertake a process of consultation with the affected communities and providers early in the 2017 calendar year.

What we know

During the consultation process, there were some challenges to the birthing numbers as reported in the Waikato DHB presentation. The data has been checked using an exhaustive process, both manual and electronic records have been scrutinised for accuracy and the figures have been verified. Please note, the maternity data in this report will be described in calendar years.

In 2016 there were 144 births across the three hospital birthing units. Forty one in Te Kuiti, fifty six in Tokoroa and forty seven in Taumarunui. In addition, four Tokoroa domiciled women birthed in Lakes DHB in 2016.

The Tokoroa Birthing unit has a staff of 3.4 FTE employed midwives (currently 2.4 FTE). In 2016 there were fifty six births of which, 46% (26) were delivered by LMCs and 54% (30) by staff midwives. (Midwife 5 changed her status from LMC to midwife in that same period.)

Table 1 – Births in the Tokoroa birthing unit by LMC and DHB employed midwife (by calendar year)

Births			
Clinician type	2016 12m	2017 ytd 4m	Total
Midwife LMC	26	22	48
Midwife Staff	30	2	32
Total	**56**	**24**	**80**

Table 2 - Tokoroa Birthing Unit activity by clinician type in the 2016 calendar year.

Midwife	LMC	Caseload Midwife	Births	Postnatal stay only	Transfer in labour to WWH	NIEL (assessed not in established labour)	Antenatal transfer to WWH
Caseload Midwife (CL)							
1		✓	**7**	5	1		1
2		✓	**9**	4	3	1	2
3		✓			1		
4		✓	2	1		1	2
5			12	3	8		5
Total (CL)			**30**	**10**	**5**	**2**	**5**
LMC							
2	✓		5	2	1	1	
6	✓		2	1			
7	✓		12				
8	✓		6				
5	✓		1	2			
9	✓					1	1
Total LMC			**26**	**8**	**9**	**2**	**6**
Grand Totals			**56**	**18**	**14**	**4**	**11**

Note: WWH Waikato Women's Hospital

Table 3 - Tokoroa Birthing Unit activity by clinician type in the 2017 calendar year.

Tokoroa Birthing unit has a staff of 3.4 FTE employed midwives (currently 2.4 FTE). In the four months to May 1st, 2017 there have been 25 births of which fifteen, or 60% have been delivered by LMCs.

Midwife	LMC	Caseload Midwife	Births	Postnatal stay only	Transfer in labour to WWH	NIEL (assessed not in established labour)	Antenatal transfer to WWH
Caseload Midwife (CL)							
1		✓	1	1			
11		✓					2
12		✓		1			
4		✓	1			1	2
5		✓	8	0	6	1	3
Total CL			**10**	**2**	**6**	**2**	**7**
LMC							
2	✓		9	3	3		
8	✓		5	1			
9	✓		1				
Total LMC	✓		**15**	**4**	**3**		
Grand Totals			**25**	**6**	**9**	**2**	**7**

Note: WWH Waikato Women's Hospital

Previous work by Dr Chris Hendry, based on births in the local facility and all births registered in the locality in 2015, indicated a potential of 205 primary births for the Tokoroa area in 2016. This suggests that if the identified service and facility deficits are addressed there is latent community demand that could be met which would increase the sustainability of the unit over time.

Te Kuiti

Forty-one women birthed at the Te Kuiti birthing unit from the Waitomo and King Country in 2016. This excludes women from north of Otorohanga who live closer to Te Awamutu than Te Kuiti. (see Appendix 1)

Fifteen of the women were from Te Kuiti, 4 from Otorohanga and 1 from Bay of Plenty DHB. Thirteen were from the rural area between PioPio and Te Awamutu. In this year, 3 women that birthed at Te Kuiti had a postnatal stay in Te Awamutu, all were from Te Kuiti central catchment.

There has been a total of six births in the Te Kuiti hospital birthing unit in the first four month of 2017, which has an FTE staffing budget of 2.2 FTE employed midwives (currently 1.0 FTE plus a locum).

Table 4 - Births in the Te Kuiti birthing unit by LMC and DHB employed midwife (by calendar year)

Births			
Clinician type	2016 12m	2017 ytd 4m	Total
Midwife LMC	17	4	21
Midwife Staff	24	2	24
Total	**41**	**6**	**51**

In 2016, 42% of the births (17) at Te Kuiti were delivered by the LMCs and 58% by staff midwives. This may be attributed to a midwife who undertook a one year, staff midwife position in 2016. In January 2017, she resumed her LMC practice.

Table 5 – Te Kuiti Birthing Unit activity by Clinician type in the 2016 calendar year)

Midwife	LMC	Caseload Midwife	Births	Postnatal stay only	Transfer in labour to WWH	NIEL (assessed not in established labour)	Antenatal transfer to WWH
Caseload Midwife (CL)							
1		✓	12	2			
2		✓	1	1			
3		✓	11	1	1		
Total CL			**24**	**4**	**1**		
LMC							
4	✓		16	3			
5	✓		1				
Total LMC			**17**	**3**			
Grand Total			**41**	**7**	**2**		

Note: WWH Waikato Women's Hospital

Table 6 - Te Kuiti Birthing Unit activity by clinician type in 2017 calendar year (4months)

Midwife	LMC	Caseload Midwife	Births	Postnatal stay only	Transfer in labour to WWH	NIEL (assessed not in established labour)	Antenatal transfer to WWH
Caseload							
1		✓	2				
2		✓					
Total CL			**2**	**4**	**1**		
3	✓			1			
4	✓		3	1			
5	✓		1				
Total LMC			**4**	**2**			
Grand Total			**6**	**6**			

Note: WWH Waikato Women's Hospital

Previous work by Dr Chris Hendry, based on births in the local facility and all births registered in the locality in 2015, indicated a potential of 66 primary births for the Te Kuiti area in 2016. This suggests that there is insufficient latent community demand to ensure the sustainability of a revamped unit over time, and the inter-relationship between the viability of having units in both Te Kuiti and Te Awamutu is an important consideration. A single birthing unit can accommodate the demands currently being met by both.

Taumarunui

Taumarunui operates a full Lead Maternity Carer (LMC) led Birthing Unit which is serviced by two independent LMCs, one of whom holds the facility contract to meet the Crown Funding obligations of the Waikato DHB. In 2016 there were forty seven births in Taumarunui and in the first four months of 2017, there have been twenty three births.

Table 5 – Taumarunui Birthing Unit activity by Clinician type in the 2017 calendar year 4m

Midwife	LMC	Births	Postnatal stay (return from birth at WWH)	Antenatal transfer to WWH	Transfer to Te Awamutu for postnatal care	Received inpatient postnatal care	Discharged home between 3 – 12 hours following birth
Caseload Midwife (CL)							
1	✓	15	3	1	2	9	1
2	✓	8	1				
Grand Total		**23**	**4**	**1**	**2**	**9**	**1**

WWH = Waikato Women's Hospital

Previous work by Dr Chris Hendry, based on births in the local facility and all births registered in the locality in 2015, indicated that the Taumarunui unit was meeting all of the expected demand from the community for primary births. While that number is comparatively low (57), the vastly increased isolation of the Ruapehu population relative to other primary birthing options means that sustaining a viable primary birthing unit in the locality is a key consideration. Enhancing access to the types of services envisaged in the primary maternity hub proposal is a deliberate measure designed to improve the health outcomes of women and babies in this community.

3. Methodology

The consultation process comprised four components, consultation meetings, an online survey, a submission process and meetings or discussions with key stakeholders in the affected communities.

10 Ten public consultation meetings were held between March 6th – 20th in 5 southern Waikato towns. Participants were representative of Māori (37%), Pasifika (23%) and others (40%).

In addition, the consultation team spoke with Te Puna Oranga staff, Te Kuiti Medical centre staff and Tokoroa Emergency Department doctors. The information regarding the consultation and its purpose was shared at the Community Health Forum (CHF) and Rural Health Advisory Group (RHAG) meetings. The NZ College of Midwives (the College) and Midwives Employee Representation and Advisory Services (MERAS) were informed of the consultation process and its purpose.

Information regarding the consultation process was made widely available. It was sent to the database for Waitomo, Ruapehu and South Waikato Community Health Forums and the Rural Health Advisory Group. Flyers were hand delivered in each of the towns chosen for the consultation meetings to publicise the meetings. The flyers and information regarding the survey and submission process were made available. outside supermarkets, libraries, WINZ offices, and through various early childhood centres, La Leche, Tokoroa High School, Putaruru High School, Plunket etc. The team acknowledged the contribution of South Waikato Pacific Islands Community Services (SWIPIC) and Maniopoto Marae Pact Trust for their support in distributing the flyers.

The Executive Director – Community & Clinical Support Services informed the relevant Mayors and the local MPs and he was also interviewed by several newspapers and Maori Television. The DHB facebook page carried a notice and other boosted facebook adverts were used with links to the Waikato DHB's internet page. Maternity consumer groups and relevant national organisations were contacted and asked to disseminate the information through their databases and networks.

4. Outcomes

a. Consultation Meetings

Ten public consultation meetings were held over a two-week period from March 6th to March 20th. Attendance varied from town to town, the meetings in Taumarunui were more representative of the "consumer" group with the Putaruru, Otorohanga and the third Te Kuiti meeting being weighted more to midwives and health professionals. The first meeting in Te Kuiti was hosted by and Maniopoto Marae Pact Trust and South Waikato Pacific Islands Community Services hosted a meeting in Tokoroa.

The consultation meetings were independently facilitated and a written record of the meeting was collected. Each meeting allocated approximately one-third of the time to a presentation of the proposed model and background data, by Dr Chris Hendry (subject matter expert) and Jill Dibble (Director – Community & Southern Rural Health Services). The remainder of the meeting was used for questions and discussion. Some interesting information emerged through the process related to current contract performance. Rachel Poaneki (Portfolio Manager) attended the majority of the consultation meetings and was able to reflect back the information to the Strategy and Funding team for relevant action.

Table 7 - Attendance at the ten public Consultation meetings

Session #	Taumarunui	Te Kuiti	Otorohanga	Tokoroa	Putaruru
1	15	20	6	20	6
2	13	4		21	
3		4		8	
Subtotal	**28**	**28**	**6**	**49**	**6**

Key issues

Five key issues emerged consistently across the meetings. These were access to:

- antenatal services,
- ultrasound locally and without co-payment (as in Lakes DHB),
- smoking cessation services,
- locally delivered lactation services
- secondary level specialist services at Waikato Hospital

Obstetric service access was a matter of concern to those women who were deemed to be "at risk". There appeared to be a range of reasons including availability and affordability of transport, the lack of local obstetric appointments and the criteria for requiring secondary care. It was acknowledged that telehealth and SmartHealth could provide opportunities to improve access for some women. Where access to wifi, mobile telecommunications and cost of data is a problem, the Hub was seen as a way forward along with planned improvements by Spark and the DHB.

For some of the women in Taumarunui, there is a genuine fear created by the distance to the Waikato Hospital. Young women talked openly about choosing an LMC in Hamilton or Te Awamutu in order to birth in the Te Awamutu Birthing unit. Their decision is based on the relative proximity of

the Te Awamutu unit to Waikato Hospital in the event of something untoward happening. One person went so far as to suggest fundraising for a helicopter that could be based in Taumarunui and available to take Taumarunui people to the Waikato Hospital in emergency situations.

Social and geographical isolation was reported as an issue for midwives and maternity service consumers. Rural midwives report spending long periods driving between rural properties when doing antenatal and postnatal checks, this reduces their overall caseload numbers (and income) and creates problems of availability to see "emergencies". This situation also applies to the caseload midwives.

For pregnant women and new mothers, distance is a problem in terms of cost of and access to transport, the logistics of travelling with other young children and taking time off work to attend appointments in Hamilton. Tokoroa meeting participants were also concerned about the lack of local access to obstetrics services.

For several of the attendees at the first meeting in Te Kuiti, there was a concern that this consultation process was a smoke screen and the real purpose of the consultation meeting was about closing the hospital. Once this fear was allayed the meeting had an open and robust discussion on the proposed model and the thoughts and ideas of the participants.

At a meeting at the Te Kuiti Medical Centre, GPs expressed a willingness to continue to deliver emergency births however, they do not wish to become a default birthing unit. The GPs were in support of the Hub model.

b. Survey

Using Survey Monkey, an online survey was available from March 6th to April 14th (see Appendix 4 for a full survey report).

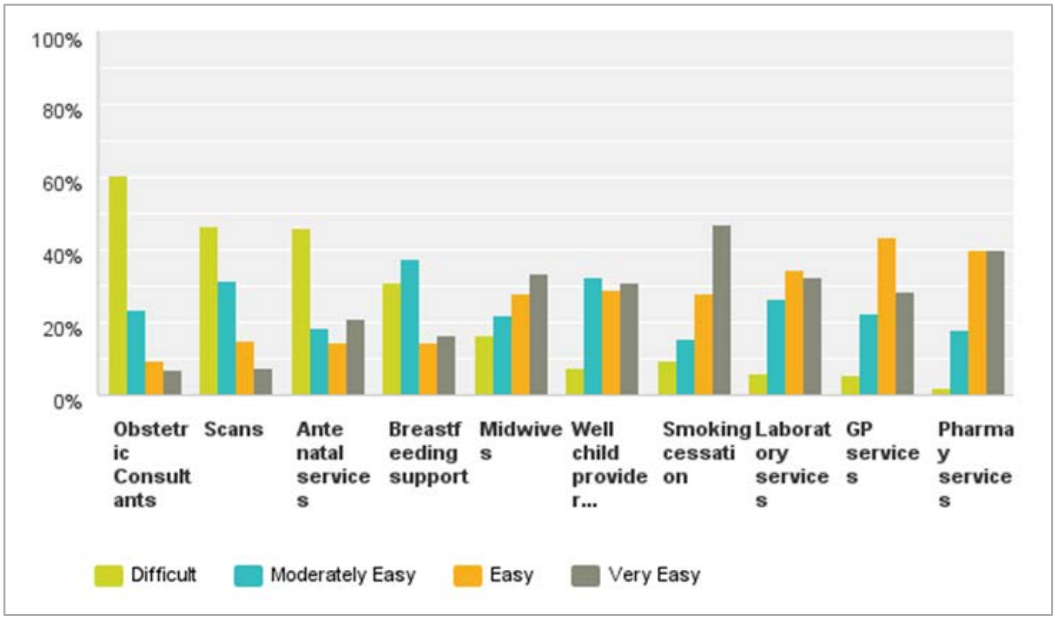
Sixty one people participated in the survey, of whom:

- 63% were in the target stakeholder group of 21 – 35 years,
- 18% in the 36 – 45 years group
- 18% were over 45 years.
- 21% of respondents had recent experience (within the past 3 years) as a birthing service user
- 11% were midwives
- 54% were parents or caregivers.
- 23% of participants were Maori
- 2 % participation from Pasifika people.

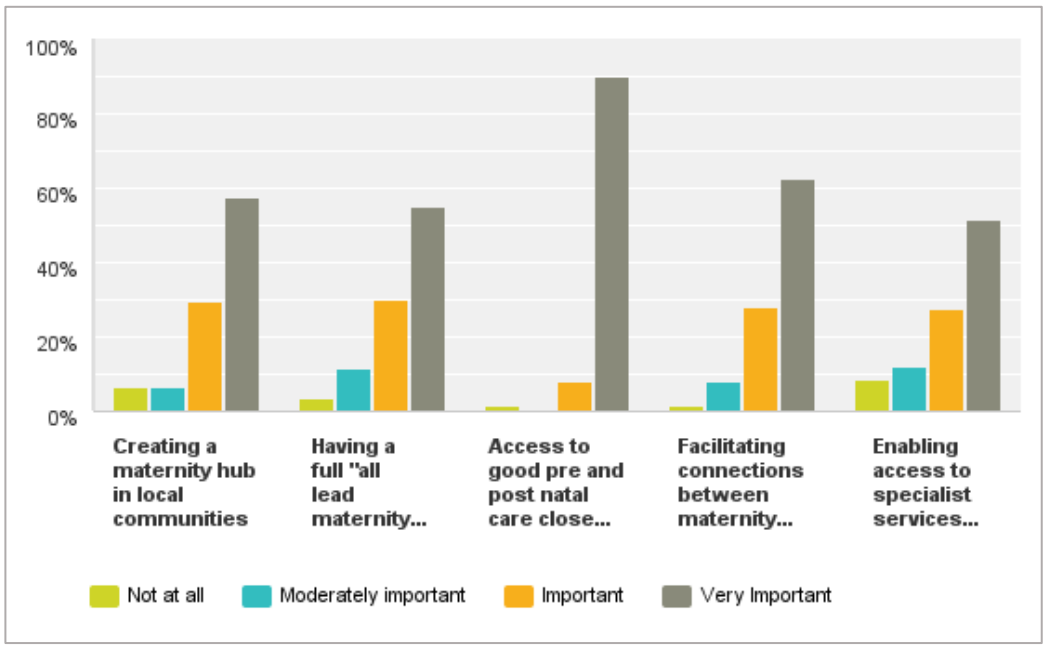
Forty six respondents answered a question relating to satisfaction with the service they had received; the response range available was 0 – 100, the median response was 84 and the mean 75. The narrative enquiry question that followed was completed by 36 people (59%) and elicited these 11 common words as shown in the word cloud below.

In the context of providing a "healthy journey for life", it is concerning to see the responses to the question regarding maternity services access. The findings regarding access to obstetric services, scans and antenatal services are consistent with the information from the meetings and some of the

submissions. At variance with the meetings is the perceived access to smoking cessation services.



The survey results support the need for the key components of the Hub model which is also consistent with feedback from the meetings.



"I live in Tokoroa and I'll be birthing in Rotorua. I find the facilities there easy to access, all in one place and information on them available from my midwife. From previous friends & family experiences in Tokoroa using Tokoroa maternity services, I am not confident this would be the same".

c. Submissions

There were 14 written submissions emailed to the District Health Board. Of the 14, three were formal submissions from organisations (NZ College of Midwives, Midwives Employee Representation and Advisory Services and Action to Improve Maternity), one from a GP and five from midwives. One submission was made by the Tokoroa nursing team and two were submitted by members of the community.

In principal, the Hub concept is supported by the NZ College of Midwives (the College)

> *"The New Zealand College of Midwives (the College) supports the Waikato DHB's work to ensure women and their whanau have access to a wide range of quality maternity services. We also agree that a strong maternity service is vital for rural areas within the Waikato and that strengthening services and investing in maternity care will provide positive results for women and their families within these communities".*

However, the College and the Midwifery Employee Representative and Advisory Services (MERAS) oppose the closure of the Te Kuiti Unit and support retaining and further investment for the rural inpatient birthing facilities. Both submissions made useful suggestions regarding supporting pregnant women, antenatal services, attracting and retaining midwives.

MERAS believes the DHB needs to liaise with the midwives and women in each community to identify the key improvements that need to occur in each facility and implement these as a priority. It believes *"more could be done to increase the range of services at each of the maternity units and increase utilization".*

By comparison, Action to Improve Maternity Charitable Trust (AIM) *"Strongly support any decision to close rural primary birthing units. Our view is that such primary birthing units should be placed alongside hospitals for ease of access to medical assistance".*

Other submissions from midwives support retaining and investing in the current facilities and they express concern regarding reduced access to services and a potential focus on cost saving.

The majority of submissions noted the outdated facilities and the need to invest in the physical space; midwives and consumers are united in their criticism.

> *"Thank you please record it needs a bloody good scrub up the DHB need to spend some money on Te Kuiti Hospital's birthing area if they want locals birthing here this weekend another local had a baby at the Te awamutu birthing centre now I wonder why it's cause it's nice and flash :)"*
>
> *"You say the facilities are underutilised and I would have to agree. If we are to promote birthing and postnatal care in our facilities then we need to have a facility worth promoting wouldn't you agree? " (a midwife)*

The birthing units at the rural hospitals are primary birthing units. This does not seem to be reflected in some of the submissions. An overall impression is that the DHB midwives see the risks and the barriers in the proposal to close the Te Kuiti birthing unit and move the Tokoroa model to an LMC led model. Consumers, some of the LMC midwives and other stakeholders, see and embrace the

opportunities to do things differently for the women in their communities – and also provide additional support for LMCs. The concept of SmartHealth and use of technology to reduce the impact of distance was supported by consumers. However, there were a few different opinions.

> *"As a* caseload midwife, we are constantly being asked to increase our workload expecting the caseload midwives to introduce and encourage women to uptake the DHB's newest computer incentives, for example, SmartHealth. I personally feel this is not what a midwife should be doing. It has not been well received by the public; it is not easy for a woman to access. I also feel this has not been the best investment made by the DHB as a caseload midwife I was given an Ipad to use for signing women up to SmartHealth. If the caseload midwives are disestablished what a waste of public funding."

d. Feedback on the proposed model

Feedback on the proposed model suggested that the concept of the Hub (see Appendix 1) was seen as important by many participants and there was general agreement that the idea of setting a baby up for a lifelong wellness journey was a good thing. It was also seen to be important in "building and strengthening relationships with hapu women and their babies".

Full engagement by LMCs was seen as vital to the success of the Hub and to providing a smooth journey for mums. Access to Plunket, well child services, smoking cessation, lactation support and other social services would be a good outcome of a Hub. Diabetes support was seen as important for this community. Newly qualified midwives saw the Hub as having the potential for them *"well supported by a Hub – a go to place".*

In Taumarunui, the cohort of participants was representative of a younger group of pregnant women and women with young children. For this group, psychosocial aspects of a Hub were seen as very important.

Five of the midwives attending the meetings believe that they currently offer antenatal services as part of their care package. However, access to antenatal was one of the common themes identified as a significant concern in the consultation meetings and in the survey. A midwife also reported that "*a key issue will be the quality and safety of postnatal care*".

Women want a locally coordinated maternity service that can support them psychosocially, with a range of maternity services and with other general health and wellbeing services (including budgeting services and family violence prevention support).

Key issues to address were identified as a lack of and/or difficulty with access to antenatal services, ultrasound, lactation and breastfeeding support, smoking cessation services and transport.

It was suggested that support with transport to and logistics of access to secondary services at Waikato Hospital and access to the Te Awamutu birthing unit for some women and their whanau should be considered.

Choice and access in relation to LMCs were seen to be of importance and the need to follow through with postnatal care was discussed.

e. Additional information

Cultural Aspects

The consultation process sought to actively engage with Maori consumers and stakeholders. The feedback in meetings was robust and focussed on the pregnancy journey including access to LMCs. For some, the relationship to the rohe and spiritual aspects were important, to others, connectedness and support within their community and to strong antenatal support were the key elements.

For both Maori and Pasifika women, not having access to health professionals who were culturally aware was seen as a barrier to access. A survey participant described her view of the future.

"Bring the services closer to the community you serve Bring the services closer to the population you service Make sure that the services you are offering are a radical improvement that leads to eliminating health inequities for Maori and those in rural communities Train your workforce (including Specialists and LMCs) to be culturally appropriate Remove the barriers so our wahine and pepe are able to access the services they need Let the Maori community have a voice to be heard Channel more resources into high quality Maori health provider services - if you want to really want a radical improvement in Maori health outcomes channel more money and resources into culturally appropriate services The proposed model will not work if your goal is to not provide equitable money and resources into Maori health provider services to deliver. It will fail miserably like all the other proposed models you have come up with. You need to put your money and resources where your mouth is. That is, in the community pre and post natal services delivering in a culturally appropriate way for Maori. Re"

Technology

Women and midwives expressed frustration regarding access to diabetes services. The diabetes service is delivered from Hamilton. Recently the service has delivered multidisciplinary training to GP practices, midwives and pharmacists, to enable the local health professionals to support women who have diabetes in pregnancy (DIP). Discussions have commenced related to using virtual health for this service.,

In principle, SmartHealth is seen as a useful addition to the suite of services and is seen as likely to enhance ease of access.

Women had several questions regarding how they could access free wifi within the rural hospitals, and how women living more remote will be able to use SmartHealth e.g. from Kawhia down the west coast to Taumarunui.

Other issues that were identified include a choice of a lead maternity carer (LMC) and LMCs that were available and accessible. Comments were made regarding the busy schedule of local LMCs due to caseload and travelling between rural addresses which impacted the ability to deliver post-natal care.

5. Data and financial information

Table 8 - Options for the Waikato DHB provision of Southern Rural Maternity Services (also at Appendix 2)

Options for Waikato DHB Provision of Maternity Services in the South Waikato and King Country

	No.	Value $	Current Model $			No.	Value $	Proposed Model $		
			Tokoroa	Taumarunui	Te Kuiti			Tokoroa	Taumarunui	Te Kuiti
Case Load Midwives (FTE) Based on Actual Salary	3.8	$ 87,548	332,682							
	2.2	$ 87,548			192,606					
Contract Services										
Facility Cover Contract				52,739		1	$ 65,700	65,700	65,700	
Leave days per year (2 days per month)						24	$ 450	10,800	10,800	
Conference Contribution						1	$ 3,000	3000	3,000	
Relief Cover										
Relief contract MMPO (Weeks)	26	1,610		41,860						
Relief contract - Sue Van Dam (Weeks)	26	849		22,079						
Contingency - 35 days relief across both Tokoroa and Taumarunui (70 days in total)						35	$ 450	15,750	15,750	
Core Midwife facilitator (step 5 core midwife)						1	$ 70,000	70,000	70,000	70,000
Administration support						1	$ 45,000	45,000	45,000	45,000
Rental for Maternity Hub								15,000	15,000	20,000
Te Puna Oranga to promote / extend the Harti Mama programme								15,000	15,000	15,000
High Needs access and support for travel and accommodation						1	$ 10,000	10,000	10,000	10,000
Note 1			332,682	116,678	192,606			250,250	250,250	160,000
Provision will be required of approx. $50k per facility in order to fit out / modify the Maternity Hubs				$ 641,966					$ 660,500	

Note 2

Maternity birthing ward upgrade. Future capital spend will be required to bring the current facilities at Tokoroa and Taumarunui up to the standard of the Women's wards at Waikato Hospital.

Note 3

The above analysis excludes overheads that would apply to both options

This table above provides a high-level outline of the current direct costs, and how that expenditure might be utilised differently under a primary maternity hub model to improve the health outcomes being achieved for women and their babies.

Within this proposal, there is an allowance for staffing; (a Hub coordinator, an admin support person and a Harti Mama facilitator). The annual lease cost for the hub facilities is included.

For Tokoroa and Taumarunui there is a proposed budget for an augmented birthing unit facility contract which would assist with attracting an LMC practice to the town. (The direct cost of LMC birthing and maternity care is met by the Ministry of Health, not the DHB.)

Finances have been allowed to assist high need access to support travel and accommodation for women who require secondary services at Waikato Hospital or other primary birthing units and who do not meet the criteria for the National Travel Assistance.

Capital costs of any upgrade to the facilities have been excluded from this operational budget. However, an approximate cost of $300,000 per hospital would be the expected cost of the maternity unit upgrades.

In summary, the enhanced maternity care provided by the proposed primary maternity hub is a cost neutral method of addressing the current service deficits. That is achieved by directing resources to two units over the long term, and by providing high-quality primary maternity hubs for service coordination across the range of health and social services in all three towns, including access to specialist services delivered from the Hamilton based teams. An additional investment in excess of $200,000 per annum and additional capital costs of approximately $300,000 would be required if the third birthing unit is retained (i.e.) a three birthing unit model is not cost neutral. The very low number of births, the lack of latent demand in the community to enable the third unit to grow sufficiently, and the close proximity of that location to desirable birthing facilities nearby, do not justify retaining that unit. The reality is that most women from the Te Kuiti area are already choosing to birth elsewhere (see Appendix 3) and the current investment in services could achieve far better health outcomes if it is re-allocated into a primary maternity hub service model as is proposed.

6. Summary and Recommendations

The comments and information shared across all parts of the consultation process are consistent with regards to what is missing from current services and what the community needs in terms of services during pregnancy and after delivery. The "what" was supported by the "why" in discussions and in the written information.

People are more divided on the question of whether the Te Kuiti birthing unit remains in operation or closes. Some of the views relate to a personal connection of the unit, some with the concept of change and loss and others with a more pragmatic view of the world that asks if forty-one births per year make this a financially viable proposition and whether it fits with the DHB's view of the equity of access. Te Kuiti Hospital to Te Awamutu birthing unit is a 38-minute journey during the middle of the day. *Appendix 2* shows a map of the places where women travelled from in the 2016 year to access the Te Awamutu unit.

A view expressed by the College, MERAS and some of the midwives is summed up in this quote from a submission by a DHB midwife

> *"The caseload midwives provide an essential service for the safety and well-being of women and babies on a daily basis in these two rural communities. I believe removing this service will put women and babies at serious increased risk".*

Currently, Taumarunui, the primary birthing unit furthest away from the Waikato Hospital, operates on a full Lead Maternity Carer model. There is a facility contract in place providing 24/7 cover for the primary birthing unit. The DHB provides four days per month locum cover to support the LMC providing the facility contract cover). Although women are anxious about the distance, any woman who is judged to be "at risk" will be transferred to the care of secondary services during their pregnancy. Emergency response systems and processes are in place and would remain unchanged by this proposal.

There is a small percentage of women in the Southern Rural community who are less likely to engage with services during pregnancy and do not easily find an LMC. A key task for the Hub and the Harti Mama programme would be to focus on that component of care which is in line with the recently announced Better Public Services (BPS) target:

> Result 2 Healthy Mums and Babies: 'By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups'

Similarly, a small number of women and their whanau may struggle to find transport or afford the cost of travelling to the Te Awamutu birthing unit or to antenatal appointments in Hamilton. A small budget line has been introduced in the proposed budget and this topic would be addressed as part of a co-design exercise.

Co-design with consumers, stakeholders, health professionals and Strategy & Funding would be the first step once a Board decision is taken. The many components of the pregnancy and after birth care for women and their babies seem fragmented in our Southern Rural communities and this needs to be addressed by collaboration between key stakeholders.

> *"I believe there needs to be more discussion and collaboration between the DHB, midwives, and all local service providers."*

From the submissions, survey and meetings it is clear that there is widespread support for the proposal to improve access to antenatal services, ultrasound, lactation and breastfeeding support, smoking cessation services and transport.

The concept of the maternity hub coordinator is also generally well supported although midwives have some concerns about who would fulfil this role. In the meetings, it became apparent that the coordinator role may not necessarily be best filled by a midwife. Communities saw this role as having a significant advocacy and brokerage. The social support function that the hub could facilitate was welcomed by pregnant women and women with children who participated in the meetings. They identified issues related to social isolation and lack of support. It became clear that this aspect of maternity services was important and may well lead to other health and wellbeing gains.

Addressing inequalities for Maori and ensuring that services are culturally appropriate came through in all parts of the consultation process.

Recommendations

Having balanced all the relevant data, the feedback and the discussion outcomes, the recommendations are:

Having balanced all the relevant data, the feedback and the discussion outcomes, the recommendations are to:

1. Implement the primary maternity hub service model as proposed
2. Close the Te Kuiti Birthing Unit
3. Move to a Lead Maternity Carer model for Te Kuiti and Tokoroa
4. Offer an enhanced facility contract for the two birthing units in Tokoroa and Taumarunui
5. Develop a physical primary maternity hub location in Te Kuiti, Tokoroa and Taumarunui
6. Commence a co-design process which includes working with Strategy & Funding, Te Puna Oranga, key stakeholders and local service providers to develop enhanced access to services and a well-coordinated antenatal and postnatal service.

7. Appendices

1. **An outline concept for a community maternity hub**
2. **Financial Data**
3. **Te Awamutu Birthing Unit, 2015 – 17 births**
4. **Summary of on-line survey results**
5. **Submissions register**
6. **References**

Appendix 1. Community Primary Maternity Hub – outline concept

Background

The more a woman knows about the available services and options during her pregnancy, the more in control and confident she is likely to feel.

A community-based primary maternity hub would provide a physical space focussed on "the start of the health journey for life". It would be a centre that promotes and supports greater collaboration to assist women and their families navigate services and determine who they need to see. The focus of the hub would be wrap around services that promote health and wellbeing through pregnancy, birthing and beyond and provide a place for women to meet and socialise.

The hub would be supported by administration staff and a maternity services coordinator. It is envisaged the hub would have a meeting room for education and support groups and would also be a place where women could navigate service options and determine a plan for their health and wellness journey.

Purpose

The hub could potentially provide a single physical location for women and providers to:

- access services to support a healthy pregnancy and postnatal experience e.g.smoking cessation, lactation services, pregnancy and parenting education
- facilitate access to well child providers, iwi providers and other voluntary or specialist services e.g. diabetes
- facilitate appropriate access or support from a Lead Maternity Carer (LMC)
- promote collaboration and interaction between providers
- provide a technology base to facilitate easier access to SmartHealth and Telehealth (secondary maternity services in Hamilton)
- provide preconception care for women with long-term conditions
- provide a whole of maternity system approach to enable closer relationships with obstetric services

The hub would also be a place for women and their whanau/families to establish social linkages.

The details of the Hub would be developed using a co-design process within each of the communities and would involve consumers, service providers and other stakeholders.

Appendix 2. Financial Data

Options for Waikato DHB Provision of Maternity Services in the South Waikato and King Country

	No.	Value $		Current Model $		No.	Value $		Proposed Model $	
			Tokoroa	Taumarunui	Te Kuiti			Tokoroa	Taumarunui	Te Kuiti
Case Load Midwives (FTE) Based on Actual Salary	3.8	$ 87,548	332,682							
	2.2	$ 87,548			192,606					
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Relief contract - Sue Van Dam (Weeks)	26	849		22,079						
Contingency - 35 days relief across both Tokoroa and Taumarunui (70 days in total)						35	$ 450	15,750	15,750	
Core Midwife facilitator (step 5 core midwife)						1	$ 70,000	70,000	70,000	70,000
Administration support						1	$ 45,000	45,000	45,000	45,000
Rental for Maternity Hub								15,000	15,000	20,000
Te Puna Oranga to promote / extend the Harti Mama programme								15,000	15,000	15,000
High Needs access and support for travel and accommodation						1	$ 10,000	10,000	10,000	10,000
Note 1			332,682	116,678	192,606			250,250	250,250	160,000
Provision will be required of approx. $50k per facility in order to fit out / modify the Maternity Hubs				$ 641,966					$ 660,500	

Note 2

Maternity birthing ward upgrade. Future capital spend will be required to bring the current facilities at Tokoroa and Taumarunui up to the standard of the Women's wards at Waikato Hospital.

Note 3

The above analysis excludes overheads that would apply to both options

Appendix 3: Te Awamutu Birthing Unit – births by domicile of mother for Tokoroa, Te Kuiti and Taumarunui Birthing Units catchment

Domicile Description	Cal Year 2015	Cal Year 2016	ytd (4m) 2017	Total
Aria		1		2
Bennydale		1		1
Kinohaku				2
Mahoenui				1
Mangakino		1		1
Maracopa				1
Matiere		1		1
Ongaure				1
Oparau		1	1	2
Piopio		3	1	5
Pokuru		1		1
Pukeatua		1		1
Putaruru		2	1	
RD 1 Te Kuiti		2		2
RD 2 Litchfield		1		
RD 3 Te Kuiti		1		1
RD 5 Te Kuiti		1		1
RD 6 Te Kuiti		2		2
RD 7 Te Kuiti		1	1	2
Taharoa		1		1
Taupiri		1		1
Te Kawa				1
Te Kuiti		16	3	20
Te Pahu		1		1
Tokanui		2		2
Tokoroa		8	3	
Taumarunui				
Waitomo		2		2
Total		**51**	**10**	**61**

The table above illustrates the domicile of the women from the Waitomo, King Country, Taumarunui and Tokoroa, who have chosen to birth at the Te Awamutu Birthing Unit in the calendar years of 2016 and 2017. Domicile north of Otorohanga that is close to Te Awamutu has been removed.

Appendix 4: Summary of on-line Survey results

Appendix 5: Submissions Register

	Date	Name	Role/status
1.	12/03/17	Shanna Burmester	Consumer
2.	17/03/17	Robyn Kehoe	Waitomo resident
3.	17/03/17	Anne Farnell	GP
4.	15/03/17	AIM - Jenn Hooper Action to Improve Maternity Trust:	Spokesperson
5.	07/04/17	Jill Arundel	LMC Midwife
6.	10/04/17	Fleur Thomas via Rachel Taylor	Caseload midwife
7.	11/0417	Margaret Paratta	LMC midwife
8.	13/04/17	Nursing Team Tokoroa via R. Bell	Nurses
9.	13/04/17	Christine McMillan	Caseload midwife
10.	13/04/17	Tania Rangi via C. McMillan	LMC midwife
11.	14/04/17	Teressa Lindsey	Caseload midwife
12.	14/04/17	MERAS – Caroline Conroy	MERAS Organiser Midwifery Employee and Representative Advisory Services
13.	14/04/17	NZCOM – Lesley Dixon	Midwifery Advisor New Zealand College of Midwives
14.	15/04/17	Jacqui Gatenby	Registered Nurse at Tokoroa Hospital

Appendix 6: References

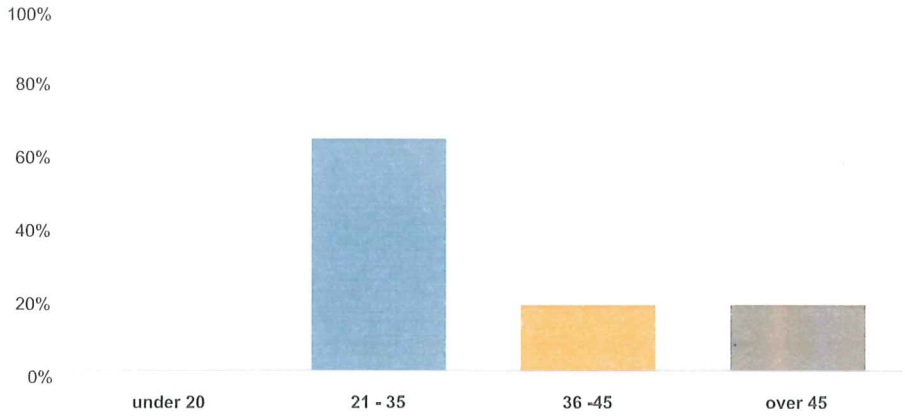
I. OPTIONS PAPER FOR WAIKATO DHB ON PROVISION OF MATERNITY SERVICES IN THE SOUTH WAIKATO AND KING COUNTRY. Dr Chris Hendry, October 2016.

II. Waikato DHB Consultation presentation

III. Waikato DHB Strategy Document

Q1 What is your age?

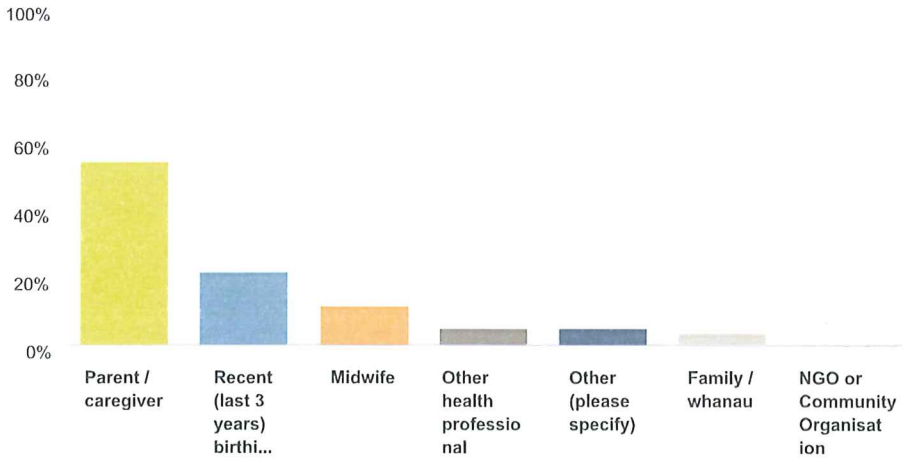
Answered: 61 Skipped: 0



Answer Choices	Responses	
under 20	0.00%	0
21 - 35	63.93%	39
36 -45	18.03%	11
over 45	18.03%	11
Total		61

Q2 How do you identify yourself?

Answered: 61 Skipped: 0



Answer Choices	Responses	
Parent / caregiver	54.10%	33
Recent (last 3 years) birthing service user	21.31%	13
Midwife	11.48%	7

Other health professional	4.92%	3
Other (please specify)	4.92%	3
Family / whanau	3.28%	2
NGO or Community Organisation	0.00%	0
Total		**61**

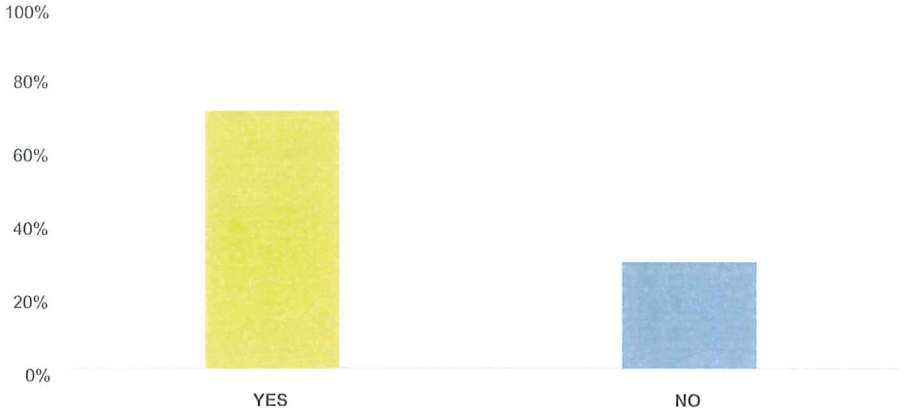
Q3 Which ethnic group do you identify with?

Answered: 61 Skipped: 0

Answer Choices	Responses	
NZ European	59.02%	36
Maori	22.95%	14
Other (please specify)	16.39%	10
Cook Island Maori	1.64%	1
Samoan	0.00%	0
Tongan	0.00%	0
Tuvaluan	0.00%	0
Fijian	0.00%	0
Niuean	0.00%	0
Tokelauan	0.00%	0
Total		**61**

Q4 Have you used the local maternity service during the past 3 years?

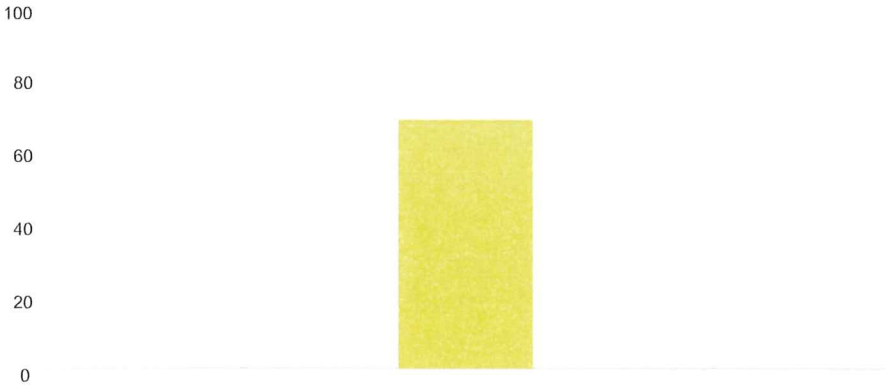
Answered: 61 Skipped: 0



Answer Choices	Responses	
YES	70.49%	43
NO	29.51%	18
Total		61

Q5 If you have used the service in the past 3 years - did you find the service easy to access?

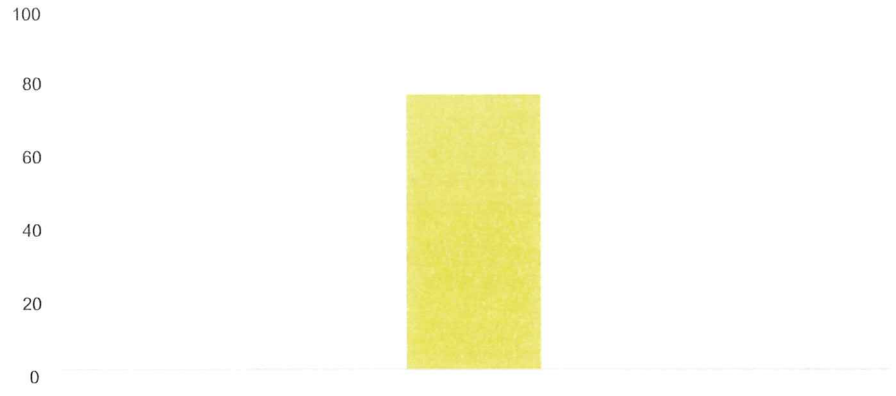
Answered: 46 Skipped: 15



Answer Choices	Average Number	Total Number	Responses
	68	3,135	46
Total Respondents: 46			

Q6 Were you satisfied with the maternity care you received?

Answered: 46 Skipped: 15



Answer Choices	Average Number	Total Number	Responses
	75	3,459	46

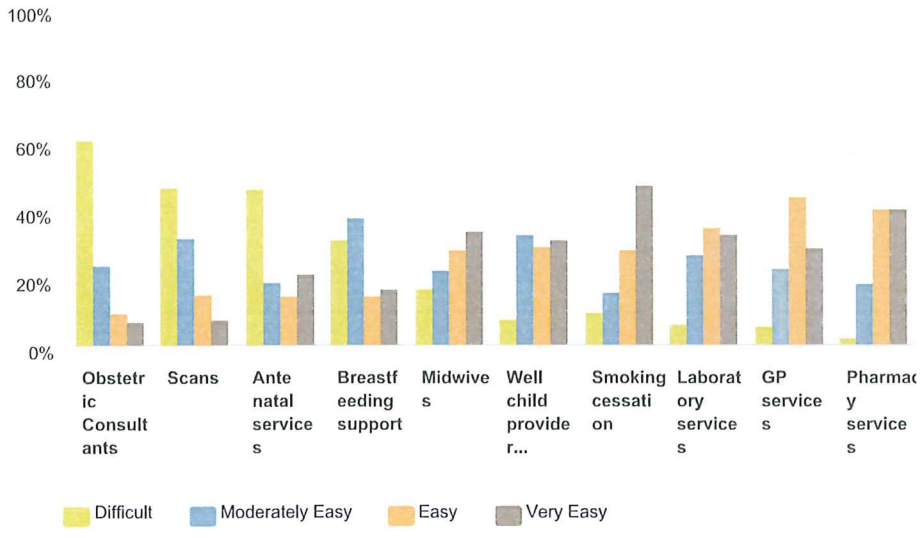
Total Respondents: 46

Q7 Can you tell us a bit more about your experience?

Answered: 36 Skipped: 25

Q8 As a maternity service user, did you find it easy to access the services that you needed - such as

Answered: 55 Skipped: 6

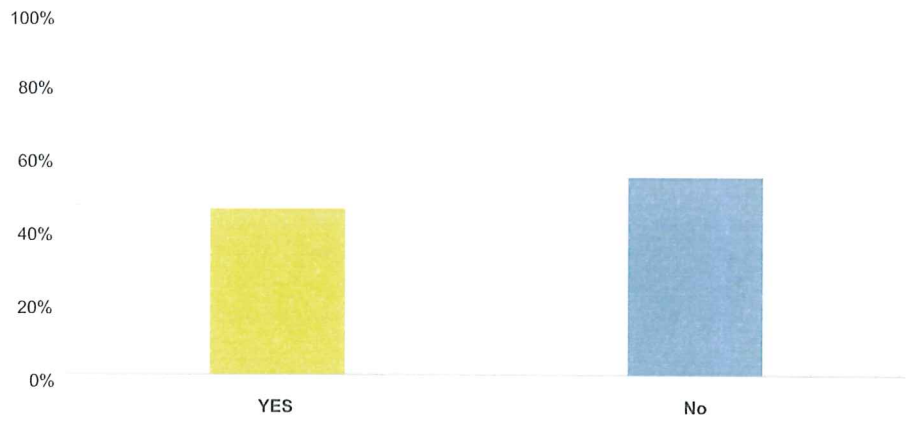


	Difficult	Moderately Easy	Easy	Very Easy	Total	Weighted Average
Obstetric Consultants	60.47% 26	23.26% 10	9.30% 4	6.98% 3	43	1.63

Scans	**46.30%** 25	**31.48%** 17	**14.81%** 8	**7.41%** 4	54	1.83
Ante natal services	**45.83%** 22	**18.75%** 9	**14.58%** 7	**20.83%** 10	48	2.10
Breastfeeding support	**31.25%** 15	**37.50%** 18	**14.58%** 7	**16.67%** 8	48	2.17
Midwives	**16.67%** 9	**22.22%** 12	**27.78%** 15	**33.33%** 18	54	2.78
Well child provider services	**7.69%** 4	**32.69%** 17	**28.85%** 15	**30.77%** 16	52	2.83
Smoking cessation	**9.38%** 3	**15.63%** 5	**28.13%** 9	**46.88%** 15	32	3.13
Laboratory services	**6.12%** 3	**26.53%** 13	**34.69%** 17	**32.65%** 16	49	2.94
GP services	**5.66%** 3	**22.64%** 12	**43.40%** 23	**28.30%** 15	53	2.94
Pharmacy services	**2.00%** 1	**18.00%** 9	**40.00%** 20	**40.00%** 20	50	3.18

Q9 Have you seen or heard about the Waikato DHB's proposed model of maternity service delivery?

Answered: 59 Skipped: 2



Answer Choices	Responses	
YES	**45.76%**	27
No	**54.24%**	32
Total		**59**

Q10 Do you understand the proposed maternity service model?

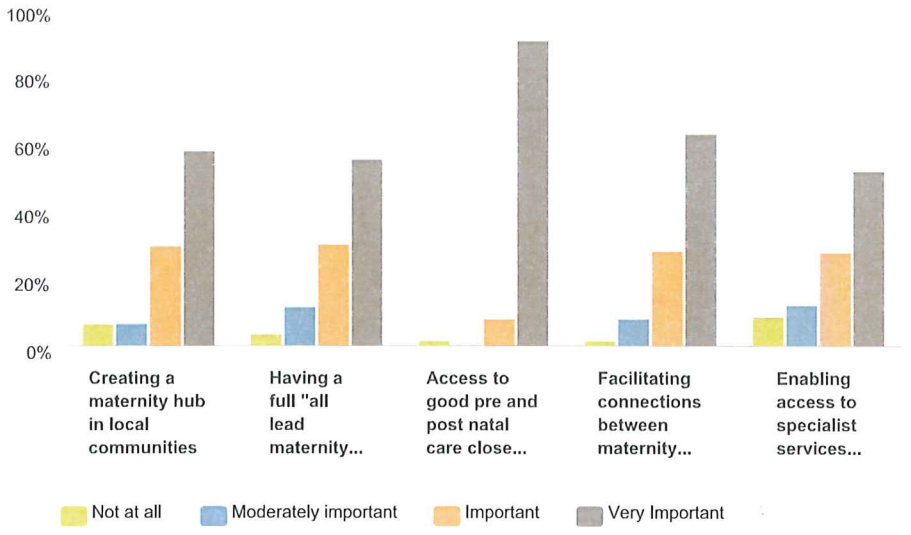
Answered: 47 Skipped: 14

Answer Choices	Average Number	Total Number	Responses
	45	2,138	47

Total Respondents: 47

Q11 How important are the following to you? (as outlined in the proposed model)

Answered: 61 Skipped: 0

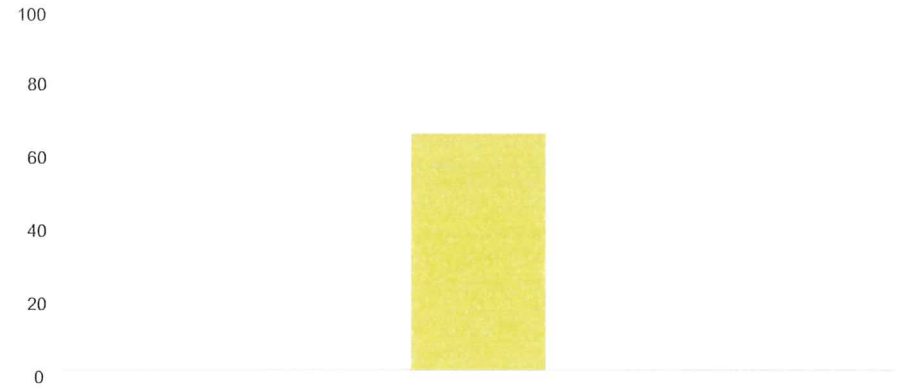


	Not at all	Moderately important	Important	Very Important	Total	Weighted Average
Creating a maternity hub in local communities	6.56% 4	6.56% 4	29.51% 18	57.38% 35	61	3.95
Having a full "all lead maternity care" (LMC) model	3.33% 2	11.67% 7	30.00% 18	55.00% 33	60	3.92
Access to good pre and post natal care close to home	1.64% 1	0.00% 0	8.20% 5	90.16% 55	61	4.77
Facilitating connections between maternity services and other health and support services	1.64% 1	8.20% 5	27.87% 17	62.30% 38	61	4.13

Enabling access to specialist services closer to home, through telehealth	**8.62%** 5	**12.07%** 7	**27.59%** 16	**51.72%** 30	58	3.74

Q12 Do you think the proposed model would work in your area?

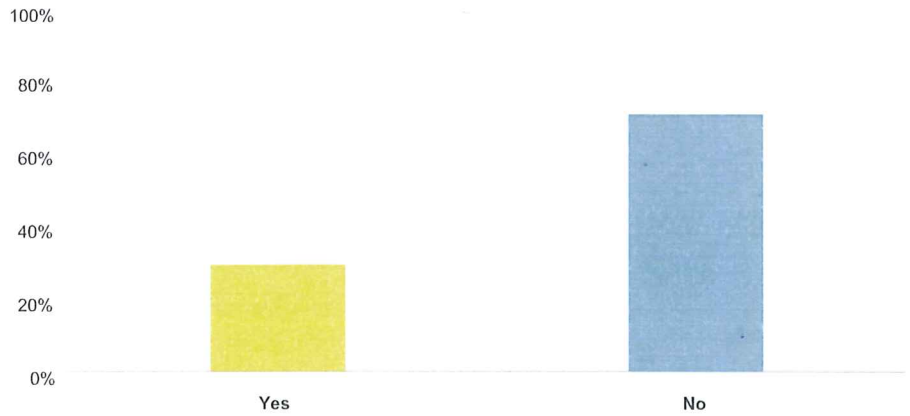
Answered: 50 Skipped: 11



Answer Choices	Average Number	Total Number	Responses
	65	3,255	50
Total Respondents: 50			

Q13 Did you attend a local consultation meeting?

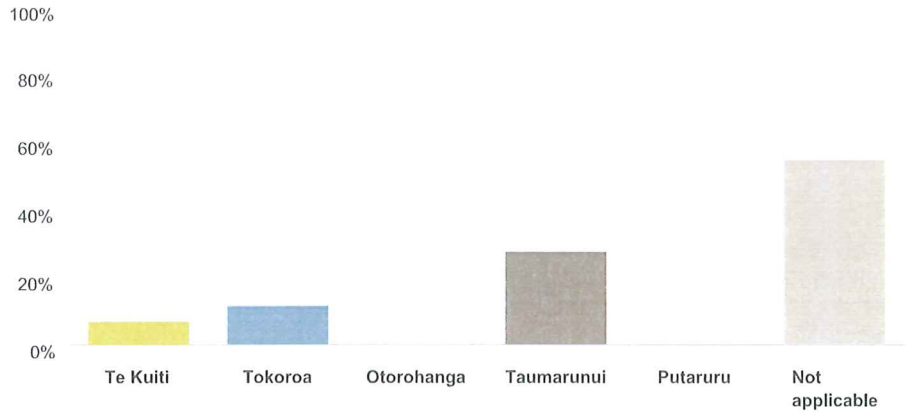
Answered: 61 Skipped: 0



Answer Choices	Responses	
Yes	**29.51%**	18
No	**70.49%**	43
Total		**61**

Q14 In which town did you attend a meeting?

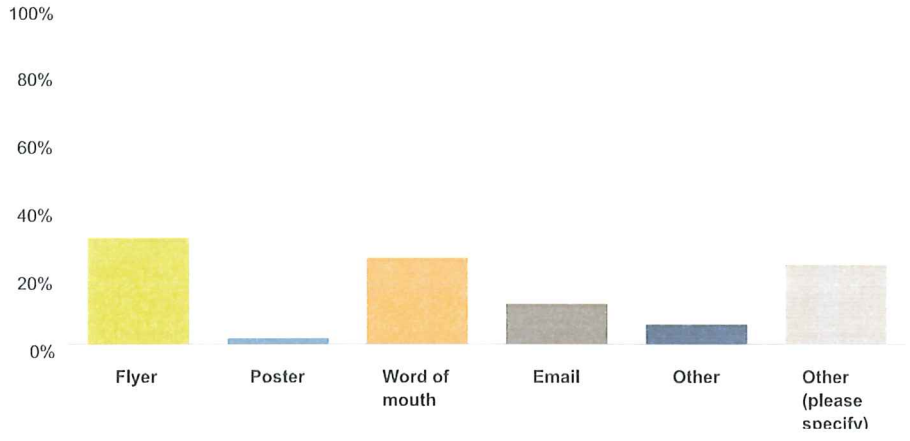
Answered: 44 Skipped: 17



Answer Choices	Responses	
Te Kuiti	6.82%	3
Tokoroa	11.36%	5
Otorohanga	0.00%	0
Taumarunui	27.27%	12
Putaruru	0.00%	0
Not applicable	54.55%	24
Total		44

Q15 How did you hear about the consultation meetings?

Answered: 51 Skipped: 10



Answer Choices	Responses

Flyer	31.37%	16
Poster	1.96%	1
Word of mouth	25.49%	13
Email	11.76%	6
Other	5.88%	3
Other (please specify)	23.53%	12
Total		**51**

Q16 Do you have any other comments?

Answered: 23 Skipped: 38

Q7 Can you tell us a bit more about your experience?

Answered: 36 Skipped: 25

#	Responses	Date
1	My midwife (Jill) was awesome, totally caring, goes above and beyond, knowledgeable, professional. Access to scans and consultants difficult in terms of availability and distance to travel. Lack of professional and confidential (as per opinions of many women in the area) second midwife in Taumarunui district leaves women exposed	4/11/2017 6:52 AM
2	Found it really hard to even find the two midwives in town, Karen was easy but Jill not. Not much information available and communication poor throughout pregnancy Going all the way to Te awamutu is a pain for scans etc when working	4/8/2017 1:50 AM
3	I found it moderately hard to find a midwife of my choice. I had a midwife in Auckland as I was living up there, and then I moved to Hamilton so had another lined up for the birth. I really liked both midwives in the end.	4/5/2017 2:32 AM
4	I had my second child approximately 2 years ago. Had the same midwife as I did with my first child. Very happy with the level of care I received from her. This was an IVF case and so I had to go to Hamilton for scans / appointments in the latter stages of my pregnancy - this was challenging with a toddler in tow as well. It basically meant a day off work for both my husband and I and a big day out for all the family for each scan I had - I think it was 3 or 4 in total plus the usual ones. And in the end I ended up having my baby at Waikato Hospital purely because I was there for a scan when I went into labour and I have very fast labours. It was a NVD and the care I received in Hamilton was great. Even though I would have liked to have given birth locally I was very relieved to not have to travel back to Taumarunui the day I gave birth and was thankful that the team at Waikato organised for me to be transferred to a local birthing centre post delivery. My post natal care from my LMC when we got back to Taumarunui was excellent as per with my first child.	3/28/2017 3:50 AM
5	I don't think that two midwives in an area like Taumarunui is adequate, not for the number of births and the support that many of these mothers need.	3/23/2017 1:01 PM
6	My experience ended up in a complaint with a head midwife in Hamilton as my after care, considering it was my first baby, was far from helpful.	3/22/2017 1:15 AM
7	Initially I was unsatisfied with my midwife. Towards the end of my pregnancy I changed to a midwife that meet my needs and respected what I wanted for my birth. Best decision I made. Her level of care was excellent.	3/19/2017 2:14 PM
8	I moved to Tokoroa at 25 weeks pregnant and found it very difficult to find a midwife. They were all booked up and I had to go with one from Hamilton and ended up birthing in Hamilton also. And my scans were either in rotorua or Hamilton which was hard to get there.	3/19/2017 12:22 PM
9	Antenatal care and deliveries conducted at this centre is suported and within easy access for woman in the area.	3/19/2017 2:42 AM
10	I live in Tokoroa and I'll be birthing in Rotorua. I find the facilities there easy to access, all in one place and information on them available from my midwife. From previous friends & family experiences in Tokoroa using Tokoroa maternity services, I am not confident this would be the same.	3/17/2017 12:14 AM
11	I was living in Perth and 16 weeks into my pregnancy my father passed away. I returned home and was home for a few. On the while I helped my mother sort out my fathers affairs. I contacted a midwife who did not hesitate to help me during my time here. I returned to Perth to then find that we were to move permanently to New Zealand. On my return I contacted the midwife I had previously seen and continued to see her through the rest of my pregnancy. Had a straight forward birth at Taumarunui hospital.	3/16/2017 12:06 PM
12	First time mum, the initial hospital visit was dreadful but our midwife was fantastic throughout the pregnancy and good afterwards.	3/15/2017 11:40 PM
13	I worked with midwives based in taumarunui as a student midwife 4 years ago. I loved that there is still an easily accessible maternity annex for remote rural women to access. It is just a shame that the unit is dated and just needs a bit of extra love in order to make it more comforting and enjoyable for these women to use. The staff are wonderful but the unit is just very old.	3/14/2017 11:54 PM
14	I wish I changed my carer.	3/14/2017 2:36 PM
15	Throughly loved my midwife was not over bearing but was very supportive. Have used same midwife with all 5 kids. Need to have scanning services here.	3/14/2017 2:15 PM
16	Karen is an amazing midwife	3/14/2017 2:11 PM

17	Professional, Needs met, Service beyond the call of Duty even in her own personal time,	3/14/2017 2:10 PM
18	My local midwife was great and I felt well supported. I had an emergency transfer to Waikato in late stages of labour which was very stressful and my midwife was very supportive. I found the fact that she had to hand over at Waikato stressful and didn't have a great birth or post natal experience there.	3/14/2017 2:08 PM
19	.ï	3/14/2017 1:31 PM
20	The midwife I had was very hands of and it's seemed like she expected me to know everything already yet it was my first pregnancy	3/14/2017 1:31 PM
21	I found such trouble trying to find an available midwife at 4months pregnant they all said unavailable and only one out of 10 gave me suggestions for who might be available. The rest weren't interested in helping me find someone who would have been available at the time.	3/14/2017 1:18 PM
22	Didn't feel comfortable birthing in Taumarunui due to limited hospital resources	3/14/2017 1:17 PM
23	Tried to have water birth but pool leaked badly.	3/14/2017 1:13 PM
24	Awesome experience with my midwife, she brought my daughter into this world with no issues.	3/14/2017 1:09 PM
25	My midwife was great but it was difficult to get scans as i had to travel out of town, there were no antenatal classes and having my baby in taumarunui was impossible as I needed a cecerian. I was also upset that she I was diagnosed with having gestational diabetes I had to travel to Hamilton regularly as there were no services in taumarunui that could deal with it!	3/14/2017 12:36 PM
26	My midwife was wonderful,very supportive	3/14/2017 12:25 PM
27	Karen walker was my midwife and done a excellent job but this was my second baby I do think it's important to have classes and scans available I also live half an hour out of Taumarunui but Karen still came to visit me every day ;)	3/14/2017 12:21 PM
28	Currently pregnant. Very approachable midwives but I feel the facilities need updating. That was my first thought and instantly thought that may be why my friends have left town to have their baby.	3/14/2017 12:11 PM
29	I have only been recieving maternity care in the last 10 months. I am 37 weeks pregnant at the moment and I am happy with her efficency so far.	3/14/2017 11:56 AM
30	In 2011 I birthed our third baby at Taumarunui hospital, I stayed there for just one night as I found it really noisy in the maternity ward. I had a home birth for our fourth child in 2016, which I found a lot more relaxing being in my own environment. My LMC is lovely and she looked after me well. I am lucky in that I have straight forward problem free pregnancies and births. And with our fourth I choose to only have the anatomy scan as travelling to Hamilton or Taupo was not possible for my 12 week scan.	3/14/2017 6:02 AM
31	I am currently pregnant with #3, and only 2 midwives in our community to pick from. I need to birth at waikato due to a previous c-section and neither of these midwives were suitable. One would not consider it and the other never returned my phone calls. I now have to travel 2 hours to Hamilton to see a midwife, have ultrasounds and blood tests.	3/14/2017 4:54 AM
32	Used the midwife sevice gave birth at waikato due to c section	3/14/2017 1:28 AM
33	I've had current midwife with 2 of my other children while being in NZ, absolutely would hate to have anyone else. Extremely happy with her. Supportive, listens, encouraging over all the best.	3/7/2017 11:55 PM
34	midwife as locum	3/7/2017 8:10 AM
35	I always had to go out of town for most of the things related to my pregnancy and birth	3/7/2017 1:29 AM
36	Lack of choice in Specialist services No consistency in perinatal specialist Lack of follow up process Not culturally appropriate Distance to services a barrier Distance to specialist services a barrier Access to culturally appropriate services a barrier	3/6/2017 3:30 AM

Q16 Do you have any other comments?

Answered: 23 Skipped: 38

#	Responses	Date
1	Whilst I see the intent to take steps to improve maternity services in South Waikato, I feel the solutions are too simplistic. It doesn't make sense to close Te Kuiti unit - it would be better to enhance it, as Tokoroa and Taumaranui also need. I have serious concerns about the presumption that LMC's will flock to cover the midwifery gaps already apparent in the community, in a time of crisis in midwifery numbers overall; when many midwives are already giving up practice because of the unsustainability of the system and payments. I see it most unlikely for midwives to be attracted to these areas in sufficient numbers without major thought being given to incentives and retention strategies, and ongoing sustainability supports. There is some merit in the idea of hubs, but much more thought needs to be given to the midwifery component of these.	4/18/2017 4:14 PM
2	Not enough focus on anti natal services such as teaching a baby to sleep, feeding etc. The focus is more on the birth and that shouldn't form the largest percentage of what is taught to expecting mothers (especially first time mothers).	4/5/2017 2:32 AM
3	midwife often missed things and I ended up seeing 6 midwives during my pregnancy so no continuity As a first time mum I expected to have more explained to me and I had to find antenatal classes myself as the midwife had no clue. Never referred to plunket, had to contact them myself at 6 weeks postpartum	3/19/2017 6:34 PM
4	I think we couldve promoted our services to the community better. Mature management in the past has issued the culture of complacentcy. I feel something as simple as adequate signage to assist with the location of the centre/hosp may have made a difference.	3/19/2017 2:42 AM
5	I feel the professionalism of the current local LMC's and the caseload midwives is not great. I have inside knowledge that LMC's are rarely on site for the birth of their patients birth leaving it to the RNs of the hospital. Communication from the patients to the midwives is not clear, often the patient left feeling excluded from their pregnancy. I feel a shake up within the department is what's needed. I'm sure the midwives are very caperble but seem to have lost their passion for the job, which is reflecting on the patients.	3/17/2017 12:14 AM
6	I commented at the public meeting about the lack of midwives. As much as I found my midwife amazing during my pregnancy and my birth I felt my aftercare was quite lacking due to her being busy with other c,ie ts, birthing babies and purely catching up on sleep from delivering babies. Even on the day I gave birth she had just delivered a baby and was surviving on a few hours sleep that she had gotten between my birth and the previous girls. As my baby that was delivered here was my second pregnancy I was not that fazed about the lack of support after delivering my baby however if I was a first time mum I would have found this very off putting and quite isolating. With birthing in both Perth with my first pregnancy and in New Zealand with my second it is not hard to compare the level of treatment of both. Yes I do understand that Perth would have more midwives to deal with the demand of pregnancies being a bigger centre but the way they work is also better. The hospital I birthed at had. Idwives that purely dealt with after care. They came out for 5 consecutive days and then handed you on to the child health nurse after that (australias version of plunket). These midwives were all trained lactation consultants as well so helped with any concerns one would have with feeding. I have noticed that with being a rural area that there is a lack of contact between new mums. With the introduction of antenatal classes this would allow for those classes to link up after birth to form a coffee group. As I new to the area (even though I grew up here) I would love to have a group of girls I can communicate with who have children around the same age of me. One thing I picked up on at the meeting too was within the statistics it was stated that we have a high rate of obesity and gestational diabetes in this area. I know that people have choices and a lot of women choose to do what they want but if there was a way of getting these obese woman more support with healthier eating options, exercise etc then they then have the choice to either accept this information or ignore it. Even working with a fitness professional to do weekly workout sessions for those who are pregnant as well as post pregnancy.	3/16/2017 12:06 PM
7	Please make our services regarding pregnancy, birthing natural and c-section more accommodating for all who need it.	3/14/2017 2:10 PM
8	It is stressful to have to go to Waikato to give birth as the facilities make it very difficult to have whanau support. This is really difficult when a mum has other children as well.	3/14/2017 2:08 PM
9	I really don't like that in order to access the maternity ward at Taumarunui hospital one must pass through E.D. It needs to be separate so that pregnant women aren't having to be exported to all the sick people.	3/14/2017 1:31 PM
10	I have lived in Taumarunui for 27 years, was involved with the service for my youngest and also with three of my grand children. From my position, we need the ability to have scans in Taumarunui as this would avoid travel, greater access to specialist. More midwives are a must, we certainly do not have enough people. I believe that if our services are improved we would increase that amount of births in Taumarunui.	3/14/2017 1:14 PM

11	We need more services available in Taumarunui as traveling is very difficult with cost, time off work for me and my partner as he wanted to be involved but couldn't make it to all the appointments! Please help us to get more care here	3/14/2017 12:36 PM
12	I think maternity services and all the others that go with it are essential and need to be supported and kept local	3/14/2017 12:25 PM
13	We need resources here that can be easily accessed. I know many low socio economic ladies that can't afford to travel for a scan etc. we have amazing midwives. Let's give them the best facilities to help us pregnant women out!! Might also mean a lot more people would deliver here then	3/14/2017 12:11 PM
14	I feel if their was some money given from the DHB as well as a someone to drive a community led project their could be an easy fix to employing someone to act as a facilitator above a midwife, provide antenatal classes and postnatal support. Kokirit trust and whanau ora are doing it already to a certain point but Im thinking a place where everyone can attend and not feel like its just for someone who has highneeds. I believe all Mums in remote areas are highneeds!	3/14/2017 11:56 AM
15	We needs to give women in small rural areas more options and support, not take it away. This puts so much pressure on a mum during a very vulnerable time. Having to travel out of your area to access maternity care and have your baby is not providing care at all.	3/14/2017 4:54 AM
16	consultation not advertised enough for the public awareness. The consultants service should be recommenced . Ante=natal services at Waikato are a distaster so much so I transferred my woman to Rotorua Maternity service where she received exceptional care. The hub might be better called something else. A hub suggests all the services required are available there. Need a new purpose built facility which is user friendly.Hospital restrictions around this need to be more relaxed for the facility if it is used by midwives and woman. The facilitator for this must be woman and baby focused, modern thinking and a support to LMCs. Should be a midwife who knows her stuff. The model will only work if everyone buys into the model rather than having it forced on us [especially the midwives who it seems no one has ever seemed to care about their health and well being.	3/13/2017 11:40 PM
17	The questions you are asking are focusing on the answers being towards the DHB proposal and no other options. .ie: Specialist services only being accessed by 'telehealth', which the dhb could give more options to choose from such as specialist in-person appointments or providing a scanning service especially in the areas where services are going to be cut such as Te Kuiti. Taumarunui women find it especially hard to travel to either Taupo or Te Awamutu/Hamilton for these referrals when many are socially, economically and physically at risk. Why doesn't the DHB fund a locum service for the 2 lmc midwives in Taumarunui to enable both to support the community. Upgrading their maternity to the standard of Te Awamutu would encourage more women to birth there from surrounding areas and help the community which has so many services taken, feel valued	3/13/2017 11:15 PM
18	I am an EN who works closely with women postnatal and as I have had a lot of feedback from these women regarding their care from conception to after birth I feel the need to note some of their concerns: 1: When birthing after hours currently it is the on-call midwife who delivers her as their own Lmc is 1-2hrs away from Tokoroa and they don't feel the continuity of care is there. 2: The facilities are "Rugged" "Overheated" "Underwhelmed" and not a very good stay. I realize a lot of it is to do with the budget and shortage of midwives, however I feel if they stick with this model I think if they take out the Core Midwife position and put 3-4 Caseload Midwives in there it would seem more sellable to the public, as a Core Midwife will not be delivering babies who's mothers just walk in off the street with no pre-natal care?	3/13/2017 4:44 AM
19	I personally think the proposed hub is a stupid idea, as that can lead to deaths from mother and/or child when there is no midwife there. The whole point in midwifes is to get the correct care and support and correct information and are there when you need them. Not having to wait around for maybe hours to see someone.	3/8/2017 1:14 AM
20	feel LMC midwives would really need to be enticed to live in area to make this work. Alongside this these LMC midwives would need to have frequent and open communication with other LMC's in Hamilton/Rotorua to easy the burden of travel times either side of labours/births and postnatal care, as Woman will definitely wish to birth in the city birthing units and Te Awamutu. It is the travel that makes LMC work in the outlying area's more difficult so this proposal would work with incentives to have Hamilton midwives do some of the Labours' and Births... then where is the continuity of care. Since working in Tokoroa I have noticed that this area has a large number of woman simply walk in to the maternity facility on any day of the year for booking visits and care. I have been there on Sunday's on boxing day and boxing day. They have little concept of days and also often no money for cell phone contact.	3/7/2017 8:10 AM
21	To get the message out contact NZEI/PPTA and their memebers to participate.	3/7/2017 1:39 AM
22	The proposed model-should be incorporated within the already used birthing unit. Upgrading the birthing facilities and having nurses who are specifically trained to provide the coordination care/and or maternity postnatal care to the mother/baby and extended whanau.	3/6/2017 7:26 AM

23	Bring the services closer to the community you serve Bring the services closer to the population you service Make sure that the services you are offering are a radical improvement that leads to eliminating health inequities for Maori and those in rural communities Train your workforce (including Specialists and LMCs) to be culturally appropriate Remove the barriers so our wahine and pepe are able to access the services they need Let the Maori community have a voice to be heard Channel more resources into high quality Maori health provider services - if you want to really want a radical improvement in Maori health outcomes channel more money and resources into culturally appropriate services The proposed model will not work if your goal is to not provide equitable money and resources into Maori health provider services to deliver. It will fail miserably like all the other proposed models you have come up with. You need to put your money and resources where your mouth is. That is, in the community pre and post natal services delivering in a culturally appropriate way for Maori. re	3/6/2017 3:30 AM

Waikato District Health Board

Waikato DHB Position Statements and Policies

Waikato District Health Board

Presentations

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 9.1

A CONSUMER COUNCIL FOR WAIKATO DHB

Purpose	For consideration and approval.

Ms Wendy Entwistle (Team Leader - Consumer Engagement, Quality and Patient Safety) will present to the Board at 3pm on establishing a Consumer Council for Waikato DHB, specifically:

- To inform the Board on progress to date of establishing a Consumer Council for Waikato DHB.
- To propose a draft Terms of Reference and Expression of Interest process, providing clarity as to the proposed purpose, function and membership of a Consumer Council.
- To promote discussion and seek support for establishing the initiative.

The presentation and supporting documents are included in the May Board agenda.

Recommendation
THAT
The report be received.

MO NEVILLE
DIRECTOR, QUALITY AND PATIENT SAFETY

A Consumer Council for Waikato DHB

Healthy People Excellent Care

WAIKATO DISTRICT HEALTH BOARD STRATEGY

Purpose and functions

Works in partnership with the Board, the CEO and senior management to help ensure services are people centred and responsive to the needs of consumers and communities

Provides advice:

- on the direction and strategic priorities of the DHB **from a consumer perspective**

- at an operational level on service design and delivery **from a consumer perspective**

Refer to Draft Terms of Reference document

Purpose and functions

Over-arching role to promote and oversee consumer involvement in the planning and delivery of services. In doing so, it supports achievement of the strategic imperatives

Purpose, functions and scope

Supports improved consumer engagement, consumer experience, patient safety, health literacy and clinical quality

Facilitates clear pathways for the DHB to engage with consumers for the purpose of service design and delivery. Sign-posting to consumer networks

Ensures the DHB remains focused on the delivery of people-centred care

Provides assurance that consumers are involved in service planning and improvement

Scope

Encompass all services the Waikato DHB provides, including PHOs.

So what might a Consumer Council do?

- Develop guidelines for DHB staff on engaging with consumers in service improvement projects.
- Promote experience based co-design
- Review and provide input into Annual Quality Account, e.g. provide advice on priorities **from a consumer perspective**
- Review and provide advice on strategy implementation: People centred care and health equity for high needs populations
- Review and provide input into key planning documents
- Review and advise on proposals for large-scale service re-design or development **from a consumer perspective**
- Promote improved health literacy, e.g. oversee the setting up a Patient Information Group

The Consumer Council is not the only vehicle for seeking consumer advice and input

So what might a Consumer Council do?

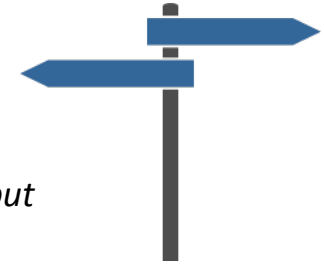
At an operational level:

Review requests from staff for advice on proposals for service redesign or improvement projects, provide advice on appropriate engagement mechanisms and signpost to consumers, groups, communities who should be involved

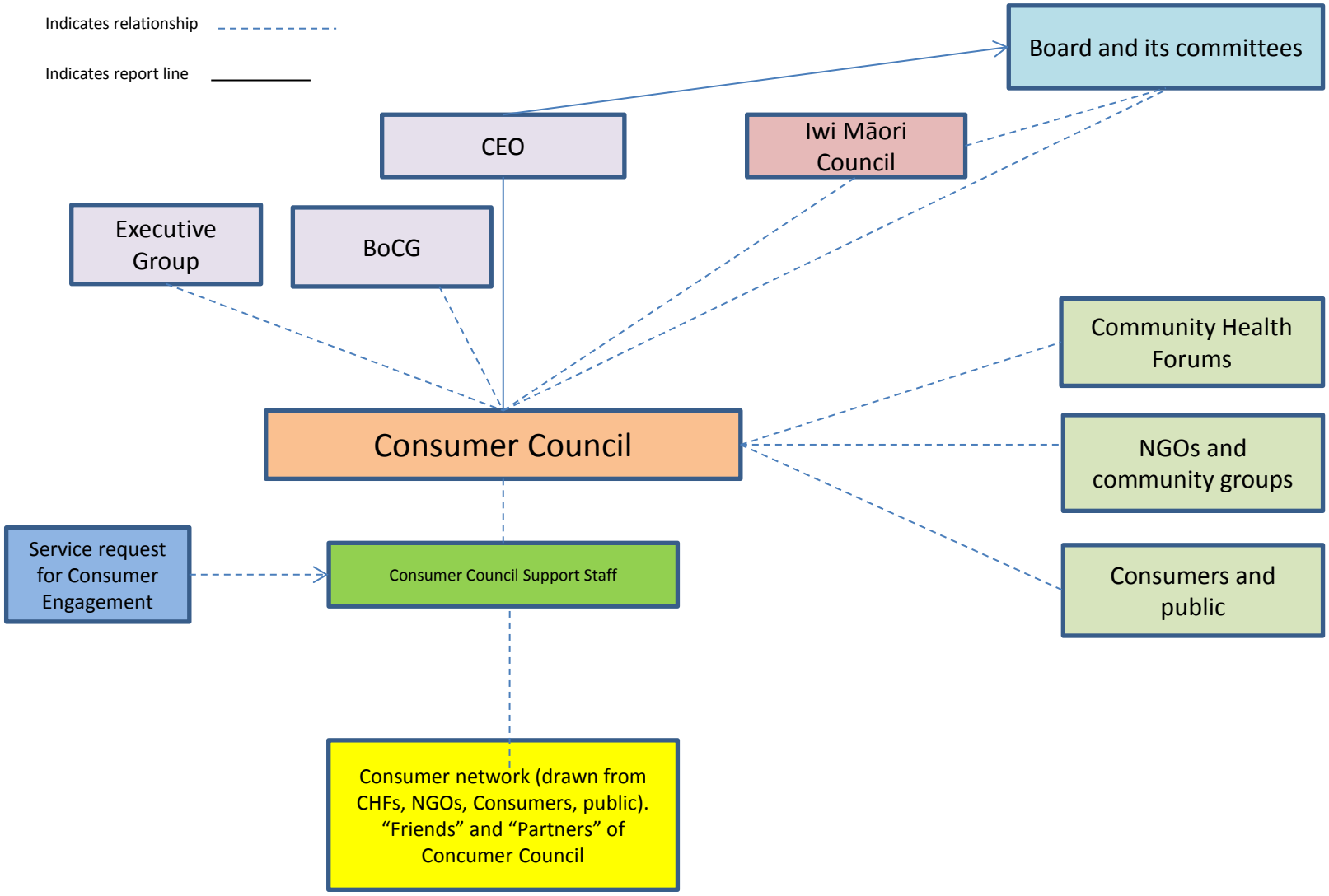
Review requests from staff for consumer involvement in specific improvement projects. Depending on the project Consumer Council may become involved, but more likely will signpost to consumers, groups, communities who should become involved

Provide advice on how to involve consumers in service redesign or improvement projects and whom to approach

The Consumer Council is not the only vehicle for seeking consumer advice and input



Consumer Council – key relationships



We already have Community Health Forums – why do we need a Consumer Council?

The Consumer Council will not replace the Community Health Forums (CHFs). The two have distinct functions

The CHFs are encouraged to take an interest in the work of the Consumer Council. Conversely, the Consumer Council will be encouraged to forge relationships with the CHFs and their networks. This will be important in terms of promoting consumer involvement

The Consumer Council will produce meeting minutes and regular newsletters. These will be available to the CHFs

Consumer Council

1 Consumer Council for Waikato district

Fixed number of appointed members (14 + chair)

Membership by appointment

Chairperson appointed

Members are paid

Provides advice and expertise to CEO, Board and senior management at:
Provides advice:

- on the direction and strategic priorities of the DHB **from a consumer perspective**
- at an operational level on service design and delivery **from a consumer perspective**

Provides assurance that consumers are involved in service planning and improvement

Reports to CEO and Board via CEO

Works to established priorities and work plan

Mixed membership model to fulfil inclusivity obligations (members from geographical localities and members with specific health interest areas)

11 meetings per year

Responsive

Holds no budget

Community Health Forums

7 Community Health Forums in Waikato district

Open public access – no fixed membership

Appointed local chair

Mechanism for

- Feedback from community to DHB
- Information from DHB to community
- "Early warning" of significant issues affecting communities in respect of healthcare
- Trends to be identified and shared
- Requests for information
- Testing ground for new ideas
- Disseminate information on behalf of DHB
- Support DHB, e.g. letters from group of CHF chairs

Report on information and feedback from CHFs provided to Board via Executive Director Strategy & Funding 3 x per year

Individuals' perspectives and concerns heard

Advocacy function

Driven by needs and activities of the moment

3 meetings per year

Reactive

Holds no budget

Who will the members be?

- Members or those close to them will:
  - have recently accessed health services (ideally within the previous 2-3 years) and/or
  - be actively engaged in a specific area of health interest

- Members should have diverse backgrounds, knowledge, skills and networks. All will be committed to ensuring that consumers are able to access the best possible services and care from Waikato DHB

- Although appointed to reflect the consumer voice in a particular area of health interest, members will not be regarded as representatives of any specific organisation or community

Who will the members be?

Membership must broadly reflect the demographics of the population and support the strategic imperative of achieving health equity for high-needs populations (i.e. Māori, people in rural communities and people living with disabilities).

To ensure diversity we propose a mixed approach to membership, which will include as a minimum*:

- One member from each of the 6 rural Community Health Forum areas
- 3 Māori members
- 1 Pasifika member
- 1 member disability
- 1 member Mental Health and addictions
- 1 member to be 'youth'
- 1 member to be an older person
- 1 member to be a family member/loved one/carer
- Male and female members

If the Consumer Council struggled to recruit to any of the above, then a space will be held open until a suitable member can be appointed.

We will also seek to ensure a range of ethnicities, including Pakeha are members of the Consumer Council, and we would like to see transgender participation in a Consumer Council.

**1 member could fulfil more than one of these guaranteed spaces.*

What skills and experience will members have?

- Experience of using health services, either directly, or via family or whānau
- Knowledge of the New Zealand health and disability sector with an appreciation of its complexities and inherent tensions
- Maturity and reliability
- Sound analytical skills
- Ability to use personal experience constructively and to see beyond own experience
- Ability to think creatively and strategically
- Effective listening and communication skills with diverse groups
- Confidence to interact positively with health professionals and managers
- A genuine commitment to helping improve the quality and safety of our health services
- Ability to earn trust and maintain confidential information

(There will be clear role descriptions and a Code of Conduct for Members)

How will members be recruited?

- Chair to be appointed first, then members
- Well-advertised Expression of Interest (EOI) process
  - role description
  - expression of interest form
- Small recruitment panel
- Robust processes for selection
  - matrix for mix of members to ensure diversity
  - shortlist
  - informal interviews
  - facility for localities to manage their process and make recommendation to recruitment panel for member from their locality area
- Appointment by CEO

Orientation, training and support for members

Comprehensive orientation will be provided. (draft schedule currently being drawn up)

Training will be provided for members, tailored to their requirements. It is likely to include:

- experience based co-design
- skills for being an effective consumer member/representative

Administrative/secretarial support for Consumer Council must be available

Support for running the Consumer Council must be available. This will likely be a part-time role with duties including:

- orientation and training
- communication and networking (see next slide)
- agenda setting
- carrying out agreed tasks arising from the work, e.g. supporting DHB services to access consumers for their projects

Members will be remunerated and travel expenses offered

Involvement of and communication with consumers, consumer groups, communities

Parties interested in the Consumer Council might include:

- Individual health consumers
- Members of the public
- Individual community members
- NGOs
- Community Groups
- Community Health Forums

Individuals and groups may be part of one or a number of other forums or networks, e.g. Community Health Forums, community Houses, Age Concern

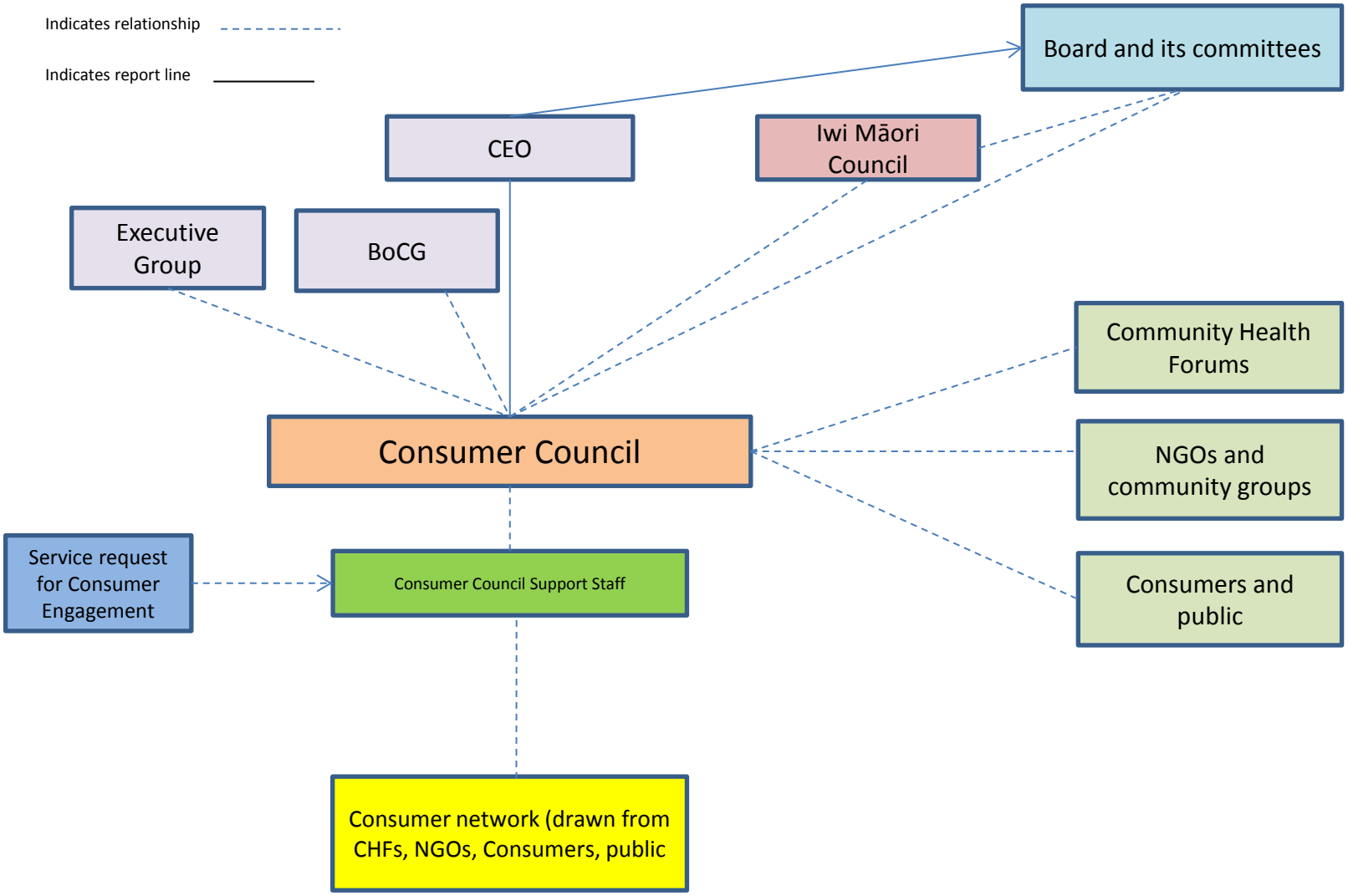
We are proposing to facilitate a network of interested individuals. Individuals and groups could sign up to the network and choose from two types of involvement:

1. *Friend of Waikato DHB Consumer Council*
2. *Partner of Waikato DHB Consumer Council*

Friends would receive all communications regarding the work of the Consumer Council and the Consumer Engagement Team, and would be willing to receive requests to take part in occasional surveys, invited to focus groups etc. in areas of specific interest to them

Partners would receive all communications as for the Friends, but in addition would be willing to be approached to be more directly involved in specific improvement projects appropriate to their interest area

Consumer Council – key relationships



Proposed timeframe for implementation

EOI process	July
Recruitment of Chair	August
Recruitment of Members	September
First meeting	October/November

What’s in a name?

- Consumer Council?
- Consumer Advisory Group?
- Other suggestions?

How will we know the Consumer Council has added value?

Review after 2 years

Possible measures / success factors:

- Increased involvement of consumers in service planning and development
- Achievement of Consumer Council priorities

Waikato District Health Board Consumer Council - Terms of Reference

Purpose and Scope

The Consumer Council works in partnership with the Waikato District Health Board (Waikato DHB), the Chief Executive Officer (CEO) and senior management to ensure the planning and delivery of health services is people centred responsive to the needs of consumers and communities.

It works with the Board and senior management to provide advice:

- on the direction and strategic priorities of the DHB from a consumer perspective
- at an operational level on service design and delivery from a consumer perspective

The Consumer Council has an over-arching role to promote and oversee consumer involvement in the planning and delivery of Waikato DHB services. In doing so, it supports the achievement of the Waikato DHBs strategic imperatives, specifically:

- Health equity for high-needs populations
- Safe, quality health services for all
- People-centred services
- Effective and efficient care and services
- A centre of excellence in learning, training, research and innovation
- Productive partnerships

It supports improved consumer engagement, consumer experience, patient safety, health literacy and clinical quality.

The Consumer Council will provide assurance to senior management and the Board that Waikato DHB is ensuring that consumers are involved in service planning and delivery.

The Consumer Council encompass all services the Waikato DHB provides. It also includes the PHOs.

Functions

The Consumer Council will:

- Provide advice on key strategic documents and plans.
- Promote consumer engagement across the Waikato DHB and ensure the organisation remains focused on the delivery of people-centred care
- Facilitate clear pathways for DHB services to engage with consumers for the purpose of service design and delivery by sign-posting to appropriate consumer networks/groups for engagement
- Advise on approaches and mechanisms for engaging consumers
- Advise on people centred care approaches to service design and delivery
- Identify opportunities where consumers should become involved in specific improvement projects
- Ensure regular communication and networking with consumer groups, communities and consumers about the work of the Consumer Council
- Maintain an overview of consumer engagement activity across the Waikato district.

The Consumer Council will not:

- Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust processes exist.
- Be involved in Waikato DHB contracting processes
- Provide clinical evaluation of health services

Responsible to

The Consumer Council will be responsible to and report to the Chief Executive Officer. It will report to the Board through the CEO.

Membership

There will be 14 members on the Consumer Council, plus a Chairperson.

Members will have diverse backgrounds, knowledge, skills and contacts. All will be committed to ensuring that consumers are able to access the best possible services and care from Waikato DHB.

Members or those close to them will:

- have recently accessed health services (ideally within the previous 2-3 years) and/or
- be actively engaged in a specific area of health interest

Although appointed to reflect the consumer voice in a particular area of health interest, members will not be regarded as representatives of any specific organisation or community.

Membership must broadly reflect the demographics of the population and support the strategic imperative of achieving health equity for high-needs populations (i.e. Māori, people in rural communities and people living with disabilities).

To ensure diversity there will be a mixed approach to membership, which will include as a minimum*:

One member from each of the 6 rural Community Health Forum areas
3 Māori members
1 Pasifika member
1 member disability
1 member Mental Health and addictions
1 member to be 'youth'
1 member to be an older person
1 member to be a family member/loved one/carer
Male and female (and if possible transgender) members

If the Consumer Council is unable to recruit to any of the above, then a space will be held open until a suitable member can be appointed.

**1 member could fulfil more than one of these guaranteed spaces.*

The Consumer Council will seek to ensure a range of ethnicities, including Pakeha are members of the consumer Council.

Initially half of the members will be appointed for a one-year term, and the remaining half for two years, with all further appointments being for terms of three years. Members may be re-appointed, but for no more than two additional terms.

If members fail to attend three meetings in a row without an apology, they will be asked by the Chair to step down as a Consumer Council member.

Consumer Council Members will be appointed by the CEO or their delegate.

Consumer Council members will be recruited via an open Expression of Interest process. [See Recruitment and Selection documents].

Chairperson

The Chairperson of the Consumer Council will be appointed by the CEO. The initial term will be for one year, with further terms being for three years. The Chair may be re-appointed, but for no more than two additional terms.

The Chairperson will be recruited via an open Expression of Interest process.

Quorum

A quorum will be half of the membership plus one.

Meetings

Meetings will be held monthly, excluding January or more frequently at the request of the Chair. Meetings will generally be open to the public however, on occasion where there are issues of confidentiality or other risks, meetings may be closed in full or part.

DHB staff members are encouraged and welcomed to be 'in attendance'.

Meetings will be scheduled to ensure that members who work are able to attend.

Video-conferencing facilities will be made available where possible to support virtual participation for people living in rural areas.

Reporting

The Consumer Council will provide a regular report to a range of internal and external stakeholders, including:

- CEO
- The Board
- Board of Clinical Governance
- Executive Group
- Iwi Māori Council
- Community Health Forums

A regular report of Consumer Council activities will be placed on Waikato DHB websites once approved by the Chair.

Key relationships

The Consumer Council will maintain relationships with the following, as illustrated in the Key Relationships Diagram:

- CEO
- Board and its committees
- Iwi Māori Council
- Board of Clinical Governance
- Executive Group
- DHB Services
- Consumer and groups
- Community Health Forums
- NGOs
- Interested individuals
- The public

Agendas and Minutes

Agendas and minutes will be circulated to all members and the Chair of the Consumer Council within one week of the meeting taking place. Minutes of those parts of any meeting held in 'public' shall be made available to any member of the public, consumer group, community etc., on request.

Remuneration

Consumer Council members will be remunerated at a fixed rate for Consumer Council meeting attendance. This will be at a rate of $250 per Consumer Council meeting (to align with rates for meeting attendance for Board and Iwi Māori Council). Mileage expenses will also be paid.

Consumer Council members who attend within their work capacity and time and with the support of their employer shall not be remunerated.

Orientation, training and support for Consumer Council Members

Council members will be provided with orientation and support to undertake their role.

A Consumer Council for Waikato District Health Board (Waikato DHB)

Invitation to Express Interest

Background

Waikato DHB is seeking Expressions of Interest from people to become a member of a new Consumer Council for the DHB. Members will live in the Waikato district and be passionate about consumers being able to access the best possible service and care from Waikato DHB.

The Consumer Council will work in partnership with Waikato DHB to ensure that planning and delivery of health services is people-centred and responsive to the needs of consumers and communities.

The Consumer Council will work with the Board and senior management to provide advice:

- On the direction and strategic priorities of the DHB from a consumer perspective, and
- at an operational level on service design and delivery from a consumer perspective (this will involve sign-posting to relevant stakeholders and groups who can add value to specific improvement projects of the DHB)

The Consumer Council will have an over-arching role to promote and oversee consumer involvement in the planning and delivery of Waikato DHB services. In doing so, it will support the achievement of the Waikato DHBs strategic imperatives:

- Health equity for high-needs populations
- Safe, quality health services for all
- People-centred services
- Effective and efficient care and services
- A centre of excellence in learning, training, research and innovation
- Productive partnerships

It will support improved consumer engagement, consumer experience, patient safety, health literacy and clinical quality.

The Consumer Council will provide assurance to senior management and the Board that Waikato DHB is ensuring that consumers are involved in service planning and delivery.

The Consumer Council encompasses all services the Waikato DHB provides. It also includes the PHOs. It will report to the CEO and the Board, via the CEO.

Who we are looking for

The Consumer Council will have 14 members, plus a Chairperson. We are looking for members and a Chairperson with diverse knowledge, skills, qualities and networks/contacts to reflect our diverse population.

Members (including the Chairperson) or those close to them will:

- have recently accessed health services (ideally within the previous 2-3 years) and/or
- be actively engaged in a specific area of health interest

Although appointed to reflect the consumer voice in a particular area of health interest, members will not be regarded as representatives of any specific organisation or community.

To ensure diversity there will be a mixed approach to membership, which will include:

- 1 member from each of six rural communities as defined by the Waikato DHB Community Health Forum catchments. These include Ruapehu, South Waikato, Waitomo/Otorohanga, North Waikato, Matamata/Piako, Thames/Coromandel)
- 3 Māori members
- 1 Pasifika member
- 1 member for disability
- 1 member for Mental Health
- 1 member to be 'youth'
- 1 member to be an older person
- 1 member to be a family member/loved one/carer
- Male and female (and if possible transgender) members

Please note, one member could fulfil more than one of these spaces.

Members will be appointed to reflect a range of interest areas. These might include:

- Māori health
- Rural health
- Sensory and physical disability
- Women's health
- Child health
- Older Persons health
- Chronic conditions
- Mental health
- Alcohol & other drugs
- Intellectual and neurological disability
- Pacific health
- Youth
- Wellness

Qualities, skills and experience required

Members of the Consumer Council will possess the following key qualities and skills:

- Maturity and reliability
- Experience of using health services, either directly, or via family or whanau
- Ability to use personal experience constructively and to see beyond own experience.
- Knowledge of the New Zealand health and disability sector with an appreciation of its complexity and the tensions implicit in this
- Effective listening and communication skills with diverse groups, including Senior Managers, DHB staff and consumers
- Sound analytical skills
- Ability to think creatively and strategically
- Ability to read reports
- Ability and willingness to work constructively in a group in fulfilling the functions of the Consumer Council
- Confidence to interact positively with health professionals and managers
- A genuine commitment to helping improve the quality and safety of our health services
- Ability to earn trust and maintain confidential information

In addition to the above, the Chairperson will possess the following key qualities and skills:

- Ability to provide inclusive leadership
- Ability to ensure Consumer Council members fulfil their duties and responsibilities
- Ability to provide clear strategic direction by ensuring the development of strategic and annual planning, priority setting and review
- Effective conflict resolution skills

- Ability to chair meetings effectively and efficiently, bringing impartiality and objectivity to discussion
- Ability to ensure discussion and decision making is always underpinned by the drive to ensure the best possible services for consumers
- Ability to foster, maintain and ensure constructive relationships with and between Consumer Council members and with the Chief Executive and senior staff

Role descriptions for members and the Chairperson are available.

How members will be selected

All potential members including people who wish to be considered for the position of Chairperson must complete and Expression of Interest (EOI). All EOIs will be considered by a panel consisting of DHB staff and consumers.

A Chairperson for the Consumer Council will be appointed first of all. Following the appointment of the Chairperson members will be appointed.

Expression of Interest forms are included with this document. They can also be completed online via the Waikato DHB website.

Completed forms should be returned by the dates indicated below (see Key Dates section).

Consumer Council members will be selected on the basis of their qualities, skills and experiences as outlined in their EOI using defined criteria and to ensure diversity amongst members again using defined criteria. Interviews will be arranged at the discretion of the panel. The selection panel will make recommendations to the CEO for appointment to the Consumer Council.

Expressions of Interest from people living in a locality which is managing selection of the member designated from their area will be considered by both the local panel and by the overarching panel. This is to ensure that where an EOI from that locality is not selected by that local panel that they are not excluded from being considered for membership on the basis of other skills, qualities and experiences.

Key dates

EOI process opens	TBC
EOI closing date	TBC
Interviews for Chairperson of Consumer Council	TBC
Successful and unsuccessful candidates notified	TBC
Chair appointed	TBC
Interviews for Consumer Council Members	TBC
Successful and unsuccessful candidates notified	TBC
Members appointed	TBC
First meeting of the Consumer Council	TBC

Expression of Interest for membership of a Consumer Council for Waikato DHB

Personal information			
First name			
Last name			
Preferred name			
Ethnicity, including iwi affiliation if applicable			
Address			
Telephone	Home	Work	Mobile
Email address			

Which positions do you wish to be considered for? (tick all that apply)	
Chairperson	
Member	

Why are you interested in being on the Consumer Council? Tell us about the qualities, skills and experiences you consider relevant, including your health consumer experience

Do you have any previous committee experience? Please tell us about this

Which areas of health are you particularly interested in?

Are you involved in any consumer and/or community groups or projects? Please tell us about this

Are you currently in paid work? If Yes, please tell us about this

Tell us about your work experience. Please provide details of up to five jobs you have held part-time or full-time, including self-employment. For “sector type” use one of the following categories: Government, Business or Community

Name of organisation and sector type	Year started and finished	Nature of experience

Relevant qualifications and awards Please tell us of any relevant professional/trade qualifications, awards or any other experience you believe is relevant to this role		
Qualification / Award	Year achieved	Institution or organisation conferring qualification or award

Referees Please give details of TWO referees relevant to this role and whom you authorise us to contact	
Name	Name
Role Organisation	Role Organisation
Contact details (Phone and email)	Contact details (Phone and email)

Declaration
Have you ever been convicted of a criminal offence? Note: All successful candidates will be required to undergo New Zealand Police clearance. This clearance is subject to the Criminal Records (Clean Slate) Act 2004 and may be subject to the exception contained in section 19(3)(e) of the Criminal Records (Clean Slate) Act 2004. For more information on the exception contained in section 19(3)(e) of the Criminal Records (Clean Slate) Act 2004 please visit www.legislation.govt.nz
I (please write your full name) declare that to the best of my knowledge, my answers to the questions in this form are correct.

Please send completed forms to Wendy Entwistle, Quality & Patient Safety, Waikato DHB, Private Bag 3200, Waikato Mail Centre, Hamilton 3240, or email them to wendy.entwistle@waikatodhb.health.nz. Alternatively, please complete the online form via the Waikato DHB website.

Completed forms must be received by DATE TO BE CONFIRMED

Waikato District Health Board

Papers for Information

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 10.1

MENTAL HEALTH & ADDICTIONS SERVICE S99 (MENTAL HEALTH (CAT) ACT 1992) INSPECTION REPORT ACTION PLAN

Purpose	For information.

An update on progress on the recommendations in the S99 (Mental Health Act) Inspection Report Action Plan is submitted for the Board's information.

Recommendation
THAT:
The report be received.

DEREK WRIGHT
EXECUTIVE DIRECTOR, MENTAL HEALTH AND ADDICTIONS SERVICE

WAIKATO DHB MENTAL HEALTH & ADDICTIONS SERVICE

S99 (Mental Health Act) Inspection Report Action Plan

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

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

			anticipated due to the requirement for ongoing union discussion and the national issues relating to rosters.
Improved staff recruitment and retention	July 2016	Complete	A specific Mental Health and Addictions Service recruitment and retention strategy has been developed and implemented across the service.
Particular areas/teams of concern to be identified and strategies developed to attract and retain staff to those areas	July 2016	Complete	This issue has been partially addressed with the implementation of the strategy noted above. In addition, specific areas such as the challenges facing inpatient psychiatrists, have been identified as requiring specific focus.
Capacity within PVS (Price Volume Schedule) to consider deployment of staff to respond to demand	July 2016	Complete	Planning and Funding have agreed to increase inpatient pricing to national pricing. There is also agreement around increased ability to offset between services within the Price Volume Schedule (PVS) to best meet demand .
Recommendation 4: *Because of the magnitude of the change agenda, the MHAS needs strong engagement and support from the wider DHB at all levels.*			
Needs Assessment and Service Reconfiguration review	July 2017	Partially complete	The first draft of the needs analysis has been prepared for discussion. Further stakeholder review/forums will occur prior to finalisation over the next few months.
Development of the business case for the new build.	July 2017	Incomplete	The Draft Model of Care for Adult Acute has been developed and the Investment Logic Mapping Exercise has been

			undertaken. The Stakeholder Working Group, that includes DHB staff, consumers, family, NGO staff & Primary Care will reconvene and review the draft Model of Care The Business Case is in development and we are working closely with the MOH & Treasury. Good progress is being made
Increased change management capacity for implementation of ICP project	July 2016	Complete	Review of the ICP project and the need for further planned change has resulted in the addition of specific project resource, in addition to a planned programme of change (Creating Our Futures), which will see significant change delivered over the next 5 years.
Recommendation 5: *The strategic direction is one of system change in the district; therefore, a systems-wide change process is needed that includes the MHAS, its strategic NGO partners, primary care services, iwi, consumers and family/whānau.*			
Mental Health and Addictions Service Needs Assessment Review of the Waikato Region 2016 - 2026			See update at Recommendation 4
Strategic Plan For MHAS Service Delivery 2016 – 2020	August 2016	Complete	
Recommendation 6: *Integrated clinical and operational governance that includes planning and funding is necessary across this continuum.*			
Development of an operational governance structure across all elements of the MHA sector with clear reporting through to the CEO and Board.	August 2016	Partially complete	A steering group for the overall programme of work has been developed which includes representation from the DHBs mental health and addiction services along with NGOs from the

			sector, consumer representative and Strategy and funding. In addition to the steering group membership has been confirmed for the first two working groups (Adult Mental health and Adult addictions) and an advisory group with broader sector and cross sector representation should be finalised over the next month Approaches to clinical governance across the mental health sector will be considered as part of this overall programme of work
Recommendation 7: *The service should report progress to the DHB Board and the Director of Mental Health.*			
	May 2016 July 2016 Sept 2016 Nov 2016	Complete and ongoing.	
Recommendation 8: *The current direction of travel is appropriate and necessary. The agenda for transformational change cannot be discarded. However, to give effect to change of this magnitude, the following are required:* *a. There needs to be appropriate shared leadership, supported by a change team with experience in embedding transformational change.* *b. There needs to be adequate resourcing for the change (including fiscal resources and staffing resources).* *c. There needs to be support for embedding practice change at the front line/consumer level, with effective feedback loops.*			

WAIKATO DHB MENTAL HEALTH & ADDICTIONS SERVICE

S99 (Mental Health Act) Inspection Report Action Plan

d. Industrial relationships need resetting to ensure partnership in change. *e. Professional leads need time to participate in and develop support for change (including service and clinical leads).* *f. The renewed strengthened nursing and allied leadership model needs ongoing monitoring and support.* *g. The MHAS needs to build up a sufficient group of 'in-service leads and champions' to support change within teams.* *h. There needs to be a clear and detailed communication and engagement strategy at all levels. The strategy needs to include the DHB's strategic partners, the people using the service and the community. The strategy should have a clearly articulated narrative that supports the transformational change agenda.*			
All transformational change in MHAS is brought under one programme of change and delivered via a Project Methodology Programme management resource as #4 The development of a Consumer advisory board to ensure effective feedback loops Executive Directors has met with unions and agreed "how we work together". We have agreed to develop a Joint Consultative Committee that will meet quarterly Prof leads to be brought into workforce development group chaired by DCS Exec Director meets regularly with professional leads of all disciplines reporting against agreed workplans With the ICP development group we will develop service champions/user groups to head the various work projects.		Complete Complete Complete Complete Complete Complete Complete	

Implementation of the MHAS communication strategy.		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
Community are aware and informed of Mental Health and Addictions Services in the Waikato		Complete	

			planning processes for future development.

MEMORANDUM TO THE BOARD
24 MAY 2017

AGENDA ITEM 10.2

A STRATEGY TO PREVENT SUICIDE IN NEW ZEALAND

Purpose	For information and feedback.

Background
In April the Ministry of Health released a consultation document "A Strategy to Prevent Suicide in New Zealand". This document (attached as appendix A) was circulated to Board members and the internal Suicide Prevention Postvention Steering Group.

To date there has been limited feedback on the draft strategy to the Waikato DHB co-ordinator, however, the document has had significant focus within the media and we appreciate that people may have chosen to feedback on the document in their individual capacity. The comments received locally were generally supportive of the document as a national strategy whilst clearly recognising that the document is very broad (in order to be inclusive) and accordingly prioritisation of focus would need to occur at A local level.

One suggestion that will be relayed to the Ministry is the need for focus to ensure that service providers are, in fact, undertaking assessments and prioritisation of risk factors (in those presenting with suicidal ideation/behaviour) and follow up/intervention and that this should receive emphasis within the strategy.

For Waikato DHB we would expect our local plan to align with the national strategy but with clear actions for implementation.

Separate from the strategy document, feedback was received that queried whether the DHB should look at a different approach for how we deal with health issues and address some of the causes for the status of ill health; and take a community development and whanau focus rather than single issue based focus. This suggestion will be raised for further discussion at a future Health Strategy Committee meeting.

Recommendation
THAT
The Board receives the report.

MO NEVILLE
DIRECTOR
QUALITY AND PATIENT SAFETY

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

A Strategy to Prevent Suicide in New Zealand

2017

Draft for public consultation

Released 2017 **health.govt.nz**

Citation: Ministry of Health. 2017. *A Strategy to Prevent Suicide in New Zealand: Draft for public consultation*. Wellington: Ministry of Health.

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HP 6585

This document is available at health.govt.nz

Foreword

Suicide has a devastating ripple effect across communities, not just for those who die by suicide, but for their whānau, families, friends, colleagues, sports teammates, neighbours and the wider community. The impacts of suicide on all our lives are long lasting and profound.

Previous suicide prevention strategies have guided work to date and while some progress has been made, more needs to be done to prevent suicide across New Zealand.

This draft strategy sets out a vision of how we can work together to prevent suicide; it is the responsibility of all of us. No one person or organisation can prevent suicide; we all need to be involved from government agencies, to employers, neighbours and families.

This document sets out ways we can work together to prevent suicide in New Zealand. It identifies a set of priority areas for action as a focus for our combined efforts. We want to hear from you about how best to work together to prevent suicide. It is vital that everyone gets involved and works together so that we can make a real impact.

Many people and organisations have contributed to the development of this draft strategy – from people in the community (including people who have attempted suicide and people who are bereaved by suicide), mental health and suicide prevention service providers, health care practitioners, researchers, government agencies, district health boards, and non-governmental organisations.

On behalf of all government agencies involved in the development of this draft strategy, I would like to thank everyone who has contributed for your well thought through advice, views and statements so far. In particular I would like to thank people who attend the 23 workshops, everyone who wrote or emailed the working group, and the members of the External Advisory Group.

I look forward to your continued input. Your feedback and continued involvement in preventing suicide will help us build a manageable set of priorities for action that gets results.

Dr John Crawshaw
Director of Mental Health

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About this draft strategy

We want a New Zealand in which everyone is able to have a healthy future and see their life as worth living. Reducing suicidal behaviour will help us become this kind of country. Suicidal behaviour is a sign of great distress and impacts on the lives of all of us in some way. Other changes that will help people to have a healthy future include increasing employment and education, and decreasing violence.

This draft strategy sets out a framework for how we can work together to reduce suicidal behaviour in New Zealand, by both focusing on prevention and supporting people while they are in distress and after suicidal behaviour. It builds on previous strategies and activity, and draws on lessons learnt and new knowledge about preventing suicidal behaviour. This information includes cultural and clinical knowledge, mātauranga Māori (Māori knowledge), literature, guidance from the World Health Organization[1] and the experiences of people in New Zealand. For further detail about some of this information, go to www.health.govt.nz/publication/strategy-prevent-suicide-new-zealand-draft-public-consultation.

Suicidal behaviour occurs in many different places and affects the lives of many people. This draft strategy takes a broader view than previous strategies and considers how different sectors and the whole community can contribute. It also focuses more strongly on preventing suicidal behaviour throughout a person's life, as well as on integrating and coordinating services and support to prevent suicidal behaviour and help people in distress.

This draft strategy has been developed by a cross-government working group. This draft strategy and the work throughout the country to prevent suicidal behaviour sit alongside a range of other government strategies, policies and programmes of work aimed at improving people's lives and responding more effectively to the needs of the most vulnerable individuals, families and whānau. It also reflects the principles of the Treaty of Waitangi.

This draft strategy is a public consultation document. It offers an opportunity to change how we think and talk about suicidal behaviour, and how we combine our efforts to achieve a shared goal. Government agencies would like your feedback on the draft strategy and your thoughts on how to turn this framework into practical action. After the consultation period, we will consider this feedback as the final strategy is developed. When Cabinet approves the final strategy, it will become the next New Zealand suicide prevention strategy.

The five sections of this draft strategy cover:

- the impact of suicidal behaviour in New Zealand, its causes and how we can prevent it
- the proposed approach and vision for preventing suicidal behaviour
- how the vision will become reality
- how we will know whether we are making progress
- how and when you can tell us your views on this draft strategy.

[1] For countries like New Zealand that already have a national strategy or response to suicide prevention in place, the World Health Organization's guidance is to continue the good work and focus on 'evaluation and improvement'. This draft strategy aims to do this and takes account of the World Health Organization's guidance on preventing suicidal behaviour.

Terms used

This draft strategy contains words related to suicide that have different meanings to different people. It uses these terms with the following meanings in mind.

- **Suicide** – a death where evidence shows that the person deliberately brought about their own death. In New Zealand a coronial ruling decides whether a death is classified as suicide.
- **Attempted suicide** – any action or actions where people intentionally try to bring about their own death but they do not die and may or may not be injured.
- **Deliberate or intentional self-harm** – behaviour or behaviours where people try to hurt themselves on purpose but do not intend to die and they may or may not be injured.
- **Suicidal ideation** – thoughts of intentionally killing oneself.
- **Suicidal behaviour** – suicide, attempted suicide, deliberate or intentional self-harm and suicidal ideation.

This draft strategy does not deal with assisted suicide and euthanasia and the substantial and separate ethical, legal and practical issues linked with them.

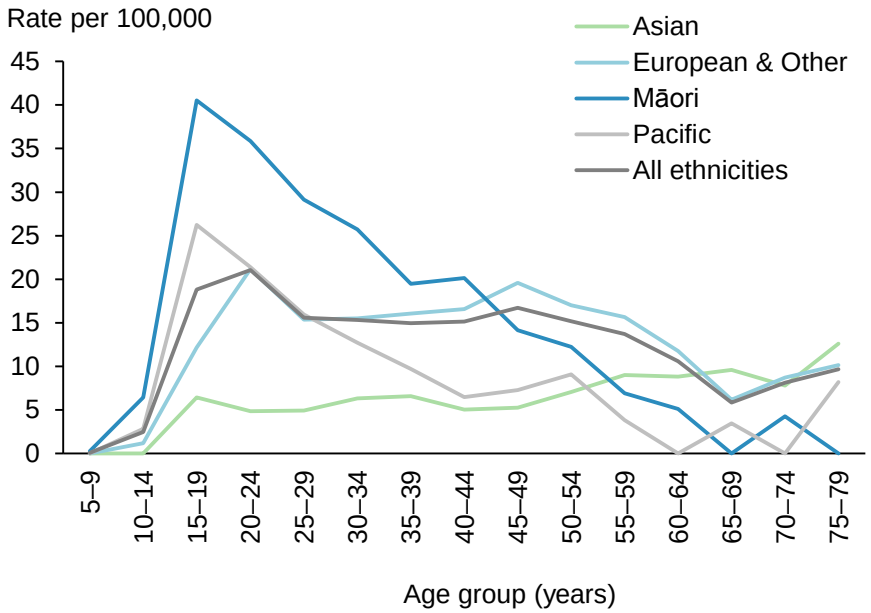
What we know about suicidal behaviour

Impact of suicidal behaviour in New Zealand

Every year over 500 people die by suicide, making it the third most common reason why people die younger than expected. Almost three-quarters of the people who die by suicide are male. Another 150,000 people think about taking their own life, around 50,000 make a plan to take their own life and around 20,000 attempt suicide. All of this behaviour has a devastating and often long-lasting impact on the lives of the people involved.

Some groups within our population, including Māori, Pacific peoples and young people, experience disproportionately higher rates of suicidal behaviour than other groups (see Figure 1).[2]

Figure 1: Suicide rates by ethnicity and five-year age group (from 5–79 years of age), 2009–2013[3]



[2] Further work is needed to better understand: (a) who within these groups is most at risk of suicidal behaviour and (b) whether other groups on which we currently do not systematically collect data (eg, the lesbian, gay, bisexual, transgender and intersex (LGBTI) population) are at higher risk of suicidal behaviour.

[3] Suicide rates are provided for the age groups and ethnic groups we can currently reliably calculate suicide rates for. Rates for groups with relatively few members are unreliable. For example, New Zealand has relatively small groups of older Asians: data shows that for Asians aged 80–84 years there were 3 suicides, but the suicide rate was 25.6 per 100,000 and for Asians aged 85 years and older there were 4 suicides, but the suicide rate was 57.1 per 100,000. In contrast for Europeans and Others aged 80–84 years (a much larger group) there were 49 suicides and a rate of 13.3 per 100,000 and for Europeans and Others aged 85 years and older there were 47 suicides and a rate of 14.1 per 100,000.

Causes of suicidal behaviour

Suicidal behaviour can affect anyone, no matter what their background and experiences are. It has no single cause – it is usually the end result of interactions between many different factors and experiences across a person's life.

Factors that make suicidal behaviour less likely by strengthening a person's wellbeing[4] are **protective factors**. Factors that make suicidal behaviour more likely are **risk factors**.

Both protective factors and risk factors can be broadly grouped into factors related to:

- the individual – genetics, individual experiences, health status and personality
- relationships – personal relationships with whānau, family, partners and friends
- the community – where people live, learn, work and play
- society – the wider social and environmental context such as the economy.

People who engage in suicidal behaviour often experience many risk factors and few protective factors across their life. The impact of different factors varies from person to person.

Protective factors against suicide include:

secure cultural identity, access to support and help, family and community support or connectedness, an ability to deal with life's difficulties and hopefulness.

Risk factors for suicide include:

experiencing stressful life events;[5] not having a sense of one's own culture or identity; exposure to violence, trauma or abuse; mental health issues; poor physical health; a lack of social support; being shamed; having a court case coming up or recent prison sentence; hopelessness and alcohol and drug misuse.

How suicidal behaviour can be prevented

Because suicidal behaviour has no one cause, there is no single solution for preventing it. What works for one person may not work for another person.

To prevent suicidal behaviour across the country, we need to do a broad range of activities over a long period. These different types of activities need to focus on giving people the best opportunity to have a healthy future and providing them with appropriate support when they need it.

The range of activities involve three different types of approaches (see Figure 2):

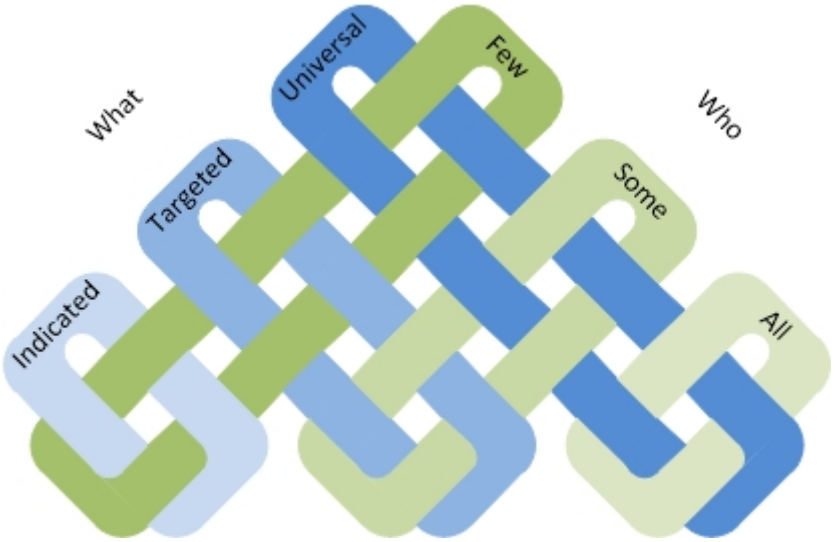
- universal – for all people
- targeted – for some people, in particular those who belong to groups at higher risk of suicidal behaviour
- indicated – for the small proportion of people who are at high risk of suicidal behaviour.

[4] Wellbeing here means how well someone is doing and feeling (their emotional resilience) and how well they are able to cope and adapt when things happen in their life (their coping skills).

[5] Examples of stressful life events include bullying, chronic pain, discrimination, relationship problems, unemployment and financial loss.

Universal activities strengthen common protective factors and reduce common risk factors for suicidal behaviour. Targeted activities try to change specific protective or risk factors that affect those groups of people at higher risk of suicidal behaviour. Indicated activities are aimed at better meeting the specific needs of individuals.

Figure 2: The range of approaches needed to prevent suicidal behaviour



Because such a wide range of factors influence suicidal behaviour, activities in a lot of different areas can contribute to preventing suicidal behaviour.

Some areas that help to prevent suicidal behaviour are those that promote or provide:

- education
- family and whānau support
- health and social services
- housing
- income support
- promoting Māori development[6]
- mental health and wellbeing
- promoting Pacific development[6]
- public health
- workplace health and safety
- disability issues
- promoting youth development[6]
- employment and skills development.

[6] Development is used broadly here to mean development in a range of different areas including cultural, financial and business.

Other areas are those that respond to and aim to reduce:

- alcohol and other drug use
- crime and reoffending
- family and sexual violence
- stigma and discrimination
- child abuse and neglect.

Policies and activities in these other areas can shape a range of influences on suicidal behaviour. Many areas that government agencies focus on, such as exposure to violence, mental health and wellbeing, educational achievement, employment status and income level, share some of the same influences on suicidal behaviour. Addressing a range of different areas helps prevent suicidal behaviour. Conversely, preventing suicidal behaviour can contribute to achieving outcomes in other areas.

We need to work with and build on policies and activities in more areas than health alone. This means that partnering across government agencies and across sectors (particularly social and justice sectors) is important. For examples of cross-sector policies and activities that help to prevent suicidal behaviour, see Appendix 1.

Our approach to preventing suicidal behaviour

Draft framework for preventing suicidal behaviour

The draft framework for preventing suicidal behaviour has three parts: a vision, a purpose and pathways (see Figure 3).

Vision

The vision for this draft strategy is a New Zealand in which all people are able to look forward, experience a life worth living and have pae ora (healthy futures). This vision is captured in the saying:

> Ka kitea te pae tawhiti. Kia mau ki te ora.
> See the broad horizon. Hold on to life.

Pae ora[7]

- Pae ora is a holistic concept that includes the following interconnected elements:
- Mauri ora – healthy individuals: people achieving good health and being able to access a range of services that are appropriate for them.
- Whānau ora – healthy families: supporting families and whānau to achieve maximum health and wellbeing.
- Wai ora – healthy communities and environments: the communities and wider environments in which we live, learn, work and play are safe and support health and wellbeing. All people are able to access appropriate health and social services, including education, housing and income support.

Purpose

The purpose of the strategy is to reduce the suicide rate through reducing suicidal behaviour.

Reducing suicidal behaviour for all people means fewer people hurting themselves intentionally, thinking about suicide, attempting suicide and dying by suicide. It is also the intention to reduce and remove the differences in the suicide rates between different groups.

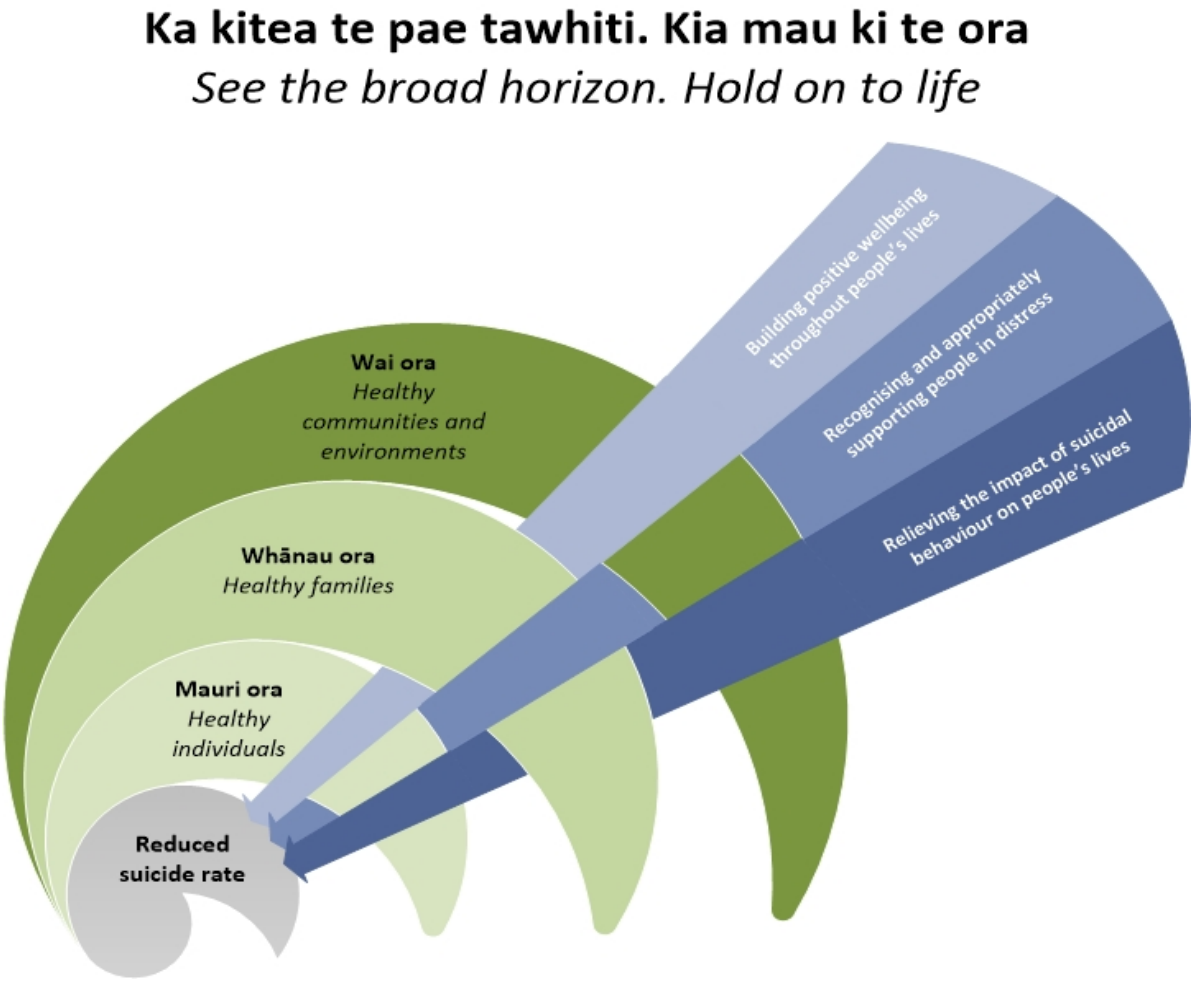
[7] Pae ora is the Government's vision and aim for He Korowai Oranga, New Zealand's Māori Health Strategy (URL: www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga (accessed 9 March 2017)).

Pathways

We can help reduce suicidal behaviour by increasing protective factors and reducing risk factors through the actions we take under one or more of the following pathways.

- Building positive wellbeing[8] throughout people's lives
- Recognising and appropriately[9] supporting people in distress
- Relieving the impact of suicidal behaviour on people's lives.

Figure 3: Draft framework to prevent suicide: an overview



How the framework can guide activity to prevent suicidal behaviour

The framework tells us about the outcomes our activities need to help achieve, to prevent suicidal behaviour.

Within each pathway are four key outcomes that we need to achieve. These four outcomes relate to the three elements of pae ora and the four categories of risk and protective factors.

[8] Here positive wellbeing means people are doing well and feeling well, and are able to cope and adapt when things happen or change in their life.

[9] Appropriate means the support meets the person's needs – this includes that it is culturally appropriate for them.

Building positive wellbeing throughout people's lives

Building positive wellbeing involves enhancing and promoting all aspects of wellbeing, including cultural, economic, emotional, mental, physical and social wellbeing. It is about enhancing protective factors for suicidal behaviour, reducing risk factors and building people's ability to get through difficult times and deal with life stresses.

To build positive wellbeing throughout people's lives, we need to:

- strengthen people's wellbeing throughout their lives – building their ability to withstand adversity and cope when they are faced with adversity
- strengthen whānau, families and friends – strengthening whanaungatanga and positive close relationships with others
- strengthen communities – helping them to be supportive and provide an environment that encourages positive wellbeing
- build environments that promote wellbeing – making sure the physical, social, economic and spiritual environments in which people live promote positive wellbeing.

Recognising and appropriately supporting people in distress

Periods of severe distress are common and most people experience some level of distress at some point in their life. It is important to recognise when people are in distress and may need some support as they may be at greater risk of suicidal behaviour. By recognising when people may be in distress, we can support them appropriately sooner.

To recognise and appropriately support people in distress we need to:

- provide appropriate care and support to people in distress
- strengthen the ability of whānau, families and friends to recognise and support people in distress
- strengthen the ability of communities to recognise and support people in distress
- build systems that seamlessly recognise and provide support to people in distress.

Relieving the impact of suicidal behaviour on people's lives

Suicidal behaviour impacts both the individual and those around them – their whānau, families, friends, workmates, carers and community. People who have previously engaged in suicidal behaviour and people who are affected by others' suicidal behaviour are at greater risk of suicide themselves. By relieving the impact of suicidal behaviour, we can make further suicidal behaviour less likely.

To relieve the impact of suicidal behaviour on people's lives, we need to:

- support individuals after a suicide attempt or self-harm
- support whānau, families and friends after suicidal behaviour in their whānau, family or peer group – whānau and friends can be distressed following suicidal behaviour and may need some support; they may also be supporting other whānau members or friends and need some help in this role
- support communities after suicidal behaviour – suicidal behaviour can have a big impact on the communities in which it occurs
- build systems that give us information we can use to prevent suicidal behaviour more effectively – we can learn from past suicidal behaviour and activities to respond to or prevent suicidal behaviour about how best to prevent future suicidal behaviour.

Turning the shared vision into action

To achieve the shared vision of this strategy, everyone – including individuals, families, whānau, hapū, iwi, non-governmental organisations, employers, businesses, health and social services and government agencies – needs to be involved and work together to prevent suicidal behaviour.

Some activities to prevent suicidal behaviour can contribute to more than one of the outcomes and pathways in this draft strategy. Concentrating our combined work will make a bigger impact. Therefore, government agencies want to hear from you about what areas and activities you think are the highest priority. This includes your ideas about how government agencies can best support you to prevent suicidal behaviour in your communities.

How we need to work

Government agencies and organisations providing activities to prevent suicidal behaviour need to work with whānau and communities that the activities are intended for, building on their strengths and meeting their needs.

We also need to respect the special relationship between Māori and the Crown through the Treaty of Waitangi. That involves:

- **partnership:** working with iwi, hapū, whānau and Māori communities
- **participation:** involving Māori making decisions about activities to prevent suicidal behaviour, and then in planning, developing and delivering those activities
- **protection:** reducing the disproportionately high suicide rate among Māori compared with non-Māori, enabling Māori to engage with their own culture, values and practices, and making services and programmes relevant to and effective for Māori.

Areas we need to work on

The areas we need to work on should cover a range of universal, targeted and indicated activities so that there are activities aimed at achieving each of the elements of pae ora. The activities chosen should be informed by evidence about what works or might work. These activities will include both existing ones that should continue and new activities.

Government agencies will lead or fund some of these activities. Other groups, including non-governmental organisations and iwi, could also lead or fund activities to prevent suicidal behaviour.

At a national level, targeted activities should first focus on groups who have markedly higher rates of suicidal behaviour than others.[10]

The focus for targeted activities can be different in different parts of New Zealand and in different settings (eg, prisons or schools). The focus could also change over time if the data suggests changes which groups are at higher risk of suicidal behaviours.

Government agencies propose that at first national targeted activities focus on the following population groups who have markedly higher rates of suicidal behaviour:

- Māori (particularly Māori aged 15–44 years in all areas, and Māori aged 15–24 years living in areas of high socioeconomic deprivation)
- mental health service users and those admitted to hospital for intentional self-harm
- Pacific peoples (particularly Pacific peoples aged 15–44 years in all areas, and Pacific peoples aged 15–24 years living in areas of high socioeconomic deprivation)
- young people aged 15–24 years.

The cross-government working group has identified these four groups based on data showing they have markedly higher rates. Data shows that of all age groups, young people aged 15–24 years have the highest suicide rate. Among Māori and Pacific peoples, almost 90 percent of people who die by suicide are aged 44 years or younger, compared with under 60 percent of non-Māori, non-Pacific people. Living in an area of high socioeconomic deprivation is also strongly linked to higher suicide rates among Māori and Pacific peoples, particularly Māori and Pacific young people.

It is also important to tailor activities, particularly universal and indicated activities, to address the needs of individuals in other groups or sub-groups with markedly higher rates of suicidal behaviour, such as males, LGBTI and the Rainbow community, and disabled people. For example, a message that is effective in encouraging men in distress to seek help may differ from the message that is effective for women or for people with other gender identities.

Data also shows that the rate of suicide is markedly higher in some subgroups of the population who are or have been in care of Child, Youth and Family, the Department of Corrections or Police. Specific targeted responses in these settings are also important. Further investigation of data about suicidal behaviour might reveal other groups with markedly higher rates of suicidal behaviour who have not yet been identified.

[10] We do not know the rates of suicidal behaviour among some groups because demographic data on them is not collected. So some groups may have markedly higher rates of suicidal behaviour but we do not know about it or do not have robust data for it. For example, as the Mortality Collection and National Minimum Dataset does not record sexual orientation and gender identity, no national information is available on suicide rates and intentional self-harm hospitalisation rates for LGBTI and the Rainbow community.

Overview of potential areas for action

Below is a list of potential areas of action for everyone to focus on together. The next section explains each of these areas in more detail and gives examples of activities that reach area might include. These potential areas and the examples of activities are based on what people in communities, academics and clinicians have said are important, and on what research suggests can work.

Building positive wellbeing throughout people's lives

1. Support positive wellbeing throughout people's lives.
2. Build social awareness of and well-informed social attitudes to suicidal behaviour.
3. Encourage responsible conversations about suicidal behaviour and preventing suicidal behaviour.
4. Increase mental health literacy and suicide prevention literacy.[11]
5. Support and partner with communities to develop and carry out activities that help to prevent suicidal behaviour.

Recognising and appropriately supporting people in distress

6. Strengthen systems to support people who are in distress.
7. Build and support the capability of the workforces in the education, health and police sectors and in the wider justice and social sectors.

Relieving the impact of suicidal behaviour on people's lives

8. Strengthen systems to support whānau, families, friends and communities.
9. Strengthen and broaden collaboration among those working to prevent suicidal behaviour.
10. Strengthen systems for collecting and sharing evidence and knowledge about suicidal behaviour and for tracking our progress.

Explaining the potential areas for action

This section gives more information about each of the potential areas for action, how these areas can help prevent suicidal behaviour and examples of activities in each area.

[11] Mental health literacy is a person's knowledge and beliefs about mental disorders that help that person to recognise, manage or prevent those disorders. It includes knowing how to seek mental health information, knowing risk factors and causes, knowing how to maintain one's own mental wellbeing and having attitudes that promote recognition of mental disorders and appropriate help-seeking. Suicide prevention literacy is an individual's knowledge and beliefs about suicidal behaviours, what help is available and how to access help when needed.

1. Support positive wellbeing throughout people's lives

- Implement programmes and strategies to promote positive wellbeing at all life stages, including school-based programmes, online programmes, programmes for young people and programmes for older adults.
- Implement culturally responsive programmes and strategies including for Māori and for Pacific peoples.
- Provide parenting support to parents and whānau of children and young people.
- Build on policies, strategies and activities in other areas that can help to promote positive wellbeing, and to increase protective factors or reduce risk factors for suicidal behaviour.

How this can help: A wide range of factors contribute to making suicidal behaviour more or less likely. Initiatives that promote positive wellbeing across a person's life, but particularly in childhood and adolescence, can reduce risk factors and strengthen protective factors for suicidal behaviour.

Activities in this area could include:

- communities working together to establish age-friendly communities[12]
- considering suicide prevention when designing new buildings and bridges
- developing initiatives to address loneliness and social isolation, including among older people
- developing policies to promote protective factors and reduce risk factors for suicidal behaviour
- employers establishing positive wellbeing programmes and strategies for the workplace (eg, to prevent and deal with bullying in the workplace)
- helping children and young people to stay in education, employment or other training
- helping people develop better problem-solving skills (eg, through online tools)
- individuals, whānau, families and friends encouraging each other to participate in programmes and activities that can improve their wellbeing (eg, physical activity)
- implementing and extending wellbeing programmes in schools
- increasing access to parenting programmes for parents and whānau
- Māori leading programmes to promote positive wellbeing and address specific needs for Māori
- Māori taking a greater role in existing initiatives that promote wellbeing of Māori
- schools improving policies around preventing bullying and processes to deal with bullying if it does occur
- supporting small communities that lose a major employer or industry
- teaching healthy relationship skills in schools
- teaching money management skills in schools
- whānau, hapū and iwi helping to promote positive wellbeing.

[12] Age-friendly communities are communities that commit to physically accessible and inclusive social living environments that promote healthy and active ageing and a good quality of life, particularly for those in their later years.

2. Build social awareness of and well-informed social attitudes to suicidal behaviour

- Increase public awareness and knowledge of suicidal behaviour and positive wellbeing.
- Reduce stigma associated with suicidal behaviour.
- Reduce myths associated with suicidal behaviour.

How this can help: When society in general is aware of and well-informed about suicide, people's attitudes, perceptions and behaviours can change, and less stigma is linked with a smaller likelihood of suicidal behaviour. Cultures also differ in their views of suicidal behaviour and mental wellbeing generally. People in distress or people who have lost a loved one to suicide may find it more difficult to seek care and support when they live in a society with negative attitudes, perceptions and behaviour related to suicidal behaviour. Building public awareness of suicidal behaviour can encourage more people to seek and receive help when they need it and can lead to more supportive behaviour and attitudes towards people in distress.

Activities in this area could include:

- developing and sharing information around some of the common myths and why they are false
- partnering with Māori communities to build social awareness and well-informed social attitudes around suicidal behaviour in Māori communities
- running a campaign to reduce the stigma around suicidal behaviour
- running a social marketing campaign to raise awareness of the signs of distress.

3. Encourage responsible conversations about suicidal behaviour and preventing suicidal behaviour

- Promote responsible conversations around suicide and suicidal behaviour.
- Encourage the media to take a responsible approach to reporting on and representing people in distress and suicidal behaviour.

How this can help: There has been a stigma around suicidal behaviour. In particular, many have believed that people cannot talk about suicide or matters related to suicidal behaviour because it might lead to further suicidal behaviour. Because of this, people in distress or people who have lost a loved one to suicide may find it more difficult to seek care and support. Encouraging responsible conversations can help to reduce stigma and increase the number of people seeking help when they need it.

Activities in this area could include:

- encouraging media to report responsibly on suicidal behaviour (eg, by reporting on stories of people who overcame suicidal thoughts and attempts)
- providing individuals and whānau with information about how to helpfully talk to someone who they are worried might be thinking about suicide
- supporting individuals and whānau to talk about suicide and preventing suicidal behaviour in a responsible way
- teaching parents and whānau how to have safe conversations about suicidal behaviour with their children and other whānau members.

4. Increase mental health literacy and suicide prevention literacy

- Increase the mental health literacy and suicide prevention literacy within communities.
  - Expand mental health literacy and suicide prevention literacy in Māori communities.
  - Expand mental health literacy and suicide prevention literacy in Pacific communities.
- Increase mental health literacy and suicide prevention literacy among frontline workforces who are likely to be in contact with people in distress.
- Increase the mental health literacy and suicide prevention literacy of individuals.

How this can help: Research has shown that people's health literacy – their knowledge and beliefs about health – is strongly linked to their health status. At some stage in their lives most New Zealanders will come into contact with whānau, family or friends experiencing mental distress or suicidal behaviour, or they will experience mental illness or suicidal behaviour themselves. People want to help others and themselves to become and remain mentally well, but they may not always know how. With better mental health literacy and suicide prevention literacy, people will know more about how to improve mental; health and wellbeing, how to prevent suicidal behaviour and how to access care and support. As a result, people in distress will be more likely to be able to access appropriate care and support when they need it.

Activities in this area could include:

- communities organising community meetings where a suitably qualified speaker talks about positive wellbeing, mental health or suicide prevention
- employers providing frontline staff with training in mental health literacy or suicide prevention literacy
- employers training managers to recognise when their staff may be distressed and how to support them
- implementing a mental health literacy or suicide prevention literacy training programme in Māori communities that is culturally responsive
- implementing a mental health literacy training programme in schools
- individuals and whānau learning to recognise and support individuals in distress
- promoting system change to increase mental health literacy and suicide prevention literacy of individuals, families and whānau.

5. Support and partner with communities to develop and carry out activities that help to prevent suicidal behaviour

- Build community capacity for suicide prevention.
- Build Māori leadership in suicide prevention.
- Build Pacific leadership in suicide prevention.
- Provide access to sources of funding to support or extend community initiatives to prevent suicide.
- Support communities after suicidal behaviour.
- Build community connectedness and safety.

How this can help: Communities play a key part in individuals achieving good health and wellbeing as well as in achieving pae ora (healthy futures). Community leadership helps enable people and communities to improve their wellbeing.

Activities in this area could include:

- councils and businesses providing spaces for communities or community groups to meet
- individuals, whānau and communities contributing to developing and implementing district health board suicide prevention action plans
- people being more involved in their communities (eg, by volunteering for local organisations, churches or sports clubs, or by mentoring young people)
- providing information to schools on how to help prevent bullying and how to deal effectively with bullying if it does occur
- whānau, hapū or iwi leading activities to prevent suicidal behaviour in their communities
- working with Māori to develop culturally responsive activities to prevent suicidal behaviour
- working with Pacific families and communities (eg, churches) to build leadership in suicide prevention
- working with whānau, hapū, iwi and communities to build leadership in suicide prevention.

6. Strengthen systems to support people who are in distress

- Make sure people in distress can get timely access to culturally appropriate care and support.
- Make sure mental health service users can get timely access to culturally appropriate care and support.
- Make available culturally appropriate and timely follow-up and support for individuals after a suicide attempt or self-harm, including for:
  - Māori
  - Pacific peoples.

How this can help: Having timely access to appropriate and relevant care and support can reduce the risk of suicidal behaviour. So it is important to have systems in place to care for and support people in distress. Care and support can come from a range of sources, including whānau, family, friends, churches, communities and government agencies.

Activities in this area could include:

- changing the opening hours of services that provide care or support to people in distress so that they are open when people need them
- developing apps to help people in distress to navigate services
- developing e-therapies and increase access to e-therapies
- developing online resources to help support people in distress
- encouraging emergency department staff to consistently follow best-practice guidance on caring for people who present to emergency departments as being at risk of suicide
- encouraging services to adopt trauma informed care[13] to help people who have experienced repeated, chronic or multiple traumas
- expanding the peer support workforce
- making sure people are able to access appropriate services and support no matter where they live
- partnering with Māori led services to care for and support Māori who are in distress
- promoting ways to restrict access to means of suicide among people who are in distress
- providing accessible and culturally appropriate information about where people in distress can go for care and support
- providing telehealth services
- supporting people with alcohol and other drug problems
- training community members to identify and support individuals in distress and refer them to services that can help.

[13] Trauma informed care is a treatment framework that involves understanding, recognising and responding to the effects of all types of trauma.

7. Build and support the capability of the workforces in the education, health and police sectors and in the wider justice and social sectors

- Build the capability of the workforces in the education, health and police sectors and wider justice and social sectors to respond to people in distress, including after suicidal behaviour.
  - Build the capacity and capability of the Māori workforces.
  - Build the capacity and capability of the Pacific workforces.
- Build the capability of the primary-level workforce to respond to people in distress, including after suicidal behaviour (eg, for those who work with children and young people, such as school nurses and guidance counsellors).
- Provide regular training and refresher courses for key frontline workforces.
- Provide supports to improve workforce retention and staff wellbeing.

How this can help: Workforces in the education, health, police and wider justice and social sectors are typically at the front line, providing care and support to people in distress, and their whānau, families and friends. With improved capability, staff can better recognise individuals in distress, and provide better quality and more timely care and support to those individuals and their whānau, families and friends.

Activities in this area could include:

- providing suicide prevention training to paramedics
- providing suicide prevention training to reception staff at health, justice and social services
- supporting capability and capacity development of the Māori workforce
- supporting teachers and schools to respond to students in distress and after suicidal behaviour
- training new police recruits and frontline police officers to respond to people who are in distress or at risk of suicide
- training teachers to talk to and support students who are in distress or who have been impacted by suicidal behaviour
- training Work and Income staff to respond to people who are at risk of suicide.

8. Strengthen systems to support whānau, families, friends and communities

- Make available culturally appropriate support for whānau, families, friends and communities who are supporting a person in distress.
- Make available culturally appropriate support for whānau, families, friends and communities after suicidal behaviour in their whānau, family or peer group.

How this can help: Whānau, families, friends and communities can be among the key sources of care and support for people in distress. Supporting whānau, families, friends and communities so that they can care for and help people in distress can help to give people in distress timely access to culturally appropriate care and support.

Activities in this area could include:

- communities providing support to their members who are supporting loved ones in distress
- establishing a peer support group for people and whānau bereaved by suicide
- partnering with whānau, hapū and iwi to develop systems to strengthen support for whānau and friends
- providing guidance for whānau, families and friends who are supporting someone who has ongoing suicidal behaviour
- providing specialist practical and emotional support to whānau, families and friends of those bereaved by suicide
- providing support to communities experiencing suicide clusters[14] or suicide contagion[15]
- providing support to facilitators of peer support groups.

[14] A suicide cluster is when multiple suicides or suicide attempts, or both, occur closer together in time, geography, or through social connections, than would normally be expected for a given community.

[15] Suicide contagion is when one suicide influences others to attempt suicide.

9. Strengthen and broaden collaboration among those working to prevent suicidal behaviour

- Better integrate the work of and strengthen the links between individuals, whānau, communities, services, agencies and organisations.
- Increase information sharing between individuals, whānau, communities, services, agencies and organisations.

How this can help: When services, agencies and organisations do not collaborate with each other and individuals, whānau and communities, gaps in services and support can result, meaning that some people do not receive the care and support they need. It can also lead to some duplication of services. Strengthening and broadening collaboration can create more efficient, seamless care and support for people in distress, and the people around them.

Activities in this area could include:

- government agencies and non-governmental organisations working together to remove gaps in services and support for people in distress
- government agencies working together to make sure people can more seamlessly between services (eg, from corrections to health services)
- linking and promoting collaboration with Whānau Ora providers
- psychologists and counsellors partnering with local schools to increase access to psychological support for young people
- working with whānau, hapū and iwi to make sure services take account of diverse Māori realities.

10. Strengthen systems for collecting and sharing evidence and knowledge about suicidal behaviour and for tracking our progress

- Improve the approach to collecting data and recording suicide attempts.
- Improve understanding of how to prevent suicidal behaviour in New Zealand, particularly among:
  - Māori
  - Pacific peoples
  - young people
  - LGBTI and Rainbow community.
- Make better use of existing data about suicide prevention.
- Share information about suicide prevention more widely.
- Make culturally appropriate and locally relevant information, support, tools and resources related to suicide prevention readily available to whānau, families and friends when they need it.

How this can help: More information on suicidal behaviour can help us better understand suicidal behaviour in New Zealand and how we can best prevent it.

Activities in this area could include:

- conducting robust evaluations of activities aimed at preventing suicidal behaviour
- developing a hub of best-practice information about preventing suicidal behaviour
- doing culturally appropriate research with a diverse range of ethnic groups (eg, diverse Pacific groups including those born in New Zealand and recent migrants)
- individuals, whānau, families and friends participating in evaluations, surveys and research related to preventing suicidal behaviour
- Māori leading research on preventing suicidal behaviour among Māori
- monitoring the impact of the strategy on preventing suicide in New Zealand
- producing a dashboard of measures and indicators showing progress on preventing suicidal behaviour
- researchers sharing findings from their research on suicide prevention in a publicly accessible format
- sharing evidence and knowledge with and between whānau, hapū and iwi
- using standardised forms to collect data on suicidal behaviour
- using the Integrated Data Infrastructure to build information about how to prevent suicidal behaviour in the future and which population groups to target support for first.

Keeping track of progress

It is important to track our progress with preventing suicidal behaviour in New Zealand. This information can tell us about whether we are making a difference, what we need to change and what we can do better in the future.

Once the final strategy is in place, we want to see suicide rates going down to lower than they are now. However, changes in suicide rates may not happen quickly. Some suicide prevention activities will take time to have an impact. This means we need to look at more than just the suicide rate to find out about how we are progressing. Looking at other measures can also give us a better understanding of why we make the progress we do.

Government agencies will monitor the impact of activities to prevent suicide in New Zealand. This will involve looking at the impact on all people as well as on specific groups within the population who experience comparatively higher rates or numbers of suicide.

Government agencies will lead the development of clearly defined outcomes and indicators to provide us with more information on the levels of progress. Where possible, they will publicly report on the outcomes and indicators each year. They will also monitor and report on those outcomes and indicators for different groups in the population. This includes groups based on age, ethnicity and gender.

The proposed outcomes and indicators include:

- the number and rate of suicides[16]
- the number and rate of intentional self-harm hospitalisations
- the number and rate of suicide attempts
- the number and rate of people who are hospitalised for intentional self-harm more than once in the same year
- housing security
- financial security
- employment participation
- education participation
- mental health
- physical health
- social and cultural connection
- wellbeing and respect
- trends in all of the above outcomes and indicators over time.

Government agencies already measure and report on some of the proposed outcomes and indicators. For the others, government agencies will need to develop appropriate measures and ways of routinely collecting the information.

[16] A rate is the number per 100,000 people in the population. For example, the suicide rate is the number of suicides per 100,000 people in the population.

Government agencies will, where possible, evaluate activities they fund from the time those activities begin. This will help build information about what is working and why. They will also put in place outcomes based performance measures for the suicide prevention activities. These performance measures will relate to:

- how many instances of each activity or function are provided
- how well each activity or function is provided
- whether anyone is better off as a result of the activity or function provided.

Appendix 1: Policies and activities related to preventing suicidal behaviour

Examples of policies and activities that sit alongside preventing suicidal behaviour are:

- Better Public Services
- bullying prevention
- Ministerial Group on Family Violence and Sexual Violence Work Programme
- the *New Zealand Health Strategy*[17]
- the Ministry for Vulnerable Children, Oranga Tamariki (previously Child, Youth and Family)
- Positive Behaviour for Learning (PB4L)
- work to improve mental health and wellbeing
- Whānau Ora.

Better Public Services

Better Public Services is about government agencies working together and with communities to deliver better public services. Some areas it focuses on are improving support for vulnerable children, boosting skills and employment, reducing crime and reoffending, and reducing welfare dependency. Improvements in these areas contribute to reducing the risk of suicidal behaviour. Preventing suicidal behaviour can also contribute to improvements in these areas. The ways of working in Better Public Services and in preventing suicidal behaviour are also consistent in that they both involve government agencies working together and with communities.

Bullying prevention

The Bullying Prevention Advisory Group is a collaboration of 17 agencies (including government agencies) committed to working together to reduce bullying in New Zealand schools. The group includes representatives from the education, health, justice and social sectors, as well as internet safety and human rights advocacy groups. Through its activities that support schools to create safe, positive environments that reduce bullying and improve student wellbeing and achievement, the group helps to improve wellbeing and prevent suicidal behaviour.

Ministerial Group on Family Violence and Sexual Violence Work Programme

The Ministerial Group on Family Violence and Sexual Violence Work Programme is a cross-government work programme that is implementing a range of initiatives to prevent violence, reduce the harm it causes, and break the cycle of re-victimisation and re-offending.

[17] Minister of Health. 2016. *New Zealand Health Strategy: Future direction*. Wellington: Ministry of Health.

The work programme is also focused on improving and co-ordinating existing services. The Minister of Justice and the Minister for Social Development jointly lead the Ministerial Group that provides leadership and oversight of the work programme.

Reduced violence and offending will contribute to preventing suicidal behaviour, while preventing suicidal behaviour in turn can involve initiatives that can make family violence and sexual violence less likely.

New Zealand Health Strategy

The *New Zealand Health Strategy* describes the vision for the health system as: 'all New Zealanders live well, stay well, get well'. Achieving this vision will help reduce suicidal behaviour.

Other strategies associated with the *New Zealand Health Strategy* include *He Korowai Oranga*, the Māori Health Strategy, *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing* and the *Healthy Ageing Strategy*. All of these strategies also contribute to preventing suicidal behaviour. For example, *He Korowai Oranga* sets the framework for guiding the achievements of the best health outcomes for Māori and has as its overarching aim 'Pae Ora – healthy futures'.[18] Action taken under *He Korowai Oranga* is one way the health system recognises and respects the principles of the Treaty of Waitangi.

The approach of this draft strategy is in line with and has been shaped by the five strategic themes of the *New Zealand Health Strategy*.

How this draft strategy fits with the strategic themes of the New Zealand Health Strategy

- People-powered – this draft strategy recognises that preventing suicidal behaviour requires everyone to be informed, involved and work together, from developing and designing activities and services to implementing them. It also recognises that for people to be informed, we need to focus on improving health literacy.
- Closer to home – this draft strategy strongly emphasises preventing suicide across a person's life, providing support in communities and to whānau, addressing people's needs and providing services that are culturally appropriate.[19]
- Value and high performance – areas that this draft strategy focuses on include achieving equity through reducing suicide rates for all people, preventing suicidal behaviour throughout people's lives rather than undertaking more costly interventions when suicidal behaviour has occurred, and evidence-informed cross-government and community activities.
- One team – this draft strategy recognises that everyone needs to work together more towards a common goal and provide integrated services and support that meet the needs of the people they are intended for.
- Smart system – developing smart systems to collect, coordinate and share information to support future suicide prevention efforts.

[18] Minister of Health. *He Korowai Oranga, New Zealand's Māori Health Strategy*. URL: www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga (accessed 9 March 2017).

[19] Culturally appropriate services provide high-quality care and are responsive. To provide such services, the workforce must be culturally competent.

The Ministry for Vulnerable Children, Oranga Tamariki

The Government's new vulnerable children's entity, the Ministry for Vulnerable Children, Oranga Tamariki (Oranga Tamariki), has responsibility for working with others to improve the long term wellbeing of vulnerable children and young people. Oranga Tamariki is concerned with prevention and early intervention, as well as better supporting children and young people in care including when they transition out of care, and the youth justice system. A focus on intervening earlier to ensure children and young people and their families receive the support they need is intended to improve the wellbeing of children and young people and will help reduce suicidal behaviour.

Positive Behaviour for Learning (PB4L)

The Ministry of Education leads the Positive Behaviour for Learning approach, which consists of a range of initiatives to help address problem behaviour, improve children's wellbeing and increase educational achievement. Making these changes will increase wellbeing and so help reduce suicidal behaviour.

Work to improve mental health and wellbeing

Many of the key approaches to improving mental health and wellbeing and addressing alcohol and other drug issues and problem gambling are also key to preventing suicidal behaviour. Examples of current work around mental health and wellbeing includes activities as part of the Prime Minister's Youth Mental Health Project (which aims to improve the mental health and wellbeing of young people), National Drug Policy and Rising to the Challenge (the Mental Health and Addiction Service Development Plan 2012–2017).

Whānau Ora

Whānau Ora is an innovative cross-government initiative which devolves delivering Whānau Ora services to community-based commissioning agencies. It aims to improve outcomes by supporting whānau to identify and drive their own solutions to challenges they are experiencing. The approach to preventing suicidal behaviour in this draft strategy includes elements that aim to support whānau to develop their own ways to prevent suicidal behaviour.

Your feedback

Government agencies welcome your thoughts and feedback on this draft strategy which outlines the proposed direction to prevent suicide in New Zealand. Your feedback is vital to help agencies develop the final strategy to prevent suicide.

How to provide feedback

You can provide feedback by:

- making a written submission using the form below (note: you can download this form at www.health.govt.nz/publication/strategy-prevent-suicide-new-zealand-draft-public-consultation or complete the form online)
- making a written submission in your preferred format
- attending a discussion about the draft strategy to prevent suicide in New Zealand.

You can email written submissions to suicideprevention@moh.govt.nz or mail a hard copy to:

Suicide Prevention Strategy Consultation
Ministry of Health
PO Box 5013
Wellington 6140.

If you are emailing your submission in PDF format, please also send us a version in Word format.

Publishing submissions

We may publish all submissions, or a summary of submissions on the Ministry of Health's website, unless you have asked us not to. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information. You can also choose to have your personal details withheld if your submission is requested under the Official Information Act 1982.

Closing date for submissions

The closing date for submissions and feedback on the draft strategy is **Monday 12 June 2017.**

Information about the person/organisation providing feedback

You are encouraged to fill in this section. The information you provide will help government agencies analyse the feedback. However, your submission will be accepted if you do not fill in this section.

This submission was completed by: *(name)* _____

Address: *(street/box number)* _____

(town/city) _____

Email: _____

Organisation *(if applicable)*: _____

Position *(if applicable)*: _____

This submission *(tick one box only)*:

☐ comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

☐ is made on behalf of a group or organisation(s).

Please indicate which sector(s) your submission represents (*you may tick more than one box)*:

☐ Māori
☐ Pacific
☐ Asian
☐ Education/training provider
☐ Service provider
☐ Non-governmental organisation
☐ Primary health organisation
☐ Academic/researcher
☐ Regulatory authority
☐ Member of the public (eg, consumer)
☐ District health board
☐ Local government
☐ Government
☐ Union
☐ Professional association
☐ Other *(please specify)*:

Privacy

We may publish all submissions, or a summary of submissions on the Ministry's website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry's website, please tick this box:

☐ Do not publish this submission.

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

☐ Remove my personal details from responses to Official Information Act requests.

If your submission contains commercially sensitive information, please tick this box:

☐ This submission contains commercially sensitive information.

Consultation questions

The following questions regarding '*A Strategy to Prevent Suicide in New Zealand: Draft for public consultation*' (the draft strategy) are designed to help you in writing your feedback on the draft strategy. You are welcome to include or cite supporting evidence in your submission.

We also welcome any other feedback on the draft strategy to prevent suicidal behaviour, or more generally any ideas on preventing suicidal behaviour in New Zealand.

Pathways

1. The three proposed pathways are (see page 9 in the draft strategy document):
   - building wellbeing throughout a person's life
   - recognising and appropriately supporting people in distress
   - relieving the impact of suicidal behaviour.

   What do you think about these pathways? Do you have any comments or suggestions about these pathways?

Prioritising actions

2. The section on 'Turning the shared vision into action' describes 10 potential areas for action (see pages 10–12 in the draft strategy).

   Do you think these are the right areas for action to prevent suicide (eg, are any areas missing; are the areas identified the most important areas)?

3. Which areas for action do you think are the most important ones to focus on first?

4. Which activities within these action areas do you think are the most important ones to focus on first?

Other views, comments or information

5. Do you have any other views, comments or information related to the draft strategy or preventing suicidal behaviour more generally?

Thank you for taking the time to provide feedback.