DISTRIBUTION

Board Members

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

Executive Management Team

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

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

Next Meeting Date: 28 March 2018

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

Agenda

Board

Date: **28 February 2018**

Time: **2pm**

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

Waikato District Health Board

Meeting of the Waikato District Health Board

to be held on Wednesday 28 February 2018
commencing at 2pm at Waikato Hospital

AGENDA

Item

1. Apologies

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

3. **MINUTES AND BOARD MATTERS**
- 3.1 Board Minutes: 24 January 2018
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 1 February 2018
- 3.3 Structure and Operation of the Board's Committees
- 3.4 Board Policies:
  - Board Remuneration and Expenses
  - Training for Board Members

4. **INTERIM CHIEF EXECUTIVE REPORT**

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

6. **DECISION REPORTS**
- 6.1 Banking Services Supplier
- 6.2 Replacement of Heart Lung Machines
- 6.3 Business Case: Surgical Assessment Unit at Level 8, Menzies Building, Waikato Hospital
- 6.4 Suicide Prevention and Postvention Intersectoral Workshop

7. **FINANCE MONITORING**
- 7.1 Finance Report
- 7.2 FY18/19 Operating Budget and Capital Plan
- 7.3 Capital Charge Invoice Approval

8. **PRESENTATION**
- 8.1 Creating our Futures

9. **PAPERS FOR INFORMATION**
- 9.1 Health Targets
- 9.2 Provider Arm Key Performance Dashboard
- 9.3 Strategy and Funding Key Performance Dashboard

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

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

THAT:

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

Item 11: Minutes – Various

- **(i) Waikato District Health Board for confirmation: Wednesday 24 January 2018 (Items taken with the public excluded)**
- **(ii) Sustainability Advisory Committee – verbal update to be received: Wednesday 28 February 2018 (All items)**
- **(iii) Audit and Corporate Risk Management Committee – verbal update to be received: Wednesday 28 February 2018 (All items)**
- **(iv) Midland Regional Governance Group – to be received: Friday 2 February 2018**

Item 12: Risk Register – Public Excluded
Item 13: Chief Executive's Report – Public Excluded
Item 14: Proposal to Conduct an Expression of Interest Process – Public Excluded
Item 15: Mobile X-Ray Units and Image Intensifiers – Public Excluded
Item 16: Ronald McDonald House – Family and Whanau – Public Excluded

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER	SECTION OF THE ACT
Item 11(i-iv): Minutes – Public Excluded		Items to be adopted / confirmed / received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 12:	Risk Register – Public Excluded	Avoid inhibiting staff advice about organisational risks	Section 9(2)(a)
Item 13:	SSC review, Office of the Auditor General review, HealthTap contract, Plastic surgery, community representation on Board Committees – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 14:	EOI for a primary care tenant – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 15:	Replacement of Mobile X-Ray units and Image Intensifiers – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 16:	Ronald McDonald House – Public Excluded	Negotiation will be required	Section 9(2)(j)

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

Item

11. MINUTES – PUBLIC EXCLUDED

11.1 Waikato District Health Board: 24 January 2018
To be confirmed: Items taken with the public excluded

11.2 Sustainability Advisory Committee: 28 February 2018
Verbal update: All items

11.3 Audit and Corporate Risk Management Committee: 28 February 2018
Verbal update: All items

11.4 Midland Regional Governance Group: 2 February 2018
To be received: All items

12. RISK REGISTER – PUBLIC EXCLUDED

13. CHIEF EXECUTIVE'S REPORT – PUBLIC EXCLUDED

14. PROPOSAL TO CONDUCT AN EXPRESSION PROCESS – PUBLIC EXCLUDED

15. MOBILE X-RAY UNITS AND IMAGE INTENSIFIERS – PUBLIC EXCLUDED

16. RONALD MCDONALD HOUSE – FAMILY AND WHANAU – PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

THAT:

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

Apologies.

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO FEBRUARY 2018

Sally Webb

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Acting 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	

Crystal Beavis

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

Sally Christie

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

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

Martin Gallagher

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

Mary Anne Gill

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

Tania Hodges

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

Note 1: Interests listed in every agenda.

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

Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None
Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None

Dave Macpherson

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

Pippa Mahood

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

Sharon Mariu

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

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

Member, Health Strategy Committee, Waikato DHB	Non-Pecuniary	None
Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived
Director/Shareholder, Asher Group Ltd	Pecuniary	Perceived
Director, Hautu-Rangipo Whenua Ltd	Pecuniary	Perceived
Owner, Chartered Accountant in Public Practice	Pecuniary	Perceived
Daughter is an employee of Puna Chambers Law Firm, Hamilton	Non-Pecuniary	Potential
Daughter is an employee of Deloitte, Hamilton	Non-Pecuniary	Potential

Clyde Wade

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

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

Conflicts related to items on the agenda.

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 24 January 2018 commencing at 2.00pm in the Board Room, in the Hockin Building at Waikato Hospital

Present:
Ms S Webb (Acting Chair)
Ms C Beavis
Ms S Mariu
Dr C Wade
Mrs P Mahood
Ms M A Gill
Mr D Macpherson
Mr M Gallagher

In Attendance:
Mr D Wright (Interim Chief Executive)
Dr G Howard (Acting Executive Director, Waikato Hospital Services)
Mr N Hablous (Chief of Staff)
Ms M Chrystall (Executive Director, Corporate Services)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Mrs J Wilson (Executive Director, Strategy and Funding)
Ms L Elliott (Executive Director, Maori Health)
Mrs V Aitken (Acting Executive Director, Mental Health and Addictions Service)
Mr M Spittal (Executive Director, Community and Clinical Support)
Mr A McCurdie (Chief Financial Officer)
Mrs S Haywood (Director Nursing and Midwifery)
Ms M Neville (Director, Quality and Patient Safety)
Dr R Tapsell (Acting Chief Medical Officer)
Mr M ter Beek (Executive Director, Operations and Performance)
Ms T Maloney (Commissioner, Women's Health Transformation Taskforce)

ITEM 1: APOLOGIES FOR ABSENCE

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

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 November 2017

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

3.2 Committee Meeting Minutes

3.2.1 Iwi Maori Council: 7 December 2017

Resolved
THAT
The Board noted the minutes of this meeting.

ITEM 4: INTERIM CHIEF EXECUTIVE REPORT

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

- HealthTap – Ernst & Young had been appointed to undertake the evaluation.

- Chief Medical Officer – Dr Rees Tapsell had agreed to be the Acting Chief Medical Officer for three months. A recruitment process would commence to appoint a permanent full-time Chief Medical Officer.

- Incident Hague Road Carpark – extra patrols of the car park were being undertaken. The Property and Infrastructure Department were reviewing safety of both Hague Road and Pembroke Street car parking buildings. The costings would be provided at the next meeting.

- Drinking water – the drinking water assessment service had to address 6 corrective actions before it could reapply to be an IANZ accredited service. Five of the corrective actions could be made quickly. The correction of the 6th action was reliant on the recommendations made by the Havelock North enquiry. Cabinet would make decisions on the recommendations of that enquiry.

- Update on Creating Our Futures – a number of milestones had been reached. Input had been received from a range of stakeholders from the community and NGO providers to inform the identification of key problem areas. The model of care looked at how health services could be made more accessible, for example, through NGOs and first responders. It was suggested that relationships with other agencies such as St John Ambulance, paramedics and police be explored. A full report was requested for the next meeting.

- Delegation to Execute a Crown Funding Agreement – the Crown Funding Agreement had been received from the Ministry of Health. The schedules included Sudden Unexpected Death in Infancy (SUDI) prevention, Disability Support Services and the Electives and Ambulatory initiative. The total value of this Agreement exceeded $10m, therefore the delegation to execute it sat with the Board. The Board were requested to approve the execution of the Agreement by the Interim Chief Executive.

- Nursing Workload and Capacity – during the holiday period, the number of patients receiving treatment had substantially exceeded the forecasted demand. The need for better contingency planning was acknowledged. The Board asked to be kept updated on how this planning was doing. The Board asked that their thanks for a job very well done be passed onto staff who worked over the holiday period.

Resolved
THAT
The Board:
1) Received the report.
2) Approved the Interim Chief Executive executing the Crown Funding Agreement covering Sudden Unexpected Death in Infancy (SUDI) prevention, disability support services and the electives and ambulatory initiative.

ITEM 5: QUALITY AND SAFETY REPORT

There was no report this month.

ITEM 6: DECISION REPORTS

6.1 Windows 10 Upgrade

Mr G King presented this agenda item.

The DHB had been notified that Windows 7 compatible desktops, laptops and tablet computer devices would no longer be supplied through the All of Government panel contractor. As a result the DHB would need to upgrade its operating system of all appropriate desktop, laptop and tablet computer devices to Windows10.

The DHB has approximately 5,500 PCs, laptops and tablets and 700 applications that would require repackaging or upgrading. The cost to repackage or upgrade each device was approximately $363.

Resolved
THAT
The Board:
1) Noted the content of the paper and business case.
2) Approved Waikato DHB's transition in a phased manner from Windows 7 to Windows 10.
3) Approved funding of $2.0m phased over two years.
4) Noted that Regional Capital Committee endorsement was required.
5) Noted that Ministry of Health approval was required.
6) Noted that the transition would be over the period from February 2018.

7) Noted that due to financial constraints, a deferred maintenance (technical debt) resulting in a number of applications not being on the current version and/or hardware not being current (as a result of the End User Device change from a five year to seven year lifecycle).
8) Noted that some vendors have not made upgrades to a Windows 10 compatible version available at the time of this business case being prepared or will not be available for some time.
9) Noted that a risk exists that application remediation costs will exceed estimates. Mitigations to manage this risk are detailed in the business case.

ITEM 7: FINANCE MONITORING

7.1 Finance Report

Mr A McCurdie attended for this agenda item.
The Chief Financial Officer asked that his report for the month of December 2017 be taken as read highlighting the following:

There was an unfavourable YTD variance to budget of $1.7m. This result included a $1.4m favourable variance. $1.1m of the $1.4 were one offs and from prior periods.

Resolved
THAT
The financial statements of the Waikato DHB to 31 December 2017 were received.

ITEM 8: PRESENTATIONS

8.1 Management of Personal Information Requests

Marc ter Beek and Marilyn Hunt gave a presentation that highlighted:

- The legislation covering privacy and personal health information
- Types of request received by the Clinical Records team.
- The process for responding to personal information requires for general clinical records.

Resolved
THAT
The Board received the presentation.

8.2 The Official Information Act 1982

Carolyn Gardner gave a presentation that highlighted:

The purpose and principles of the Official Information Act 1982

- How we are performing – scrutiny by external agencies

- Detail on how individuals can make information requests together with information on how these are processed internally.

Resolved
THAT
The Board received the presentation.

ITEM 9: NEXT MEETING

Date of Next Meeting

The next meeting to be held on Wednesday 28 February 2018 commencing at 2.00 pm at in the Board Room in the Hockin Building, Waikato hospital.

BOARD MINUTES OF 24 JANUARY 2018

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

THAT:

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

Item 11: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 22 November 2017 (Items taken with the public excluded).**
- **(ii) Audit and Corporate Risk Management Committee: Wednesday 22 November 2017 (Verbal update all Items taken with the public excluded).**
- **(iii) Sustainability Advisory Committee – 29 November 2017**
- **(iv) Midland Regional Governance Group – Friday 1 December 2017 (All items to be received).**

Item 12: Independent view on previous Chief Executive's expenses (verbal report) – Public Excluded

Item 13: Forecast and Savings Plan Update – Public Excluded

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER	SECTION OF THE ACT
Item 11 (i-iv): Minutes	Items to be adopted/ confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 12: Independent view on previous Chief Executive's expenses (Verbal Report)	To Protect the Privacy of naural persons including that a deceased natural person	Section 9(2)(a)
Item 13: Forecast and Savings Plan Update	Negotiations will be required	Section 9(2)(j)

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

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

Item 12: **Section 9(2)(a) of the Official Information Act 1982 – to Protect the Privacy of naural persons including that a deceased natural person**

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

ACTION LIST

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

	ACTION	BY	WHEN
	• Following recent tragic incident - review of security Hague Road and Pembroke Street Carparks	Chris Cardwell	February 2018 meeting
	• Update on Creating our Futures	Vicki Aitken	February 2018 meeting

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Maori Council

Held: Thursday 1st February 2018 at 9.30am

Venue: Board Room, Hockin Building, Waikato Hospital

Present:	Mr H Mikaere	Chair
	Ms T Thompson-Evans	Waikato Tainui Te Whakakitenga o Waikato Inc
	Mr G Tupuhi	Hauraki Māori Trust Board
	Ms T Hodges	Waikato DHB Board
	Ms M Balzer	Te Rūnanga o Kirikiriroa
	Ms K Gosman	Tuwharetoa Māori Trust Board
	Ms K McClintock	Waikato Tainui Te Whakakitenga o Waikato Inc
	Loraine Elliott	Executive Director Maori Health
	Pippa Mahood	Waikato DHB Board
	Matua Hemi Curtis	Pou Herenga Te Puna Oranga
	Sarah Greenwood	Minute taker

ITEM 1 **KARAKIA:** Matua Hemi Curtis

ITEM 2 **MIHI:** Harry Mikaere

ITEM 3 **APOLOGIES**

Bobby Bryan, Kataraina Hodge, Tureiti Moxon, Derek Wright, Gaylene Roberts

Received by: Glen
Seconded by: Te Pora

ITEM 4 **MINUTES OF LAST MEETING**

- Discussion around KK not giving a name for the KPMG building regarding feedback from G. Roberts.
- Main doors of the KPMG building open towards the river.

Minutes Passed
Received by: Kim
Seconded by: Glen

ITEM 5 **GOVERNANCE**

Nothing noted in this meeting.

ITEM 6 **6A/6B/6C/6D - PRESENTATIONS**

6A TIO SEWELL – Te Roopu tautoko ki Waikato (TRTKW)

- Presented along with Laurie Hakiwai and Taipu Moana.
- Te Pae Tawhiti – Strategy and Funding also use this name but feels aligned.

- Waikato has a rich history of focusing on Maori and an increase in specialisations.
- Little changed in terms of health inequities for Maori.
- Maori children not engaged in education are missing out of services particularly in rural areas.
- Mental Health Services has a younger overall population.
- Higher proportion of Maori in mental health and addictions.
- Membership is inclusive and meet bi-monthly.
- What does a 'fit for purpose' model of care look like for Maori by 2030?
- Eleven Maori providers in the Waikato.
- Often feels as though providers must compete with each other rather than work together in terms of funding – a divide and conquer approach.

Pippa asked, what do you want done to make this change? Tio answered; to be clear about articulating a vision, speak from a shared and informed space.
Pippa asked, Where do you believe the pathway to change will occur? Laurie answered; IMC can advise / support / influence those working on front lines. Cohesion between IMC and Board. Why aren't the other 11 organisations being heard?
Kahu asked if TRTKW wants a relationship with IMC. Laurie answered yes.
Te Pora wanted to understand the mandate for TRTKW. Tio responded that it's about accountability to the kaupapa and to community. To stakeholders through membership. They operate to a kaupapa informed by goals and objectives. Primary focus to WDHB boundaries. A formal understanding with mental health and addictions in terms of strategy and funding. IMC have a duty of care to represent Maori. In order to do so IMC should be communicating with a range of people including providers, whanau, tangata whaiora and the wider community.
Kahu would welcome a Maori voice, support the courage to do what TRTKW are doing. Advises submitting to other mental health providers.
Glen noted that group voices become stronger with the support of IMC.
Tania noted that information has to feed in to the operational activities. Mental health and addictions is one of the crucially important areas that IMC is involved in.
Kahu noted that groups supported by IMC allows for proper consultation rather than there being one spokesperson and that Creating our Futures and Te Pae Tawhiti need to resonate with what TRTKW is saying.

6B DARRIN HACKETT – HEARTY HAUORA KAUPAPA EVENT

- Nga Mangaru members and their community feel like they can trust the DHB.
- Patches were excluded at the event.
- The event was put on because "our people want help" and to get them engaged in health and health services.
- They thought the stats looked poor at first but recognised that even the smaller numbers are a victory as people attended services they had never been to before.
- The barriers when first approaching the WDHB were that Maori providers weren't keen to help and that discrimination was the biggest of the barriers.
- Nga Mangaru had historically had no healthcare education or preventative healthcare, usually presenting at crisis point.
- 60% of members had no GP and were entirely disengaged.
- Believe that the next event will produce 3 times the number who attended this event on 11/11/17.

Carol spoke that the event model wasn't a sustainable long term event but had allowed relationships to be built and trust to build. The relationship has been building for slightly longer than 12 months.
Harry asked why they thought Maori providers had turned their backs. Griff replied that Maori would have whanau in one gang or another and from historical gang behaviours they were reluctant. Griff believes a mindset of looking to the future and not living in the past is necessary to overcome this.
Mere asked what processes the DHB were putting into place to ensure the sustainability of groups such as Nga Mangaru.

6C NINA SCOTT – HOSPITAL TRANSFERS PROJECT

- Looking at issues of how whanau are able to support whanau who are/have been transferred from one hospital to another outside the area they normally reside.
- No data currently available about transfers.
- No sense of the scale of the issue.
- No sense of whether this disadvantages Maori although suspect that it does.
- The National travel policy is being revised.
- Looking at potential loss of income / earnings and other incurred costs such as accommodation – not easy for the poorest members of our community.
- Inconsistencies at WDHB with information being given to patients/ whanau such as subsidised parking tickets and whare accommodation – all fixable.

6D TE PUNA ORANGA - TEAM LEADERS

Nikki Barrett – Te Roopu Rautaki (pages 12-19 of Feb agenda)
Millie Berryman – Kaitakawaenga (pages 8-10 of Feb agenda)
Brogan Lomax – Whare Ora (pages 11, 20-21 of Feb agenda)
John Kopa – Kaitiaki (no report provided)

Question was asked, how are the resources or activities with TPO being done for achieving radical improvement for Maori Health Outcomes?
Answered: By looking at the inequities and people, by addressing the systemic and institutional racism, to change this will take time.
Discussion around staff doing Tikanga training and Treaty training within 6-12 months. KPI's for CE and Exec's include attending these courses.

Received by: Te Pora
Seconded by: Glen

ITEM 7 GENERAL BUSINESS

- **Mental Health Review**
  - Shown what is being coordinated/consolidated.
  - Creating our futures – not consultation, it's feedback.
  - What happens at Executive level shared with IMC.
  - Discussion around wishing to understand the DHB Psychiatrist (Maori) focus or belief regards a model of Mental health intervention. Was his primary focus from a Medical Model perspective or not?
  - Collectively make Board papers with IMC to determine who comes in.
  - More collaborative environment noticed since Derek was appointed as CE.

- Been noted at Board level regarding measurable KPI's, Glen would like to hear this from Derek at the next meeting.

- Discussion around fiscal plan and what do we disinvest in?
- Where is the best place to prioritise our resources and services in order to provide best Maori health outcomes?
- Who will be the replacement for Janise Eketone?
- Are IMC looking at replacing the Chair position? Yes.
- Could a proxy member attend meetings where a member is unable to attend to avoid losing information?
- Could we 'Zoom' people into meetings where they live too far away to travel?

ITEM 8 **Hui Closed:** Matua Hemi Curtis at 13:05

Next IMC Hui: 9.30am 1st March 2018

	Action List	Completed	Who
1.	Summary of HSC agenda for commentary for IMC.		Te Pora
2.	A full review, report and discussion to be requested from Strategy and Funding regarding review of three significant Maori Health providers.		Loraine to talk with Julie Wilson
3.	Can IMC have permanent exit passes?		Loraine
4.	Loraine to discuss the PhD students coming to Waikato DHB from Auckland in next meeting.		Information from Nina Scott
5.	A letter to be written on behalf of IMC Chair in support of the Treaty of Waitangi Tribunal Claim: Wai 1350. To cc: Health Minister and Sally Webb.		Glen
6.	Dr Lawrenson to come and talk to the IMC re: progress and Te Pae Tawhiti work stream.		Loraine
7.	Is there already a mental health nurse in ED?		Loraine
8.	Submit letter to Ministry from IMC on Maori Mental Health		Glen, Kahu, Harry
9.	Conflict of Interest Register	✓	Sarah

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 3.3

STRUCTURE AND OPERATION OF THE BOARD'S COMMITTEES

Purpose	For approval.

On 14 February 2018 the Board convened a workshop to discuss the structure and operation of its committees, and the frequency of their meetings.

A presentation was provided to that meeting which, following a meeting of a sub-group of the Board convened for that purpose, recommended reversion to the statutory model for the operation of the committees.

This was accepted as a general principle. A significant number of other observations and decisions were made. It was agreed that these would be brought back to the Board for further consideration at its February meeting.

Accordingly what follows is a list of the key conclusions reached at the meeting framed as a recommendation. Given the workshop I have not attempted to justify them further but merely to get them down for the Board to endorse or otherwise. However, I have in places put flesh on bones to ensure coherence.

It needs to be stressed that as discussed at the workshop the ability to feed the committees the information they seek is to a considerable extent a function of the disposition of the (parts of the) organisation servicing them. In that regard the Interim Chief Executive acknowledges that change is required but stresses that it will take some time to implement.

Recommendation
THAT

1. The Waikato DHB maintains the existing non-statutory committees (Maori Strategic Committee, Sustainability Advisory Committee, Remuneration Committee and Audit and Corporate Risk Management Committee) and their existing membership subject to the change at 2 below.
2. The Remuneration Committee is retitled the Chief Executive Performance Review Committee.
3. The Performance Monitoring Committee is replaced with a Hospital Advisory Committee[1] (with terms of reference to be adopted at the March meeting).

[1] I decided to use the title Hospital Advisory Committee rather than the title used previously of Health Waikato Advisory Committee as "Health Waikato" is no longer a "brand" the Waikato DHB uses. This may itself need to be discussed.

4. The Health Strategy Committee is replaced with a Community and Public Health Advisory Committee (with terms of reference to be adopted at the March meeting).
5. The Community and Public Health Advisory Committee includes on each agenda a dedicated disability section which concentrates on matters falling within the scope of a Disability Support Advisory Committee as stated in the legislation.
6. The terms of reference to be provided in March are broadly as outlined at the workshop in that they are modified version of the legislative purpose but incorporating the decisions that follow below.
7. The Hospital Advisory Committee and the Community and Public Health Advisory Committee meet every second month as at present.
8. The membership of the Hospital Advisory Committee (including chair and deputy chair) is as for the current Performance Monitoring Committee, and the membership of the Community and Public Health Advisory Committee (including chair and deputy chair) is as for the current Health Strategy Committee, noting that further discussion will occur on consumer representation or otherwise.
9. Monitoring (defined as reports for information and achievement against targets and KPIs) no longer occurs at the Hospital Advisory Committee and the Community and Public Health Advisory Committee.
10. The preferred suite of monitoring information is broken down into a number of segments and one is provided to the Board each month to achieve a complete cycle every three months.
11. Monitoring reporting is reduced in total volume.
12. The Chief Executive for the Board and the supporting executives for the Hospital Advisory Committee and Community and Public Health Advisory Committee respectively report by exception on what is bothering them in their portfolios to supplement the reduced monitoring reporting (style can be idiosyncratic; intent is to share/explore issues with a view to helping resolve them and allow the committee to provide support).
13. The Board's strong preference is to remain strategic at both committees and the Board noting the approach to monitoring/reporting described above.
14. Without attempting to define exhaustively what the content of strategic reporting will be the Board envisages it will cover dimensions such as:
    a. Integration between Waikato DHB services and services delivered by others;
    b. Implementation of our strategy;
    c. Risk.
15. As a proxy for defining the strategic content of committee agendas and the Board agenda in the short term, the executives supporting the committees and the Chief Executive in relation to the Board, will as soon as possible meet with their chairs and convene workshops with their committees/Board to determine (working drafts for) the content of agendas for the next 18 months through to the 2019 elections (the committees should perhaps go first and the Board conclude the process with the results of the committee exercise to hand).

16. The chairs of the main committees (including of those committees not explicitly required by statute) meet regularly to help ensure alignment (Chief Executive PA to provide appointments).
17. The Board's agenda in general covers the following:
    a. The Chief Executive's report as "real-time" assessment of present issues;
    b. Adoption or otherwise of committee advice;
    c. Monitoring as described above;
    d. High level Quality and Patient Safety reporting as the raison d'etre of the delivery part of the organisation;
    e. Health and Safety reporting;
    f. Global financial performance;
    g. Workshopping unformed issues;
    h. External relationships, stakeholder management and understanding the aspirations of key sector players;
    i. Any issues whose timing precludes committee review;
    j. Waikato Medical School;
    k. SmartHealth/Virtual Health Strategy;
    l. Significant multi-dimensional business cases.
18. The assumption is that items go to the committees unless there is good reason for them to go to the Board rather than the other way around.
19. The committees do not have delegated authority.
20. It is noted that executive support for the statutory committees will flow from the Chief Executive's restructure proposal and will be advised as soon as possible.
21. The Board determines oversight of which specific programmes and projects will fall within the scope of each of the three statutory committees either at the present meeting or over time.
22. The quality assurance framework (Director Quality and Patient Safety) comes to the Board as soon as possible.
23. The Board of Clinical Governance develops an approach to anticipating and maximising the chance of achieving the various (main) forms of accreditation and external compliance to which the organisation is subject and to ensuring the Board is kept informed on these matters.

NEVILLE HABLOUS
CHIEF OF STAFF

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 3.4

BOARD POLICIES

Purpose	For approval.

Attached are copies of two Board policies as follows:

1. Board Remuneration and Expenses; and
2. Training for Board Members.

These two Board policies have been affirmed by successive Boards for many years. I have modified the Board expenses provisions to reflect some of the learnings of the past few months.

The Chair supports Board consideration of these policies.

Recommendation
THAT
The Board policies "Board Remuneration and Expenses" and Training for Board Members" are adopted for the current term of the Board.

NEVILLE HABLOUS
CHIEF OF STAFF

Waikato District Health Board

POLICY

Board Remuneration and Expenses

Policy Responsibilities and Authorisation

Department Responsible for Policy	Board Governance
Position Responsible for Policy	Chief of Staff
Document Owner Name	Neville Hablous
Sponsor Title	Chief of Staff
Sponsor Name	Neville Hablous
Target Audience	All Staff
Committee Approved	
Date Approved	
Committee Endorsed	Waikato DHB Board
Date Endorsed	28 February 2018
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Waikato District Health Board

POLICY

Board Remuneration and Expenses

Policy Review History

Version	Updated by	Date Updated	Summary of Changes
04	Neville Hablous	Jan 2017	Three year review

Waikato District Health Board

POLICY

Board Remuneration and Expenses

Contents

Waikato District Health Board

POLICY

Board Remuneration and Expenses

1. Introduction

1.1 Purpose

- The purpose of this policy is to provide guidance on the methods to be used in obtaining approval for payments to/for Board members and appointed members of Board committees, and to clarify the categories of expenditure for which payment may be sought. It also sets out the Board's approach to payment of Board members generally.

1.2 Scope

- This policy applies to all Board members, all appointed members of Board committees, and to the staff that process payments on behalf of these two groups.

2. Definitions

Remuneration	Any annual payment for Board members that is set by the Minister of Health.
Meeting fee	Any payment for Board members or other appointed members of committees for attendance at meetings of the Board or committees that is set by the Minister of Health.
Expenses	Expenditure incurred by the Chair or a Board member in the course of discharging their responsibilities either through the Waikato DHB or personally for which payment is sought.
Committee	Any committee of the Board established pursuant to the New Zealand Public Health and Disability Act 2000 and does not include working parties, working groups or other informally constituted bodies irrespective of whether or not they involve Board members.
Member	Any member of the Board or of any Committee established by the Board pursuant to the New Zealand Public Health and Disability Act 2000.
Responsibilities	Meetings of the Board and its Committees or attendance at other events where this is requested by the Chair of the Board or the Chief Executive.

3. Policy Statements

- Payments to Board members and appointed members of Board committees shall be made in accordance with this policy.

Waikato District Health Board

POLICY

Board Remuneration and Expenses

4. Policy Processes

4.1 Payment of Board members and payment of expenses

- All Board members shall be paid remuneration and meeting fees at the rate and for the purposes set by the Minister of Health.
- All Committee members who are not Board members shall be paid meeting fees at the rate and for the purposes set by the Minister of Health.
- Any member using a private vehicle to attend to responsibilities of the Board may claim reimbursement of costs incurred at the appropriate rate identified by the Inland Revenue Department.
- The distance for which vehicle reimbursement may be claimed shall be the distance from home to the site at which the responsibility of the Board is required to be discharged and return.
- Any member required to stay overnight to attend to responsibilities of the Board occurring on consecutive days, may claim reimbursement of actual and reasonable costs incurred in so doing. These costs may include accommodation, meals and transport. Alternatively the member may seek through the Office of the Chief Executive for these arrangements to be made on his/her behalf. As a general principle no member living more than 100km from Hamilton would be expected to travel to their place of residence at the end of a day of Board business that was to be followed by a second such day.
- Irrespective of the wishes of the member, the Chair may direct that a member shall forfeit their mileage expenses if the cost of mileage reimbursement for them to return to their place of residence outweighs the cost of staying overnight.
- Any member whose employment, family or other responsibilities require them to travel away from their residence may seek payment of actual and reasonable travel and other costs resulting from the need to travel back to attend to responsibilities of the Board. Payment shall not occur where it is apparent that the personal affairs of the member could have been readily re-organised so as to avoid the expenditure being incurred. The onus shall be on the member to demonstrate why the expenditure is necessary and not on the approver to demonstrate why it is not.
- It is recognised that from time to time the Chair and other Board members will be required to travel to represent the Waikato DHB at regional and national meetings, and that in principle this constitutes on acceptable organisational overhead.
- At every Board meeting a schedule of expense paid (excluding remuneration, meeting fees and mileage to attend meetings) will be submitted for information and for discussion as to accountability if this is required.
- The office of the Chief Executive shall generally organise in advance travel and accommodation and any other expenses necessitated by the Board activities of the Chair or other Board members. The general approach shall be to leave as little expenditure as possible to personal discretion.

4.2 Approval of payments

- Approval of remuneration payments that are in accordance with a directive of the Minister of Health may be given by the Chair, the Chair of the Audit and Corporate Risk Management Committee, the Chief Executive or the Executive Director Corporate Services or delegate.
- Approval of meeting fees that are in accordance with a directive of the Minister of Health may be given by the Chair, the Chair of the Audit and Corporate Risk Management Committee, the Chief Executive or the Executive Director Corporate Services or delegate.
- Approval of expenses (comprising mileage costs calculated in accordance with IRD rates) to and from a regular scheduled meeting of the Board or a Committee may be given by the Chair, the Chair of the Audit and Corporate Risk Management Committee, the Chief Executive or the Executive Director Corporate Services or delegate.
- All other approvals of expenses excluding those relating to the Chair shall be given in advance by the Chair.
- All other approvals of expenses relating to the Chair shall be given in advance by the Chair of the Audit and Corporate Risk Management Committee.
- Where the precise quantity of expenses is not know in advance (for example parking and taxi charges) and/or the member has for other compelling reason had to pay for themselves, reimbursement shall be authorised retrospectively by the Chair for the Board, and by the Chair of the Audit and Corporate Risk Management Committee for the Chair.
- Any expenses incurred outside of this policy shall be considered for approval retrospectively by Board resolution.

4.3 Onus

- All members shall be deemed to have read and understood this policy. The responsibility to obtain signed approval for expenses shall lie with the member.

Waikato District Health Board

POLICY

Board Remuneration and Expenses

5. Legislative Requirements

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

- NZ Public Health and Disability Act 2000
- Health and Safety in Employment Act 1992
- Human Rights Act 1993
- Privacy Act 1993
- Employment Relations Act 2000
- Treaty of Waitangi Act 1992

6. Associated Documents

- Waikato DHB Managing Behaviour and Performance policy (Ref. 5250)
- Waikato DHB Code of Conduct for Board Members Policy (5456)
- Waikato DHB Delegations of Authority Policy (Ref. 2175)
- Waikato DHB Fraud Policy (Ref. 3274)

Waikato District Health Board

POLICY

Training and Familiarisation for Board Members

Policy Responsibilities and Authorisation

Department Responsible for Policy	Board Governance
Position Responsible for Policy	Chief of Staff
Document Owner Name	Neville Hablous
Sponsor Title	Chief of Staff
Sponsor Name	Neville Hablous
Target Audience	All Staff
Committee Approved	
Date Approved	
Committee Endorsed	Waikato DHB Board
Date Endorsed	28 February 2018
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Waikato District Health Board

POLICY

Training and Familiarisation for Board Members

Policy Review History

Version	Updated by	Date Updated	Summary of Changes
04	Neville Hablous	Jan 2017	Three year review

Waikato District Health Board

POLICY

Training and Familiarisation for Board Members

Contents

Waikato District Health Board

POLICY

Training and Familiarisation for Board Members

1. Introduction

1.1 Purpose

Training and personal development are essential to maximise the contributions of Board members. This policy defines a process for identifying and approving relevant training while ensuring the prudent use of public funds.

1.2 Scope

- This policy applies to all Board members of Waikato District Health Board.

2. Policy Statements

- The Chair of the Board shall assess the training needs of Board members in the context of their roles, aspirations and prior skills and experience.
- Within the parameters laid down members are encouraged to take advantage of relevant training opportunities.

3. Policy Processes

3.1 Training process for board members

- The Chair shall assess and agree with each Board member their training and personal development needs in the context of their particular responsibilities and their personal development needs/interests in relation to the Board generally.
- A sum of $5000 shall be available to each member in each calendar year to meet identified training and personal development needs.
- The use of that funding (whether in whole or in part) shall be agreed with the Chair prior to any personal or other obligations involving the use of those funds being entered into.
- Subject to Chair approval, members are free to allocate the funding available in the way that suits their personal circumstances so long as all costs are reasonable and relevant and the training actually occurs.
- Carry-over of funding from one calendar year to the next will not be automatic but will only occur with the agreement of the Chair.
- To remove all doubt, the Chair is authorised to approve or turn down all relevant training and personal development proposals submitted either on a one-off basis or because in the Chair's assessment sufficient training opportunities have already been taken.
- The Chair's own training and personal development needs shall be agreed with the Deputy Chair and Chair of the Audit and Corporate Risk Management Committee. The Deputy Chair and Chair of the Audit and Corporate Risk Management Committee shall

also approve the use of funding for training and personal development on the part of the Chair.

Note: The annual sum of $5000 is not intended to necessarily result in total expenditure of $15,000 per member by the end of the term but is rather to ensure that in any year in which training does occur it is at a meaningful level.

4. Legislative Requirements

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

- NZ Public Health and Disability Act 2000
- Health and Safety in Employment Act 1992
- Human Rights Act 1993
- Privacy Act 1993
- Employment Relations Act 2000
- Treaty of Waitangi Act 1992

5. Associated Documents

- Waikato DHB Code of Conduct for Board Members Policy (5456)
- Waikato DHB Delegations of Authority Policy (Ref. 2175)
- Waikato DHB Fraud Policy (Ref. 3274)

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information and approval.

HealthTap Review

The awarding of the contract for the HealthTap review has been completed with the successful tenderer being Ernst and Young. The contract order has been completed and the initial work is underway.

As part of the review there will be a series of surveys for patients and clinicians to provide an avenue for their feedback to be collected and integrated into the final report. There will also be 20 dedicated stakeholder interviews to be undertaken for in-depth commentary. These interviews will be across the community, partner organisation and clinical staff. The review will be finalised for presentation to the May board meeting.

Virtual Health Care Strategy Refresh Project Update

Work to update and engage on a refreshed Virtual Health Care Strategy began in October 2017, with a new draft strategy due to the Board in May 2018 and a final Virtual Health Care Strategy ready to be adopted by the Board in June 2018.

The refresh project is currently in phase three, which focuses on engagement. Eight open two-hour workshops have been organised (Paeroa, Tokoroa, Raglan, Hamilton, Huntly, Otorohanga, Morrinsville, and Taumarunui), an on-line survey, an email address, and targeted staff workshops have been organised for the period 16 February to 16 March. The focus for engagement includes the following:

- Guidance from our clinicians about how they can deliver services (where appropriate) virtually
- Guidance that reflects our communities' perspectives about what they want from virtual health care and services
- Guidance from health care and service providers about collaborating on delivering virtual health care and services
- Direction that responds to the strategic priorities from the Ministry of Health
- Direction that responds to Waikato DHB's Strategy and long-term plans, especially:
  - models that will enable people-powered healthcare where patients have a greater say in their own care, and when and where it is delivered
  - models to deliver equitable health care and services when using virtual health care services

– models that provide 'care closer to home', making it more convenient for patients who often live far from a hospital, giving everyone access to timely care.

If Board members would like to attend workshops or require further information, please contact Darrin Hackett.

Planning for 2018/19

In previous years the general timeframe has involved the planning guidelines, advice from the Minister of Health around his direction to the sector (the Ministers letter of expectations), population data and Funding advice being received in the period leading up to Christmas. For the 2017/18 year this process had a number of delays with the most significant being the delays in the final funding advice. This created a number of challenges in relation to the budgeting process where budgets were developed based on some fairly broad revenue assumptions.

For 2018//19 there are expectations that the process will be similarly delayed. At this stage we have received information on revised population projections for 2018/19 but are yet to receive the Minister's letter of expectations or planning guidelines. We have had indications that this advice should be received over the next few weeks. Initial indications are that this will occur prior to the funding advice, however, at this stage there is not a definitive date for when this will be received and if it will be received prior to budget announcements on 17 May 2018.

Whilst our overall population numbers are appearing to increase slightly above national levels, our increase in the older population groups, whilst significant, are slightly below the national average. This impacts on the PBF formula so we would expect our PBF share to remain constant for 2018/19.

Work has commenced in relation to the annual plan, production planning and budgeting based on some initial assumptions including the structure of the plan and priorities remaining in line with 2017/18 advice. Initial indications from the Ministry of Health are that they are aware that the timeframes for submission of the draft annual plans will need to be extended, however no indicative dates have been received.

Coronial Support Services

Waikato is part of a consortium of providers who have jointly bid to provide coronial support services to the Ministry of Justice. The other organisations involved are Communio (a private provider), Pathlab and Southern Community laboratories. The Ministry of Justice have awarded the consortium with a long term service contract for all of New Zealand except Palmerston North, Canterbury, Auckland and Northland. The lead provider will be Communio and Waikato will subcontract its mortuary services and staff to them. It is expected that the number of invasive post mortems will decrease overall but that the number undertaken in Waikato will increase. A realignment of the catchment boundary northwards into South Auckland and southwards into Taranaki is anticipated. The new contact will commence in the first quarter of 2018/19.

Executive Restructure

A verbal update will be given at the Board meeting.

Ten Year Services Plan

A verbal update will be given at the Board meeting.

Chief Medical Officer

The DHB has advertised for a Chief Medical Officer. We have already had interest from internal and external applicants, including the UK. This is very encouraging and I hope demonstrates that this DHB is once again being seen as an attractive place for staff to work.

Audit of the Universal Newborn Hearing Screening and Early Intervention Programme

Waikato DHB has received advice from the Ministry of Health that all corrective actions from the audit of this programme have been completed which means the DHB has achieved all the standards that were assessed by the audit. Many of the actions were addressed quickly and demonstrate commitment to delivering a quality newborn hearing screening service.

Recommendation
THAT
The Board receives the report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

Quality and Safety

Quality and Safety: No report.

Decision Reports

MEMORANDUM TO BOARD
28 FEBRUARY 2018

AGENDA ITEM 6.1

BANKING SERVICES SUPPLIER

All DHBs are progressing transition from Westpac to BNZ for transactional and other banking services. Waikato DHB has agreed to transition after implementation of the National Oracle Solution (NOS), planned for 1 July 2018. This requires extension of the current Westpac contracts from 28 March 2018 to 21 December 2018. This memo seeks the Board resolution required for Westpac's records to agree with this extension, and agree completion of the attached board member's certificate.

The board member's certificate references the following documents:

1. Letter of Variation to the Master Banking Services Agreement. This agreement focuses on the banking services provided by Westpac. Summary of key changes are:
    a. Extension of the term from 28 March 2018 to 21 December 2018.
    b. Decrease in the terms of notice to terminate the contract.
    c. Changes and clarity to Westpac charges over the term of the extension including:
        i. decrease in the interest rate on the New Zealand Health Partnerships account of OCR to OCR less 25bps.
        ii. changes to transactional charges with an estimated total cost to Waikato DHB of $8,800 (per table below), noting an alternative accelerated transition creates high risk if we attempt to change banks during NOS implementation.

Transaction Type	Annual Volume[1]	Unit Price		Estimated Impact	
		Current	Transitional period[2]	Monthly	Transitional period
Over the Counter	1,200	$0.11 to $0.16	$0.30	15	$1,150
Cheques	250	$0.11	$0.30	5	$55
Electronic	220,000	$0.0375	$0.08	780	$8, 805
Waikato DHB – Transaction fee cost increase				**800**	**$8,800**

2. Letter of Variation to the Treasury Services Agreement. This agreement focuses on the agreement between New Zealand Health Partnerships and DHBs. Summary of key changes are:
    a. Remove requirements on DHBs and subsidiaries to exclusively use Westpac's banking services.
    b. Clarify that a DHB's or subsidiary's cancellation of the sweep instructions under the Westpac master agreement will also terminate the Treasury Services Agreement in respect of that DHB or subsidiary.

Recommendation
THAT
The Board:

1) Approves the transactions contemplated by the documents listed in the board member's certificate (attached), and the documents themselves.
2) Authorises execution of the documents by Waikato DHB.
3) Confirms that Andrew McCurdie (Chief Financial Officer) and Rowan Cramond (Treasurer) are authorised by the Board to execute the documents on behalf of Waikato DHB.
4) Authorises the persons currently authorised to give any notices and other communications in connection with the existing documents referred to in the schedule, to give any notices and other communications, and take any other action required, under or in connection with the documents on behalf of Waikato DHB.
5) Approves Sally Webb (Acting Chair) to sign the attached board member's certificate on behalf of the Board confirming approval of the points above.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

BOARD MEMBERS CERTIFICATE

To: Westpac New Zealand Limited (Bank)
And to: Chapman Tripp
And to: Buddle Findlay
And to: NZ Health Partnerships

I, Sally Webb, a member of Waikato District Health Board (**DHB**) certify as follows:

Board Resolutions

1. The Board of the DHB has, by all necessary resolutions duly passed:
    a. approved the transactions (the **Transactions**) contemplated by the documents listed in the schedule attached (the **Documents**), and the Documents themselves;
    b. authorised execution of the Documents by the DHB;
    c. confirmed that Andrew McCurdie (CFO) and Rowan Cramond (Treasurer) are authorised by the Board to execute the Documents on behalf of the DHB; and
    d. authorised the persons currently authorised to give any notices and other communications in connection with the existing documents referred to in the schedule below, to give any notices and other communications, and take any other action required, under or in connection with the Documents on behalf of the DHB.
2. Each of the relevant board resolutions was duly passed at a meeting of the Board:
    a. which was properly convened; and
    b. in respect of which all quorum requirements were duly observed.
3. The Board resolutions remain in full force and effect.

Consents

4. All necessary consents and other requirements of governmental public and other bodies and authorities required by the DHB for or in connection with the execution, performance and delivery of the Documents and the carrying on of the business operations of the DHB have been obtained and are in full force and effect.
5. There are no consents and other requirements arising from or relating to any provision of any contract or other arrangement to which the DHB is a party or which relates to or refers to any of the DHB's assets or revenues required for or in connection with the execution, performance and delivery of the Documents by the DHB which have not been obtained and which are not in full force and effect.

Dissolution

6. As at the date of this Certificate no step has been taken for the dissolution, liquidation or dis-establishment of the DHB nor, as far as I am aware, is any such action intended to be commenced by any person or anticipated by the DHB.

SIGNED by

Sally Webb))

Board Member's Name | Signature

Dated this 28th Day of February 2018

Schedule of Documents

1. Letter of Variation to the Master Banking Services Agreement dated 26 March 2012 as amended from time to time (including an Amending Deed (relating to a Master Banking Services Agreement) dated 30 September 2014, an Amending Deed No.2 (relating to a Master Banking Services Agreement) dated 17 June 2015 and a letter agreement dated 28 March 2017) between Health Benefits Limited (now NZ Health Partnerships Limited pursuant to the Health Sector Transfers (NZ Health Partnerships Limited) Order 2015), Westpac New Zealand Limited, certain District Health Boards (the **DHBs**) (including the DHB) and certain District Health Board Subsidiaries (the **DHB Subs**);
2. [Letter of Variation to the DHB Treasury Services Agreement dated 26 March 2012 as amended from time to time (including an Amending Deed (relating to a DHB Treasury Services Agreement) dated 30 September 2014 and an Amending Deed No.2 (relating to a DHB Treasury Services Agreement) dated 17 June 2015) between Health Benefits Limited (now NZ Health Partnerships Limited pursuant to the Health Sector Transfers (NZ Health Partnerships Limited) Order 2015), certain DHBs (including the DHB) and certain DHB Subs]; and
3. any other documents necessary, desirable, advisable or incidental to or in connection with the document[s] described above.

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 6.2

REPLACEMENT OF HEART LUNG MACHINES

Purpose	For approval.

1. INTRODUCTION

The Cardiovascular Service at Waikato DHB has a requirement to replace three core critical Heart Lung Machines (HLM) and four arterial pumps. The HLM and arterial pumps are essentially one unit in that the HLM cannot function without the arterial pump. The arterial pump however can and is used independently for other procedures such as extracorporeal membrane oxygenation (ECMO).

Cardiopulmonary bypass or the HLM temporarily takes over the function of the patients heart and lungs during surgery, maintaining the circulation of blood and the oxygen content of the patient's body. Our current HLM and arterial pumps have known function problems which are becoming more numerous rendering them unreliable.

Approval is sought for expenditure of capital to replace these machines. The Capital Plan includes a total of $680k in 2017/18. The price to replace based on the recent request for quote (RFQ) process is $1.5m.

2. PROBLEM STATEMENT

Approximately 650 cardiac procedures are performed in the Waikato cardiothoracic surgical department annually. All cardiac surgery procedures require the support of a HLM during surgery.

The department currently has three HLM and three arterial pumps:

- 2 x S3 Stockert HLMs manufactured in 2001 and which have now passed their expected end of life. The manufacturer has given notice that they will not be able to provide future support for these HLMs beyond December 2018.
- 1 x S5 Stockert HLM manufactured in 2006 and which has now passed its expected end of life.
- 3 x Medtronic arterial pumps – these are attached to the above HLM machines. All three pumps are around 20 years old and while we continue to have these serviced Medtronic have indicated that they will no longer be able to source replacement parts for them. Until recently we had four functioning arterial pumps but one has failed and is unable to be repaired.

Usual practice is that when two cardiac theatres run concurrently it is safe practice for a third machine to be available in the event of equipment failure, as occurred

recently, or should an emergency case arise or if an earlier case needs to return to theatre.

However, there is increasing risk of equipment failure due to the aging of the HLMs and the increased workload. The risk impacts on patient safety and the potential for the Waikato DHB to continue to deliver Cardiac services.

This is evidenced when on Friday 8 December 2017 one of the arterial pumps failed at around six minutes after bypass had begun on a patient undergoing coronary artery bypass surgery (CABG). We were able to replace the pump with one from another HLM and the procedure continued. We are fortunate that there was no harm caused to the patient. The arterial pump had been serviced the week before. The arterial pump was returned to Medtronic and they have confirmed that the failure was due to a faulty external drive motor circuit board and that it is unable to be replaced and/or repaired. Medtronic's Service and Repairs department has recommended the scrapping of the equipment due to end of life parts and repairs.

3. EXISTING RISK EXPOSURE

The age of the HLMs and Arterial Pumps has been recognised as a risk to the DHB and has been entered onto the risk register with a status rating 12 (major) due to:

- Unreliable end of life machines with potential to fail inter operatively as evidenced recently
- Risk to patients if machines fail inter operatively
- Risk to Service delivery due to insufficient functional machines
- Increasing inability to repair and maintain existing machines
- Lower capability to provide specific information around patient monitoring during surgery.

4. OBJECTIVES

This initiative will achieve the following objectives:

- Ensure that Cardiovascular Services maintains an adequate fleet of safe and serviceable HLM to meet current service demand
- Ensure the safety of patients undergoing cardiac surgery
- Maintain timely asset replacement of core critical equipment.

5. REQUIREMENT FOR REPLACMENT

The requirement to replace the HLMs is driven from age, the subsequent risk of failure inter operatively and the manufacturer indicating that they will not be able to provide support for the 2 x S3's past December 2018. Or in other words these machines have reached their technical obsolescence and can no longer be considered fit for purpose. However, the demands for patient care are obvious – we cannot undertake cardiac surgery procedures without putting patients on cardiopulmonary bypass.

6. OPTIONS

The following options have been considered:

No.	Option	Status	
1	Do nothing	Rejected	The do nothing option is not viable as

			it does not mitigate the risk that the HLM may fail inter-operatively. Nor does this option ensure that we have the right equipment to deliver safe patient care.
2	Replace 4 arterial pumps (and not the base HLMs)	Rejected	HLMs are end of life so this option does not address the current risk that the machines may fail inter operatively. Nor does this option ensure that we have the right equipment to deliver safe patient care.
3	Replace 2 x HLM and 4 x arterial pumps	Rejected	Addresses the risk around two of the machines but still leaves a risk around the third machine. This option would cost $1.3m.
4	Replace 3 x HLM and 4 x arterial pumps	Recommended	Addresses the risk around all of the equipment and ensures that we have the right equipment to deliver safe patient care. This option would cost $1.5m.

7. RECENT RFQ PROCESS

In September and October of 2017 we went out to RFQ to replace the HLMs. We received only one response from a supplier base of around four who are currently in the market and that the respondent was from our incumbent supplier. It should be noted that their proposed solution did not address all of the requirements of the RFQ – namely that they did not have a solution for ECMO. However, ECMO requires the use of a standalone pump and not the use of a HLM. We decided to include the requirement for an ECMO solution in the RQF for completeness so the fact that the solution from the supplier did not provide a solution to this does not compromise the HLM solution that they submitted.

Two of the suppliers declined to respond as their current solution is at the end of the product cycle and they expect to launch new solutions to the market within the next six months.

After discussion with the Clinical Director, Adam El Gamel we decided that there would be benefit in ceasing this process and joining with the NZ Health Partnerships national procurement activity for perfusion capital and consumables that is starting in early 2018. That would allow us to leverage volume for the pricing of HLM bases, as well as having more engaged competition in the process than what we received in the RFQ.

But the recent failure of an arterial pump during surgery has caused us to reconsider the decision to wait. After consultation with the Clinical Director and senior management we are looking to continue with the RFQ process as has already been started.

It should be noted that the new models that are coming onto the market in the next six months are not new technology as such. The primary function of a HLM is to take over the function of the heart and lungs during surgery and the new models will not perform this function materially differently from the current machines – ie these are like for like replacement. The new models are however, more compact, lighter and more easily manoeuvrable.

The current quote from the preferred suppliers indicates that the replacement HLM could be here in around 12 weeks from placement of the order.

8. FINANCIAL OVERVIEW

Shown below is a breakdown of the cost to deliver new HLMs and arterial pumps.

Capital Costs	$m
HML Replacement	$1.5m[1]
Total	**$1.5m**
Capital Budgeted	**Partly - $680k**

Recommendation
THAT
The Board:

1) Receives this report.
2) Notes that $680k is on the approved capital expenditure plan.
3) Approves an increase in budget from $0.7m to $1.5m for 2017-18 noting that this can be managed within the overall capital plan.
4) Approves the capital expenditure of $1.5m to replace the three heart lung machines and four arterial pumps.
5) Approves that cash flow all be in the current year.

DR GRANT HOWARD
CHIEF OPERATING OFFICER, WAIKATO HOSPITAL (INTERIM)

[1] Per the RFQ process that was run last year.

MEMORANDUM TO THE BOARD
18 FEBRUARY 2018

AGENDA ITEM 6.3

BUSINESS CASE: SURGICAL ASSESSMENT UNIT AT LEVEL 8 MENZIES BUILDING, WAIKATO HOSPITAL

Purpose	For approval.

BACKGROUND

As the outcome of a number of signals that the hospital inpatient capacity was insufficient, and as part of future planning, the Board requested a workshop item in December 2017 to discuss future capacity options for the Waikato Hospital and the Services delivered therefrom.

Two ongoing issues were identified being:

- There was a deficit in identifiable models of care describing how care was to be delivered.
- Whilst there was physical space available in the hospital for development (or refurbishment) this would require significant investment.

At the end of the workshop, an undertaking was made to present to the Board a rolling series of presentations and business cases to support the development of, and justification for, such investment. This is the first of such.

PROPOSAL

The attached business case addresses two issues:

1) The Waikato Hospital has not had a planned nett increase in inpatient bed capacity since the 1980's when the Elizabeth Rothwell building was erected. The Service and Campus redevelopment programme conducted from 2004 to 2018 has not delivered a material increase in inpatient bed capacity, based as it was on the development of an ambulatory model of care. This issue must be addressed in the short, medium and long term, this proposal is a short term solution that does not limit future options, but actually increases these options.
2) Much has been made of the lack of a set of service plans, and demonstrable models of care. This proposal supports a re-casting of the campus into acute and elective services and starts to put in place suitable models of care for acute surgical care.

The business case is for the refitting of a vacant area within the Waikato Hospital campus - Level 8 Menzies, previously the "Day Surgery Unit". The proposal is to get this area to a usable standard and configured with 26 beds. This ward would then be

used as an Acute Surgical Assessment Unit and will be operational by July 2018, in time for the winter increase in bed demand, if immediate Board approval and procurement exemption is given,

The proposed option has been costed at **$1,561,254** capital investment**,** and direct ongoing of operational expenditure of **$5,214,585** per annum.

Strategically, this business case has significant and clear alignment to:

- Strategic Priority 2.1: Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement and innovation.
- Strategic Priority 2.2 – Prioritise fit for purpose care environments.
- Strategic Priority 4.3 – Redesign services to be effective and efficient without compromising the care delivered.

Recommendation
THAT
The Board approves the proposed redevelopment of level 8 of the Menzies Building and implementation of the linked model of care.

DR GRANT HOWARD
CHIEF OPERATING OFFICER, WAIKATO HOSPITAL (INTERIM)

Waikato District Health Board

HW1808-001-01
Surgical Assessment Unit at Level 8 Menzies

Business Case

Purpose This business case proposes the refitting of the unoccupied L8 Menzies into a Surgical Assessment unit holding 26 beds.

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Business Case Owner	Grant Howard
Group\Department	Surgical Services
Author	Grant Howard
Last Updated	19 February 2018
Document Name	Surgical Assessment Unit at L8 Menzies
Version	1.7

Mandate

As the outcome of a number of signals that the hospital inpatient capacity was insufficient, and as part of future planning, the Waikato District Health Board requested a workshop item in December 2017 to discuss future capacity options for the Waikato Hospital and the Services delivered therefrom.

Two ongoing issues were identified:

- There was a deficit in identifiable models of care describing how care was to be delivered.
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This is the first of such.

Revision History

Date	Author	Summary of Changes	Version
8/2/2018	Matthew Johnston	Initial Document pre circulation & feedback	1.1
11/2/2018	Grant Howard	Revision	1.2
12/2/2018	Grant Howard	Revision	1.3
14/2/2018	Derlys Jones	Revise resource requirements	1.4
16/2/2018	Derlys Jones	Revise resource requirements	1.5
19/2/2018	Matthew Johnston	Include Allied Health resourcing, Update costing based on P+I feedbac	1.6
19/2/2018	Grant Howard	Final Revision	1.7

Engagement – Visible Help

Name	Service	Date	Impact Y/N
Erika Barrie	Finance	10/01/2018	Y
Kurt Fredericks	Biomedical Engineering	31/01/2018	Y
Rob Rope	Procurement		N
Di Brough	Human Resources	30/01/2018	Y
Graham Dudfield	Property & Infrastructure – has been involved in considering different options and developing this business case.	10/01/2018	Y
Melinda Ch'ng	Business and Support – increased operational services to support new area in Level M3	9/2/2018	Y
Geoff King	Information Services		N

Name	Service	Date	Impact Y/N
Mo Neville	Quality & Patient Safety		N
Anne Welsh	Learning & Development		N
Dean McLeod	Supply Chain	26/01/2018	Y

Mandate

An initial short form of this business case was presented to the Waikato DHB Executive (Operations), the membership of which is reflected below. The advice of this committee to the Chief Executive was that the refurbishment of level 8 of the Menzies Building be undertaken as soon as possible[1].

Name	Project Role \ Title	Issue Date	Version
Derek Wright	CE and Chair: Operations Executive	19 January 2018	n/a
Loraine Elliott	Executive Director Te Puna Oranga	19 January 2018	n/a
Maureen Chrystal	Executive Director Corporate Services	19 January 2018	n/a
Sue Hayward	Chief Nursing and Midwifery Officer	19 January 2018	n/a
Rees Tapsell	Interim Chief Medical Officer	19 January 2018	n/a
Mo Neville	Director of Quality and Patient Safety	19 January 2018	n/a
Lydia Aidon	Executive Director Public and Organisational Affairs	19 January 2018	n/a
Vicki Aitken	Interim Executive Director Mental Health & Addictions	19 January 2018	n/a
Marc ter beek	Executive Director Operations and Performance	19 January 2018	n/a
Mark Spittal	Executive Director Community & Clinical Support	19 January 2018	n/a

[1] Not all of the above were present at the meeting where this issue was discussed however the agenda was distributed prior to the meeting and the proceedings of the previous meeting confirmed at subsequent committee meetings.

Name	Project Role \ Title	Issue Date	Version
Grant Howard	Interim Chief Operating Officer Waikato Hospital Services	19 January 2018	n/a

Approvals

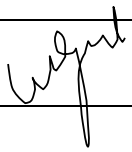
Approver	Signature	Issue Date	Version
Derek Wright Interim Chief Executive			
Grant Howard Interim Chief Operating Officer		19/02/2018	1.7

Table of Contents

1. Summary of Proposal

This proposal seeks to address two issues.

1. The Waikato Hospital has not had a planned nett increase in inpatient bed capacity since the 1980's when the Elizabeth Rothwell building was erected. The Service and Campus redevelopment programme conducted from 2004 to 2018 has not delivered a material increase in inpatient bed capacity, based as it was on the development of an ambulatory model of care[2]. This issue must be addressed in the short, medium and long term, this proposal is a short term solution that does not limit future options, but actually increases these options.
2. Much has been made of the lack of a set of service plans, and demonstrable models of care. This proposal supports a re-casting of the campus into acute and elective services and starts to put in place suitable models of care for acute surgical care.

This proposal is for the refitting of a vacant area within our current campus - Level 8 Menzies, previously the "Day Surgery Unit". The proposal is to get this area to a usable standard and configured with 26 beds. This ward would then be used as an Acute Surgical Assessment Unit.

Assuming immediate Board Approval and procurement exemption this ward will be operational by July2018 – in time for the winter increase in bed demand.

The proposed option has been costed at **$1,561,254** capital investment**,** and direct ongoing of operational expenditure of **$5,214,585** per annum.

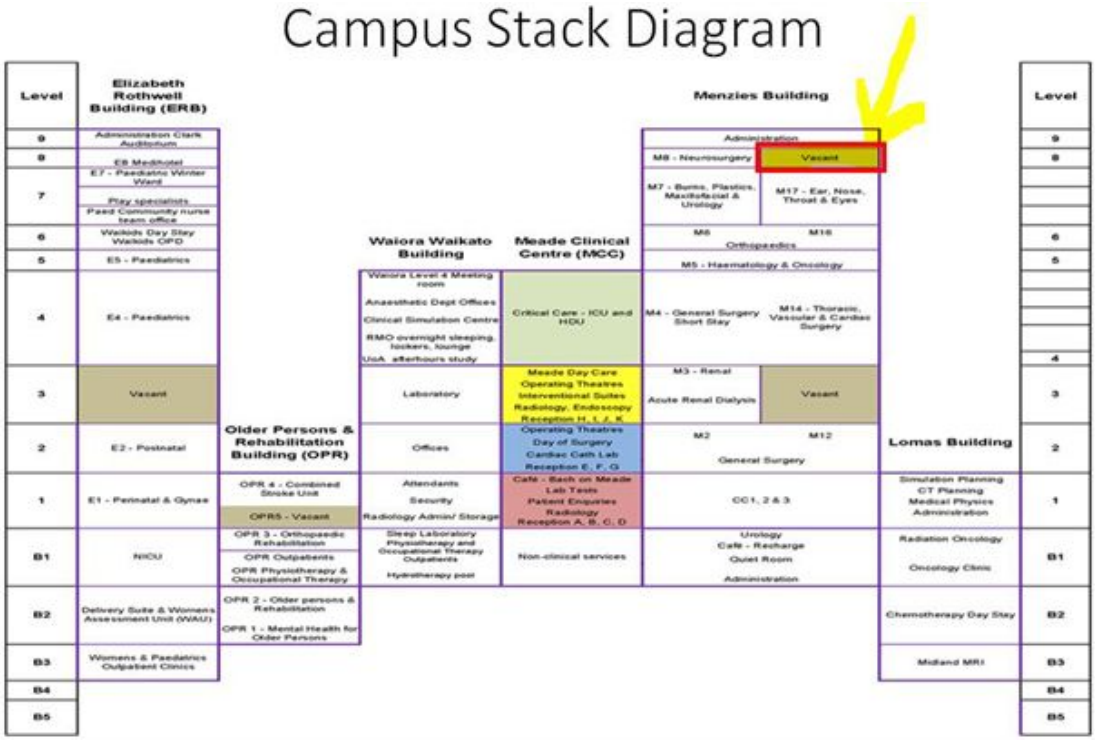
Strategically, this business case has significant & clear alignment to

- Strategic Priority 2.1: Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement and innovation
- Strategic Priority 2.2 – Prioritise fit for purpose care environments
- Strategic Priority 4.3 – Redesign services to be effective and efficient without compromising the care delivered

[2] See appendix 3: Change in bed capacity 2004-2018.

1.1. The Physical Space Now

The physical location being upgraded back in to service is:



Level 8 –Main Corridor (Photo Jan 2018)

Level 8 – vacant bed locations (Photo Jan 2018)

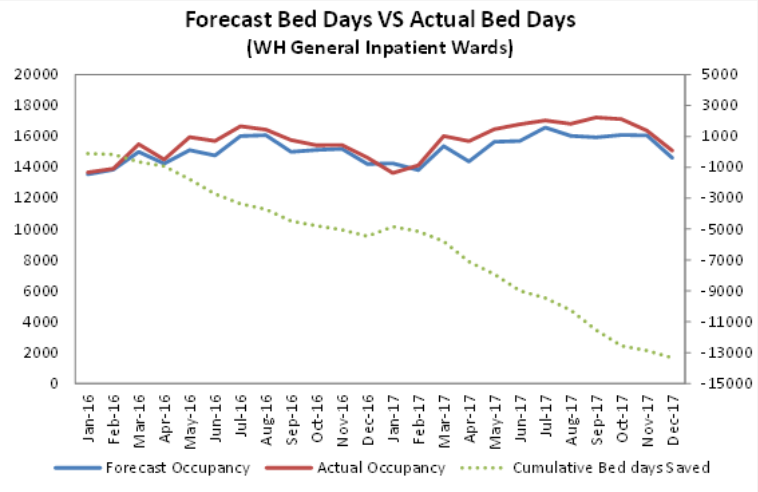
Level 8 – Unused Reception Desk (Photo Jan 2018)

1.1. The Proposed Physical Space

2. Reasons

2.1. Problem statement

1. Notwithstanding the fact that services within the Waikato Hospital can be designed better and delivered more effectively, we have a bed plan that identifies month in and month out that we have a deficit in beds required to service the patients admitted for care.
    a. This deficit is now not a winter-only phenomenon, but is present all year round, peaking in winter at 60 or more beds more required than staffed.
    b. Our ability to predict this deficit is reliable as shown by a reconciliation of beds required to beds occupied.



    c. The constant pressure of trying to admit more patients than can be safely accommodated is reflected in increased dysfunction, deteriorating morale, increasing nursing workload measured through objective tools, the use of areas like the emergency department as a buffer zone, and must inevitably result in worse care for patients.

2. The absence of appropriate models of care and mid to longer term clinical services planning means that there is no plan for staff to follow, or more importantly to believe in, that will show them how they get from where they are now, to a better place. This is a critical function of District Health Board leadership and management, that there is some identifiable and believable path we are following. The absence of this plan is telling. Our ability to describe a different future and a path thereto that people can believe is the number one priority for leadership at this point.

NB: We can clearly do things better than we are currently doing. This leads inevitably to a rational argument that changing the way we work will free up capacity, and that rather than adding to the overall capacity to relieve pressure we should just work differently. This argument has merit but it overlooks some significant issues:

- The entire organisation is tired of change. The last decade has been incessant change and organisation resilience has diminished for a number of reasons.
- Getting people to work differently must be supported by a degree of concrete change that seems to address the problems.
- The organisation must plan around the long run average of healthcare management capability as demonstrated in this District Health Board.

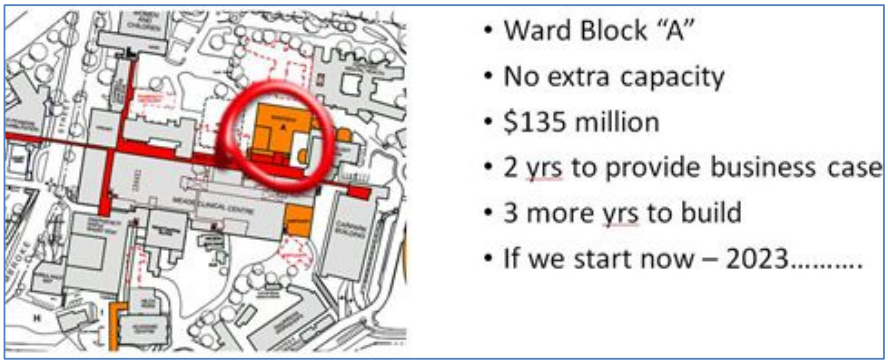
2.2. Objectives

This business case will achieve the following objectives:

1. An increase in overall hospital capacity to close the gap between projected bed capacity requirements and available (and staffed) hospital beds, in a way that is consistent with a longer term development plan.
2. The development of a model of care for acute surgical patients that provides tangible benefits for these patients and that are reflected in the performance of the District health Board using currently accepted measures.

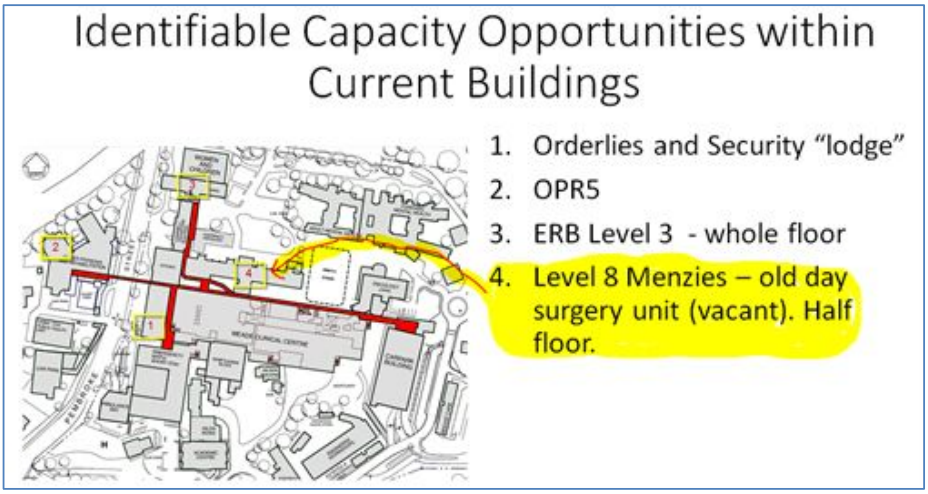
2.2.1. Increase in hospital capacity

Waikato Hospital has an identified capcity shortfall of approximately 60 beds this coming winter and somewhere between 90 and 130 beds within the next 3 years. There is currently no approved plan to address this issue barring the development of three ward blocks identified as part of the Service and Campus Redevelopment plan, the first of which (Ward Block "A") is unlikely to be built in less than 5 years, costing 135 million dollars and which will not increase bed stock as it will serve as a decant from ward space that will be concurrenly demolished.



Powerpoint slide: Board Workshop December 2017.

Based on the neccesity of addressing hospital capacity in the short term, yet having no reliable long term plan to rely on as yet, 4 options have been identified at previous board & executive level briefings, where additional beds can be found within the existing campus.



Powerpoint slide: Board Workshop December 2017.

Of these four options, the orderlies and security lodge would be the most suitable site but cannot be delivered in an acceptable time frame[3]. The OPR5 space will be staffed to accommodate predominantly medical patients as part of the development of a model of care to integrate the acute care of elderly and frail patients[4]. Whilst the Elizabeth Rothwell building has more floor space it is remote from theatres and the emergency department. Furthermore the airconditioning of this entire building should be upgraded at a cost of around 2 million dollars.
For this reason the vacant area of level 8 Menzies stands out as the obvious short term solution. With regard future options, should the Board approve what is now the Orderlies and Security lodge as the end state for the acute surgical assessment area (and other co-located functions) the area in Menzies level 8 could be used as a decant ward as part of a rotational program for ward maintenance or developed as a spinal and trauma service, adjacent as it is to the existing neurosurgical ward.

2.2.2. Development of Suitable Models of Care.

At present there is no segmentation of acute and elective surgical services, which is a fundamental requirement of improved service function.

In addition patients who present to the Emergency Department are being held in the department awaiting review even when it adds no further value to their care.

The development of an acute surgical admission and assessment unit is a well-established strategy to improve the quality of care for surgical patients, adopted widely throughout the world.

In addition we propose to use the unit as a short stay unit, so that patients admitted acutely only go to one ward for their treatment where this can be facilitated as part of a shorter stay[5].

2.2.2.1. Proposed Model of Care

An acute surgical admission, assessment and short stay facility.

- **Access criteria:** A patient requiring admission for an acute surgical review and/or the associated surgical procedure.
- **Access path:** Emergency Department[6].
- **Decision to admit**: By agreement (emergency physician and accepting surgical team)
- **Length of stay:** no more than 48 hours (TBC – capacity constraints may foreshorten this horizon).
- **Patient disposition:** Discharge home, theatre event, or admit to standard ward.
- **Estimated volume of patients:** Approximately 1000 patients per month (528 of whom proceed to theatre).
- **Modelling of capacity:** 1000 patients staying 2 days would require 70 beds. When we apply an average length of stay to the number of patients admitted, we require 30 beds.
- **Deployment option mitigations:**
    - Complex patients directed to home ward from ED or at first opportunity
    - Some patients will be discharged in less than 24 hours
    - Some patients will progress to theatre and disposition thereafter will not include a return to the SAU.
    - Some patients are admitted by necessity to other destinations (eg: ICU)

[3] A proposal to develop this area as an end-state will be provided to the Board as part of a rolling plan and development of a comprehensive roadmap.

[4] Francis Group project now in week 5 of 26 week programme at time of Board meeting.

[5] There is a dependency clearly between theatre capacity and length of stay, being addressed in the surgical reinvention project.

[6] Some consideration must be paid to “as arranged” patients, however these are currently out of scope.

2.2.3. Benefits

2.2.3.1. Quantifiable Benefits

- Contribution to a bed plan that meets current demand for inpatient beds.
- Decrease in measured nursing workload (AWM) across current surgical wards.
- Improvement in ED 6 hr target breaches by patients in surgical pathway. (Currently 10 – 14 patients/day or 6% improvement).
- Decrease in length of stay for surgical patients in the long run (Un-modelled locally. Equivalent 20 beds in neighbouring DHB).

2.2.3.2. Benefit realisation

- Fit for purpose model of care.
- Better decisions made sooner for surgical patients
- Patient flow from ED not affected by indecision or disagreement about which surgical discipline will co-ordinate care.
- Improved morbidity (and mortality?)
- Better staff morale

2.2.4. Strategic Alignment

1. Health equity for high needs populations:
    - 1.1 Radical improvements in Maori health outcomes by eliminating health inequities for Maori
    - 1.2 Eliminate health inequities for people in rural communities
    - 1.3 Remove barriers for people experiencing disabilities
    - 1.4 Enable a workforce to deliver culturally appropriate services

1.1 An improvement in acute surgical care will benefit disadvantaged communities presenting as acute and unplanned care episodes.

1.2 Indirectly rural communities would benefit from a better surgical service, of which this proposal is one part, in terms of access to planned surgical care.

1.3 At present the model of care does not support care and consideration for patients with disability.

1.4 At present the model of care does not support care and consideration for patients in a culturally sensitive manner

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

2.1 At present the emergency department is both the gateway for acute surgical patients and a buffer against the availability of surgical teams. This creates a gating effect that delays the philosophy of “right place right time right team”

2.2 Staff of this unit will become specialised in this area. Processes will be tailored for this patient grouping rather than have these patients held in ED or sent to a general ward.

2.3 This change in model of care was first considered as part of the SCR program a decade or more ago.

2.4 An acute surgical assessment area as part of admission flow provides an opportunity for decision making at the front end of the care episode.

3 People centred services:

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

3.1 This model of care is well accepted nationally and internationally as an effective way to improve patient centred services, including in the NZ setting.[7]

3.2 See 1.4

3.3 The current model of care places professional teams in a conflict situation.

3.4 Not Applicable

4 Effective and efficient care and services:

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

4.1 This is using existing capacity that is currently been left vacant

4.2 At present we are stretching our nursing staff beyond reasonable limits by not providing a fit for purpose facility in sufficient quantity.

4.3 This proposal outlines a model of care where previously there has

[7] Alexandra Jacobson, Garth Poole, Andrew G Hill, Magdalena Biggar. The impact of a surgical assessment unit on numbers of general surgery outliers. 2nd December 2016, Volume 129 Number 1446

not been one.

4.4 We are adopting effective models to improve service.

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

5.1 Not Applicable

5.2 Not Applicable

5.3 Not Applicable

5.4 Not Applicable

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

6.1 This proposal does not address Treaty issues specifically. It does attempt to address health service pressures to allow staff to respond to the needs of people in a culturally sensitive manner rather than to scramble constantly reacting to an overloaded health system.

6.2 Not Applicable

6.3 Not Applicable

6.4 Not Applicable

3. Business Options Considered

	Option 1:	Option 2:	Option 3:
Summary of the option:	Do nothing	**PREFERRED OPTION** Refurbish Level 8 Menzies to accommodate 26 bed Surgical Assessment Ward	Fast Track the Permanent Solution of refitting Security/Attendants area on Level 1 Waiora Waitara into a Surgical Assessment Unit
Advantages of this option:	Nil additional direct costs.	Near immediate increase of 26 beds into a endemically bed constrained hospital Beds available before winter demand System Performance - Improvements in ED Health Target - shorter surgical length of stay in the long run. Patients will be grouped appropriately with others receiving the same level of care. Faster transition out of Emergency Department for surgical patients “Right place, “right time” right person” model of care. ---------- Level 8 Menzies will be bought back up to a serviceable state and can be re-purposed / recommissioned as required	See option 2. And, Creates an Assessment Unit Physically closer to ED, less time spent for staff/patients moving between locations. Provides a greater number of beds for the hospital Removes the requirement for a later relocation
Disadvantages of this option:	Continued bed shortages and flow on effects. Continued operational inefficiencies	Building works put into a location that is not the final solution. It’s not the solution that delivers the maximum number of beds	No current plan in place for the substantial relocation / decantation of the security & attendant functions currently utilising this space More substantial structural changes to building

	Option 1:	Option 2:	Option 3:
			as this area was never configured as a ward Longer time frame to carry out this program means no additional beds in place by winter Additional costs – greater cost. No definitive floor map or operational map as to how this area would function – yet.
Indicative Cost: Capital Cost: One-Off Operating Cost: Ongoing Operational Cost:	Although this option would appear to be cost neutral, in the long run it is an expensive option. $0 $0 $0	 $1,212,360 $348,894 $5,214,585	 $ NA $ NA . $ NA Costs Not applicable as no foreseeable plan exists to make this option work I required timeframe
Hard Benefits	Nil	26 Additional Beds Improvement ED 6 hr target 5-6% Decreased surgical Length of stay (equivalent to 20 beds over 2 years).	Unknown additional beds
Indicative Timescale	N/A	Completion July 2018	Indicative - completion June 2019 ALTHOUGH No foreseeable plan to achieve this option by this date has been compiled
Stakeholder Support:	Nil	Grant Howard, iCOO	Nil

	Option 1:	Option 2:	Option 3:
Option appraisal – extent to which the option solves the problem and meets the benefits	Does not achieve the stated objectives at all.	Minimises the problem in the shortest available time, with the greatest amount of certainty and with the smallest amount of money	Meets long term operational aspects completely but fails to deliver short term operational imperatives.
Recommendation – please provide the reasons that support the recommendation:	Not recommended	Recommended option as: - Option1 (status quo) does not resolve any of the problems identified - Option 3 (permanent solution) has no articulated pathway to completion.	Not recommended

4. Scope of Recommended Solution

4.1. In Scope

- Demolition / Construction / Building Works
- Fit-out
- Change management to establish operations within ward and model of care.
- Ongoing running of ward

4.2. Out of Scope

- Issues not related to level 8
- Issues not related to acute surgical flow

4.3. Assumptions

Key business case assumptions are:

Assumption1: Schedule:

- Board Approval February 2018
  (required if plan is to mitigate winter admissions bed shortages)

Assumption 2: Procurement

- An exemption on standard procurement process
- An available & suitably skilled builder is found - who is able to accept the job immediately and has capacity to complete this building works within the required timeframes. No informal market sourcing has occurred – so this is unknown.

4.4. Dependencies

This project has no dependencies

Note.. Although this project is “stand-alone”, it is envisioned a subsequent business case relating to the permanent location of the Surgical Assessment Unit will be compiled within 3 months consistent with the development of a mid to long term campus development and utilisation plan.

4.5. Change Management

Structural requirements aside, the changes required to accommodate the model of care are low impact.

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5. Expected Benefits of Recommended Option

5.1. Hard Benefits

Benefit *<What benefit will the organisation receive?>*	Measure *<How will you measure this?>*	Baseline *<What is the current level of the measure?>*	Tolerance	17/18 yr1 *<What is the target of the measure to be achieved?>*	18/19 yr2 *<What is the target of the measure to be achieved?>*	19/20 yr3 *<What is the target of the measure to be achieved?>*	20/21 yr4 *<What is the target of the measure to be achieved?>*	21/22 yr5 *<What is the target of the measure to be achieved?>*	Dependencies *<Is there another initiative this is reliant on to be realised?>*	Responsible	Accountable
26 acute beds	Count of actual beds + Number of beds displaying within CapPlan	566 beds in hospital currently 592 at completion of project	Nursing staffing level decisions may see not all beds opened in periods of reduced demand	26	26	26	26	26	NO	Surgical Assess CNM	Surgical Clinical Director

5.1. Measurable Soft Benefits

Benefit *<What benefit will the organisation receive?>*	Measure *<How will you measure this?>*	Baseline *<What is the current level of the measure?>*	Tolerance	17/18 yr1 *<What is the target of the measure to be achieved? >*	18/19 yr2 *<What is the target of the measure to be achieved? >*	19/20 yr3 *<What is the target of the measure to be achieved? >*	20/21 yr4 *<What is the target of the measure to be achieved? >*	21/22 yr5 *<What is the target of the measure to be achieved? >*	Dependencies *<Is there another initiative this is reliant on to be realised?>*	Responsible	Accountable
ED Length of Stay Breaches – Reduction in breaches of surgical services improvement in the ED LOS target from	Reduction from "15" to "0" on the number of patients staying >6hrs in ED (5-6%)	15	Nil	Full achievement	n/a	n/a	n/a	n/a	no	Assess Surgical CND	Service manager acute services
Length of Stay - Reduction in average Length of Stay for patients admitted to the acute service	Reduction from 2.4 to 2.0 (Enterprise Reporting)	2.4 Days Stay	n/a	2.2	2.0	2.0	2.0	2.0	no	Surgical Assess CNM / CND	Service manager acute services

5.2. Other Soft Benefits

- Fit for purpose model of care.
- Better decisions made sooner for surgical patients
- Patient flow from ED not affected by indecision or disagreement about which surgical discipline will co-ordinate care.
- Improved morbidity (and mortality?)
- Better staff morale

6. Timescale

This is a highly compressed delivery timeline – heavily dependent on assumptions as listed in this business case..

Project Name:	Month 1				Month 2				Month3	
	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2
BUILDING PHASE	x									
Apply for building Consent	x									
Finalise Procurement methodology	x									
Prepare Tender Docs	x									
Invite tenders		x								
Vet tenders and select Contractor/s		x								
Building consent granted		x								
Appoint Contractors		x								
Order long lead items - fire, doors, medical gases, pipeline equipment, joinery.			x							
Establish contractor on site			x	x	x	x	x	x		
Building works			x							
Demolition works			x	x						
Install drains level 7 ceiling space.				x						
Framing - preline				x	x					
Install medical gases mains. ASVU					x					
Install joinery first fix					x					
Electrical Works prewire					x					
Data pre wire					x	x				
Ceiling installation , modifications						x				
Sprinkler system - new heads						x				
Flooring prep							x			
Plumbing Work							x			

Preline Inspections							x			
Lining							x			
Stopping and plastering							x	x		
Flooring / wall vinyl							x	x		
Painting							x			
Installation Joinery								x		
2nd Fix plumbing/ Electrical / medical gases/ data outlets								x		
Finishing works Testing and commissioning								x		
Cleaning									x	
CPU Granted									x	
Handover to Operations									x	
OPERATIONAL PHASE										
HR/Staff Appointments		x	x	x	x	x				
Commission IS to add new ward enterprise ward list (IPM, Patient Transfer etc)		x								
Procure Fittings, Furnishings & Medical; equipment		x	x							
Write Policies & Procedures on patient pathways in & out of ward			x	x						
Communications regarding new ward to wider organisation					x	x	x	x		
Test mock patient through the system to ensure IT systems setup								x		
Stock ward with consumables									x	
Host open day to other departments – come have a look-see									x	
Test mock patient through the system to ensure IT systems setup									x	
GO LIVE – WARD OPENING[8]										x

[8] Final project schedule requires project authorisation before it can be fully completed

7. Procurement Compliance

Does this solution involve external parties/suppliers? *If the answer is **no** please move to the next section*	Yes
Is a current and relevant contract already in place for the same product/hardware/service?	No
If no contract in place, have you engaged with Procurement to discuss the Procurement activity required to ensure compliance with the Procurement and Contracts Policy?	Yes
P&I will manage the procurement process regarding building contractors.	

8. Costs

8.1. Implementation Costs

CAPITAL COSTS	TOTAL
Demolition	$30,000
Reconfiguration works	$270,000
Fire Compliance works	$75,000
Replace old plaster tile ceilings	$25,000
Flooring and wall protection	$65,000
Ward Redecoration	$60,000
Plumbing	$55,000
Electrical reticulation to ANZS 3003-2011 with RCDs - bedhead panels BPA Standard & upgraded	$65,000
Upgrade Lighting	$25,000
Bedhead panels - (28 off)	$25,000
Medical Gases Upgrade	$115,000
Mechanical	$30,000
Nurse call system	$48,000
subtotal	**$888,000**
Builders	
- P & G 7%	$62,160
- Margin 5%	$44,400
Contingency - 10%	$88,800
IT Works	$60,000
Fees - HCC	$15,000
Project management fees	$44,000
Signage & Wayfinding	$10,000
Total Implementation Cost	**$1,212,360**

Detailed setup cost breakdown

EQUIPMENT & SETUP COSTS	Number	Price	TOTAL
Beds 14 trauma, 16 standard (Attendants cost centre)			$170,400
Wheelchairs (attendants cost centre)			$6,000
Alaris GP infusion pumps - (Biomedical Cost Centre)	12	$2,775	$33,300
Asena GH Syringe Drivers - (Biomedical Cost Centre)	5	$1,000	$5,000
Scales	1	$2,000	$2,000
Patient Bedside Monitors	5	$10,000	$50,000
Dressing Trolleys	15	$700	$10,500
Patient Over-tables	26	$370	$9,620
IT Expenditure - Computers	6	$1,400	$8,400
IT Expenditure - Telephones	6	$280	$1,680
IT Expenditure - Photocopier	1	$1,500	$1,500
Medication Trolley	2	$600	$1,200
Filing Cabinets	2	$150	$300
Nutrition and Food - Meal Trays and trollies			$4,250
Office chairs	12	$212	$2,544
Office Desks	4	$300	$1,200
Visitor Chairs	40	$150	$6,000
One-Off increase to medical consumables pool)			$10,000
Additional HR internal costs for recruitment of nursing staff to run the unit			$5,000
Equipment Contingency			$20,000
Total Implementation Cost			**$348,894**

8.2. Ongoing operational costs

ONGOING COSTS	Total
Nutrition and Food - includes food, and associated consumables, crockery cutlery	$94,163
Medical Gas Hire	$25,000
Waste Removal	$5,000
Cleaning - 6 hours of cleaning a day (with a 2nd toilet clean included)	$78,000
Linen & Laundry	$66,000
Software Licenses	$5,000
Total Ongoing Costs	**$273,163**

9. Resource Requirements

9.1. Resources to deliver the project

Department / Unit / Service / Supplier	Resource type	% of FTE	Duration required
Service	Nursing	.5	1 month - Prior to setup of ward.. Commissioning assistance
Change Team	Change Team	.5	1 month - Prior to setup of ward.. Commissioning assistance
Property & Infrastructure	Construction Project Management	1	3 months
Information Services	n/a		Some isolated tasks
Learning & Development	n/a		
People and Performance (HR)	Recruit staff for running ward	1	HR provided a cost of $5,000 to complete this task Options: a) Utilise casual staff if available = 120 @ 27.50 = $3,300 b) Overtime for the recruiter for this project (and other team members if available) = 120 @ $41.25 (T1.5) = $4,950 c) Temp = 120 @ $40 per hour = $4,800 plus GST

9.1. Ongoing FTE Impact

DIRECT FTE's

	Current paid FTE	Proposed paid FTE	Budgeted (Y/N)
CNM	0	1.2	N
ACNM	0	2.6	N
RN	0	31.7	N
HCA's	0	8.4	N
Reception	0	3.2	N
Total	**0**	**47.1**	

This 47.1 additional Direct FTE's within the ward has a fully loaded annual cost of **$3,744,853** – see appendix 1.

INDIRECT FTE's

	Proposed additional FTE
Nutrition & Food	
- Kitchen Assistants	+3.4
- Diet Techs	+1.8
Attendants	
- Patient attendants	+0.6
- Other (Mail, Gas, CEP, Pharmacy, Records)	+0.6
- Waste Removal	+0.2
Allied Health	
- Physiotherapists	+2.8
- Occupational therapists	+2.8
- Social Workers	+2.8
- Therapy Assistants	+1.4
Medical Services	
- Pharmacist	+1.0
- Phlebotomist	+0.6
Total	**18**

These 18 additional nominated indirect FTE's have an annual cost of **$1,196,568 –** see appendix 2

9.2. Delivery Capability

Excellent | **GOOD** | Average | Poor | Unclear

GOOD:

- The likely team (including any potential vendors) have a proven, successful track record relevant to the outcomes of this initiative, AND
- Strong leadership is in place, AND
- Any capability gaps can be addressed through explicit training and the use of defined support, AND
- There is a clearly defined scope and agreement of the clinical and business benefits required

Factors that drive delivery of this project towards Excellent on the scale are:

- Executive Leadership is fully behind the project & will drive success for this project
- P+I is experienced in hospital refit project management
- A Clinical Nurse Manager for this ward has been identified and has taken substantial input into the design of ward layout, remaining poised to continue to take a keen interest in the correct setup of this ward as the project progresses

However, the project on the whole can only be assessed with a Good delivery capability due to the following limitations that may hinder cot and/or timeliness of delivery:

- The builder (vendor) is a key component to delivering this project within the compressed timeframe. We do not know who that is in advance, and it is uncertain an available & suitable vendor will be found who is ready to start immediately with a full complement of available trades.
- Despite being an experienced hospital fit-out project manager – P&I may be operating without their full standard toolset of specifications, procurement plans and other tools. This may constrain their usual project management processes.

10. Major Risks

ID#	Risk description	Risk Response	Probability	Impact
	ORGANISATIONAL RISKS Full hospital capacity leads to adverse patient outcomes	**Threat**: Reduce	80% Likely	5: Extreme
	Lack of Surgical Assessment Unit leads to non-optimal queuing of patients through surgical stream	**Threat**: Reduce	100% Almost Certain	3: Moderate
	Media criticism of Waikato DHB failed capital program linking future adverse patient outcome with unavailable beds	**Threat**: Avoid	60% Possible	2:Minor
	Delivery of this interim solution leads to slowed impetus for other required bed creating capital program	**Threat**: Reduce	40% Unlikely	3: Moderate
	PROJECT RISKS - Capital construction portion of the project experiences financial overruns due to a focus on quick delivery, especially related to vendor selection	**Threat**: Accept	40% Unlikely	3: Moderate
	Inability to deliver project within proposed timeline	**Threat**: Reduce	60% Possible	3: Moderate
Legend:		**Threat**: Avoid, Reduce, Fallback, Transfer, Accept **Opportunity**: Exploit, Enhance, Reject	20% Rare 40% Unlikely 60% Possible 80% Likely 100% Almost Certain	1:Minimal 2:Minor 3:Moderate 4:Major 5:Extreme

10.1. GCIO Risk Profile Assessment

Risk Profile Assessment		Rating
Project's Strategic Context	• Project's External Impact • External Impacts on Project	N/A
Project's Scope and Complexity	• Impact on State Sector and Agency • Project Scope and Complexity • Information Technology Element • Procurement Element • Infrastructure Element	N/A
Project Delivery Capability &	• Supplier and Agency Experience • Agency's Project Management Framework	N/A

Approach	and Approach	
Overall indicative risk rating for the project: NA		N/A

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11. Investment Appraisal

11.1. Funding Source

No funding source has been identified for this proposal within the existing hospital envelope. It is entirely possible that the addition of a fit-for-purpose model of care will cost less than the existing model once bedded down.

One strategy would be to allocate budget to the ward and add the same amount as a savings plan against the Chief Operating officer's responsibility centre. In the 2018/19 financial year.

The 2018/19 capital plan has yet to be approved.

11.2. FOREX Impact

Not Applicable

11.3. Net Present Value Calculations

Key Financial Information:					
Costs	**$'000**	**Budgeted**	**Key Indicators:**		
Capital cost:	-1,212		Net Present Value	-23,643	$'000
Opex Current Year (- increases deficit/ + increases surplus)			Period of NPV	5	Years
Incremental Costs $'000	-298		Interest Rate used	6	%
Benefits $'000	0		Payback:	No Payback	Years
Net Impact on Opex $'000	-298		Internal Rate of Return	0.0	%
Opex Next Year (- increases deficit/ + increases surplus)			Average Life of Assets	13.4	Years
Incremental Costs $'000	-5,358		(for depreciation)		
Benefits $'000	0		Total Impact on Opex	-298	$'000
Net Impact on Opex $'000	-5,358		For Period of	5	Years

Business Case

NPV Calculation	Year 0 2018	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	
	$'000 (- Outflows / + Benefits)						
Capital Cost							
Demolition	-30						-30
Reconfiguration works	-270						-270
Fire Compliance works	-75						-75
Replace old plaster tile ceilings	-25						-25
Flooring and wall protection	-65						-65
Ward Redecoration	-60						-60
Plumbing	-55						-55
Electrical reticulation to ANZS 3003-2011	-65						-65
Upgrade Lighting	-25						-25
Bedhead panels - (28 off)	-25						-25
Medical Gases Upgrade	-115						-115
Mechanical	-30						-30
Nurse call system	-48						-48
Builders - P & G 7%	-62						-62
- Margin 5%	-44						-44
Contingency - 10%	-89						-89
IT Works	-60						-60
Fees - HCC	-15						-15
Project management fees	-44						-44
Signage & Wayfinding	-10						-10
							0
							0
Total Capital Cost	**-1,212**	**0**	**0**	**0**	**0**	**0**	**-1,212**
Incremental Operating Cost							
Beds 14 trauma, 16 standard (Attendants cost centre)	-170						-170
Wheelchairs (attendants cost centre)	-6						-6
Alaris GP infusion pumps - (Biomedical Cost Centre)	-33						-33
Asena GH Syringe Drivers - (Biomedical Cost Centre)	-5						-5
Scales	-2						-2
Patient Bedside Monitors	-50						-50
Dressing Trolleys	-11						-11
Patient Over-tables	-10						-10
IT Expenditure - Computers	-8						-8
IT Expenditure - Telephones	-2						-2
IT Expenditure - Photocopier	-2						-2
Medication Trolley	-1						-1
Filing Cabinets	-0						-0
Nutrition and Food - Meal Trays and trollies	-4						-4
Office chairs	-3						-3
Office Desks	-1						-1
Visitor Chairs	-6						-6
One-Off increase to medical consumables pool)	-10						-10
Additional HR internal costs for recruitment of nursing staff to ru	-5						-5
Equipment Contingency	-20						-20
Nutrition and Food - includes food, and consumables)		-94.16	-94.16	-94.16	-94.16	-94.16	-471
Medical Gas Hireage		-25	-25	-25	-25	-25	-125
Waste Removal		-5	-5	-5	-5	-5	-25
Cleaning - 6 hours of cleaning a day		-78	-78	-78	-78	-78	-390
Linen & Laundry		-66	-66	-66	-66	-66	-330
Software Licenses		-5	-5	-5	-5	-5	-25
DIRECT FTEs							
CNMs		-121	-121	-121	-121	-121	-605
ACNM		-302	-302	-302	-302	-302	-1,510
RN		-2682	-2682	-2682	-2682	-2682	-13,410
HCA		-451	-451	-451	-451	-451	-2,255
Reception		-187	-187	-187	-187	-187	-935
INDIRECT FTE's							
Kitchen Assistants		-138	-138	-138	-138	-138	-690
Diet Techs		-136	-136	-136	-136	-136	-680
Attendants		-58	-58	-58	-58	-58	-290
Physiotherapists		-228	-228	-228	-228	-228	-1,140
Occupational therapists		-228	-228	-228	-228	-228	-1,140
Social Workers		-228	-228	-228	-228	-228	-1,140
Assistants		-75	-75	-75	-75	-75	-375
Pharmacist		-88	-88	-88	-88	-88	-440
Phlebotomist		-47	-47	-47	-47	-47	-235
Total Operating Cost	**-349**	**-5,242**	**-5,242**	**-5,242**	**-5,242**	**-5,242**	**-26,560**

Business Case

Impact on Operating Statement		Year 0 2018	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	
		$'000 (Incremental Change from Year 0)						
Incremental Operating Cost								
Beds 14 trauma, 16 standard (Attendants cost centre)		-170						**-170**
Wheelchairs (attendants cost centre)		-6						**-6**
Alaris GP infusion pumps - (Biomedical Cost Centre)		-33						**-33**
Asena GH Syringe Drivers - (Biomedical Cost Centre)		-5						**-5**
Scales		-2						**-2**
Patient Bedside Monitors		-50						**-50**
Dressing Trolleys		-11						**-11**
Patient Over-tables		-10						**-10**
IT Expenditure - Computers		-8						**-8**
IT Expenditure - Telephones		-2						**-2**
IT Expenditure - Photocopier		-2						**-2**
Medication Trolley		-1						**-1**
Filing Cabinets		-0						**-0**
Nutrition and Food - Meal Trays and trollies		-4						**-4**
Office chairs		-3						**-3**
Office Desks		-1						**-1**
Visitor Chairs		-6						**-6**
One-Off increase to medical consumables pool)		-10						**-10**
Additional HR internal costs for recruitment of nursing staff to run the unit		-5						**-5**
Equipment Contingency		-20						**-20**
Nutrition and Food - includes food, and consumables)			-94	-94	-94	-94	-94	**-471**
Medical Gas Hireage			-25	-25	-25	-25	-25	**-125**
Waste Removal			-5	-5	-5	-5	-5	**-25**
Cleaning - 6 hours of cleaning a day			-78	-78	-78	-78	-78	**-390**
Linen & Laundry			-66	-66	-66	-66	-66	**-330**
Software Licenses			-5	-5	-5	-5	-5	**-25**
DIRECT FTEs								
CNMs			-121	-121	-121	-121	-121	**-605**
ACNM			-302	-302	-302	-302	-302	**-1,510**
RN			-2,682	-2,682	-2,682	-2,682	-2,682	**-13,410**
HCA			-451	-451	-451	-451	-451	**-2,255**
Reception			-187	-187	-187	-187	-187	**-935**
INDIRECT FTE's								
Kitchen Assistants			-138	-138	-138	-138	-138	**-690**
Diet Techs			-136	-136	-136	-136	-136	**-680**
Attendants			-58	-58	-58	-58	-58	**-290**
Physiotherapists			-228	-228	-228	-228	-228	**-1,140**
Occupational therapists			-228	-228	-228	-228	-228	**-1,140**
Social Workers			-228	-228	-228	-228	-228	**-1,140**
Assistants			-75	-75	-75	-75	-75	**-375**
Pharmacist			-88	-88	-88	-88	-88	**-440**
Phlebotomist			-47	-47	-47	-47	-47	**-235**
Finance Costs			-46	-44	-41	-39	-36	
Depreciation			-70	-70	-70	-70	-70	
Total Operating Cost	**0**	**-298**	**-5,358**	**-5,356**	**-5,353**	**-5,351**	**-5,348**	**-298**
Benefits								
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	0	0	0	0	0	**0**
								0
								0
Total Benefits	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Over/-Under Recovery	**0**	**-298**	**-5,358**	**-5,356**	**-5,353**	**-5,351**	**-5,348**	**-298**

Appendix 1:

FTE Matrix

Proposed

CNM	Cost per FTE (base rate)	$ 96,922		$ 101,475	Including Penals			
Shift	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**Total FTEs**	**Total Cost**
1	1	1	1	1	1	0	0	5.0	
2	0	0	0	0	0	0	0	0.0	
3	0	0	0	0	0	0	0	0.0	
								5.0	
							FTE	1.0	
							19.30%	0.2	
Proposed							**Total FTE**	1.2	$121,060

ACNM	Cost per FTE (base rate)	$ 89,350		$ 115,234	Including Penals			
Shift	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**Total FTEs**	**Total Cost**
1	0	0	1	1	0	1	1	4.0	
2	1	1	1	1	1	1	1	7.0	
3	0	0	0	0	0	0	0	0.0	
								11.0	
							FTE	2.2	
							19.30%	0.4	
							Total FTE	2.6	$302,442

Proposed

RN	Cost per FTE	$ 66,755		$ 84,526	Including Penals			
Shift	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**Total FTEs**	**Total Cost**
1	8	8	8	8	8	8	8	56.0	
2	7	7	7	7	7	7	7	49.0	
3	4	4	4	4	4	4	4	28.0	
								133.0	
							FTE	26.6	
							19.30%	5.1	
							Total FTE	31.7	$2,682,339

Proposed

HCA's	Cost per FTE	$ 42,650		$ 54,031	Including Penals			
Shift	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**Total FTEs**	**Total Cost**
1	2	2	2	2	2	2	2	14.0	
2	2	2	2	2	2	2	2	14.0	
3	1	1	1	1	1	1	1	7.0	
								35.0	
							FTE	7.0	
							19.30%	1.4	
							Total FTE	8.4	$451,213

Proposed

RECPTIOI	Cost per FTE	$ 47,000		$ 58,171	Including Penals			
Shift	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**Total FTEs**	**Total Cost**
1	1	1	1	1	1	1	1	7.0	
2	1	1	1	1	1	1	1	7.0	
3	0	0	0	0	0	0	0	0.0	
								14.0	
							FTE	2.8	
							15.30%	0.4	
							Total FTE	3.2	$187,799
							Total Proposed	47.1	$3,744,853

Appendix 2:

		Base Salary	Including On Costs	$
Kitchen Assistants	3.4	37,089	40,798	138,713
Diet Techs	1.8	68,707	75,578	136,040
Attendants	1.4	38,278	42,106	58,948
Physiotherapists	2.8	74,203	81,624	228,547
Occupational therapists	2.8	74,203	81,624	228,547
Social Workers	2.8	74,203	81,624	228,547
Therapy Assistants	1.4	49,322	54,255	75,956
Pharmacist	1	79,932	87,925	87,925
Phlebotomist	0.6	71,255	78,381	47,029
	18			**$1,230,253.66**

Appendix 3:

Waiora Waikato Campus 2004 to End State SCR
Comparison to Beds Resourced as at 1 August 2017 (Excludes Mental Health)

Service	Bed Status December 2004		Bed Numbers +/- over 13 years		Bed Numbers Available		Bed Status Aug 2017 Resourced	Bed Status Aug 2017 Closed
Cardiovascular Medicine & Surgery								
Medicine								
Acute Cardiology	50		-2		48		48	
Chest Pain			6		6		4	2
CCTVS	32		5		37		32	5
		82		**9**		**91**	**84**	**7**
Internal Medicine								
Gen Med, gastro, diabetes, endo	63		-13		50		50	
Acute Medical Unit (AMU)			20		20		15	5
Respiratory	26		-1		25		25	
Renal	16		0		16		12	4
		105		**6**		**111**	**102**	**9**
Oncology/Haematology								
Oncology/Haematology		**30**		**0**		**30**	**30**	**0**
Orthopaedics								
Orthopaedics		**81**		**-27**		**54**	**54**	**0**
Surgery								
General Surgery	55		1		56		54	2
Ophthalmology/ENT	16		3		19		16	3
Plastics/MF/Dermatology	25		0		25		25	
Neurosurgery			15		15		12	3
Urology	13		-13		0			
Same Day / Short Stay	17		-3		14		14	
Day Case Specialities Meade CC			11		11		7	4
Endoscopy/Interventional Radiology			18		18		18	
		126		**32**		**158**	**146**	**12**
Older Persons (OP & R)								
AT & R > 65 years	29		51					
AT & R < 65 years			8					
Acute Stroke			10					
		29		**69**		**98**	**71**	**27**
Paediatrics								
Medical	24		8		32		32	
Surgical	24				24		24	
		48		**8**		**56**	**56**	**0**
Women's Health								
Gynaecology	20				20		20	
Ante/Postnatal	40		-20		20		20	
Delivery Suite	18		-5		13		13	
Delivery Suite HD	2				2		2	
Women's Assessment Unit			9		9		9	
		80		**-16**		**64**	**64**	**0**
Critical Care Unit								
HDU	12				12		12	
ICU	15		1		16		12	4
ICU/HDU			6		6			6
		27		**7**		**34**	**24**	**10**
NICU								
Neonatal ICU	29							
New Born Care	13							
		42		**-1**		**41**	**41**	**0**
Other								
ED Observation Adult	8		2		10		10	
ED Observation Paediatric	6		0		6		6	
Medihotel			18		18		10	8
		14		**20**		**34**	**26**	**8**
TOTALS		**664**		**107**		**771**	**698**	**73**

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 6.4

SUICIDE PREVENTION AND POSTVENTION INTERSECTORAL WORKSHOP

Purpose	• To update the Board on the current situation regarding suicide prevention and postvention in the Waikato District Health Board area. • To request support for an intersectoral workshop and an aspiration to work toward zero suicides.

Introduction
Waikato District Health Board has employed a suicide prevention and postvention co-ordinator since early 2016.

A Suicide Prevention and Postvention Health Advisory Group (SPPHAG) made up of DHB, NGO and PHO representatives, guides the co-ordinator in her work.

Over the past three years Waikato DHB has been working to our Suicide Prevention and Postvention action plan 2014-2017. This plan was reviewed over 2017 through a series of interviews, focus groups, community presentations and surveys in order to confirm our focus areas for the next three years.

We are now planning for further engagement, particularly with our intersectoral partners so that the 2018-2021 plan reflects the reality that the Health sector is only a part of the complex picture that can influence a reduction in suicide in the Waikato DHB area.

It is proposed that a workshop is held in April 2018 with the following local partners:

- Iwi partners
- PHOs
- Housing NZ
- Ministry of Social Development (employment)
- Office for Seniors
- Ministry of Education
- Hamilton City Council
- Waikato Regional Council
- Waikato DHB area district councils.

Background
In from July 2016 to June 2017 there were 50 suicides in the Waikato DHB area. This is a reduction from 55 in 2015/2016. However no conclusions can be drawn from this due to rate fluctuation over time (see Appendix 1).

The co-ordinator collects month by month information on local suicides to inform the Suicide Prevention and Postvention Health Advisory Group and to better target her work.

All prevention work is planned accordingly.

Zero suicides concept
Recent discussions within the SPPHAG about a target for the DHB to work towards have identified that a zero suicide concept should be considered. This is a system-wide approach to improve outcomes and close gaps. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/zero_suicide_final6.pdf

Proposed Workshop Approach

As previously stated, the Health Sector cannot be solely responsible for reducing the suicide rate. Many other non-health related life events impact people's lives sometimes leading them to consider taking their lives. The research shows that unemployment, relationship and economic stressors can be major factors. Hence we will be promoting a partnership approach to reducing suicide, and will introduce the concept of zero suicides.

While our 2018 – 2021 Suicide Prevention and Postvention Plan will contain objectives for the DHB we wish to propose that each of our partner sectors develop some internal organisational objectives that they take responsibility for, and that will be contained within the 2018 – 2020 plan.

The final plan will therefore reflect this cross sector approach, while still remaining true to the feedback gained from the communities, focus groups and interviews held over 2017 (report to Health Services Committee October 2017).

The intent is that the final 2018 – 2020 plan will be owned not only by the DHB, but by the community.

Recommendation
THAT
The Board supports:
1) The intent to hold an intersectoral workshop as proposed
2) Suicide Prevention and Postvention Health Advisory Group's aspiration to work toward zero suicides.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

Appendix 1 Provisional Suicide deaths by DHB Region
Source: Mental Health Foundation of NZ (2017)

DHB Region	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	Total
Auckland	53	53	39	51	42	46	41	48	50	43	466
Bay of Plenty	20	41	21	36	31	31	27	32	35	41	315
Canterbury	61	61	74	63	73	60	68	61	78	79	678
Capital and Coast	32	24	26	25	28	34	30	30	36	30	295
Counties Manukau	59	38	52	46	55	50	48	47	48	44	487
Hawke's Bay	16	23	23	25	27	18	28	29	26	27	242
Hutt	25	9	20	22	12	14	25	16	17	19	179
Lakes	12	20	21	23	18	15	15	10	21	17	172
Mid Central	27	25	22	24	32	18	41	27	22	35	273
Nelson Marlborough	16	17	13	12	24	17	13	18	24	17	171
Northland	19	15	16	20	24	29	21	28	21	36	229
South Canterbury	10	4	7	8	17	8	2	8	5	7	76
Southern	37	49	60	45	42	47	31	42	43	52	448
Tairawhiti	14	8	6	8	3	5	2	13	8	6	73
Taranaki	17	17	18	20	12	17	14	19	11	16	161
Waikato	38	47	47	51	33	45	44	49	55	50	459
Wairarapa	6	5	11	5	7	10	8	9	6	12	79
Waitemata	62	56	51	55	50	62	52	63	49	52	552
West Coast	7	6	3	5	4	6	8	7	10	10	66
Whanganui	8	12	10	12	12	7	11	8	13	12	105
Off Shore	1	1	1	2	1	2	0	0	1	1	10
Total	540	531	541	558	547	541	529	564	579	606	5536

ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

» LEAD

» TRAIN

» IDENTIFY

» ENGAGE

» TREAT

» TRANSITION

» IMPROVE

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

SPRC

National Action Alliance for Suicide Prevention

2.10.15

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential elements of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health programs, integrated delivery systems, and comprehensive primary care programs). These elements include:

1. **LEAD** » Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
2. **TRAIN** » Develop a competent, confident, and caring workforce.
3. **IDENTIFY** » Systematically identify and assess suicide risk among people receiving care.
4. **ENGAGE** » Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. **TREAT** » Use effective, evidence-based treatments that directly target suicidality.
6. **TRANSITION** » Provide continuous contact and support, especially after acute care.
7. **IMPROVE** » Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

If we do not set big goals, we will never achieve them. In the words of Thomas Priselac, president and CEO of Cedars-Sinai Medical Center:

"It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize. It's about purposefully aiming for a higher level of performance."

Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems. While we do not yet have proof that suicide can be eliminated in health systems, we do have strong evidence that system-wide approaches are more effective.

To assist health and behavioral health plans and organizations, the Suicide Prevention Resource Center (SPRC) offers an evolving online toolkit that includes modules and resources to address each of the elements listed above. SPRC also provides technical assistance for organizations actively implementing this approach.

Learn more at www.zerosuicide.com.

FOR MORE INFORMATION, PLEASE CONTACT:

Julie Goldstein Grumet, PhD
Director of Prevention and Practice
Suicide Prevention Resource Center

Education Development Center, Inc.
1025 Thomas Jefferson Street, NW
Suite 700W
Washington, DC 20007

Phone: 202.572.3721
Email: jgoldstein@edc.org

Finance Monitoring

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 7.1

FINANCE REPORT

Purpose	For information.

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

Recommendation
THAT
The Board receives the report.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD

YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Group Result for January 2018	Year to Date Group Actual $m	 Group Budget $m	 Variance $m	Group Budget Jun-18 $m
Funder	18.8	21.7	(2.9) U	34.0 F
Governance	0.1	0.1	0.0 F	0.2 F
Provider	(25.4)	(27.2)	1.8 F	(44.7) U
Waikato Health Trust	(0.2)	0.1	(0.3) U	0.5 F
DHB Surplus/(Deficit)	**(6.7)**	**(5.3)**	**(1.4) U**	**(10.0) U**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

January 2018 YTD	Episodes			CWDS		
Acute	Actual	Plan	Variance %	Actual	Plan	Variance %
Surgical & CCTVS	10,176	10,301	-1.2%	17,551	17,611	-0.3%
Medicine & Oncology	10,527	9,522	10.6%	12,491	11,551	8.1%
Child Health	5,716	5,568	2.7%	4,106	3,728	10.1%
Women's Health	5,136	5,533	-7.2%	2,877	2,923	-1.6%
	31,555	30,924	2.0%	37,025	35,813	3.4%
January 2017 YTD	30,237	4.4% increase 2018 over 2017		35,261	5.0% increase 2018 over 2017	

January 2018 YTD	Episodes			CWDS		
Elective	Actual	Plan	Variance %	Actual	Plan	Variance %
Surgical & CCTVS	8,630	8,948	-3.6%	12,247	12,708	-3.6%
Medicine & Oncology	403	617	-34.7%	306	360	-15.0%
Child Health	396	433	-8.5%	328	391	-16.2%
Women's Health	640	678	-5.6%	598	663	-9.8%
	10,069	10,676	-5.7%	13,479	14,122	-4.6%
January 2017 YTD	9,155	10.0% increase 2018 over 2017		11,802	14.2% increase 2018 over 2017	

Total Acute plus Electives	**41,624**	**41,600**	**0.1%**	**50,504**	**49,935**	**1.1%**

January 2018 YTD	Actual	Prior year	Change
ED Attends	68,791	64,778	6.2%
Beddays	132,303	126,720	4.4%

MONTHLY COMMENTS

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

Delivery Plan Performance

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

The volumes achieved in the current year have increased against the prior year for acute, elective, ED attends and Beddays which is reflected in a number of unfavourable cost variances. January YTD costs are approximately $4m (0.7%) lower than the same time last year, after adjusting last years costs for this increase in activity, as well as for inflation increases.

Financial Performance Monthly Comment:
For January 2018 we have an unfavourable YTD variance to budget of $1.4m. However this result includes $1.4m one off favourable variances so a normalised result is $2.8m unfavourable. Furthermore, $14.1m of the centrally held savings plan, which contains high risk initiatives, is phased in the budget to take effect over the balance of the year.
Provider:
The Provider is favourable to budget $1.8m - see detail for explanations. Variances include: 1. Revenue $11.0m favourable to budget due mainly to favourable internal revenue (eliminates against Funder), a favourable acute volume variance, IDF in and the reimbursement of NOS costs. 2. Employed personnel costs favourable to budget $10.4m - analysis below. 3. Outsourced Personnel costs unfavourable $8.6m, the dominant variances relate to medical locums ($3.9m partly offset by savings in medical personnel costs), nursing personnel ($1.2m) and Management and Administration $3.4m ($2.2m NOS costs recovered in other government revenue). 4. Outsourced Services favourable $3.5m. 5. Clinical supplies unfavourable to budget $4.9m. 6. Infrastructure & Non Clinical supplies are unfavourable to budget $9.4m. 7. Interest, depreciation and capital charge unfavourable to budget $0.2m.
Funder and Governance:
The results for the Funder is $2.9 unfavourable to budget. This mainly as a result of unfavourable internal provider payments (eliminates against Provider). This is partially offset by higher additional funding received across a number of areas. Governance is on budget.
Waikato Health Trust
The result for the Waikato Health Trust is unfavourable to budget mainly due to unfavourable grants variance arising from increased grants paid against budget assumptions.

RECOMMENDATION(S):

That this report for January 2018 year to date be received.

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Group Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$6.2 F**	
CFA Revenue		
● CFA revenue $0.8m favourable to budget which includes increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year).	$0.8 F	Neutral
Crown Side-Arm Revenue		
Side-arm contracts revenue is close to budget	$0.3 F	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is favourable to budget mainly due to:		
● Reimbursement of costs associated with the implementation of National Oracle Solution (NOS) $2.2m favourable (offset in Outsourced Personnel $2.6m contractor cost).	$5.0 F	Neutral
● ACC income $0.2m favourable which includes increases in income as a result of a change to a new annual contract.		
● Return to Employment project income $0.4m unfavourable due to lower referrals from MSD for enrolment. This variance is offset by lower outsource, clinical supplies and infrastructure costs.		
● Inter District Flow (IDF) income from other DHBs $1.1m (1.4%) favourable. High volume specialities compared to budget for the year to date include haematology, neurosurgery, plastic & burns, and paediatric surgery.		
● Inter District Flow (IDF) income relating to 2016/17 $1.8m favourable. This as a result of the annual wash up of IDF activity across all DHBs. The final adjustment is not known until coding of all activity across all DHBs is completed. This variance is partly offset by an unfavourable variance on the IDF outflow wash up ($0.8m), which is included in NGO payments.		Favourable
Other Revenue		
Other revenue is close to budget.	$0.1 F	Favourable

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($7.6) U**	
Personnel (employees and outsourced personnel total)	**$1.8 F**	
Employed personnel are favourable to budget mainly due to:	$10.4 F	Neutral
● Medical costs are favourable to budget by $7m. This includes a higher than expected vacancy level, partly offset by an unfavourable annual leave movement for the year to date. This favourable variance is partly offset by outsourced personnel unfavourable variance $3.9m.		
● Nursing costs are unfavourable to budget by $0.1m. This variance, along with the unfavourable outsourced personnel cost for nursing $1.2m, is due to higher patient numbers entering ED (6.2% above plan), and a higher level of mental health inpatient services and acuity. An unfavourable annual leave movement for the year to date and higher than budget overtime are both offsetting variances. The overall improvement in the nursing costs variance in January included a favourable annual leave movement for the month due to bed closures over the holiday season.		
● Allied Health costs are favourable to budget by $1.0m. Variances continue to be mainly as a result of higher than expected vacancy levels. The net favourable variance of $0.9m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.9% of total allied health personnel budget to date.		
● Management, Administration and Support costs are favourable to budget by $2.4m. Variances are spread across the DHB including clinical support, and are mainly as a result of higher than expected vacancy levels. Partially offset in Outsourced Personnel ($0.8m).		
Outsourced personnel are unfavourable to budget mainly due to:	($8.6) U	Neutral
● Medical personnel $3.9m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $7.0m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.		
● Nursing personnel $1.2m unfavourable. As for employed nursing personnel this is due to higher patient numbers entering ED (6.2% above plan), and higher level of mental health inpatient services and acuity and higher than budgeted patient watches.		
● Allied health $0.1m unfavourable. The net favourable variance of $0.9m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.9% of total allied health personnel budget to date.		
● Management, Administration and Support costs are $3.4m unfavourable largely due to contractor costs of $2.6m for the implementation of the new NOS ERP solution (to date $2.2m of this cost is offset by additional other government revenue) and $0.8m to cover management, administration and support vacancies (offset in favourable employed personnel variance).		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$3.5 F**	
Outsourced services are favourable to budget mainly due to:		
● Outsourced clinical service costs are $3.1m favourable as facility lists run through external providers did not reach full capacity. This is reflected in total elective episodes being 5.7% below plan, despite in house throughput being to plan. There continues to be a recovery plan in place to meet the elective services target.	$3.5 F	Neutral
● Outsourced corporate service costs are $0.4m favourable to budget due mainly to a delay in commencing Information Systems outsourcing including a new national IS infrastructure.		
Clinical Supplies	**($4.9) U**	
Clinical supplies are unfavourable to budget mainly due to:		
● Instruments & equipment - favourable to budget by $0.6m. These particular supplies are not volume related, and instead the variance is due to timing of ordering.	$0.6 F	Neutral
● Implants & prosthesis are close to budget.	$0.1 F	Neutral
● Treatment disposables - unfavourable to budget by $3.6m (10.6% of budgeted costs). High cost areas include theatres (mix including high cost specialities of orthopaedics and neurosurgery), blood services (high product demand within the hospital), renal dialysis (9% up on budget), and respiratory patients (case weights for 8% up on plan).	($3.6) U	Unfavourable
● Pharmaceuticals - unfavourable to budget by $2.0m. Relates mainly to $1.5m unbudgeted increase in oncology drug costs. The initial Pharmac forecast included a lower usage assumption for new melanoma drugs. The variance includes a favourable offset of $0.3m in December due to a rebate adjustment for the increase in costs in 2017/18.	($1.8) U	Unfavourable
● Pharmaceuticals rebate adjustment relating to 2016/17 $0.2m favourable to budget. This is a wash up amount relating to prior year costs that we were notified of in December 17.		Favourable
● Diagnostic Supplies & Other Clinical Supplies are close to budget.	($0.2) U	Unfavourable
Infrastructure and non-clinical supplies	**($9.3) U**	
● Infrastructure and non clinical supplies - $2m favourable variance as a result of delays in moving in to new buildings. The net variance includes ongoing additional costs due to extended leases in existing buildings.	($9.3) U	Neutral
● Savings plan - $11.4m unfavourable variance in infrastructure relates to centrally held savings plan not specifically allocated. We continue to monitor closely actual savings achieved across the organisation.		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$1.5 F**	
External Provider payments are favourable to budget mainly due to:		
• Payments to providers are $1.5m favourable. Payments to mental health providers are favourable to budget by $1.9m due to a delay in commencement of NGO contracts. Other variances arise due to timing, with payments not matching CFA revenue received, as well as MoH and accrual adjustments relating to prior year funding.	$1.5 F	Neutral
• IDF out payments for the 2017/18 are $0.8m favourable. This relates mainly to lower volumes for personal health services.		
• IDF out payments for 2016/17 are $0.8m unfavourable. As for IDF in receipts, this relates to the annual wash up of IDF activity across all DHBs. This final adjustment is not known until coding of all activity across all DHBs is completed. Variance is offset by a favourable variance on the IDF inflow wash up ($1.8m), which is included in Other Government and Crown Agencies Revenue.		
Interest, depreciation and capital charge	**($0.2) U**	
Interest charge is close to budget	$0.1 F	Favourable
Capital charge is close to budget	($0.1) U	Unfavourable
Depreciation is close to budget	($0.2) U	Unfavourable

TREASURY

Opinion on Group Result:

Cash flows are favourable to budget as detailed below.

YTD Actuals Jan-17 $'000	Waikato DHB Cash flows for year to January 2018	Year to Date Actual $'000	Year to Date Budget $'000	Year to Date Variance $'000	Budget Jun-18 $'000
	Cash flow from operating activities				
787,529	Operating inflows	848,826	838,894	9,931	1,438,153
(753,574)	Operating outflows	(824,500)	(804,917)	(19,583)	(1,395,578)
33,955	**Net cash from operating activities**	**24,325**	**33,977**	**(9,652)**	**42,575**
	Cash flow from investing activities				
960	Interest income and proceeds on disposal of assets	870	682	188	1,170
(13,017)	Purchase of assets	(21,948)	(32,100)	10,152	(55,056)
(12,057)	**Net cash from investing activities**	**(21,078)**	**(31,418)**	**10,340**	**(53,886)**
	Cash flow from financing activities				
0	Equity repayment	0	0	0	(2,194)
(5,032)	Interest Paid	(448)	(457)	9	(810)
(109)	Net change in loans	(180)	(176)	(4)	12,700
(5,141)	**Net cash from financing activities**	**(628)**	**(633)**	**5**	**9,696**
16,757	**Net increase/**(decrease) in cash	**2,620**	**1,926**	**692**	**(1,616)**
856	Opening cash balance	9,577	9,577	(0)	9,577
17,613	**Closing cash balance**	**12,197**	**11,503**	**692**	**7,962**

Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Total Net cash flow from Operating Activities	**($9.7) U**	
Operating inflows	**$9.9 F**	
Operating inflow is favourable to budget mainly due to:	$9.9 F	
o Unbudgeted IDF 2016/17 wash-up revenue received in December $1.8m.		Favourable
o Inter District Flow (IDF) income from other DHBs $1.1m (1.4%) favourable. High volume specialities compared to budget for the year to date include haematology, neurosurgery, plastic & burns, and paediatric surgery.		Neutral
o Unbudgeted NOS implementation cost reimbursement ($2.2m), and ACC ($0.2m) funding due to the new annual contract.		
o CFA revenue $0.8m favourable to budget which includes increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year).		
o Income in Advance $2.7m higher than budgeted due to Public Health contracts funding received in December 2017, and net Pay Equity movement.		
o Other operating inflow variance is due to timing of cash received compared to budget phasing.		

Cash flow variances resulted from:	Variance $m	Impact on forecast
Operating outflows	**($19.6) U**	
Operating cash outflows for payroll costs are favourable mainly due to:		
○ Personnel costs are favourable against budget mainly due to higher than planned vacancies. Vacant positions are in many instances filled by outsourced personnel. Offset in unfavourable non payroll cash flows.	$8.1 F	Neutral
Operating cash outflows for non-payroll costs are unfavourable largely as a result of:	($30.7) U	
○ Unfavourable operating costs including outsourced personnel (offset in personnel cost), outsourced services, clinical supplies, infrastructure & non clinical supplies and provider payments (net - $21.2m).		Neutral
○ Higher prepayment balance due to timing of payments $0.4m.		
○ Hhe timing of vendor payments against budget assumptions as the budget is evenly phased.		
○ GST cash movement is favourable due to timing variances on GST transacted.	$3.0 F	Neutral
Net cash flow from Investing Activities	**$10.4 F**	
○ Interest received is close to budget.	$0.2 F	Favourable
○ Capital spend is slower than planned YTD. This is as a result of deferred timing of spend.	$10.2 F	Neutral
Net cash flow from Financing Activities	**$0.0 F**	
○ Cash flow from financing activities is on budget.	$0.0 F	Neutral

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

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

WAIKATO DISTRICT HEALTH BOARD (EXCLUDING WAIKATO HEALTH TRUST)
CASHFLOW FORECAST (GST INCLUSIVE) $000

As at 31-Jan-18	Jan-18 Actual	Feb-18 Forecast	Mar-18 Forecast	Apr-18 Forecast	May-18 Forecast	Jun-18 Forecast	Jul-18 Forecast	Aug-18 Forecast	Sep-18 Forecast	Oct-18 Forecast	Nov-18 Forecast	Dec-18 Forecast	Jan-19 Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	4,596	4,116	4,340	4,116	4,564	4,228	6,764	4,708	4,366	5,843	4,594	4,468	6,650
Funder inflow (MoH, IDF, etc)	124,310	126,687	138,802	126,131	126,131	130,811	131,880	131,880	136,560	131,880	131,880	136,750	131,880
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	2,175	2,297	2,527	2,297	2,757	2,412	2,642	2,757	2,412	2,642	2,642	2,297	2,415
Rents, ACC, & HealthPac (General Accou	2,949	2,504	2,681	2,514	2,761	2,651	2,733	2,816	2,641	2,756	2,814	2,654	2,672
	134,029	135,604	148,350	135,058	136,213	140,102	144,018	142,161	145,979	143,121	141,930	146,169	143,617
Cash was applied to:													
Personnel Costs (incl PAYE)	(52,998)	(46,826)	(43,592)	(43,472)	(49,034)	(45,462)	(44,506)	(57,168)	(44,310)	(50,008)	(46,224)	(53,755)	(44,732)
Other Operating Costs	(24,782)	(29,500)	(37,200)	(33,900)	(39,433)	(37,300)	(35,426)	(34,324)	(35,622)	(30,524)	(35,226)	(35,728)	(30,120)
Funder outflow	(46,227)	(43,624)	(49,659)	(45,599)	(46,617)	(45,700)	(46,808)	(50,807)	(46,148)	(47,037)	(46,808)	(45,818)	(46,478)
Interest and Finance Costs	(10)	(10)	(10)	(10)	(10)	(10)	(20)	(15)	(20)	(10)	(11)	(11)	(15)
Capital Charge	0	0	0	0	0	(18,711)	0	0	0	0	0	(18,711)	0
GST Payments	(14,921)	(9,000)	(7,325)	0	(15,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(13,710)
	(138,938)	(128,960)	(137,786)	(122,981)	(150,304)	(154,394)	(133,971)	(149,525)	(133,311)	(134,790)	(135,480)	(154,024)	(135,056)
OPERATING ACTIVITES	**(4,909)**	**6,644**	**10,564**	**12,077**	**(14,091)**	**(14,292)**	**10,048**	**(7,364)**	**12,669**	**8,331**	**6,450**	**(7,855)**	**8,562**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	113	90	90	90	90	90	75	75	75	75	75	75	75
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
	113	90	90	90	90	90	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(2,531)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(4,000)	(4,000)	(5,000)	(3,500)	(5,500)	(3,500)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(2,531)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(4,000)	(4,000)	(5,000)	(3,500)	(5,500)	(3,500)
INVESTING ACTIVITIES	**(2,418)**	**(3,410)**	**(3,410)**	**(3,410)**	**(3,410)**	**(3,410)**	**(3,425)**	**(3,925)**	**(3,925)**	**(4,925)**	**(3,425)**	**(5,425)**	**(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 (sweep)	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance Lease received	0	0	0	0	0	0	2,600	2,600	2,600	2,600	2,600	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
	0	0	0	0	0	0	2,600	2,600	2,600	2,600	2,600	0	0
Cash was applied to:													
Capital Repayment	0	0	0	0	0	(2,194)	0	0	0	0	0	0	0
Transfer to NZHPL (sweep)	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0	0
Working capital facility repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	(26)	0	0	(26)	(2,194)	0	(26)	0	0	(26)	0	0
FINANCING ACTIVITIES	0	(26)	0	0	(26)	(2,194)	2,600	2,574	2,600	2,600	2,574	0	0
Opening cash balance	12,758	5,431	8,638	15,792	24,459	6,932	(12,964)	(3,741)	(12,456)	(1,112)	4,894	10,493	(2,787)
Overall increase/(decrease) in cash	(7,327)	3,208	7,154	8,667	(17,527)	(19,896)	9,223	(8,715)	11,344	6,006	5,599	(13,280)	5,137
CLOSING CASH BALANCE	5,431	8,638	15,792	24,459	6,932	(12,964)	(3,741)	(12,456)	(1,112)	4,894	10,493	(2,787)	2,350
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Investment funds/(loan)													
NZ Health Partnerships Ltd	5,431	8,638	15,792	24,459	6,932	(12,964)	(3,741)	(12,456)	(1,112)	4,894	10,493	(2,787)	2,350
Long-term Loans													
Finance Leases	0	0	0	0	0	0	(2,600)	(5,200)	(7,800)	(10,400)	(13,000)	(13,000)	(13,000)
EECA Loan	(221)	(195)	(195)	(195)	(169)	(169)	(169)	(143)	(143)	(143)	(117)	(117)	(117)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	5,210	8,443	15,597	24,264	6,763	(13,132)	(6,510)	(17,798)	(9,055)	(5,649)	(2,623)	(15,903)	(10,767)
Working capital facility	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(66,968)	(66,968)	(66,968)	(66,968)	(66,968)	(66,968)	(66,968)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(65,655)	(66,968)	(66,968)	(66,968)	(66,968)	(66,968)	(66,968)	(66,968)

BALANCE SHEET

Opinion on Result:

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

Prior Year June 2017 $'000	Waikato DHB Group Financial Position	As at January 2018 Actual $'000	Budget $'000	Variance $'000	Budget Jun-18 $'000
88,517	Total current assets	83,513	77,231	6,282 F	65,434
(181,405)	Total current liabilities	(176,862)	(179,226)	2,364 F	(160,570)
(92,888)	**Net working capital**	**(93,349)**	**(101,995)**	**8,646 F**	**(95,136)**
736,618	Term assets	729,641	740,026	(10,385) U	739,628
(21,053)	Term liabilities	(20,367)	(20,667)	300 F	(34,411)
715,565	**Net term assets**	**709,274**	**719,359**	**(10,085) U**	**705,217**
622,677	**Net assets employed**	**615,925**	**617,364**	**(1,439) U**	**610,081**
622,677	**Total Equity**	**615,925**	**617,364**	**(1,439) U**	**610,081**

Prior Year June 2017 $'000	Waikato DHB Group Ratios	As at January 2018 Actual $'000	Budget $'000	Achieved	Trend
63,670	Borrowing facilities available at month end	65,319	65,318	✓	⇔
0.5	Current ratio	0.5	0.4	✓	⇔
75.5%	Equity to total assets	75.7%	75.5%	✓	⇧
0.3%	Return on equity	-1.1%	-0.8%	✓	⇩

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is favourable to budget mainly due to:		
Current Assets		
• Cash held with New Zealand Health Partnership Limited is higher than budget by $0.9m due to timing of receipts and payments.	**$6.3 F**	Neutral
• Total accounts receivable and accrued debtors is higher than planned by $4.5m largely due to the timing of cash received compared with budget assumptions.		
• Prepayments are higher than planned by $0.4 mainly due to the timing of annual IS spend.		
• Other favourable variances across a number of areas $0.5m.		
Current Liabilities		
• Payroll liabilities are $1.3m favourable mainly due to the timing of pay runs.	**$2.4 F**	Neutral
• Income in Advance $2.7m unfavourable to budget mainly due to quarterly unbudgeted pay equity settlement and Public Health Contract funds received in December.		
• GST $3.1m unfavourable to budget mainly due to the timing of processing of vendor invoices and unbudgeted income.		
• Other Current Liabilities are favourable to budget $6.9m mainly due to the variances arising from the actual timing of transactions compared with budget assumptions.		
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $10.2m and unfavourable YTD depreciation $0.2m. Please see attached for latest forecast of capital spend for the year for further detail.	**($10.4) U**	Neutral
Non Current Liabilities:		
Close to provisional budget.	**$0.3 F**	Neutral
Equity:		
Driven by variance in overall results.	**($1.4) U**	Neutral

CAPITAL EXPENDITURE AT 31 January 2018 ($000s)

Capital Plan					Cash Flow Forecast					Full Project Forecast		
Activity	Total Prior year Board Approvals	New Approvals FY17/18	Transfers During 17/18	Total Board Approved Capital Plans	Prior year expenditure for active Projects	Total Expenditure Forecast FY 17/18 (Actual + Planned)	Actual Expenditure YTD from 1 Jul-17 to 31 Jan 18	Approved and Planned Expenditure 01 Feb 18 - 30 Jun 18	Approved and Planned Spend Subsequent Years	Total Planned Expenditure (Actual + Forecast to Project completion)	Total Planned Expenditure Versus Total Board Approved	Commitments
Under $50K Subtotal		3,000		3,000		3000	1,349	1,651	0	3,000	0	692
Clinical Equipment Subtotal	10,028	20,354	697	31,079	563	9,717	5,210	4,507	17,968	28,248	2,831	3,333
Property & Infrastructure Subtotal	41,230	7,803	-697	48,336	17,151	16,629	7,722	8,907	14,405	48,185	151	1,493
IS Subtotal	19,576	7,729	109	27,414	8,244	9,083	3,732	5,351	7,543	24,870	2,544	1,473
Corporate Systems & Processes Subtotal	3,822	8,325	0	12,147	450	3,705	2,671	1,034	7,953	12,108	39	116
Regional Subtotal	9,419	798	-109	10,108	270	8,514	4,046	4,468	824	9,608	500	70
MOH Subtotal	0	0	0	0	0	0	0	0	0	0	0	0
Trust Funded Subtotal	0	0	0	0	0	0	0	0	0	0	0	8
Savings to be managed during 17/18 approval process						-8,508		-8,508		-8,508	8,508	
REPORT TOTALS	84,075	48,009	0	132,085	26,678	42,140	24,730	17,410	48,693	117,511	14,573	7,186

Waikato DHB
CAPITAL EXPENDITURE AT 31 January 2018 ($000s)

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
Echo Ultrasound Machine Replacement / Portable	-	-	-	-
CT Machine Replacement Waikato x3	3,553	2,174	1,448	(69)
CT Machine Replacement Waikato x1	725	73	652	(0)
Ventilators (Critical Care)	400	-	400	-
Endoscopes	300	-	300	-
Replacement Theatre Lights OT 20-25	286	235	51	(0)
Glucose meters	275	-	-	275
Other items - identfied per Clinical asset review	781	-	781	-
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	48	1,265	(0)
Mobile Dental Unit Replacements - level 2	600	-	600	-
X-ray mobile (Taumarunui)	300	-	300	-
X-ray mobile (Te kuiti)	300	-	300	-
X-ray mobile (Thames)	300	-	300	-
X-ray mobile (Tokaroa)	300	-	300	-
Bed Replacement Programme	400	-	400	-
Digital Mobile X-Ray	600	-	600	-
X-ray general (Radiology ED Room 1)	350	-	350	-
X-ray general (Radiology MCC Room 5)	350	-	350	-
Mobile Image Intensifier - Waikato	300	-	300	-
Microscope - Platics- Plastics Theatre	300	-	300	-
Linear Accelerator (replacement)	4,000	-	4,000	-
Anaesthetic machine - Aisys Carestation	380	-	380	-
Heart Lung Machines	680	-	680	-
Vascular & Interventional Replacement	1,750	-	1,750	-
General X-Ray replacement Thames	700	-	700	-
Biochemistry main Analysers	300	-	300	-
Liquid Chromatography Mass Spectometry Analyser	600	433	167	(0)
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	20	805	0
Trauma Gantry (radiology)	350	-	350	-
Projects Removed to be Capitalised	2,515	2,516	-	(1)
Other Clinical Services Projects Budgeted <$250K	9,526	1,623	7,777	127
Adjustment to reflect capacity to deploy			(2,500)	2,500
Clinical Equipment Subtotal	34,079	7,122	24,126	2,831
Property and Infrastructure				
Mental Health Facility - scoping	606	163	443	0
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Gallagher Build - Fitout	4,238	3,775	150	313
Gallagher Building - Med Store & CSES Clinic	406	402	4	(0)
Gallagher Building - Racking System	362	486	-	(124)
Gallagher Building - Converyor System	348	351	-	(3)
SCEP racking - hospital wide	400	-	400	-
Hamilton Consolidation of CBD facilities - 9th Floor	850	850	-	0
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	1,375	7,749	(0)
Hamilton CBD - Collingwood Street Development - First Floor	5,584	89	5,495	0
ED - Reconfiguration of entry / Front of House (Potential substitution for ED Expansion)	400	-	400	-
Menzies L3 development (Potential substitution for ED Expansion)	450	-	450	-
Pain Clinic to L8 Menzies (Potential substitution for ED Expansion)	450	-	450	-
Hilda Ross - Remediation	3,683	3,855	238	(409)
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	-	550	-
Hague road carpark - Seismic and Beam support	375	-	375	-
Urology to L8 Menzies	320	6	314	0
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Waikato Hauora iHub	321	25	225	71
Waikato switchboard upgrades core buildings	675	7	667	1
Infrastructure Replacement Pool (17/18)	510	71	294	145
Infrastructure Replacement Pool (15/16)	600	725	20	(145)
Infrastructure Replacement Pool (16/17)	641	175	25	441
OCB Replacements	350	-	350	-
Waikato Distribution Boards	250	213	67	(30)
Lift car upgrades (Stage 1)	1,835	2,059	-	(224)
Electrical Systems Improvement	6,714	5,969	745	0
Food & Nutrition Software	921	26	895	(0)
Projects Removed to be capitalised	3,165	3,165	-	(0)
Projects no longer in flight with expenditure	274	272	-	2
Other P&I Projects Budgeted <$250K	3,384	724	2,456	204
Property & Infrastructure Subtotal	**48,336**	**24,873**	**23,312**	**151**
Regional				
HSL - eSpace Programme	4,885	2,773	2,256	(144)
National Oracle Solution - Elevate	4,399	1,542	2,212	645
Other Regional Projects Budgeted <$250K	824	-	824	-
Regional Subtotal	**10,108**	**4,316**	**5,292**	**500**
MOH & Trust Funded				
National Patient Flow Phase 3	377	253	131	(7)
Telestroke Pilot	449	49	272	128
16/17 Trust Account	303	303	-	(0)
Other MOH & Trust Funded Projects Budgeted <$250K	(1,129)	(605)	(403)	(121)
MOH & Trust Subtotal	0	0	-	(0)
Information Systems				
Platform	2,688	629	2,510	(450)
Storage & Reporting	1,125	407	717	1
Network & Communications	3,735	1,747	2,006	(18)
IAAS	1,686	674	1,012	0
Devices	2,253	611	1,298	344
Licensing	1,154	217	937	-
Enterprise Service Business	937	212	725	(0)
Tools	3,254	1,468	1,721	65
Security	817	99	710	8
Clinical Systems	6,862	3,634	3,435	(206)
Other Projects	422	98	324	(0)
CORPORATE SYSTEMS & PROCESSES	12,147	3,121	8,987	39
Projects to be Capitalised	2,481	2,180	-	301
Adjustment to reflect capacity to deploy			(2,500)	2,500
IS Subtotal	39,561	15,097	21,881	2,583
Savings to be managed during 17/18 approval process			(8,508)	8,508
Grand total	**132,085**	**51,408**	**66,103**	**14,573**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
January 2018

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

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

Travel costs - Executive Group	Month			Year to Date			
Jan-18	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AYDON LYDIA HELEN MS	-	-	-	610.70		610.70	
AITKEN VICKI ANN	52.17	-	52.17	538.83		538.83	
CHRYSTALL MAUREEN MS	-	-	-	493.49		493.49	
ELLIOTT LORAINE	-	-	-	316.69		316.69	
HABLOUS NEVILLE MR	-	-	-	557.25		557.25	Detail below
HACKETT DARRIN MR	-	-	-	126.35		126.35	
HAYWARD SUSAN MRS	439.13	-	439.13	2,480.20	3,144.68	5,624.88	Training related $2,779
LAWRENSON ROSS PROF	-	-	-	353.63		353.63	
MALONEY TANYA	123.50	-	123.50	280.12	3,011.97	3,292.09	Training rrelated $3,011.97
MURRAY NIGEL MR	-	-	-	6,478.89	(499.90)	5,978.99	Detail below
NEVILLE MAUREEN MS	406.44	-	406.44	1,574.46		1,574.46	
PARADINE BRETT MR	-	-	-	312.26		312.26	
SPITTAL MARK MR	-	-	-	1,358.21		1,358.21	
TER BEEK MARC MR	-	-	-	607.67		607.67	
TOMIC DAMIAN MR	354.10	-	354.10	2,939.34		2,939.34	
WATSON TOM MR	-	-	-	1,292.58		1,292.58	
WILSON JULIE MS	104.35	-	104.35	3,010.40		3,010.40	
WOLSTENCROFT IAN	-	-	-	146.96		146.96	
WRIGHT DEREK MR	1,018.00	-	1,018.00	1,997.42	63.48	2,060.90	Detail below
Taxi	-	-	-	350.63		350.63	Largely N Murray
Grand Total	2,497.69	-	2,497.69	25,826.08	5,720.23	31,546.31	

CE Travel Expenditure: Nigel Murray

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

Acting CE Travel Expenditure Neville Hablous

Travel charges for the year to 31 January 2018				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
7 Sept 2017	557.25	National DHB CE meeting	Airfare (return)	Wellington

Interim CE Travel Expenditure Derek Wright

Travel charges for the year to 31 January 2018				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
October YTD	887.25	Prior to CE appointment	Prior to CE appointment	
November 2017	69.57	Conference cost	Nga Tumanako Conference	Ngaruawahia
December 2017	702.42	DHB CE Meeting & MoH DG Health	Airfare (return), taxi	Wellington
December 2017	401.66	DHB CE Meeting - RMO bargaining strategy	Airfare (return)	Wellington
	2,060.90			

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 7.2

FY18/19 OPERATING BUDGET AND CAPITAL PLAN

Purpose	For information and approval.

The FY18/19 budget Ministry of Health deadlines are:
- First submission – 2 March 2018
- Second submission – 25 May 2018.

The Board timetable therefore is:
- First submission high level bottom line tabled for approval – 28 February 2018
- Budget update – 28 March and 24 April 2018
- Final operating budget and capital plan for approval – 23 May 2018.

High Level bottom line for 2 March first submission

17/18 Forecast	(21.3)		
17/18 Business Cases annualised	(6.1)		
17/18 Pending Business Cases	(4.0)		
17/18 updated for full year committed		**(31.4)**	
Revenue Growth:			
MoH Funding & IDF Increase	49.3		4.04%
IDF In	5.6		4.04%
Tertiary Adjuster decrease	(4.2)		
Other Provider Revenue	1.7	**52.4**	2.0%
Cost Growth:			
+ MECA/Step Increases	(16.0)		2.8%
Demographic / volume growth	(2.0)		
Out Source Personnel	(0.5)		2.0%
Out Source Services	(1.2)		2.0%
Clinical Supplies	(2.8)		2.0%
Infrastructure	(1.6)		2.0%
Provider Payments	(12.9)		2.95%
IDF Out	(2.4)	**(39.5)**	4.04%
Result before service pressures and savings plan		**(18.6)**	

This excludes:

- 18/19 service pressures
- Removal of 17/18 one-off removals
- 18/19 impacts of savings initiatives, especially Surgical Re-Engineering, Patient Flow and Acute Demand Management.

Therefore the recommendation is to file a $20m deficit budget, based on the assumption that savings will offset service pressures.

As the budget process progresses, obviously a firmer view of 18/19 expected results will be defined.

We continue to work on two key aspects for future budgets:

- The connection of volumes to budgets
- A rolling 24 month forecast approach to avoid a repeat of an annual budget process – the plan is that it will become an extraction and validation process, rather than a full budgeting process.

Recommendation
THAT
The Board

1. Receives this report.
2. Approves a first budget submission to the Ministry of Health on 2 March of a $20m deficit.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 7.3

CAPITAL CHARGE INVOICE APPROVAL

The capital charge is imposed on all Crown Entities. It is calculated by multiplying the liable net assets (adjusted for donated assets) of the entity at the relevant date (either 31 December or 30 June) by the public sector discount rate (currently 6%) applying on that date (currently 6%), and then dividing that sum by 2 (to reflect 6 monthly payments).

Historically the Chief Executive is able to approve purchase orders up to $10m, and the capital charge invoice used to fall within this delegation at approximately $9m. Following the debt to equity conversion in February 2017, the capital charge invoice has doubled to approximately $18m (with interest no longer being charged). This falls outside the Chief Executive's delegation level. It is expected all future capital charge invoices will be approximately $18m every six months.

In December 2017, the attached capital charge invoice for $18.6m was received, payable to the Ministry of Health on 20 December 2017. In the absence of an available board meeting, the Chief Executive contacted the Chair of the Board to gain approval to pay the invoice. The invoice was paid after receiving this approval.

Under the updated Delegations of Authority Policy that aligns with the delegation limits available in the National Oracle Solution (where implementation is planned for July 2018), the maximum purchase order amount that a Chief Executive can systematically approve will be $5m.

Recommendation
THAT
The Board:

1) Note the pre-approval given by the Chair outside of an available board meeting, to pay the December 2017 capital charge invoice.
2) Retrospectively approve the payment of the December 2017 capital charge invoice for $18,640,646.
3) Provide the standing approval of full payment of all future capital charge invoices payable to Ministry of Health, subject to approval of the calculated amount charged by the Chief Financial Officer or Treasurer.

DEREK WRIGHT
CHIEF EXECUTIVE

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth St
PO Box 5013
Wellington
New Zealand
Phone (04) 496 2516
Fax (04) 816 3320
Contact: Joanna Quirke
E-mail: receivables@moh.govt.nz

TAX INVOICE

(GST No:60-463-727)

INVOICE TO:

WAIKATO DISTRICT HEALTH BOARD
PO BOX 934
HAMILTON

Invoice No: 254114
Invoice Date: 10-DEC-2017
Order No:
Customer Number: 1068
Page Number: 1 of 1

Attention: Andrew McCurdie

Line	Description	Qty	Unit Cost (GST Excl)	Amount
1	Capital Charge - 1 July to 31 December 2017. Liable net assets as at 30 June 2017 as per attached calculation sheet.			
	PURCHASE ORDER PO447431	1	18,640,646.00	18,640,646.00
			NET	18,640,646.00
			GST	0.00
		Balance Due By	20-DEC-2017	18,640,646.00

Please notify above contact by fax one day before payment.
Direct Credit to bank account 03 0049 0001805 29

Ministry of Health
PO Box 5013
Wellington
E-mail: receivables@moh.govt.nz

Please Check Details
WAIKATO DISTRICT HEALTH BOARD
PO BOX 934
HAMILTON

Customer No: 1068

Tax Invoice No: 254114

Invoice Total: $18,640,646.00

Primary Contact Number

Waikato DHB
Capital Charge Calculation
For the six month period 1 July 2017 to 31 December 2017

Capital charge rate 6%

Crown Equity[1]	Donated Assets Net Book Value [1]	Liable net assets	6% of liable net assets	Six months capital charge due
$000's	$000's	$000's	$0's	$0's
A	B	C = A - B	D = 6% of C *1,000	E = D divided by 2
622,676	1,321	621,355	37,281,292	18,640,646

Note(s)
1. Data for these calculations were taken from financial templates received by the Ministry of Health in October 2017 for 30 June 201

2. Invoice will follow by post and by email in December 2017.

3. For addititional details and background on calculation please see the Crown Entities (Capital Charge) Regulations 20

http://www.legislation.govt.nz/regulation/public/2011/0135/latest/DLM3721830.html?search=ts_regulation_capital_resel&p=1&sr=1

Presentations

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 8.1

CREATING OUR FUTURES

Purpose	For information.

An overview of the DHB's Creating our Futures programme will be presented by Vicki Aitken, Interim Executive Director for Mental Health and Addictions Services.

Recommendation
THAT
The Board receives the presentation.

VICKI AITKEN
EXECUTIVE DIRECTOR, MENTAL HEALTH AND ADDICTIONS SERVICES (INTERIM)

MENTAL HEALTH AND ADDICTIONS SERVICE

Creating our Futures
Mental Health and Addictions Service

Programme Overview

MENTAL HEALTH AND ADDICTIONS SERVICE

What are the issues?

- Lack of an integrated and holistic model is resulting in significant barriers to timely and appropriate care.
- Current building, designed to fit an outdated institutional model, does not provide a safe, therapeutic and effective environment for service users and staff.
- Existing service capacity is not meeting the increasing acuity / complexity and demand which at times results in compromised and unsafe care.

MENTAL HEALTH AND ADDICTIONS SERVICE

Objectives

- To transform service delivery in order to improve safety, effectiveness and efficiency.
- To create safe and therapeutic environments that support holistic quality care at all times.
- To build sustainable capacity and capability of service to meet future demand, values and need.

MENTAL HEALTH AND ADDICTIONS SERVICE

Creating Our Futures: system of care

Pathway Transformation

Whole-system pathway for acute and integrated Mental Health and Addictions services. Changes to practice and end-to-end workflow across the continuum of care; and trust in transformative change. Priority deliverables include, e.g, care coordination, 'front gate' approach to addressing immediate needs alongside primary care and NGO's, (place of assessment), ED Crisis Response.

* Puawai model of care and pathway.

Whole Approach to MH and Addictions

A strategic and collective impact approach to how the service works with others: partnerships; values and culture; and, peer and community resiliency.

Environments

Capital infrastructure development (design / construction) and intensive co-design process.

- Acute MH
- Specialty services for multiple and variable needs
  - Alcohol and other Drugs
  - High and complex
  - Cognitive Impairment
  - Youth
  - Perinatal / Antenatal
  - Eating Disorders
- Puawai

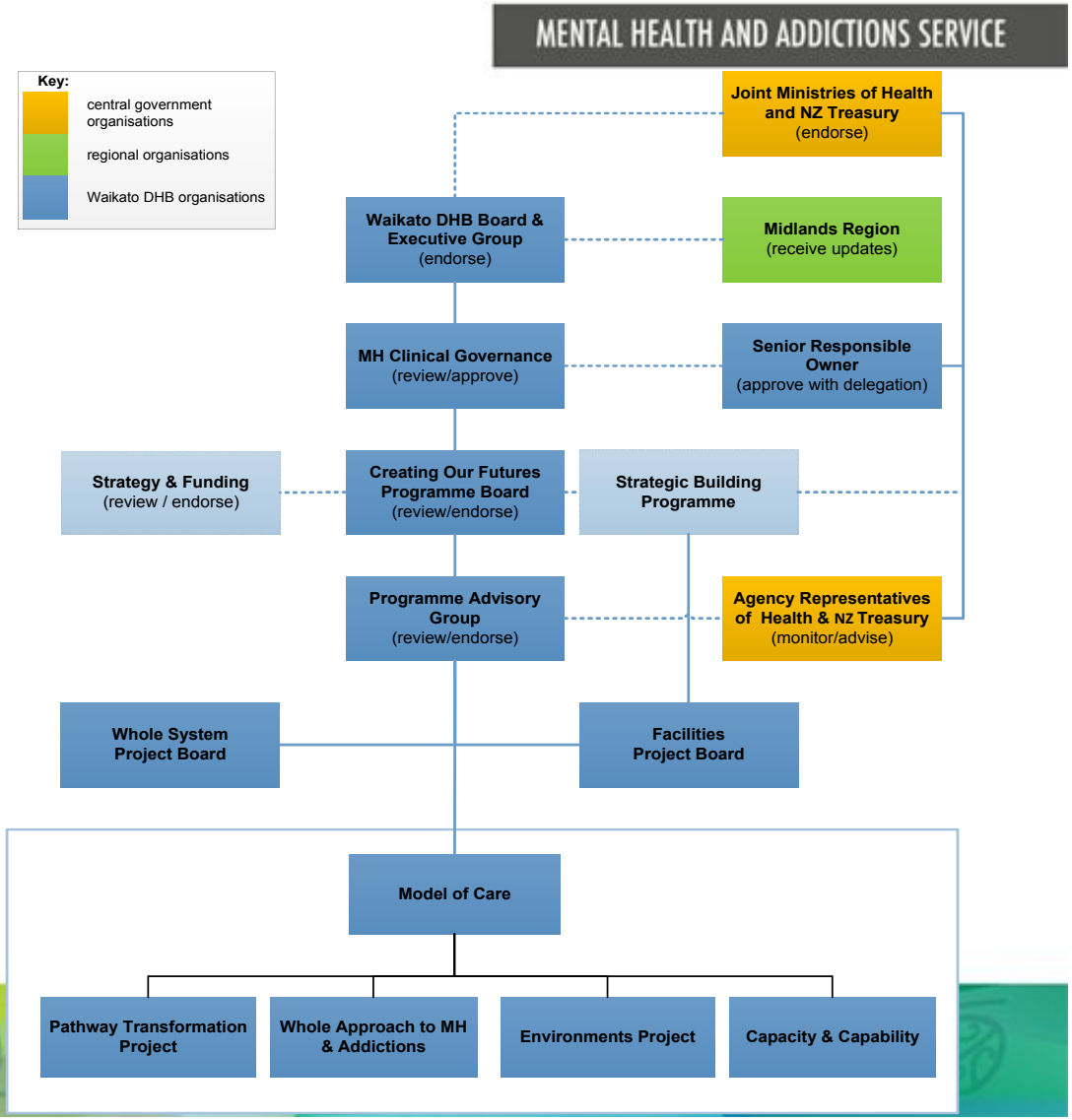
Capacity and Capability

Investment into the business as usual requirements for future focus of workforce development inclusive of professional practice development, recruitment and retention, and, leadership capability.

Waikato District Health Board

creating OUR futures

Programme Governance

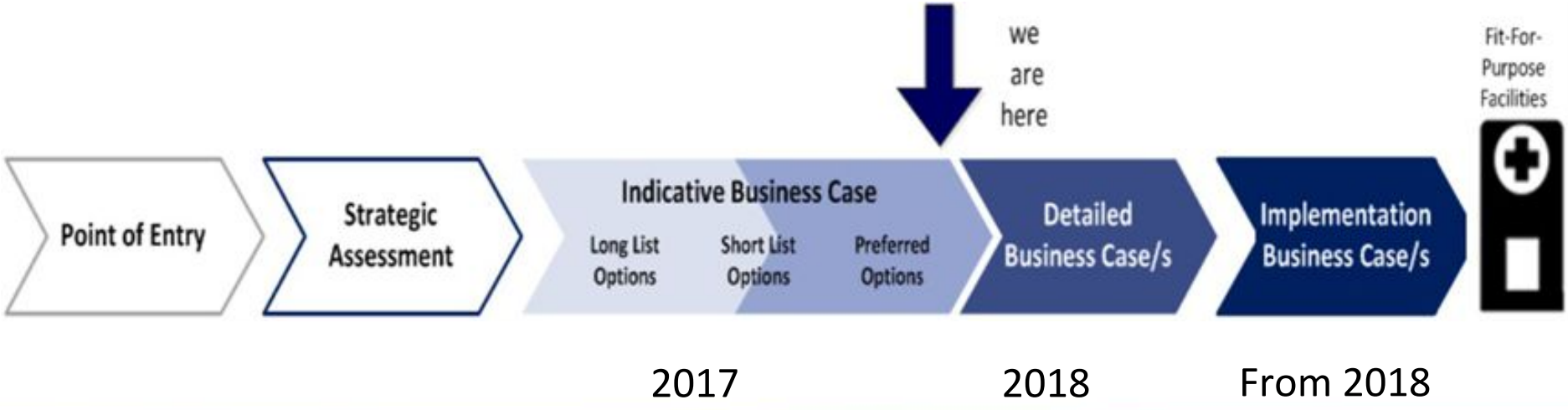


Waikato District Health Board

creating OUR futures

MENTAL HEALTH AND ADDICTIONS SERVICE

Where are we at?



Waikato District Health Board

Papers for Information

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 9.1

HEALTH TARGETS REPORT

Purpose	For information.

Most recent results

Table 1 shows a summary of the officially published performance for Waikato DHB's health target results including 2017/18 quarter one and two results. These results are still provisional as the Ministry of Health has not yet obtained approval from the Minister to publish them. The most recent results in the last column give the most up to date picture of performance using local data where available.

Table 1- Health targets performance summary

HEALTH TARGETS		16/17 Target	2016/17 Q1 results & ranking	2016/17 Q2 results	2016/17 Q3 results	2016/17 Q4 results	16/17 Target	2017/18 Q1 results (provisional)	2017/18 Q2 results (provisional)	Target achieved	2017/18 Most recent result
Shorter stays in emergency departments		**95%**	89.3% 19th ✗	87.6% 20th ✗	88.4% 20th ✗	86% 20th ✗	**95%**	82% 20th ✗	89% 20th ✗	X	86% Jan-18 YTD
Improved access to elective surgery		**100%**	108% 7th ★	106% 10th ●	110% 3rd ★	114% 2nd ★	**100%**	111% 5th ★	104% 8th ●	√	104% Dec-17 YTD
Faster Cancer Treatment (FCT)	Achievement	**85%**	81.4% 5th ★	85.9% 4th ★	86.1% 5th ★	86% 2nd ★	**85%**	98% 1st ★	98% 2nd ★	√	98% Dec-17
Better Help for Smokers to quit	Primary Care	**90%**	87% 12th ●	86% 13th ●	87% 12th ●	88% 15th ✗	**90%**	87% 12th ●	87% 12th ●	X	86% 16/17 Q3 result
	Maternity	**90%**	93% 12th ●	96%	98% 4th ★	95% 8th ●	**90%**	94% 8th ●	97% 4th ★	√	97% 17/18 Q2 result
Increased immunisation (8 months)		**95%**	92.3% 13th ●	92% 15th ✗	90% 16th ✗	89% 15th ✗	**95%**	88% 15th ✗	90% 15th ✗	X	89% Jan 18 3 mth rolling
Raising Healthy Kids[1]		**95%**	47% 11th ●	79% 6th ★	84% 9th ●	81% 14th ●	**95%[1]**	76% 19th ✗	100% 1st ★	X	100% Q2 provisional result

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

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2017

Q1 17/18	Q2 17/18
82.1%	**86.6%**

Table 3 - Emergency Department Q2 results by site and by clinical unit

Shorter Stays in Emergency Departments (EDs) health target
DHB name: Waikato
Quarter: 2 - 2018

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:	25298	28473	88.8%
Waikato	16961	19582	86.6%
Taumarunui	1410	1447	97.4%
Thames	3948	4380	90.1%
Tokoroa	2979	3064	97.2%

Quarterly results – by ethnicity

- Please use the ethnicity provided at the time of the ED presentation. Where that is not available, please use the ethnicity listed on the patient's NHI.

	Māori Ethnicity			Pacific Ethnicity		
	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	6982	7732	90.3%	570	777	73.4%
Waikato	4552	5210	87.4%	435	620	70.2%
Taumarunui	577	588	98.1%	10	12	83.3%
Thames	623	670	93.0%	29	39	74.4%
Tokoroa	1230	1264	97.3%	96	106	90.6%

<u>Thames, Tokoroa and Taumarunui Hospitals</u>

January is the peak period for Thames hospital due to the increase in domestic and international tourist numbers to the Coromandel. The clinic based approach to managing GP level patients who attended the ED that was successfully trialled least year was adopted again this year. The Thames medical centre, which has been short of GPs for some time, has undertaken successful recruitment and the primary care situation was improved by the end of the period. A proposal to introduce a CNS pilot into the Thames ED is currently under evaluation. A formal EOI will be conducted in late February, subject to final board approval, to seek respondents willing to establish a primary care centre within the Thames hospital facility.

The work to implement the single Point of entry service model in Taumarunui continues to be on track for implementation of the new service model from 1 July.

Additional nursing resources have been established at Tokoroa ED to assist with the significant increase in workload at that facility.

Work continues with local airframe providers to implement a clinical response team to facilitate the urgent retrieval of complex and unstable patients in the rural EDs back to Waikato hospital. This work is being done in such a way that the work being done under the national review of rotary wing provision will not be compromised. The outcome of that national work will not be sufficiently rapid to meet Waikato's needs for winter 2018 and an interim local solution is therefore being developed.

Waikato Hospital

Presentations to ED in Waikato Hospital for the month of January have shown marked increases on the previous year, with a 15% increase. January's presentation volumes proved to be second only to the all-time record, registered in July 2017. However, due to a slightly less constrained bed resource and improved throughput, the achievement of 84.6% is a marked improvement on the 74% in July and 77% in August.

The ED only target improved to 93.5% for January with year to date performance of 91.6% reflecting the additional ED staffing resource and Change team work occurring at the front of house.

Bed availability is the key problem area, with the admitted pathway performance sitting at 72% for the month, consequently having the greatest impact on the overall percentage performance.

The acute bed capacity has invariably been under significant and sustained pressure, operating at, or near, capacity most days. This results in the all too frequent holding of patients in ED.

Actions currently being taken in Waikato Hospital:

- General Medicine rostered an extra SMO over 2 weekends in January, with indications that this resulted in improved patient flow and turn-around times in ED for this cohort of patients.
- General Medicine plans to move to a ward based model of care in late February, with the stated aim of further enhancing patient flow on the Medical wards.
- A further key deliverable from the Rapid Improvement event (RIE), namely the use of electronic SBARR handover sheets, is due to go live in February with the aim of reducing time from bed request to actual placement on the ward.
- The Francis Group have been engaged to support the Patient flow process from ED to Medical and OPR wards, and are due to start in Waikato Hospital in early February.
- GP enrolments continue to be actively promoted in the ED, through designated resource, in an attempt to reduce repeat presentations.
- IHT to Renal have been reviewed along the same lines as Cardiology with these patients no longer being sent through ED but admitted directly to the Renal service, with an agreement signed with ED. Any patients who may deteriorate on route are still directed through ED if necessary.

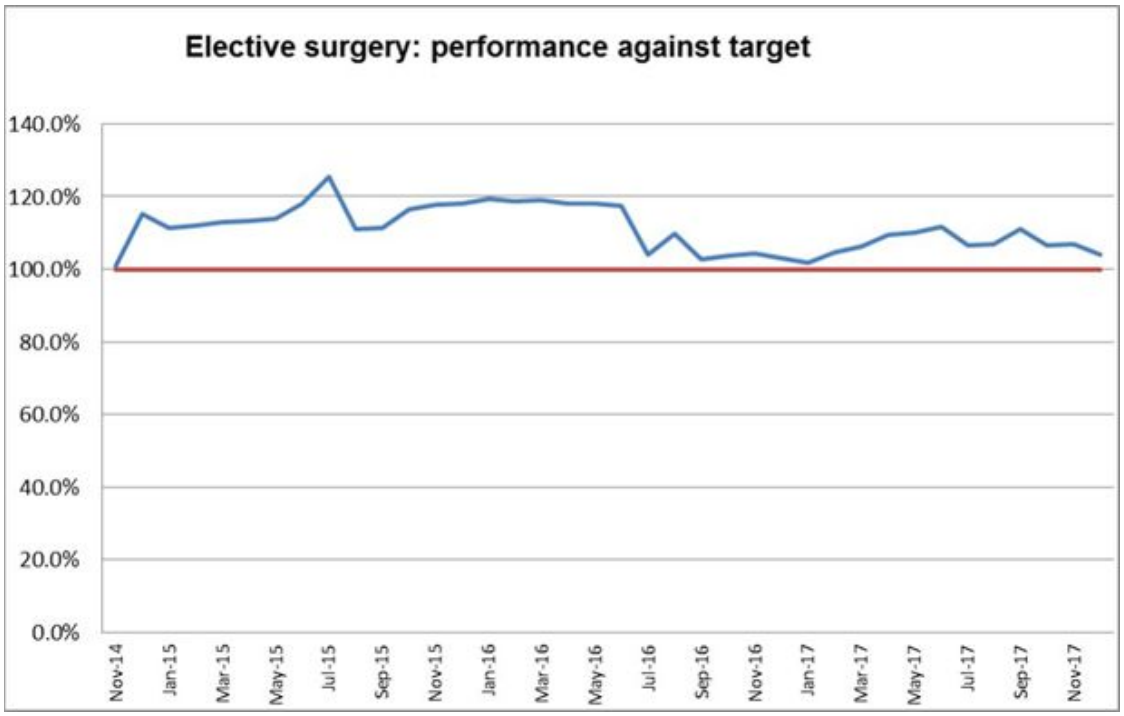
Target: Elective Surgery

Table 4 – Elective Surgery Results by Quarter

Quarter	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
Result	102.6%	103.1%	106.3%	111.8%	111%	104%
Ranking	**7**	**10**	**3**	**2**	**5th**	**8th**

Graph 1 below provides the most recent provisional result of 104%.

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



Target: Faster Cancer Treatment (FCT)

Table 5 - Summary of achievement against the FCT health target from July 2015 to October 2017

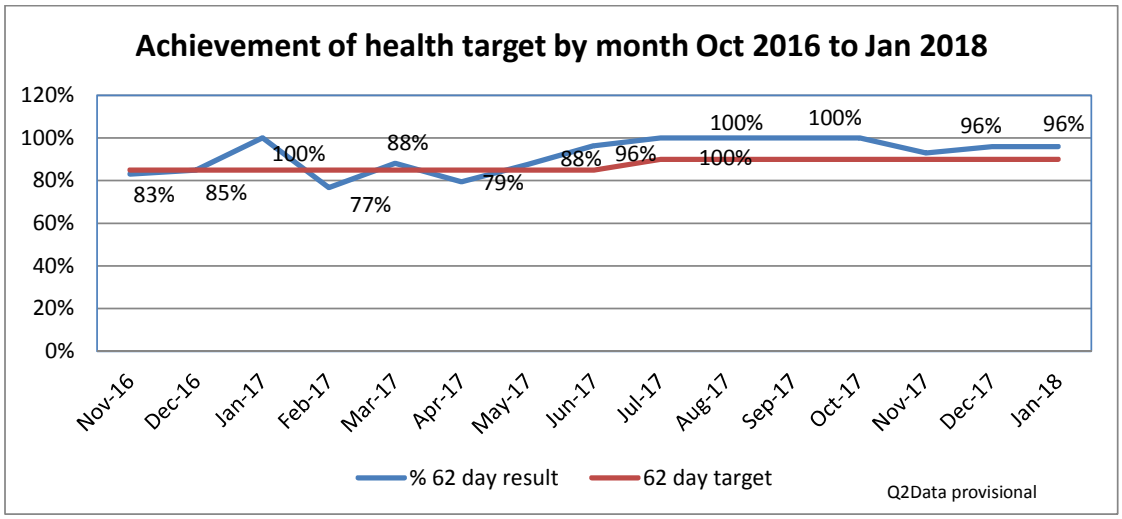
FCT 62 DAY HEALTH TARGET							
DHB Current Target	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18
90%	72.6% 14th ranking	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 1st Ranking	96.6% 2nd Ranking

FCT VOLUME TARGET							
DHB Current Target	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18
25%	14%	17%	19%	19%	22%	14%	**18%**

Waikato has continued to deliver sustained achievement against the FCT health target, with Quarter 2 being the second quarter for achievement against the new health target of 90%, and with a final result of 96.6% shows that Waikato continues to strongly deliver on this key national target. This result also includes the newly excluded breach reasons of patient choice and clinical considerations. We are pleased to be able to report that we continue to be ranked in the top 3 nationally, Quarter 2 showing a final result of 98.6% for the last 6 months giving us a national ranking of 2nd.

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

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



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

- FCT Business Manager and FCT Nurse Tracker are working very closely with cancer care coordinators and clinical nurse specialists to monitor the patient pathways from the initial date of referral.
- Improving the timeliness of gynaecology triaging and first specialist appointment.
- Weekly coordinated meeting with the gynaecology clinical nurse specialist and cancer care coordinator to discuss individual patients and tracking pathways to ensure patients are discussed at the Auckland multi-disciplinary meetings in a timely manner.
- Ongoing monitoring of respiratory triaging and time to FSA.
- Weekly coordinated meeting with upper gastro-intestinal surgeons and upper gastro-intestinal cancer nurse coordinator to discuss and track individual patients to ensure patients proceed along the pathway in a timely manner.
- 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.
- Monitoring and collaborative approach between breast care and plastics for women requiring immediate breast reconstruction.
- Engagement with Te Puna Oranga to minimise inequity in FCT, including addressing DNAs and identifying barriers.
- Daily reports are now being generated to highlight any DNAs for FCT patients.

Table 6

Local FCT Database	Nov-17	Dec-17	Jan-17	Q2 Total
Number of records submitted	30	26	25	81
Number of records within 62 days	28	25	24	77
% 62 day Target Met (90%)	93%	96%	96%	95.06%
% Volume Target Met (15%)	19%	16%	16%	19.08%

Target: Increased immunisations for 8 months

Table 7 – 8mth Milestone Immunisation Results by Quarter

Quarter	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
Result	**91.8%**	**90.0%**	**89.0%**	**88.0%**	**90.0%**
Maori	**89.1%**	**91.0%**	**86.0%**	**82.0%**	**86.0%**
Ranking	**15**	**16**	**15**	**15**	**15 (provisional)**

Data for this target is reported on a three month rolling basis. Graph 4 shows our most recent result of 89% for the three month period from 1 November 2017 to 31 January 2018.

We have not achieved the target this quarter as has been the case since it was advised to all DHBs by the Ministry of Health.

Since our last report to the Board we have developed a draft Immunisation Action Plan (IAG) to replace our current resolution plan. This plan has assisted us to achieve around 90% most quarters but not the target of 95%.

The focus in the IAG is to maintain or enhance current activity and consult further on the proposed new areas listed below.

The Waikato Child and Youth Health Network “the network” has overall responsibility of taking an updated IAG for approval to the next Primary Care Inter-Alliance meeting to be held in March.

Members of the group supported the need to review/redesign immunisation services and the importance of co-design with Maori. All agreed a whole of system approach alongside Māori, primary, secondary, maternity and population health needs to occur to meet the target.

The members would like to see the plan reconfigured to focus on the following NEW work streams, with clear goals and actions listed, responsibilities stated and measures of effectiveness clearly defined. All members have agreed they will feed back to us in time to send the revised action plan to the Ministry by Monday 26 February 2018 (as requested by the Ministry) which will subsequently then be presented to the next Waikato/DHB wide Primary Care Inter-Alliance meeting.

Proposed new work streams:

- Work with PHOs to reduce the percentage of informed non consent (currently over 5%), the number of vaccinations given late and those who opt out of one of more scheduled immunisation events.
- Ensuring all our outreach immunisation services maintain focus on unenrolled children and PHOs improve coverage of their enrolled children with both systems together covering the entire district.
- Opportunistic Immunising is increased at every encounter with the health system including accident and medical services and afterhours.
- Consideration of incentives for families/whanau such as petrol vouchers when a high needs baby has completed all vaccination events on time at their usual general practice.
- Ongoing engagement with LMCs and facilitation of early enrolments with general practice and working closely with the new project manager for Midland United Regional Internallaince Leadership (MURIAL) who is responsible fro implementing free general practice visits for high needs women in the third trimester of pregnancy – a region wide approach to improving child health.

- Rapidly progressing the inetersectoral work with started in late 2017, with the Ministry of Children Oranga Tamariki, to improve outcomes for the children who receive services from the five Family Start providers in Waikato as key indicator of perromacne fo these providers is immunisation coverage of 95%.

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

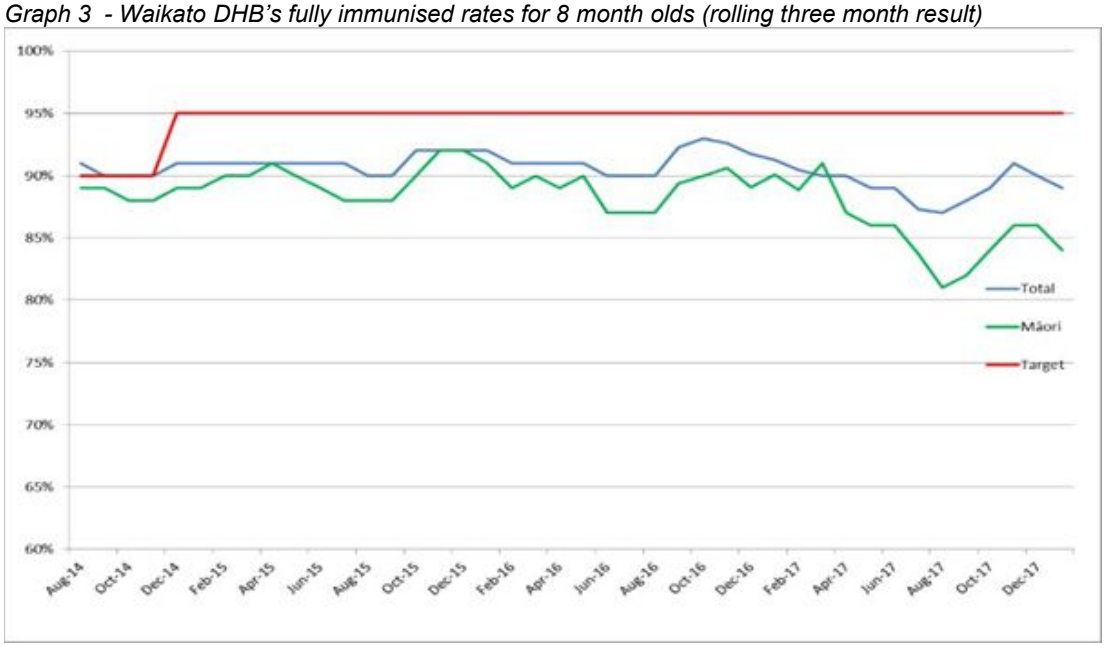


Table 8 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 89 additional children needed to be immunised to meet the 95% target.

Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from July 2017 to September 2017

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
Asian	147	141	96%	0
Māori	521	439	84%	56
NZ European	593	540	91%	24
Other	82	68	83%	10
Pacific	66	62	94%	1
Total across ethnicities				91
Total	1,409	1,250	89%	89

Table 9 below shows the latest immunisation rates for the eight month population for Waikato DHB by PHO.

Table 9 - Waikato DHB's PHO level results for 8 month old immunisation from Jul 2017 to Sep 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	559	504	90%	273	241	88%
Midlands Health Network – Waikato	818	747	91%	229	209	91%
National Hauora Coalition (historical data as recent breakdown not available)	25	25	100%	16	16	100%

Target: Better help for smokers to quit - primary care

Table 10 – Quarterly Results

DHB Q4 result 14/15	Q3 result 15/16	Q4 result 15/16	Q1 result 16/17	Q2 result 16/17	Q3 result 16/17	Q4 result 16/17	Q1 result 17/18 (provisional)	**Most recent result Q2 17/18 (provisional)**
90.4% 10th ranking	88% 6th ranking	89% 8th ranking	87% 7th ranking	87% 12th ranking	86% 13th ranking	88% 15th ranking	88% 14th ranking	**88% 12th ranking**

Graph 4 showing data up to the quarter two 17/18 provisional result of 88% shows Waikato DHB has maintained the results from the previous quarters.

Graph 4 - Waikato DHB's percentage of smokers offered help to quit in primary care

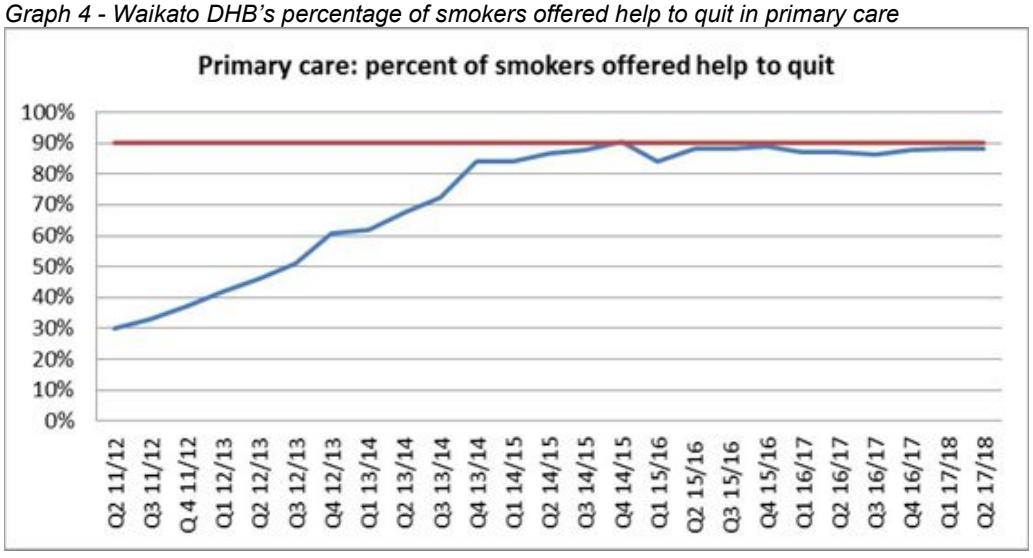


Table 11 shows a breakdown of primary care smoking results by PHOs up to 2016/17 quarter four as 17/18 results are not yet available from the Ministry.

Table 11 – 2016/17 Q4 primary care smoking results by PHOs (target 90%)

PHOs	Tobacco Numerator	Tobacco Denominator	2016/17 Q4 result	2016/17 Q3 result	2016/17 Q2 result	2016/17 Q1 result
Midlands Health Network	25,527	29,324	87%	88%	88%	88%
Hauraki PHO	20,771	23,397	89%	86%	86%	86%
National Hauora Coalition	1,258	1,345	94%	87%	86%	87%
Total	46,791	54,204	**86%**	**86%**	**87%**	**87%**

Target: Better help for smokers to quit - maternity

Table 12 – Quarterly Results

DHB Q2 result 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18 Provisional	**Most recent result Q2 17/18**
89% 15th ranking	93% 12th Ranking	98% 4th Ranking	96% 12th Ranking	95% 8th Ranking	94% 8th Ranking	**97% 4th Ranking**

Graph 5 quarter two result of 95% shows we continue to met this target.

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

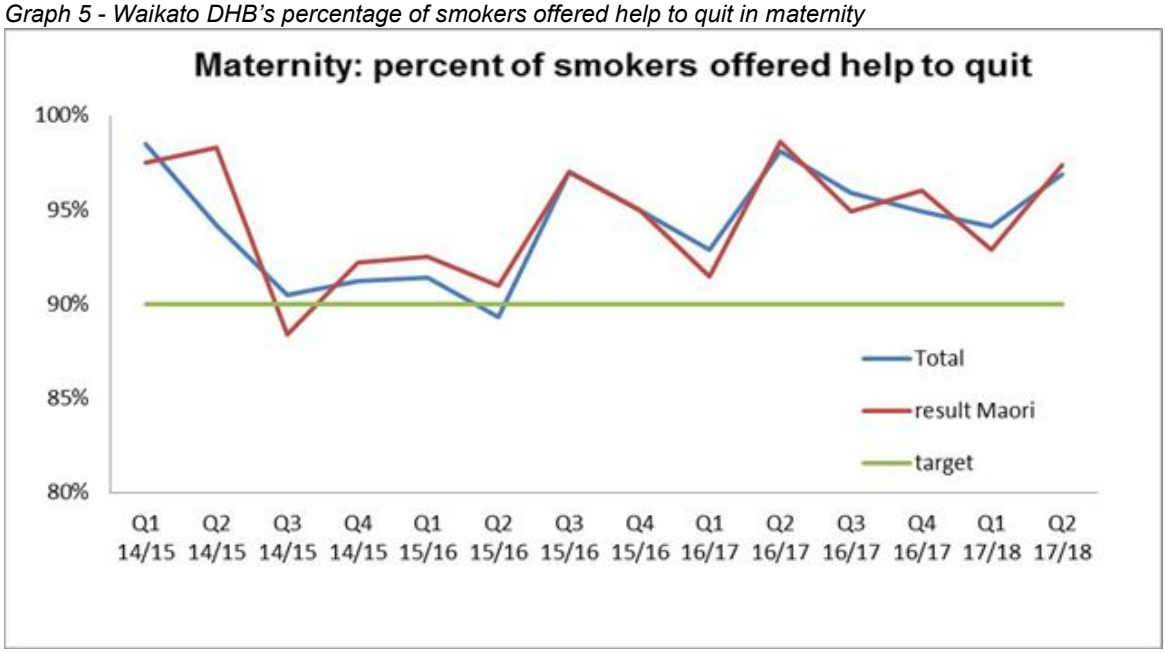


Table 13 shows our quarter three results provided by the Ministry for our total and Maori population.

Table 13 – 2016/17 Q4 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	83	38	37	46%	97.4%
Total	383	65	63	17%	96.9%

**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.

Target: Raising healthy kids

Waikato DHB has been rated as an outstanding performer by the Ministry of Health this quarter.

This target requires practice nurses to ensure children identified as having a very unhealthy weight are referred to a health professional (usually their own GP) for a clinical assessment and referral (if the family/whanau consents) to a healthy lifestyle programme which in Waikato is run by Sport Waikato.

After our drop in performance in quarter one, our local analysis identified that a reporting error was occurring. As a result of this investigation the B4SC clinical team contacted practices to advise them of referrals that required follow up. This follow up process continues with practices past the initial investigation period. For auditing purposes the B4SC coordination team have confirmed that retrospective changes have been documented following the tracking processes set up in the national database.

The ministry congratulated us on achieving the health target this quarter and noted we had achieved near perfect results across all ethnicities, and are also managing to keep the rates of referrals that are declined relatively low with a decline rate of 16% compared to national decline rate of 27% in quarter two.

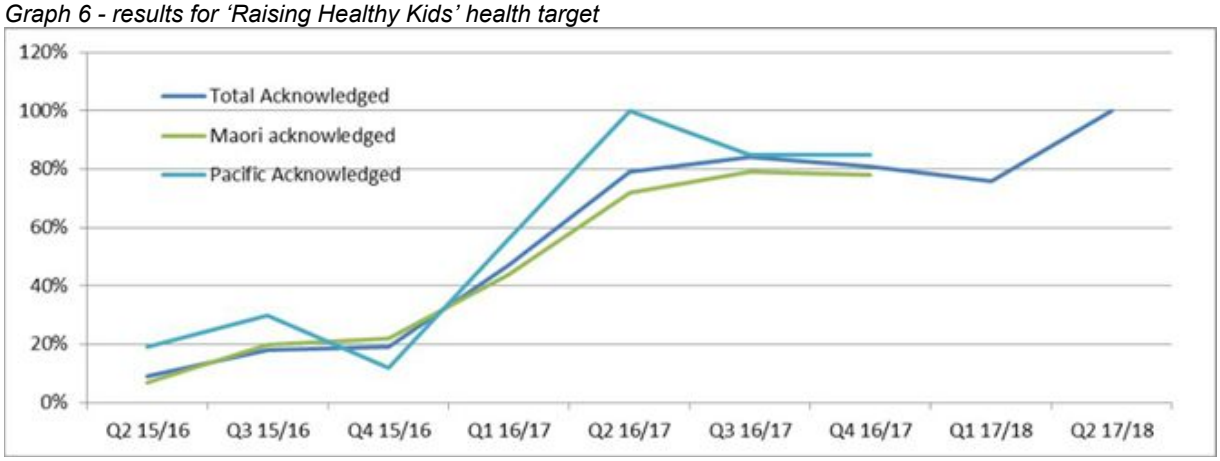
Waikato DHB, The Psychology Centre and Sport Waikato is setting up new options for community regional wide approach to support families with young children identified as having an unhealthy weight. This will be an extension of our current active families programmes offered by Sport Waikato. We are in the establishment phase and will be offering new programmes from March 2018.

Table 14 – 2016/17 Q4 Raising Healthy Kids Results (target 95%)

		Waikato DHB						National
		2016/17 Q1	**2016/17 Q2**	**2016/17 Q3**	**2016/17 Q4**	**2017/18 Q1**	**2017/18 Q2**	**2017/18 Q2**
		Six mths Aug 16	**Six mths Nov 16**	**Six mths Feb 17**	**Six mths May17**	**Six mths Aug 17**	**Six mths Nov 17**	**Six mths Nov 17**
Total	Referral Sent	50%	82% (141)	86% (133)	83% (102)	77% (93)	100% (144)	99% (1,515)
	Referral Sent and Acknowledged	**47%**	**79% (135)**	**84% (127)**	**81% (98)**	**76% (91)**	**100% (144)**	**98% (1,492)**
Maori	Referral Sent	49%	76% (63)	82% (65)	80% (43)	79% (36)	100% (69)	98% (493)
	Referral Sent and Acknowledged	**44%**	**72% (58)**	**79% (61)**	**78% (41)**	**79% (36)**	**100% (69)**	**97% (484)**
Pacific	Referral Sent	56%	100% (11)	90% (9)	88% (10)	87% (13)	95% (12)	99% (411)
	Referral Sent and Acknowledged	**56%**	**100% (11)**	**85% (8)**	**75% (8)**	**83% (12)**	**95% (12)**	**99% (408)**

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

Graph 6 - results for 'Raising Healthy Kids' health target



Data for a 6 month rolling period up to Nov 2017

Recommendation
THAT
The Board receives this report.

JULIE WILSON
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

DR GRANT HOWARD
CHIEF OPERATING OFFICER
WAIKATO HOSPITAL (INTERIM)

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY AND CLINICAL SUPPORT

MEMORANDUM TO THE BOARD
28 FEBRUARY 2017

AGENDA ITEM 9.2

PROVIDER ARM KEY PERFORMANCE DASHBOARD

Purpose	For information.

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

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

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

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

Recommendation
THAT
The Board notes the report.

MARK SPITTAL
EXECUTIVE DIRECTOR, COMMUNITY AND CLINICAL SUPPORT

VICKI AITKEN
EXECUTIVE DIRECTOR, MENTAL HEALTH AND ADDICTIONS SERVICES (INTERIM)

DR GRANT HOWARD
CHIEF OPERATING OFFICER, WAIKATO HOSPITAL (INTERIM)

Key Performance Dashboard

Community & Clinical Support

January 2018

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	93.5	95.0	(1.5)	93.1	95.0	(1.9)		
Number of long wait patients on outpatient waiting lists	# > 4 mths	0	0	0					
Number of long wait patients on inpatient waiting lists	# > 4 mths	0	0	0					
CTs reported within 6 weeks of referral	%	73.1	90.0	(16.9)	84.2	90.0	(5.8)		1
MRIs reported within 6 weeks of referral	%	64.1	85.0	(20.9)	79.0	85.0	(6.0)		2

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			35,431	34,961	(470)		
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			79.3	81.0	(1.8)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			94.6	99.6	(5.0)		3
Laboratory – Histology specimens reported within 7 days of receipt	% for Dec YTD	40.0	80.0	(40.0)	42.9	80.0	(37.1)		4
Pharmacy - Chart turnaround times, % within 2.5 hours	%	83.8	80.0	3.8	90.3	80.0	10.3		
Pharmacy on Meade script turnaround time in minutes	minutes	11.7	10.0	(1.7)	10.2	10.0	(0.2)		
Outpatient DNA Rate	%	11.2	10.0	(1.2)	11.4	10.0	(1.4)		5
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	83.5	100.0	(16.5)	92.0	100.0	(8.0)		6
Output Delivery Against Plan - Inpatient Number of Episodes	%	95.8	100.0	(4.2)	98.9	100.0	(1.1)		
Output Delivery Against Plan - Inpatient CWD Volumes	%	81.5	100.0	(18.5)	93.2	100.0	(6.8)		7
District Nurse Contacts (DHB Purchased)	Numbers	9,849	-		69,888				
District Nurse Contacts (ACC Purchased)	Numbers	1,829	-		14,350				

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Assigned EDD (SAFER)	%	83	100	(17)	84	100	(17)		8
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			3.28	3.24	(0.04)		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			1.87	1.10	(0.77)		9
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			0.32	0.32	(0.01)		

Health target measures

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	90.7	95.0	(4.3)	89.2	95.0	(5.8)		10

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	1,842	1,481	361	13,052	12,572	480		
Breast screening Maori volumes - Waikato DHB	Numbers	343	160	183	2,439	1,973	466		
Hospital Acquired MRSA (Department)	Numbers	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 resolved within 20 wd (1 month lag)	% for Dec-17	50	70	(20)	360	70	290		
Falls Resulting in Harm	Numbers	0	0	0	2	2	0		
Pressure Injuries - Total	Numbers	0	0	0	2	0	(2)		11
Patient Feedback	*Not yet collected - in Development*								

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Expenditure vs Budget ($000s)	$000s	14,884	14,744	(140)	106,769	104,356	(2,413)		
Actual FTEs vs Budget	FTEs	1,014.1	1,041.5	27.4	1,008.4	1,030.3	21.9		
Sick Leave	% of paid hours	2.2	1.6	(0.6)	3.2	3.0	(0.2)		12
Overtime $'s	$000s	219	151	(68)	1,321	1,009	(312)		13
Annual Leave Taken	% of Budget	Rolling 12 month measure			85.0	100.0	(15.0)		14

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

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

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

KPI Report: Community & Clinical Support Services

Commentary on the current KPI report (to 31 January 2018).

Note	Indicator	Commentary
1	CTs reported within 6 weeks of referral	As at December 2017 the national average was 82.3% with Waikato sitting at 85% (the third highest performing tertiary DHB). A drop off is expected over the Christmas holiday period. Meeting this KPI will become increasing difficult due to radiologist staffing gaps. Locum arrangements are being sought.
2	MRIs reported within 6 weeks of referral	As at December 2017 the national average was 56.4% with Waikato sitting at 78.9% (the best performing tertiary DHB by a significant margin; some are as low as 27 and 29%). A drop off is expected over the Christmas holiday period.
3	Elective and Arranged Day of Surgery Admissions	Phenomenally good performance in Australasian terms.
4	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.
5	Outpatient DNA rate	No concerns of note other than in Radiology where the DNA rates show significant variation by ethnicity. All Radiology services using the Karisma PACs will implement text reminders for appointments from May onwards as part of a Midland Regional Radiology Group (MRAG) initiative. Phone call reminding is being targeted to those least likely to attend.
6	Output delivery against plan – FSA/FUP/ nurse consults	No concerns of note other than that more clinics are being run in Hamilton in lieu of rural locations due to service pressures which increases the barriers to access for rural patients. Some services are, however, re-establishing rural clinics so it's a mixed bag. This KPI is too generic to be useful and will be modified.
7	Output delivery against plan – inpatient cwd	No concerns of note; the volumes are as expected but the revenue is not. The latest version of WEIS used to calculate CWD has a disproportionate impact on low CWD cases.
8	Assigned EDD (SAFER)	Further work to improve the EDD status across all rural hospitals is underway. Given occupancy relative to minimum facility staffing this work has a lesser ROI than at Waikato Hospital and has been prioritised accordingly.
9	Inpatient LOS –(As arranged)	Very few arranged admissions occur at the four rural hospitals. This KPI result is an artefact of small numbers.
10	Better help for smokers to quit	This KPI has been declining across the board and reflects the difficulties in maintain effort to record the data to support a less than useful KPI. Unrelated to the KPI, significant work is underway to reduce smoking on the hospital campus. The next step in the work programme will be to install refreshed signage.

	Breast Screening – Māori volumes	Both the KPI for breast screen total volume and the Breast Screen Māori women volume have previously been reported as negative. A recovery plan was enacted in September/October. The success of that plan is shown in the KPI report as at January.
11	Pressure injuries – total	No issues of note.
9	Sick leave	No issues of note.
10	Overtime $'s	No particular concerns are evident that have not been reported in prior periods. This primarily reflects the issues in Radiology. A comprehensive review of staffing relative to schedule and service demand is underway and will better inform the 18/19 budget cycle. Significant staffing gaps which result in the high use of overtime and outsourcing are evident.
11	Annual leave taken	No particular concerns are evident; the KPI reflects better performance than industry averages.

Key Performance Dashboard

Mental Health

January 2018

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	81.1	95.0	(13.9)	86.7	95.0	(8.3)		1

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health seclusion hours	Hours	495	736	241	3,376	5,151	1,775		
Mental health recovery plans	% Cases	78.5	95.0	(16.5)	85.3	95.0	(9.7)		2
Mental health HoNos matched pairs	% Cases	95.1	95.0	0.1	96.3	95.0	1.3		
Mental health inpatient bed occupancy	%	96.4	85.6	10.8	96.0	49.0	47.1		
Mental health GP methadone cases	Cases	86.0	76.0	10.0	87.6	76.0	11.6		

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	%	72.6	90.0	(17.4)	86.0	90.0	(4.0)		
Mental health follow up - numbers seen in 7 days	Number of Cases	45	56	(11)	74	77	(3)		
Mental health community contract positions filled	% FTEs	97.2	95.0	2.2	97.7	95.0	2.7		
Mental health 28 day readmission rate	%	8.5	15.0	6.5	10.8	15.0	4.2		

Health target measures

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

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints resolved within 20 wd (1 month lag)	% for Dec-17	33	70	(37)	262	70	192		
Falls Resulting in Harm	Numbers	3	1	(2)	9	9	0		

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Expenditure vs Budget ($000s)	$000s	6,477	6,811	334	44,473	44,035	(438)		
Actual FTEs vs Budget	FTEs	754.1	749.6	(4.5)	749.1	749.9	0.8		
Sick Leave	% of paid hours	2.8	1.5	(1.3)	3.5	3.2	(0.3)		3
Overtime $'s	$000s	166	78	(88)	973	539	(434)		4
Annual Leave Taken	% of Budget	Rolling 12 month measure			86.1	100.0	(13.9)		5

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

The following is a current state KPI dashboard for the directorate (to 31 January 2018)

Note	Indicator	Commentary
1	Emergency Hours <6 hours	Overall 167 MH related presentations for January 122 of these were included in the MH 6 hour target 23 people breached the 6 hour target – 81.1% The highest number of MH presentations on a single day was 10 on the 31st of January 118 of the 167 presentations occurred after hours (17:00pm to 08:00am) – 70.66% 23 breached presentations include: 15 x suicidal/overdose 1 x Hearing voices 1 x Seizures 2 x Psychotic symptoms 1 x Acute paranoia 1 x Drug induced psychosis 1 x self-harm Complex physical symptoms and anxiety. Further information is available in the PMC report.
2	Recovery Plans	There is still a real service focus on improving both the quantity and quality of Recovery Plans across all areas. We are closely monitoring the current trend and reminding all clinicians of the importance of this documentation. However demand on services and the time of year (annual leave use) means that January results are consistently poor. Despite this there are pockets of good practice and an attempt is being made to understand what could be learnt from these areas. A performance improvement plan for managers around recovery plans is in place.
3	Complaints - 1 month lag	December 2017 Target of 70% Actual 64%. This equates to 7 complaints received of which 6 were closed within 20 working days whilst 1 remains open due to the complainant and clinicians being on leave in regards attempts to arrange a meeting to discuss. 3 complaints re staff attitude 2 complaints re clinical treatment 1 complaint about premises 1 complaint about admission/discharge/transfer processes.
4	Falls resulting in harm	The report states in numbers target 19 actual 22 Jan 2017. There appears to be come discrepancy in the data of this report and reports in Datix, which the service identifies as being 11 falls. 63% of these occurred in OPR1 and falls minimisation equipment has been identified by Productive wards and this has been added to the capital plan for 18/19.

5	Sick Leave	The 12 month sick leave trend is currently above target, however due to sustained capacity, demand and pressure on all our services, staff have been doing overtime and not taking annual leave in order to meet the needs of our clients. Sick leave was set at 1.5 for January, which is lower than industry standards and therefore sick leave use of 2.8 in a summer period with the demands on the service is not concerning. The overtime use is reflective of high occupancy, acuity and a crisis team only operating an overtime system for nights. Overtime for RMO's had been high for the last 6 months due to 5 vacancies and should settle with all registrar roles recruited to. The service continue to have strong plans in place to manage annual leave and December showed a rolling measure of 90% taken against 100% earned. With the challenges in annual leave and shift leave reporting last year staff have been cautious about using leave they may not actually have. As this has been corrected staff have begun to build trust in the system again and managers will work on leave plans with them. SMO's with high leave balances have been met with and plans to reduce them enacted.
6	Overtime	
7	Annual leave taken	

Key Performance Dashboard

Waikato Hospital Services

January 2018

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	84.5	95.0	(10.5)	82.3	95.0	(12.7)		1
Faster Cancer Treatment - Referral received to first treatment <= 62 days	% of patients	95.7	100.0	(4.3)	97.4	100.0	(2.6)		
Faster Cancer Treatment - DTT to first treatment <= 31 days	% of patients	89.7	90.0	(0.3)	93.0	90.0	3.0		
Number of long wait patients on outpatient waiting lists	# > 4 mths	308	0	(308)					
Number of long wait patients on OPRS outpatient waiting lists	Patients	0	0	0					
Number of long wait patients on inpatient waiting lists	# > 4 mths	88	0	(88)					

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	%	73.6	85.0	(11.4)	75.1	85.0	(9.9)		2
Hospital initiated elective theatre cancellations (< 24hrs)	numbers	80			396				
Hospital initiated elective theatre cancellations (< 24hrs)	%	7.0	2.5	(4.5)	5.0	2.5	(2.5)		3
Waiting Time for acute theatre < 24 hrs	%	74.2	80	(5.8)	72.3	80.0	(7.7)		4
Waiting Time for acute theatre < 48 hrs	%	86.6	100	(13.4)	86.4	100.0	(13.6)		5

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Elective Services Standardised Intervention Rates (SIRs)	Discharges per 10,000 pop	Rolling 12 month measure			287.3				
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			51.0	53.1	(2.1)		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			75.5	81.3	(5.8)		6
Outpatient DNA Rate	%	10.5	10.0	(0.5)	9.7	10.0	0.3		
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	98.3	100.0	(1.7)	98.9	100.0	(1.1)		
Output Delivery Against Plan - Inpatient Number of Episodes	%	110.3	100.0	10.3	100.2	100.0	0.2		
Output Delivery Against Plan - Inpatient CWD Volumes	%	98.8	100.0	(1.2)	101.7	100.0	1.7		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Number of long stay patients (>20 days length of stay)	Discharges	52	58	6	428	439	11		
Number of long stay patient bed days (>20 days los)	Bed Days	1,663	1,846	183	14,189	14,843	654		
Assigned EDD (SAFER)	%	96	100	(4)	90	100	(10)		7
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			4.01	4.01	0.00		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			2.11	2.15	0.04		
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			1.06	1.00	(0.06)		

Health target measures

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	92.6	95.0	(2.4)	92.2	95.0	(2.8)		

Organisational Quality Safety Markers

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Patients assessed as being at risk have an individualised care plan which addresses their falls risk.	% for Dec-17	96.1	90.0	6.1	97.6	90.0	7.6		
Compliance with good hand hygiene practice (Cluster Rate)	%	85.8	85.0	0.8	86.0	80	6.0		

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 resolved within 20 wd (1 month lag)	% for Dec-17	64	70	(6)	66	70	(4)		8
Falls Resulting in Harm	Numbers	22	19	(3)	146	132	(14)		9

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Revenue vs Budget ($000s)	$000s	9,217	8,974	243	69,575	68,471	1,105		
Actual Expenditure vs Budget ($000s)	$000s	38,618	40,047	1,429	267,230	266,703	(527)		
Actual FTEs vs Budget	FTEs	3,267.1	3,320.5	53.3	3,234.6	3,301.5	66.9		
Sick Leave	% of paid hours	2.3	1.8	(0.5)	3.1	2.9	(0.2)		10
Overtime $'s	$000s	666	386	(280)	3,832	2,098	(1,734)		11
Annual Leave Taken	% of Budget	Rolling 12 month measure			80.9	100.0	(19.1)		12

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

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

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

KPI REPORT: WAIKATO HOSPITAL SERVICES

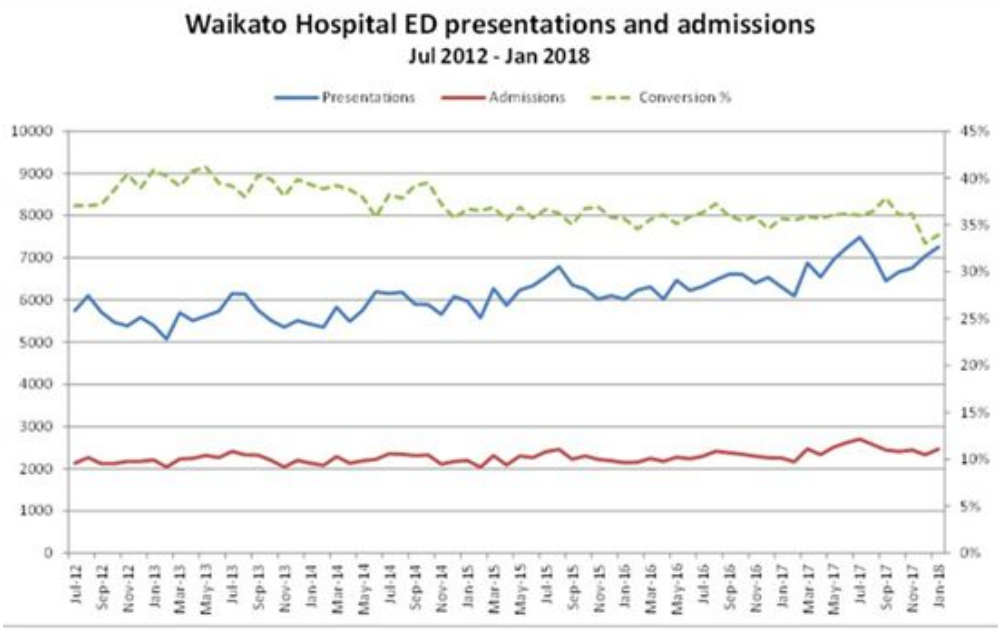
The Performance dashboard is attached.

Current financial status
No exception report.

ED performance and acute flow
The 6 hour target has not continued to improve over the summer months for a number of reasons.

1. January has been an exceptional month. It has been the second busiest month ever, topped only by midwinter last year, and exceeding January 2017 by 15%. We are, as a DHB, the highest service provider of emergency department consultations.

WAIKATO HOSPITAL ADMISSIONS BY MONTH OVER 6 YEARS

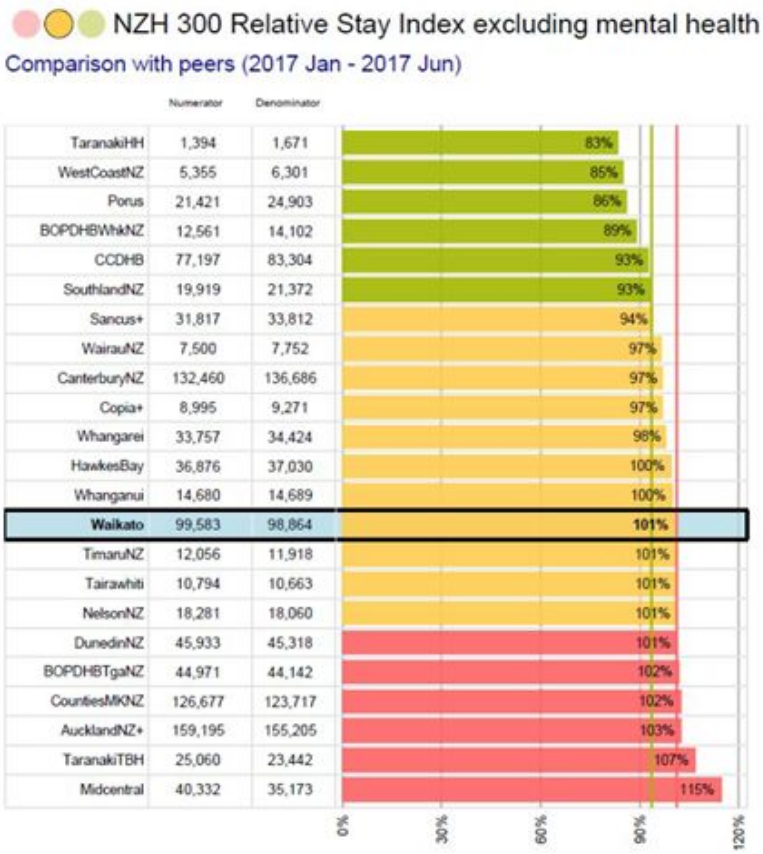


2. We have not been able to improve the downstream flow from ED and this has adversely affected the 6 hour target. Two questions are often asked.
    a. Are we admitting patient we don't need to
    b. Are we discharging patients at the appropriate time

With regard the first question, the average triage score for patients presenting to ED continues to rise while the conversion rate (ratio of people presenting relative to those admitted) continues to fall. This would suggest we are not deteriorating in terms of unnecessary admissions.

With regard the second question, the Australasian Health Roundtable provides some insights.

RELATIVE STAY INDEX FOR WAIKATO HOSPITAL

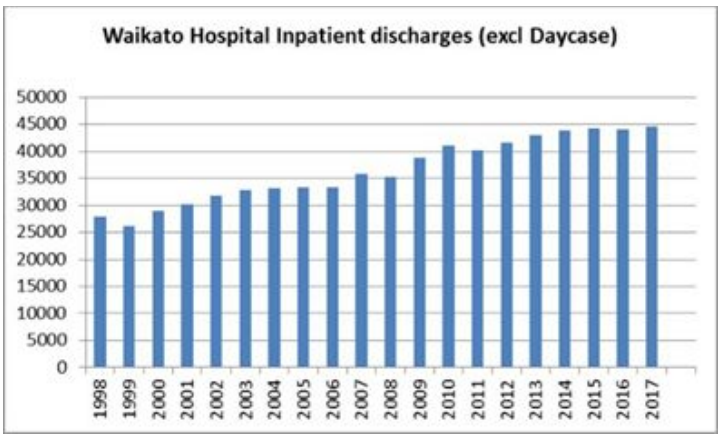


Waikato has a relative stay index at about the average for all health providers in New Zealand.
In addition we have made significant improvements over a sustained period.

IMPROVEMENTS IN RELATIVE STAY INDEX 2013-2017

The data suggests that whilst we could do better, we are not profligate in the use of our inpatient capacity.
The history of the Waikato Hospital suggests the last real nett increase in hospital beds was in 1980. We don't have reliable data to compare admission rates over that period but since 1998 there has been an increase in utilisation of more than 40% through what is essentially the same number of beds

TWENTY YEARS OF ADMISSION DATA TO WAIKATO HOSPITAL



This increase in admission numbers must be considered in the context of a service and campus redevelopment program that focussed on ambulatory models of care, such that between 2004 and 2018 whilst there was significant investment in buildings and services the number of core inpatient beds was not increased materially and bed stock was transferred from acute services to rehabilitation services where they were also sorely needed.

Remediation of the 6 hour target and linked patient flow issues includes at this point:

- Increase in bed stock (see business case in this edition of the Board for redevelopment of level 8 Menzies by July 2018).
- A change in acute surgical models of care at the "front door" by virtue of a surgical admission and assessment unit.
- Engagement of the "Francis Group" portfolio of patient management approaches to integrate care for the elderly and frail with emergency and acute care.
- Operationalisation of OPR5 Ward (26th February 2017).

As an aggregate of these approaches the forecast deficit of 66 bed-equivalents in the middle of the next winter with progressive improvements in the ED 6hr target.

These comments do not consider improvements within the emergency department in the way non-admitted patients are managed.

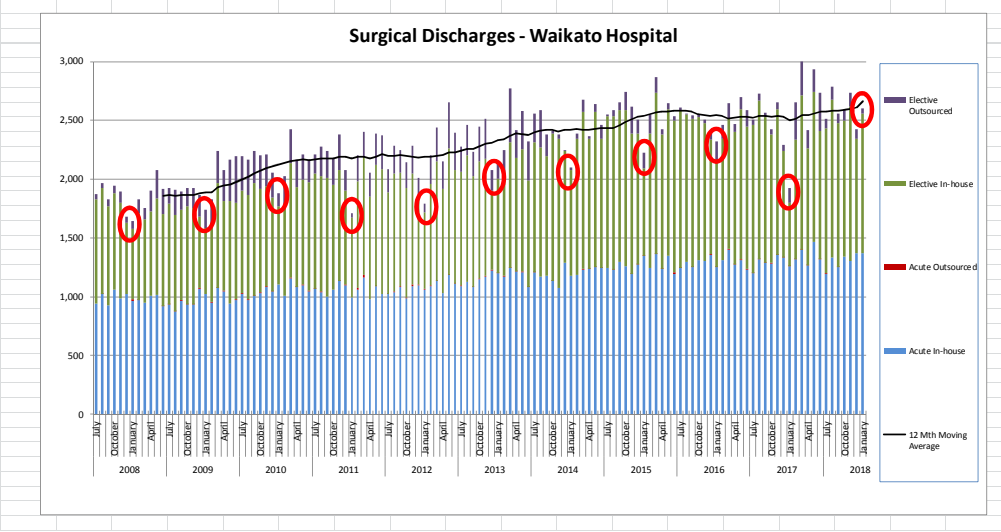
Theatre performance and ESPIs
The Christmas Break and theatre shutdown is a challenging time for elective services where there has been no margin between performance and compliance with standards for most of 2017.

Accordingly we will not be ESPI compliant for ESPI 2 or 5 for January. This situation is reflected across almost all DHB's, something we take no comfort from.

The Keezz project was instituted to deal with this issue and to provide a sustainable clinical management environment in 2018 and beyond.

Significant effort has been put into elective planning tools that extend the planning horizon, match resource to demand and decrease churn and re-work. December and January are notoriously difficult to interpret given the Christmas shut down for two weeks of elective service and the desire for people to take summer holidays. Nonetheless we have seen encouraging increases in patients receiving surgery in January 2018 relative to January 2017 and prior years.

SURGICAL DISCHARGES JANUARY 2018



Further reporting against the Keezz project will be included in the next Board report with regard elective planning tools and ESPI compliance.

There are a number of regional and national issues to be noted with regard surgery at Waikato Hospital:

1. Tairawhiti DHB does not at present have a sustainable orthopaedic surgical service with Waikato providing support as required.
2. Lakes District Health Board has requested help with the management of subspecialty orthopaedic elective services.
3. Disruption to the National Burns Unit has resulted in Waikato keeping and treating a massive burns patient with significant flow on resource requirements for theatre capacity.

With regard acute surgical performance, the Keezz project has reorganised orthopaedic surgery acute work and provided a more structured approach to plastic surgery.
As this work progresses, pressure points on services have become more apparent and will need to be addressed as a matter of urgency (for example: plastic surgery)

Additional Notes

1. Our performance against faster cancer treatment standards remains excellent overall.

FCT 62 DAY HEALTH TARGET							
DHB Current Target	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18
90%	72.6% 14th ranking	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 1st Ranking	96.6% 2nd Ranking

2. We have made significant improvement in our Women's Service as recognised in a recent accreditation visit by the College of Obstetrics and Gynaecology, following which we expect their Board will ratify our centre for training of specialists in this field again when they next meet, which possibly might lead to trainees being present in the latter half of the year.

3. The Women's Health Service successfully managed to cope with the increased number of pregnant women enrolled with the DHB community midwifery team as a result of the shortage of LMCs over December and January. The community midwifery team had more than a 400% increase in the numbers of women booked with them, from the normal 8 women booked to 35 women in one month. The summer plan that was developed in partnership with the College of Midwives and the Birthing Centres worked well given it was an incredibly busy time for the maternity services at Waikato Hospital.

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 9.3

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.

Recommendation
THAT
The report be received.

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY & FUNDING

Strategy and Funding KPI Dashboard Commentary

Note	Indicator	Commentary
1	Proportion of older people waiting greater than 20 days for initial assessment or reassessment	Data has been updated and shows most recent quarter. This indicator continues to improve and the service is managing the issues previously identified.
3	2 year old immunisations	Latest 2 year old coverage result is 91% (target 95%). The 4% point gap represents 54 children not immunised on time. For children aged 2 years, this quarter the highest coverage was for Asian children (99%) and lowest for Other (non Maori, Pacific, or Asian) (82%). Our latest results also show NZ European 4% ahead of Maori for this cohort by 2 years. This measure is a contributory measure for the 17/18 Service Level Measure Improvement Plan for ASH rates for 0-4 year olds. In line with the approach taken in under 8 month immunisations an initial focus will be on addressing enrolment status of any children not enrolled and identifying reasons for declines.
4	Ambulatory sensitive hospitalisations	The data shows pleasing improvements in the rates for 0-4 years (Pacific Islander) but have increased for Maori and the other population in this age group. The rates have deteriorated for the 45-64 year old age group for both Maori and other ethnicities. For Maori ethnicity in this age group, the increase is driven by admissions for angina/chest pain, COPD, cellulitis and pneumonia. As for the Pacific ethnic group, it is driven by angina/chest pain, cellulitis, pneumonia and gastroenteritis/dehydration.

Appendix A **Strategy and Funding KPI RESULTS**

Strategy and Funding - Key Performance Dashboard

January	2018

Health Targets

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Quarter Actual	Target	Variance		Trend
CVD risk assessments	%	↑	5yrs to Jun-17	No	91%	90%	1%	✓	92%	90%	2%	✓	
8 month old immunisations	%	↑	Rolling 3 months to Jan-18	Yes	89%	95%	-6%	✗	90%	95%	-5%	✗	
Better help for smokers to quit (primary care)	%	↑	15mths to Dec-17	Yes	87%	90%	-3%	!	87%	90%	-3%	!	

Finance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Month Actual	Target	Variance		YTD Actual	Target	Variance		Trend
IDF inflow estimate	$		Jan-YTD	Yes	10,441	11,273	-832	✗	82,317	79,429	2,888	✓	
IDF outflow estimate	$		Jan-YTD	Yes	4,973	4,967	6	!	35,344	35,376	-32	✓	

Other Performance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Period Actual	Target	Variance		Trend
AOD waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Oct 17	Yes	85%	80%	5%	✓	84%	80%	3%	✓	
MH waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Oct 17	Yes	80%	80%	0%	!	80%	80%	0%	!	
AOD waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Oct 17	Yes	96%	95%	1%	✓	96%	95%	1%	✓	
MH waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Oct 17	Yes	91%	95%	-4%	!	92%	95%	-3%	!	
Proportion of Health of Older people initial needs assessments Waiting greater than 20 days	%	↓	Oct -Dec 17	Yes	6%	0%	-6%	✗	6%	0%	-6%	✗	
Proportion of health of older people need re-assessments Waiting greater than 20 days	%	↓	Oct -Dec 17	Yes	5%	0%	-5%	✗	6%	0%	-6%	✗	
Proportion of older person funding in community based services	%	↑	Dec YTD	Yes	27%	25%	2%	✓	27%	25%	2%	✓	
Pharmacy Items claimed	Items		Dec-17	Yes	537,526	N/A			559,823	N/A			
Laboratory turnaround tmes	%	↑	Dec-17	Yes	100%	97%	3%	✓	100%	97%	3%	✓	
Breast Screening (total eligible population)	%	↑	Dec-17	Yes	69%	70%	-1%	!	68%	70%	-2%	!	
Cervical screening (total eligible population)	%	↑	Sep-17	Yes	76%	80%	-4%	!	76%	75%	1%	✓	
Cervical screening (High Need)	%	↑	Sep-17	Yes	68%	80%	-12%	✗	68%	75%	-7%	✗	
2 year old immunisations (total population)	%	↑	Rolling 3 months	Yes	91%	95%	-4%	!	92%	95%	-3%	!	
2 year old immunisations (Maori)	%	↑	Rolling 3 months	Yes	88%	95%	-7%	✗	92%	95%	-3%	!	
Green Prescriptions	%	↑	Oct - Dec 2017	Yes	1,389	1,675	-286	✗	1,417	1,675	-258	✗	

Ambulatory Sensitive Admissions - Rates per 100,000 Population

Indicator	Unit	⇵	Data period	Updated from prior report	YT Sep 2017				YT Jun 2017				
Ambulatory sensitive admissions 0-4	rate	↓	YT Sep 2017	y	7323	7298	-25	!	7172	7298	126	✓	New ASH Definitions
Ambulatory sensitive admissions 0-4 (Maori)	rate	↓	YT Sep 2017	y	8367	7936	-431	✗	8015	7936	-79	!	New ASH Definitions
Ambulatory sensitive admissions 45-64	rate	↓	YT Sep 2017	y	4386	3936	-450	✗	4243	3936	-307	✗	New ASH Definitions
Ambulatory sensitive admissions 45-64 (Maori)	rate	↓	YT Sep 2017	y	8807	5838	-2969	✗	8303	5838	-2465	✗	New ASH Definitions

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

Next Board Meeting: 28 March 2018.