Board Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	25 July 2018	Time:	1pm

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
In Attendance:	Ms T Thompson-Evans, Chair Iwi Maori Council Mr D Wright, Interim Chief Executive and other Executives as necessary

Next Meeting Date:	22 August 2018	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680

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Board 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: 27 June 2018
   3.2 Committees Minutes:
      3.2.1 Iwi Maori Council: 5 July 2018
      3.2.2 Maori Strategic Committee: 18 July 2018

4. INTERIM CHIEF EXECUTIVE REPORT

5. QUALITY AND PATIENT SAFETY
   5.1 Quality and Patient Safety Report

6. FINANCIAL PERFORMANCE MONITORING
   6.1 Finance Report
   6.2 Year End Matters

7. HEALTH TARGETS

8. HEALTH AND SAFETY
   8.1 Health and Safety Service Update

9. SERVICE PERFORMANCE MONITORING
   9.1 Interim Chief Operating Officer
   9.2 Mental Health and Addictions Service
   9.3 Strategy and Funding (report due in August)
   9.4 People and Performance (report due in September)
   9.5 Facilities and Business (report due in September)
   9.6 IS (report due in September)
   9.7 Chief Data Officer Directorate (report due in October)

10. DECISION REPORTS
   10.1 Equity Focussed Reporting (report due in October)
   10.2 PHO Services Agreement – Hauraki PHO
   10.3 PHO Services Agreement – Midlands Health Network
   10.4 Request for Change Approval – Patient Flow Manager Infrastructure

11. SIGNIFICANT PROGRAMMES/PROJECTS
   11.1 Medical School (no report this month)
   11.2 Creating our Futures (refer item 9.2)

12. PAPERS FOR INFORMATION
   No papers

Board Agenda

13. **PRESENTATIONS**

No presentations

14. **NEXT MEETING: 22 August 2018**

Board Agenda

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

THAT:

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

Item 15: Minutes – Various
- (i) Waikato District Health Board for confirmation: Wednesday 27 June 2018 (Items taken with the public excluded)
- (ii) Audit and Corporate Risk Management Committee to be adopted: Wednesday 23 May 2018

Item 16: FY18/19 Operating Budget and Future Year Projections – Public Excluded
Item 17: Replacement of Radiology Angiography Equipment – Public Excluded

(2) 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.

(3) Pursuant to Clause 33 (1) of Schedule 3 of the NZ Public Health & Disability Act 2000 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 15 (i-ii):	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 16:	2018/19 operating budget and future year projections – Public Excluded	Negotiation with Ministry will be required	Section 9(2)(j)
Item 17:	Radiology Angiography equipment replacement – Public Excluded	Negotiation with suppliers will be required	Section 9(2)(j)

(4) Pursuant to clause 33(3) of the NZ Public Health & Disability Act 2000 Ms Te Pora Thompson-Evans who is the Chair of the Iwi Maori Council is permitted to remain after the public have been excluded because of her knowledge of the aspirations of Maori in the Waikato that is relevant to all matters taken with the public excluded.

(5) Pursuant to clause 33(5) of the NZ Public Health & Disability Act 2000 Ms Te Pora Thompson-Evans must not disclose to anyone not present at the meeting while the public is excluded any information she becomes aware of only at the meeting while the public is excluded and she is present.

Board Agenda

15. MINUTES – PUBLIC EXCLUDED

15.1 Waikato District Health Board: 27 June 2018
To be confirmed: Items taken with the public excluded

15.2 Audit and Corporate Risk Management Committee: 23 May 2018
To be adopted: All items

16. FY18/19 OPERATING BUDGET AND FUTURE YEAR PROJECTIONS – PUBLIC EXCLUDED

17. REPLACEMENT OF RADIOLOGY ANGIOGRAPHY EQUIPMENT – PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

THAT:

(1) The Public Is Re-Admitted.
(2) The Executive is 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 JULY 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
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health Advisory 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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Chief Executive Performance Review 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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Thames Coromandel District Council	TBA	TBA	
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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Mayor, 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	
Wife employed by 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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Life Unlimited Charitable Trust	Pecuniary	Perceived	
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, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)	Pecuniary	Potential	
Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None	
Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None	
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None	

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

Interest	Nature of Interest	Type of Conflict	Mitigating Actions
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None	
Member, Whanau Ora Review Panel	Non-Pecuniary	None	
Trustee and Shareholder, Whanau.com Trust	TBA	TBA	

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, Hospitals Advisory 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, Waikato Regional Passenger Transport Committee	Non-Pecuniary	Potential	
Member, Waikato Regional Transport Committee	Non-pecuniary	Potential	
Member, Future Proof Joint Council Committee	Non-pecuniary	None	
Partner is an occasional contractor to Waikato DHB in "Creating our Futures"	TBA	Potential	

Pippa Mahood

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Community and Public Health Advisory 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	
Member/DHB Representative, Waikato Regional Plan Leadership Group			

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

Sharon Mariu

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived	
Director/Shareholder, Asher Business Services 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, Community and Public Health Advisory 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.

SCHEDULE OF INTERESTS FOR CHAIR IWI MAORI COUNCIL AS STANDING ATTENDEE AT BOARD

Te Pora Thompson-Evans

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB **Member, Iwi Maori Council Representative for Waikato-Tainui, Waikato DHB** **Iwi: Ngāti Hauā** **Member, Te Whakakitenga o Waikato** **Trustee, Ngāti Hauā Iwi Trust** **Trustee, Tumuaki Endowment Charitable Trust** **Director, Whai Manawa Limited** **Director/Shareholder, 7 Eight 12 Limited**	Non-Pecuniary	None	Refer Notes 1 and 2

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 27 June 2018 commencing at 1.00pm in the Board Room, Hockin Building at Waikato Hospital

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

In Attendance:
Ms T Thompson-Evans (Chair, Iwi Maori Council)
Mr D Wright (Interim Chief Executive)
Dr G Howard (Acting Executive Director, Waikato Hospital Services)
Ms L Aydon (Executive Director, Public and Organisational Affairs)
Ms L Elliott (Executive Director, Maori Health)
Ms T Maloney (Executive Director, Strategy and Funding)
Mr A McCurdie (Chief Financial Officer) part of the meeting
Ms M Neville (Director, Quality and Patient Safety)
Mr D Hackett (Executive Director, Virtual Health)
Mr M ter Beek (Chief Data Officer)
Mr C Cardwell (Executive Director, Facilities and Business)
Dr R Tapsell (Clinical Services Director, Mental Health and Addictions Services)

ITEM 1: APOLOGIES FOR ABSENCE

An apology for absence was received from Ms Mariu.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

Ms Beavis, Mrs Mahood and Mr Gallagher wished to notify that they had changes to be made to the register and would email the Chief Executive's personal assistant with those changes.

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: 23 May 2018

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 23 May 2018 taken with the public present was confirmed as a true and accurate.

3.2 Committee Meeting Minutes

3.2.1 Iwi Maori Council: 7 June 2018
3.2.2 Hospitals Advisory Committee: 13 June 2018
3.2.3 Community and Public Health Advisory Committee: 13 June 2108
3.2.4 Maori Strategic Committee: 20 June 2018

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:

- Proposed medical school – the proposal was still with the Minister of Health.
- Darrin Hackett was leaving the position of Executive Director Virtual Care and Innovation as this positon had been disestablished. The Board passed on their thanks to Darrin for the work he had done for Waikato DHB.
- Care in the community – direction setting workshop – it was proposed to hold a workshop on 25 July 2018.
- The Tiriti O Waitangi, and Tikanga Best Practice and Powhiri training – it was noted that the scheduled date of 6 September 2018 was not convenient for some Board members, however, it was recognised that at this late stage it might not be convenient to change this date as Iwi members will already have their travel plans in place.
- Why Ora Business Case – a proposal for the Board to fund this project was an agenda item. The Chief Executive explained the reasons why this business case was being submitted in this way.
- NZNO nurses strike - NZNO members had issued a strike notice from 07.00 on 5 July 2018 to 07.00 on 6 July 2018. DHB contingency planning was taking place. The NZNO was negotiating on providing life preserving services (LPS). The Board passed on their thanks for the level of communication and noted their respect for nurses as a workforce
- Health Volunteer of the Year Award – the Board members wished to pass on their compliments to Kim Gosman on receiving the 2018 Health Volunteer of the Year Award and Individual Maori Volunteer of the Year Award.

Resolved
THAT
The Board received the report.

ITEM 5: QUALITY AND SAFETY REPORT

5.1 Quality and Safety Report

Ms M Neville presented this agenda item. The report was taken as read. Of note:

- A new national dashboard had gone live at the end of May 2018.
- A question regarding complaint and compliment data and whether it could be used to show how the DHB is tracking.
- A report showing which services get accolades might help to balance the view. Ms Neville will consult with the Consumer Council to obtain their view on this.

Resolved
THAT
The Board received the report.

5.2 Report from the Health and Disability Commission (HDC) – complaints report to July to December 2017

Ms M Neville presented this agenda item. The report was taken as read. Of note:

- Ms Neville and Dr Stephenson had met with Mr Anthony Hill, HDC Commissioner. Mr Hill's feedback regarding Waikato DHB had been positive particularly around the Emergency Department and Women's Health Services.

Resolved
THAT
The Board received the report.

ITEM 6: FINANCIAL PERFORMANCE MONITORING

6.1 Finance Report

Mr A McCurdie attended for this agenda item. The report for the month of May 2018 was taken as read highlighting the following:

- Unfavourable variance to budget of $20m. This amount included accrual of additional costs expected to arise from:
  - the nursing MECA
  - annual leave
  - increased pharmaceutical costs
  - unachieved savings plan
- focus was on making sure volumes were connected with resources – noting that they were growing up by 5% per year.

- There would not be a written report at the July Board Meeting. A verbal update would be provided at the meeting. This was to enable the team to concentrate on the NOS programme.

Resolved
THAT
The Board received this report.

ITEM 7: HEALTH TARGETS

Dr G Howard and Ms T Maloney attended for this item.

The Health Targets report was tabled for the Board's information. It was noted:

- Emergency Department target was still an issue and it was acknowledged there is still a lot of work to do.
- There was some discussion around large number paediatrics in ED and whether those were avoidable readmissions due to respiratory conditions or linked to previous discharges.
- Still in the process of negotiating for Mental Health Specialist in ED this. A report will be tabled at a future meeting
- Elective Surgery – 104% result was consistent.
- Faster Cancer Treatment – continued to deliver sustained results against the target. Quarter Three showed a result of 99%.
- Increase in 8 month olds being fully immunised – performance had dropped again. The service is to commence a review and redesign of immunisation and related services including the role of the Waikato Child Health Co-ordination Service. An initiative was being considered to have opportunistic immunisations carried out by local pharmacies. The Medical Officer of Health had authorised this.
- It was suggested that it is still important that people are kept informed and retain in control of when their child's immunisations are due.

Resolved
THAT
The Board received the report.

ITEM 8: HEALTH AND SAFETY

There was no report this month. Next report is due in July.

ITEM 9: SERVICE PERFORMANCE MONITORING

9.1 Chief Data Officer Directorate Report

Mr M ter Beek attended for this item. The report was taken as read. It was noted:

- The Chief Data Officer (CDO) position was a new position created to lead the organisation to adopt data-driven, evidence based, decision

making culture. The CDO is a member of the DHB's Executive Leadership Team.
- There would be a focus on capturing information on ethnicity .
- National Patient Flow – quality of oncology data was of concern.
- An ophthalmology discovery process was underway at present.

Resolved
THAT
The Board received the report.

9.2 Waikato Hospital Services (report due in June)
9.3 Community and Clinical Support (report due in July)
9.4 Mental Health and Addictions Service (report due in July)
9.5 Strategy and Funding (report due in August)
9.6 People and Performance (report due in September)
9.7 Facilities and Business (report due in September)
9.8 IS (report due in September)

ITEM 10: DECISION REPORTS

10.1 Equity Focussed Reporting

Mr M ter Beek and Ms L Elliott attended for this item. The report was taken as read. It was noted:

- An equity focused report to be provided to the Board on a quarterly basis. The report will include measures from across the health system and used as a tool to identify inequalities and plan remedy.
- DNA rates were concerning.
- Waikato DHB was committed to eliminating inequalities for Māori.
- KPIs will be added to the report with time.

Resolved
THAT
The Board:

1) Received the report.
2) Supported the approach for improvement of inequities in performance measures.
3) Noted that this work will form the foundation of the outcome measurement framework in the Iwi Māori Health Strategy (ki te Taumata o Pae Ora).

10.2 Why Ora Business Case

Ms L Elliott attended for this item. The report was taken as read. It was noted:

- A business case had been prepared to encourage rangatahi Māori into the health workforce.

Resolved
THAT
The Board approved the report and financially supported the Why Ora Programme.

10.3 NZ Health Partnerships Statement of Performance Expectations 2018/19

Mr D Wright presented this item. The report was taken as read. It was noted that NZ Heath Partnerships were required to prepare a Statement of Performance Expectations and Annual Plan every year.

Resolved
THAT
The Board:

1) Approved the NZ Health Partnerships Statement of Performance Expectations 2018/19 and provided written confirmation of this to Megan Main, Chief Executive, no later than 30 June 2018.
2) Noted progress on the development of the NZ Health Partnerships key performance indicators to support the Statement of Performance Expectations 2018/19.

10.4 Midland Regional Services Plan 2018/19

Mr Andrew Campbell Stokes and Ms Suzanne Andrew from HealthShare Limited attended for this item. The report was taken as read.

It was noted:

- There was no reference to disaster recovery in the report.
- Equity – it was suggested that an endorsement from iwi would be good to confirm the relationship with them.
- Board members queried how it connected to our local Annual Plan.

Resolved
THAT
The Board:

1) Noted that the 2018/21 Midland Regional Services Plan (Strategic Directions, and initiatives and Activities documents) were still a “work in progress” and subject to further refinement following feedback from Boards, DHB Executives and clinicians and the Ministry of Health.
2) Endorsed the 2018/21 Midland Regional Services Plan (Strategic Directions and Initiatives and Activities documents) for submission to the Ministry of Health for review.
3) Approved delegated approval of the 2018/21 Midland Regional Services Plan (Strategic Directions and Initiatives and Activities documents) to Midland DHB Chairs and Chief Executives. If changes to these documents are deemed to be material then the documents will be provided to the DHB Boards again for consideration.

10.5 Waikato DHB Working Draft Annual Plan 2018/19

Mr T Maloney and Mr W Skippage attended for this item. The report was taken as read.

It was noted that the plan was still a work in progress however, Board members would like to see mention of:

- Smoking prevention
- It being more purposeful for Māori
- The effects and recovery processes from natural disasters caused by climate change

Resolved
THAT
1) The Board received the report.
2) Provided comments on the working drat Annual Plan 2018/19

ITEM 11: SIGNIFICANT PROGRAMMES/PROJECTS

11.1 Update on Disengagement from HealthTap

Mr D Hackett attended for this item. The report was taken as read.

It was noted that:

- Renal and Speech Language Therapy services would transition to CISCO Jabber in the near future.
- for patients who were using the HealthTap service the deployment of CISCO Jabber guest capability in July 2018 will reinstate some of the benefits that had been provided by HealthTap

Resolved
THAT
The Board received the report.

11.2 Medical School (refer to agenda Item 4)
11.3 Creating our Futures (report due in July)

ITEM 12: PAPERS FOR INFORMATION

There were no papers for information this month.

ITEM 13: PRESENTATIONS

13.1 Health of the Nation Outcomes Scale Presentation

Dr Rees Tapsell presented this item to provide the Board members with context and information in relation to the use of the HoNOS tool as a measure of acuity for Mental Health service users.

Resolved
THAT
The Board received the presentation.

ITEM 14: NEXT MEETING

The next meeting is to be held on Wednesday 25 July 2018 commencing at 1.00 pm at in the Board Room in the Hockin Building, Waikato hospital.

BOARD MINUTES OF 27 JUNE 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 15: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 23 May 2018 (Items taken with the public excluded).**
- **(ii) Hospital Advisory Committee: Wednesday 13 June 2018 to be adopted: (All items)**
- **(iii) Midland Regional Governance Group – Friday 1 June 2018: to be received (All items)**

Item 16: HealthTap Lessons Learnt – Public Excluded
Item 17: Oncology Facility Development (New Building Interim Facility) – Public Excluded
Item 18: Hague Road Care Park Upgrading Works – Public Excluded
Item 19: Renewal of PathLab Agreement – Public Excluded
Item 20: All of Government Microsoft Negotiations – Public Excluded
Item 21: Appointment of Consumer Council Nominees to Hospitals Advisory Committee and Community and Public Health Advisory Committee – Public Excluded
Item 22: Replacement of Radiology Digital X-ray Equipment – Public Excluded
Item 23: Orthotic Services – 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 15: (i-iii): Minutes	Items to be adopted/ confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 16: HealthTap Lessons Learnt	Negotiations will be required	Section 9(2)(j)
Item 17: Oncology facility development	Negotiations will be required	Section 9(2)(j)
Item 18: Upgrading works for car park building	Negotiations will be required	Section 9(2)(j)
Item 19: Renewal of Pathlab agreement	Negotiations will be required	Section 9(2)(j)
Item 20: All of Government (AOG) Microsoft Negotiations	Negotiations will be required	Section 9(2)(j)

Item 21: Appointment of Consumer Council Nominees to Hospitals Advisory Committee and Community and Public Health Advisory Committee	**Protect the Privacy of an Individual**	**Section 9(2)(a)**
Item 22: Replacement of Radiology Digital X-ray Equipment	**Negotiations will be required**	**Section 9(2)(j)**
Item 23: Orthotic Services	**Negotiations 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.**

(4) **Pursuant to clause 33 of Schedule 3 of the NZ Public Health & Disability Act 2000 the Chair of the Iwi Maori Council (or their proxy) is allowed to remain after the public has been excluded because of their knowledge of the aspirations of the Iwi Maori Council specifically and Maori generally which are relevant to all matters taken with the public excluded.**

ACTION LIST

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

ACTION	BY	WHEN
• Item 9.1 Chief Data Officer Directorate Report – the Board would like a presentation around eSPACE and its transition with CWS interface	Maureen Chrystal	August 2018
• General Business – presentation from the 'Equity and Systemic Racism Workshop' to be uploaded to Diligent and further discussion at next Board only session	Derek Wright	July 2018

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Māori Council

Held: Thursday 5th July 2018 at 9.30am

Venue: Board Room, Hockin Building, Waikato Hospital

Present:		
	Mrs T Thompson-Evans (Chair)	Waikato-Tainui
	Ms T Moxon (Deputy Chair)	Te Rūnanga o Kirikiriroa
	Ms K Gosman	Tūwharetoa Māori Trust Board
	Ms P Taiaroa	Whanganui
	Ms C Brears	Whanganui
	Ms K Gosman	Tūwharetoa Māori Trust Board
	Ms K McClintock	Waikato-Tainui
	Mr A Chase	Hauraki Māori Trust Board
	Mr G Tupuhi	Hauraki Māori Trust Board
	Ms L Elliot	Executive Director – Māori Health
	Ms P Mahood	Waikato DHB Board
	Ms S Greenwood	Minute taker

Other attendees: Ikimoke Tamaki-Takarei, Janise Eketone, Justine Crittenden

ITEM 1 KARAKIA: Ikimoke Tamaki-Takarei

ITEM 2 MIHIMIHI Ikimoke Tamaki-Takarei

ITEM 3 APOLOGIES

Ms S Webb (Acting Board Chair), Ms T Hodges, Mr T Turner, Ms T Ake, Ms S Hetet, Mr T Bell, Ms K Hodge, Ms M Balzer, Mr D Wright, Mr B Bryan, Ms K Hodge

Kaituku Mōtini/Moved: Hauraki Māori Trust Board
Kaitautoko Mōtini/Second: Te Rūnanga o Kirikiriroa

ITEM 4 CHAIR REPORT

Comments:

- It was suggested that the IMC should have been a part of the Institutional Racism workshop, however the IMC are of the understanding that this was a starting point for the Board.
- Further the IMC commend the Board for taking the initiative to commence action with the Institutional Racism kaupapa.
- P Mahood noted that the S.T.I.R. presentation by Heather Came-Friars was well received by the Board and was scene setting rather than a one-off
- Noted that different forums require different voices.
- It was noted that a submission to the IMC agenda was made regarding Breast Cancer screening - the Chair responded opportunities for discussion will be available throughout the Agenda.

Mōtini/Motion: That the Chair's report be received.

Kaituku Mōtini/Moved: Tūwharetoa Māori Trust Board
Kaitautoko Mōtini/Second: Whanganui

ITEM 5 WHAKAPAKARI TE WHARE

Outstanding conflicts of interest declaration forms to be updated asap and forwarded to Te Puna Oranga.

ITEM 6 MINUTES AND ACTIONS

- **Amendments:**
  - Item 7.1 bullet point 1 : delete "funding and"
  - Item 7.1 bullet point 3: Insert another sub-bullet point "UNDRIP (United Nations Declaration of Indigenous Peoples) articles 21-29."
  - Item 12 Discussion and questions : noted that the Model of Whanau Ora was accepted in the past should read – "Christine Brears noted that the Waikato District Health Board approved the Model of Whānau Ora to be the integrated model of care in Taumarunui. Presented to the Board by the Integrated Health Governance Group Taumarunui."
  - Action list: 2 + 3: amend to IMC Chair. Remove Action 4.

Mōtini/Motion: That, subject to amendments, the 7 June 2018 minutes are received as true and correct.

Kaituku Mōtini/Moved: Waikato-Tainui
Kaitautoko Mōtini/Seconded: Hauraki Māori Trust Board (Hauraki)

6.2 – Follow-up re: Chair/CE appointment process

- Action 6 - IMC advised of response by Board Chair. Now removed.

6.3 – Follow-up re: He Pikinga Waiora research article

- N Scott presented this to the MSC, will present again to IMC in August.

ITEM 7 GOVERNANCE

7.1 – Māori Strategic Committee Minutes and Verbal Update: 20 June

- Noted correction of date for minutes to June not May
- Noted discussion of annual review of the Māori Strategic Committee and feedback on progress to date.
- IMC reaffirmed mandate of IMC representatives to the Māori Strategic Committee

7.2 – Hospital Advisory Committee update

- Hospital Advisory Committee representative noted absence from last meeting, alternate representative advised not able to attend.
- The Chair will follow up to ensure that the IMC have a lead and alternate representative to the Statutory Committees

DRAFT

- M Balzer (Te Rūnanga o Kirikiriroa) noted as the alternative representative and to be notified to the Board.

7.3 – Community & Public Health Advisory Committee update

- Tobacco Control Plan to come back to IMC
- Two items that have been asked to come back to IMC:
    a. Disability responsiveness plan
    b. Tobacco Control Plan
- Noted that M Balzer as the alternative representative and to be notified to the Board.

Mōtini /Motion: That all updates be received.

Kaituku Mōtini/Moved: Te Rūnanga O Kirikiriroa
Kaitautoko Mōtini/Second: Hauraki Māori Trust Board

ITEM 8 STRATEGIC AGENDA ITEMS

8.1 – Sepsis Presentation : Drs Paul Huggan & Mania Campbell-Selwyn

Key points:

- Explanation/definition of sepsis given by Paul Huggan. Internationally sepsis is poorly understood, not taught well or dealt with well in health care professions. Sepsis affects all departments throughout the hospital so isn't always recognised as an issue on its own. Sepsis should be part of the DHB strategy of radical health outcomes for Māori as P Dugan believes it is an issue of inequity. Sepsis could be considered a measure of the health of the community at large.
- Whole body reaction to infection – the individual likely looks a lot sicker than they should. Can affect the brain, the person often has ongoing health issues after sepsis.
- If the sepsis programme works, how will you know? Answer - Death rates would be the measure.
- Noted that many Māori traditional medicines relate to cleansing of the blood. There should be research on Māori ancient practices and beliefs of healing that could improve sepsis rates. What is it we are presenting to our Māori people that is a barrier to seeking good health?
- IMC Chair noted that she would like the sepsis action group to return to IMC when they have considered how we can best work together. Would be good to have a representative in this action group.
- Noted that the statistics are unsettling and are similar to what they already knew and looked for in the 1950's. Are primary health specifically GP's in rural areas getting this message?
    a. P Huggan submitted that people aren't presenting to GP's but going directly to the ED as they recognise they are more seriously sick.
- IMC and TPO to kōrero about strategies required to move this forward and highlight to the Board.

Mōtini / Motion: That IMC endorses the following:

1. Acknowledges the significant impact sepsis is having on Māori communities.
2. Notes the Trust position of sepsis is a biological expression of racism.
3. Commends the recent establishment of the Sepsis Trust NZ.

DRAFT

4. Endorses and expects a morbidity and mortality of sepsis being included in the WDHB annual plan and Ki te Taumata o Pae Ora.
5. Endorses the development of a WDHB action plan that compliments the Trust Action Plan in the areas of: research; awareness raising; advocacy.

Kaituku Mōtini/Moved: Te Rūnanga o Kirikiriroa
Kaitautoko Mōtini/Second: Whanganui

8.2 – HSP Update

- Handout of report to Health System Plan distributed on the day.

8.3 – CE Report to Board

- Noted that all decision papers going to the Board must now include a section on how the proposal will contribute to radical improvement in Māori health outcomes.

8.4 – Creating Our Futures

Presentation by Vicky Aitken & Virginia Endres

Key points:

- Capital investment committee has seen the draft business case and WDHB is waiting to hear the outcome.
- IMC question raised - who is the Māori voice and Māori decision makers throughout this entire process?
    a. Multiple voices in multiple settings such advisory group with community stakeholders, service users and whanau, programme Board (L Elliott sits on this board). Māori decision makers are the Board. Recommendations come from the Programme Board and Programme Advisory Group.
- Comments from IMC:
    - That a Kaumatua Kaunihera member ought to be representative alongside L Elliott particularly if you are to be looking after our 'people'. Also, noted that Maatua Hemi Curtis attends, however he is TPO not KK.
    - That we don't want a repeat of the HRBC. So, any new building should be a 'healing' base with environmental considerations - a Greenfields site would be a good option to ensure healing.
    - Who/where would V Aitken want a Māori representative to come from to represent community as a protection for Māori?
        a. V Aitken responded - Programme Board is important and representation from IMC would be welcome - will take direction from IMC regarding who.
- 49 consultation hui to date, feedback was honest and emotive.
- On Monday 9th July will be a workshop hui to look at options for re-build and Puawai forensic service options.
- Workshop will look at Māori equity for each of the options presented and then looks at the business case. The business case is to go to the July Board hui.
- IMC question raised – are the 100 new Waikeria beds in place of or in addition to existing WDHB forensic beds. Noted that Waikeria 100 beds are additional
- Chair concluded that it is important that all feedback at all levels be taken on board and that the IMC must be confident in assurances that transformational services and facilities will take into account Māori wellbeing and more importantly radical

improvements to Māori health and equity. Anything less will have a more dire impact.

- IMC noted that the business case would be going to board for approval prior to the next IMC meeting. Therefore another approach for IMC being able to review the business case was needed. Preferably this could occur with the Board in a facilitated session.

Mōtini / Motion: That IMC:

a. Is concerned with the lack of Māori representation within CoF and recommends additional Māori representatives from Te Pae Tawhiti; Kaunihera Kaumaatua; Te Roopu Tautoko ki Waikato and rural for the workshop and programme board
b. Requests a copy of the record of unsummarised feedback from 'Let's Talk' consultation.
c. Requests confirmation of date around specific engagement facilitated along with the Board around the business case approval.

Kaituku Mōtini/Moved: Hauraki Māori Trust Board
Kaitautoko Mōtini/Second: Te Rūnanga o Kirikiriroa

Motion: That all the strategic agenda items are received.

Kaituku Mōtini/Moved: Waikato-Tainui
Kaitautoko Mōtini/Second: Tūwharetoa Māori Trust Board

ITEM 9 TE PUNA ORANGA UPDATE REPORT

- Taken as read and received.
- Puna Waiora has now been approved and in recruitment phase. IMC noted this achievement favourably.
- Name change noted from Why Ora to Puna Waiora.
- MSC to have more strategic capabilities.

ITEM 10 IMC WORK PLAN

IMC work plan was reviewed and the following edits made:

- Added whanau ora paper to August 2018 agenda
- Add date for IMC review of CoF business case (when known)
- Added virtual health update to September 2018 agenda
- Moved Māori health workforce reporting to November 2018
- Correct September Board date

ITEM 11 GENERAL BUSINESS

11.1 – Iwi Wananga – Care in the Community Plan

- Dates changed for North Waikato to 3rd Aug, South Waikato to 8th August.

DRAFT

- Ernst and Young joint meeting with Board on 25th July. Chair noted that this hui must remain a Board/IMC hui to maintain the partnership at a Governance Level.

11.2 – Annual Plan

- As per the MOU, the Annual Plan has been provided here for IMC to review and provide feedback.

11.3 – Panui

- Treaty Primary Health Claim (Wai1315) against MOH is going to be heard on 15th – 19th October, 23rd – 26th October, 1st and 2nd November and closing submission in Wellington on 17th and 18th December.
- Hauraki Māori Trust Board representatives advised that they will not yet sign the MOU regarding MOU 5.5.
    a. Waikato-Tainui expressed concern given all other Iwi had signed.
    b. Exec. Director Māori advised process insofar.
    c. IMC Chair to follow up with Hauraki Māori Trust Board to sign MOU.

- Mental Health Claim (Wai5252) is also under action. Relevant papers will be distributed.

11.4 – Next joint IMC/Board hui

- Chair noted that two Board members are unable to attend joint Board meeting in September. IMC noted that it is important for all members to attend and therefore will consider changing the date. Dates will be sent out. Thursday 6th September to be kept standing however. Date to be agreed for September for the joint IMC/Board meeting other than Thursday 6th September.

Hui Whakakapi: Meeting closed at 1.40pm

Next meeting held on: Thursday 2nd August 2018

DRAFT

	Action List	Completed	Action by:
1.	Submit letter to Ministry from IMC on Māori Mental Health. (18th and 27th for consultation).		IMC Chair
2.	IMC to write a letter in support of purchasing a new hyperbaric chamber by the WDHB for the prevention of the removal of limbs and death by diabetes.		IMC Chair
3.	Chair and CEO appointment process update		ED – TPO
4.	Chair to follow-up to ensure that the IMC have a lead and alternate representative to the Statutory Committees		IMC Chair
5.	Request confirmation of date around specific engagement facilitated along with the Board around the business case approval.		IMC Chair

DRAFT

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Māori Strategic Committee held on Wednesday 18 July 2018 commencing at 10:00am in the Board Room, Hockin Building

Present: Ms T Hodges (Chair)
Dr C Wade (Deputy Chair)
Ms S Christie
Ms T Thompson-Evans
Ms M Balzer
Ms T Moxon

In Attendance: Mr D Wright
Ms L Elliott
Ms J Eketone
Mr N Hablous
Ms N Te Ahu
Ms J Sewell
Ms S Greenwood (minutetaker)

DRAFT

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Ms T Hodges.

ITEM 2: APOLOGIES

Apologies received from: Mr G Tupuhi, Mr D McPherson, Ms L Were, Mr H Curtis

ITEM 3: MINUTES OF 20 JUNE 2018

Taken as read and accepted as a true and correct record.

Moved: Dr C Wade
Second: Ms S Christie

ITEM 4: MATTERS ARISING

4.1 MSC TERMS OF REFERENCE

The final draft of the MSC TOR was tabled and discussed. The discussion focussed on options regarding payment of Consumer Council (CC) Māori Caucus attendees at MSC. These options will be finalised by the MSC Chair in discussion with the CC Māori Caucus chair. The approval of the TOR was deferred to next meeting.

4.2 DNA REMEDIATION UPDATE

Key points noted:

- o Further work needs to be undertaken regarding the 'why' DNAs occur and understanding the key drivers
- o Māori DNAs are linked to service delivery and require a formal programme
- o There had been a management agreement to focus on two specialties for the next deep dive e.g. patient survey
- o Oncology is the only speciality where Maori DNAs are within the 10 percent target. There may be learnings to be understood from this team's approach
- o CEO will take the lead on this issue
- o MSC will receive a further update on progress at its next hui

ITEM 5: ASSESSING MĀORI EQUITY IN CREATING OUR FUTURES (COF)

Key point noted:

- At their last hui IMC raised a concern about the level of Maori representation on the CoF programme board and have recommended 4 more representatives.
- The 4 representatives attended the COF workshop on 9th July and will continue on the COF programme board.
- The workshop considered and further contributed towards the development of a Maori equity assessment tool for the assessment of Māori equity in the *Creating our Futures: Facilities Redevelopment and Relocation Project* business case.
- All workshop members are to invited be part of the Maori equity assessment of the business case
- The current business case does not have sufficient information regarding Māori equity and this needs to be addressed.
- Concern was raised for a better method going forward as Maori equity appears to be 'playing catch up' as opposed to being addressed from the outset.
- The Mental Health team have met with Ministry of Health to make sure the all CoF is aligned to the national mental health inquiry.
- Need to ensure that any proposed changes / transformaton make a real difference as opposed to doing more of the same which hasn't worked historically.
- Suggested improvement to tool is to have the question "how does this contribute to radically improving Maori health?" as the overarching assessment query.

Resolved
THAT:

The Maori Equity Dimensions framework, with suggested amendment, is used by the CoF Māori equity group to assess Māori equity of the *Creating our Futures: Facilities Redevelopment and Relocation Project* business case.

ITEM 6: DRAFT EMPLOYEE (IEA) KPIS

Key points noted:

- The draft employees KPIs were presented to the Committee with the caveat that they were only draft and had not yet been discussed with the executive team.
- In general the KPIs were supported by the Committee and edits requested were noted. In particular, some wording would need further clarification and teasing out
- Staff will need support and training to achieve the right level of matauranga Māori knowledge and the KPIs will support this process along with Tikanga Best Practice applied training.
- It was suggested that the KPIs list was comprehensive and action will need to be prioritised. In response it was identified that the KPIs were not onerous and it would be reasonable and efficient for line managers to ensure they were being achieved.
- It is expected that managers and senior executives already have a reasonable level of understanding regarding this area and if not then there is an issue with recruitment.
- Organisation culture change in this area is everyone's responsibility and the KPIs will help support this.
- There are small pockets of Te Reo Māori classes taking place amongst departments around the hospital which is laying a great foundation for the KPIs.
- Strategy & funding has started the process of amending provider contracts to include "Maori health outcomes" clauses.

ITEM 7: MSC UPDATES

Key points noted:

- Puna – Maori strategic capability : this is dependent on Board approval of the budget
- Recruitment of Puna Waiora team has started and interview are underway
- CCP Iwi wananga communication strategy needs to be more deliberate in relation to rangatahi Maori and using a more sophisticated approach such as social media. Current methods are not adequate.

ITEM 8: GENERAL BUSINESS

No general business items.

ITEM 9: DATE OF NEXT MEETING

Wednesday 15th August 2018, Board Room, Level 1, Hockin Building

ITEM 10: KARAKIA WHAKAMUTUNGA

Karakia whakamutanga by Ms T Moxon.

Chairperson: ___________________________________

Date: ___________________________________

Meeting closed at. 11.15am

DRAFT

ACTION POINTS

	Action List	Completed	Who
1.	Agenda Item 4: 1. That Te Puna Oranga consider: a. How He Pikinga Waiora can be implemented and actioned within Waikato DHB. Identify the steps for implementation.		ED - TPO
2.	Agenda Item 4.1: That MSC Chair and Consumer Council Māori Caucus Chair meet to discuss and finalise the decision for payment of Māori Caucus members attending MSC.		MSC Chair
3.	Agenda Item 4.1: That the payment method for Consumer Council Māori Caucus members is investigated and finalised.		ED - TPO
4.	Agenda Item 4.2: That clear actions regarding DNA remediation are implemented and the deep dives are undertaken. Approach will be presented at the next Māori Strategic Committee meeting.		CEO
5.	Agenda Item 5: That the COF Māori Equity Dimensions Framework (page 37, MSC agenda) is applied to the *Creating our Futures: Facilities Redevelopment and Relocation Project Business Case* and presented to Iwi Māori Council 2 August 2018. To be discussed with Ms V Aiken and Ms V Endres (Creating our Futures)		ED – TPO / D-TPO
6.	Agenda Item 7: Health System Plan/Care in the Community That a savvy and sophisticated approach for Māori engagement using social media in addition to the Iwi Wānanga to ensure all Māori have the opportunity to contribute to the CCP. To be discussed with Mr D Wu (Health System Plan).		ED – TPO / D-TPO

DRAFT

Chief Executive Report

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

Radical Improvement in Maori Health Outcomes by Eliminating Health Inequities for Maori

A Statement explaining how what is proposed in each Board paper will achieve the DHB's major strategic priority – radical improvement in Maori Health outcomes by eliminating health inequities for Maori – will be added to all future appropriate Board papers.

Mental Health Services

Mental Health Services remains extremely busy, with occupancy regularly exceeding 100%. The rebuild of the Henry Bennett Centre will not be completed until at least 2021/22. I have asked Vicki Aitken and her team to look at options for increasing beds/reducing pressure on services. These proposals will be discussed at the Operational Executive meeting and then, if approved, will be presented to the Board.

NZNO Issue

As you will be aware contractual negotiations with NZNO have not yet been completed. On Thursday 12 July there was a nationwide 24 hour strike. DHB's had prepared for the strike and a number of operations and clinics had been rescheduled. Both parties have resumed negotiations and we are hopeful for a resolution soon.

Health Targets Report

We are proposing to refine our approach to reporting on health targets. At times in the past we have had the same commentary in the Health Target report as was in monitoring reports. We are now proposing to use the Health Target report to advise of the extent to which we are meeting (or not) our targets – the numerical aspect – and then report on what we are doing to improve our performance in monitoring reports. Monitoring reports are submitted on rotation so there will be less frequent reporting on how we are trying to improve performance.

Our view is that this is probably still acceptable given:

- Improvements rarely make a difference in less than three or four months.
- The "owners" of each target will still be there each month to answer specific questions.
- (Without wishing to overplay this point) the Government has stepped back from current health targets.

For this month the Health Target report will be a little uneven as a result of this change.

Transport Plan

Board members Gill, Macpherson and Christie met with staff to advance the idea discussed at a previous Board meeting of developing a transport plan for the organisation.

The way forward was agreed as follows:

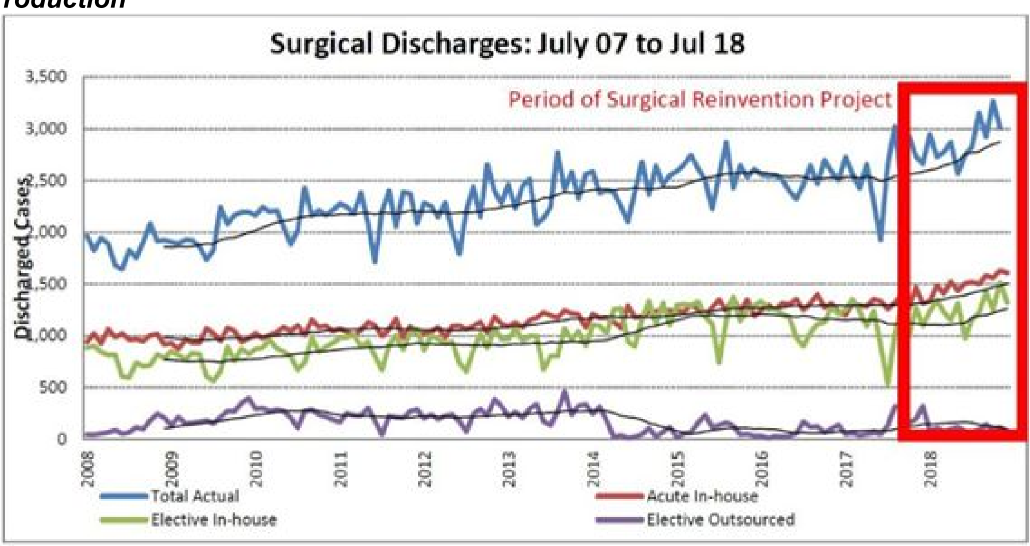
1) We will develop terms of reference for an empirical review of Waikato DHB's transport issues and what other parties are doing which impact upon our response to those issues. This review will be wide-ranging and extend to transport flows from rural centres and other Midland district health boards. We will be looking for support from "fresh" thinkers. In the first instance the work will not include recommendations for change/improvement.
2) In tandem with this we will agree a number of tactical issues on which we can make progress while this work is occurring.
3) The time taken to complete the empirical review will allow the Health System Plan and Care in the Community Plan to become available.
4) We will then convene with the external advisor and with the other plans and talk through what recommendations we wish to pursue arising from the information we have available at that point.
5) This will then be written up in a "part two" from the external advisor, which in combination with part one will effectively at that point become our transport plan.
6) A reasonably firm assumption through this process will be that we do not wish to build further parking capacity on the Waikato campus if it can be avoided.

This is not a small piece of work and will involve procurement.

The combined group will convene as necessary and will provide updates to the Board as it proceeds.

Surgical Reinvention Project

Production



In the year 2017/18 surgical discharges increased by 12% (34 473) over any of the prior three years, where the highest total was 30 918 surgical discharges three years ago. The surgical reinvention project ran for the second half of the financial year in operational terms.

This includes a similar increase in elective "in-house" episodes of 12% and a reduction in outsourced elective surgical services of 48% year on year.

Process Control
The Waikato DHB has been compliant with the main ESPI process measures (ESPI 2 and ESPI 5) from February 2018 to June 2018. No other large DHB has been compliant with both measures for the same period. Waikato DHB has never been compliant with both measures for a 5 month period previously[1].

Sustainability and Future Benefits
The surgical reinvention program has provided the DHB with an operating model based on patient orientated service models, trained DHB staff to work in the system, supported by state of the art information systems and the establishment of a world class operating centre in what might best be described as very basic facilities and surrounds. These management practices still require to be scaled up to other areas amenable to the same production model (medical disciplines) and there is significant extension required into the outpatient setting.

Executive Director Human Resources and Organisational Development

Last week we interviewed six applicants for this position; this was from twenty applications for the role. The General Manager Human Resources from Auckland DHB was the external advisor on the panel.

I will verbally update the Board on progress.

Chief Advisor Allied Health, Scientific and Technical

Next week we will undertake interviews for this position. Like the HR position we received twenty applications and we have shortlisted eight applicants.

The Executive Director Allied Health, Scientific and Technical from Bay of Plenty DHB is the external advisor on this panel.

Ian Wolstencroft

After many decades in health, Ian has decided to hang up his spurs and retire. I am sure the Board will join with me in thanking Ian for his service to Waikato DHB and wish him well in his retirement. The Board will have an opportunity to say farewell at the 22 August board meeting.

Recommendation
THAT
The Board receives this report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

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[1] It is unclear whether proposed punitive financial measures for non-compliance would have been imposed had this compliance not been achieved, however if this had been the case it may have run to 2 million or more per month for the period.

Quality and Patient Safety

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 5.1

QUALITY AND PATIENT SAFETY REPORT

Purpose	For information.

NATIONAL EFFORT

There have been two key national documents published by the Health Quality and Safety Commission (HQSC) during June 2018:

- ***'A window on the quality of New Zealand's Health Care'***
  https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/Windows_Document/Window-Jun-2018.pdf

  This report is attached and where possible some comparator detail is given for Waikato DHB. The Executive group have discussed the report and agreed some actions that will be put in place over the next few months.

- ***Open 4 results***

  Open 4 Results is a six monthly report in the harm prevented, and money saved, in areas where the HQSC focus on or raises awareness about. Again local data has been added for comparator

NATIONAL DASHBOARD

There has been no update on the national dashboard HQSC since the last Board meeting but focus needs to be on child ASH rates and the results from the last national inpatient survey which shows deterioration

LOCAL QUALITY IMPROVEMENT PROJECTS

Local quality improvement initiatives are in place such as sepsis, early detection of deteriorating patients and end of life, which focus on areas where our local data shows we have an issue.

RADICAL IMPROVEMENT IN MAORI HEALTH OUTCOMES BY ELIMINATING HEALTH INEQUITIES FOR MAORI

The sepsis project will improve outcome outcomes for Maori where currently Māori and Pacifica people are 3 x more likely to be admitted with sepsis. 27% is the average mortality rate for patients with sepsis so the work will also impact on our amenable mortality rate.

Recommendation
THAT
The Board:

1) Notes the report and the action outlined which includes:
    a. Improving our reporting and monitoring of service quality (national dashboard / atlas of variation / Health round table etc.) and prioritising work according to this with input from our Consumer Council.
    b. Supporting the quality improvement projects on deteriorating patients and sepsis.
    c. Prioritising the effort to develop the quality improvement capability and capacity framework.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

Quality and Patient Safety report July 2018

There have been two key national documents published by the Health Quality and Safety Commission (HQSC) during June 2018.

1.0 A window on the quality of New Zealand's Health Care 2018

The latest window on quality highlights where the system in New Zealand is performing less well and where possible weaknesses may put future performance at risk. Key issues identified nationally:

- Equity
  - Disparity and inequity on health status can be compounded by poor health care or countered by high quality care that effectively meets specific needs.
  - highlights inequity across ethnic, age and socio economic groups in terms of treatment, experience, access to service and outcomes.
- Safety
  - Performing well internationally in areas of specific harm where there has been focus eg. falls prevention, surgical site infection hip / knees.
  - Issues related to delays and clinical management process remain.
- Patient experience
  - Information on medication and side effects needs improvement.
  - System integration and patient journey need more focus.
- Effectiveness
  - Compares well internationally but variation exists across the country.

The increasing financial gap between expenditure in the NZ health system and those of similar countries is highlighted.

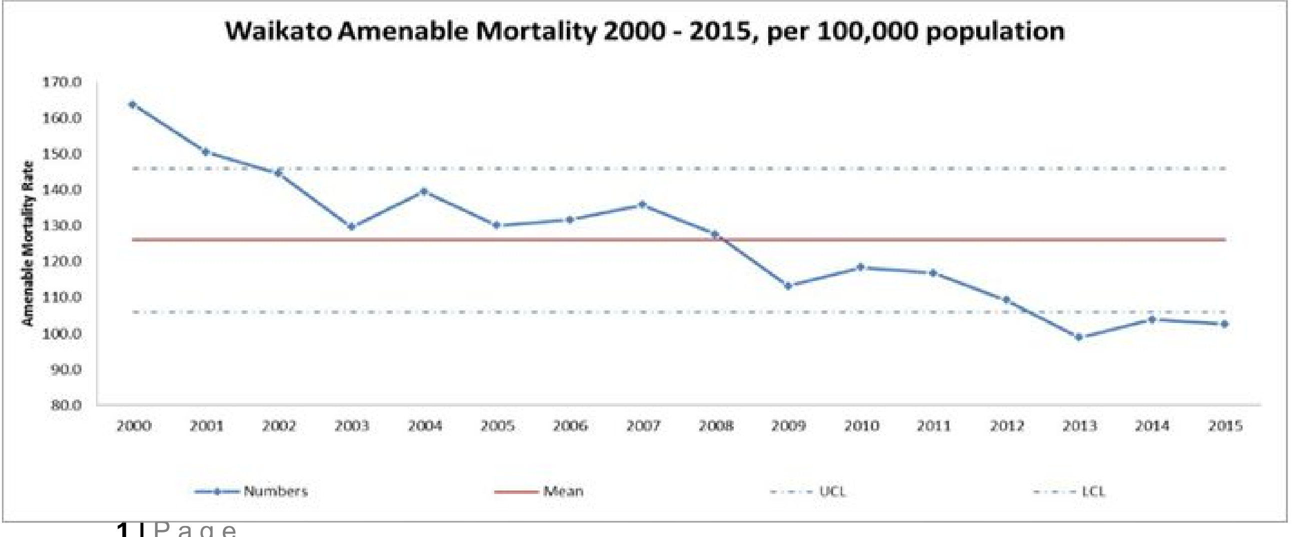
The national picture is reflected in our local data.

Waikato DHB -Amenable Mortality - *deaths that can be improved by health care.*
Data Sources: Ministry of Health, Amenable Mortality SLM Data
Rates per 100,000 age standardised to WHO world standard population
Rates are suppressed where there are less than 30 deaths

Age standardised rates, Ages 0-74, 2000-2015

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Waikato	163.6	150.4	144.4	129.6	139.5	130.0	131.6	135.8	127.6	113.2	118.3	116.8	109.2	98.8	103.8	102.5

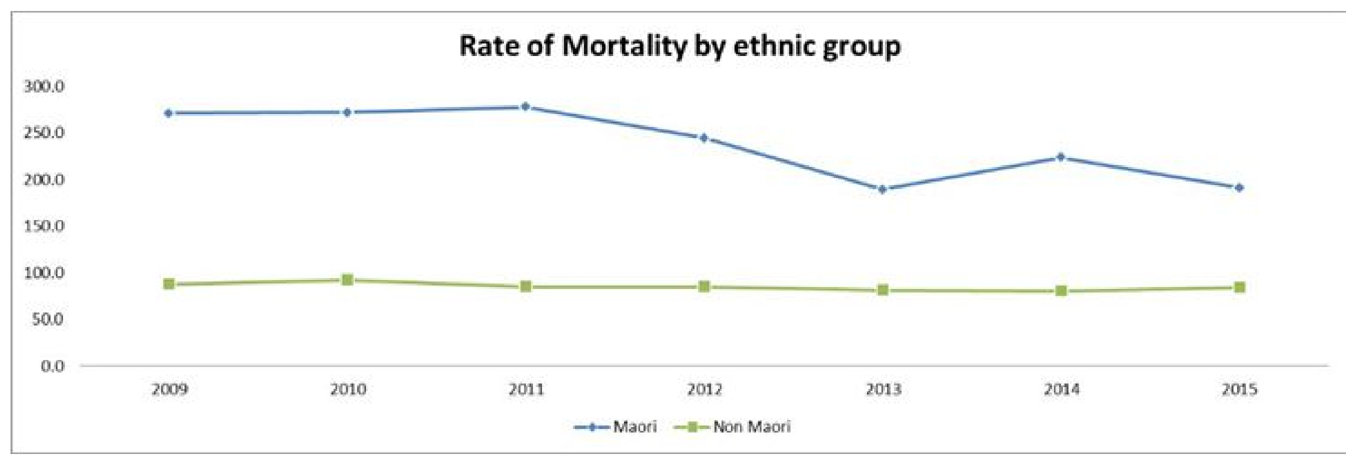
Figure 1.

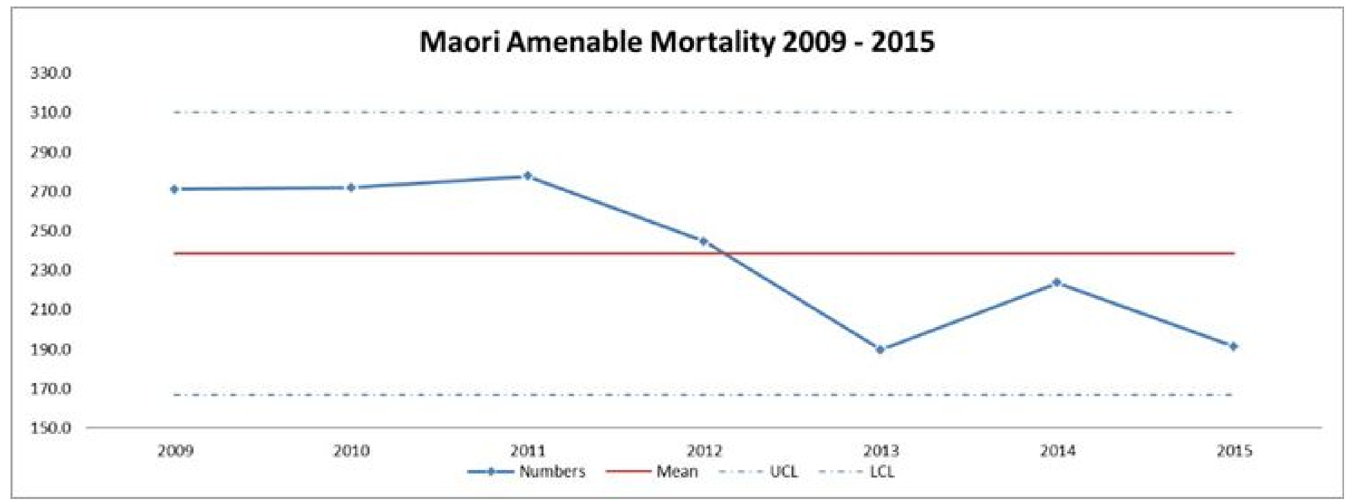


The above graph is local equivalent to Fig. 1 in the 'Window on the quality of New Zealand's Health care 2018' where the best in the country is 62.9 in Waitemata DHB.

Amenable Mortality for the Waikato DHB by ethnicity
Age standardised rates, Ages 0-74, 2009-2015
Figure 2.

		2009		2010		2011		2012		2013		2014		2015	
		Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Waikato															
Maori		157	270.9	166	271.7	180	277.8	160	244.5	132	189.5	165	223.7	146	191.3
Pacific		14	...	12	...	15	...	15	...	18	...	22	...	18	...
Non Maori, Non-Pacific		332	88.1	354	92.5	342	85.4	334	85.5	343	81.8	338	80.5	364	84.3





The above graph is local equivalent to Fig. 9 in the 'window on the quality of New Zealand's Health care 2018'

- National rate for Maori 189 compared to Waikato DHB 191.
- National rate for Non Maori 75 compared to Waikato DHB 84.3.
- The difference in rate for Maori is more than double that of non-Maori locally.

Amenable Mortality for all New Zealand DHBs

Age standardised rates, Ages 0-74, 2000-2015

Figure 3.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Trend
Total New Zealand	144.9	144.6	137.7	132.6	127.6	119.2	115.0	114.8	109.8	107.8	103.7	99.1	97.5	92.8	91.6	90.8	
Northland	187.8	168.4	199.4	180.3	157.6	158.4	150.5	143.1	148.6	148.7	134.8	132.5	140.4	119.6	116.0	106.7	
Waitemata	111.5	110.4	105.7	101.2	93.2	92.8	89.2	81.6	82.7	76.7	69.3	78.1	74.3	65.6	68.9	62.9	
Auckland	138.7	121.6	118.5	117.4	118.3	97.0	92.0	101.7	96.1	98.4	85.4	82.2	84.2	72.9	79.2	74.0	
Counties Manukau	147.9	144.8	158.5	139.7	126.6	130.3	123.3	123.9	114.3	115.7	116.5	110.3	109.3	104.4	101.4	101.2	
Waikato	163.6	150.4	144.4	129.6	139.5	130.0	131.6	135.8	127.6	113.2	118.3	116.8	109.2	98.8	103.8	102.5	
Lakes	176.0	203.8	191.0	162.4	171.9	137.1	157.3	141.3	146.7	160.3	131.7	131.2	126.6	120.6	119.4	130.4	
Bay of Plenty	161.1	164.2	143.3	146.1	146.3	126.6	122.4	134.8	119.8	118.0	115.4	107.1	112.9	107.4	93.8	103.6	
Tairawhiti	193.4	197.5	220.8	243.8	207.0	183.2	202.3	189.0	151.7	185.2	163.4	130.4	138.3	149.6	144.5	138.4	
Hawkes Bay	179.1	179.3	154.3	177.6	144.9	166.8	142.4	141.5	134.9	114.5	123.8	115.3	107.5	104.2	101.4	104.9	
Taranaki	149.3	134.4	128.9	132.1	137.3	153.8	115.7	142.0	103.0	135.3	124.5	102.0	104.5	95.6	101.6	97.9	
Midcentral	154.1	165.7	136.6	149.4	139.3	137.9	129.8	125.1	120.5	136.2	113.7	103.9	92.7	110.9	120.2	104.0	
Whanganui	193.9	200.1	178.3	162.0	149.0	163.4	161.5	140.4	143.7	148.4	144.5	148.4	113.4	110.5	128.6	133.2	
Capital & Coast	127.7	122.4	124.7	115.8	106.1	105.1	99.5	88.4	95.0	76.7	81.2	75.9	76.2	80.5	71.8	70.0	
Hutt Valley	146.0	138.7	124.7	151.1	118.9	107.6	104.7	120.1	122.1	94.0	91.1	93.4	92.2	97.2	85.2	98.0	
Wairarapa	155.9	172.8	123.3	163.5	156.9	101.8	104.2	113.3	151.9	118.8	119.1	132.5	100.3	120.2	89.6	89.8	
Nelson Marlborough	140.9	135.1	123.7	104.9	102.2	106.3	104.1	113.6	88.4	97.1	91.7	76.1	78.0	78.0	76.8	68.9	
West Coast	152.0	214.8	177.4	154.7	168.8	144.9	143.8	113.3	120.0	145.4	126.8	123.1	89.1	141.4	123.0	127.0	
Canterbury	119.6	127.3	119.3	113.0	118.0	92.6	98.9	100.1	89.2	96.0	96.6	87.2	86.5	91.1	79.6	85.3	
South Canterbury	117.7	157.1	142.3	111.7	117.1	136.9	110.4	98.1	119.4	113.2	120.0	118.5	125.0	93.2	107.8	78.2	
Southern	138.6	146.3	131.8	128.5	126.5	112.3	108.0	112.9	109.2	102.9	99.0	93.3	99.4	81.9	92.2	96.9	

There is wide variation across the country with the national rate of 90.8 compared to Waikato DHB 102.5. Waikato sits at 12 of 20 DHBs with a similar rate to Counties Manukau.

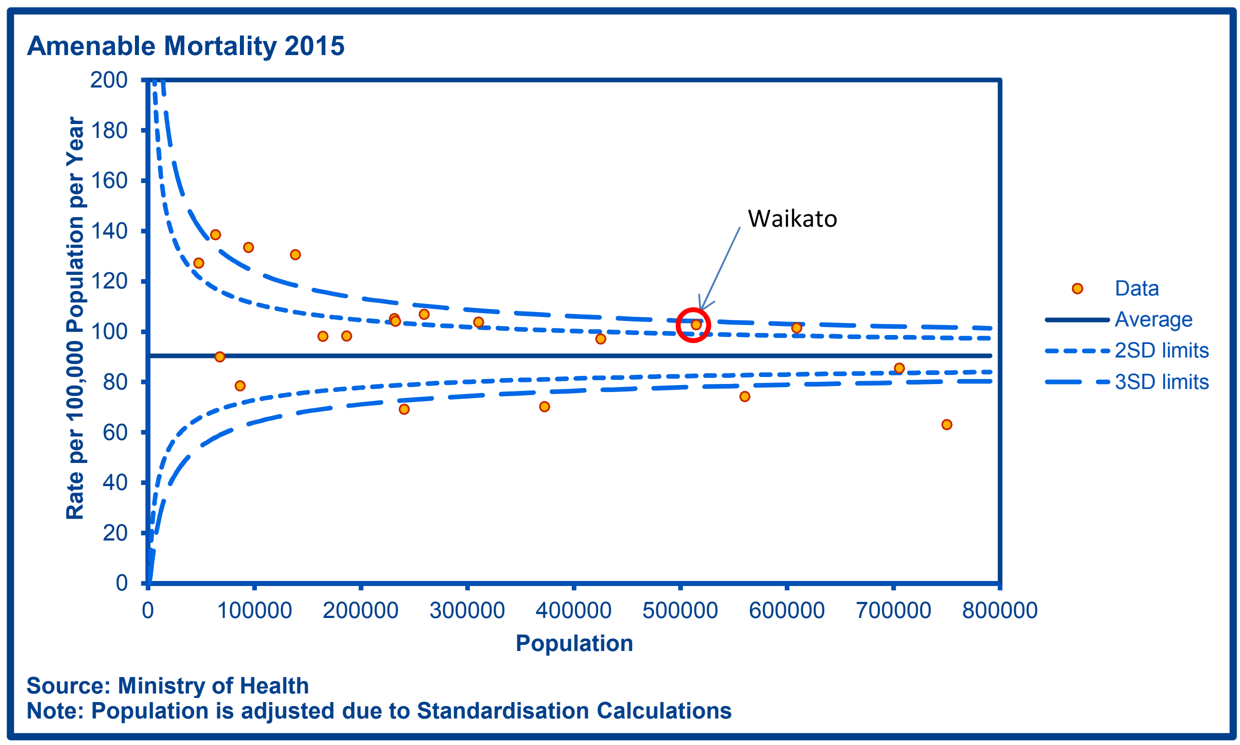
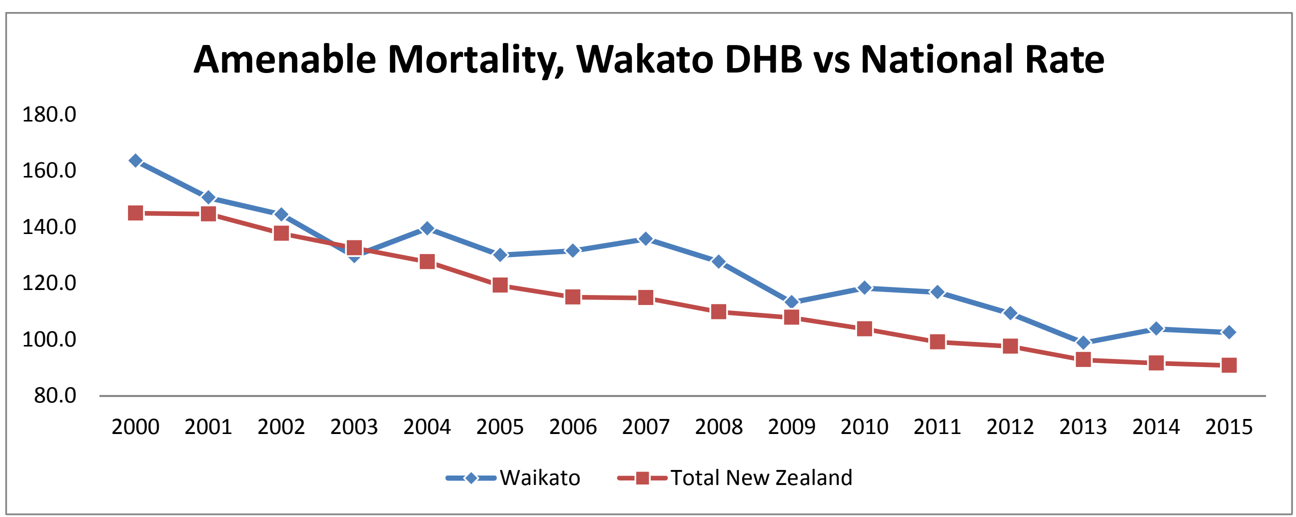


Figure 4. Whilst the rate at Waikato is declining it is still above the national rate



Further development of our national approach to emerging issues within the health care system is required so we can act to prevent potential harm. This includes improving the wellbeing of the health workforce.

Nationally, increasing numbers of adverse events and consumer complaints about harm relate to cross organisational boundary and system issues – these need a different approach to resolve. Locally we have begun to review adverse events with LMC and birthing unit staff to capture the whole journey, and there is a suicide review group in place that includes membership from primary care, NGO and police. We will continue to expand our joint review processes where possible.

Nationally, less progress has been made on tackling long standing 'wicked' or complex problems such as inequity in access, treatment and outcomes, and unwarranted variation in treatment. The new national dashboard will enable oversight of these variations and the executive group have agreed that we will improve our reporting and monitoring of service quality (national dashboard / atlas of variation / Health round table etc.) and prioritise work according to this with input from our Consumer Council. The new Chief Data Officer has a key role in this. The Executive group also agreed that we needed to gain visibility of the system level measures work and outcomes.

New approaches are needed such as co-design with consumers and workforce, driving continuous quality improvement methodology and strengthening the safety culture. The introduction of the Consumer Council for Waikato DHB will assist us with co-development of new models of care and our community engagement models. We are also in our second year of co-design projects with consumers with a further workshop being planned for staff and consumers later in the year. The Cognitive Institute work, set to start in February next year will assist us with our safety culture.

Two new approaches were identified nationally:

- Building on existing approaches to monitoring of service quality.
- Developing a mechanism for spotting and addressing potential problems early.

One of the DHBs strategic imperatives is 'safe high quality health services for all' which includes a number of priority areas that reflect this national direction:

- Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement, and innovation.
- Early intervention for services in need.

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

The executive group agreed to prioritise effort to develop the quality improvement capability and capacity framework that had been proposed some months ago.

2.0 Open 4 Results

Open 4 Results is a six monthly report in the harm prevented, and money saved, in areas the HQSC focuses on or raises awareness about:

- **Falls** - ongoing reduction nationally, with 147 fewer falls resulting in a broken hip and a saving of $6.9 million. At Waikato we had 7 patients fall resulting in a broken hip over the last twelve months. A reduction from 12 the year before
- **DVT –** since 2013, 351 DVT/PE cases have been avoided nationally. Waikato rate of 0.88 is better than the national rate 0.95
- **Surgical site infection** (SSI)– rate has dropped nationally from an infection rate of 1.2% to 0.9% of operations:
  - At Waikato we have a cumulative surgical site infection rate for cardiac surgery of 5.1% (with a last quarter rate improving to 3.7%). The service is working on a number of improvements including an SSI bundle and theatre behaviour
  - For orthopaedic surgery we have a cumulative surgical site infection rate for cardiac surgery of 1.2 % (with a last quarter rate of 0.9%, up from the previous quarter rate of 0.4%)
- **Fewer older people admitted repeatedly to hospital** – reducing, with 138,000 fewer bed days used since 2013. Locally the work with DSL and the frailty work will assist this area
- **Fewer children and young people dying** - reducing mostly due to work around unexpected death in infancy and fewer road crashes involving young people. Locally the work with pepi pods, the local child youth mortality group (CYMG) and the work on suicide prevention will help.

3.0 Local quality improvement

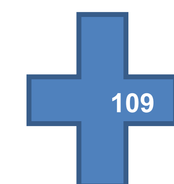
Local quality improvement initiatives include work in relation to sepsis, early detection of deteriorating patients, and end of life focus on areas where our local data shows we have an issue.

The early detection of deteriorating patient's project led by Quality and Patient Safety – Doug Stephenson / Sue Hayward leads, has two current streams of work:

- Embedding the national early warning score observation process
- Developing a business case to procure and implement an electronic vital signs / observation system.

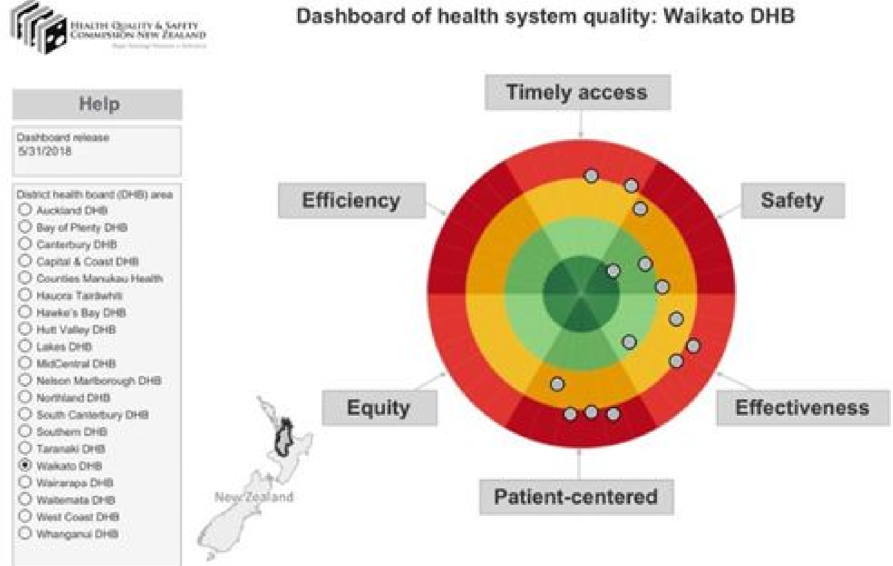
Aim of the Sepsis project led by Quality and Patient Safety – Paul Huggin lead:

- Increase recognition of sepsis and prompt initiation of treatment
- Reduce the number of patients dying from sepsis
- Reduce the number of ICU inpatient days relating to sepsis and ICU/inpatient lengths of stay.

From July 2017-March 2018 ➢ Māori and Pacifica people are **3 x** more likely to be admitted with sepsis. ➢ Sepsis can affect any age group ➢ **713** patients were admitted with an infection ➢ **494** of these patients were diagnosed with sepsis ➢ The average LoS is **13** days ➢ **109** were admitted to ICU ➢ **42** were in septic shock ➢ **27%** is the average mortality rate for patients with sepsis	 109 patients with sepsis were admitted to ICU The average LoS in ICU was 5 days	ICU cost per bed day is approximately **$6400** **109** patients admitted to ICU over the past 6 months cost approximately **$3,488,000** **It does not take into account the distressing impact on the patient and their families and the ongoing increased morbidity and** **mortality rate**

4.0 National Dashboard

There has been no update since the last Board meeting but focus would be on child ASH rates and the results from the last national inpatient survey which shows deterioration.



A Window on the Quality of New Zealand's Health Care

2018

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Prepared for publication in May 2018 by the Health Quality & Safety Commission, PO Box 25496, Wellington 6146, New Zealand.

ISBN 978-0-908345-68-7 (print)

ISBN 978-0-908345-69-4 (online)

This document is available online at www.hqsc.govt.nz

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Abbreviations

ACC	Accident Compensation Corporation
ANZCA	Australian and New Zealand College of Anaesthetists
BDSH	bullying, discrimination and sexual harassment
COPD	chronic obstructive pulmonary disease
DALYs	disability-adjusted life years
DHB	district health boards
DVT/PE	deep vein thrombosis leading to pulmonary embolism
FTEs	full-time equivalents
GDP	gross domestic product
GP	general practitioner
NZDep2013	New Zealand index of deprivation
OECD	Organisation for Economic Co-operation and Development
PDSA	plan-do-study-act
PPP	purchasing power parity
RACS	Royal Australasian College of Surgeons
SAB	*Staphylococcus aureus* bacteraemia
SLMF	System Level Measures Framework
SSIs	surgical site infections
TAS	Technical Advisory Services

Executive summary

New Zealand's health system achieves remarkable things every day. Ultimate outcomes supported by health care – reduced death and disability – are continuing to improve at a rate comparable to similar countries, even though New Zealand has been spending increasingly less than many other countries on health care.

This year's edition of the Health Quality & Safety Commission's *A Window on the Quality of New Zealand's Health Care* (*Window*) 'shines the light' beyond ultimate outcomes to look at where the system is performing less well and where possible system weaknesses may put future performance at risk. 'Shining the light' aims to start the thinking and discussion needed to lead to change.

Chapter 1 considers measures of equity, safety, patient experience and effectiveness.

Equity

- Disparity and inequality in the health status of patient groups in New Zealand can be compounded by poor health care or, alternatively, countered by high-quality care that effectively meets specific needs.
- This year's *Window* highlights inequities across ethnic, age and socioeconomic groups in terms of treatments, patient experience, access to services, and outcomes. The findings suggest New Zealand's health care system needs to perform better at each stage of the patient journey, to deliver more equitable health outcomes.

Safety

- With regard to safety, this *Window* shows New Zealand is performing well internationally in areas of specific harm. Continued improvements are evident in safe practice and patient outcomes, through quality improvement approaches, in most areas where the Commission focuses its efforts (ie, falls prevention, surgical site infections for hip and knee operations, deep vein thrombosis and pulmonary embolism).
- Many more issues of patient harm remain to be tackled, most notably, those related to delays and clinical management processes.

Patient experience

- Patient experience is an important component of high-quality care. Both the Commission's inpatient experience and primary care patient experience surveys show generally positive, consistent results over time.
- However, inequities across groups can be seen, and more work is needed on providing patients with information on their medication, particularly in relation to side effects.
- The picture is mixed for interactions with other parts of the health care system, suggesting system integration and the patient journey need more focus. Variation exists across different providers, suggesting room for improvement.

Effectiveness

- A high-quality system will provide the most effective treatment at the right time and in the right place, organised around the patient and their condition.
- While New Zealand compares well internationally for measures of effectiveness, variation exists across the country, suggesting effective treatment and coordination are not universal. No single district health board provides the best or worst care across all conditions and patient groups.

Chapter 2 highlights the need for further development in our approach to anticipating emerging issues within the health care system, so we can act more quickly to prevent potential harm.

The importance of social determinants of health mean that poverty, social inequity, poor housing and other challenges beyond the immediate control of health systems affect the services we need to provide. Similarly, the wellbeing of the health workforce is itself important for ensuring a high-performing system.

Chapter 2 considers 'soft' intelligence alongside hard data, and highlights the need to sift through various signals that may be 'just noise' to identify those that matter. Financial pressures, the health and wellbeing of the workforce, and changing patterns of adverse events and consumer complaints are covered.

Financial

- The increasing gap between expenditure on the New Zealand health care system and those of similar countries is highlighted. Continuing district health board deficits are also raised.
- Too much focus on delivering specific results can inadvertently cause the deprioritisation of other important work or investment required to strengthen the system or improve the patient journey.

Workforce

- The health and wellbeing of the health workforce is discussed. Even though the health workforce is increasing over time, staff shortages and wellbeing concerns are being raised within the sector. Sickness absenteeism and, the opposite, presenteeism (working through illness) are considered.
- Of particular concern is the evidence that bullying is widespread in the New Zealand health care system. This is not unique to health care, but bullying is destructive to culture and affects both the physical and psychological wellbeing of staff and their ability to provide high-quality and safe patient care.

Safety

- Increasing numbers of adverse events reports and consumer complaints about harm relating to complex cross-organisational boundary and system issues (ie, clinical management processes and delays) are discussed. These challenges will require different approaches to resolve them.

The overall impression from these two chapters is of a system adept at responding to individual quality issues with effective, focused initiatives. Yet, as a system, it has made less progress in tackling long-standing 'wicked' or complex problems, such as continuing inequity in access, treatment and outcomes, and unwarranted variation in treatment. The system's inability to address these issues matters. We cannot continue with our current approaches and ignore our lack of progress in these important areas.

Some of the challenges outlined in chapter 2 were not so visible four years ago. We are now seeing issues that do not lend themselves to the sort of targeted methods and single-organisation approaches widely used in recent years. New approaches are needed, grounded in co-design with consumers and the health workforce.

As well as continuing quality improvement and further strengthening safety culture, chapter 3 suggests two new approaches that may help address emerging challenges while also improving the overall quality of services and our system. These are:

- building on existing approaches to encourage focused monitoring of service quality
- developing a mechanism for spotting and addressing potential problems early.

If we are truly to achieve equitable and excellent health outcomes for all New Zealanders, it is essential that a whole-of-system approach is adopted.

Introduction

Welcome to the fourth edition of the Health Quality & Safety Commission's (the Commission's) report *A Window on the Quality of New Zealand's Health Care* (*Window*).

This *Window* focuses mostly on the quality of health services delivered rather than population health, broader measures of system capability, sustainability, workforce or productivity. Health outcomes depend on all of these issues, including factors such as poverty, housing, employment and education, just as much as they do on ensuring all New Zealanders have timely access to effective and safe health services. As our approach to reporting on the quality and safety of health care evolves, the *Window* is necessarily expanding to consider wider issues, opportunities and flags for deeper analysis and attention.

As in previous editions, chapter 1 uses a modification of the US Institute of Medicine's (now the National Academy of Medicine's) dimensions of quality. The chapter concentrates on the value, equity, safety, patient experience and effectiveness of delivered health services to provide structure.

Chapter 2 draws on the wider work of Charles Vincent and others who are encouraging a broader approach to the measurement and monitoring of safety in health care. We focus on 'anticipating' early warnings for system safety and sustainability in New Zealand.

Chapter 3 suggests two new approaches that may help address the ongoing and emerging challenges highlighted in this *Window*, while improving relationships, the overall quality of services and our system. These are:

- building on existing approaches to encourage focused monitoring of service quality
- developing a mechanism for spotting and addressing potential problems early.

(Unless otherwise stated, the source for figures and tables in this *Window* is the Health Quality & Safety Commission.)

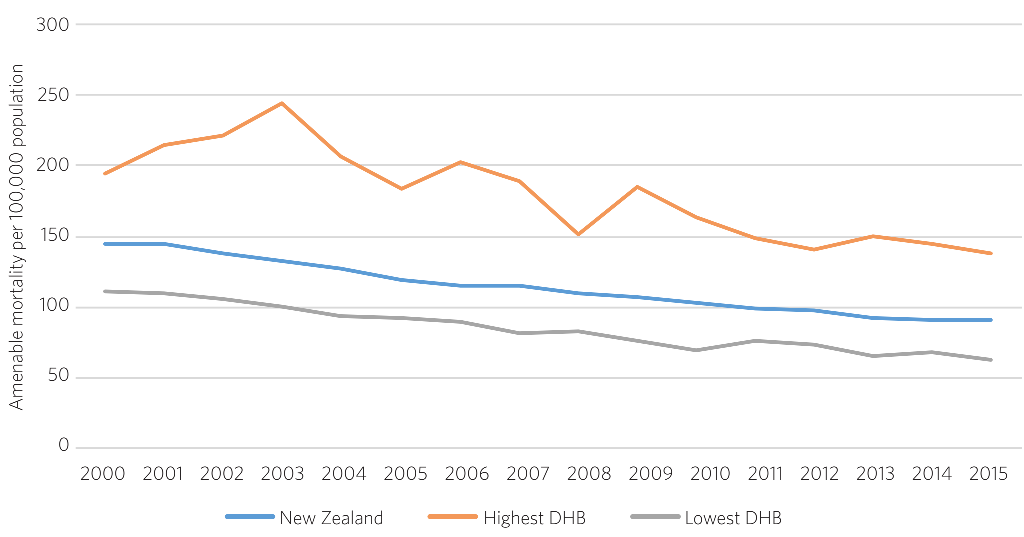
1 Where are we now?

A high-level view – outcomes and value for money

Measures of the ultimate outcomes of care, such as deaths from treatable conditions, life expectancy and loss of quality of life, continue to show improvement in New Zealand at rates in line with other similar countries.

Deaths from conditions that can be improved by health care continue to reduce for all parts of the country (see Figure 1). However, a two-fold variation exists between the district health boards (DHBs) with the highest and lowest rates of these premature deaths.

Figure 1: Mortality from conditions amenable to health care per 100,000 population aged 0–74, New Zealand, 2000–15 (source: Ministry of Health)



Box 1: Measuring ultimate outcomes of care

Amenable mortality measures the number of premature deaths from diseases that effective and timely health care might have prevented.

Disability-adjusted life years (DALYs) measure the gap between a population's current state of health and that of an ideal population where everyone experiences long lives free of illness or disability. DALYs provide a means of considering quality of life, as well as length. A DALY lost is a year of healthy life lost to New Zealanders. Therefore a reduction in DALYs lost represents an improvement in outcome.

Ultimate outcomes of care in New Zealand are similar to those in other developed nations and are improving at a similar, if not faster, rate. Figure 2 shows that DALYs lost in New Zealand are very similar to most other developed countries. Figure 2 compares New Zealand with 30 high-income (Organisation for Economic Co-operation and Development (OECD)) countries. International comparisons after this graph, unless otherwise stated, use a smaller group of comparable countries (Australia, Canada, Ireland, Sweden, United Kingdom and United States of America).

Figure 2: Age-standardised disabilty-adjusted life years (DALYs) lost per 1,000 population, high-income countries, 2016 (source: University of Washington)

DALYs per 1,000 populatoin

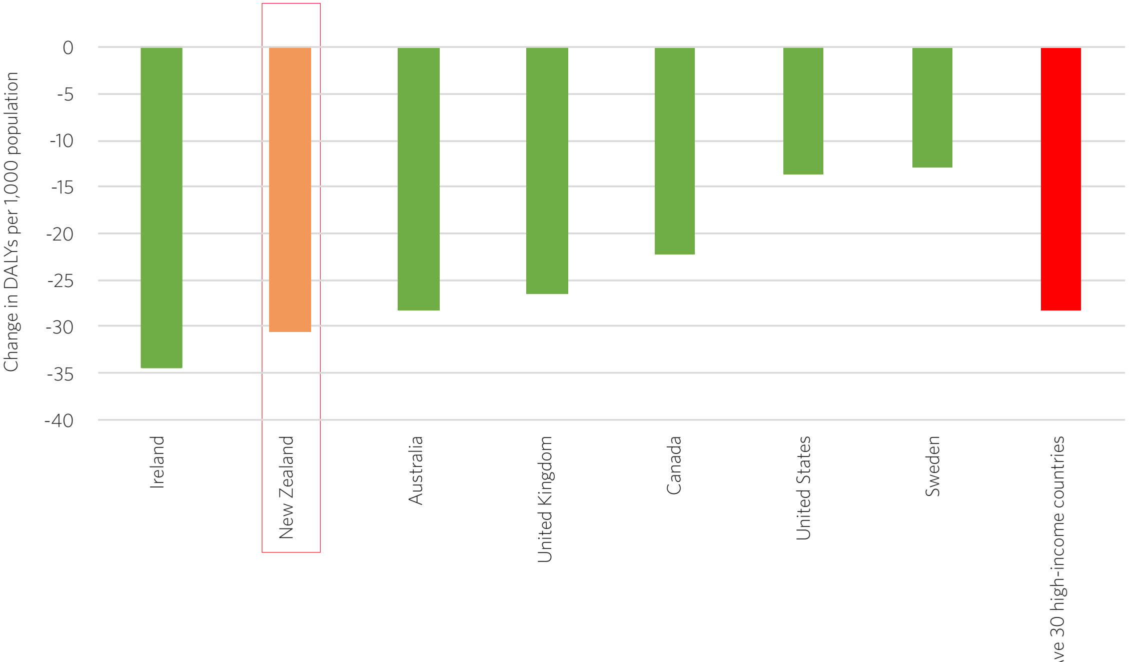
300
250
200
150
100
50
0

Singapore, Japan, Spain, Switzerland, Italy, Norway, Iceland, Israel, France, Australia, Luxembourg, Sweden, Austria, Netherlands, South Korea, Canada, Finland, Greece, Portugal, Ireland, New Zealand, Germany, Belgium, Denmark, United Kingdom, Czech Republic, Poland, United States, Estonia, Slovakia

DALY
Lower bound
Upper bound
High income

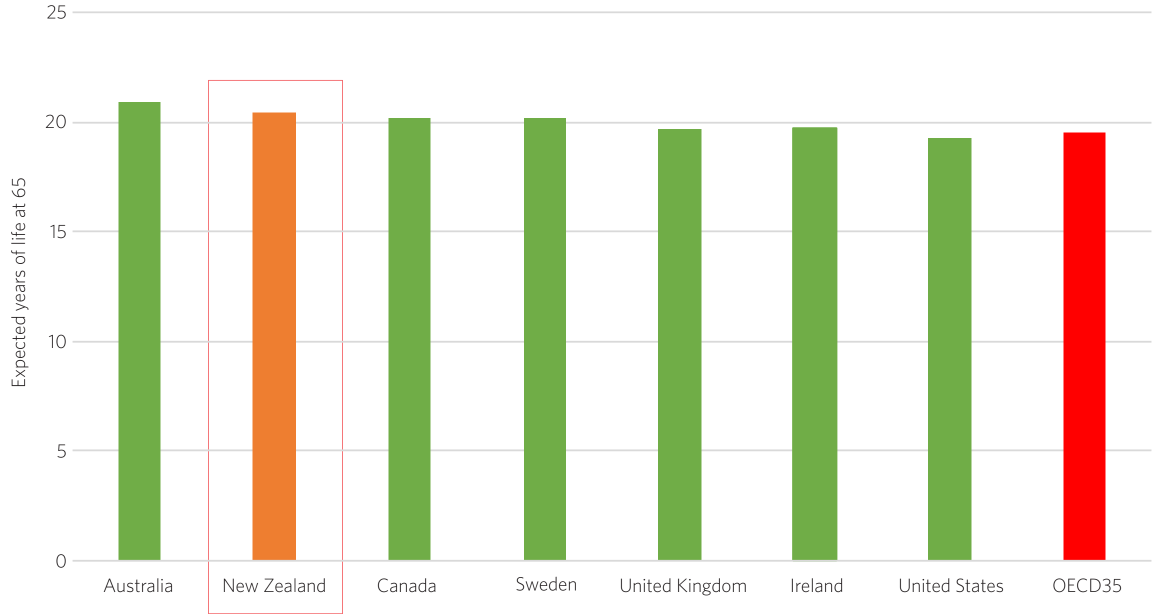
Since 2000, the rate of per-capita DALYs lost has fallen slightly more in New Zealand than in the average of the high-income countries, in line with the trend observed in previous *Windows* (Figure 3).

Figure 3: Change in age-standardised disability-adjusted life years (DALYs) per 1,000 population, high-income countries, 2000–16 (source: University of Washington)



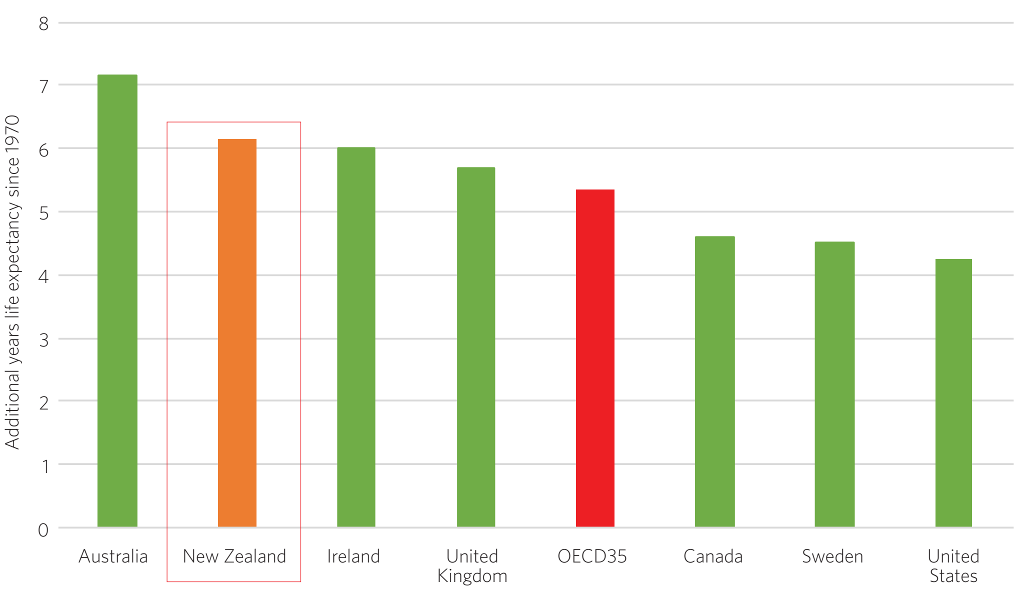
New Zealanders aged 65 can expect to live 20 more years. Again, this puts New Zealand close to comparable high-income countries and very close to the average of the 35 countries in the OECD (Figure 4).

Figure 4: Life expectancy at 65, by OECD country, 2015 (source: OECD)



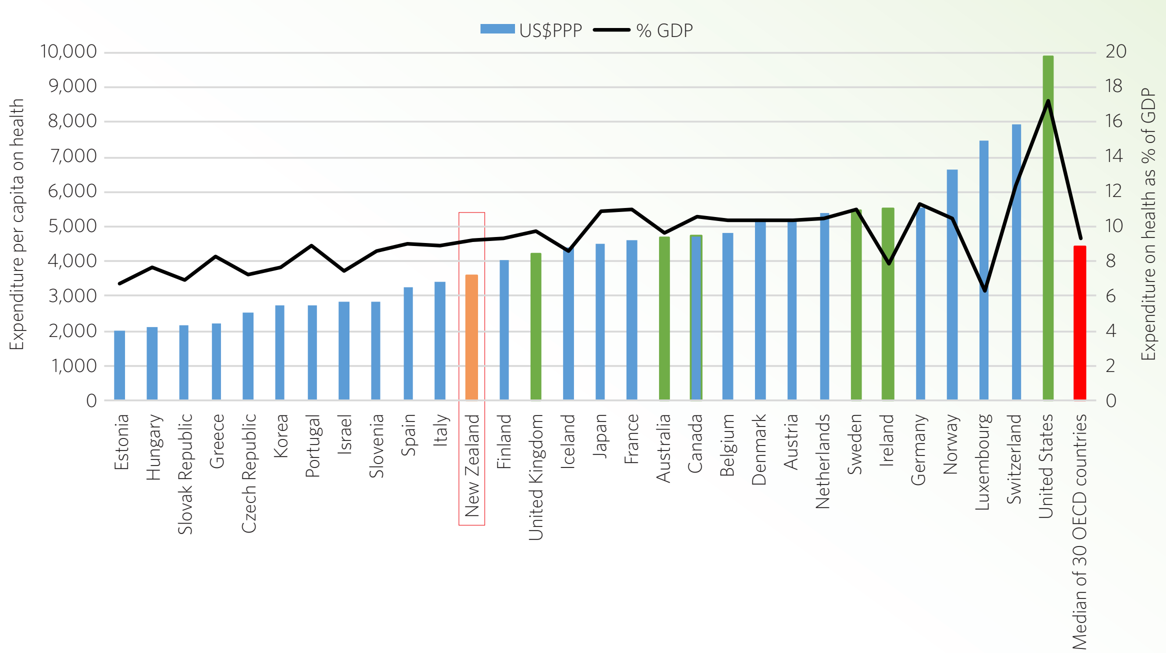
Life expectancy at 65 has improved by just over six years since 1970, slightly above the average improvement of the OECD nations (Figure 5).

Figure 5: Change in life expectancy at 65, by OECD country, 1970–2015 (source: OECD)



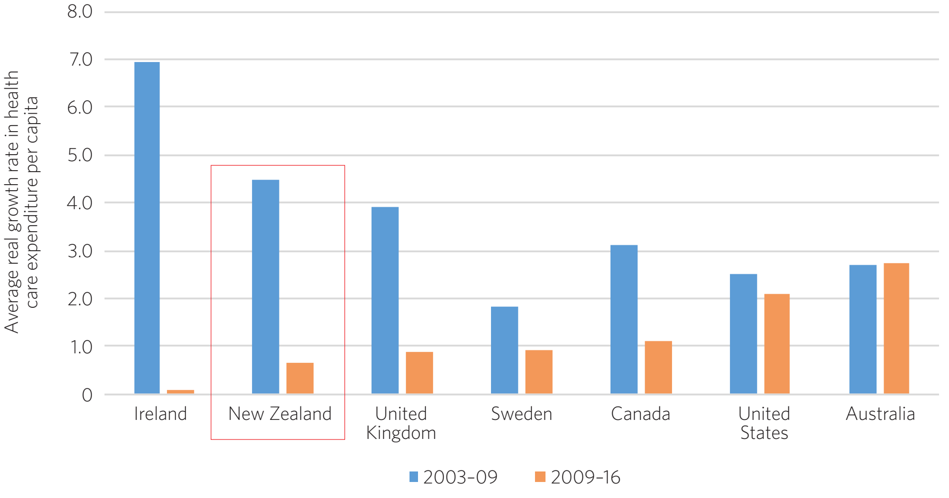
New Zealand has had lower expenditure on its health care system than most comparable countries for many years, both as total expenditure per person and as a percentage of gross domestic product (GDP). Figure 6 presents the most recent data (expenditure per head in bars, percentage GDP as a line) for 30 high-income countries. The comparator group is coloured green in this graph. New Zealand consistently has not only lower per-head expenditure, but also a smaller share of national income spent on health care than similar countries. This is potentially important. For example, matching the Australian share of national income spent on health would add US$700 million to New Zealand's health expenditure.

Figure 6: Expenditure on health care per head, US$ purchasing power parity (PPP), by OECD country, 2016 (source: OECD)



Since 2009, the growth in New Zealand's expenditure on health care has slowed notably, both in comparison with 2003–09 and with similar countries (Figure 7).

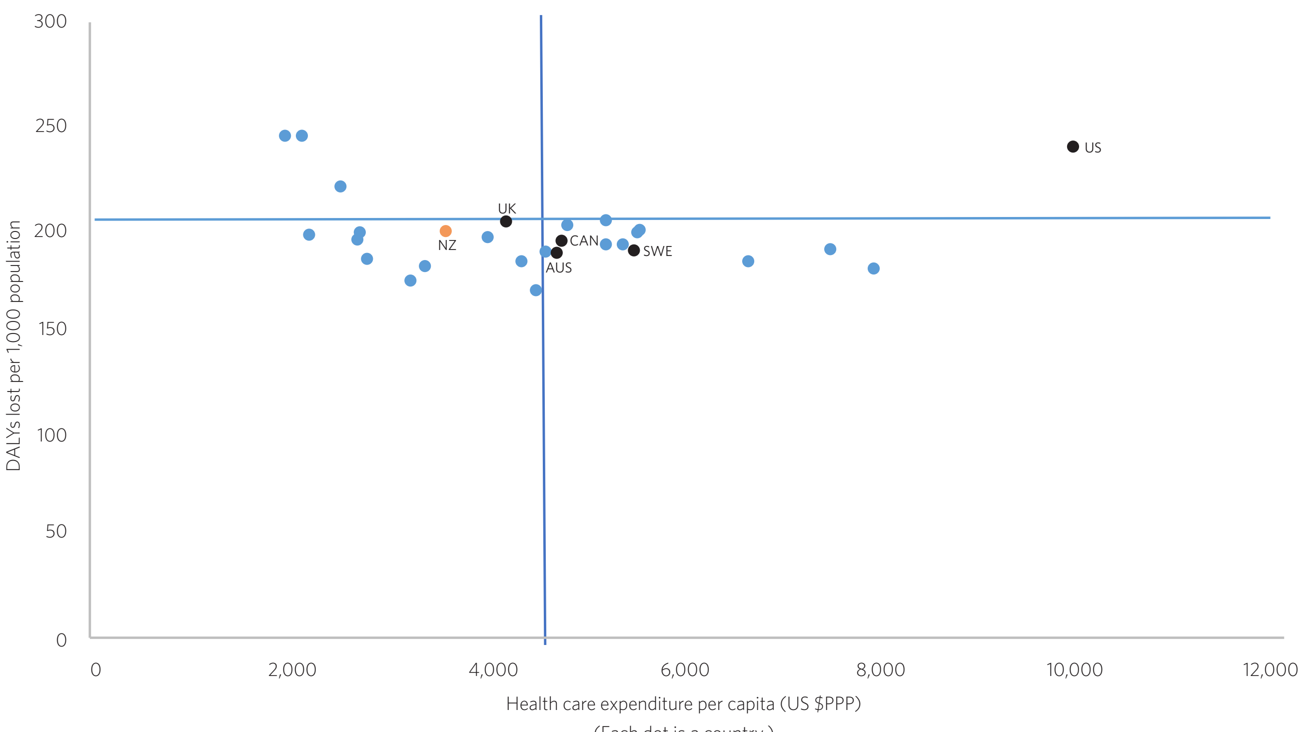
Figure 7: Annual average growth rate in per-capita health expenditure, real terms, by OECD country, 2003–09 and 2009–16 (or nearest year) (source: OECD)



So, New Zealand (the orange dot in Figure 8) remains in the low-cost, low-DALY loss quadrant of 30 high-income countries. This result is slightly ambiguous. It can be taken to mean that New Zealand is performing as well as similar nations, despite spending less money, or that it is failing to achieve some of the best health outcomes in the world by not spending relatively small amounts more on its health services.[1] Regardless, the potential effect of long periods of flat expenditure in the face of a population with increasing health needs warrants further consideration, which is given in chapter 2.

1 The value to New Zealand's society of this investment is potentially substantial. The Accident Compensation Corporation (ACC) has estimated the value of an avoided DALY using a method that, for 2015 prices, would give a value of around $180,000. Were New Zealand to reduce its DALY per-capita rate to that of Australia (that is, a reduction of around 10 DALYs per 1,000 population), New Zealand would have roughly a further 47,000 years of healthy life each year, worth around $8.5 billion under the ACC estimation.

Figure 8: Expenditure on health care per head, US$ purchasing power parity (PPP), 2016, versus age-standardised disability-adjusted life years (DALYs) lost per 1,000 population, 2016, high-income countries (sources: OECD; University of Washington)



All of the measures reported in chapter 1 (and in previous editions of the *Window*) cover what has occurred in the past. At best, the data is six months to a year old. A lot can change in that time, and pressures on a system can take several years to show up in results. While these 'lagging' indicators are useful and important, we need to do two things to understand the current position. First, we need to examine these indicators in greater depth. We do this in the rest of chapter 1. Second, we need to supplement them with more prospective measures ('leading indicators') to see where the system might be heading. This is discussed in chapter 2.

The first 'lagging indicator' is health outcomes for different groups of people. As shown in Figure 1, mortality from conditions we can treat varies around the country. Figure 9 shows, for different ethnic groups, this distinction is even more stark.

Figure 9: Mortality from conditions amenable to health care per 100,000 population aged 0–74, by ethnic group, New Zealand, 2009–15 (source: Ministry of Health)

Similarly, Figure 10 shows that a strong relationship exists between the mortality rate for these conditions in individual DHBs and the local levels of deprivation (r^2= .68). In broad terms, for every 10 points that deprivation increases on the NZDep2013 index of deprivation scale, a further five people per 100,000 population die from treatable diseases.

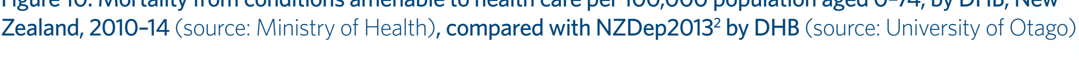
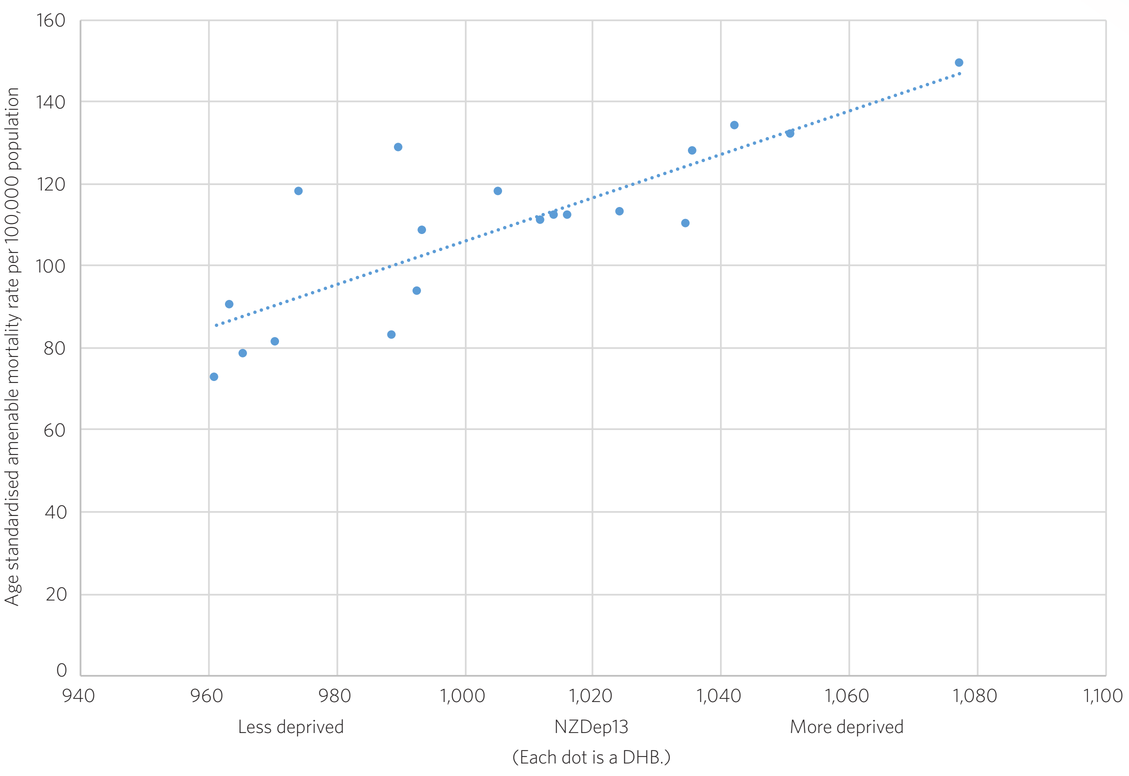


Figure 10: Mortality from conditions amenable to health care per 100,000 population aged 0–74, by DHB, New Zealand, 2010–14 (source: Ministry of Health)**, compared with NZDep2013[2] by DHB** (source: University of Otago)



2 NZDep2013, calculated by the School of Public Health at the University of Otago, is an index of deprivation of local areas that includes: people aged below 65 with no access to the internet at home; people aged 18–64 receiving a means-tested benefit; people living in equivalised households with income below an income threshold; people aged 18–64 unemployed; people aged 18–64 without any qualifications; people not living in their own home; people aged over 65 living in a single parent family; people living in equivalised households below a bedroom occupancy threshold; and people with no access to a car. For the purposes of Figure 10, the weighted mean of NZDep2013 scores for area units within each DHB are used. Further details of the NZDep2013 scores are available from www.otago.ac.nz/wellington/otago069929.pdf (accessed 14 May 2018).

The pattern of worse outcomes and experiences for deprived populations is especially notable for children. The recent report of the Child and Youth Mortality Review Committee notes that children living in deprived areas are three times more likely to die than those in the most affluent areas.[3] Similarly, the New Zealand Child and Youth Epidemiology Service shows that children living in areas in the most deprived quintile are three times as likely to be admitted to hospital for respiratory and infectious diseases.[4]

Every previous *Window* has noted that New Zealand's health care system struggles to provide high-quality services to all New Zealanders, and that outcomes for some groups of people are not as good as for others. The effects of deprivation are clear, but the solutions will require measures beyond those that involve direct investment in health services.

Equity

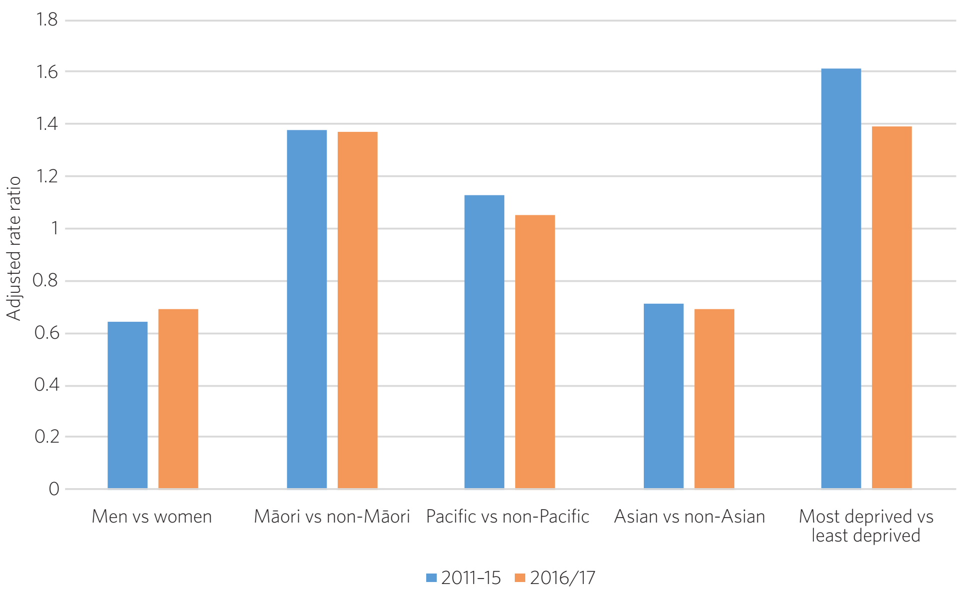
The pattern of worse outcomes for some groups is reflective of inequity for Māori and Pacific peoples and those living with greater socioeconomic deprivation. These groups are more likely to have greater health needs and to find it difficult to access care. They are less likely to get the best care, even when they do access it, and are less likely to find care a positive experience.

Previous *Windows* have highlighted issues of ethnic inequity. Inequity can also be seen across socioeconomic status, age, gender and rurality. This section considers types of inequity among different population groups. Concerning examples are evident for all groups.

Inequity of access

Cost barriers to accessing primary care affect Māori, younger and more deprived populations disproportionately and have done so consistently for the past five years, despite changes in public health funding to reduce these barriers (Figure 11). For example, the figure shows that Māori are 1.4 times more likely than non-Māori to identify cost barriers to accessing primary health care.

Figure 11: Adjusted rate ratio of respondents identifying cost barriers to accessing primary care (second mentioned group = 1.0), New Zealand, 2011–15 and 2016/17 (source: Ministry of Health health survey)



3 Health Quality & Safety Commission. 2018. *Child and Youth Mortality Review Committee 13th data report 2012–2016*, figure 1.5. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/CYMRC/Publications/CYMRC-13th-data-report-FINAL-Apr-2018.pdf (accessed 14 May 2018).

4 New Zealand Child and Youth Epidemiology Service. 2017. *Child Poverty Monitor: Technical Report*, figure 39. Dunedin: New Zealand Child and Youth Epidemiology Service. URL: http://nzchildren.co.nz/#Hospitalisations (accessed 14 May 2018).

Even if we restrict this question to people who have at some point been able to access services, the pattern holds for ethnic groups (Figure 12) and can also be seen, even more starkly, for age groups (Figure 13). Younger people in need of health care are much more likely to experience cost barriers to accessing care. For Figures 12 and 13, lower percentages reflect lower reported access barriers due to cost. Therefore, lower percentages are better.

Figure 12: Percentage of respondents reporting cost barriers to access in the primary care patient experience survey, by ethnic group, New Zealand, November 2017

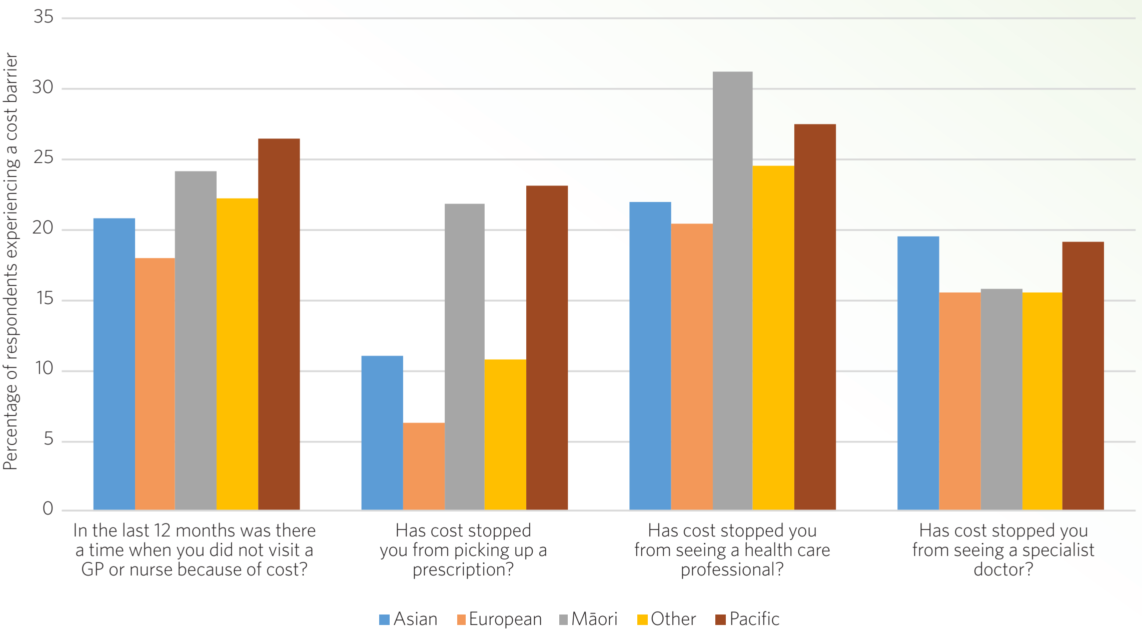
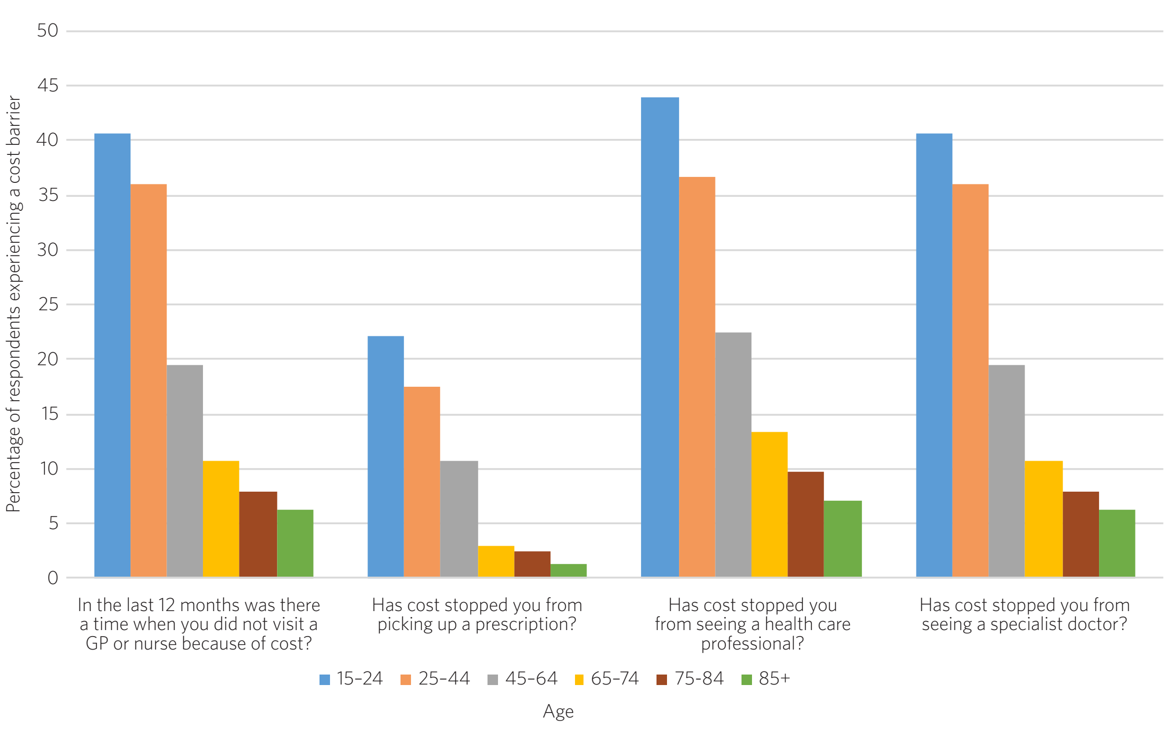
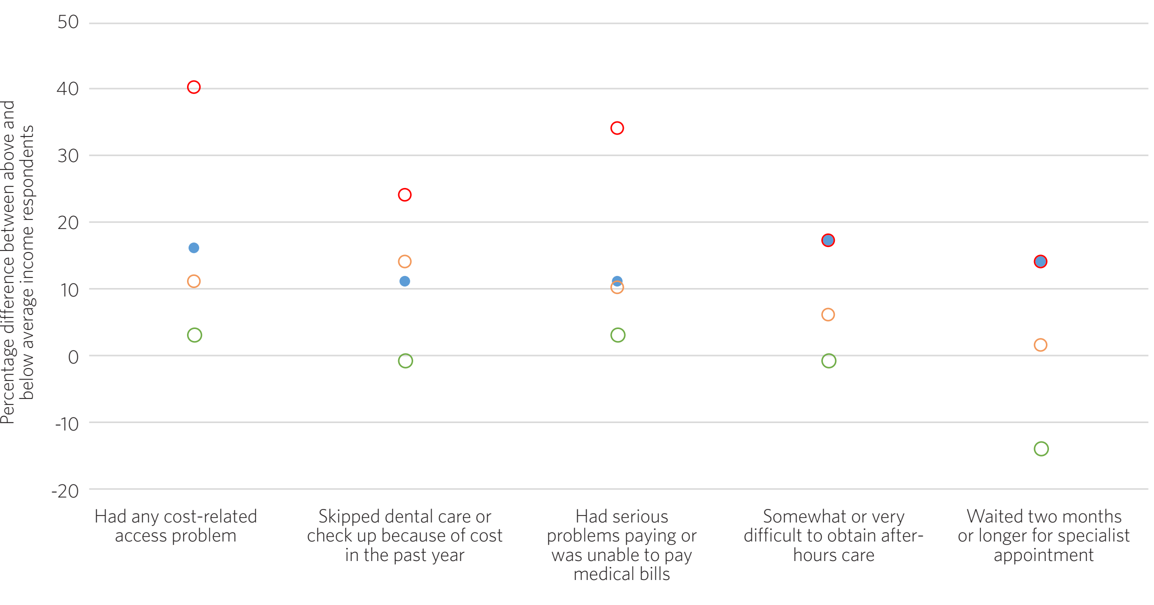


Figure 13: Percentage of respondents reporting cost barriers to access in the primary care patient experience survey, by age group, New Zealand, November 2017



Cost barriers are also related to socioeconomic status. Figure 14, reproduced from the Commonwealth Fund's biennial review of developed world health systems, shows that people with lower incomes are typically 10–20 percent more likely to report cost barriers to accessing care in New Zealand. For obtaining out-of-hours care or long waits for specialist appointments, New Zealand's results show the greatest disparity among all 11 countries reported on.[5] In Figure 14, lower scores reflect less inequity.

Figure 14: Disparity in access to care between above and below average income respondents, 2016
(source: Commonwealth Fund, *Mirror, Mirror*)



Inequity of treatment

Thirteen questions in the primary care patient experience survey relate to operation of the health care system in treating people, ensuring different parts of the system work well together to coordinate care for a patient. Results for different ethnic and age groups are telling. When compared with European respondents, both Māori and 'Other' respondents reported a worse experience of coordination of care on a range of dimensions (Table 1).

Table 1: Number of questions where respondents from Asian, Māori, Other and Pacific peoples ethnic groups gave significantly different responses about coordination of care than respondents from the European ethnic group, primary care patient experience survey, New Zealand, November 2017

Ethnic group	More positive	Less positive
Asian	0/13	0/13
Māori	0/13	3/13
Other	0/13	7/13
Pacific peoples	1/13	1/13

This disparity is even more pronounced for age groups (Table 2). People below 65 years of age reported poorer coordination of care than those aged 65 and over.

5 The group comprises: Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom and United States of America.

Table 2: Number of questions where different age groups gave significantly more or less positive responses about coordination of care than the overall rate, primary care patient experience survey, New Zealand, November 2017

Age group (years)	More positive	Less positive
15–24	0/13	8/13
25–44	0/13	13/13
45–64	0/13	5/13
65–74	12/13	0/13
75–84	10/13	0/13
85+	7/13	0/13

Inequity of experience

The primary care patient experience survey provides a similar picture for questions about experience of care, which concentrate on quality of communication and meeting of physical and emotional needs (Table 3). We noted in last year's *Window* that the hospital inpatient survey showed questions about experience of care were reported more negatively by Māori. The same result holds for the primary care patient experience survey.

Table 3: Number of questions where respondents from the Asian, Māori, Other and Pacific peoples ethnic groups gave significantly different responses about experience of care than respondents from the European ethnic group, primary care patient experience survey, New Zealand, November 2017

Ethnic group	More positive	Less positive
Asian	0/20	5/20
Māori	0/20	8/20
Other	0/20	5/20
Pacific peoples	1/20	5/20

Again, a pattern is evident of younger people reporting less positive experiences than older people, with 65 years marking a clear cut-off point (Table 4).

Table 4: Number of questions where different age groups gave more or less positive responses about experience of care than the overall rate, primary care patient experience survey, New Zealand, November 2017

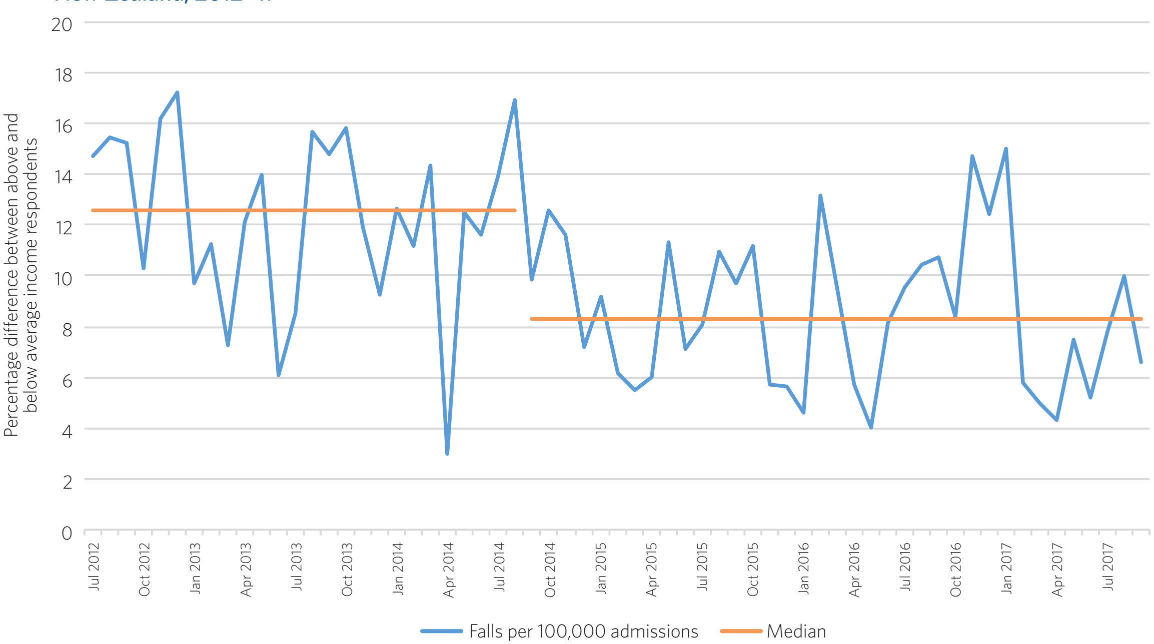
Age group (years)	More positive	Less positive
15–24	0/20	15/20
25–44	0/20	17/20
45–64	0/20	4/20
65–74	18/20	0/20
75–84	14/20	1/20
85+	8/20	0/20

Safety

The Commission has worked with the sector to introduce national quality improvement programmes that address identified areas of patient harm where improvement is needed. When a national quality improvement programme is under way, we generally see patterns of reduced patient harm that have persisted, suggesting good – and effective – practice has become embedded.

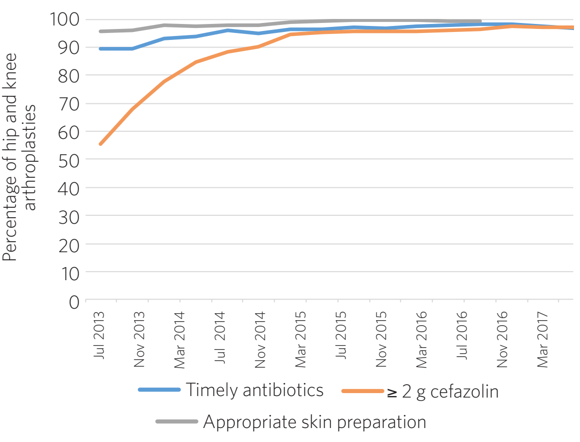
Since the introduction of the Commission's reducing harm from falls programme in 2012, rates for falls in hospital resulting in a fractured hip (known as a fractured neck of femur) reduced by 30–40 percent in 2014 and have stayed down (Figure 15).[6,7]

Figure 15: In-hospital falls leading to a fractured neck of femur in people aged 15 and over, by month, New Zealand, 2012–17



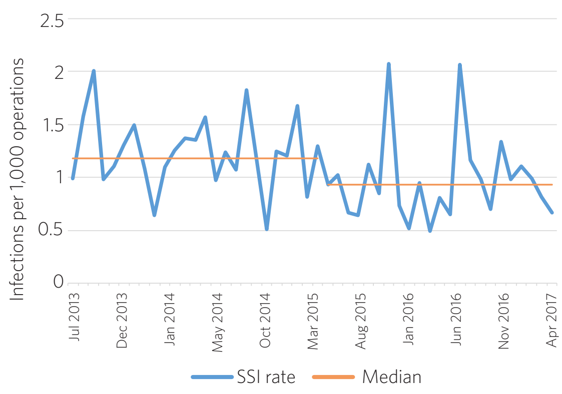
Thanks to the spread of good practice in avoiding wound infections after hip and knee operations since 2014…

Figure 16: Hip and knee operations where good practice in antibiotic prophylaxis and skin preparation was followed, by quarter, New Zealand, 2013–17



… rates for surgical site infections (SSIs) reduced in 2015 and have stayed down.

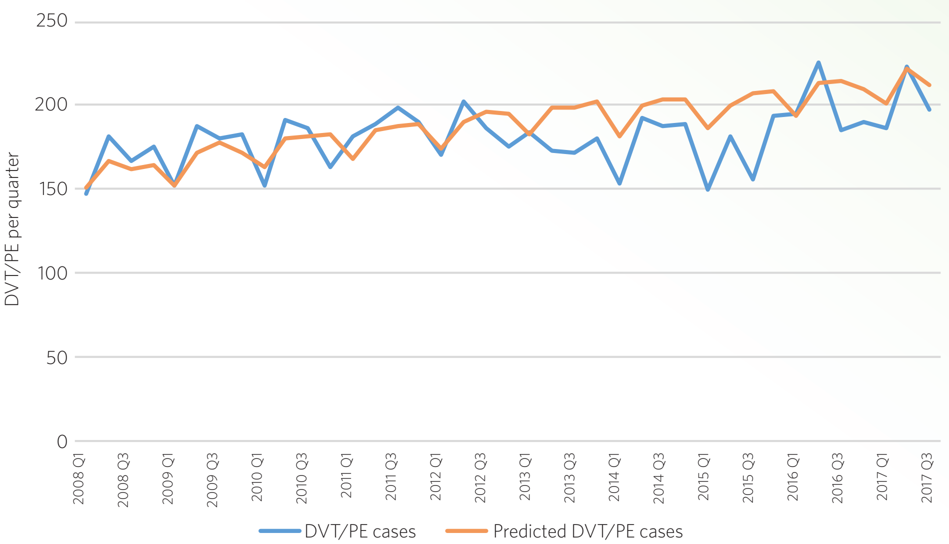
Figure 17: SSIs for hip and knee operations, by month, New Zealand, 2013–17



6 Jones S, Blake S, Hamblin R, et al. 2016. Reducing harm from falls. *New Zealand Medical Journal* 129(1446): 89–103.
7 Healey F. 2016. Falls prevention as everyday heroism. *New Zealand Medical Journal* 129(1446): 14–16.

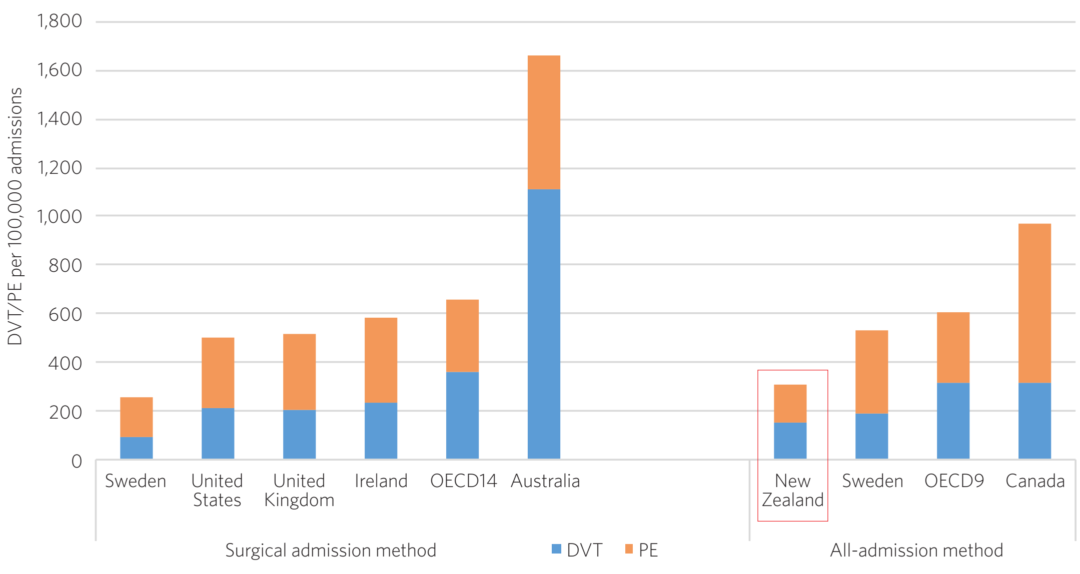
Postoperative deep vein thrombosis leading to pulmonary embolism (DVT/PE) is an avoidable and often fatal complication following surgery. Since 2013, rates for DVT/PE have remained statistically significantly lower than we would have predicted, with 16 out of 18 quarters having had fewer postoperative DVT/PEs, based on historic rates. This is shown by the blue line being consistently lower than the orange line in Figure 18.

Figure 18: Postoperative DVT/PE, actual and predicted based on underlying patient risk, by quarter, New Zealand, 2008–17



... and New Zealand's rates of DVT/PE appear to be low by international standards (Figure 19).

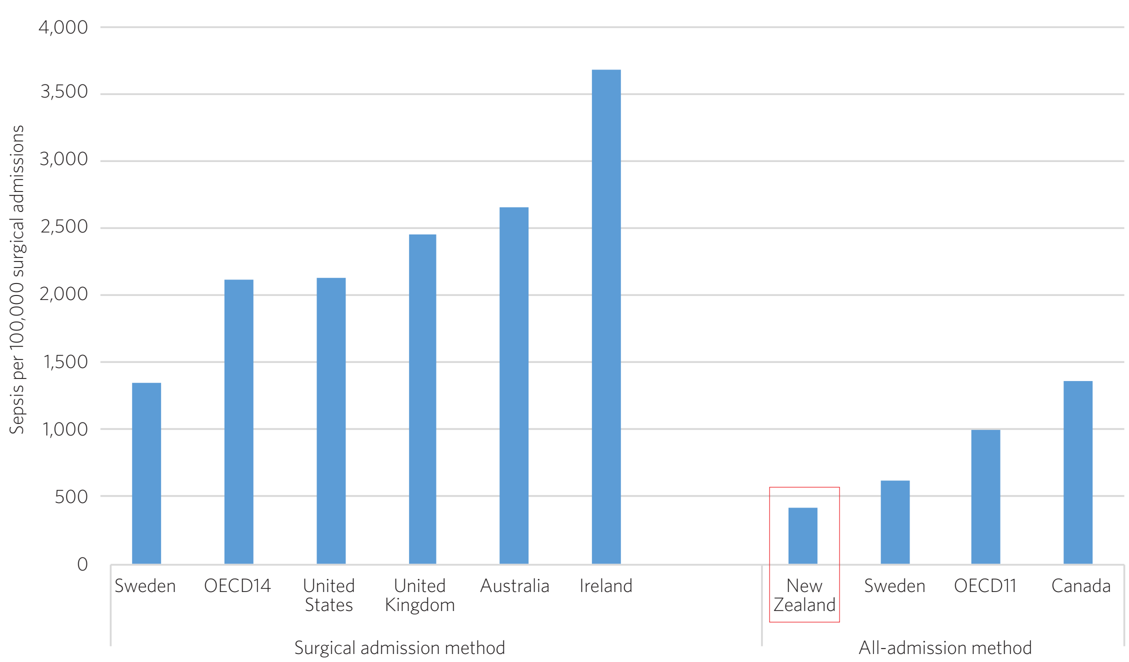
Figure 19: Postoperative DVT/PE, hip and knee surgeries, by OECD country, 2015 (source: OECD)[8]



8 Reflecting the differences in the way that countries collect data, the OECD provides two methods for calculating the postoperative complications shown in Figures 19 and 20, which are not comparable to each other. The all-admission method is considered more accurate, because it allows re-admissions with the complication to be included in the numerator. Sweden calculates using both methods, which provides very different results. Full details can be found in the OECD *Health at Glance 2017*. URL: https://read.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en#page118 (accessed 14 May 2018).

Instances of postoperative sepsis in New Zealand are also low by international standards…

Figure 20: Postoperative sepsis, abdominal surgeries, by OECD country, 2015 (source: OECD)

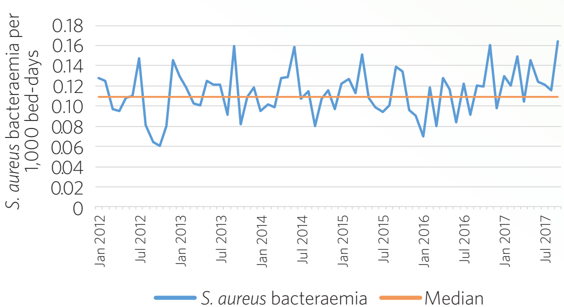


… although with postoperative sepsis, we do not see the same lower trend of observed versus predicted instances as with DVT/PE (in Figure 18) (Figure 21).

Figure 21: Postoperative sepsis, actual and predicted based on underlying patient risk, by quarter, New Zealand, 2009–17

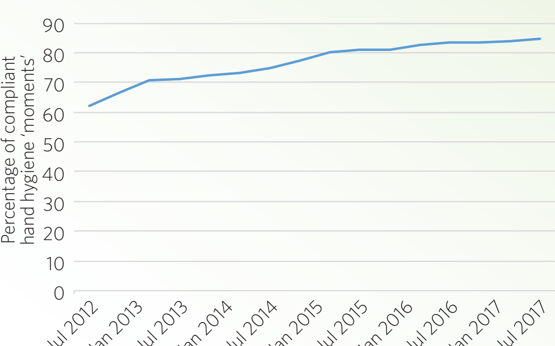
Similarly, no reduction has occurred in healthcare-associated *Staphylococcus aureus* infections in New Zealand…

Figure 22: *Staphylococcus aureus* bacteraemia rate per 1,000 bed-days, by month, New Zealand, 2012–17



…despite five years of ever-increasing compliance, with good hand hygiene practice being recorded in audits.

Figure 23: Hospital hand hygiene compliance rate (%), New Zealand, 2012–17



Recent research has questioned the extent to which good hand hygiene affects rates of *Staphylococcus aureus* bacteraemia (SAB).

The drivers of SAB rates are complex and similar to those of *S. aureus* disease in general. These drivers are established in the community and relate to the social, environmental and economic determinants of health (relative deprivation, overcrowding, poor nutrition, diabetes and obesity, for example).

Limitations exist in the rigour of studies that have evaluated whether hand hygiene correlates directly with SAB reduction. Confounding factors, such as infection prevention interventions introduced at the same time as a hand hygiene initiative, may make it difficult to determine how much impact was due to improvement in practice. A randomised controlled trial would provide the most robust study design to determine cause and effect. However, it would be problematic to carry out this type of study because of methodological and ethical concerns. Similarly, hand hygiene data based on observational audits may be subject to confounding factors.

The Commission is reviewing options for future approaches to achieving reductions in rates of SAB.

In addition to specific quality improvement programmes, the Commission monitors numerous aspects of patient safety through its Atlas of Healthcare Variation. One aspect of recent concern is the use of opioids.

Opioids are an important part of managing many types of pain, but overprescribing is associated with many direct and indirect problems. New Zealand's opioid consumption, though increasing since around 2009, is lower than similar countries but greater than the European average (Figure 24).

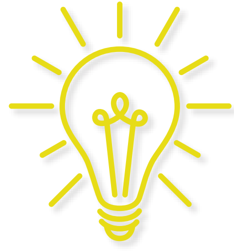
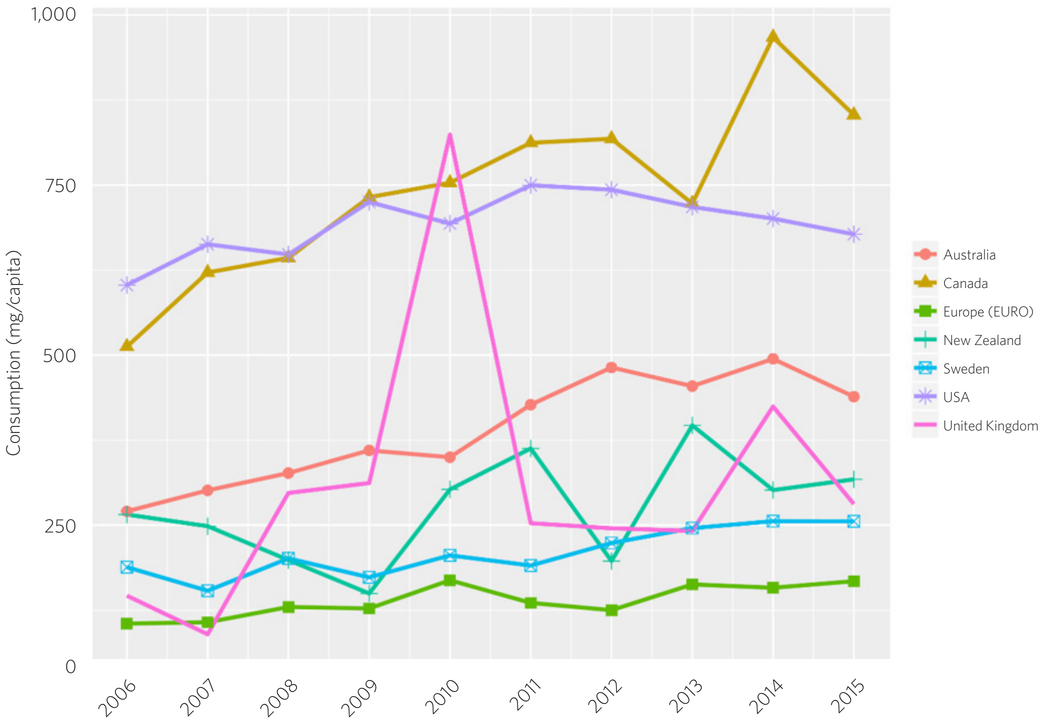
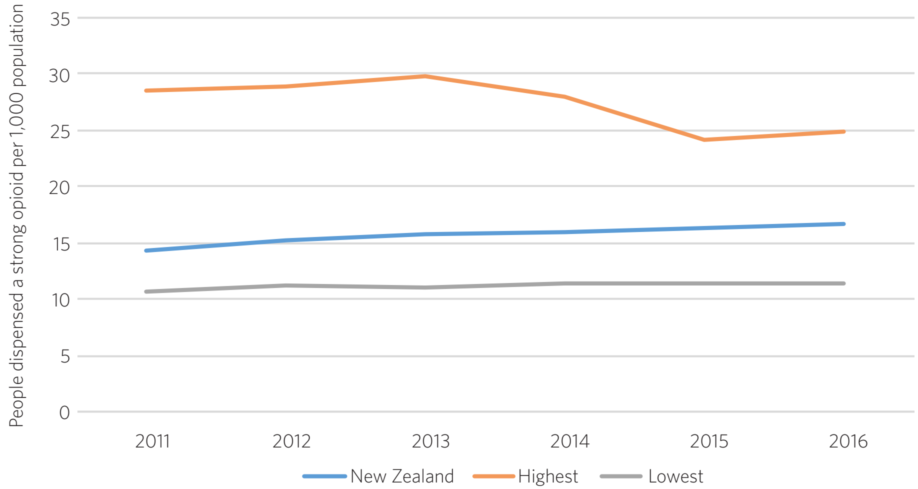


Figure 24: Total opioid consumption (morphine equivalence mg/capita), 2006–15 (sources: Pain & Policy Studies Group, University of Wisconsin; International Narcotics Control Board; World Health Organization)



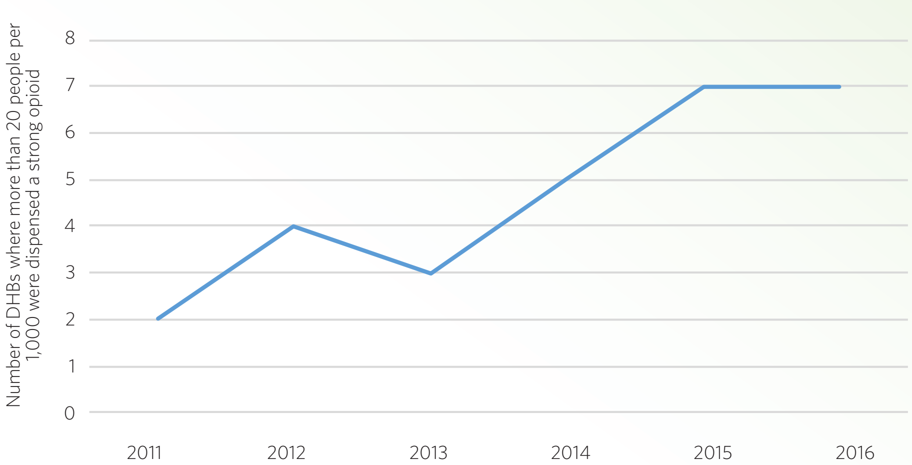
Although the number of New Zealanders being dispensed a strong opioid continues to increase, the highest rates in the country have reduced a little (as the orange line on Figure 25 shows)…

Figure 25: People dispensed a strong opioid per 1,000 population, highest and lowest DHBs, New Zealand, 2011–16



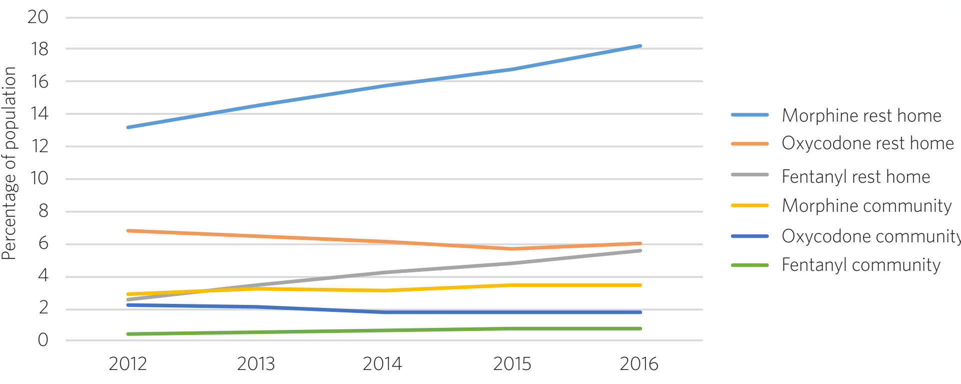
… but more DHBs have high dispensing rates. They are no longer outliers, because the number of DHBs with more than 20 people per 1,000 dispensed a strong opioid has nearly quadrupled in five years (see Figure 26)…

Figure 26: Number of DHBs where more than 20 people per 1,000 were dispensed a strong opioid, New Zealand, 2011–16



… and different patterns of dispensing seem to be emerging, including increased prescribing of morphine and fentanyl in rest homes (see Figure 27).

Figure 27: Dispensing of strong opioids by site of residence, New Zealand, 2012–16



In general, where the Commission has a quality improvement programme focused on a specific aspect of patient safety, improvements are seen in safe practice and patient outcomes. Many more issues of patient safety can, however, be tackled through national programmes.

Patient experience

Patient experience is an important part of quality of care. Providing a better experience, developing partnerships with patients, and patient and family/whānau-centred care are linked to improved health, clinical, satisfaction and financial outcomes.[9] To monitor this, the Commission conducts an inpatient experience survey and a primary care patient experience survey.

Results for the inpatient experience survey have been remarkably consistent over three-and-a-half years, as shown in Figure 28, which provides data for the whole country. The orange bars show the range of average national scores over the 14 iterations of the survey undertaken.

9 Balik B, Conway J, Zipperer L, et al. 2011. *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement. URL: www.ihi.org/resources/Pages/IHIWhitePapers/AchievingExceptionalPatientFamilyExperienceInpatientHospitalCareWhitePaper.aspx (accessed March 2018).

Figure 28: Variation in proportion of respondents giving the most positive response over time, inpatient experience survey, New Zealand, August 2014 to November 2017

Over that time, however, the variation between the best- and worst-scoring DHBs has been much greater, suggesting improvement is possible in at least some parts of the country (Figure 29). The orange bars in Figure 29 show the inter-DHB range of average results.

Figure 29: Variation in proportion of respondents giving the most positive response between DHBs, inpatient experience survey, New Zealand, average August 2014 to November 2017

Because considerable variation exists between DHBs, we should be able to see improvement for these questions in some areas over time.

The variation in the proportion of respondents agreeing that the hospital in which they were treated was 'very clean' is striking and concerning. This has potential links with control of infection, and other jurisdictions have seen significant improvement in this measure when concerted efforts have been made.

The consistent low scores for information about medication side effects hold over time and between DHBs, and are mirrored for primary care (see Figure 31). The Commission responded by commissioning research into how this could be, and in some cases has been, addressed. A range of potential approaches could do this, including improving discharge documentation and targeting medications with common or serious side effects.[10]

Both issues raise the question, however, of how best can we get improvement in responses to the survey results. This is an issue reflected on by the Commission's Director of Partners in Care below.

Drowning in data: Let's focus on some action

by Chris Walsh, Director, Partners in Care, Health Quality & Safety Commission

With over three years of data from the patient experience surveys in DHB inpatient services, we can be pretty sure of a few things. One, the lower-scoring areas haven't shifted nationally. Two, the variation in these scores between the best- and worst-scoring DHBs is wide. Three, this is a worry.

Why? Because good patient experience equates with better health outcomes, and because mediocrity is not good enough.

The lower-scoring areas are around communication about medication, how patients can manage their condition when they leave hospital and how families/whānau or someone close is involved in discussions about the patient's care.

All are critical to patient health and wellbeing.

What's to be done? Let's have a nationally based approach.

The national falls and infection prevention and control programmes have resulted in fewer falls and infections.

Maybe it's time to refresh our approach to targets and consider how this could be used to improve patient experience.

We first reported results from the primary care patient experience survey in December 2017.[11] Since then, uptake of the survey has increased considerably, with over half of all practices now undertaking it once a quarter. The most recent available quarter results are reported in this section.

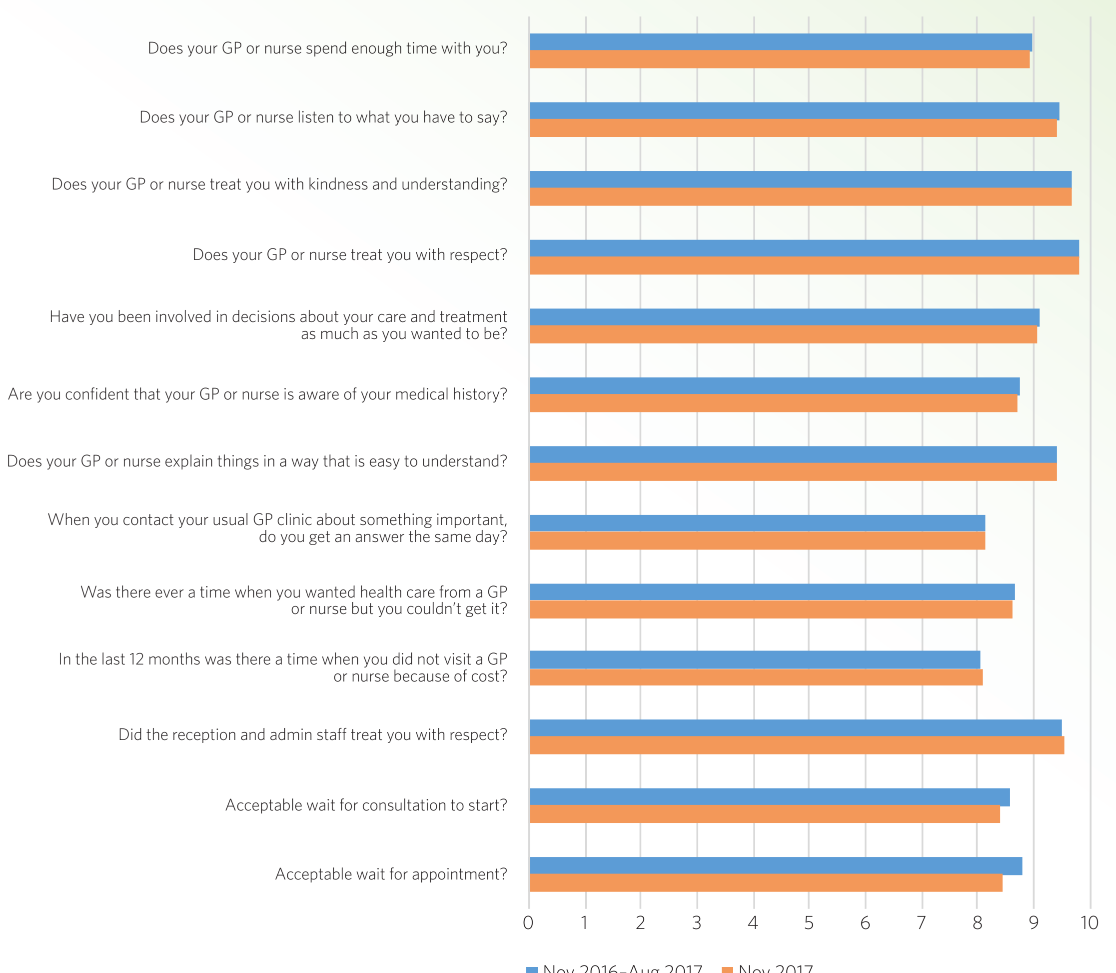
Despite the dramatic increase in uptake and much more widespread use of the survey, the responses have been remarkably consistent at a national level from the year 1 results reported in December 2017 (Figure 30; orange new and blue old).

Responses from the general practitioner (GP) surgeries are generally positive, for example, more than 85 percent of respondents felt wait times at the GP were acceptable. Even more positive results were evident for respect and kindness.

10 Health Quality & Safety Commission. 2017. *Raising the bar on the national patient experience survey: Report findings and recommendations.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/Consumer-Engagement/Publications/Raising_the_bar_on_the_National_Patient_Experience_Survey_-_May_2017.pdf (accessed 22 May 2018).

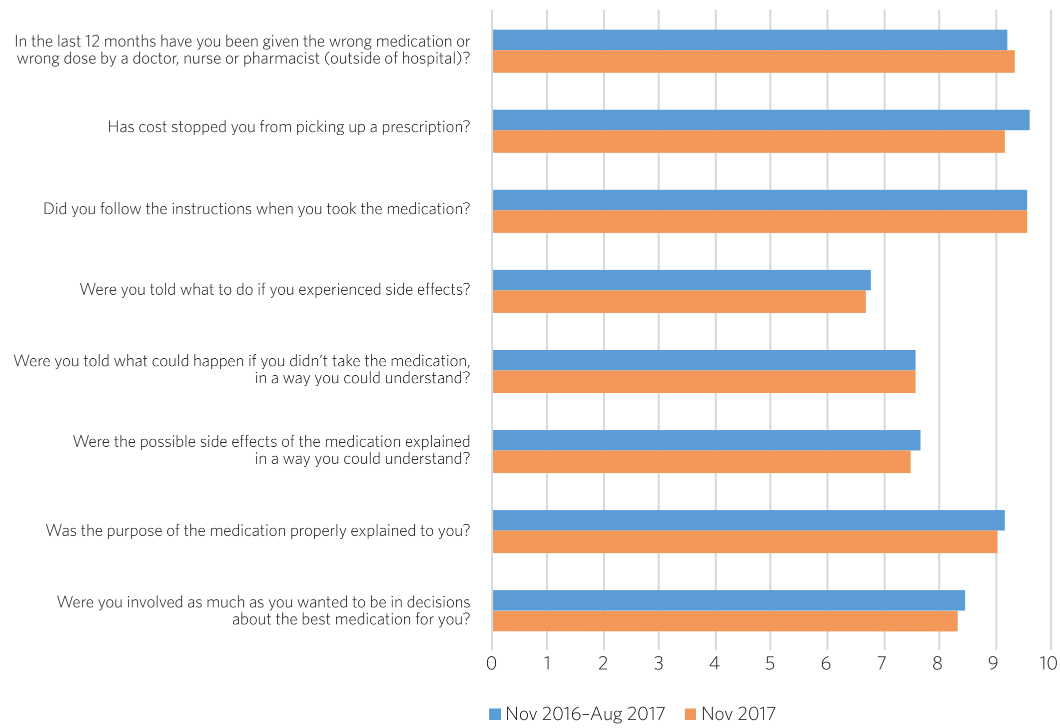
11 Health Quality & Safety Commission. 2017. *Primary care patient experience survey: Results from the first year of pilots.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Primary_care_experience_survey_report_Dec_2017_final.pdf (accessed 26 April 2018).

Figure 30: Average score out of 10 for questions about care in the GP practice, primary care patient experience survey, New Zealand, November 2016 to August 2017 compared with November 2017



However, results for medication are less positive. As first reported last year, around 8 percent of respondents noted some error in their medication (Figure 31).

Figure 31: Average score out of 10 for questions about medication, primary care patient experience survey, New Zealand, November 2016 to August 2017 compared with November 2017



The Commission is committed to ensuring patient experience is part of its measurement of health care quality and safety, because the evidence shows that patient experience is a good indicator of the quality of health services.

Effectiveness

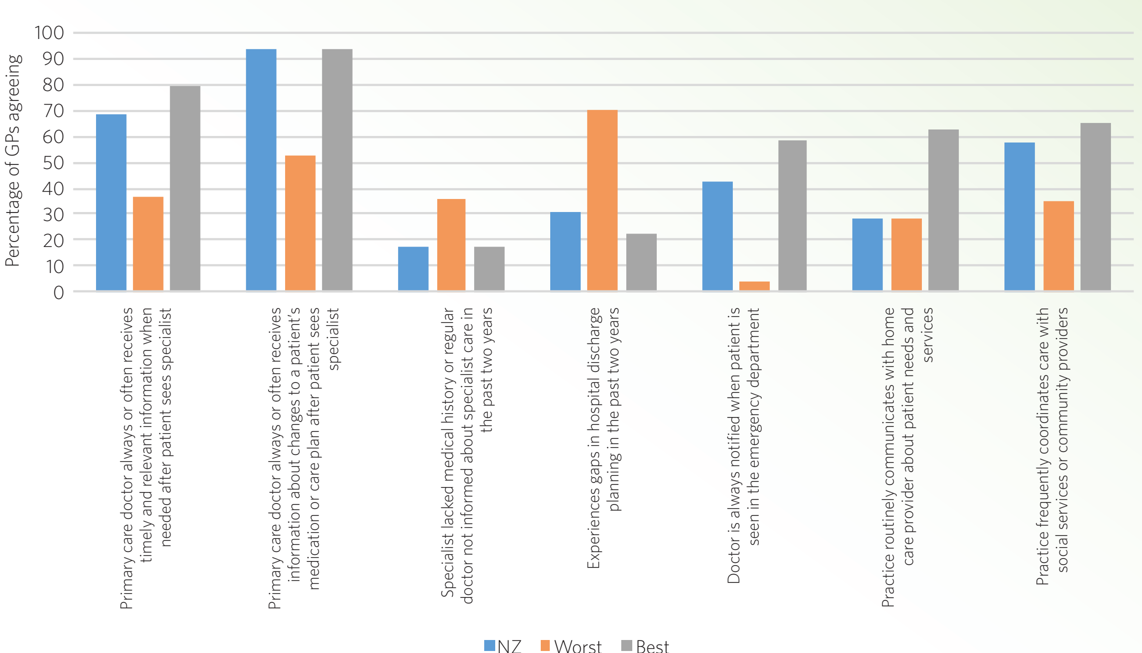
A high-quality health care system will provide the most effective treatment at the right time and in the right place. To review this, we can look at the ultimate outcomes of care, how well different health services are organised around the patient, and whether or not the right treatments are provided for individual conditions.

Care organised around the patient

A Commonwealth Fund survey of New Zealand GPs found that, while coordination of different parts of New Zealand's health care system tended to be better than similar countries, room for improvement remained (Figure 32).[12]

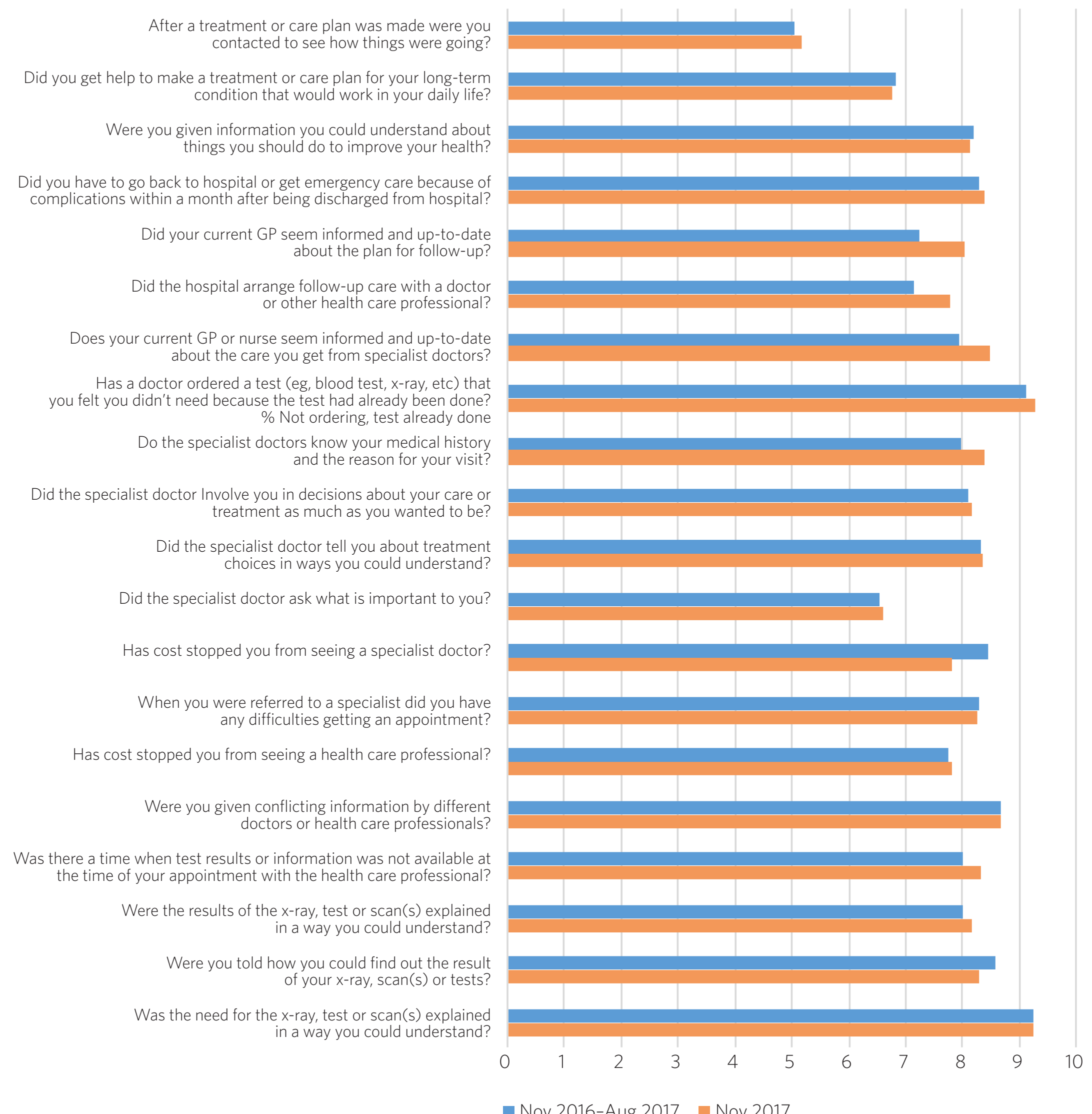
12 Schneider C, Sarnak D, Squires D, et al. (nd). *Mirror, Mirror 2017*. New York: The Commonwealth Fund. URL: www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017 (accessed 26 April 2018).

Figure 32: GP responses to queries about coordination of patient care across 11 countries, 2015 (percentage answering question with most positive answer) (source: Commonwealth Fund, *Mirror Mirror*)



The primary care patient experience survey asks a range of similar questions to the Commonwealth Fund survey. The results are broadly similar from the patient point of view (Figure 33).

Figure 33: Average score out of 10 for questions about interactions with other parts of the health system, primary care patient experience survey, New Zealand, November 2016 to August 2017 compared with November 2017



The consequences of better coordination should be reduced acute hospital bed-days, emergencies avoided and people being able to leave hospital more quickly because follow-up care is in place. Use of a System Level Measures Framework has encouraged many improvement programmes around the country designed to reduce acute hospital bed-days.[13] Encouragingly, improvements are evident, although they are not consistent across the country (Figure 34).

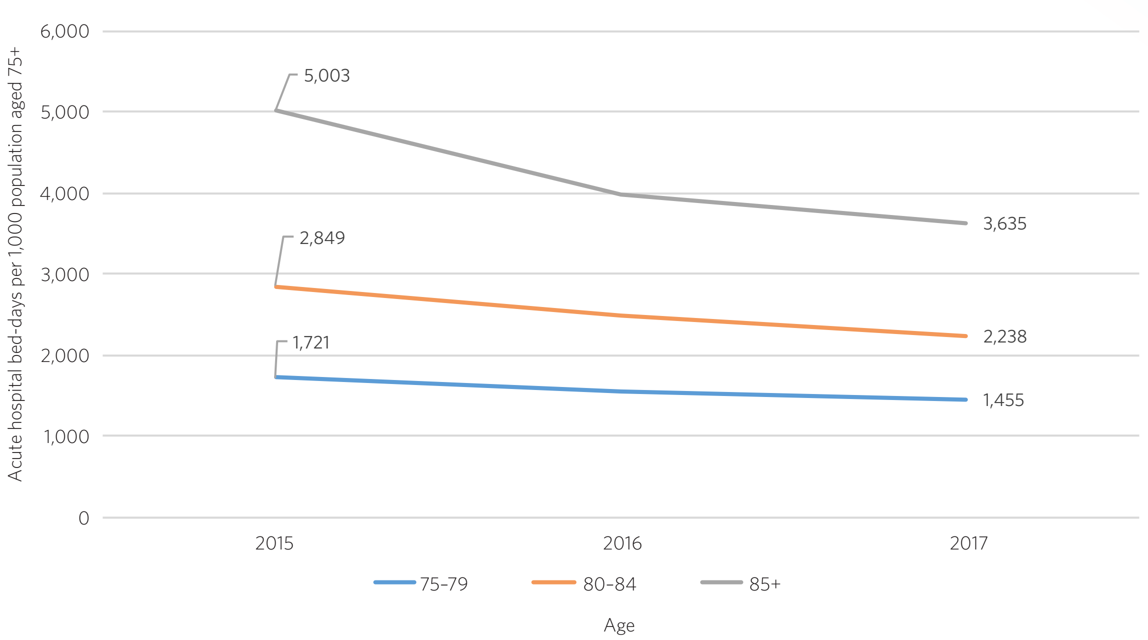
13 Ministry of Health. 2017. Nationwide Service Framework Library: System Level Measures Framework. Wellington: Ministry of Health. URLs: https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework and https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/data-support-system-level-measures/acute (accessed 18 May 2018).

Figure 34: Acute hospital bed-days per 1,000 population, New Zealand and highest and lowest DHBs, 2015–17

Acute hospital bed-days per 1,000 population
700
600
500
400
300
200
100
0
586
499
450
407
344
242
2015
2016
2017
New Zealand
Most acute bed-days
Fewest acute bed-days

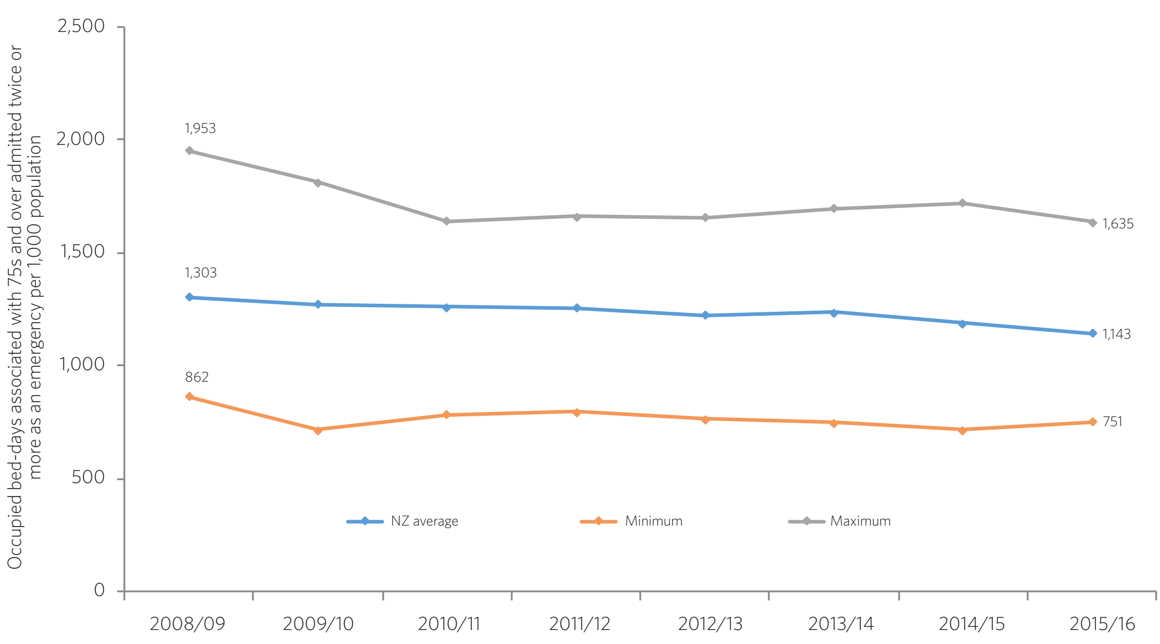
Eighty percent of this improvement can be attributed to reductions in acute hospital bed-days for people aged 75 and over (Figure 35).

Figure 35: Acute hospital bed-days per 1,000 population aged 75 and over, New Zealand, 2015–17



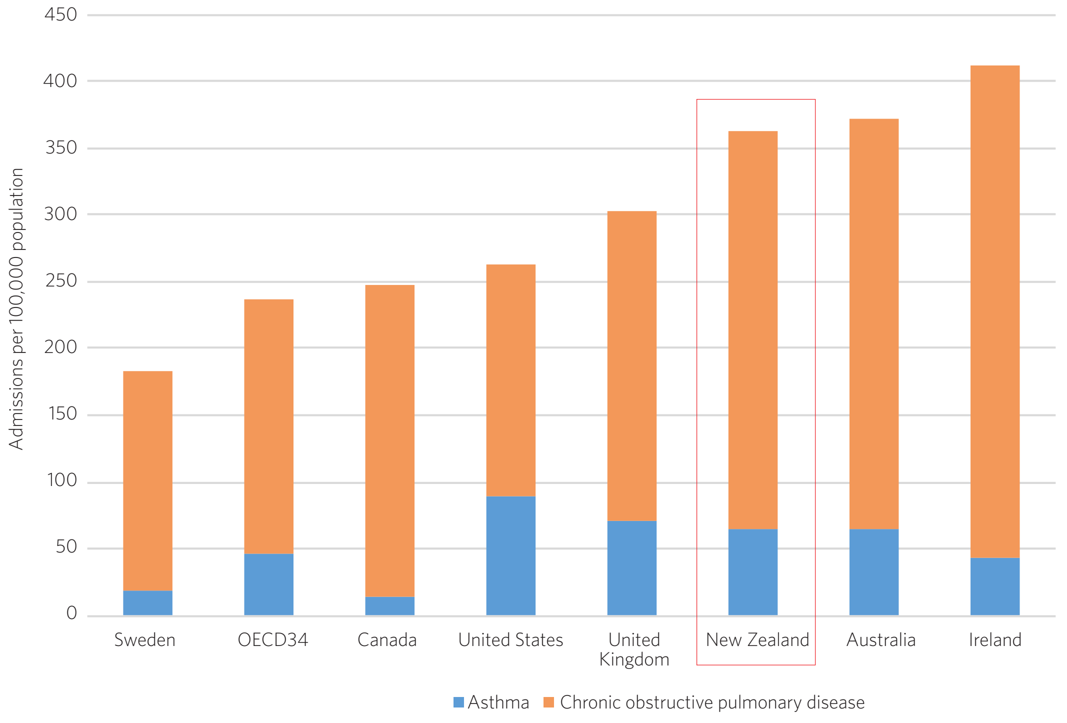
The reduction in acute bed-days occupied by older people is driven by an ongoing reduction in older people admitted more than once as an emergency, which is a marker of services not being well coordinated (although, again, variation is widespread around the country) (Figure 36).

Figure 36: Occupied bed-days associated with those aged 75 and over admitted twice or more as an emergency per 1,000 population, New Zealand and highest and lowest DHBs, 2008/09–2015/16



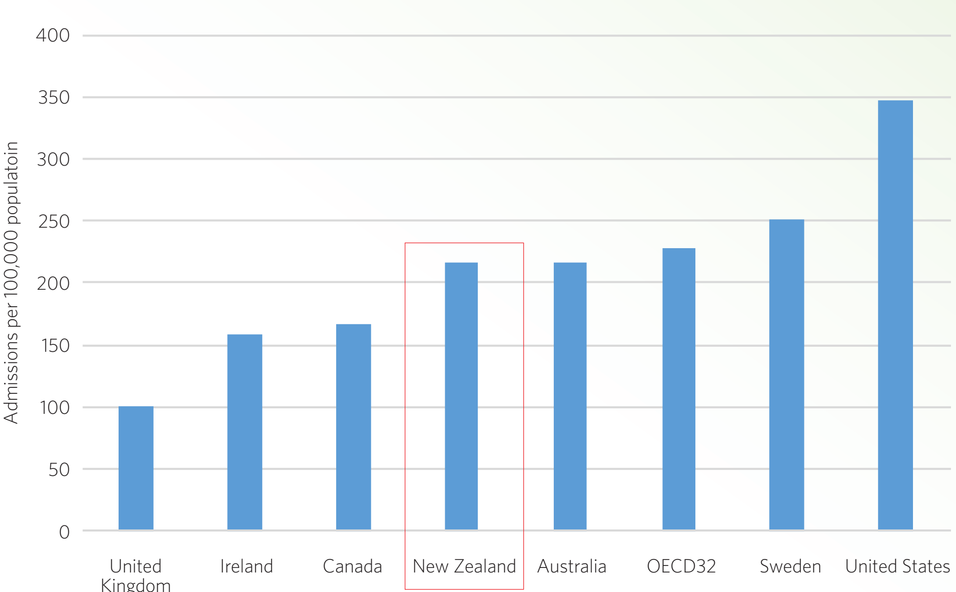
When looking at acute hospital bed-days associated with potentially preventable admissions, New Zealand's position is mixed. For asthma, and particularly chronic obstructive pulmonary disease, New Zealand's admission rates are high compared with other countries, as defined by the OECD (Figure 37).

Figure 37: Hospital admissions for asthma and chronic obstructive pulmonary disease per 100,000 population admission, OECD average and selected countries, 2015 (source: OECD)



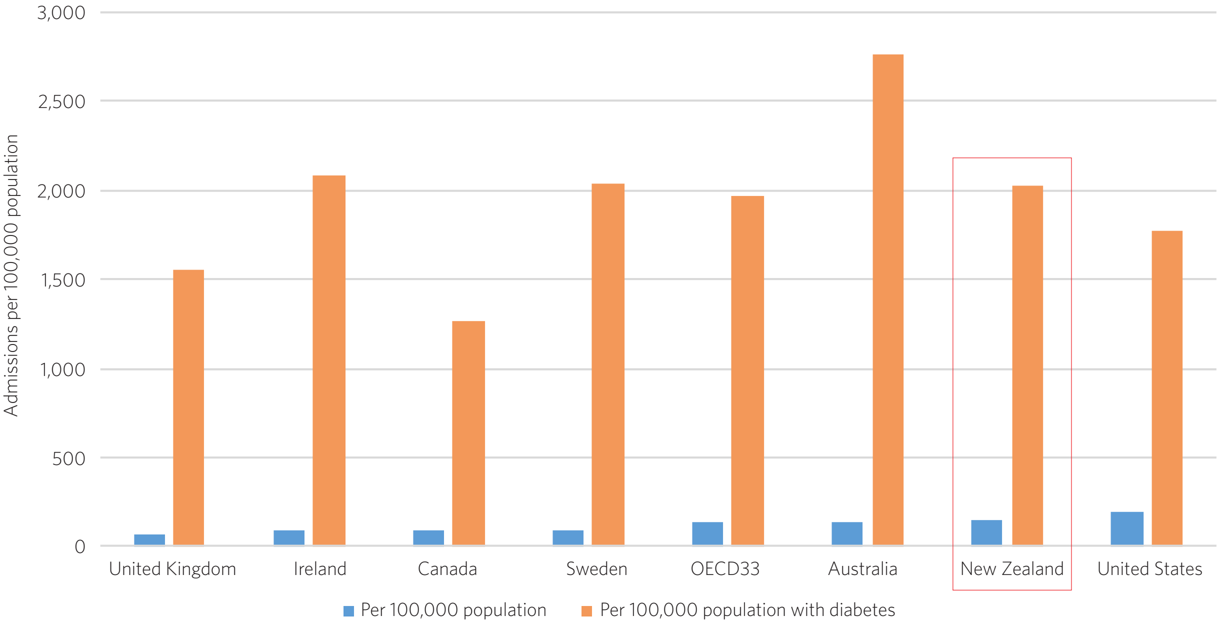
In contrast, admissions for congestive heart failure are more typical by international standards (Figure 38).

Figure 38: Hospital admissions for congestive heart failure, per 100,000 population, OECD average and selected countries, 2015 (source: OECD)



For diabetes, New Zealand's relatively high admission rate reflects the prevalence of diabetes in the community. However, effective community-based prevention and early treatment would reduce the need for in-hospital disease management.

Figure 39: Hospital admissions for diabetes per 100,000 population, and per 100,000 population with diabetes, OECD average and selected countries, 2015 (source: OECD)



To conclude, New Zealand has a relatively unified health care system, and this may be reflected in it appearing to be quite well coordinated compared with other health systems. Bed-days taken up by emergency admissions, which may be a result of failing to coordinate care well, have fallen by 12 percent since 2015. However, this is not uniform around the country or between conditions, and the capacity to improve still exists.

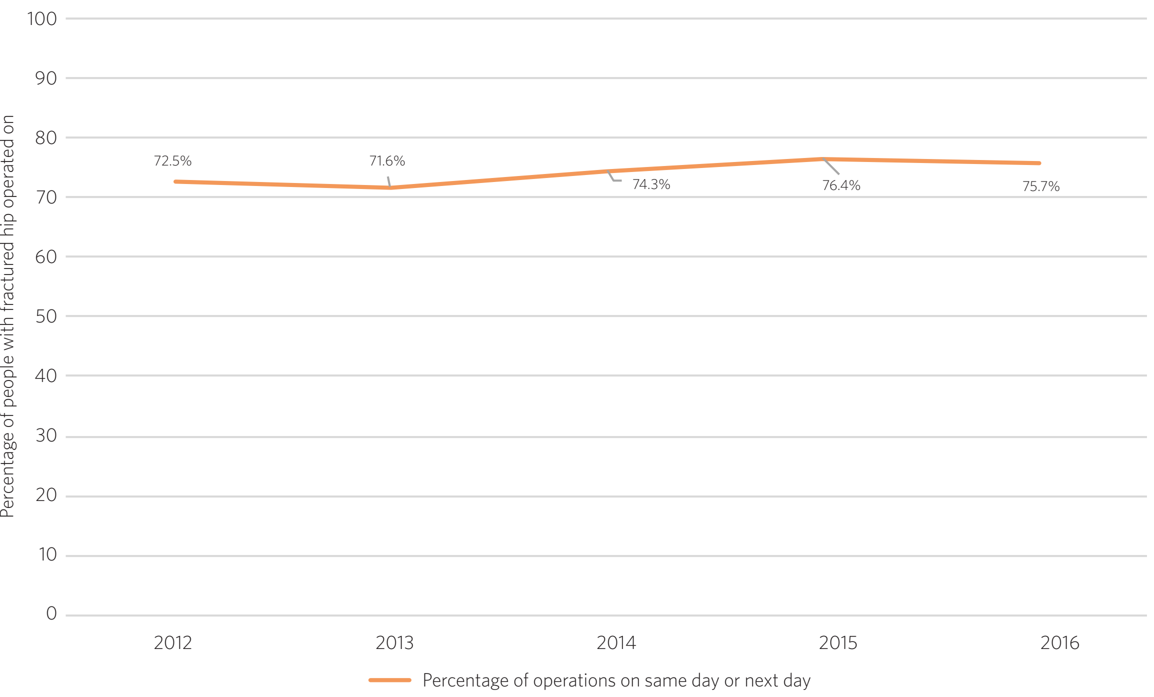
Doing the right thing

Looking at services in further detail, we can measure how widely good practice in the treatment of specific diseases has been adopted in New Zealand. The Atlas of Healthcare Variation now covers around 20 different diseases and patient groups, and shows a consistent pattern of variation that cannot be explained by patient needs and preferences. In this *Window*, we consider two examples: treatment of patients who break their hips and care of people with bowel cancer.

Fractured hip

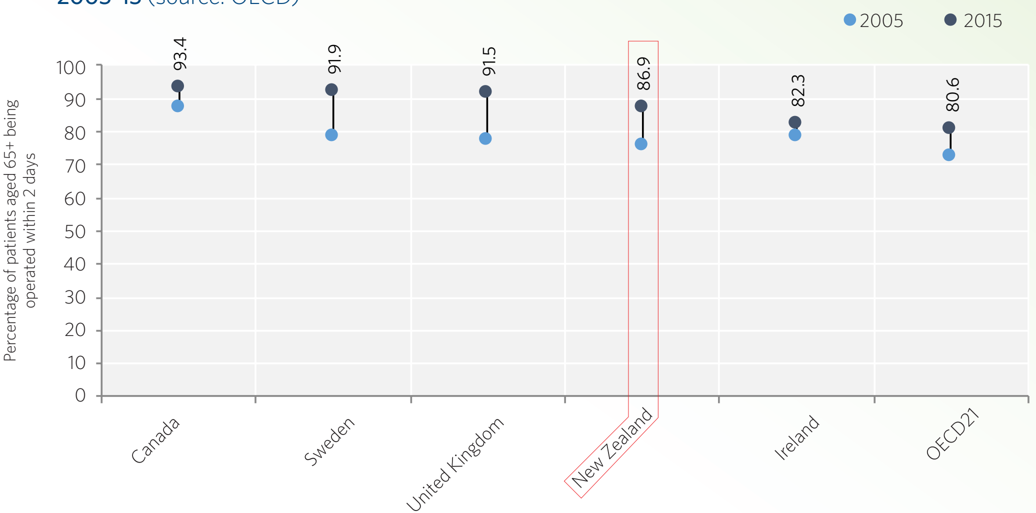
Around three-quarters of New Zealanders with a fractured hip have surgery on the day of admission or the day after, a timing associated with better outcomes. This has remained fairly consistent over the past five years (Figure 40).

Figure 40: Percentage of people with hip fracture operated on, on the day of admission or the day following, New Zealand, 2012–16 (source: Live stronger for longer)



Using the OECD's slightly different measure of operation on the day of admission or the next two days, New Zealand is reasonably typical of developed countries, and some improvement has occurred since 2005 (Figure 41).

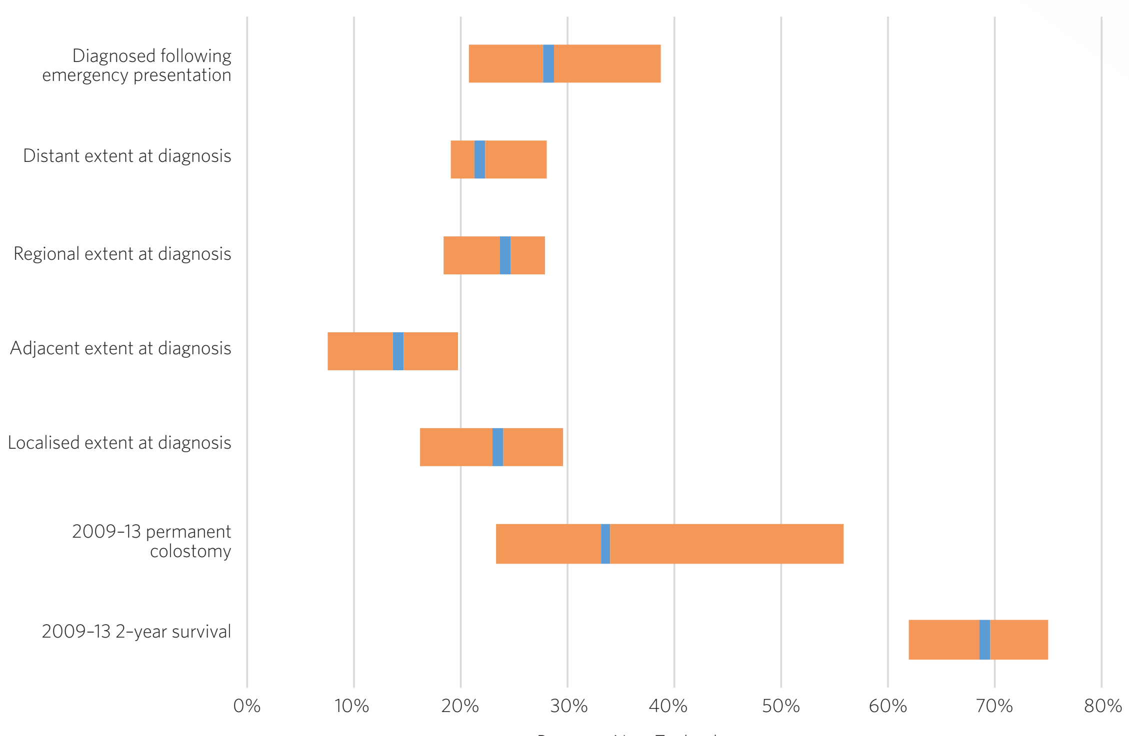
Figure 41: Percentage of people with hip fracture operated on within 0–2 days of admission, by OECD country, 2005–15 (source: OECD)



Bowel cancer

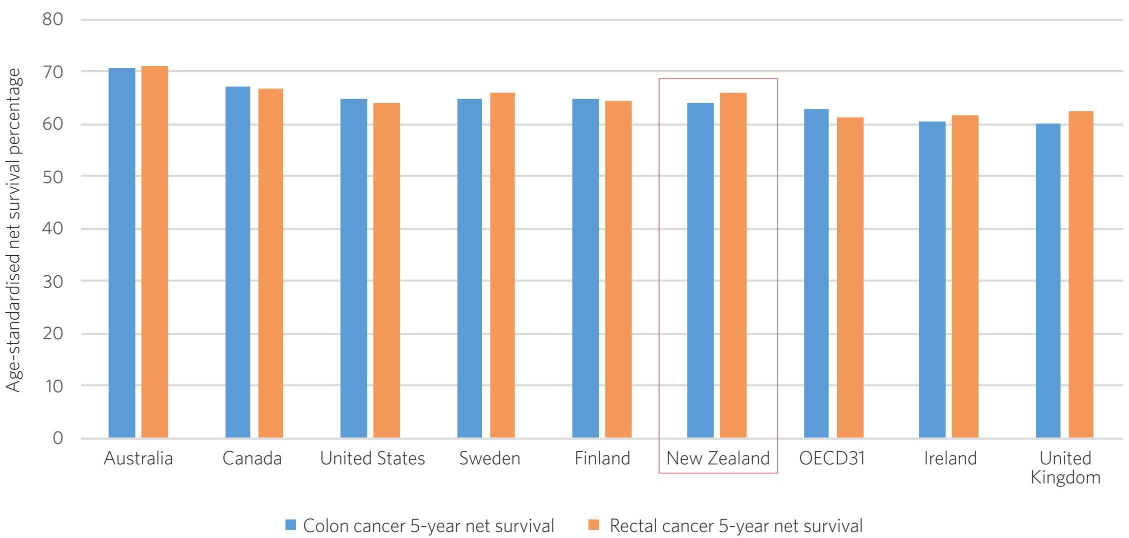
With bowel cancer, wide variation occurs between DHBs in when and where the cancer is identified and in the ultimate outcomes for patients (Figure 42).

Figure 42: Inter-DHB ranges in the percentage of people with a diagnosis of bowel cancer by diagnosis location and extent and outcomes, New Zealand, 2009–13



However, internationally, New Zealand is fairly typical, with a comparable five-year survival rate (Figure 43). On the other hand, we have fallen quite a long way behind Australia, and most New Zealanders would expect comparable outcomes with our nearest neighbour. Understanding these differences is complex. Potential drivers include how aggressively treatment is pursued for older populations, and the size of disadvantaged groups in the whole population.

Figure 43: Colon and rectal cancer five-year net survival, OECD average and selected countries, 2010–14 (source: OECD)



Most conditions would show a similar pattern. In general, patients in New Zealand receive the right treatment, and New Zealand's record is broadly in line with similar countries. The degree of variation between regions in New Zealand, however, shows that the right treatment is not universal, and some services are less likely to provide the right care and get such good outcomes. Further, the Atlas of Healthcare Variation shows there is no consistency in this pattern. No DHB is uniformly providing the best care or less good care across all patient groups.

2 Future safety of the system

Chapter 1 suggests New Zealand has a health system that is functioning reasonably well in comparison with other developed countries, but with some areas where improvement is still required. However, as this report has consistently identified since 2015, New Zealand faces issues of inequity and unwarranted variation in the provision of health care. Our health system's inability to address these issues matters. We cannot continue with current approaches and ignore the lack of progress in these important areas. We need to look for solutions, and although not all are to be found within health services, some are.

This is the first time the *Window* has looked both forward, towards future prospects, and backward at results achieved. Health systems are dynamic and can change quite rapidly. Because the most recent outcome data available is routinely 6–18 months out of date, usual *Window* results indicate how the system was performing at that time, rather than how it is performing now or will in the future. More 'leading indicators' are essential to fairly reflect the current situation and help to proactively avoid future harm. Leading indicators can point to areas of strain, even while lagging indicators remain robust.

The tension between looking forward and back is reflected in emerging new approaches to safety in health care, which emphasise the importance of proactive identification of problems (anticipation) and early system responses to resolve them.[14, 15, 16, 17] It is crucial to understand the past, but we also need to look to the future.

> Developing more anticipatory safety capability should be a strategic goal for departments, organisations and systems.[18] (p 29)

The dominant public narrative in New Zealand describes a health system under increasing pressure – even a casual observer of relevant media coverage would agree. How accurate is this story? It is not an exceptional one on an international level. To some extent, a similar narrative has surrounded nearly all developed nations' health systems for at least 30 years, and this seems unlikely to change soon. In this context, it is important to consider available leading indicators as to whether the pressures on New Zealand's health system are as serious as is implied. Succumbing to hyperbole is unwise, but so too is assuming any negative coverage is simply routine 'background noise'.

How do we look to the future?

Strengthening our ability to anticipate future issues for the health care system in New Zealand involves drawing on a wider range of techniques, tools and information than those we use when considering the past. As well as risk registers and other traditional organisational monitoring tools, peer review reports, service reviews, financial information, whistle-blowing, human resources, workforce information and formal investigations can all provide useful intelligence to help us anticipate and respond early to problems.[19] Both formal and informal information can be valuable, including what we think of as 'soft' intelligence, alongside robust data. Even informal conversations can be helpful for understanding emerging harm.[20]

Broadening our sources of information outside of health care alone can be useful for anticipating future issues. For example, major events taking place in a city can affect public transport demands, which may lead to access issues for those expected at appointments. Weather forecasting can also provide helpful early warning mechanisms. A large weather event may cause harm, creating subsequent higher demand for acute and emergency services. Obviously deprivation, particularly child poverty, is very important in this

14 Vincent CA, Aylin P, Franklin BD, et al. 2008. Is health care getting safer? *BMJ* 337: 1205–07.
15 Francis R. 2013. *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009*. London: Department of Health.
16 Vincent C, Burnett S, Carthey J. 2013. *The Measurement and Monitoring of Safety*. London: The Health Foundation. URL: www.health.org.uk/sites/health/files/TheMeasurementAndMonitoringOfSafety_fullversion.pdf (accessed 26 April 2018).
17 Machi L, Pietkainen E, Reiman T, et al. 2011. *Patient Safety Management: Available models and systems*. Finland: VTT.
18 The Health Foundation. 2016. *A Framework for Measuring and Monitoring Safety: A practical guide to using a new framework for measuring and monitoring safety in the NHS*. London: The Health Foundation.
19 OPM and wdid. 2017. *Measurement and Monitoring of Safety Framework e-Guide: Better questions, better care*. Bradford: The UK Improvement Alliance.
20 Waring J, Bishop S. 2010. "Water cooler" Learning: Knowledge sharing at the clinical "backstage" and its contribution to patient safety. *Journal of Health Organization and Management* 24(4): 325–42.

context. Social factors, such as family violence, crime, diet, exercise, smoking and excessive consumption of alcohol or drugs, can have a huge impact on health outcomes.[21]

Effectively anticipating issues involves sifting through various signals, which may or may not be important, to focus on those most likely to indicate a developing problem. Emerging safety issues can go unnoticed in busy health organisations and systems. Barriers to attending to warnings include the busy reality of work at the front line of health care, the profusion of information transmitted and received, and the challenge of distinguishing real signals from 'noise'. We need organised and systematic approaches to isolate and detect safety signals, so we can respond to the ones that are most important and accurate, enabling us to prevent emerging harm.[22, 23]

Chapter 1 shows that, in general, the New Zealand health care system appears to have been performing well. But we are not achieving equitable outcomes for all. We need to ask, what evidence do we have that our system will continue to perform as well as it does? Are early warning signals evident that we should be concerned about for the New Zealand health care system?

In this chapter, we have drawn on multiple sources of information to help us understand emerging and growing concerns. We use information from the OECD, Ministry of Health, Auditor-General, Health and Disability Commission, workforce unions, Central Technical Advisory Service (TAS), medical colleges (including the Royal Australasian College of Surgeons (RACS) and the Australian and New Zealand College of Anaesthetists (ANZCA)), and the Commission's own adverse events learning programme and culture survey work.

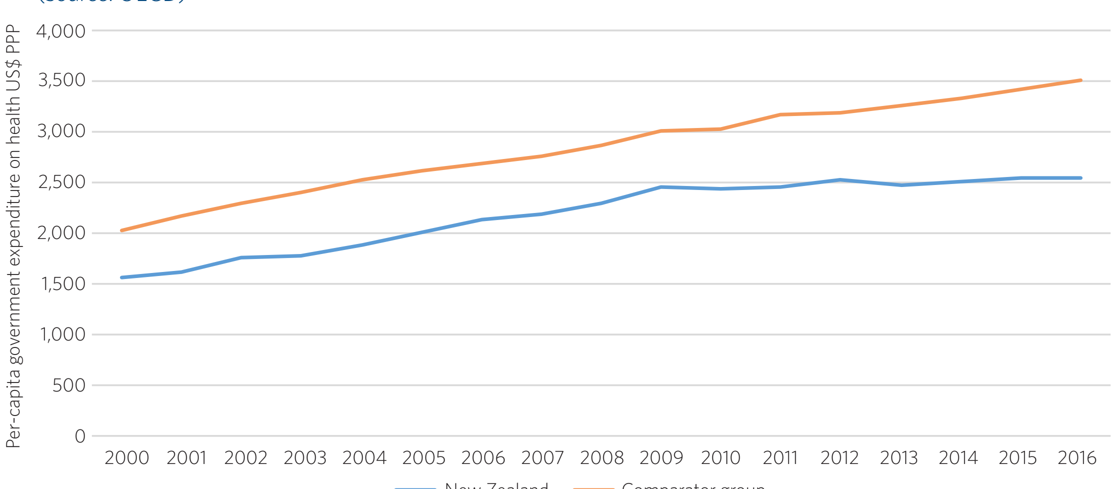
What are the possible 'early warning signals' that raise concern?

We are aware of areas of challenge within our health system, including financial pressure, workforce health and wellbeing, and changing patterns of safety that will need new approaches to resolve.

Financial pressures

A tightening fiscal environment, combined with an increasing number of DHBs in deficit, should be seen as an early warning signal for possible future quality, safety and sustainability issues. Prior to the 2018 budget, no real increase in funding had occurred for the health system for nearly 10 years. Following the global financial crisis, a long-term trend of growth in health spending came to a halt in New Zealand, as it did in countries in Western Europe and the rest of the English-speaking world. For most other countries, this constraint eased from 2011 onwards, but evidence shows this did not happen in New Zealand (see Figure 44). During this time, the population has increased and aged, so health care needs have increased in complexity. In this context, the allocation of additional funding to the health sector announced in the 2018 Budget will be welcomed.

Figure 44: Per-capita government expenditure on health US$ purchasing power parity (PPP), 2010 constant prices (source: OECD)

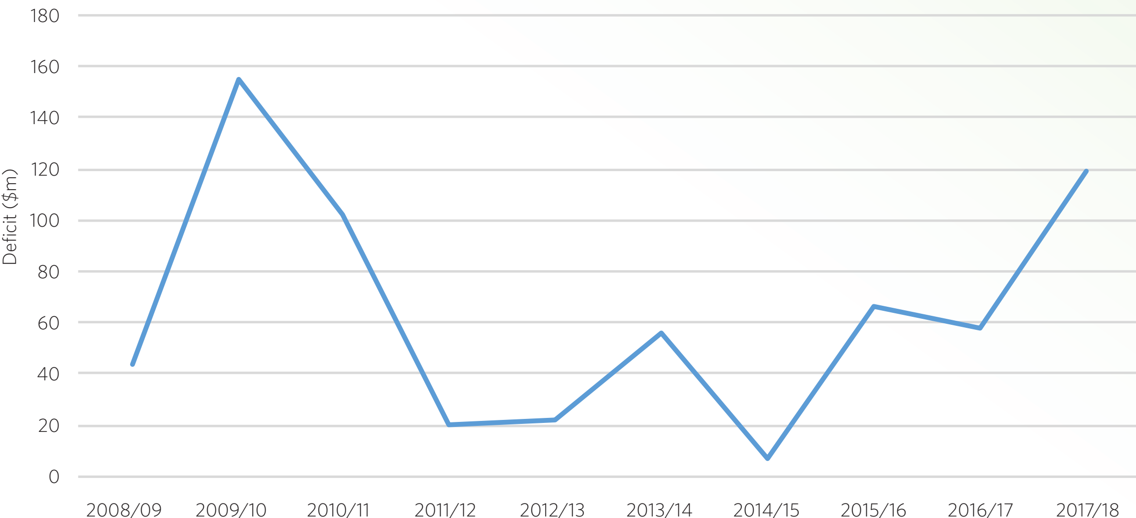


21 Family Violence Death Review Committee. 2016. *Fifth Report: January 2014 to December 2015*. Wellington: Family Violence Death Review Committee.
22 Canyon DV. 2012. The state of systemic threat surveillance in some Australian health organisations. *Journal of Business Continuity & Emergency Planning* 6(2): 102–10.
23 Macrae C. 2014. Early warnings, weak signals and learning from healthcare disasters. *BMJ Quality & Safety* 23(6): 440–5.

None of this is to deny the importance of spending money as wisely as possible (which is why reducing unwarranted variation in patterns of treatment is so important). However, long periods of no real growth in expenditure – while demand increases – create financial pressures on the system.

The reality of increasing financial instability is also demonstrated in the deficit position of DHBs, as reported in the New Zealand media and by the Ministry of Health to the Minister of Health.[24, 25] In its 2017 Briefing to the Incoming Minister, the Ministry highlighted the cost pressures of changing demographics, prices and patterns of illness. It noted that the track of DHB deficits (referring to the figure reproduced below as Figure 45) indicates efficiency gains are becoming increasingly difficult.[26]

Figure 45: Combined DHB deficits, New Zealand, 2008/09–2016/17 (source: Ministry of Health)



The Ministry of Health provides sector financial performance reporting to the Minister on a monthly basis. At February 2018, only three DHBs were on target with their budget expenditure for the month. Fourteen out of 20 DHBs are not expected to meet their forecast end-of-year results. The monthly report notes that the Ministry closely monitors and works with DHBs with unfavourable financial results to help them improve these results.[27]

In the 2014/15 health sector audits published in August 2016, the Auditor-General raised concerns about an increasing focus on short-term deliverables within DHBs, at the expense of other important objectives:[28]

> We saw indications in our 2014/15 audits that some DHBs are especially focused on achieving a particular financial result, and are basing their decisions on how they account for expenditure and revenue on this objective. This suggests that there is too much focus on the 'bottom line', which could detract from other important objectives, such as sound asset management and financial resilience.[29] (p 3)

24 Broughton C. 2017, 25 August. $117m deficit for Kiwi health boards more than double original forecast. *Stuff*. URL: www.stuff.co.nz/national/health/96144261/117m-deficit-for-Kiwi-health-boards-more-than-double-original-forecast (accessed 26 April 2018).
25 Williams K. 2017, 7 December. DHB deficits have leapt by $100m since May, Health Minister David Clark claims. *Stuff*. URL: www.stuff.co.nz/national/health/99633554/dhb-deficits-have-leapt-by-100m-since-may-health-minister-david-clark-claims (accessed 26 April 2018).
26 Ministry of Health. 2017. *Briefing to the Incoming Minister of Health, 2017: The New Zealand Health and Disability System***.** Wellington: Ministry of Health. URL: www.health.govt.nz/system/files/documents/publications/briefing-to-the-incoming-minister-of-health-2017-the-new-zealand-health-and-disability-system_0.pdf (accessed 26 April 2018).
27 Ministry of Health. (nd). *District Health Board Sector Financial Performance for year to date 28 February 2018*. Wellington: Ministry of Health. URL: www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/summary-financial-reports/dhb-sector-financial-reports-2017-18 (accessed 26 April 2018).
28 Controller and Auditor-General. 2016. *Health Sector: Results of the 2014/15 audits*. Wellington: Office of the Auditor-General. URL: www.oag.govt.nz/2016/health-audits/docs/health-audits.pdf (accessed 26 April 2018).
29 *Ibid*.

It is concerning that this pattern may also occur across the wider work of the DHBs. Important work that strengthens and safeguards the future of the health system (like better meeting the broader needs of patients, improving services or the system, or investing in necessary capital infrastructure) can become secondary to more immediate and narrowly defined targets. A focus on narrowly defined targets can be exacerbated by the directions, expectations and emphases of national agencies. Particularly in times of financial constraint, performance management approaches can have contradictory and perverse effects.[30, 31]

Health and wellbeing of the workforce

The health and wellbeing of the health sector workforce is a prerequisite for delivery of safe, effective services. Research from the United Kingdom has shown associations between staff unhappiness and negative experiences and reduced patient satisfaction.[32]

Low morale

The health workforce is increasing over time. Health Workforce New Zealand reports that, as at the end of March 2017, the DHB sector had 2,260 more medical employed full-time equivalents (FTEs) (a 38.1 percent increase) and 4,642 more nursing employed FTEs (a 23.5 percent increase) than at 30 November 2008.[33] The Ministry of Health's monthly report to the Minister for the 2017 calendar year tells a similar story of increasing staffing.[34]

However, several health workforce unions highlight membership surveys that raise concerns about staff shortages,[35, 36] staff health and wellbeing,[37] declining morale[38] and high levels of stress and depression[39] within their workforce groups.

Government agencies and DHBs are working on specific initiatives to improve workforce wellbeing.

- TAS has been actively working with DHBs to develop policies and practices to support staff happiness and wellbeing. TAS has partnered with DHBs and unions to provide a 'Wellbeing for Health' website that serves as a central repository for information and resource sharing on workforce issues for DHBs.[40] Topics covered include: culture and values; communication and engagement; better work practices; leadership; and personal and mental health.

30 National Advisory Group on the Safety of Patients in England. 2013. *A Promise to Learn – A Commitment to Act: Improving the safety of patients in England*. URL: www.gov.uk/government/publications/berwick-review-into-patient-safety (accessed 26 April 2018).
31 Barber, M. 2015. *How to Run a Government: So that citizens benefit and taxpayers don't go crazy*. London: Penguin.
32 NHS England. 2018. *Links between NHS Staff Experience and Patient Satisfaction: Analysis of surveys from 2014 and 2015*. URL: www.england.nhs.uk/wp-content/uploads/2018/02/links-between-nhs-staff-experience-and-patient-satisfaction-1.pdf (accessed 26 April 2018).
33 Ministry of Health. 2017. *District Health Board Clinical Staffing Numbers (March 2017)*. Wellington: Ministry of Health. URL: www.health.govt.nz/system/files/documents/pages/dhb-clinical-staffing-numbers-mar2017.docx (accessed 26 April 2018).
34 Ministry of Health. 2017. *District Health Board Sector Financial Performance for Year Ended 31 December 2017*. Wellington: Ministry of Health. URL: www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/summary-financial-reports/dhb-sector-financial-reports-2017-18 (accessed 26 April 2018).
35 Association of Salaried Medical Specialists. 2017. *Briefing to the Minister of Health, October 2017*. Wellington: Association of Salaried Medical Specialists. URL: www.asms.org.nz/wp-content/uploads/2017/11/BIM-2017_168920.6.pdf (accessed 26 April 2018).
36 New Zealand Nurses Organisation. 2017. *NZNO Research Employment Survey 2017: Our Nursing Workforce: Resilience in adversity*. URL: www.nzno.org.nz/Portals/0/publications/Research%20report%20-%20Employment%20Survey,%202017.pdf (accessed 26 April 2018).
37 Association of Salaried Medical Specialists 2017, *op. cit.*
38 New Zealand Nurses Organisation 2017, *op. cit.*
39 Dixon L, Guilliland K, Pallant J, et al. 2017. The emotional wellbeing of New Zealand midwives: Comparing responses for midwives in caseloading and shift work settings. *New Zealand College of Midwives Journal* 53.
40 Wellbeing for Health. (nd). URL: https://wellbeingforhealth.nz (accessed 17 May 2018).

Kath Cook, chair of the 20 DHB Chief Executive Officers Group

> All of us who work in health have an interest in creating work environments that enable us to be our very best. Workplaces that prioritise wellbeing have better engagement, higher productivity and reduced absenteeism. We are keen to share resources that enable this to happen and this website is an opportunity to introduce, or strengthen, practices and policies that will lead to improved wellbeing. We are pleased to be working in partnership with our union colleagues so that we can make the greatest difference in having healthy and thriving environments for ourselves and ultimately, those we provide care to.

Wellbeing for Health. URL: https://wellbeingforhealth.nz/about-wellbeing-for-health.

- Individual DHBs have a range of programmes and activities underway to create healthy workplaces, and a number have created roles specifically to work on this goal.
- On 23 January 2018, Health Workforce New Zealand announced its commitment to developing an updated national health workforce strategic plan, in collaboration with the sector and consumers. It is expected the strategic plan will be published by the end of 2018.[41]

Sick leave patterns

Internationally, sick leave is seen as an indicator of the wellbeing of the workforce.[42]

Since January 2016, TAS has tracked average annualised sick leave taken by the health workforce in New Zealand on a quarterly basis, and has published this information. The Commission has not been able to locate a central record of information on health sector workforce sick leave prior to 2016, so we have been unable to consider changing patterns of sick leave across time in this edition of *Window*. However, Figure 46 shows the average annualised sick leave hours of occupational groups for the years to 31 December 2016 and 2017. In 2017, care and support workers took the most hours of sick leave, at 89.6 hours on average per FTE for the year. Midwives, on average, took 85.3 hours per FTE and nurses took 81.6 hours per FTE. Average annualised sick leave patterns are similar across the two years.[43]

While we cannot compare across time beyond the two years of data we have, we can look internationally. We note these levels of sick leave are comparable with those seen in the United Kingdom's National Health Service.[44]

41 Ministry of Health. (nd). *Health Workforce Strategic Plan*. Wellington: Ministry of Health. URL: www.health.govt.nz/our-work/health-workforce/health-workforce-strategic-plan (accessed 17 May 2018).
42 Kuoppala J, Lamminpää A, Väänänen-Tomppo I, et al. 2011. Employee well-being and sick leave, occupational accident, and disability pension: A cohort study of civil servants. *Journal of Occupational and Environmental Medicine* 53(6): 633–40. URL: www.researchgate.net/publication/51202541_Employee_Wellbeing_and_Sick_Leave_Occupational_ Accident_and_Disability_Pension (accessed 15 May 2018).
43 Technical Advisory Services. (nd). *District Health Board Employed Workforce Quarterly Report to 31 December 2016* (page 17). Wellington: TAS. URL: https://tas.health.nz/strategic-workforce-services/health-workforce-information-programme-hwip/ (accessed 8 May 2018).
44 Quality Watch. (nd). *NHS Staff Sickness Absence*. London: Nuffield Trust and the Health Foundation. URL: www.qualitywatch.org.uk/indicator/nhs-staff-sickness-absence (accessed 26 April 2018).

Figure 46: Average annualised sick leave hours per FTE for workforce occupational groups in New Zealand, for the years to 31 December 2016 and 2017 (source: TAS)[45, 46]

Average annualised sick leave hours per FTE
100
90
80
70
60
50
40
30
20
10
0
Nurses
Corporate and other
Allied and scientific
Care and support
Senior medical
Junior medical
Midwifery
2016
2017

Rates of sick leave taken by junior and senior medical staff (25.2 hours and 34.7 hours per FTE for the 2017 year, respectively) are low, compared with care and support workers, nurses and midwives.

In its Briefing to the Incoming Minister, the Association of Salaried Medical Specialists raised concerns about senior doctors working through illness, based on an earlier membership survey.[47, 48] Sick leave patterns reported by TAS (Figure 46) may be interpreted as indicating that junior medical staff may be present, despite illness, to an even greater degree than their more senior colleagues.

> The term sickness presenteeism (SP) has been described as the act of going to work despite having a state of health that may be regarded as poor enough to justify sick leave. SP has been observed to be prevalent among three-quarters of health care providers (HCPs). Working while sick not only puts patients at risk but also decreases productivity and increases the probability of medical errors. Moreover, SP has been identified as a risk factor for many negative health outcomes among the HCPs themselves, such as depression, burnout, and serious cardiac events.[49] (p 711)

Both high and low levels of sick leave can be of concern, if staff morale is in question. The Commission will continue to consider sick leave over time.

Bullying

RACS and ANZCA have published reports expressing concerns about levels of bullying in the New Zealand health workforce. Concerns are also evident in Australia and internationally, as jurisdictions recognise the importance of the health workforce and the centrality of the role in delivering the best possible care to patients. Bullying is also a matter of concern in other professions, such as law, and in the workforce more generally.

45 Technical Advisory Services. (nd). *District Health Board Employed Workforce Quarterly Report to 31 December 2017* (page 17). Wellington: TAS. URL: https://tas.health.nz/assets/SWS/HWIP/DHB-Employed-Workforce-Quarterly-Report-December-2017.pdf (accessed 26 April 2018).
46 Technical Advisory Services. (nd). *District Health Board Employed Workforce Quarterly Report to 31 December 2016* (page 17). Wellington: TAS. URL: https://tas.health.nz/strategic-workforce-services/health-workforce-information-programme-hwip/ (accessed 8 May 2018).
47 Association of Salaried Medical Specialists 2017, *op. cit.*
48 Chambers C. 2015. Superheroes don't take sick leave: Presenteeism in the New Zealand senior medical workforce – a mixed method study. *ASMS Health Dialogue* 11.
49 Al Nuhait M, Al Harbia K, Bustami R, et al. 2017. Sickness presenteeism among health care providers in an academic tertiary care center in Riyadh. *Journal of Infection and Public Health* 10(6): 711–15.

- In 2015, RACS published a report from its expert advisory group on discrimination, bullying and sexual harassment in surgery in Australia and New Zealand.[50] The advisory group found 49 percent of fellows, trainees and international medical graduates reported being subjected to discrimination, bullying or sexual harassment. Also, 71 percent of hospitals reported discrimination, bullying or sexual harassment by a surgeon in their hospital in the past five years, with bullying the most frequently reported issue. The report highlighted that:

  > Bullying is endemic in surgery; common in training and the surgical workplace; and central to the culture of surgery.[51] (p 5)

  RACS introduced an action plan in 2015, with the goal of changing behaviours that are bad for individuals, impair teams and put patient care and safety at risk.[52] In June 2016, ANZCA and RACS agreed to work together to explore further opportunities to address discrimination, bullying and sexual harassment.[53]

- ANZCA has established a bullying, discrimination and sexual harassment (BDSH) working group to address these concerns. The *BDSH Working Group Report 2017* highlights the results of a survey of ANZCA trainees completed in 2016. Across Australia and New Zealand, New Zealand has the highest percentage of survey respondents that report having personally experienced workplace bullying (43 percent) and having witnessed workplace bullying (66 percent). The report also reflects that New Zealand survey respondents reported knowing how to report or seek help for bullying, discrimination or sexual harassment, across all the contexts considered (hospital department, hospital, college, and through outside bodies), less than any of the other five comparator areas across Australasia.[54]

Clinical governance and safety culture slow to progress

In 2017, the Commission supported the repeat of a 2012 DHB workforce clinical governance and safety culture survey, using the same methodology and many of the same questions that had been previously asked in 2012. The response rate was 18.4 percent, compared with 25 percent in 2012.[55]

In 2012, the largest-ever health workforce survey was undertaken by the Commission, Ministry of Health and DHBs in partnership with the University of Otago, focusing on assessing clinical governance culture in DHBs.[56] All registered DHB health professionals working across New Zealand were invited to participate. The 2012 survey had a response rate of 25 percent.

The survey was repeated in December 2017, achieving a response rate of 18.4 percent. The work was commissioned from the University of Otago, by the Commission. The survey was undertaken and the report has been written by Professor Robin Gauld (Pro-Vice-Chancellor and Dean, Otago Business School, University of Otago) and Dr Simon Horsburgh (Senior Lecturer in Epidemiology, Department of Preventive and Social Medicine, University of Otago). The report, due to be published at a similar time to this *Window*, highlights that change in staff perceptions about clinical governance from 2012 to 2017 is limited.

The 2017 survey found, in comparison to 2012, there were small increases in the percentage of respondents who:

- were familiar with the concept of clinical leadership and decision-making
- perceived DHBs had sought to foster clinical leadership

50 Expert Advisory Group on Discrimination, Bullying and Sexual Harassment. 2015. *Report to the Royal Australasian College of Surgeons*. Melbourne: RACS. URL: www.surgeons.org/media/22086656/EAG-Report-to-RACS-FINAL-28-September-2015-.pdf (accessed 26 April 2018).
51 *Ibid.*
52 Royal Australasian College of Surgeons. 2015. *Building Respect, Improving Patient Safety: RACS action plan on discrimination, bullying and sexual harassment in the practice of surgery*. Melbourne: RACS. URL: www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf (accessed 26 April 2018).
53 Australian and New Zealand College of Anaesthetists. 2017. *ANZCA Bullying, Discrimination and Sexual Harassment Working Group Report – 2017*. Wellington: ANZCA. URL: www.anzca.edu.au/documents/comms_bdsh-wg-report_20170219.pdf (accessed 26 April 2018).
54 *Ibid.*
55 Gauld R, Horsburgh S. 2018. *Health professionals' perceptions of clinical governance and the quality and safety environment in DHBs* (unpublished draft report).
56 Gauld R, Horsburgh S. 2013. *Clinical Governance Assessment Project. Final Report on a National Health Professional Survey and Site Visits to 19 New Zealand DHBs*. Dunedin: Centre for Health Systems, University of Otago. URL: https://www.hqsc.govt.nz/assets/General-NEMR-files-images-/clinical-governance-final-report.pdf (accessed 1 June 2018).

- believed health professionals in their DHB involved patients and families in improving patient care
- thought their DHB had an established governance structure that ensured a partnership between health professionals and management.

However, there were small declines in the percentage of respondents reporting:

- staff involvement in changing the system to benefit patients
- that their DHB sought to give responsibility to their team for clinical service decision-making
- that it was easy to speak up if they perceived a problem with patient care.

There was little change in the percentage of respondents who:

- believed their DHB had worked to enable strong clinical leadership
- thought health professionals in their DHB worked together as a well-coordinated team.

Most DHBs had mixed results, with some improvement and some declines over the series of questions asked. The variation in response across DHBs on any given question is notable as well as variation in response within many DHBs on different questions. This pattern of variation suggests improvement is possible in a number of DHBs.

Key findings highlighted in the report of the 2017 survey are that:

- progress on questions asked in 2012 has been limited; in many cases, respondents are less positive than they were in 2012
- the findings have implications for health sector policy, governance and management as well as for health professionals
- in particular, there may be a need to refresh the emphasis on clinical governance and aspects of the quality and safety environment nationally and within DHBs.

The study found limited progress had been made since 2012 in terms of how staff perceive clinical governance and safety culture in their organisations and services. While slight progress was made in some areas, in many cases, respondents were less positive than they were in 2012. Responses also varied across DHBs, with some having a considerable decline in staff perceptions in some areas since 2012.

In the 2017 clinical governance survey, participants were asked about their agreement with the statement 'In this clinical area, it is easy to speak up if I perceive a problem with care'. Results were compared with 2012. In the 2017 survey, five DHBs had a statistically significant decrease in staff agreeing to the statement, compared with 2012.

The results from the 2017 survey suggest that an increased focus on clinical governance and safety culture is required, into the future, if we want to see improvement.

Another DHB staff survey undertaken by the Commission in late 2017 focused on the area of patient deterioration. A draft report is in development.[57] The survey found that staff find the national patient deterioration recognition and response system useful, in particular because it enables and empowers staff to escalate their concerns to those more senior.

> The more confident a recogniser is, the less likely they are to hesitate to escalate care and the less likely they are to seek a second opinion about escalating care when escalation trigger points are reached. We also heard that some recognisers might not, or might hesitate to, escalate care because they were afraid of how responders might react. Being able to draw on the nationally and locally mandated recognition and response system helps address some of these issues (a sense of lack of support and/or fear of being blamed or reprimanded).[58] (p 56)

Similarly, how much a responder trusts and respects their colleagues influences how they respond to escalation.

57 Point Research. 2018. *All DHBs staff survey for the patient deterioration programme: Draft for HQSC review* (unpublished draft report).
58 *Ibid.*

> How supportive a responder is of a decision to escalate care is strongly correlated with how likely they are to respond within response protocol timeframes. Responders' support for a decision to escalate care is affected by the extent to which they 'trust' the recogniser's judgement that a response is in fact urgently needed.[59] (p 56)

These results suggest further work is required to create working environments where 'it's okay to ask for help'.

Safety

Chapter 1 has shown that clear improvements have been made in specific areas of harm that can be addressed within organisational boundaries. However, changing patterns of adverse events reporting and consumer complaints reflect harm from cross-boundary and system issues that are complex and that will require organisational collaboration to resolve.

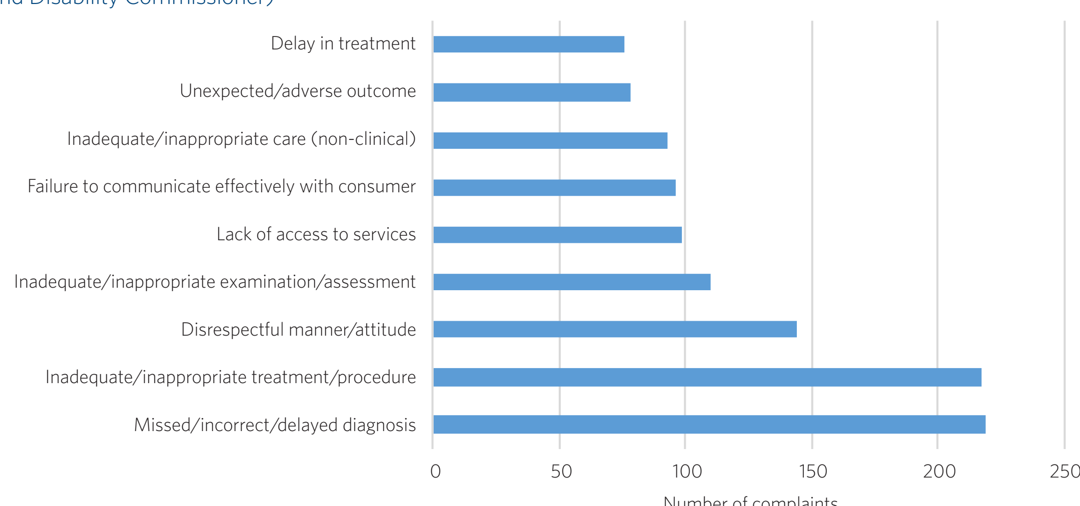
Growing complexity in adverse events and complaints

The balance of harm being reported through the Commission's adverse events learning programme is shifting over time, from the relatively straightforward to the more complex. 'Clinical management events', which tend to have a combination of causes and require complex, multi-system, cross-boundary resolution, are now the most common type of adverse event reported by DHBs to the Commission (52 percent). In contrast, the number of falls reported has dropped. Falls have been addressed, to a great degree, within the boundary of a particular service or organisation, through clinical practice improvement, with support from the Commission's falls quality improvement programme.

Complaints to the Health and Disability Commissioner also highlight a variety of complex issues. Figure 47 reflects the most commonly received complaints in 2016/17, which are reasonably consistent across recent years.[60] The themes of delays (diagnosis, treatment and assessment) and unexpected or adverse outcomes from treatment are common across both events reported to the Commission from the health sector and in consumer complaints made to the Health and Disability Commissioner.

To address much of the harm reflected in these adverse events and complaints, organisations will need to work across their boundaries, and national agencies will need to collaborate to find system-level resolutions. This can be challenging if organisations are under financial stress and performance expectations encourage a focus on their core business ('doing it right') and not beyond it ('doing the right thing').

Figure 47: Health and Disability Commissioner complaints by category, New Zealand, 2016/17 (source: Health and Disability Commissioner)



59 *Ibid.*
60 Health and Disability Commissioner. 2017. *Annual Report for the Year Ended 30 June 2017*. Wellington: Health and Disability Commissioner. URL: www.hdc.org.nz/media/4540/hdc-annual-report-for-the-year-ending-june-2017.pdf (accessed 26 April 2018).

Addressing the complex issues: A case study of change in ophthalmology services

The Commission's *Learning from adverse events 2015–16* report[61] identified increased reporting of adverse events in ophthalmology services and delays in access to follow-up care.

The increase in adverse events reflected pressures from increased demand driven by both an ageing population and the availability of new treatments, such as Avastin injections. These new treatments offered benefits for conditions that were previously difficult to treat, but they required frequent follow-up appointments.

Quality improvement science teaches a systems approach; to measure and monitor any new change we introduce, to avoid unintended consequences.

Avastin was introduced in different ways in different parts of the country, with no national systems approach.

Consequently, local services responded variably to the demand pressures, with different processes, planning and models of care. The unintended result was delays in follow up in some DHBs, leading to loss of vision or blindness for a small number of people. Some DHBs responded well at a local level and avoided harm. However, their local experience and learning was not initially shared nationally.

Since the publication of the Commission's report, various clinical groups, professional bodies, DHB management and the Ministry of Health have worked collaboratively to develop solutions. Work to date includes a consistent approach to service production planning, as well as updated national guidelines and prioritisation tools.

While the Commission's report has encouraged and facilitated a system-wide, collaborative response, if the problems that occurred had been noted and shared earlier, harm may have been avoided, with less negative impact on patient eyesight.

Where to next?

The health system's struggle to address the complex issues highlighted over the past four to five years matters. Continuing inequity and variation matter. The lack of progress in these important areas cannot continue to be ignored. Financial strain (deficits and possible under-investment in important areas), workforce wellbeing concerns and increasingly complex safety issues are all present. Each issue would benefit from a collaborative approach to understanding and to coordinating action for resolution, where this is not already occurring.

The case study of change in ophthalmology services emphasises organisations working together in the system to ensure safety. The challenge is to support our health system to look forward and to foresee and prevent harm from happening to people.

This chapter has started discussion on new approaches we can use to do this. The use of 'soft' intelligence and more leading indicators, alongside the traditional lagging indicators, can help us to better anticipate emerging issues. In turn, this will enable us to work together to proactively prevent harm. Chapter 3 considers how we might collaborate better, as a system, to prevent, and to respond early, to harm.

61 Health Quality & Safety Commission. 2017. *Learning from Adverse Events 2015–16*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2684 (accessed 26 April 2018).

3 Where to from here?

How best can New Zealand ensure its health system is set up to address future demands while maintaining, and where necessary improving, the quality of services provided?

This question has many different, overlapping answers. We have three suggested approaches that may help. The first is the further extension of quality improvement approaches across the sector. Chapter 1 demonstrates that, correctly used, the sorts of quality improvement approaches the Commission has adopted over the last five years can reap dividends.

These can help into the future in two ways. First, they can be extended into other areas where harm exists: pressure injuries, hospital inpatients with deteriorating conditions, other healthcare-associated infections and medication harms, to name but a few. Perhaps more importantly, the techniques and capabilities of quality improvement can also be applied to underlying causes of quality such as the development of good safety cultures, patient-centred care, effective clinical governance and well-coordinated services.

Being able to apply these techniques to these broader issues is important. As we have noted throughout this *Window*, many of the issues our health system faces are complex and wicked problems. A culture of quality improvement still has an important role to play.

In contrast to this development of an existing approach to 'lending a helping hand', the other two approaches are new, and relate to the Commission's mission of 'shining a light' on the quality of the system:

- building on existing approaches to encourage focused monitoring of service quality
- developing a mechanism for identifying and addressing potential problems early.

Building on existing approaches to encourage focused monitoring of quality

Chris Walsh suggests, in the text box on page 26, that we should consider a national target to improve patient experience. The system is already moving in this direction. Although not a target as such, the System Level Measures Framework[62] (SLMF) includes patient experience as one of six top level measures.

This is important because both the SLMF and the quality and safety markers[63] that the Commission uses to track progress in patient safety represent a development from traditional process targets used in health and public sectors internationally. Together, they reflect several useful principles for capitalising on the strengths of target regimes while minimising their less positive effects.[64, 65]

These principles are as follows.

1. The ultimate outcome or aim of the system must be understood and measured at a national level. This is critical to any evaluation of how well the system is working.
2. Any process changes measured and incentivised must have evidence that they will actually affect the linked outcome being assessed, without generating perverse or unintended consequences.
3. Changing processes without improving the ultimate outcome constitutes failure. If this happens, we need to understand why, whether the process measurements are reliable, and whether a different process change is required to achieve the desired outcome. Given that an outcome is generally measured by an indicator, rather than in its entirety, it is also relevant to ask if the right indicator is being measured and if this measurement is reliable.

62 Ministry of Health. (nd). *System Level Measures Framework*. Wellington: Ministry of Health. URL: www.health.govt.nz/new-zealand-health-system/system-level-measures-framework (accessed 18 May 2018).
63 Health Quality & Safety Commission. 2018. *Quality and Safety Markers*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers (accessed 18 May 2018).
64 Bevan G, Hood C. 2006. What's Measured Is What Matters: Targets and gaming in the English public health care system. *Public Administration* 84(3): 517–38.
65 Deber R, Schwartz R. 2016. What's Measured Is Not Necessarily What Matters: A cautionary story from public health. *Health Policy* 12(2): 52–64.

4 Ideally, changes in practice should be driven at a local level, believed in by local services and populations, and be made in response to local circumstances. This requires the selection, planning and implementation of changes to be determined by local providers, not the 'centre'. On the other hand, alignment with overarching central objectives is also important.

The Commission suggests that the fundamental approach, of specific local actions and changes driving improvements to reach a national goal, should be the centrepiece of how the functioning of the health system is managed. The effects of these actions can be strengthened, while avoiding an imposed 'master–servant relationship' on DHBs, by two mechanisms.

1 First, we believe that the Government, through the Ministry of Health, should set national aims at a high level, rather than precisely targeted ones. The Ministry and other central agencies, rather than local health alliances, would then have overall responsibility for delivering these aims. As now, local health alliances would be required to identify locally relevant areas for improvement that would contribute towards achieving these national aims, and agree these with the centre. This would create a partnership between the centre and local providers in delivering high-quality services, effectively moving relationships away from a 'funder and provider' contracting model. The role of the centre in such an arrangement is more facilitative, providing focus on national priorities and access to useful data analyses, helping to foster a culture of continuous quality improvement and building capacity and capability for improvement work.

2 Second, we would advocate that all health alliances should work with appropriate local populations to co-produce their plans for local improvement. These plans should include a clear statement of the overall objective, how this aligns with the Government's priorities, the proposed changes to services and processes, how success will be measured locally and how this will feed into national estimates of the quality of health care. Many local health alliances have already adopted this general approach with considerable success. The Commission would advocate that this should be seen as expected practice.

Thinking nationally, acting locally

There are several advantages to this approach.

1 Aims that are agreed, rather than targets that are imposed, have a greater likelihood of local professional ownership and support, and are more likely to lead to genuine, clinically and locally relevant change.

2 Locally agreed aims are more likely to address local priorities, which should be aligned with the overall, high-level priorities of the Government.

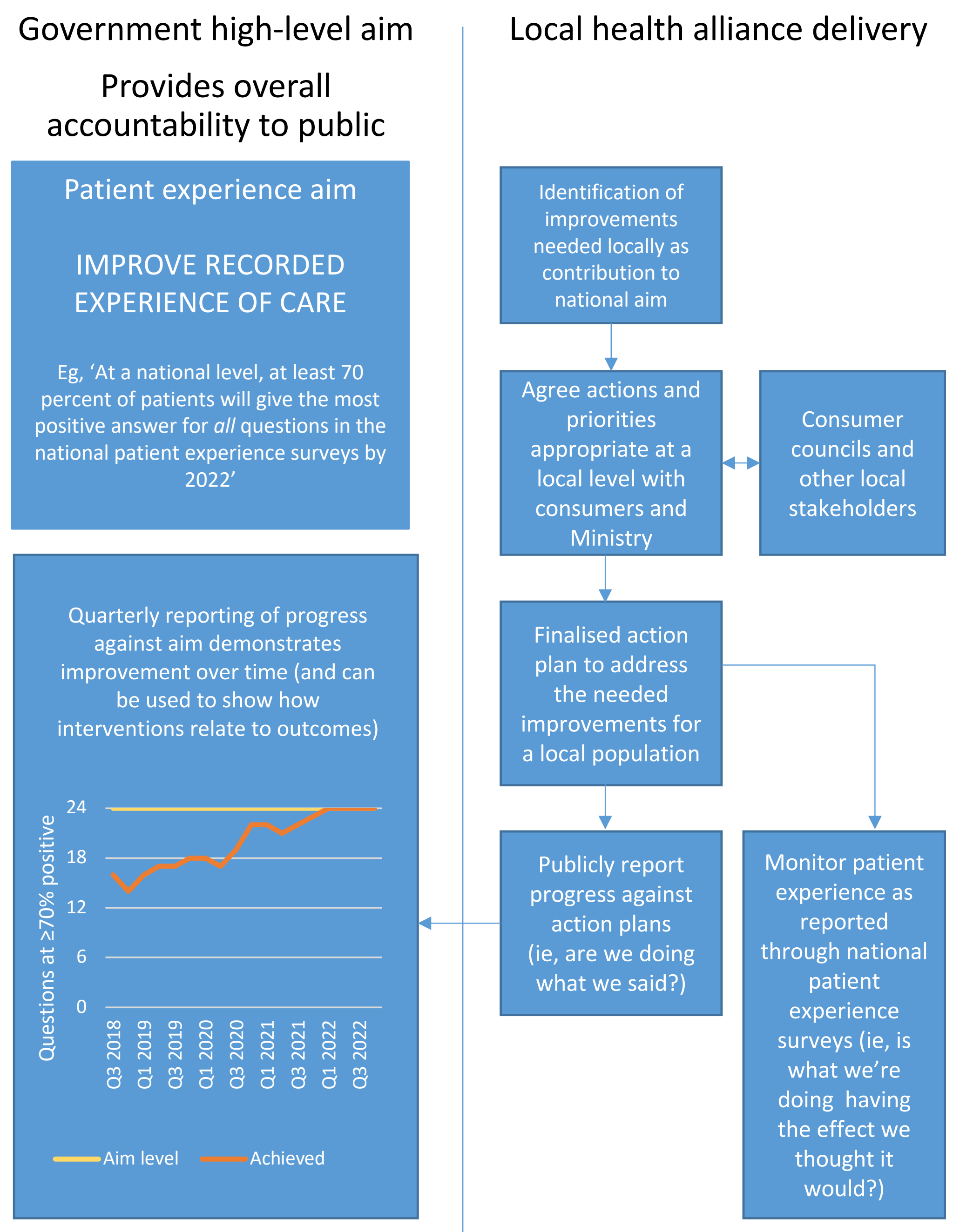
3 Both of the above advantages limit the risk of the measures failing to be meaningful.

4 Mutually agreed aims are more likely to generate trust across the system, which will be essential for identifying and addressing the emerging issues currently faced by the health system.

5 The approach is more likely to have a beneficial impact on equity, if local ownership appropriately involves local communities and consumers (especially Māori, as Treaty of Waitangi partners).

An example of how this might work for patient experience is outlined in Figure 48.

Figure 48: Example of a redesigned target for improving patient experience of care



Although this builds on current approaches, many aspects are novel. If this approach is seen as worth pursuing, work will be needed by the Commission, DHBs, the Ministry of Health and other willing parties to develop the concept further, undertake important pilot projects, produce an agreed national framework and implement it.

Developing a mechanism for identifying and addressing potential problems early

Chapter 2 identifies a range of emerging issues that are complex in origin and need trust and collaboration to resolve. The problems associated with provision of Avastin described on page 46 – and, for that matter, the issues associated with surgical mesh and the emerging threat of antimicrobial resistance – are all examples of complex system problems. These are not necessarily caused by poor performance of clinical staff or DHB administration, and cannot always be solved by focused performance management of individual providers. Instead, they require early identification of their presence, scale and nature, followed by early communication with key players to establish agreement on what, if anything, needs to be done.

Responding effectively to complex system problems requires different actors in the system to share what they know about these emerging issues, diagnose their cause and work together to intervene appropriately. This implies combining various 'hard' numeric measures, like those reported in this *Window,* with 'soft' intelligence (the stories and patterns of concern that individuals at the workface (staff and patients) know about). The challenge lies in connecting organisations that may be unaware that they share a common problem, to triangulate these anecdotal reports with systematic data held by various agencies, and then to evaluate the true significance of emerging potential problems.

This cannot be undertaken by one agency or local service alone. A common theme in reviews and investigations into system and organisational failure in health care is a failure to recognise the significance of fragmented intelligence held by agencies that, combined, may have highlighted a problem more quickly. It is only by bringing all relevant information together that the significance becomes clear.

Similarly, no sole agency or service holds all the necessary levers to resolve an emerging issue. Regulation, performance management, quality improvement activities, leadership development or additional funding may all be appropriate responses to specific circumstances. However, each organisation has a different role in the system, and with this comes a natural tendency to see that specific role as the correct solution to any particular problem. Collaboration between agencies with different roles and perspectives makes it more likely problems will be identified early in their evolution, and effective and appropriate responses will be found in time to minimise harm to patients.

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Finance Performance Monitoring

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 6.1

FINANCE REPORT

Purpose	For information.

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

Recommendations
THAT
The Board receives this report.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Group Result for June 2018	Year to Date Group Actual $m	 Group Budget $m	 Variance $m
Funder	26.3	34.0	(7.7) U
Governance	(0.1)	0.2	(0.3) U
Provider	(64.7)	(44.7)	(20.0) U
Waikato Health Trust	1.0	0.5	0.5 F
DHB Surplus/(Deficit)	**(37.5)**	**(10.0)**	**(27.5) U**

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

VOLUMES

Episodes	June 2018 YTD				
Acute	**Actual June 2018**	**Plan**	**Variance to Plan %**	**Actual June 2017**	**Variance to Prior year %**
Surgical & CCTVS	17,873	17,615	1.5%	17,577	1.7%
Medicine & Oncology	22,134	20,889	6.0%	20,852	6.1%
Child Health	5,447	5,000	8.9%	4,892	11.3%
Women's Health	8,937	9,355	-4.5%	9,049	-1.2%
TOTAL	54,391	52,860	2.9%	52,370	3.9%
Elective	**Actual June 2018**	**Plan**	**Variance %**	**Actual June 2017**	**Variance to Prior year %**
Surgical & CCTVS	15,337	15,574	-1.5%	14,239	7.7%
Medicine & Oncology	660	1,075	-38.6%	983	-32.9%
Child Health	702	753	-6.8%	728	-3.6%
Women's Health	1,255	1,042	20.4%	1,141	10.0%
TOTAL	17,954	18,444	-2.7%	17,091	5.0%
Total Episodes - Acute plus Electives	**72,345**	**71,304**	1.5%	**69,461**	4.2%

CWDS	June 2018 YTD				
Acute	**Actual June 2018**	**Plan**	**Variance to Plan %**	**Actual June 2017**	**Variance to Prior year %**
Surgical & CCTVS	30,634	30,176	1.5%	30,817	-0.6%
Medicine & Oncology	20,752	19,893	4.3%	19,890	4.3%
Child Health	6,842	6,345	7.8%	6,194	10.5%
Women's Health	5,027	4,943	1.7%	4,704	6.9%
TOTAL	63,255	61,357	3.1%	61,605	2.7%
Elective	**Actual June 2018**	**Plan**	**Variance %**	**Actual June 2017**	**Variance to Prior year %**
Surgical & CCTVS	21,949	22,118	-0.8%	19,147	14.6%
Medicine & Oncology	503	626	-19.7%	617	-18.5%
Child Health	561	681	-17.6%	598	-6.2%
Women's Health	1,158	1,126	2.8%	1,043	11.0%
TOTAL	24,171	24,551	-1.5%	21,405	12.9%
Total CWDS - Acute plus Electives	**87,426**	**85,908**	1.8%	**83,010**	5.3%

June 2018 YTD	Actual	Prior year	Change
ED Attends	116,439	112,167	3.8%
Beddays	228,884	219,069	4.5%

MONTHLY COMMENTS

This report includes commentary on current year to date performance for the Waikato DHB Group compared to the budget for the year ended 30 June 2018.

Delivery Plan Performance

Now that FY18/19 budget work is essentially complete, we will accelerate the work to allow for more meaningful volume variance analysis and extrapolation into related cost variance analysis. 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 overall volumes in the current year have increased against plan which is reflected in a number of unfavourable YTD cost variances.

Financial Performance Annual Comment:

For the June 2018 year we have an unfavourable variance to budget of $27.5m. The following table and explanations includes the key items that contribute to this variance. With the exception of savings achieved against the savings plan, this summary excludes offsetting variances (e.g. Outsourced Personnel costs for NOS that are recharged as Other Government and Crown Agencies Revenue):

Item	Ref	Category	$m's
Budgeted result			**-$10.0**
Favourable Variances			
ACC Income	1	Other Government and Crown Agencies Revenue	$1.5
R&M	1	Infrastructure and non-clinical supplies	$0.6
Health Tap	1	Outsourced Services	$4.7
NGO Payments	5	NGO Payments	$6.7
Leases	6	Infrastructure	$3.2
Depreciation	7	IDCC	$1.9
Unfavourable Variances			
Savings Plan	1	Infrastructure and non-clinical supplies	-$25.4
Nursing	2	Personnel	-$6.5
Nursing	2	Outsourced Personnel	-$3.2
Clinical Supplies	3	Clinical Supplies	-$8.1
Asset impairment	4	IDCC	-$1.5
Other items			-$1.4
			-$37.5

Unfavourable Variances

1. Savings Plan – High risk centrally held savings plan. Actual savings achieved include deferred R&M, prior period correction to Health Tap costs, and higher than budget ACC income. Savings are otherwise largely not achieved ($18.6m).
2. Nursing – Costs $9.7m unfavourable to budget includes $4.0m accrued estimated costs above budget for MECA rate changes. The balance of the variance equates to approximately 2% of total nursing costs, which aligns with acuity pressures acknowledged by MoH nationally.
3. Clinical Supplies – $8.1m unfavourable variance includes not achieving savings targets, theatre specialty mix, and high costs for blood and pharmaceuticals. Total episodes across hospital services were up by 1.5% for the year, and total CWDs up by 1.8%.
4. Unbudgeted impairment of NOS and Healthtap related assets $1.5m.

Favourable Variances

5. NGO Payments – $6.7m favourable variance (after offsets) includes delays in the commencement of NGO contracts, costs not being incurred in line with CFA revenue received, and MoH and accrual adjustments relating to prior year funding.
6. Leases – $3.2m favourable variance for infrastructure and non-clinical supplies includes net savings as a result of delays in moving into new buildings.
7. Depreciation $1.9m favourable due to slower than planned capital spend and the timing of capitalisation of IS projects.

The result is subject to year-end wash-ups (such as IDF,Pharmac rebates, Elective Services Revenue, Pay Equity accruals) and audit adjustments.

RECOMMENDATION(S):

That this report for the year ended June 2018 be received.

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Group Result:		
The Waikato DHB YTD Revenue Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$5.4 F**	
CFA Revenue		
CFA revenue is unfavourable to budget mainly due to:		
• General surgery and orthopaedic revenue not earned as a result of elective volumes not delivered $0.7m. • A year end accounting adjustment for non exchange transactions was $0.4m unfavourable, which is partly offset by a corresponding favourable $0.6m variance for expenses (NGO payments). • These unfavourable variances were partly offset by increased funding from MoH for prior year wash ups ($0.2m net), and also for current year initiatives ($0.3m). Current year funding changes are offset in NGO payments.	($0.6) U	N/A
Crown Side-Arm Revenue		
• Crown side-arm revenue $1.0m favourable to budget which includes increased contract revenue for DSS U65 inpatient and outpatient ($0.4m above budget), and variability of volumes compared to budget for breast screening ($0.4m above budget).	$1.0 F	N/A
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) $4.0m favourable (offset in Outsourced Personnel $4.3m). • ACC income $1.5m favourable which includes increases in income as a result of gains from improved administration processes ($1.3m), along with a change to a new annual contract ($0.2m). • Return to Employment project income $1.1m unfavourable due to lower referrals from MSD for enrolment. This variance is partly offset by lower outsourcing, clinical supplies and infrastructure costs $0.8m. • Inter District Flow (IDF) income from other DHBs $2.2m unfavourable. $0.9m unfavourable has an offsetting adjustment in IDF In ($1.0m) for treatment of pay equity wash up. The balance of $1.3m unfavourable represents service changes by other DHBs impacting on IDF revenue (net $0.8m), and net outflow from services subject to annual wash up (net $0.6m). • Inter District Flow (IDF) income relating to 2016/17 $1.8m favourable. This is 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.	$4.3 F	N/A
Other Revenue		
Other revenue is favourable to budget $0.7m mainly due to higher than budgeted revenue received by the Waikato Health Trust $0.4m. Balance of variance is across multiple areas.	$0.7 F	N/A

The Waikato DHB YTD Expenditure Variance resulted from:	**Variance $m**	**Impact on forecast**
Operating expenditure including IDCC	**($32.9) U**	
Personnel (employees and outsourced personnel total)	**($13.0) U**	
Employed personnel are favourable to budget mainly due to:		
• Medical personnel are favourable to budget by $8.1m. 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 $6.5m.	$4.5 F	N/A
• Nursing personnel are unfavourable to budget by $6.5m. This variance, along with the unfavourable outsourced personnel cost for nursing of $3.2m, is due to accrued estimated costs for MECA rate changes ($4.0m, which is unchanged from previous offer), unfavourable annual leave movement for the year to date and higher than budget overtime. The variance also includes the impact of higher beddays (4.5%), and a higher level of mental health inpatient services and acuity.		
• Allied Health personnel are favourable to budget by $1.3m. Variances continue to be mainly as a result of higher than expected vacancy levels. The net favourable variance of $1.0m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.2% of total allied health personnel budget to date.		
• Management, Administration and Support personnel are favourable to budget by $1.6m. Variances are spread across the DHB including clinical support, and are mainly as a result of higher than expected vacancy levels. Offset in Outsourced Personnel ($1.7m).		
Outsourced personnel are unfavourable to budget mainly due to:		
• Medical costs are $6.5m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $8.1m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.	($17.5) U	N/A
• Nursing costs are $3.2m unfavourable. As for employed nursing personnel this is due to the impact of higher beddays (4.5%), a higher level of mental health inpatient services and acuity and higher than budgeted patient watches.		
• Allied health costs are $0.3m unfavourable. The net favourable variance of $1.0m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.2% of total allied health personnel budget to date.		
• Management, Administration and Support costs are $7.5m unfavourable largely due to contractor costs of $4.3m for the implementation of the new NOS ERP solution ($4.0m of this cost is offset by additional other government revenue) and $3.2m 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	**$2.7 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced clinical service costs are $1.0m favourable. This is dominantly due to Virtual Health costs $4.7m favourable to budget. This is a prior period correction to Health Tap costs, as these costs were allocated in advance of the contract starting. Unfavourable offsetting variances include $1.8m for higher demand for diagnostic services as a result of higher usage of scans as part of determining treatment plans. Waikato Hospital services are $2.3m unfavourable for the year. This arises mainly as a result of savings not achieved, including delays in bringing services in house.	$2.7 F	N/A
• Outsourced corporate service costs are $1.7m favourable to budget which includes $1.1m lower than budget costs for the Waikato DHB contribution to HealthShare Limited shared services organisation. Other variances mainly relate to delays in commencing Information Systems outsourcing, including a new national IS infrastructure.		
Clinical Supplies	**($8.1) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Instruments and equipment – favourable to budget by $1.0m. These particular supplies are not volume related. The variance is due to timing of ordering, as well as coding of some costs as treatment disposals (i.e. part offset to the treatment disposals unfavourable variance).	$1.0 F	N/A
• Implants and Prosthesis is close to budget.	($0.2) U	
• Treatment disposables - unfavourable to budget by $6.8m (11.5% of budgeted costs). Savings plans related to clinical supplies are allocated against treatment disposals, and total $2.4m year to date. High cost areas include theatres (mix including high cost specialities of orthopaedics and neurosurgery), blood services (high product demand within the hospital), renal dialysis (volumes 7% up on budget), and respiratory patients (case weights 4% up on plan).	($6.8) U	
• Pharmaceuticals - unfavourable to budget by $1.5m. Relates mainly to unbudgeted increases in oncology drug costs. The initial Pharmac forecast included a lower usage assumption for new melanoma drugs.	($1.3) U	
• 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.		
• Diagnostic Supplies & Other Clinical Supplies - unfavourable to budget by $0.8m due to higher lab costs related to higher volumes.	($0.8) U	
Infrastructure and non-clinical supplies	**($21.6) U**	
• Favourable variance including savings as a result of delays in moving in to new buildings - $3.2m. The net variance includes ongoing additional costs due to extended leases in existing buildings. Maintenance costs are $0.6m favourable. This includes timing differences at year end.	$3.8 F	N/A
• Savings plan - $25.4m unfavourable variance in infrastructure relates to centrally held savings plan not specifically allocated. Whilst savings have been achieved across the business, certain high risk initiatives have under delivered against projected outcomes.	($25.4) U	N/A

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$6.7 F**	
External Provider payments are favourable to budget mainly due to:		
● Payments to providers are $7.2m favourable which includes: - Payments to mental health providers are favourable to budget by $3.1m, and to disability support providers $2.7m. These variances include delays in the commencement of NGO contracts. - Mental health and disability variances include a favourable year end accounting adjustment for exchange and non exchange transactions ($0.6m). This is partly offset by a corresponding unfavourable $0.4m variance for income (CFA revenue). - Other variances arise due to costs not being incurred in line with CFA revenue received, MoH and accrual adjustments relating to prior year funding and costs arising from additional targeted revenue from MoH.	$6.7 F	N/A
● IDF out payments for 2017/18 are $0.3m favourable. $1.0m favourable has an offsetting adjustment in IDF In ($0.9m) for treatment of pay equity wash up. The balance of $0.7m unfavourable relates mainly to wash up of personal health inpatient 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	**$0.5 F**	
Interest charge is close to budget.	$0.1 F	N/A
Capital charge is on budget.	$0.0 F	N/A
Depreciation is favourable to budget due mainly to:		
● Slower than planned capital spend and the timing of capitalisation of IS projects.	$1.9 F	N/A
● Offset by unfavourable variance relating to the unbudgeted impairment of Intangible Assets - NOS and Healthtap related assets.	($1.5) U	
Extraordinary costs	**($0.1) U**	
Loss on disposal of fixed assets - not budgeted.	($0.1) U	N/A

TREASURY

Opinion on Group Result:

Cash flows are unfavourable to budget as detailed below.

YTD Actuals Jun-17 $'000	Waikato DHB Cash flows for year to June 2018	Year to Date Actual $'000	Budget $'000	Variance $'000
	Cash flow from operating activities			
1,348,420	Operating inflows	1,439,180	1,438,153	1,026
(1,306,857)	Operating outflows	(1,413,120)	(1,396,156)	(16,964)
41,563	**Net cash from operating activities**	**26,060**	**41,997**	**(15,938)**
	Cash flow from investing activities			
1,837	Interest income and proceeds on disposal of assets	1,742	1,171	571
(32,210)	Purchase of assets	(37,016)	(55,056)	18,040
(30,373)	**Net cash from investing activities**	**(35,274)**	**(53,885)**	**18,611**
	Cash flow from financing activities			
0	Equity repayment	(2,194)	(2,194)	(0)
(8,606)	Interest Paid	(818)	(809)	(9)
6,137	Net change in loans	(324)	12,700	(13,024)
(2,469)	**Net cash from financing activities**	**(3,336)**	**9,697**	**(13,034)**
8,721	**Net increase/(decrease) in cash**	**(12,550)**	**(2,192)**	**(10,360)**
856	Opening cash balance	9,577	9,577	(0)
9,577	**Closing cash balance**	**(2,973)**	**7,385**	**(10,360)**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($16.0) U**	
Operating inflows	**$1.0 F**	
Operating inflow is favourable to budget mainly due to: • Unbudgeted IDF wash-up revenue received in December $2.0m. • Crown side-arm revenue $1m favourable to budget which includes increased contract revenue for DSS U65 inpatient and outpatient ($0.4m) and for breast screening ($0.4m). • ACC income $1.5m favourable which includes increases in income as a result of a change to a new annual contract ($0.2m) along with gains from improved processes ($1.3m). • CFA revenue $0.2m favourable to budget mainly due to increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year) offset by general surgery and orthopaedic volumes not met $0.7m. • Return to Employment project income $1.1m unfavourable due to lower referrals from MSD for enrolment. • Income in Advance inflows are $0.7m unfavourable to budget mainly due to unbudgeted quarterly pay equity funding received. • The balance of the operating inflow unfavourable variance relates to timing of actual cash inflows compared with budget assumptions. Budget assumptions phase most income evenly. Timing of actual receipts for certain revenue is impacted by invoicing, contract signing date or periodic payment agreements.	$1.0 F	N/A

Cash flow variances resulted from:	Variance $m	Impact on forecast
Operating outflows	**($17.0) 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.	$17.6 F	N/A
Operating cash outflows for non-payroll costs are unfavourable largely as a result of:		
• Unfavourable operating costs including outsourced personnel (offset in personnel cost), outsourced services, clinical supplies, infrastructure & non clinical supplies and provider payments (net - $35.8m).	($36.0) U	
• Higher prepayment balance due to timing of payments $3.8m - largely IS contracts.		
• The actual timing of vendor payments against budget assumptions.		
• GST cash movement is favourable due to timing variances on GST transacted.	$1.4 F	
Net cash flow from Investing Activities	**$18.6 F**	
• Interest received is close to budget.	$0.6 F	N/A
• Purchase of assets is slower than planned for the year. This is as a result of deferred timing of spend.	$18.0 F	
Net cash flow from Financing Activities	**($13.0) U**	
• Cash flow from financing activities is unfavourable due to the deferment of planned finance leases.	($13.0) U	N/A

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

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

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

As at 30-Jun-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	5,782	6,764	4,708	4,366	5,855	4,594	4,468	6,650	3,252	4,480	6,422	4,708	4,252
Funder inflow (MoH, IDF, etc)	138,145	131,692	131,880	136,560	131,880	131,880	136,750	131,880	131,880	136,750	131,880	131,880	136,750
Donations and Bequests	35	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	5,395	3,060	2,757	2,412	2,642	2,642	2,297	2,415	2,185	2,415	2,185	2,645	2,185
Rents, ACC, & HealthPac (General Accou	3,564	2,736	2,886	2,645	2,760	2,751	2,658	2,676	2,562	2,739	2,547	2,889	2,549
	152,921	144,252	142,231	145,983	143,137	141,867	146,173	143,621	139,879	146,384	143,034	142,122	145,736
Cash was applied to:													
Personnel Costs (incl PAYE)	(46,924)	(46,541)	(65,312)	(47,608)	(52,587)	(49,497)	(56,609)	(47,788)	(49,992)	(46,696)	(46,168)	(54,771)	(45,624)
Other Operating Costs	(50,957)	(19,526)	(35,624)	(36,722)	(32,624)	(35,826)	(35,218)	(32,620)	(33,520)	(37,122)	(35,820)	(36,524)	(31,520)
Funder outflow	(50,090)	(48,576)	(52,787)	(47,896)	(48,905)	(48,576)	(47,556)	(48,329)	(47,792)	(51,848)	(47,626)	(49,009)	(47,556)
Interest and Finance Costs	(4)	(15)	(12)	(20)	(15)	(12)	(10)	(15)	(10)	(10)	(10)	(10)	(10)
Capital Charge	(18,483)	0	0	0	0	0	(18,483)	0	0	0	0	0	(18,711)
GST Payments	(6,821)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(13,710)	(9,000)	(7,210)	0	(14,420)	(7,210)
	(173,279)	(121,868)	(160,945)	(139,456)	(141,341)	(141,121)	(157,876)	(142,462)	(140,314)	(142,886)	(129,624)	(154,734)	(150,631)
OPERATING ACTIVITES	(20,358)	22,384	(18,714)	6,527	1,796	746	(11,703)	1,159	(435)	3,498	13,410	(12,612)	(4,895)
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	142	75	75	75	75	75	75	75	75	75	75	75	75
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
	142	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(6,612)	(3,500)	(11,000)	(11,000)	(11,000)	(11,000)	(11,000)	(3,500)	(11,000)	(11,000)	(11,000)	(11,000)	(11,000)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(6,612)	(3,500)	(11,000)	(11,000)	(11,000)	(11,000)	(11,000)	(3,500)	(11,000)	(11,000)	(11,000)	(11,000)	(11,000)
INVESTING ACTIVITIES	(6,470)	(3,425)	(10,925)	(10,925)	(10,925)	(10,925)	(10,925)	(3,425)	(10,925)	(10,925)	(10,925)	(10,925)	(10,925)
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	10,000	10,000	10,000	10,000	10,000	0	10,000	10,000	10,000	10,000	12,500
Finance Lease received	0	0	0	3,000	3,000	3,000	3,000	3,000	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	10,000	13,000	13,000	13,000	13,000	3,000	10,000	10,000	10,000	10,000	12,500
Cash was applied to:													
Capital Repayment	(2,194)	0	0	0	0	0	0	0	0	0	0	0	(2,194)
Finance lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	0	(26)	0	0	(26)	0	0	(26)	0	0	(15)	0
Working capital facility repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
FINANCING ACTIVITIES	**(2,194)**	**0**	**9,974**	**13,000**	**13,000**	**12,974**	**13,000**	**3,000**	**9,974**	**10,000**	**10,000**	**9,985**	**10,306**
Opening cash balance	19,505	(9,518)	9,442	(10,222)	(1,620)	2,250	5,045	(4,584)	(3,850)	(5,236)	(2,662)	9,823	(3,729)
Overall increase/(decrease) in cash	(29,023)	18,960	(19,664)	8,602	3,870	2,795	(9,629)	734	(1,386)	2,573	12,485	(13,552)	(5,515)
CLOSING CASH BALANCE	(9,518)	9,442	(10,222)	(1,620)	2,250	5,045	(4,584)	(3,850)	(5,236)	(2,663)	9,823	(3,729)	(9,244)
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	0	0	0	0	0	0	0	0	0	0
NZ Health Partnerships Ltd	(9,518)	9,442	(10,222)	(1,620)	2,250	5,045	(4,584)	(3,850)	(5,236)	(2,662)	9,823	(3,729)	(9,244)
Long-term Loans													
Finance Leases	0	0	0	(3,000)	(6,000)	(9,000)	(12,000)	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)
EECA Loan	(169)	(169)	(143)	(143)	(143)	(117)	(117)	(117)	(91)	(91)	(91)	(76)	(76)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(9,687)	9,273	(10,365)	(4,763)	(3,893)	(4,072)	(16,701)	(18,967)	(20,327)	(17,753)	(5,268)	(18,805)	(24,320)
Working capital facility	(70,937)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(70,937)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)

BALANCE SHEET

Opinion on Result:

There are no material concerns on the balance sheet.

Prior Year June 2017 $'000	Waikato DHB Group Financial Position	As at June 2018 Actual $'000	Budget $'000	Variance $'000
88,517	Total current assets	78,902	65,434	13,468 F
(181,405)	Total current liabilities	(196,870)	(160,569)	(36,301) U
(92,888)	**Net working capital**	**(117,968)**	**(95,135)**	**(22,833) U**
736,618	Term assets	722,164	739,628	(17,464) U
(21,053)	Term liabilities	(22,122)	(34,410)	12,288 F
715,565	**Net term assets**	**700,042**	**705,218**	**(5,176) U**
622,677	**Net assets employed**	**582,074**	**610,083**	**(28,009) U**
622,677	**Total Equity**	**582,074**	**610,083**	**(28,009) U**

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is unfavourable to budget mainly due to:		
Current Assets		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $10.3m. The $10.8m overdraft is recorded in Current Liabilities, which resulted in a $0.5m favourable variance in Current Assets and $10.8m unfavourable variance in Current Liabilities. • Total accounts receivable and accrued debtors is higher than budgeted by $8.6m mainly due to the reclassification of the $13m Pharmac Rebate Receivable to receivables and unbudgeted accrual of NOS recoveries $3.7m. The remaining variance is as a result off the timing of cash received compared with budget assumptions. • Prepayments are higher than planned by $3.8 mainly due to timing of payment of e-Space and other prepaid license to use. • Other favourable variances across a number of areas $0.6m.	**$13.5 F**	N/A
Current Liabilities		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $10.3m. The $10.8m overdraft is recorded in Current Liabilities, which resulted in a $0.5m favourable variance in Current Assets and $10.8m unfavourable variance in Current Liabilities. This is due mainly to the unfavourable variance relating to operating activities($16.0m) and financing activities ($13.m) offset by an favourable variance from investing activities $18.6m. • Payroll liabilities are $13.1m unfavourable mainly due to accrual for the potential liability arising from a Nursing MECA settlement, year end adjustment for actuarial valuation of leave liabilities and timing of pay runs (PAYE & leave) as compared with the phasing of the budget. • Income in Advance $0.7m favourable to budget mainly due to unbudgeted quarterly pay equity funding received. • GST $1.4m unfavourable to budget mainly due to the timing of processing of vendor invoices and unbudgeted income received.	**($36.3) U**	N/A

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Current Liabilities (continued		
• Accrued Creditors $26.4 unfavourable mainly due to the reclassification of the $13m Pharmac Rebate to accrued debtors, unbudgeted accrual of NOS costs, higher operational expenses which is evident in the results for the month and the timing of payments.		
• Accounts Payable is $14.7m favourable mainly due the early payment of Creditors to ease the NOS transition.		
• Other Current Liabilities are favourable to budget $0.1m mainly due to the variances arising from the actual timing of transactions compared with budget assumptions.		
Net Term Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $18.0m and impairment of Intangibles $1.5m, offset by favourable YTD depreciation $1.9m. Please see attached for latest forecast of capital spend for the year for further detail.	($17.6) U	N/A
Investment in HealthShare has increased by $0.1m due to the share of profits for the 2017/18 year.	$0.1 F	
Non Current Liabilities:		
Non Current Liabilities are favourable due to deferment of budgeted finance leases.	**$12.3 F**	N/A
Equity:		
Driven mainly by variance in overall results and a movement in Waikato Health Trust Partially Reserved Funds.	**($28.0) U**	N/A

CAPITAL EXPENDITURE AT 30 June 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 30 Jun 18	Approved and Planned Expenditure 01 Jul 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		3415	3,415	-	1,293	4,708	(1,708)	1,293
Clinical Equipment Subtotal	12,725	20,018	3,672	36,415	2,462	12,845	12,845	-	16,139	31,446	4,969	2,933
Property & Infrastructure Subtotal	43,838	7,978	-686	51,130	19,371	9,893	9,893	-	18,829	48,093	3,037	1,835
IS Subtotal	20,804	8,675	109	29,587	8,314	7,421	7,421	0	12,061	27,796	1,791	1,217
Corporate Systems & Processes Subtotal	3,326	8,325	68	11,719	450	3,070	3,070	0	8,180	11,700	19	55
					-							
Regional Subtotal	4,425	798	0	5,223	270	773	773	0	2,951	3,994	1,229	21
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	0
REPORT TOTALS	85,118	48,794	3,163	137,074	30,867	37,418	37,418	0	59,453	127,738	9,336	7,354

Waikato DHB
CAPITAL EXPENDITURE AT 30 June 2018 ($000s)

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
CT Machine Replacement Waikato x3	3,828	3,846	-	(19)
CT Machine Replacement Waikato x1	725	724	2	(1)
Ventilators (Critical Care)	400	-	-	400
Endoscopes	300	-	-	300
Replacement Theatre Lights OT 20-25	286	235	51	(0)
Glucose meters	275	-	-	275
Renal Dialysis (CCD) machines x4 Prismaflex	564	601	-	(38)
Other items - identfied per Clinical asset review	719	-	-	719
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	860	453	0
Mobile Dental Unit Replacements - level 2	600	34	486	80
Bed Replacement Programme	400	-	260	140
Digital Mobile X-Ray	351	-	-	351
Digital Mobile X-Ray Project	1,246	1,205	42	(0)
X-ray general (Radiology ED Room 1)	350	-	350	-
X-ray general (Radiology MCC Room 5)	350	-	350	-
Mobile Image Intensifier - Waikato	300	-	275	25
Microscope - Platics- Plastics Theatre	300	-	300	-
Linear Accelerator (replacement)	4,000	-	4,000	-
Anaesthetic machine - Aisys Carestation	380	-	365	15
Heart Lung Machines	1,493	1,392	101	(0)
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	500	6	94
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	20	805	(0)
Trauma Gantry (radiology)	350	-	350	-
L8 Menzies Surgical Assessment Unit (Acute)	1,561	316	1,285	(40)
Projects Removed to be Capitalised	4,880	4,407	-	473
Other Clinical Services Projects Budgeted <$250K	9,550	4,583	4,481	486
Clinical Equipment Subtotal	39,415	18,722	17,432	3,261
Property and Infrastructure				
Mental Health Facility - part 2	1,513	-	1,462	51
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
#REF!	-	-	-	-
Gallagher Building - Med Store & CSES Clinic	406	402	-	4
Gallagher Building - Racking System	362	522	-	(160)
Gallagher Building - Converyor System	348	356	-	(8)
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	2,102	7,463	(441)
Hamilton CBD - Collingwood Street Development - First Floor	5,584	376	4,766	442
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
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	17	550	(17)
Hague road carpark - Seismic and Beam support	375	-	-	375
Urology to L8 Menzies	320	22	298	0
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Waikato Hauora iHub	321	161	264	(104)
Waikato switchboard upgrades core buildings	675	10	569	96
Infrastructure Replacement Pool (17/18)	510	348	150	12
Infrastructure Replacement Pool (15/16)	600	731	3	(134)
Infrastructure Replacement Pool (16/17)	641	205	-	436
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
	-	-	-	-
Projects Removed to be capitalised	13,743	13,680	63	(0)
Projects no longer in flight with expenditure	274	-	-	274
Other P&I Projects Budgeted <$250K	3,535	1,240	1,479	816
Property & Infrastructure Subtotal	**51,130**	**29,264**	**18,829**	**3,037**
Regional				
National Oracle Solution - Elevate	4,399	1,043	2,127	1,229
Other Regional Projects Budgeted <$250K	824	-	824	-
Regional Subtotal	**5,223**	**1,043**	**2,951**	**1,229**
MOH & Trust Funded				
National Patient Flow Phase 3 16/17	257	267	-	(10)
Telestroke Pilot	321	49	272	-
16/17 Trust Account	303	303	-	(0)
Other MOH & Trust Funded Projects Budgeted <$250K	(881)	(619)	(272)	10
MOH & Trust Subtotal	-	(0)	-	0
Information Systems				
Platform	3,438	990	2,070	378
Storage & Reporting	1,125	684	543	(102)
Network & Communications	3,793	1,907	1,630	256
IAAS	1,686	1,084	602	0
Devices	2,553	973	1,436	144
Licensing	1,125	212	627	286
Enterprise Service Business	937	380	550	7
Tools	3,129	1,606	1,536	(13)
Security	817	105	712	(0)
Clinical Systems	6,447	4,640	2,126	(319)
Other Projects	1,319	206	229	884
Corporate Systems	11,719	3,520	8,180	19
Projects to be Capitalised	3,219	2,949	-	270
			-	-
IS Subtotal	41,306	19,256	20,241	1,810
Grand total	**137,075**	**68,285**	**59,453**	**9,337**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
June 2018

Travel costs include airfare, accommodation, taxis/shuttles and meals. Travel relating to training or conferences does 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 accommodation. For this reason, costs reflected in this report may relate to prior months' travel.

Travel costs - Executive Group	Month			Year to Date			
June 2018	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AYDON LYDIA HELEN MS	-	-	-	1,572.39	-	1,572.39	
AITKEN VICKI ANN	284.39	-	284.39	1,842.64	-	1,842.64	
CHRYSTALL MAUREEN MS	11.00	-	11.00	1,110.89	-	1,110.89	
ELLIOTT LORAINE	-	-	-	937.10	-	937.10	
HABLOUS NEVILLE MR - Acting CE	-	-	-	557.25	-	557.25	Detail below
HACKETT DARRIN MR	-	-	-	126.35	-	126.35	
HAYWARD SUSAN MRS	441.61	690.90	1,132.51	5,747.51	4,135.86	9,883.37	Training related $3,445
LAWRENSON ROSS PROF	-	-	-	353.63	-	353.63	
MALONEY TANYA	581.44	-	581.44	861.56	4,157.48	5,019.04	Training related $4,157
MURRAY NIGEL MR	-	-	-	6,829.52	(499.90)	6,329.62	Detail below
NEVILLE MAUREEN MS	599.59	-	599.59	2,476.85	-	2,476.85	
PARADINE BRETT MR	-	-	-	312.26	-	312.26	
SPITTAL MARK MR	-	-	-	2,001.87	-	2,001.87	
TAPSELL REES	717.04	-	717.04	1,234.52	1,759.00	2,993.52	
TER BEEK MARC MR	521.86	-	521.86	1,324.40	-	1,324.40	
TOMIC DAMIAN MR	-	-	-	3,206.32	690.43	3,896.75	
WATSON TOM MR	-	-	-	1,292.58	-	1,292.58	
WILSON JULIE MS	-	-	-	4,474.24	-	4,474.24	
WOLSTENCROFT IAN	-	-	-	146.96	-	146.96	
WRIGHT DEREK MR - Executive	-	-	-	1,302.35	63.48	1,365.83	
WRIGHT DEREK MR - Interim CE	2,735.70	-	2,735.70	7,823.75	-	7,823.75	Detail below
Grand Total	**5,892.63**	**690.90**	**6,583.53**	**45,534.94**	**10,306.35**	**55,841.29**	

Interim CE Travel Expenditure Derek Wright

Travel costs for the period October 2017 to June 2018				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
November 2017	69.57	Conference cost	Nga Tumanako Conference	Ngaruawahia
November 2017	77.83	Mental Health and Addictions Services NGO Commissioning workshop	Mileage and parking expenses	Auckland
December 2017	702.42	DHB CE Meeting & MoH DG Health	Airfare (return), taxi	Wellington
December 2017	471.44	DHB CE Meeting - RMO bargaining strategy	Airfare (return)	Wellington
December 2017	73.48	Mental Health and Addictions Services NGO Commissioning workshop	Mileage and parking expenses	Auckland
February 2018	199.13	Midlands DHBs regional meetings	Accommodation	Auckland
February 2018	692.90	National DHB CE meeting	Airfares, taxi and parking	Wellington
February 2018	584.90	Health Select Committee, Ministry of Health executives, Health and Disability Commissioner	Airfares, parking and taxi	Wellington
March 2018	130.43	Midland United Regional Integration Alliance Leadership Team, Midland Regional meetings	Accommodation	Tauranga
March 2018	990.84	Oranga Mahi Governance Board meeting, National Chair and DHB meetings	Accommodation, Taxi, parking and airfare	Wellington
April 2018	70.00	Midlands CE,eSpace CEO Governance, HealthShare Board and Midland Regional Governance Group meetings	Mileage	Rotorua
3-4 May 2018	766.35	Midland Regional Meetings	Airfares, mileage to airport, taxi and parking	Gisborne
10 May 2018	974.58	National DHB CE meeting, SSC & Social Investment agency	Airfares, Taxi, Hotel accommodation	Wellington
12-13 May 2018	153.91	Education Summit	Mileage and parking expenses	Auckland
8 June 2018	552.21	Meet & Welcome new MoH Director General	Airfares, taxi	Wellington
14 June 2018	530.92	National DHB CE meeting	Airfares, taxi	Wellington
18-19 June 2018	782.84	MoH - WDHB annual plan and Budget meeting, meeting Dept. Corrections	Airfare, Taxi, Hotel accommodation	Wellington
	7,823.75			

Acting CE Travel Expenditure Neville Hablous

Travel costs for the period July to October 2017				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
7 Sept 2017	**557.25**	National DHB CE meeting	Airfare (return)	Wellington

CE Travel Expenditure: Nigel Murray

Travel costs for the period 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 Smart health	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
June 2017	350.63	Use of domestic taxi chits	Taxi chits	Domestic
	6,329.62			

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 6.2

YEAR END MATTERS

Purpose	For consideration and approval prior to the letter of representation and annual report being signed.

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

Potential changes to provisional result

The provisional consolidated result for year to 30 June 2018 is $37.5m deficit but the following are not yet finalised and could affect the result:

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

Estimates have been made for all the above items. In addition other items may be identified in the final audit, but will have a materiality consideration applied.

Timetable for finalisation of Annual Report

Due Date	Action	Comment
25-Jul-18	Unaudited CFIS templates files sent to Ministry and auditors	
30-Jul-18	Audit NZ on site for CFIS audit	
30-Jul-18	Draft financial statements for Annual Report sent to auditors	
13-Aug-18	CFIS template agreed with DHB auditor	
13-Aug-18	Joint Statement of Representation sent to Ministry (to agree to CFIS)	Further detail below
13-Aug-18	Audited CFIS template filed with Ministry	
Late August-18	Final wash-up of Inter District Flows to be provided to DHB’s	

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

Purpose of the CFIS template

CFIS (Crown Financial Information System) is used to provide financial results for consolidation of all Crown entity results by the Government Treasury Department.

Annual Report

The draft annual report for Waikato DHB is planned to be presented at the September 2018 board meeting.

Letter of Representation

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

Capital Review

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

Waikato Health Trust

The DHB has the right to appoint and remove trustees so substantially has control over the trust. Because of this, the trust meets the definition of a subsidiary in FRS-37 and therefore will be consolidated into the Board's financial statements. This treatment is consistent with prior years.

Recommendation for signing on behalf of Deputy Chair

In the absence of a Board Deputy Chair, it is recommended that for the purposes of signing the Letter of Representation and Annual Report, Sharon Mariu sign as Chair of the Audit and Corporate Risk Management Committee.

Recommendation
THAT
The Board:

1) Receive this report.
2) Nominate Sally Webb, Sharon Mariu, Derek Wright and Andrew McCurdie to sign the Finance Letters of Representation in relation to the CFIS template and annual report.
3) Nominate Sally Webb and Sharon Mariu to sign the Annual Report.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

Joint Statement of Representation

13th August 2018

Ben H Halford
Director
Audit New Zealand
Level 4, 127 Alexandra Street
PO Box 256, Hamilton 3240

Dr Ashley Bloomfield
Director-General of Health
Ministry of Health
PO Box 5013
WELLINGTON

Dear Ben and Ashley

Letter of Representation for the year ended 30 June 2018 – template provided to the Ministry of Health for the Government's Financial Statements

This representation letter is given to you in connection with your responsibility to provide audit clearance to the auditors of the Government's financial statements as to whether the financial information included in the DHB financial templates and attached schedules (the schedules) provided to the Ministry of Health fairly reflects the financial position of Waikato DHB as at 30 June 2018 and of the results of its operations and cash flows for the year then ended.

The Board and management of Waikato DHB confirm, to the best of our knowledge and belief, the following representations:

1 We accept responsibility for the preparation of the financial information included in the schedules provided to the Ministry of Health and the judgements made in the process of producing that template.

2 We accept responsibility for establishing and maintaining, and have established and maintained, a system of internal control procedures that provide reasonable assurance as to the integrity and reliability of the financial information in the schedules. We confirm that the system of internal control has operated adequately throughout the period.

3 We confirm that the following key financial information is fairly and appropriately reflected in the schedules:

- Opening equity balance agrees to the closing balance of 2017;
- Income in Advance;
- Accruals for primary referred expenditure (particularly community pharmaceuticals);
- Pharmac rebate accrual;
- Accrual for Inter-district flows;
- The carrying value of land and buildings does not materially differ from fair value; and

- Revenue and expenses with other Crown owned entities (eg, Air New Zealand, New Zealand Post, energy companies).

In addition we verify that:

a. Consolidated Net Result for the financial year ending 30 June 2018 is ………………

b. Consolidated total Crown Equity as at 30 June 2018 is …………………

c. The schedules contain information that accurately reflects our financial activities and cashflows during the period 1 July 2017 to 30 June 2018. Where the date of the information supplied differs from 30 June 2018, there were no significant movements in our net equity position up to 30 June 2018 that would affect the financial statements of the Government.

d. The amounts recorded in the schedules are complete.

e. We are satisfied that all guarantees, indemnities, securities and other contingent liabilities or assets that remain outstanding at 30 June 2018 have been included in the Contingencies Template.

f. We are satisfied that all contractual commitments have been disclosed accurately in the schedule on the Statement of Commitments.

g. The schedules have been prepared in accordance with the accounting policies of the Crown and Generally Accepted Accounting Practice (Public Benefit Entity Accounting Standards), as applicable for the year ending 30 June 2018, except for:

   [INSERT DETAILS]

h. Transactions and balances with entities within the Crown reporting entity greater than $10 million have been confirmed with the other entity.

i. We confirm we used Treasury's central table of risk-free discount rates and CPI assumptions for valuations to comply with *PBE IFRS 4 Insurance Contracts* and *PBE IPSAS 39 Employee Benefits.*

j. There have been no material events subsequent to 30 June 2018 that should be reported in the financial statements, except for:

   [INSERT DETAILS]

k. We agree to notify Treasury, the Ministry of Health and the appointed Auditor immediately of any material amendments to the schedules, or subsequent events that should be reported in the financial statements, identified after this Statement of Representation is signed but prior to the finalisation of the financial statements of the Government on 30 September 2018.

l. There are no other matters that you should be aware of in the preparation of the financial statements of the Government for the year ended 30 June 2018.

These representations are made at your request, and to supplement information obtained by you from the records of Waikato DHB and to confirm information given to you orally.

Yours sincerely

Andrew McCurdie Chief Financial Officer Date:	Sharon Mariu Board Member Date:
Derek Wright Chief Executive Officer Date:	Sally Webb Chairperson Date:

Health Targets

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 7

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. Official quarter four 2017/18 results are not yet available so there isn't a lot of change from last month's report to Board. All 17/18 results are still provisional as the Ministry of Health has not yet obtained final 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. Work is currently underway to redesign this report to clearly show the equity gap for Māori in line with the Board's focus on this priority area.

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	17/18 Target	2017/18 Q1 results	2017/18 Q2 results	2017/18 Q3 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	86% 19	X	85% Jun-18 YTD
Improved access to elective surgery		100%	108% 7th	106% 10th	110% 3rd	114% 2nd	100%	111% 5th	104% 8th	105% 6th	√	104.5% Jun-18 YTD
Faster Cancer Treatment (FCT)	Achievement	85%	81.4% 5th	85.9% 4th	86.1% 5th	86% 2nd	85%	98% 1st	98% 2nd	97% 3rd	√	93% May-18
Better Help for Smokers to quit	Primary Care	90%	87% 12th	86% 13th	87% 12th	88% 15th	90%	88% 14th	89% 12th	88% Ranking unavailable	X	88% 17/18 Q3 result
	Maternity	90%	93% 12th	96%	98% 4th	95% 8th	90%	94% 8th	97% 4th	99% Ranking unavailable	√	99% 17/18 Q3 result
Increased immunisation (8 months)		95%	92.3% 13th	92% 15th	90% 16th	89% 15th	95%	88% 15th	90% 15th	89% 14th	X	88% Jun 18 3 mth rolling
Raising Healthy Kids[1]		95%	47% 11th	79% 6th	84% 9th	81% 14th	95%	76% 19th	100% 1st	100% 1st	√	100% 6 mths May 18

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 2018

Q1 17/18	Q2 17/18	Q3 17/18
82.1%	**88.8%**	**85.8%**

Table 3 - Emergency Department Q3 results by site and by clinical unit

Shorter Stays in Emergency Departments (EDs) health target
DHB name: Walkato
Quarter: 3 - 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:	24834	28940	85.8%
Waikato	16556	20055	82.6%
Taumarunui	1423	1462	97.3%
Thames	3833	4327	88.6%
Tokoroa	3022	3096	97.6%

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:	6918	7851	88.1%	641	862	74.4%
Waikato	4552	5388	84.5%	474	671	70.6%
Taumarunui	570	587	97.1%	19	22	86.4%
Thames	612	667	91.8%	33	48	68.8%
Tokoroa	1184	1209	97.9%	115	121	95.0%

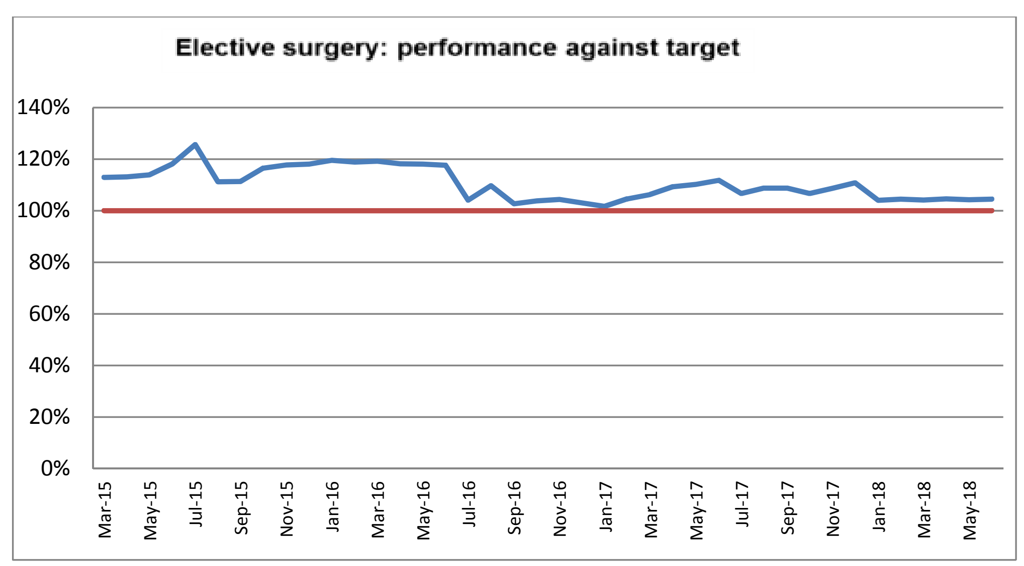
Target: Elective Surgery

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	Q3 17/18	Q4 17/18 provisional
Result	102.6%	103.1%	106.3%	111.8%	111%	104%	105%	104%
Ranking	**7**	**10**	**3**	**2**	**5th**	**8th**	6th	

Graph 1 below provides the most recent result of 104.5%.

Graph 1 - Waikato DHB's elective surgery performance up to Jun 2018



Target: Faster Cancer Treatment (FCT)

Table 5 - Summary of achievement against the FCT health target from July 2015 to March 2018

FCT 62 DAY HEALTH TARGET								
DHB Current Target	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	DHB Q3 Result 17/18	**DHB Q4 Result Provisional**
90%	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 3rd equal ranking	96.6% 2nd ranking	99.0% 3rd ranking	93%
FCT VOLUME TARGET								
DHB Current Target	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	DHB Q3 Result	**DHB Q4 Result Provisional**
25%	17%	19%	19%	22%	14%	14%	14%	20%

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

Achievement of health target by month Mar 2017 to May 2018

120%
100%
80%
60%
40%
20%
0%

88% 79% 96% 100% 100% 96% 93% 93%

Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18

% 62 day result   62 day target

Q2Data provisional

Table 6

Local FCT Database	Mar-18	Apr-18	May-18	Total
Number of records submitted	23	27	38	86
Number of records within 62 days	23	25	41	91
% 62 day Target Met (90%)	100%	93%	93%	97%
% Volume Target Met (15%)	14%	17%	24%	14%

Target: Increase in 8 month olds fully immunised

Table 7 – Eight month Milestone Immunisation Results by Quarter

Quarter	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18 (Provisional)
Result	**90%**	**89%**	**88%**	**90%**	**89%**	**88%**
Māori	**89%**	**86%**	**82%**	**86%**	**83%**	**82%**
Ranking	**16**	**15**	**15**	**15**	**14**	**Unavailable**

We are in the process of implementing the new immunisation action plan which includes a redesign of immunisation and related services.

Measles, Mumps and Rubella (MMR) Vaccination in Samoa

- The MoH has sent out an advisory to the health sector given the media attention to two recent deaths in Samoa shortly after vaccination. We will report to the next meeting of the Board. The Ministry of Health will update all DHBs on the international investigation by UNICEF.

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

Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from Apr 2018 to Jun 2018

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	621	568	91%	22
Māori	535	439	82%	70
Pacific	59	55	93%	2
Asian	133	124	93%	3
Other	86	73	85%	9
Total across ethnicities				106
Total	1,434	1,259	88%	104

Target: Better help for smokers to quit - primary care

Table 9 – Quarterly Results

Q1 result 16/17	Q2 result 16/17	Q3 result 16/17	Q4 result 16/17	Q1 result 17/18	Q2 17/18	**Q3 17/18**
87% 7th ranking	87% 12th ranking	86% 13th ranking	88% 15th ranking	88% 14th ranking	89% 12th ranking	**88% Ranking unavailable**

No new data since last month's report.

Target: Better help for smokers to quit - maternity

Table 11 – Quarterly Results

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	**Q3 17/18**
93% 12th Ranking	98% 4th Ranking	96% 12th Ranking	95% 8th Ranking	94% 8th Ranking	97% 4th Ranking	**99% *Ranking unavailable**

No new data since last month's report.

Target: Raising healthy kids

Our quarter four result showed we are maintaining our result of 100%. Waikato has also maintained a lower number of declines with a quarter four result of 12% which is lower than the national decline rate of 22%.

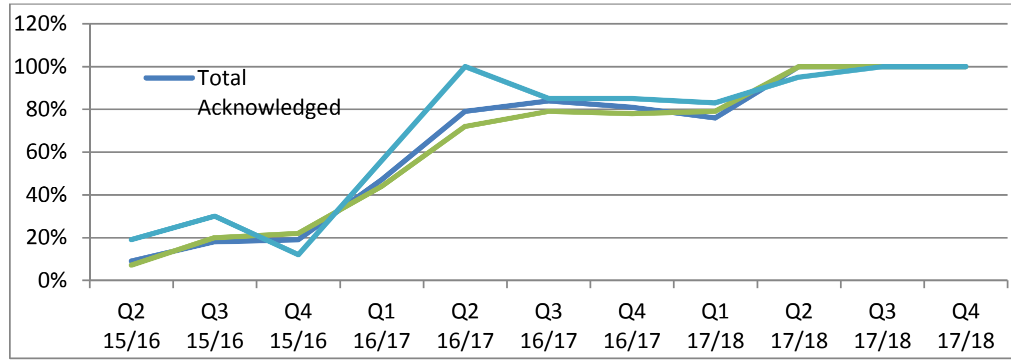
Whaanau Kori, Tamariki Ora is a new programme being offered by Sport Waikato funded for two years from the Raising Healthy Kids funding. The programme was launched in quarter four and we are delighted that referrals have been received from across the Waikato region. The programme has been specifically developed as an intervention programme for 4-6 year old children and their whānau in the unhealthy weight range. Content focuses on supporting whānau to make healthy lifestyle changes including food options, ideas to keep kids moving and active, reducing screen time and improving sleep with evaluation embedded in the intervention programme.

Table 13 – 2017/18 Q3 Raising Healthy Kids Results (target 95%)

		Waikato							**National**
		2016/17 Q1	**2016/17 Q3**	**2016/17 Q4**	**2017/18 Q1**	**2017/18 Q2**	**2017/18 Q3**	**2017/18 Q4** Provisional	**2017/18 Q4** Provisional
		Six mths Aug 16	**Six mths Feb 17**	**Six mths May17**	**Six mths Aug 17**	**Six mths Nov 17**	**Six mths Feb 18**	**Six mths May18**	**Six mths May 18**
Total	Referral Sent	50%	86% (133)	83% (102)	77% (93)	100% (144)	100% (142)	100% (158)	98% (1,289)
	Referral Sent and Acknowledged	**47%**	**84% (127)**	**81% (98)**	**76% (91)**	**100% (144)**	**100% (142)**	**100% (158)**	**98% (1,277)**
Māori	Referral Sent	49%	82% (65)	80% (43)	79% (36)	100% (69)	100% (70)	100% (79)	98% (452)
	Referral Sent and Acknowledged	**44%**	**79% (61)**	**78% (41)**	**79% (36)**	**100% (69)**	**100% (70)**	**100% (79)**	**98% (448)**
Pacific	Referral Sent	56%	90% (9)	88% (10)	87% (13)	95% (12)	100% (14)	100% (14)	100% (372)
	Referral Sent and Acknowledged	**56%**	**85% (8)**	**75% (8)**	**83% (12)**	**95% (12)**	**100% (14)**	**100% (14)**	**99% (371)**

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 May 2018



Recommendation
THAT
The Board receives this report.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

DR DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

DR GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER, WAIKATO HOSPITAL

Health and Safety

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 8.1

HEALTH AND SAFETY SERVICE UPDATE

Purpose	For information.

There are four branches to Principles of Due Diligence in Health and Safety Governance:

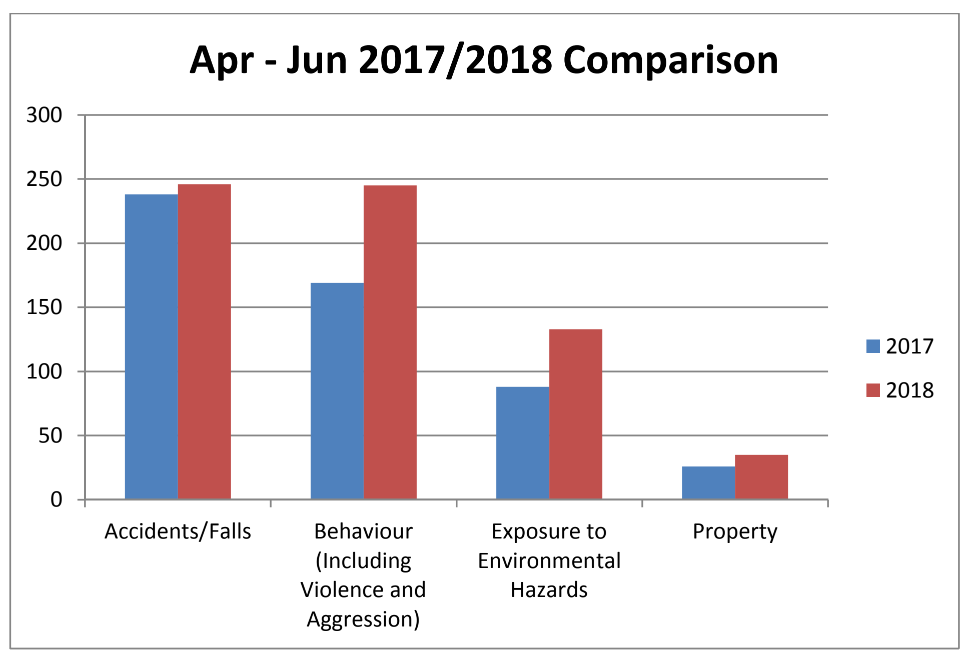
- Policy and Planning
- Monitor
- Delivery
- Review.

Incidents Reported to WorkSafe NZ year to date

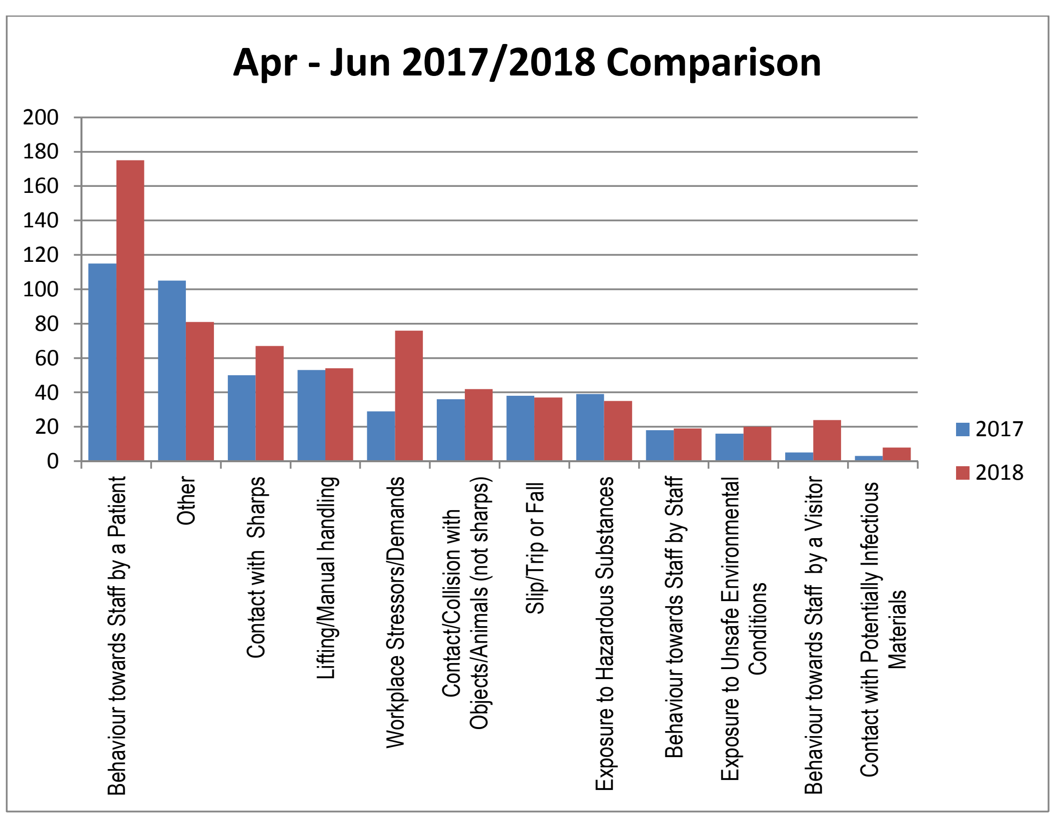
	Year to date
Total Incidents reported	**3**

- Employee collapsed in carpark displaced fracture to right leg – March 2018
- Employee tripped on stairs and sustained fractured right leg – May 2018
- Contractor sustained electric shock-nil injuries sustained – June 2018.

DATIX Incidents (Health & Safety)



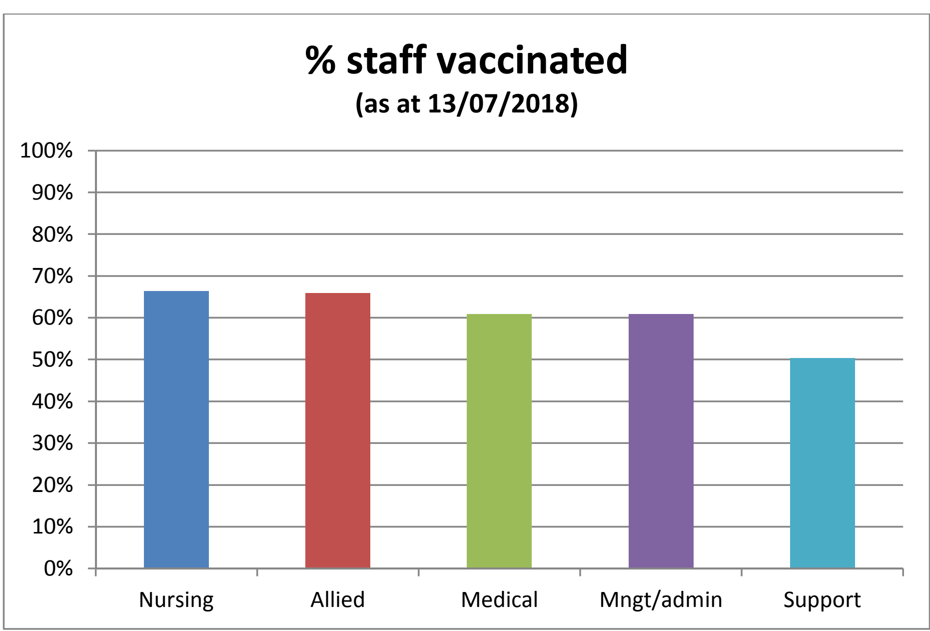
Datix reported incidents by incident type tier 1.



Datix reported incidents by incident type tier 2 (top 12 only).

The capacity issues occuring within the inpatients wards of the HRBC continue to be a significant driver of both the increased incident reporting of patient behaviour/aggression to staff and the workplace stressors/demands reported incidents.

Employee Influenza Vaccination



66% of staff received influenza vaccination as at 20.6.18.18. Programme started on 9 April 2018. It is expected by the time this report is received that the threshhold to decelare the actual influenza season would have been reached.

Health & Safety Audit

Waikato DHB was audited in accordance with our obligatations as an accredited employer the ACC partnership program. The audit was conducted over four days on 3- 6 July 2018. The audit on focussed on the Theatres (primary site) and Te Kuiti Hospital as the secondary site.

The audit standards are specified by ACC as encompassing: *the spirit and intent of relevant legislation was considered (including the Accident Compensation Act 2001 (The Act), and the Health and Safety at Work Act 2015 (HSWA). The audit standards are aligned to AS/NZS 4801:2001, the joint Australia/New Zealand Standard for Occupational Health and Safety Management Systems*

As of the date of writing the report, Waikato DHB has not received official confirmation from ACC as to the outcome of the report; however, the auditor has recommended that Waikato DHB retain tertiary status. Tertiary status is the highest status and reflects an organisation that has an established best practice framework and is undertaking to continuously improve its health and safety framework.

A copy of the audit report is attached as an appendix to this update. The recommendation for improvements are contained on page 4 of the report.

Recommendation
THAT
The Board receives the report.

GREGORY PEPLOE
DIRECTOR PEOPLE AND PERFORMANCE

Accredited Employer Programme Audit Report

Waikato District Health Board

July 2018

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Conformance to the programme standards set out in the audit tool should not be relied on to satisfy compliance with legal and other obligations of the employer. It is the responsibility of the individual employer to be satisfied that these legal and other obligations are met.

Within the standard there are three measurable levels of performance:

primary = Programme entry level requirements	
secondary = consolidation of good practice	
tertiary = continuous improvement, best practice framework	no shading

Shading used throughout the standards indicates the levels as above.

The employer needs to meet the primary level requirements as detailed in each section of the standard to gain entry to the ACC Accredited Employer Programme, and continue to meet these requirements in subsequent annual audits to remain in the ACC Accredited Employer Programme.

Business and audit details

Name of business:	Waikato District Health Board
Contact person: Telephone: Email:	Sheryl Penehio, Manager Health & Safety Service (07) 839 8899 ext 23332 sheryl.penehio@waikatodhb.health.nz
Date(s) of audit: Audit completion date:	3-6 July 2018 6 July 2018
Location(s) of audit:	Theatres (Waikato DHB) (primary site) Te Kuiti Hospital (secondary site)

Summary of workplace information:

Audit Findings

Audit findings have confirmed that Waikato District Health Board (Waikato DHB) has met tertiary level requirements in ACC's accredited employer programme audit.

Audit findings were supported by three focus group interviews and review of nine claim files. Insufficient case studies were available for interview so feedback from those who had experienced the claim management process has been included in focus group feedback to ensure confidentiality.

Three focus groups were held with participants representing areas selected for audit. Participants spoke about positive health and safety achievements which included:

- Improved reporting through the Datix electronic reporting system.
- Positive levels of engagement across disciplines.

The need to hold scenario exercises to test response to security incidents was the main area identified by participants for ongoing improvement.

ACC selected Theatres Waikato Hospital and Te Kuiti Hospital as sites for audit. Built in 1926, Te Kuiti Hospital is one of Waikato DHB's rural hospitals located to the south of Hamilton at Te Kuiti. The 12-bed (plus Emergency Department) hospital has 52 FTE employed across several disciplines that includes nursing, allied health, support, management/administration laboratory and community.

With over 200 staff, Theatres located across Meade Clinical Centre and Kempthorne Theatre Building at Waikato Hospital is a large and complex service comprising a number of services such as Day of Surgery (DOSA), Operating Theatres, Consulting Rooms, Recovery, Endoscopy, Interventional Radiology and Sterilising Unit.

The following strengths/continuous improvement initiatives were specifically noted by the auditor:

- Executive Leadership Quality & Safety Walks – the use of notes to record major discussion points included the identification of good practice initiatives.
- Continued initiatives under the framework of the Staff Safety Action Plan.
- Continued consolidation of contractor management processes.
- Positive support for workplace rehabilitation.

- Wellbeing week scheduled for later in the year by Theatres.

The following recommendations have been made:

Element One

1.2.3 Reinforce the need for performance reviews (including the assessment of health and safety performance) to be consistently completed at all levels within the organisation in a timely manner. Health and safety accountabilities identified in the Health and Safety Policy could be used as the framework for this process.

1.3.1 Continue to strengthen recognition of health and safety performance.

Element Two

2.1.1 The development of a legislative compliance framework is supported.

2.2.1 Strengthen procedures that explain how the effectiveness of Waikato DHB's health and safety management system will be reviewed for example this procedure may include:

- The nature of the review(s) and timeframes.
- Identifying who will be involved.
- How the review(s) findings will be communicated and actioned.

Element Five

5.3.4 Continue to reinforce the importance of investigation sign off once corrective actions are complete.

Element Eight

8.1.1 Strengthen existing procedures to show how Waikato DHB will consult, cooperate and coordinate its activities with other PCBU's where there are overlapping duties e.g. on site food outlets. This may consider:

- Who is involved and an outline of responsibilities.
- Consultation and communication processes.
- Steps to be taken in situations such as an emergency or a notifiable event.

Element Nine (Theatres)

General

It is recommended that environmental monitoring is undertaken in the specimen room during the decantation of Formalin to assess whether hazardous levels of exposure exist in which case, improved ventilation such as a fume cabinet may be needed.

Element Sixteen

16.3.3 Continue to reinforce the need for Managers to document weekly monitoring of rehabilitation progress when the injured employee is participating in workplace rehabilitation.

Element Seventeen

17.1.1 There is an opportunity to give a wider scope of thought to rehabilitation/return to work objectives particularly in light of the recommendations contained within this report e.g. Manager documentation of weekly monitoring of rehabilitation progress.

Note that objectives should be S.M.A.R.T objectives i.e. the objectives should be specific, measurable, achievable, realistic and time bound.

Element Twenty

General

Manual handling training needs to be widened to include non-clinical staff involved in moving and handling activities e.g. Health Care Assistants.

The Health and Safety Service is responsible for coordinating health and safety activity and assisting Managers discharge their duties. The Service comprises the Manager (reporting to the Director People and Performance), Administrator and five Health and Safety Advisors, one of whom is seconded to Property and Infrastructure to oversee contractor management.

Processes for the management of health and safety are held on the intranet and each work area has a health and safety folder with printed policies and procedures, the hazard register, hazard control plans, inspection checklists and material safety data sheets (MSDS).

Several unions are represented across Waikato DHB; Unite; NZNO (NZ Nurses Organisation), PSA (Public Service Association), ASMS (Association of Salaried Medical Specialists), First Union, Etū; NZRDA (NZ Resident Doctors' Association), APEX (Association of Professional and Salaried Employees), NZMLWU (NZ Medical Laboratory Workers' Union), AWUNZ (Amalgamated Workers' Union of New Zealand).

Key hazards/risks include the following:

- Workplace violence.
- Exposure to blood and body fluids.
- Chemicals/hazardous substances.
- Moving and handling.
- Slips trips and falls.

Top three injury trends are; assaults, exposure to blood and body fluids and sprains/strains. Several injury prevention initiatives are in place to target these injuries such as online personal safety training and the inclusion of manual handling training as a core module within the organisational orientation. The appointment of an HR Information Service Analyst who has responsibility for HR analytics (including health and safety) is strengthening the quality and interpretation of data held in the electronic reporting system Datix.

An Employee Participation Agreement is in place between Waikato DHB, NZNO, PSA and participating unions. The Agreement which was updated (August 2017) to align with the Health & Safety at Work Act 2015 outlines definitions, selection and functions of health and safety representatives, health and safety forums and training. A health and safety role description has also been developed to outline requirements of the role and responsibilities.

Organisation-wide employee participation is primarily facilitated through JUMCF (Joint Union Management Consultative Forum) which is held quarterly with representatives from unions and DHB management. Terms of reference are developed which outline the purpose of this forum "to foster cooperation and consultation between unions and management".

Waikato DHB continues to contract WorkAon as TPA to provide claims administration and case management services. Processes for managing work injury claims (including claims lodgement) are outlined in the Work Injury Claims Management & Rehabilitation Manual updated September 2017 to align with the new audit standards.

Information on the management of work injury claims, including claim lodgement is provided to new staff at orientation through the Workplace Accident Insurance pamphlet. Annual refresher information attached to payslips 25/01/18 and 1/02/18 included an overview of above.

Organisational Overview

Waikato DHB which employs 6633 staff is one of 20 district health boards responsible for the planning and funding, and provision of health and disability services for its population of 390,000 which covers a geographical area stretching from northern Coromandel to close to Mt Ruapehu in the south, and from Raglan on the west coast to Waihi on the east.

There are 10 territorial local authorities within Waikato DHB boundaries – Hamilton City, Hauraki, Matamata-Piako, Otorohanga, (part of Ruapehu), South Waikato, Thames Coromandel, Waikato, Waipa and Waitomo.

Waikato DHB receives funding from government to undertake its functions.

About 60 per cent of funding received by Waikato DHB is used to directly provide hospital and health services, including:

- five hospital sites including a tertiary teaching hospital (Waikato Hospital in Hamilton), a secondary hospital in Thames, and three rural hospitals in Tokoroa, Te Kuiti and Taumarunui
- two continuing care facilities
- one mental health inpatient facility
- community based services
- population health services.

The remaining 40 per cent is used to fund contracted services provided by non-government organisations (NGOs), primary health care organisations (PHOs), pharmacies and laboratories, including:

- 57 aged related residential care facilities
- 76 pharmacies
- 75 general practitioner (GP) practices
- 18 Māori organisations
- two Pacific organisations
- three primary health alliance partners.

Some services are funded and contracted nationally by the Ministry of Health and National Health Board, for example public health services, breast and cervical screening, as well as the provision of disability support services for people aged less than 65 years.

Waikato Hospital based in Hamilton has in-patient 800 beds and is the main tertiary teaching hospital that provides all secondary and tertiary hospital services for the Midland Region.

The Board and Executive Offices are located in Hamilton City on the Waiora Waikato Hospital Campus.

AEP current status

☐ Is this an initial audit? (tick as appropriate)	√ Is this a renewal audit? (tick as appropriate)

Recommendation to ACC

Based on the audit I recommend that this business:

√ has successfully met the requirements of the Accredited Employer Programme audit at the following level:

☐ Primary ☐ Secondary √ Tertiary

☐ was unsuccessful in meeting the requirements of the Accredited Employer Programme audit.

Note: The final decision regarding the level of conformance to the Accredited Employer Programme tool will be made by ACC.

ACC-approved auditor

Name: Martha Rowbotham	
Company name: PricewaterhouseCoopers	
Postal address: PO Box 92162	Suburb:
City: Auckland	Postcode: 1142
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Auditor signature:	
Date: 10 July 2018	

Summary of results

Safety management practices		*Level demonstrated*
1.	Employer commitment to safety management practices	Tertiary
2.	Planning, review and evaluation	Tertiary
3.	Hazard identification, risk assessment and management	Tertiary
4.	Information, training and supervision	Tertiary
5.	Incident and injury reporting, recording and investigation	Tertiary
6.	Employee participation in health and safety management	Tertiary
7.	Emergency planning and readiness	Tertiary
8.	Ensuring the health and safety of employees and others in the workplace	Tertiary
9.	Workplace observation	Primary
Injury management practices		
10.	Cover decisions	Primary
11.	Entitlements	Secondary
12.	File management	Primary
13.	Administration and reporting	Primary
14.	Complaint and review management	Primary
15.	Development of rehabilitation policies, procedures and responsibilities	Tertiary
16.	Assessment, planning and implementation of rehabilitation	Tertiary
17.	Rehabilitation outcomes, return to work and follow-up procedures	Tertiary
18.	File reviews and case studies, confirmation of injury management procedures in action	Tertiary
19.	Case study interviews	Primary
20.	Focus group interviews; confirmation of safe systems and injury management in action	Primary
20.	Number of focus groups	3

Note:

- Primary level is the maximum level that can be achieved for Elements 9, 10, 12, 13, 14, 19 and 20
- Secondary is the maximum level that can be achieved for Element 11
- Element 15 has only Primary and Tertiary requirements

SAFETY MANAGEMENT PRACTICES REQUIREMENTS

Employers will have **established** occupational health and safety systems functioning **actively** in the workplace, covering the following elements, and meeting all the specific primary requirements, before seeking entry to the AEP.

Elements

1. Employer commitment to safety management practices
2. Planning, review and evaluation
3. Hazard identification, risk assessment and management
4. Information, training and supervision
5. Incident and injury reporting, recording and investigation
6. Employee participation in health and safety management
7. Emergency planning and readiness
8. Ensuring the health and safety of employees and others in the workplace
9. Workplace observation

Element 1 - Employer commitment to safety management practices

(AS/NZ 4801:2001 Sections 4.2,4.4 and 4.6)

Objective The employer is able to demonstrate an active, consultative commitment to all areas of work health and safety management.

Details of requirements	Verified by	Achieved Yes/No
1. There is a documented statement or policy that demonstrates an employer's commitment to health and safety.	The policy or statement includes: 1. management commitment to health and safety	Yes
	2. a commitment to comply with relevant legislation, safe work instruments* (SWI), codes of practice (CoP)*, standards and safe operating procedures* (SoPs)	Yes
	3. individual responsibilities for work health and safety	Yes
	4. a requirement to accurately report, record and follow up all health and safety events	Yes
	5. a commitment to consult with employees, health and safety representatives* and, where applicable, unions regarding matters relating to work health and safety	Yes
	6. evidence* that senior management* (or officer*, if applicable) have reviewed the policy or statement in the last 24 months	Yes
	7. appropriate signature/authorisation, position and date	Yes
	8. a statement of commitment to continuous improvement in health and safety.	Yes
2. There is an understanding of health and safety management in the workplace.	1. Specific health and safety responsibilities are designated at the senior management level (this may include PCBU, officers, managers).	Yes
	2. People in charge of others* have position descriptions (or similar) that include specific health and safety responsibilities relevant to their role.	Yes
	3. Evidence that people in charge of others (including senior management) have had performance reviews against their specific health and safety responsibilities.	Yes
3. The employer actively supports health and safety.	1. Evidence that excellence and/or innovation in health and safety are recognised.	Yes

Summary of Element 1:

√	It is recommended that this employer has successfully met the requirements of Element 1 at the following performance standard: ☐ Primary ☐ Secondary √ Tertiary
☐	It is recommended that this employer has *not* met the requirements of Element 1.

Comments:

The Health and Safety Policy remains unchanged from the last audit completed September 2017. Dated 21/12/16 and endorsed by the Board of Clinical Governance the Policy is scheduled for biennial review.

Waikato DHB outlines its commitment to achieving excellence in health and safety management as well as the following:

- Promoting a safety culture.
- Actively training managers and employees to understand their responsibilities.
- Encouraging participation.
- Continuous health and safety improvement.
- Providing appropriate rehabilitation to employees who have suffered a work related injury/illness.
- Legislative/statutory compliance.

The policy clearly outlines health and safety roles and responsibilities (by delegation of authority) that includes people in charge of others, workers, contractors and external personnel.

Managers are specifically responsible for reporting and recording and investigation, implementation of corrective and preventative actions for all work related incidents. Also detailed in the policy is applicable legislation, standards and associated documentation.

Health and safety accountabilities are included in management position descriptions e.g. Charge Nurse Manager (CNM) included accountabilities such as ensuring compliance with infection control and hand hygiene standards. One CNM position description also included the accountability to “follow established health and safety policies and procedures to ensure safety of oneself and others.”

The annual performance review process is used to facilitate the assessment of health and safety performance for those in charge of others. Examples reviewed (including management positions at Te Kuiti Hospital) were variable in their content relating to health and safety performance. Some examples had well documented comment on staff safety initiatives and established individual health and safety KPI’s while others had minimal comment or in one case no comment (see recommendation 1.2.3).

While there was some evidence of the recognition of health and safety performance/initiative this has lapsed somewhat since the last audit. Two examples of emailed recognition through “values cards” were sighted and in one excellent example, a documented Executive Leadership Quality & Safety Walk recognised a Health & Safety Representative for the development of a safety newsletter to raise awareness (see recommendation 1.3.1).

Critical issues:
None
Improvement recommendations:
1.2.3 Reinforce the need for performance reviews (including the assessment of health and safety performance) to be consistently completed at all levels within the organisation in a timely manner. Health and safety accountabilities identified in the Health and Safety Policy could be used as the framework for this process. 1.3.1 Continue to strengthen recognition of health and safety performance.

Element 2 - Planning, review and evaluation

(AS/NZ 4801:2001 Sections 4.3, 4.4 and 4.5)

Objective The employer is able to demonstrate a systematic approach to occupational health and safety that includes a focus on continuous improvement. This involves setting objectives, developing plans and programmes to achieve objectives, regular review of progress, and evaluation of outcomes.

Details of requirements	Verified by	Achieved Yes/No
1. The employer is able to demonstrate knowledge of current health and safety information including legislation, regulations, safe work instruments (SWI)*, codes of practices (CoP), standards and specialist information relevant to the work that is done.	1. Procedure/s* that explain how the employer will identify relevant legislation, SWI, CoP, standards, guidelines and other industry information. Timeframes for checking, reviews and responsibilities are included.	Yes
	2. Procedure/s are in place to ensure compliance or conformance with relevant requirements.	Yes
	3. Evidence that the employer has reviewed relevant information within the last 24 months and, where appropriate, made changes.	Yes
2. There is a system in place to ensure the effectiveness of health and safety management for the organisation is reviewed regularly and after a notifiable event*.	1. Procedure/s that explain how the effectiveness of organisational health and safety management will be reviewed.	Yes
	2. Evidence that the effectiveness of health and safety management has been reviewed in the last 12 months.	Yes
	3. Procedure/s to review health and safety management that occurs after: • a notifiable event • changes in work procedures • changes in health and safety policies and procedures.	Yes
3. Health and safety objectives are set that are: • appropriate to the size and type of business or undertaking • relevant to each level within the business or undertaking • related to identified hazards* and risks*.	1. Evidence of health and safety objectives and plans to achieve these.	Yes
	2. Procedure/s to review and update or reset health and safety objectives at least every 12 months.	Yes
	3. Evidence that health and safety objectives have been reviewed, updated or reset in accordance with the procedure.	Yes

Details of requirements	Verified by	Achieved Yes/No
	4. Evidence that senior management and employees, or employee or union representatives, have been included in the review and setting of objectives.	Yes
4. Systems are in place to undertake a self-assessment every 12 months to ensure the AEP audit standards are met and maintained. The assessment involves management, union, and other nominated employee representatives. NB: May be immediately prior to initial audit	1. Self-assessment procedure/s.	Yes
	2. Evidence of self-assessments conducted in accordance with the procedure/s.	Yes
5. There is a system in place to control health and safety-related documents and information.	1. A document control system (paper-based or electronic).	Yes
	2. Evidence of current versions of documents in use.	Yes

Summary of Element 2:

√ It is recommended that this employer has successfully met the requirements of Element 2 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 2.

Comments:

The Health and Safety Policy states that it is the responsibility of Waikato DHB's Officers to ensure processes are implemented for assurance. Health and safety legislative compliance requirements, external standards and associated Waikato DHB documents are listed in the Health and Safety Policy as well as organisational policies reviewed at scheduled timframes.

A legislative compliance framework is under development for the Midland Region (see recommednation 2.1.1). Waikato DHB's internal audit programme is established to provide assurance to the Board and management that:

- Waikato DHB's Health and Safety Policy recognises the key elements of the Health and Safety at Work Act.
- Systems and processes are aligned with the Policy.
- Health and safety systems operate as expected.
- Health and safety systems operate in a way that minimioses personal liabilities to the Board and employees defined by the Act as PCBU's.

The internal audit of legislative compliance was underway at the time of audit.

There were a number of examples of updated policies and management role descriptions to reflect the Health and Safety at Work Act 2015. The Board was briefed April 2016 about the new legislation, "drivers for change", health and safety governance and due diligence principles.

The Health and Safety Policy outlines the requirement for regular review and audit of health and safety management systems and practice (see recommendation 2.2.1) and while this is an element of the internal audit underway currently, this also is achieved through the annual self assessment process, ongoing review of incident/accident reports (including variance reporting) and the annual AEP audit.

The incident/accident management system in conjunction with the critical incident management for staff policy (serious and sentinel event review) facilitates the review of health and safety following a critical event (classified as SAC 1&2). A formal process is in place for staff debriefing for critical events includes consideration of and identification of strengths and weaknesses of current systems and areas for future learning. An example of a potential critical event resulted in the implementation of identification lanyards with two breakpoints.

Waikato DHB continues to develop is staff safety initiative with the Staff Safety Culture Working Group (SSCWG) and Plan. Consultation in the development of the plan arose directly from the Staff Safety Culture Survey. The Safety and Wellbeing Plan 1/07/16 – 30/06/18 was developed and reviewed by the SSCWG which has a multidisciplinary membership that includes union and employee representation. The review recently completed outlines progress on a number of work streams. Initiatives within the Staff Safety workstream included:

- Analysis of Datix reports on assaults/disorderly behaviour.
- Introduction to Personal Safety online training.
- Promotion of CALM (effective communication) online training.
- Manager online briefings.

A further Staff Safety Culture Survey is planned for October 2018 which will serve to validate the recent review of the Plan.

Self assessments were appropriately completed and signed off by by Managers and Health and Safety Representatives Theatres 19/06/18 and Te Kuiti Hospital 23/05/18.

The management of policies and guidelines policy outlines processes for the the review of policies and guidelines including their endorsement and publication. A policies and guidelines facilitator is appointed to review and align service specific procedures.

A list of health and safety policies and guidelines is held on the intranet and this outlines the policy version, document reference, current issue date, review date, facilitator name and title.

Critical issues:

None

Improvement recommendations:

2.1.1 The development of a legislative compliance framework is supported.

2.2.1 Strengthen procedures that explain how the effectiveness of Waikato DHB's health and safety management system will be reviewed for example this procedure may include:

- The nature of the review(s) and timeframes.
- Identifying who will be involved.
- How the review(s) findings will be communicated and actioned.

Element 3 - Hazard identification, risk assessment and management

(AS/NZ 4801:2001 Sections 4.3, 4.4 and 4.5)

Objective The employer has implemented a method to systematically identify, assess and manage the actual and potential work hazards and risks over which the employer has authority or influence.

Details of requirements	Verified by	Achieved Yes/No
1. There are procedure/s* to identify and record actual and potential hazards and risks in the workplace.	1. Procedure/s explain how to identify hazards and risks, and include an understanding of the range of hazards facing employees, wherever they are working.	Yes
	2. Procedure/s to identify hazards and associated risks include any: • new projects or contracted works • new material, substances, services or work processes • new, modified or hired equipment • modified practices or processes • changes that may have modified any known hazards or risks.	Yes
	3. Evidence of a register (or similar) that records hazards and/or risks to support the process in action.	Yes
	4. Evidence of consultation* with relevant or affected people about any new or modified equipment, material, services, work practices or processes introduced into the workplace.	Yes
2. There are procedures to assess the risks associated with the identified hazards.	1. Procedures that explain when and how to assess risk associated with identified hazards.	Yes
	2. Evidence that assessments of risks have been completed.	Yes
	3. The hazard or risk register (or similar) clearly identifies those hazards or risks that could cause serious injury, illness or death to employees (or others).	Yes
	4. Evidence that health and safety issues and assessment/s of risks have been considered as part of the design and pre-purchase decisions, and before any changes/modifications to (where applicable): • materials or substances • work practices, processes or services • plant*, buildings, structures or equipment.	Yes

Details of requirements	Verified by	Achieved Yes/No
3. Appropriate hazard and/or risk controls have been developed and implemented (based on the hierarchy for risk control in the health and safety at work legislation).	1. Procedure/s for developing controls includes an assessment of whether risks to health and safety can be: a. Eliminated and, if elimination is not reasonably practicable*, then: b. Minimised by: • substitution • isolation • use of engineering controls • use of administrative controls • use of Personal Protective Equipment (PPE)*.	Yes
	2. Procedure/s to support the appropriate use of specialist advice (where applicable).	Yes
	3. Reference information is readily accessible to those who need it.	Yes
	4. Evidence that the hazard and risk controls developed are based on appropriate advice or information (where applicable).	Yes
	5. Details of appropriate risk controls developed for hazards that have health and safety risks.	Yes
	6. Where safety equipment, including PPE, has been identified as a risk control, there is evidence of a system in place for its issue, renewal and maintenance.	Yes
	7. Evidence that hazard and risk controls have been communicated to relevant people.	Yes
4. There is a system in place to review the risk controls of the identified hazards.	1. Evidence that risk controls have been reviewed to ensure controls are working, effective and are still appropriate.	Yes
	2. Responsibilities assigned to ensure reviews have been undertaken and signed off.	Yes
5. Occupational health monitoring* is managed.	1. Procedures that explain how to determine if health monitoring is needed. (If health monitoring is not required, the employer must provide a documented rationale to show whey they reached that conclusion.)	Yes
	2. Where the employer has identified health monitoring is required, procedure/s explain how health monitoring will be conducted, including (if applicable) requirements for baseline monitoring.	Yes
	3. Where the employer has identified health monitoring is required, evidence is available of completed health monitoring assessments (where applicable).	Yes
	4. Evidence that notification of health monitoring results has been provided to employees (only applicable when monitoring undertaken).	Yes

Details of requirements	Verified by	Achieved Yes/No
	5. Health monitoring procedure/s explain how sub-optimal test results are managed, including consideration of individual medical and vocational needs.	Yes
	6. Health monitoring procedure/s explain how sub-optimal results are fed back into the hazard or risk management system.	Yes
	7. Procedure/s explain when pre-employment health screening assessments are required (where applicable). (Where pre-employment health screening is not required, the employer must provide a documented rationale to show why they reached that conclusion.)	Yes
	8. Evidence that pre-employment health screening assessment have been completed (where applicable).	Yes

Summary of Element 3:

√ It is recommended that this employer has successfully met the requirements of Element 3 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 3.

Comments:

Supported by the Risk Management Policy, the Hazard Management Policy was updated August 2017 to align with the Health and Safety at Work Act 2015. The Policy outlines responsibilities, definitions and processes for:

- Hazard/risk identification.

  Generic organisational hazards are identified and departments/wards use this information to develop their own hazard registers.

  Each work area held a hazard register which identified hazards by task and area. Hazard identification is also a well established part of the change and procurement process with the requirement for Health and Safety Service sign off.

- Hazard/risk assessment.

  Hazard registers record risk rating based on a risk scoring matrix aligned to SAC (Severity Assessment Code) criteria that considers consequence and likelihood.

- Hazard/risk control.

  Hazard controls reflect the hierachy of controls outlined in the legislation i.e elimination/minimisation. Master hazard control plans are held on the intranet as a resource for work areas and there are a number of policies that outline organisational control strategies such as the Manual Handling Policy.

- Hazard/risk monitoring.

  Hazard registers are required to be reviewed at least annually when workplace inspections are carried out. Hazard registers had been reviewed and workplace inspections completed six monthly in areas selected for audit.

Hazard registers are also reviewed as part of an accident/incident investigation and also if there are any suboptimal health monitoring results.

The Procurement and Contracts Policy sets out Waikato DHB's policy requirements for its procurement and contracting processes, including compliance with minimum safety standards. Coordinated by the Clinical Product Coordinator, all products are required to comply with standards for safety and use in the New Zealand Health Industry.

Risk identification and management is accepted as a key part of the procurement lifecycle and there is an established process to consult with Infection Control and the Health and Safety Service in the review of purchasing decisions. Examples reviewed such as single patient use slings (March 2017) and Community Health Backpack (February 2018) clearly identified health and safety considerations.

The trial of a robotic cleaning machine is currently underway in consultation with the Health and Safety Advisor. As part of this trial a Work Method Statement has been developed that outlines safety features, potential hazards and applicable Codes, Regulations.

The Hazard Management Policy states that specialist advice should be accessed through the Health & Safety Service. A significant resource of subject matter experts exists within the DHB e.g. Occupational Physician (health management), Respiratory Physician (sub optimal health monitoring results management) Moving and Handling Trainers and Medical Officer of Health (infectious diseases). Examples reviewed included, environmental noise monitoring and health monitoring services for the Flight Crew.

An extensive range of health and safety information is held on the intranet and each policy contains references to applicable legislation, standards and associated DHB documentation. The People and Performance News provides information such as injury prevention reminders, Learning and Development updates, staff survey, peer support, influenza vaccinations and Datix reporting reminders.

The process for the issue/use of personal protective equipment (PPE) is documented in the internationally recognised procedures "Lippincott's Nursing Procedures & Skills" and a range of infection control policies. This includes several single use items such as gloves, aprons and masks as well as eye/face protection such as face guards in place in sluice rooms. Theatres and Te Kuiti Hospital maintain a schedule of PPE checks such as lead protection clothing and radiation exposure monitoring devices.

Processes are established for the routine testing of safety and performance of medical devices through Waikato DHB's Biomedical Engineering Department i.e. 'Routine Safety & Performance Testing' procedure. The fume cupboard in the Laboratory at Te Kuiti Hospital was checked and in date according to procedures.

The Management of Employee Health and Rehabilitation Policy (June 2017) outlines requirements for the identification and management of health monitoring.

Health screening and ongoing monitoring requirements are identified in relation to hazard exposure and level of patient contact and is governed by a number of policies such as:

- Recruitment and Selection.
- Vaccination for Health Care Workers.
- Tuberculosis Management for Employees.
- Blood and Body Substance Exposure and Management.
- Cidex OPA Health Questionnaire.

Several categories of pre-employment screening are in place:

- Clinical screening e.g. nursing/allied health

  Prospective staff are required to provide evidence of immunity status prior to employment and where immunity is not verified a vaccination programme is required to be completed.

- Non clinical screening e.g. management/administration

  Immunity validation for MMR and Boostrix.

- Nutrition and Food

  Immunity validation for Hepatitis B, MMR and Boostrix.

- Property & Infrastructure

  As for clinical with additional hearing baseline screening and spirometry.

Ongoing monitoring is based on hazard exposure and includes annual TB (Tuberculosis), Cidex/OPA and Hepatitis B (if no seroconversion).

Post-critical event testing is initiated when indicated, and examples included blood & body fluid exposure and exposure to specific infectious diseases such as TB. National Guidelines for 'The Interpretation of Laboratory Results for Health Care Workers' following Blood/Body Fluid Substance Exposure' are used to manage this process.

Critical issues:
None
Improvement recommendations:
None

Element 4 - Information, training and supervision

(AS/NZ 4801:2001 Section 4.4)

Objective The employer will ensure all employees are informed of their own responsibilities and the responsibilities of all other relevant parties for health and safety when working. The employer will ensure that employees have specific knowledge, skills and the appropriate information, training and supervision with respect to the hazards and risks to which they are exposed.

Details of requirements	Verified by	Achieved Yes/No
1. There is appropriate health and safety induction training for new employees and employees transferring to a new environment, role or task.	1. Evidence that health and safety induction includes the following: • emergency procedures • hazard and incident reporting • how risk assessments are undertaken • work hazards and risks • health and safety responsibilities of employer, employees and, where applicable, any other relevant parties • employee or worker* participation and representation processes • information about health and safety meetings • injury management and return to work processes • use and care of general health and safety equipment, including PPE.	Yes
	2. Signed employee induction training records (or similar individual verification).	Yes
2. There is identification of health and safety training needs in relation to hazards and risks associated with specific roles, tasks or areas of work.	1. Evidence that training needs for specific roles, tasks, or areas of work have been identified.	Yes
3. All task-related health and safety information and training is delivered so key messages are clearly understood, taking into account language, literacy and other factors that can affect understanding.	1. Evidence that task-related training has occurred.	Yes
	2. Evidence that employees issued with role-specific PPE or clothing have been trained on its use and maintenance (where applicable).	Yes
	3. Evidence that employees issued with task-specific safety equipment (in addition to PPE or clothing) have been trained on its use and maintenance (where applicable).	Yes
	4. A “reminder” system (or similar) for recurring training or certification including assignment of responsibilities.	Yes

Details of requirements	Verified by	Achieved Yes/No
	5. Evidence that employers have verified that employees/workers understand: • role or task-specific hazards related to their work • the risk of harm* • how to use the controls in place for their protection.	Yes
4. There are appropriately trained and/or experienced people leading the identification of hazards and management of risks.	1. Records of training and/or skills and experience for people leading hazard identification and risk assessments.	Yes
	2. Evidence of ongoing training or increased experience for people leading hazard identification and/or risk assessment that has occurred in the previous 24 months.	Yes
5. There is access to trainers with the relevant skills, experience or qualifications.	1. Selection criteria for internal trainers specifies their required experience and relevant skills (where applicable – i.e. only where internal trainers are to be used).	Yes
	2. Selection criteria for external trainers specifies their required experience and relevant skills (where applicable – i.e. only where external trainers are to be used).	Yes
	3. Records of trainers' skills, experience or qualifications.	Yes
6. Employees undergoing on-the-job training are supervised by skilled, experienced and/or qualified staff.	1. Selection criteria for those supervising employees/workers undergoing on-the-job training are defined and documented.	Yes
	2. Evidence of supervision of employees/workers undergoing on-the-job training (where applicable).	Yes
7. Training is provided to employees (e.g. employee health and safety representatives) involved in health and safety management.	1. Evidence that training needs have been identified for those employees with designated health and safety roles and/or responsibilities.	Yes
	2. Evidence of health and safety training, or refresher courses, relevant to health and safety roles and/or responsibilities, have been undertaken by employees and/or their representatives within the past 24 months.	Yes
8. Senior management, managers and people in charge of others have an understanding of health and safety management relative to their positions.	1. Evidence that senior management, managers and people in charge of others have increased or refreshed their health and safety knowledge within the previous 24 months.	Yes
9. The designated employees or wardens for each work area	1. Training records (or similar) for people with specific roles in emergency situations.	Yes

Details of requirements	Verified by	Achieved Yes/No
are trained to respond to emergency situations.	2. Evidence that refresher emergency training has been undertaken with designated employees within the previous 12 months.	Yes
	3. Evidence that designated employees have completed specific emergency training within the previous 24 months for situations documented in the emergency plan/s (see 7.1.1).	Yes

Summary of Element 4:

√ It is recommended that this employer has successfully met the requirements of Element 4 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 4.

Comments:

The Learning and Development Policy provides the framework for learning and development for Wakato DHB staff.

Within the framework of the Orientation Policy, the orientation process is well established and includes a comprehensive range of health and safety information and mandatory health and safety modules:

Organisational orientation

The orientation programme includes a presentation from the Health and Safety Service where information provided includes; general safety and compliance, staff wellness, staff support and advice, education and training, workplace accident and injury management, electrical safety, emergency management planning and infection control.

An employee orientation pack is provided that extensively covers health and safety such as responsibilities and employer duties, health information (health screening), hazard management, accident/incident reporting, training and supervision, workplace accidents and claim lodgement, rehabilitation, Code of ACC Claimant Rights, dispute resolution and where to locate health and safety information on the intranet.

Service/Department orientation

Each area selected for audit had an established orientation programme. Theatres have work area specific orientation programmes e.g. Theatre; Post Anaesthetic Care Unit Perioperative. Information includes infection control, PPE Use in Healthcare Settings: How to Safely Don, Use and Remove PPE. Te Kuiti Hospital has developed an orientation checklist that includes key health and safety information.

New managers have an Orientation and Career & Development Plan developed, based on the level of management delegation and included in this, is a health and safety introduction (personal safety, Datix incident reporting, occupational health monitoring, hazard registers, staff safety culture working group, emergency management systems and managing workplace accident insurance) and a 1:1 meeting with the Health & Safety Advisor.

Waikato DHB's Learning & Development Service plans and co-ordinates training with the development of an annual training calendar which outlines mandatory training as well as training associated with professional development.

As outlined in the Learning and Development Policy, training needs are identified in relation to organisational needs (core mandatory training), hazard exposure and role (career pathways & compliance internal education). The annual performance review process also facilitates the identification of ongoing training needs.

Mandatory training provided via Ko Awatea LEARN (online) for all roles includes manual handling, Datix reporting, fire and electrical safety and introduction to personal safety. Currently health and safety training records are held by the Health and Safety Service, entered manually into PeopleSoft.

Evidence of a range of task-specific training was reviewed such as:

- Manual handling techniques associated with Hovermats.
- Heavy crate lifting.
- Patient positioning of large BMI patients.
- Handling and knowledge of gases and gas mixtures.
- Train the trainer.
- CALM (de-escalation).

Ongoing hazard management training is provided through the following

- Managers update
- New managers orientation
- Health and safety representative's (HSR's) two-day introductory training plus ongoing updates.

Health and safety advisors have completed HSR 'Transition Training' (Health and Safety at Work Act).

Managed through Learning and Development, external trainers are sourced through a formal procurement process that requires trainers to be appropriately qualified for specific course content. Internal training is provided by subject matter experts such as Learning & Development and Health & Safety Service, Manual Handling Trainer, as well as Nurse Educators, Preceptors and Clinical Nurse Specialists where this is a formal component of their role description.

Nominated/elected HSR's are provided with an initial two days internal training 'Introduction to Health and Safety, Hazard Management and Accident Investigation' followed by ongoing health and safety updates 'what's new what's changed' scheduled throughout the year. Training records confirmed that 300+ HSR's have completed training and updates over 2017-2018.

Health and safety training provided for senior leaders and managers over the last two years includes the following:

- Board presentation on the Health and Safety at Work Act update for new Board members August 2017.
- Ongoing "Managers updates" e-learning module that covers an overview of the Health and Safety at Work Act, health and safety representation, hazards and risks in your area of work, incident management (including notifiable events). Over 1/01/18 – 3/07/18 44 managers have completed these updates.

The following emergency training was verified through attendance records which are maintained on PeopleSoft:

- Fire safety.
- Floor warden (training sessions are staggered to ensure coverage of all shifts).
- CIMS in Health (six sessions per year).
- CIMS 4 Working in an Emergency Coordination Centre.

• Electrical safe work practice/basic life & first aid. • De-escalation, breakaway and RESPEC. • Handling and knowledge of gases and gas mixtures (in accordance with the Health and Safety at Work (Hazardous Substances) Regulations 2017.
Critical issues:
None
Improvement recommendations:
None

Element 5 - Incident and injury reporting, recording and investigation

(AS/NZ 4801:2001 Sections 4.4 and 4.5)

Objective The employer has effective reporting, recording and investigation systems to ensure work-related incidents, injuries and illnesses are reported and recorded, and the appropriate investigation and corrective actions are taken. This includes all "near miss" or "near hit" events that might have harmed any employee during the course of their work.

Details of requirements	Verified by	Achieved Yes/No
1. A system is in place to record workplace injuries, illnesses and incidents, and notify these to all relevant parties.	1. Procedure/s that explain when and how to: Record • all incidents, injuries and illnesses for both notifiable* and non-notifiable events. Notify • relevant internal parties • regulatory agency* (of all notifiable events).	Yes
	2. Workplace injury, illness and incident report forms (or similar) are completed (where applicable).	Yes
	3. Evidence of prompt and appropriate notification to the regulatory agency (where applicable).	Yes
2. A system has been implemented to investigate incidents that harmed, or might have harmed, people in the workplace.	1. Procedure/s that explain how incidents will be investigated.	Yes
	2. Evidence of completed investigations of reported and/or recorded events (where applicable).	Yes
3. A system is in place to ensure that corrective action is undertaken for any deficiencies identified by the investigation.	1. Procedure/s that explain how corrective actions are identified, managed and implemented.	Yes
	2. Procedure/s include feedback into hazard and/or risk management.	Yes
	3. Evidence that affected employees are advised of any corrective actions (where applicable).	Yes
	4. Evidence that corrective actions have been implemented (where applicable).	Yes

Details of requirements	Verified by	Achieved Yes/No
	5. Evidence that senior management (or similar) have been informed of (and, where appropriate, have approved) any corrective actions in response to notifiable events (where applicable).	Yes
4. All incident, injury and illness data is collated and reviewed to identify trends and provide information to managers and employees that can be used in injury prevention initiatives and/or improved health and safety outcomes.	1. Procedure/s for the collation of all incident data for analysis and review.	Yes
	2. Evidence of an annual review of collated data to identify trends.	Yes
	3. Evidence that collated data and (where applicable) trend analysis is communicated to managers and employees.	Yes
	4. Evidence of proactive injury prevention activities that are based on workplace hazard/risk factors (other than trend analysis results).	Yes
	5. Evidence of implementation of reactive injury prevention initiatives that are based on results of trend analysis (where applicable).	Yes
5. There is a system in place to support early intervention* strategies following reports of pain, discomfort or injury.	1. Early intervention procedures include: • responsibilities of employee, union (if applicable), health and safety representatives* and management • opportunities for alternative duties* • responsibilities for monitoring and follow-up • support available and the right to union and other nominated employee representation.	Yes
	2. Evidence of management of early intervention upon receipt of reported pain, discomfort or injury (where applicable).	Yes
	3. Evidence information is readily available to all employees (e.g. notifications, publications, posters or similar staff communications).	Yes

Summary of Element 5:

√ It is recommended that this employer has successfully met the requirements of Element 5 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 5.

Comments:

The Incident Management Policy is being updated following the issue of the National Adverse Events Reporting Policy by the HQS (Health Quality Safety) Commission. As the Policy is currently, responsibilities, definitions and processes for for reporting, risk assessment and investigation are outlined.

The Policy is supported by a number of associated documents such as:

- Managing Incidents using Datix 'Managers Manual'.
- Reporting incidents using Datix 'Reporters Manual'.
- Variety of "tip sheets" such as 'Logging behaviour incidents in Datix'.
- Guidelines for completing an incident report for a needlestick or blood & body fluid exposure.
- Notifiable Events Management Policy which is aligned to the Health and Safety at Work Act. Requirements are appropriately outlined for first response, reporting to Worksafe NZ, leaving the scene undisturbed and the need to identify risks and review existing hazard/risk registers.

  Two examples of notifiable events were reviewed to verify appropriate compliance with this legislative requirement. No further action was taken by Worksafe NZ in relation to these events.

Waikato DHB uses Datix electronic reporting system with ongoing Datix training (open to all staff) facilitated quarterly. Due to restricted computer access, Nutrition and Food Service personnel continue to use a manual form which once completed, is given to a nominated staff member for entry into Datix.

Once an incident/accident/near miss is entered into Datix an automatic notification is sent to the Manager and Health & Safety Service. Initially the reporter completes a risk rating using a SAC (severity assessment code) matrix which means the event is categorised on the basis of actual harm and does not include potential harm.

While this categorisation has the potential to mask high potential severity staff events the Health and Safety Service review all events to ensure appropriate assessment and guide the level of investigation.

While the Manager is responsible for the investigation of staff events, the Health and Safety Service is actively involved in this process. Reviewed accident investigation reports demonstrated identification of corrective actions, assigned responsibilities and timeframes although they were not consistently signed off (see recommendation 5.3.4). Datix sends automatic reminders when investigations are nearing their expected close out date (within 30 working days) and this is a KPI tracked as a lead performance measure.

An HR Information Service Analyst has responsibility for HR analytics (including health and safety) including data cleansing.

Data is collated and analysed with reports being provided quarterly to JUMCF (Joint Union Management Consultative Forum) and the Board. Information presented includes incidents reported to WorkSafe NZ, lost time injuries by source, breakdown of assault numbers and claim data.

Proactive injury prevention initiatives include:

- Ongoing work streams under the umbrella of the Staff Safety Work Plan:
    - EAP (Employee Assistance Programme) promotional campaign.
    - Training for Workplace Support Personnel (support for staff who have concerns about bullying).
    - Personal safety training (part of orientation).
    - WorkWell workplace wellbeing initiative.

Reactive injury prevention initiatives primarily relate to moving and handling with training included as a core module within the organisational orientation and area-specific training facilitated by Manual Handling Trainers who have completed a Train the Trainer course. Theatres have reviewed their interview template for Health Care Assistants and included a manual handling questionnaire.

Early reporting of pain and discomfort in reinforced in hazard control plans where staff are encouraged to report early any discomfort. The booklet 'Self Management of Work Areas and Work Organisation' is developed to complement the Hazard Management, Incident Management and Management of Employee Health and Rehabilitation Policies providing employees with an understanding of workplace discomfort.

Waikato DHB outlines a commitment to early reporting of pain and discomfort and the return of employees to their pre-incapacity duties and hours whever possible. The booklet guides staff through a self assessment of their workstation which, upon completion, is assessed by the Health and Safety Service regarding further levels of assistance required.

Critical issues:

None

Improvement recommendations:

5.3.4 Continue to reinforce the importance of investigation sign off once corrective actions are complete.

Element 6 - Employee participation in health and safety management

(AS/NZ 4801:2001 Section 4.4)

Objective The employer will ensure that their employees have on-going opportunities to participate and be represented in the development, implementation and evaluation of safe and healthy workplace* practices.

Details of requirements	Verified by	Achieved Yes/No
1. There is an agreed employee participation system in place that explains how employees, unions, or nominated employee representatives will be involved in the development, monitoring and reviews of workplace health and safety matters.	1. Procedure/s that explain how employees are involved in the development, monitoring and reviews of health and safety issues.	Yes
	2. Evidence that the participation system: • has been agreed to • is communicated to employees at appropriate periods (including initial induction) • information about the system is readily available.	Yes
	3. Evidence of consultative development, monitoring and review of health and safety policies, processes and performance at least every 12 months.	Yes
2. Confirmation of employee participation systems.	1. Evidence of health and safety forum/s that include the participation of management and employee representatives occur at least quarterly (may be immediately prior to entry for new applications).	Yes
	2. Evidence of ongoing opportunity for joint involvement in injury prevention and (where applicable) injury management initiatives.	Yes

Summary of Element 6:

√ It is recommended that this employer has successfully met the requirements of Element 6 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 6.

Comments:

An Employee Participation Agreement is in place between Waikato DHB, NZNO, PSA and participating unions. The Agreement which was updated (August 2017) to align with the Health & Safety at Work Act 2015 outlines definitions, selection and functions of health and safety representatives, health and safety forums and training. A health and safety role description has also been developed to outline requirements of the role and responsibilities.

Information on employee participation including the nomination/election process for health and safety representatives is held on the intranet and provided at orientation.

Unions represented across Waikato DHB; Unite; NZNO, PSA, ASMS, First Union, Etū; NZRDA, APEX, NZMLWU and AWUNZ.

Organisation-wide employee participation is primarily facilitated through JUMCF (Joint Union Management Consultative Forum) which is held quarterly with representatives from unions and DHB management. Terms of reference are developed which outline the purpose of this forum "to foster cooperation and consultation between unions and management".

A review of meeting minutes (April 2018) confirmed presentation and discussion about the health and safety report and policies out for consultation.

Each service is required to have forums where health and safety matters are discussed regularly and at each of the areas selected for audit this was achieved through scheduled staff meetings. Theatres have monthly health and safety meetings. A review of meeting minutes confirmed discussed of fire evacuation, Formalin decantation, specimen leakage/spills, and Datix themes, review of manual handling education and planned health and safety promotion week.

Te Kuiti Hospital's six weekly quality and patient safety is the forum for discussion about health and safety.

As reflected in the last audit, there are several initiatives (work streams) underway within the framework of the Safety Culture Working Group which comprises management, staff and union representation. The following work streams are in place each of which as multidisciplinary representation comprising managers, union and employee representatives:

- Staff safety action group established to address aggression and physical violence. Initiatives underway include; implementation of a traffic light system to deal with challenging behaviour and Introduction to Personal Safety course.
- WorkWell programme that has identified three areas of focus; physical exercise, mental wellbeing and sun safety.
- Workplace support is a programme being developed which will encompass the identification of peer support people (workplace support persons), review of applicable polices, management workshops and on-line training resources.

Critical issues:

None

Improvement recommendations:

None

Element 7 - Emergency planning and readiness

(AS/NZ 4801:2001 Section 4.4)

Objective The employer has emergency plans in place to prepare and respond to potential emergency situations that may occur within any part of the employer's operation.

Details of requirements	Verified by	Achieved Yes/No
1. There is a documented emergency plan that identifies potential emergency situations and meets relevant emergency service requirements.	1. Evidence of identification of the range of potential emergency situations and relevant responses that considers the type and location of the work being done.	Yes
	2. Evidence that emergency service requirements have been considered.	Yes
2. Emergency instructions are readily accessible at all worksites or work areas.	1. Evidence that emergency instructions are communicated to all employees and other relevant parties.	Yes
	2. Emergency responders* or other designated employees are known to staff.	Yes
3. Emergency procedures are tested at regular intervals – of no greater than six months apart.	1. Evidence of emergency evacuation drills at intervals of no greater than six months apart and cover all shifts, worksites and employees.	Yes
	2. In addition to 7.3.1, for other emergency scenarios (documented in the employer's emergency plan/s) the employer needs to provide evidence that the documented response to emergencies, with a high likelihood of occurring, have been tested at least every 24 months. Evidence includes consideration of relevant risks, and testing includes relevant shifts, worksites and employees.	Yes
4. Consultative review of emergency response procedures occurs after any practice drills and actual emergency event(s).	1. Evidence of post-emergency response review.	Yes
	2. Evidence of updated procedures and plans (where applicable).	Yes
5. First aid resources are available.	1. Evidence that the number and availability of trained first aiders, and the type and quantity of first aid equipment, has been assessed.	Yes
	2. Evidence that the appropriate number of trained first aiders and the type and quantity of first aid equipment, are available for all work emergencies.	Yes
6. Emergency equipment is available.	1. Evidence that the need for emergency equipment for identified emergencies has been assessed.	Yes

Details of requirements	Verified by	Achieved Yes/No
	2. Evidence that the identified emergency equipment is available. Evidence includes regular equipment serviceability checks at appropriate intervals.	Yes

Summary of Element 7:

√ It is recommended that this employer has successfully met the requirements of Element 7 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 7.

Comments:

A tiered approach to emergency planning is in place coordinated by the Manager Emergency Management. Planning documents are held on the intranet as well as emergency management instructions, templates and hyperlinks to additional resource information.

An external resource is contracted to oversee building compliance, facilitation of fire evacuation drills and fire warden training. Property & Infrastructure acts as the logistical arm of the incident management team with additional responsibilities for test location certificates.

A tiered approach to emergency planning is in place comprising:

National Health Emergency Plan (HEP).

Midland Regional Health Emergency Plan.

Waikato Health Emergency Plan 2016-2019 (available on the intranet).

Waikato Hospital Campus Emergency Plan.

Using a CIMS (coordinated incident management system) structure this plan outlines response activities for a number of potential emergency scenarios. The Influenza Pandemic Plan was updated August 2017.

Department/Service Emergency Response Plan ('red folder')

Developed by departments/services for a number of potential emergency scenarios such as mass casualty, fire, hazardous substances, bomb threat and earthquake.

Roles and responsibilities in the event of a fire total evacuation and horizontal evacuation for buildings with emergency warning and intercommunication systems (EWIS).

Emergency Response Flip Charts

These flipcharts are displayed around work areas and contain abbreviated information about response requirements for a range of potential emergency scenarios as well as emergency contact numbers.

Approved fire evacuation schemes are in place for sites selected for audit; Te Kuiti Hospital (updated following construction activites) and Theatres (Meade Clinical Centre & Kempthorne Theatre Building).

Waikato DHB subscribes to Chemwatch and has a manifest for all chemicals verified through its test location certificate.

In clinical areas the most senior nurse on duty is the designated fire warden and in non-clinical areas fire wardens are appointed. The role of wardens and the first response team are clearly outlined.

A review of evacuation drills records confirmed that evacuation drills occur six monthly at variable times in an effort to cover all shifts. Te Kuiti (10/05/18); Kempthorne Theatre Building (18/06/18) and Meade Clinical Centre 22/06/18. Trial evacuation reports were completed.

Emergency planning exercises are held annually. A hazardous substance exercise involving release of oxidising material was held 4/05/18 with a range of services and personnel involved such as Biomed, Approved Handler, Attendants, Inventory & Distribution, Information Services, Central Sterile Supplies and the Mail Room. A worksheet summarising performance was subsequently completed which identified areas for improvement. The rationale for the provision of first aid and first aid equipment is outlined in the First Aid Policy. Emergency equipment including firefighting equipment, spill kits and first aid cabinets in non-medical areas were appropriately checked and in-date.
Critical issues:
None
Improvement recommendations:
None

Element 8 – Ensuring the health and safety of employees and others in the workplace

(AS/NZ 4801:2001 Section 4.4)

Objective The employer can demonstrate, so far as is reasonable practicable, that work being undertaken does not pose a health and safety risk to workers or other people. The same obligations apply to workplaces under the control of the employer.

Details of requirements	Verified by	Achieved Yes/No
1. A system is in place for the employer to consult other PCBU/s where there are overlapping health and safety duties*.	1. Procedure/s that outline how the employer (PCBU) will: • consult, • co-operate with, and • co-ordinate health and safety activities with other PCBU/s.	Yes
	2. Evidence of PCBU/s consultation and communication (where applicable).	Yes
2. A system is in place to induct another PCBU's workers or other people.	1. Induction procedure/s that include any site-specific rules, hazards and/or risks and their controls.	Yes
	2. A designated person/s to co-ordinate health and safety induction for other workers.	Yes
	3. Evidence that inductions have included the exchange of relevant information and have been completed and signed off by both parties (where applicable).	Yes
3. Criteria to select PCBU/s (who will undertake work on behalf of the employer), including an assessment of their management of health and safety.	1. Documented selection criteria.	Yes
	2. Evidence that the competency of the PCBU/s has been assessed against the selection criteria (where applicable).	Yes
4. Where an employer engages other PCBU/s, health and safety responsibilities are agreed.	1. Evidence that health and safety responsibilities are documented.	Yes
5. Where there is a shared duty of care* for health and safety, responsibilities for overlapping duties are agreed with other PCBU/s.	1. Evidence to show the employer and other PCBU/s are working together to protect the health and safety of people in the workplace (where applicable).	Yes
6. Where an employer engages other PCBU/s to undertake work, a system is in place to monitor and review the health and safety performance of the	1. Procedure/s that outline how and when the employer will monitor and review the health and safety performance of the PCBU/s.	Yes

Details of requirements	Verified by	Achieved Yes/No
PCBU/s, at intervals appropriate for the duration of the work.	2. Evidence of monitoring of the other PCBU's health and safety performance (where applicable).	Yes
	3. Evidence of feedback from the other PCBU into hazard identification, risk assessment and event reporting (where applicable).	Yes
	4. Evidence of review of other PCBU/s' health and safety performance every 12 months or when the work is completed, whichever comes sooner (where applicable).	Yes

Summary of Element 8:

√ It is recommended that this employer has successfully met the requirements of Element 8 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 8.

Comments:

Processes for the management of contractors and others are outlined in Property & Infrastructure's (P&I) Standing Instructions for Safety Management. These instructions detail definitions, responsibilities, templates and information on hazard management, use of PPE, safety management processes depending on level of risk and emergency preparedness.

While processes outline how Waikato DHB will consult, cooperate and coordinate its activities with contractors, to fully meet audit expectations these procedures need to be expanded to show how Waikato DHB will meet these responsibilities for other PCBU's where there are overlapping duties e.g. on site food outlets (see recommendation 8.1.1).

The procurement and contracts policy sets out requirements for procurement and contracting processes. With reference to the Health and Safety at Work Act the policy includes:

- Consideration of hazards or risks that goods or services may introduce to the work environment.
- The level of risk.
- Due diligence.
- Undertaking regular reviews of the contract.
- Identify and manage risks.

P&I manages a variety of contractual agreements from trades, specialist providers and campus rebuild (in conjunction with project managers and independent consultants). P&I is split into two portfolios; Asset Management and Property.

The Hospitality Support Services Manager is responsible for managing contractual agreements associated with cleaning and laundry services.

As part of the non-pricing attributes an evaluation matrix is used to assess health and safety capability. During the tender process tenderers are required to complete a questionnaire that

requests response to questions on responsibilities, existing accreditations, health and safety policy, training and information, accident management, subcontractor selection and monitoring and site management and provide supporting evidence. A range of examples provided demonstrated that this process is well established.

A re-evaluation of existing contractors was underway at the time of audit. A new initiative is underway to develop a prequalification process that will be applicable for all contractors categorised on the basis of government rules of sourcing.

Contracts are based on the Waikato DHB template which includes a range of health and safety requirements (among other things) such as compliance with legislation and Waikato DHB safety rules, completion of induction, management of subcontractors and health screening.

Valid for a period of two years, satisfactory completion of the contractor health and safety induction is required prior to being issued with an access card. A questionnaire is required to be completed and signed records are maintained by the Health and Safety Advisor P&I.

A pre-start meeting is held with main contractors engaged to carry out project-based work and an example for negative pressure rooms Ward E7 included an overview of the work programme, work site management and presentation of the Site Specific Safety Plan (SSSP).

Risk assessments are undetaken for all activities. Work orders generate the requirement for a JSA (Job Safety Analysis) or Take 5 (risk review) or, depending on the risk assessment SWMS (safe work method statement) will be completed to identify potential hazards and control measures. The Manager P&I Rural Hospitals has implemented the SWMS process for all work on site e.g. installation of access control and roofing repair.

Monitoring of contractor health and safety performance is well established and occurs in a number of ways:

- Regular meetings where health and safety is an agenda item. Meeting minutes are maintained verifying health and safety discussion.
- Safety audits completed by the Health & Safety Advisor.
- Ad hoc safety observations using a site safety checklist, completed by P&I Supervisors.
- Monthly reports provided by cleaning/laundry services.
- Audits (AS/NZS 4146:2000) and spot checks undertaken for cleaning/laundry services.

A review of Datix reports completed by contractors demonstrated active reporting and in one recent case this included reporting of a notifiable event to WorkSafe NZ. In this example, the PCBU had submitted their investigation to P&I and this was in the process of being reviewed by the Health and Safety Advisor.

Post project review has become an established part of contractor management processes. Under the framework of “what worked well” and “what could be improved” the review makes comment on health and safety performance e.g. SWMS and audit/observation findings.

Critical issues:

None

Improvement recommendations:

8.1.1 Strengthen existing procedures to show how Waikato DHB will consult, cooperate and coordinate its activities with other PCBU’s where there are overlapping duties e.g. on-site food outlets. This may consider:

- Who is involved and an outline of responsibilities.
- Consultation and communication processes.
- Steps to be taken in situations such as an emergency or a notifiable event.

Element 9 - Workplace observation to confirm systems in action

Objective There are a number of systems-related requirements that need to be observed at each audited site. This will provide some indication of how the documented systems work in practice. (NB: This is NOT a detailed site inspection and should not be relied on to satisfy legal compliance with other health and safety obligations.)

Details of requirements	The auditor will observe the following	Achieved Yes/No
1. The auditor is able to observe selected audit standard requirements in practice.	1. There are hazard or risk registers (or similar) that detail hazards, risk assessments and risk controls.	Yes
	2. Evidence that risk controls have been implemented.	Yes
	3. Safety information is readily available and current.	Yes
	4. Event reporting forms for injuries, illnesses and incidents are readily available.	Yes
	5. PPE is available for employees, other workers and site visitors (if required).	Yes
	6. PPE is consistent with details of hazard and risk controls, is appropriate for the area visited, and is being used.	Yes
	7. Restricted work areas are clearly identified.	Yes
	8. Appropriate escorting and sign-in/out processes are in place.	Yes
	9. Emergency evacuation procedure information is readily available.	Yes
	10. Emergency exits, routes and assembly points are clearly identified and unobstructed.	Yes
	11. Emergency equipment is clearly identified, unobstructed, well maintained and (where applicable) with current certification.	Yes
	12. First aid equipment and facilities are adequate, available and maintained.	Yes

Summary of Element 9:

√ It is recommended that this employer has successfully met the requirements of Element 9 at the following performance standard:

√ Primary — Primary is the highest level of achievement for this element.

☐ It is recommended that this employer has *not* met the requirements of Element 9.

Comments:

Two sites were selected by ACC for audit:

Theatres Waikato Hospital

This large service incorporates Day of Surgery (DOSA), Operating Theatres, Consulting Rooms, Recovery, Endoscopy, Interventional Radiology and Sterilising Unit.

Access to work areas is strictly regulated and theatre attire is required to be worn beyond designated areas.

Emergency procedure flip charts and fire action procedures were displayed. Firefighting equipment was in date and spill kits were held. Exits were marked and oxygen cylinders were appropriately restrained. The 5S concept had been used to organise work and storage areas.

Lead protection image intensifier checks are carried out quarterly tracked through a spreadsheet. Noticeboards displayed a range of information such as Datix reporting instructions, in-service education and hazard alerts e.g. surgical smoke. Hand hygiene posters were displayed.

Respirators are used when decanting Formalin in the specimen room and records are maintained of mask and filter checks. It is recommended that environmental monitoring is undertaken in the specimen room during the decantation of Formalin to assess whether hazardous levels of exposure exist in which case ventilation such as a fume cabinet may be needed (see general recommendation).

Te Kuiti Hospital

This observation focussed on the Laboratory, Radiology, Inpatient Ward, Kitchen and Community Services.

Visitors are required to sign in at reception acknowledging information provided in relation to emergency procedures and reporting. Restricted access areas are marked. The hospital is locked down at 5pm. Currently swipe card access is being installed to increase security. 24hour access is available through the Emergency Department where a security guard is located.

Duress alarms are positioned in key areas and a video camera enables staff to screen visitors after hours.

Emergency procedures flip charts and fire action procedures were displayed. Firefighting equipment was in date. Sharps containers were available in key areas and the biohazard cabinet in the Laboratory had recently been checked. MSDS (material safety data sheets) were held on line.

PPE was observed; single use/disposable such as gloves and aprons. Lead aprons in Radiology are checked annually and monitoring badges three monthly.

Hazard register manuals were located in each department. Cleaning products held in the kitchen are self-dispensing to minimise contact. A folder of MSDS was held.

Community Services use a white board to track staff whereabouts. Each vehicle also has a GPS Smart Tracking Device.

Critical issues:

None

Improvement recommendations:

Theatres

General

It is recommended that environmental monitoring is undertaken in the specimen room during the decantation of Formalin to assess whether hazardous levels of exposure exist in which case, improved ventilation such as a fume cabinet may be needed.

Hazard/risk management table Theatres (Waikato Hospital) (primary site)

Item	Hazard/risk identified by the workplace	Control methods	Details of controls documented by the business	Auditor's observation of controls in place
1	Patient handling	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* ☐ *Isolation* ☐ *Engineering* √ *Administration* ☐ *PPE*	• Manual handling training at orientation • Manual handling training specific to work area • Manual handling updates • Manual handling policy • Safe work practices; risk assessment and use of L.I.T.E principles	√ Mostly observed ☐ Partially observed ☐ No evidence observed
2	Formalin decanting	☐ **Eliminate** ☐ **Minimise by:** ☐ *Substitution* ☐ *Isolation* ☐ *Engineering* √ *Administration* √ *PPE*	• PPE – filtered mask • Place specimen container into sink area prior to decanting to minimise contamination from spillage • Removal of any inco sheets contaminated during decanting process • Education of theatre staff on availability of spill kit • Submission has been made to Purchasing and Procurement for review of available systems that will remove or control the current risk of having to decant formalin	☐ Mostly observed √ Partially observed ☐ No evidence observed It is recommended that environmental monitoring is undertaken to determine if a hazardous level of formalin fumes are present during decanting. Fume extraction may need to be considered.
3	Radiation exposure	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* √ *Isolation* ☐ *Engineering* ☐ *Administration* √ *PPE*	• Staff education • Reduce radiation exposure by moving away from ray source • Use of personal protective clothing/thyroid guards/lead jackets/skirts • Use of monitoring devices which are changed three monthly • Lead PPE to be checked annually • Lead PPE to be stored appropriately	√ Mostly observed ☐ Partially observed ☐ No evidence observed

Item	Hazard/risk identified by the workplace	Control methods	Details of controls documented by the business	Auditor's observation of controls in place
4	Exposure to blood and body fluid	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* ☐ *Isolation* ☐ *Engineering* √ *Administration* √ *PPE*	• Health screening • Vaccination programme as required • Determine Hepatitis immunity status • Standard precautions • Sharps containers, use and disposal • Avoid recapping • PPE to minimise exposure • First aid procedures • Reporting	√ Mostly observed ☐ Partially observed ☐ No evidence observed
5	Stress and fatigue	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* ☐ *Isolation* ☐ *Engineering* √ *Administration* ☐ *PPE*	• Pre-employment screening "fit for role" • Orientation • Training and development programmes • Healthy rostering • Workplace supervision • Wellness programmes • EAP • Critical incident debriefing • Control plan for verbal and physical abuse • Management of Health Policy	√ Mostly observed ☐ Partially observed ☐ No evidence observed

Recommended outcome

√ Yes	It was observed that these hazards were being managed in line with the documented health and safety management system.
☐ No	It was observed that these hazards were not being managed appropriately in line with the documented health and safety management system.

Note: Potential exposure to Formalin fumes while decanting needs to be investigated.

Hazard/risk management table Te Kuiti Hospital (secondary site)

Item	Hazard/risk identified by the workplace	Control methods	Details of controls documented by the business	Auditor's observation of controls in place
1	Exposure to blood and body fluids (risk of contracting Hepatitis B)	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* √ *Isolation* ☐ *Engineering* √ *Administration* √ *PPE*	• Health screening questionnaire • Hepatitis immunity check • Universal precautions • PPE • Safe work practices • Sharps disposal • Clean up body fluid spills • Staff education re hazard management • Reporting	√ Mostly observed ☐ Partially observed ☐ No evidence observed
2	Potential abuse from clients	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* √ *Isolation* ☐ *Engineering* √ *Administration* ☐ *PPE*	• Approach calmly in a non-threatening manner • Clear communication • Designate appropriate person to co-ordinate the situation • Arrange debriefing	√ Mostly observed ☐ Partially observed ☐ No evidence observed
3	Stress and fatigue	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* ☐ *Isolation* ☐ *Engineering* √ *Administration* ☐ *PPE*	• Pre-employment screening "fit for role" • Orientation • Training and development programmes • Healthy rostering • Workplace supervision • Wellness programmes • EAP • Critical incident debriefing • Control plan for verbal and physical abuse • Management of Health Policy	√ Mostly observed ☐ Partially observed ☐ No evidence observed
4	Patient handling	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* ☐ *Isolation* ☐ *Engineering* √ *Administration* ☐ *PPE*	• Manual handling training at orientation • Manual handling training specific to work area • Manual handling updates • Manual handling policy • Safe work practices; risk assessment and use of L.I.T.E principles	√ Mostly observed ☐ Partially observed ☐ No evidence observed

Item	Hazard/risk identified by the workplace	Control methods	Details of controls documented by the business	Auditor's observation of controls in place
5	Radiation exposure	☐ **Eliminate** √ **Minimise by:** ☐ *Substitution* √ *Isolation* ☐ *Engineering* ☐ *Administration* √ *PPE*	• Staff education • Reduce radiation exposure by moving away from ray source • Use of personal protective clothing/thyroid guards/lead jackets/skirts • Use of monitoring devices which are changed three monthly • Lead PPE to be checked annually • Lead PPE to be stored appropriately	√ Mostly observed ☐ Partially observed ☐ No evidence observed

Recommended outcome

√ Yes	It was observed that these hazards were being managed in line with the documented health and safety management system.
☐ No	It was observed that these hazards were not being managed appropriately in line with the documented health and safety management system.

INJURY MANAGEMENT PRACTICES REQUIREMENTS

The employer will:

- **Demonstrate clearly an established**, systematic approach to claims administration and case management.
- This means from the time of injury, the employer will provide seamless support to enable an injured employee to remain at work safely, return to work early, and/or to achieve maximum independence.
- Ensure there is regular monitoring and review of injury management to determine whether the audit standards are being met and maintained and to encourage continuous improvement towards better practice.

An integrated injury management system will provide feedback into robust injury prevention initiatives and will eventually be able to demonstrate a reduction in the human and economic impact of workplace injuries.

If a third party is subcontracted to the employer, their participation in the audit process will be noted and the employer will receive confirmation from ACC of the approval of the use of the selected Third Party Administrator (TPA)*.

If a TPA is used, it remains the final responsibility of the employer according to The Agreement to ensure that the AEP standards are met and maintained.

Elements

10. Cover decisions
11. Entitlements
12. File management
13. Administration and reporting
14. Complaint and review management
15. Development of rehabilitation policies, procedures and responsibilities
16. Assessment, planning and implementation of rehabilitation
17. Rehabilitation outcomes, return to work and follow-up procedures
18. File reviews and cast studies; confirmation of injury management procedures in action
19. Case study interviews
20. Focus group interviews; confirmation of safe systems and injury management in action

Element 10 – Cover Decisions

Objective The employer has evidence that systems have been implemented for making workplace injury cover decisions that comply with the legislation and include review rights.

Details of requirements	Verified by	Achieved Yes/No
1. There are claims lodgement systems in place for workplace injury claims.	1. A claims lodgement procedure.	Yes
2. There is a system in place for making timely work-related cover decisions that comply with the legislation.	1. Procedures to determine whether an injury is work-related.	Yes
	2. Evidence that cover decisions comply with the legislation.	Yes
	3. Evidence that any delayed cover decisions meet legislative requirements (where applicable).	Yes
3. Cover decisions are confirmed in writing and include review rights according to the legislation.	1. Evidence that cover decisions are confirmed in writing and include review rights.	Yes
	2. Evidence that all declined cover decisions are confirmed in writing, state the reasons for declinature and include review rights (where applicable).	Yes
	3. Evidence that efforts are made to discuss unfavourable or revoked cover decisions with the employee prior to written notification.	Yes
4. Cover decisions are made by a designated person/s with knowledge of the legislation and more than 12 months' claims management experience.	1. Evidence that a trained and/or experienced, designated person/s determines cover for work-related injuries according to the legislation.	Yes
	2. Evidence that a selection of cover decisions on claims are reviewed at least annually for accuracy and compliance against legislative requirements (where applicable).	Yes
	3. Procedures for making cover decisions are reviewed when there is a material change to legislation or personnel.	Yes
5. All employees are informed of the claims lodgement procedure.	1. Evidence that information is readily available to all employees (e.g. notifications, publications, posters or similar staff communications).	Yes
	2. Evidence employees are made aware of the claims lodgement procedure annually.	Yes
	3. Evidence employees are made aware of, and have access to, the ACC Code of	Yes

Details of requirements	Verified by	Achieved Yes/No
	Claimants' Rights when the cover decision is made.	
	4. Employees can inform service providers of their employer's Accredited Employer Programme status (e.g. identification cards, brochures, or introductory letters).	Yes
6. There is a system in place for the transfer of claims that are not the responsibility of the employer (e.g. non-work related claims or those belonging to another employer received in error).	1. Transfer procedures meet any guidelines and directives issued by ACC.	Yes

Summary of Element 10:

√ It is recommended that this employer has successfully met the requirements of Element 10 at the following performance standard:

√ Primary — Primary is the highest level of achievement for this element.

☐ It is recommended that this employer has *not* met the requirements of Element 10.

Comments:

Waikato DHB continues to contract WorkAon as TPA to provide claims administration and case management services. Processes for managing work injury claims (including claims lodgement) are outlined in the Work Injury Claims Management & Rehabilitation Manual (the Manual) updated September 2017 to align with the new audit standards.

Work injury claims were lodged by WorkAon on receipt of the ACC45 claim form. The initial needs assessment completed by the Health & Safety Advisor serves to confirm work relatedness and a copy of the Datix report or statement of events outline the circumstances of the injury.

Cover decisions were issued by WorkAon on behalf of Waikato DHB with reference to the Accident Compensation Act (including applicable section) and review rights. In one instance the cover decision was re-issued with an amended diagnosis. In cases where eligibility for cover required further investigation time extension letters were appropriately issued.

Unfavourable decisions are discussed prior to the issue of the decision letter and case notes record this contact.

Cover decisions are made by appropriately trained and experienced staff at WorkAon where a buddy programme for new staff is in place through a Senior Claims Manager. The Team Manager is responsible for assessing and confirming competency of new staff including completion of the induction process. Evidence of appropriate training and competencies was verified at the annual TPA audit 2017.

WorkAon has quality procedures and checks to ensure cover decisions are accurate and timely which include:

- Rationale for cover decisions documented in claim database.
- All declined cover decisions are signed off prior to issue.
- A sample of decisions are independently reviewed each month.

A spreadsheet was provided to verify that a cross section of Waikato DHB files had been reviewed. When there is significant change to legislation or regulations governing the determination of cover Waikato DHB is notified by WorkAon of these changes and where appropriate WorkAon will develop appropriate process changes. Information on the management of work injury claims, including claim lodgement is provided to new staff at orientation through the Workplace Accident Insurance pamphlet (and wallet card) which includes an overview of the Partnership Programme, claim lodgement process, determination of cover, entitlements, Code of ACC Claimant Rights and what to do in the event of a dispute/concern. Annual refresher information attached to payslips 25/01/18 and 1/02/18 included an overview of above. The People & Performance News June 2018 included an overview of the claims lodgement process, contacts and Code of ACC Claimant Rights and posters displayed in work areas included the “Have you had a Work Injury” flowchart. Information on the Code of ACC Claimant Rights is documented in the Manual and also included in the entitlement fact sheet issued with all accepted cover decision letters. The Workplace Accident Insurance pamphlet distributed to all new staff at orientation also makes reference to the Code. WorkAon is responsible for the transfer of claims that are not Waikato DHB’s responsibility including the completion of a transfer sheet to ACC and notification to the claimant – an additional example was provided to verify conformance with this requirement.
Critical issues:
None
Improvement recommendations:
None

Element 11 – Entitlements

Objective The employer has evidence that procedures have been implemented for ensuring entitlements are assessed and paid in an accurate and timely manner, and that injured employees are notified of entitlements in compliance with the legislation.

Details of requirements	Verified by	Achieved Yes/No
1. There is a system in place to ensure injured employees are aware of their entitlements and how to apply for them.	1. Notification procedures.	Yes
	2. Evidence that information on entitlements is easily accessible to all employees (e.g. Intranet, fact sheets, and brochures).	Yes
	3. Evidence that information on entitlements is provided with accepted cover decisions.	Yes
2. There is a system in place to screen new claims to determine priorities for management (e.g. a triage procedure or similar).	1. Screening procedures (or similar).	Yes
3. There is a system in place to contact injured employees and undertake an initial needs assessment* that is consistent with the screening procedure. *(Not applicable for "medical-fees-only" claims.)*	1. Evidence that managers/supervisors forward workplace injury reports to the injury management advisor* within **three working days** of receipt of injury notification*.	Yes
	2. Evidence that needs assessments are carried out by the injury management advisor within **two working days** of receipt of the work injury report.	Yes
	3. Evidence that managers/supervisors forward workplace injury reports to the injury management advisor within **two working days** of receipt of injury notification.	Yes
4. There is a system in place for accurately assessing eligibility to all entitlements according to the legislation.	1. Assessment procedure that considers the range of entitlements available.	Yes
	2. Evidence that all entitlement decisions are confirmed in writing and include review rights according to the legislation.	Yes
	3. Evidence of confirmation to advise injured employees where more than the statutory minimum is being paid (where applicable).	N/A
	4. Evidence that attempts are made to contact the injured employee to discuss unfavourable, cancelled or suspended entitlement decisions before they receive written notification.	Yes

Details of requirements	Verified by	Achieved Yes/No
	5. Procedures that explain how to confirm the accuracy of assessed entitlements.	Yes
	6. Evidence that assessed entitlements have been confirmed for accuracy at least annually.	Yes
5. There is a system in place to assess entitlement to weekly compensation and abatement according to the legislation.	1. Procedures to calculate and pay weekly compensation and abatement according to the legislation.	Yes
	2. Evidence that weekly compensation and/or abatement decisions are confirmed in writing and include review rights according to the legislation.	Yes
	3. Evidence that earnings details, medical certificates and calculation sheets are maintained on all files where weekly compensation is paid or considered.	Yes
	4. Evidence that copies of calculation sheets are sent to injured employees.	Yes
	5. Evidence of indexation increases (where applicable).	Yes
	6. Evidence that staff responsible for calculating and paying weekly compensation have participated in training on the assessment and payment of weekly compensation within the previous 24 months.	Yes

Summary of Element 11:

√ It is recommended that this employer has successfully met the requirements of Element 11 at the following performance standard:

☐ Primary √ Secondary Secondary is the highest level of achievement for this element.

☐ It is recommended that this employer has *not* met the requirements of Element 11.

Comments:

Entitlement fact sheets were issued with accepted cover decisions outlining the full range of medical, social and vocational entitlement provisions. Additional information was included in information provided at orientation through the Workplace Accident Insurance Pamphlet and annual refreshers.

Once the claim is lodged/registered WorkAon carries out a triage process comprising high risk, gradual process, low risk to direct the claim for appropriate action depending upon:

- Level of incapacity.
- Diagnosis.

- Previous claim history.
- Employer feedback.
- Gradual process.
- Non work injury.

Examples of a completed triage checklists were consistently held in claim files.

Once the accident has been reported into Datix the Health and Safety Service receives automatic notification. On submission of an ACC45 claim lodgement form WorkAon requests a copy of the accident report form and claim files confirmed that in the majority of cases (seven of eight) the accident report was submitted to WorkAon in a timely manner. On two of these occasions there was delayed reporting by the injured employee.

Health and Safety Advisors are responsible for early contact and completion of the initial needs assessment and action plan. In the majority of cases (five of eight applicable claims) audit timeframes were met. In two cases, case notes confirmed difficulty in contacting the injured employee.

All entitlement provisions were approved in writing and contained review rights e.g. additional physiotherapy, specialist radiology (MRI), and home help.

Waikato DHB pays the legislated amount of 80% weekly compensation so a top up letter is not required. Surcharges are not covered.

As with cover, unfavourable entitlement decisions are required to be discussed prior to the issue of the decision letter. One additional claim file was provided to show suspension of ongoing entitlements which was discussed prior to the decision letter. The decision letter contained a hyperlink to the Code of ACC Claimant Rights.

Evidence of completed claim file quality checks included verification of the review of weekly compensation and other entitlement decisions.

The process to calculate and pay weekly compensation, abated earnings and application of indexation is documented in the Manual. WorkAon's web-based Weekly Compensation Calculator Manual outlines instructions for use of the calculator, log in, adding a new calculation form, entering short term and long term earnings, viewing and approving calculations, adding payments and subsequent calculations.

Once earnings details are entered by Waikato DHB's payroll into the web-based calculator (webcalc) they are checked for accuracy by the WorkAon Claims Manager or Senior Claims Manager (complex) prior to advising payroll to release the payment. Case Managers are responsible for the approval of all entitlement decisions.

Claim files appropriately held calculation sheets and entitlement decision letters. There were examples of abated weekly compensation and application of indexation increases where applicable.

Waikato DHB's Payroll Administrators recently completed weekly compensation training through ACC's eLearning platform (5/07/18). The Senior Payroll Administrator completed this training 6/04/18.

Critical issues:

None

Improvement recommendations:

None

Element 12 – File management

Objective The employer has evidence that procedures have been implemented to ensure work-injury claim files are managed and administered in a way that complies with all appropriate legislation.

Details of requirements	Verified by	Achieved Yes/No
1. There is a system in place to manage the collection and release of information on a claim.	1. Procedures explain what information is to be contained on a claim file and how files are to be securely stored.	Yes
	2. Procedures include reference to any applicable Privacy Acts and Health Information Privacy Codes and are included in consent forms.	Yes
	3. Evidence of a written explanation to employees who are required to sign a consent form.	Yes
	4. Evidence of signed consent forms to enable information to be collected and/or released.	Yes
2. There is a system in place to manage claim information appropriately and securely.	1. A secure storage area restricted to designated personnel.	Yes
	2. Evidence that individual claim information is kept separately from other employment-related information (e.g. personnel files).	Yes
	3. Evidence that all claim information is amalgamated upon closure of a claim into one master file.	Yes
	4. Files not requiring transfer at the end of the claims management period are not destroyed, are held securely and are accessible to ACC on request.	Yes
3. Claims contain running sheets* summarising the management of the claim. *(Not applicable for "medical-fees-only" claims.)*	1. Evidence that running sheets are maintained on files (either hard copy or electronic).	Yes
4. There is a system in place to transfer claims to ACC (e.g. claims handback, reactivated claims).	1. Procedures explain how to transfer claims and • include the requirement for claims to contain a transfer summary and current rehabilitation plan (where applicable); and • include notification to the injured employee, ACC and any other parties actively involved in the management of the claim; and	Yes

Details of requirements	Verified by	Achieved Yes/No
	• include a review of payment accuracy and rehabilitation prior to transfer; and • require sign off by a designated senior person; and • conform with any guidelines and directives issued by ACC.	
5. Private information is managed appropriately.	1. Evidence that checks are undertaken on files to ensure only individual claim related information is held. Checks must be undertaken at handback, referral to a specialist, request from the injured employee, at review or when the file is being released externally.	Yes
	2. There are procedures in place for managing and reporting identified privacy breaches to ACC monthly.	Yes
	3. Evidence to show that privacy breaches are managed in accordance with procedures (where applicable).	Yes

Summary of Element 12:

√ It is recommended that this employer has successfully met the requirements of Element 12 at the following performance standard:

√ Primary — Primary is the highest level of achievement for this element.

☐ It is recommended that this employer has *not* met the requirements of Element 12.

Comments:

File management procedures are documented in the Manual and include reference to the Privacy Act 1993. WorkAon manages the primary and only claim file in line with the Privacy Act 1993 and Health Information Privacy Code 1994. Files presented for audit had been printed off the claims management database Carica. Each claim file had been reviewed and was tagged for ease of reference.

The Management of Employee Health and Rehabilitation Policy requires any health information held by Waikato DHB to be done so considering the DHB's Information Privacy Policy.

The Health and Safety Service maintains basic claim information related to claim lodgement only (e.g. ACC45 and initial needs assessment) and access to this information is appropriately restricted.

WorkAon's consent form (Authority to collect medical and other records) includes reference to the Privacy Act and Health Information Code. Signed consent forms were consistently held on claim files.

Running notes were held on claim files documenting ongoing communications and interventions.

The process for ACC claim handback is documented in the Manual, required when the agreed management period has expired and the claim remains open. All claims transferred to ACC are

required to include a completed transfer summary report (ACC 413) and be reviewed and signed off to ensure accuracy of payments and rehabilitation. One example was provided to verify conformance with this requirement. WorkAon uses a privacy checklist to record evidence that privacy checks are undertaken on claim files i.e.: • File has been checked to ensure only information relating to this worker is contained on the claim file. • File has been checked to ensure the worker's contact details are correct. • Any information not relating to the worker has been removed. • A letter is created and saved in Carica (Figtree) confirming the extent of the information being released. In all applicable cases, privacy checks were completed, recorded and held on claim files. There is an established process for the reporting of privacy breaches to ACC at the end of the month on which they occur. WorkAon and Waikato DHB's Health and Safety Service maintain spreadsheets that record any privacy breaches. Two privacy breaches were reported to ACC and confirmed in accordance with privacy reporting procedures.
Critical issues:
None
Improvement recommendations:
None

Element 13 – Administration and reporting

Objective The employer has evidence that an electronic reporting system has been implemented that holds all appropriate data and allows the timely and accurate reporting to ACC as required by The Agreement.

Details of requirements	Verified by	Achieved Yes/No
1. There is an electronic reporting system that contains all data required by ACC that is reported in a timely and accurate manner.	1. The programme used to record ACC data: • Is backed up to the employer's information technology standards • Is technically supported (e.g. by employer's IT department or vendor supplying programme) • has documented procedures which conform to ACC's data specifications.	Yes
	2. Procedures include the requirement for reports to be submitted within 5 working days of month end and cleared by the third week of each month in a format specified by ACC.	Yes
	3. Reporting responsibilities are defined for leave and sickness.	Yes
	4. Evidence of systems in place to check the accuracy of data.	Yes
	5. Evidence that the accuracy and timeliness of data reported to ACC is monitored and managed according to procedures.	Yes
2. Electronic systems are secure and access is only available to designated personnel.	1. Evidence that electronic systems: • are restricted to designated personnel • have security that meets the requirements of the Privacy Act 1993 (or any applicable Privacy Acts) and Health Information Privacy Codes • have a Digital Certificate for data transmission.	Yes
3. There is a system in place to identify and manage issues of inappropriate claiming or fraud.	1. Procedures to identify and manage issues of inappropriate claiming or fraud.	Yes
	2. Fraud identification procedures include: • prompt contact with ACC to seek advice; and • the requirement for any investigation to be managed independently from the injury management process.	Yes

Details of requirements	Verified by	Achieved Yes/No
4. There is a system in place to liaise with, and notify ACC regarding: • Fatal claims, serious injury claims or claims of a sensitive, complex or prolonged nature* • Changes in the employer's injury management operation or injury management personnel.	1. Evidence that a liaison and notification procedure exists and that there is a designated "single point of contact" responsible for ACC notification and examples (where applicable).	Yes

Summary of Element 13:

√ It is recommended that this employer has successfully met the requirements of Element 13 at the following performance standard:

√ Primary — Primary is the highest level of achievement for this element.

☐ It is recommended that this employer has *not* met the requirements of Element 13.

Comments:

Data recording and reporting procedures are outlined in the manual. WorkAon is responsible for registering all claims and loading transactions into their Figtree system which is used to record ACC data. The system which is backed up daily has the claims data specification fields and reporting template built into the system.

WorkAon is contracted by Waikato DHB to undertake claims administration and monthly ACC reporting functions as required by the Partnership Programme and has a current digital certificate to facilitate this reporting in a secure environment within five working days of month end.

The Figtree database used by WorkAon contains a number of data validation fields which requires mandatory data to be entered when claims are registered and updated. These data validations automatically update data fields for reporting to ACC.

Evidence was provided by WorkAon to confirm that the accuracy and timeliness of data reported to ACC is monitored and managed according to procedures (May 2018).

Fraud management procedures are documented in the Manual and include information on actions required to prevent, identify and act on suspected fraudulent activity including the requirement for the investigation to be managed independently from the injury management process. There have been no cases of suspected fraudulent activity over the last 12 months.

The Manager Health & Safety Service is the single point of contact for ACC liaison and notification

Critical issues:

None

Improvement recommendations:

None

Element 14 – Complaint and review management

Objective The employer has evidence that procedures have been implemented to manage complaints* and reviews* arising out of injury management that comply with the legislation and the requirements of The Agreement.

Details of requirements	Verified by	Achieved Yes/No
1. There is a system in place to manage complaints.	1. Complaints management procedure includes: • how complaints are raised • how the complaint will be managed • process and timeframes to carry out the review of the complaint • process for escalation • consideration of The Code.	Yes
	2. Records of complaints (where applicable).	N/A
	3. Evidence that options for informal resolution* are used in the first instance/as early as possible (where applicable).	N/A
	4. Evidence that work injury disagreements include consideration of all relevant information (e.g. medical, employee and employer information).	N/A
	5. Evidence that management of the complaint process is completed in line with the procedure (where applicable).	N/A
2. There is a system in place to manage formal reviews.	1. Procedure to manage formal reviews includes: • consideration of The Code • compliance with legislation and The Agreement • how reviews are raised/requested • how reviews are managed • process and timeframes for processing reviews.	Yes
	2. Records of formal reviews (where applicable).	Yes
	3. Evidence the review procedure is completed in line with the documented procedure (where applicable).	Yes
3. Employees are aware of the complaints management procedure,	1. Evidence of information provided to employees (e.g. notifications, publications, posters or similar).	Yes

Details of requirements	Verified by	Achieved Yes/No
The Code and their rights of review and appeal.	2. Evidence that employees have been advised of their rights and obligations in relation to the employer and ACC.	Yes
4. There is a designated senior person/s responsible for complaints management.	1. A designated "complaints manager"* (not the initial decision-maker, case manager or source of the complaint) and their contact details are readily available to all employees (e.g. notifications, publications, posters or similar).	Yes
5. There is a system in place to evaluate the outcomes of complaints and reviews to identify any opportunities for improvement every 12 months.	1. Evaluation procedure that includes consideration of all relevant information.	Yes
	2. Evidence of evaluations occurring annually or when a decision is overturned (where applicable).	Yes

Summary of Element 14:

√ It is recommended that this employer has successfully met the requirements of Element 14 at the following performance standard:

√ Primary — Primary is the highest level of achievement for this element.

☐ It is recommended that this employer has *not* met the requirements of Element 14.

Comments:

The disputes management procedure is documented "Complaints and Reviews", and includes options for informal resolution of concerns, complaints and formal review by Fairway Resolution and timeframes for response. Procedures make specific reference to the Code of ACC Claimant Rights.

14.1.2 – 14.1.5 have been marked as not applicable since there have been no complaints over the past 12 months to verify the informal resolution process.

The Complaints & Disputes Manager for Waikato DHB is the Employee Relations Consultant Human Resources.

One additional claim file was provided to verify conformance with review procedures i.e. acknowledgement of review application, administrative review by Branch Medical Advisor, original claim file sent to Fairway following privacy check, provision of submissions, hearing decision communicated.

WorkAon's Legal Advisor maintains a spreadsheet of review applications for accredited employers. This logs information such as employer/injured employee details, date review application lodged, decision under review, file administrative review outcome, review hearing date and outcome. Any learnings coming from dispute evaluation are communicated back to the accredited employer.

Review rights are issued with all decision letters with information also contained in the Workplace Accident Injury Management pamphlet provided at orientation. Rehabilitation rights and responsibilities signed at the first case meeting also contains information about right of review as does the Code of ACC Claimant Rights.

An evaluation of disputes was undertaken by Waikato DHB and WorkAon for the year 1/04/17 – 31/03/18. The disputes management evaluation considered concerns raised by an employee or a formal complaint most commonly via the ACC Complaints Investigator or when a formal review application is lodged.

Concerns & Formal Complaints - there have been no concerns or formal complaints regarding the management of work injury claims over the last 12 months. Review applications - for the year ending 31/03/17 there were three review applications lodged against Waikato DHB; two in relation to suspension of entitlements (dismissed/on hold) and one in relation to cover (quashed). WorkAon/Waikato DHB remain "satisfied that the process to inform injured employees about their review rights is robust and is managed in-line with the Code of Claimant Rights and ACC legislation".
Critical issues:
None
Improvement recommendations:
None

Element 15 – Development of rehabilitation policies, procedures and responsibilities

Objective The employer has evidence that policies and procedures have been documented and implemented to promote a supportive workplace environment so that workplace-based rehabilitation following an injury becomes the usual course of action whenever possible.

Details of requirements	Verified by	Achieved Yes/No
1. There is a commitment to timely rehabilitation.	1. There is a documented commitment to timely rehabilitation that: • is current, dated and signed by a senior manager • is widely accessible in the workplace • is included in staff induction • includes the objectives and responsibilities for rehabilitation • was developed in consultation with nominated employee representatives and union (if applicable) • recognises the employee's right to support, advice and representation from, health and safety representative or other nominated employee's representative (e.g. colleague, friend, family, union).	Yes
2. There is an implemented system in place to provide rehabilitation and safe and early return to work (or support to remain at work) following injury.	1. Rehabilitation procedures include: • responsibilities of the employee, union (if applicable), health and safety representatives and management • early return to work expectations • opportunities for return to work duties* • responsibilities for monitoring and follow-up • recognises the employee's right to support, advice and representation from the employee's union (if applicable), a health and safety representative or other nominated employee's representative (e.g. colleague, friend, family).	Yes
	2. Rehabilitation resourcing responsibilities are designated at senior management level.	Yes

Details of requirements	Verified by	Achieved Yes/No
3. There is a system in place to provide rehabilitation opportunities for employees with non-work injuries.	1. A statement of commitment supporting rehabilitation opportunities for employees with non-work injuries.	Yes
	2. Procedures explain how to support rehabilitation opportunities for employees with non-work injuries.	Yes
	3. Procedures outline the roles and responsibilities for supporting employees with non-work injuries (e.g. management, employees and union and other nominated employee representatives, rehabilitation facilitator).	Yes
	4. Evidence of employer supporting the rehabilitation of employees with non-work injuries (where applicable).	Yes
4. Workplace rehabilitation is managed by a designated and trained or experienced person(s).	1. The designated ACC AEP case manager has at least: • 24 months workplace rehabilitation experience; or • a tertiary qualification in rehabilitation (or equivalent) and 12 months' workplace rehabilitation experience; or • is working under the direct, close supervision of someone who meets the above requirements (e.g. within a subcontracting relationship with a TPA).	Yes
	2. Roles and responsibilities of claims management personnel are defined, and covered for leave and sickness.	Yes
5. Designated personnel, line managers, union (if applicable) and health and safety representatives are involved in rehabilitation, and have an understanding of supporting safe and early return to work (or support to remain at work) following injury.	1. Designated management responsibilities for rehabilitation are assigned at each work site.	Yes
	2. Evidence of training for those with designated rehabilitation responsibilities (or similar awareness programme).	Yes
	3. Evidence of training or refresher sessions (or similar awareness programme) within the previous 24 months.	Yes

Summary of Element 15:

√ It is recommended that this employer has successfully met the requirements of Element 15 at the following performance standard:

☐ Primary √ Tertiary This element has only Primary or Tertiary requirements.

☐ It is recommended that this employer has *not* met the requirements of Element 15.

Comments:

The Management of Employee Health and Rehabilitation Policy was consultatively reviewed and approved by the Health and Safety Committee (1/08/17) and Health and Safety Manager.

The policy provides a framework for investigation, management and rehabilitation following injury and illness with the primary goal to return the employee to their pre-incapacity duties and hours wherever possible or to support them to remain in the workplace.

Applicable to all Waikato DHB employees, the Policy promotes early reporting and management of discomfort, pain, injury, illness or impairment as is, early intervention, employee participation and use of support networks to assist employees through the return to work process.

Definitions and applicable legislation are outlined as well as responsibilities for all parties including Employees, Managers, Health and Safety Service, Human Resources, Case Manager/TPA and Treatment Provider.

Rehabilitation resourcing responsibilities are allocated to the Health and Safety Manager.

WorkAon continues to partner with ACC to manage workplace rehabilitation for Waikato DHB employees who have experienced a non work injury claim where incapacity exceeds seven days. Examples reviewed confirmed return to work planning in consultation with the GP, Manager and Occupational Therapist. Focus group participants also confirmed strong levels of support for employees with non work injuries/illness.

Line Managers are responsible for the day-to-day support of workplace rehabilitation and are actively supported and coached in this responsibility by Health and Safety Advisors and WorkAon Case Managers.

The following training has been facilitated for those with rehabilitation responsibilities, some of which, was outlined in the last audit dated September 2017 as it remains valid (within the 24 months):

- WorkAon facilitated workplace rehabilitation training for managers 22/09/16 that included information on roles and responsibilities, rehabilitation planning, weekly monitoring, and graduated return to work (six Managers attended).
- WorkAon facilitated training on the new audit standards and guidelines for the Health and Safety Service 26/05/17.
- New managers orientation and ongoing updates includes workplace accidents, rehabilitation and return to work. Records indicate that 46 Managers have completed these updates 1/01/18 to 3/07/18.
- HSR's two day training includes an overview of claims management.

Critical issues:

None

Improvement recommendations:

None

Element 16 – Assessment, planning and implementation of rehabilitation

Objective The employer has evidence that procedures have been implemented that support safe, early and sustainable return to work (or support to remain at work) for injured employees, or maintenance at work where early intervention support is identified. Procedures ensure timely and appropriate rehabilitation is provided in an open, consultative manner and in line with agreed procedures.

Details of requirements	Verified by	Achieved Yes/No
1. Individual action plans are developed following the initial needs assessment to provide the initial rehabilitation direction.	1. Evidence that action plans* specific to the injured person are developed within 14 days of injury notification and are reviewed and updated every 14 days until the cover decision is made.	Yes
	2. Evidence that action plans specific to the injured person are developed within seven days of injury notification and are reviewed and updated every 14 days until the cover decision is made.	Yes
2. Where the need for rehabilitation is identified, individual rehabilitation plans are developed in consultation with relevant parties and are based on legislative requirements.	1. Evidence that individual rehabilitation plans* include: • goals • actions to be taken • responsibility for actions • timeframes (based on expected recovery timeframes) • agreed outcomes resulting from discussions with employees.	Yes
	2. Evidence that individual rehabilitation plans, specific to the injured person are: • developed in direct consultation* with the injured person within a maximum of 21 days of the cover decision • developed in direct consultation with key stakeholders (e.g. line manager and union and health and safety representatives) (where applicable) • consider any relevant workplace* health and safety issues (e.g. the safety of other workers).	Yes
	3. Evidence that rehabilitation plans specific to the injured person are developed in direct consultation within a maximum of 14 days of the cover decision.	Yes

Details of requirements	Verified by	Achieved Yes/No
3. Rehabilitation plans are monitored, reviewed and updated at agreed timeframes for the duration of rehabilitation, to accurately reflect current rehabilitation interventions.	1. Evidence that the responsibility for monitoring and timeframes for reviews are specified in the rehabilitation plan.	Yes
	2. Evidence of the employer monitoring rehabilitation progress monthly on active claims.	Yes
	3. Evidence of weekly monitoring by direct consultation with employees rehabilitating in the workplace.	Yes
	4. Evidence that individual rehabilitation plans are updated to reflect the status of rehabilitation, i.e. milestone completion or new rehabilitation requirements.	Yes
4. Return to work is assessed for potential hazards to prevent injury aggravation.	1. Examples that the work environment where the employee will work has been considered in terms of hazards or risks that may affect them.	Yes

Summary of Element 16:

√ It is recommended that this employer has successfully met the requirements of Element 16 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 16.

Comments:

Action plans were developed by the Health and Safety Advisor as part of the initial needs assessment process and and again by the Case Manager (high risk claims). Claim files verified that individualised action plans were prepared within 14 days of injury notification and where applicable were subsequently updated until the cover decision was made.

Individual rehabilitation plans (IRP's) were developed in direct consultation with the injured employee either by face-to-face meeting or over the telephone. Claim files confirmed that in all but two instances the IRP was developed within 14 days of the cover decision and in the two cases where there was a delay there was difficulty in contacting the injured employee.

IRP's reviewed, were signed by participating parties and contained the rehabilitation goal, actions, responsibilities and timeframes. Expected outcome dates were identified and review rights were appropriately issued. There were two occasions where the IRP was not signed and in these cases the IRP was appropriately deemed.

Responsibility for monitoring was detailed in the IRP which included responsibilty for weekly monitoring and also monthly review of rehabilitation progress.

Employer monitoring of rehabilitation progress occurs through:

- Monthly meeting with WorkAon where open claims and rehabilitation prgress is an agenda item.
- Monthly open claims report that tracks rehabilitation status and costs.

- Monthly contact between the Case Manager and injured employee's Manager recorded in case notes. There were several examples of updated IRP's e.g to reflect initiation of vocational independence and specialist review findings.

An annual review of rehabilitation processes was carried out by WorkAon and Waikato DHB 1/04/17 – 31/03/18 which considered:

- Key health and safety personnel.
- Updates to the AEP audit standards and guidelines.
- Surcharge payment policy.
- Managing ACC non work injury claims.
- Referrals to the ACC Integrity Unit.
- Claims experience – break down of claims where costs have exceeded $5000.00 as well as summary of claims experience.
- Evaluation of preferred providers – includes reference to claim file privacy checks required to now be undertaken when files are shared externally i.e on referral.
- Privacy breach management.

The injured employee's Manager is primarily responsible for weekly monitoring of rehabilitation progress when the employee is participating in a graduated return to work programme. The Case Manager is resposible for weekly contact when the employee is fully unfit for work but evidence confirms that in general the injured employee's Manager maintains contact irrespective of level of incapacity.

Claim files in general confirmed documented weekly monitoring where applicable. In one case documentation was missing but an email from the manager confirmed that the monitoring had infact been done (see recommendation 16.3.3).

Return to work is assessed for potential hazards to prevent injury aggravation through the workplace assessment undertaken by the Occupational Therapist. There was one example where an injured employee required ergonomic interventions to support the return to work programme.

Critical issues:

None

Improvement recommendations:

16.3.3 Continue to reinforce the need for Managers to document weekly monitoring of rehabilitation progress when the injured employee is participating in workplace rehabilitation.

Element 17 – Rehabilitation outcomes, return to work and follow-up procedures

Objective The employer has evidence of procedures that have been implemented to review claim files and rehabilitation and to consider other options for rehabilitation as appropriate.

Details of requirements	Verified by	Achieved Yes/No
1. Rehabilitation and return to work objectives and goals for the organisation are developed.	1. Documented objectives/goals and a plan to achieve these.	Yes
	2. Evidence of annual review and update of objectives/goals to ensure they remain relevant, in consultation with key parties.	Yes
2. There is a system in place for the review of rehabilitation plans that continue beyond the agreed initial outcome date or non-progressive rehabilitation.	1. Procedures for the review of rehabilitation plans that continue beyond the initial outcome date or for non-progressive rehabilitation.	Yes
	2. Evidence of review of on-going rehabilitation cases (e.g. intervention options, medical case review, pain management) that includes: • how the outcome date was calculated • barriers to successful outcome • consideration of rehabilitation options.	Yes
	3. Evidence of initiation of relevant vocational and medical assessments (where applicable).	Yes
3. There is a system in place to consider the range of vocational rehabilitation* options, as expressed in the legislation, when a return to work in the pre-injury job is not an option.	1. Procedures give guidance on the range of vocational rehabilitation options, as expressed in the legislation, when a return to work in the pre-injury job is not an option.	Yes
	2. Evidence of consideration of rehabilitation options.	Yes
	3. Evidence of initiation of relevant initial occupational assessment (IOA) and initial medical assessments (IMA) (where applicable).	Yes
4. Providers support rehabilitation and return to work (e.g. general practitioners, specialists etc.).	1. Evidence that medical providers are given sufficient information about the workplace to support their assessments.	Yes
	2. Evidence of collated information sent to the medical providers to support their assessments.	Yes

Summary of Element 17:

√ It is recommended that this employer has successfully met the requirements of Element 17 at the following performance standard:

☐ Primary ☐ Secondary √ Tertiary

☐ It is recommended that this employer has *not* met the requirements of Element 17.

Comments:

Within the Management of Employee Health and Rehabilitation Policy, Waikato DHB has outlined several injury management objectives:

- Provision of transitional duties for employees to enable them to stay at work or return to work whenever reasonable or practicable.
- Work in partnership with the employee, union or representative and family/whanau to enable early return to optimal health and work capacity.

These objectives are tracked through WorkAon's monthly report and the monthly meeting between the two parties.

It is recommended that injury management objectives are broadened and framed as S.M.A.R.T objectives (see recommendation 17.1.1).

Procedures are documented for the review of rehabilitation plans that continue beyond their initial outcome date or are non-progressive. The vocational independence process is considered which follows the hierarchy of outcomes.

There were examples of referrals for medical case review and initiation of vocational independence, with IOA (initial occupational assessment) and IMA (initial medical assessment) completed, with findings reflected in the updated IRP.

Specialists are provided with supporting information at the time of the referral e.g. signed consent, medical certificates, workplace assessment and completed privacy check.

Critical issues:

None

Improvement recommendations:

17.1.1 There is an opportunity to give a wider scope of thought to rehabilitation/return to work objectives particularly in light of the recommendations contained within this report e.g. Manager documentation of weekly monitoring of rehabilitation progress.

Note that objectives should be S.M.A.R.T objectives i.e. the objectives should be specific, measurable, achievable, realistic and time bound.

Element 18 – File reviews and case studies, confirmation of injury management procedures in action

Objective The employer is able to confirm and validate claims and injury management procedures through the review of all selected files and case studies.

Details of requirements	Verified by	Achieved Yes/No
1. Cover decisions.	1. ACC45s.	Yes
	2. Timely cover decisions that comply with legislation.	Yes
	3. Cover decisions include review rights.	Yes
2. Entitlements.	1. Managers/supervisors forward workplace injury reports to the injury management advisor within **three working days** of receipt of injury notification.	Yes
	2. Needs assessments are carried out by the injury management advisor within **two working days** of receipt of the work injury report.	Yes
	3. Managers/supervisors forward workplace injury reports to the injury management advisor within **two working days** of receipt of injury notification.	Yes
	4. Evidence of referrals based on needs assessments.	Yes
	5. Entitlement decisions are confirmed in writing and include review rights.	Yes
	6. Signed consent forms (ACC45 sufficient for medical-fees-only claims).	Yes
	7. Medical certificates cover all periods of incapacity. Where gaps are identified on claims with continuous incapacity, evidence of approval of entitlements is provided.	Yes
	8. Calculation and abatement sheets are maintained on all files where a request for weekly compensation is received and a copy is sent to the injured employee.	Yes
	9. Written confirmation to advise injured employees in all situations where more than the statutory entitlement is paid (where applicable).	N/A
3. File management.	1. Claim files only contain injury-related information.	Yes

Details of requirements	Verified by	Achieved Yes/No
	2. Running sheets are held on all files that are more than medical-fees-only costs.	Yes
	3. Files contain all claim activity, weekly compensation calculations and any other information relevant to the management of the claim.	Yes
4. Assessment, planning and implementation of rehabilitation.	1. Action plans are developed within 14 days of injury notification and that are reviewed and updated every 14 days until the cover decision is made.	Yes
	2. Action plans are developed within seven days of injury notification and that are reviewed and updated every 14 days until the cover decision is made.	Yes
	3. Rehabilitation plans are developed in direct consultation within a maximum of 21 days of the cover decision.	Yes
	4. Rehabilitation plans are developed in direct consultation within a maximum of 14 days of the cover decision.	Yes
	5. The responsibility for monitoring and timeframes for review are specified in the rehabilitation plan.	Yes
	6. Evidence of monthly monitoring and review of rehabilitation progress.	Yes
	7. Evidence of employer involvement in monthly direct consultation monitoring and review of progress for employees unable to return to work.	Yes
	8. Evidence of weekly direct consultation monitoring and review of progress for employees rehabilitating in the workplace.	Yes
5. Rehabilitation outcomes, return to work and follow-up procedures.	1. Evidence of review of on-going rehabilitation cases.	Yes
	2. Evidence of monthly reviews of on-going rehabilitation cases.	Yes
	3. Evidence of actions taken following review, including scheduled case meetings, consultative review or entitlement updates.	Yes

Details of requirements	Verified by	Achieved Yes/No
	4. Evidence that individual rehabilitation plans are updated to reflect the status of rehabilitation, i.e. milestone completion or new rehabilitation requirements.	Yes

Summary of Element 18:

√	It is recommended that this employer has successfully met the requirements of Element 18 at the following performance standard: ☐ Primary ☐ Secondary √ Tertiary
☐	It is recommended that this employer has *not* met the requirements of Element 18.

Comments:

Eight claim files were reviewed as requested. Each claim file had been reviewed and tagged for ease of reference. Additional claims files were provided to verify a number of audit requirements not evidenced in claim files selected for audit.

Work injury claims were lodged by WorkAon on receipt of the ACC45 claim form. Cover decisions were issued by WorkAon on behalf of Waikato DHB with reference to the Accident Compensation Act and review rights.

Accident reports were in most cases submitted to WorkAon to assist the cover decision making process in a timely manner.

Health and Safety Advisors are responsible for early contact and completion of the initial needs assessment and action plan. In the majority of cases (five of eight applicable claims) audit timeframes were met. In two cases, case notes confirmed difficulty in contacting the injured employee.

All entitlement provisions were approved in writing and contained review rights e.g. additional physiotherapy, specialist radiology (MRI), and home help.

Signed consent forms were consistently held.

Any gaps in medical certificates or back dated medical certificates were approved prior to being processed for payment. Waikato DHB pays the legislated amount of 80% weekly compensation so a top up letter is not required. Surcharges are not covered.

Claim files held injury-related information only and evidence of privacy checks were held appropriately. Case notes were held that outlined ongoing communications, progress notes and interventions.

Action plans were developed by the Health and Safety Advisor as part of the initial needs assessment process and and again by the WorkAon Case Manager (high risk claims). Claim files verified that individualised action plans were prepared within 14 days of injury notification and where applicable were subsequently updated until the cover decision was made.

IRP's were developed in direct consultation with the injured employee in most cases within 14 days of the cover decision being issued.

Responsibility for monitoring was detailed in the IRP which included responsibilty for weekly monitoring and also monthly review of rehabilitation progress. The employer is involved in the monthly review of rehabilitation progress with contacts recorded in the case notes.

The injured employee's Manager is primarily responsible for weekly monitoring of rehabilitation progress when the employee is participating in a graduated return to work programme. In general claim files confirmed documented weekly monitoring but in one case the documentation was missing from the claim file – this has been raised as a recommendation in element sixteen (16.3.3).

Critical issues:

None

Improvement recommendations:

Recommendation raised in element 16

Element 19 – Case study interviews

Objective The employer is able to confirm and validate safety and injury management procedures in action through interviews with employee / management / case manager / union or other employee support person (where applicable).

Details of requirements	Verification	Achieved Yes/No
1. The injury was reported and recorded in the accident or injury register (or similar).	1. Interview with employee and manager or supervisors.	N/A
2. The injury was investigated by designated staff and included input from the injured employee and the manager or supervisor.	1. Interview employee and manager to confirm involvement.	N/A
3. Hazard management, injury prevention and training issues arising from the injury investigation were reported, action was taken and issues communicated to staff (where applicable).	1. Interview with employee, manager or supervisor and health and safety manager (or similar).	N/A
	2. Evidence of feedback from the injury investigation into hazard management (where applicable).	N/A
4. The employee was aware of the claims lodgement process or where to find information about the process.	1. Interview with employee.	N/A
	2. Employee identification card (or similar).	N/A
5. The employee was informed of the cover decision (including review rights) and entitlements (where applicable) were paid in a timely manner.	1. Interview with employee, manager and injury management advisor (case manager, case coordinator).	N/A
6. Contact between the injured employee and the workplace was maintained throughout the period of incapacity and continued for the time while on alternative duties.	1. Interview with employee, manager and injury management advisor (case manager, case coordinator).	N/A
7. Employee responsibilities to participate in the rehabilitation process were understood.	1. Interviews with employee, manager and injury management advisor (case manager, case coordinator).	N/A
8. The employee was aware of the complaints management process and how to formally question a decision.	1. Interview with employee to confirm understanding.	N/A
9. Rehabilitation needs were assessed according to the needs of the injured employee.	1. Interview with employee, injury management advisor.	N/A

Details of requirements	Verification	Achieved Yes/No
10. The employee was given the opportunity to include a support person throughout the rehabilitation process.	1. Interviews with employee, manager, injury management advisor and employee representative (as appropriate).	N/A
11. Consultative rehabilitation meeting(s) took place for the duration of incapacity.	1. Interviews with employee, manager and injury management advisor (case manager, case coordinator).	N/A
12. Selected work within the medical restrictions was discussed, agreed on and documented in a signed rehabilitation plan.	1. Interviews with employee, manager and injury management advisor (case manager, case coordinator).	N/A
13. Monitoring and review of the rehabilitation plan was agreed on and responsibilities were assigned.	1. Interviews with employee, manager and injury management advisor (case manager, case coordinator).	N/A
14. Evidence of completed case study interview employee declarations (or n/a if no case studies are requested).	1. Completed case study interview declarations where case studies are requested.	N/A
15. Confirmation that, where the standard requires it, the rehabilitation plan was negotiated via direct consultation.	1. Interviews with employee, manager and injury management advisor (case manager, case coordinator).	N/A

Summary of Element 19:

☐ It is recommended that this employer has successfully met the requirements of Element 19 at the following performance standard:

√ Primary — Primary is the highest level of achievement for this element.

☐ It is recommended that this employer has *not* met the requirements of Element 19.

Number of case studies undertaken: Not Applicable

Positions and interests of those interviewed to support employee's perspective:

Positions and interests of those interviewed to support employer's perspective:

Comments:

Insufficient case studies were available for interview. Comments from those who had experienced the claims management process have been incorporated into focus group feedback to ensure confidentiality.

Critical issues:

Improvement recommendations:

Element 20 – Focus group interviews; confirmation of safe systems and injury management in action

Objective The employer is able to confirm and validate hazard and risk management systems and subsequent injury management systems through management and employee focus groups.

Details of requirements	Achieved Yes/No
1. What constitutes a hazard or risk in the workplace.	Yes
2. The process for hazard and risk identification.	Yes
3. The process to assess hazards or risks.	Yes
4. #The hierarchy of controls to manage these hazards and risks.	Yes
5. Event reporting and recording requirements.	Yes
6. Event investigations and designated responsibilities.	Yes
7. Responsibilities for corrective actions.	Yes
8. Involvement and participation of workers in health and safety matters and how union and other nominated employee representatives participate.	Yes
9. Involvement and participation of other workers (e.g. contractors) in health and safety matters (where applicable).	Yes
10. Emergency procedures.	Yes
11. Roles and responsibilities in the AEP.	Yes
12. How to lodge a claim and access rehabilitation support.	Yes
13. #The collection and storage of work and non-work claim information in relation to the Privacy Act 1993 and the Health Information Privacy Code 1994.	Yes
14. The complaints and review processes.	Yes
15. Awareness of entitlements being medical, social and vocational.	Yes
16. #Understanding of the key roles and responsibilities in rehabilitation (e.g. the roles of the case manager, injured employee, team manager and union* and other nominated employee representatives).	Yes
17. #Understanding of rehabilitation and support from management.	Yes

#While these questions may be asked at the management and employee focus groups, primary responsibility for understanding rests with the management focus group.

Summary of Element 20:

√ It is recommended that this employer has successfully met the requirements of Element 20 at the following performance standard: √ Primary — Primary is the highest level of achievement for this element. ☐ It is recommended that this employer has *not* met the requirements of Element 20.
Number of focus groups undertaken: 3
Positions and interests represented in the employee focus group(s): Anaesthetic Technicians (2), Clinical Nurse Coordinators (3), Nurse Educator, Attendants (2), Health Care Assistant, Public Health Nurse, Enrolled Nurse, Registered Nurses (2).
Positions and interests represented in the management focus group: Service Managers (2), Charge Nurse Managers (3), Theatre Manager.
Comments:

Three focus groups were held with participants representing areas selected for audit. Participants spoke about positive health and safety achievements which included:

- Improved reporting through the Datix electronic reporting system.
- Positive levels of engagement across disciplines.

There was a good understanding of hazards associated with the working environment and tasks. Examples discussed included; blood and body fluid exposure, infectious diseases, moving and handling, hazardous substances, slips trips and falls and workplace violence.

Manual handling training is a component of orientation training as well as targeted training relevant to the work area. Feedback did indicate that manual handling training for non-clinical staff is an area that could be strengthened (see general recommendation).

Participants spoke about the risk assessment process and there was an appreciation of what constitutes high/moderate risks and low risks.

There was a good awareness of electronic accident/incident reporting through Datix and although feedback about whether the system is user friendly was variable the general consensus that reporting has improved.

Managers understood their responsibility to investigate reported accidents/incidents but are guided in this process by the Health and Safety Service. Feedback confirmed that there is good communication of corrective actions and learnings post-event.

Nominated/elected health and safety representatives are active and feedback indicated that ongoing training ensures that there is an understanding of the role. All services confirm that there are a number of ways health and safety issues can be communicated and these range from health and safety meetings, staff/shift meetings and emails.

A range of emergency scenarios were discussed that included fire, violence/security incidents and hazardous substances spill. There was variable feedback about coverage of evacuation drills with some indicating that they had not experienced a drill for some time – this has been raised as a recommendation in element seven.

Participants had a good understanding of the AE Programme and the responsibility Waikato DHB has to self-manage work injury claims with the assistance of WorkAon.

Several participants had experienced the claims management process for work and non-work related injuries and confirmed that the workplace is supportive of early return of work.

Entitlement provisions discussed included social support such as home help and transport assistance, medical treatment and specialist assessment. There was an understanding that Waikato DHB pays 80% earnings related compensation and that treatment surcharges are not covered.

Rehabilitation responsibilities were described with managers stating that in the event of a staff injury it is important to maintain contact with the injured employee, participate in monitoring rehabilitation progress and the identification of alternate duties in line with restrictions identified on the medical certificate.

The need to hold scenario exercises to test response to security incidents was the main area identified by participants for ongoing improvement.

Critical issues:

None

Improvement recommendations:

General

- Manual handling training needs to be widened to include non-clinical staff involved in moving and handling activities e.g. Health Care Assistants.

Service Performance Monitoring

MEMORANDUM TO THE BOARD
25 JULY 2018

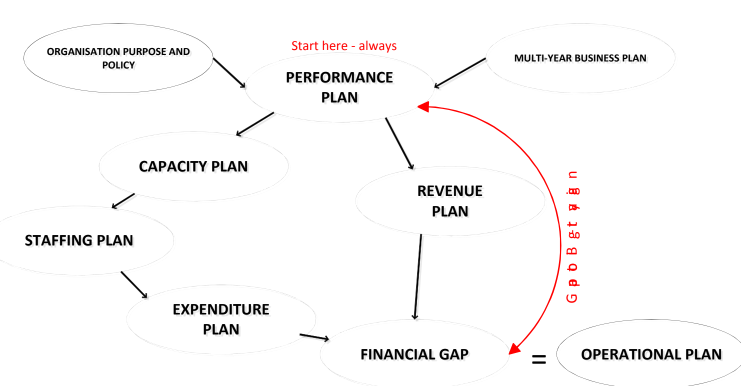
AGENDA ITEM 9.1

INTERIM CHIEF OPERATING OFFICER

Purpose	For information.

For the purposes of consistency this report will follow an operational planning format. i.e.

The Operational Plan Development Process



The reason for following this format is that the various parts of the operational reality ought to be aligned and congruent. The following sections approximate the headings of the above planning process as a mapping tool.

Performance

For the purposes of examining performance, Waikato Hospital Services comprise three groups, acute (rescue) services, elective services where the aim is to help people deal with long term health problems, and services that are hospital based to a greater or lesser extent, but where the service delivery is in the community or on a regional scale.

Acute Services

- Relevant performance indicators:
  - Emergency Department 6 hour target
  - Acute theatre access percent (80% in 24 hours, 100% in 48 hours)
  - Acute Coronary Syndrome pathway (diagnostic coronary angiography within 72 hrs of presentation to a medical facility in the Midland Region).

Emergency Department

The Emergency Department continues to operate under very difficult conditions. Relative to the 6hr target we have not made significant progress. We have closely matched constraints in terms of the department's ability to see and treat patients, and the ability to admit patients into a hospital that is yet to deliver a bed-plan that meets or exceeds the forecast demand. The bed plan issue should be largely resolved when Ward 18 is commissioned as an acute surgical unit.

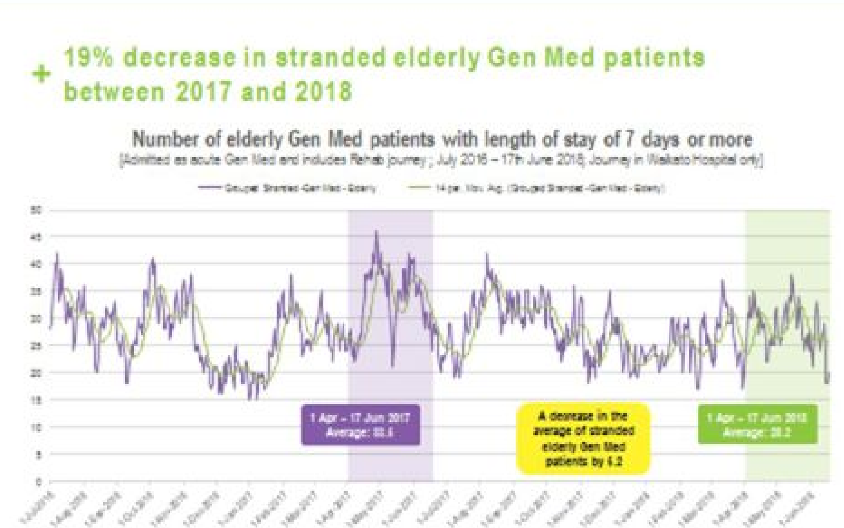
In the absence of a short stay ward into which patients can be decanted from ED, there are a number of small but significant things that can be done to improve flow within ED and flow out of ED, and we are in the process of implementing these, from changing the management orientation to improve cross department function, to moving bed management staff closer to the Emergency Department.

With the Francis Group we are focussing on three areas of acute care, the Emergency Department, the acute medical wards and care of the elderly.

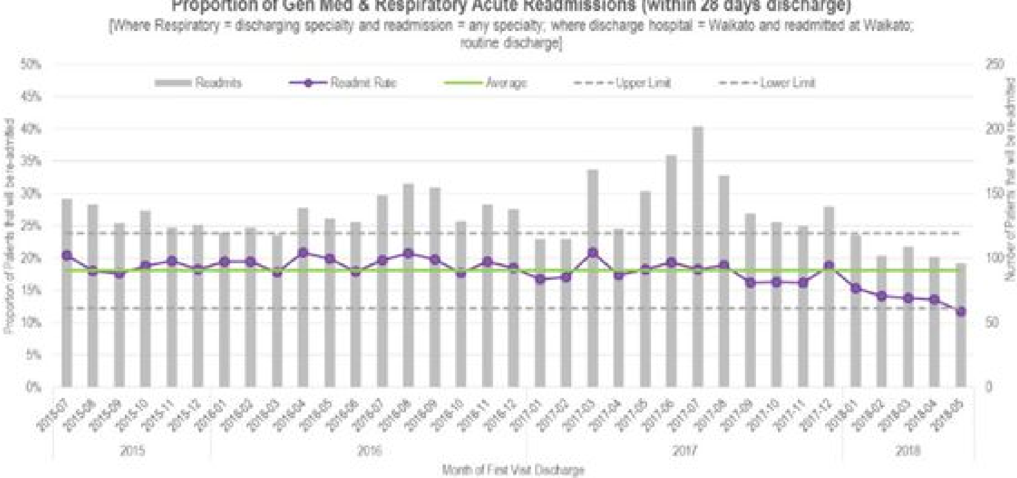
We have trialled, and are now implementing, a hot-zone model based on Kanban principles within the Emergency Department. Ongoing change in the department remains difficult given the fragility of the staff and the unrelenting pressure they are under day in and day out.

In addition we continue to pursue strategies aimed at keeping elderly and at risk patients ambulatory and in the community rather than in hospital.

As a result we are seeing fewer elderly patients with a long length of stay relative to last winter.

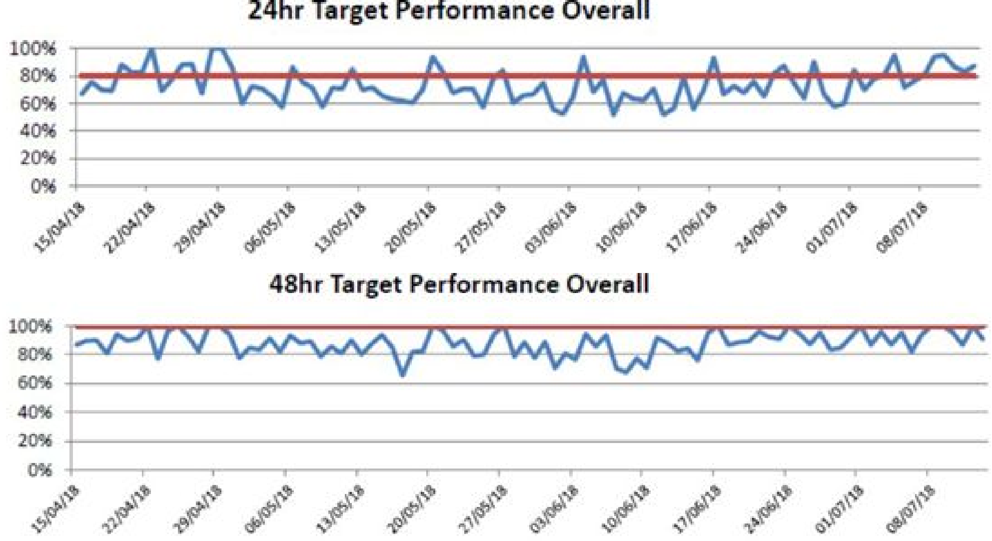


When we do discharge patients home we are seeing a lower readmission rate suggesting we are not putting patients at risk by pursuing earlier discharges and we are placing people in a more supported environment when they do return into the community.



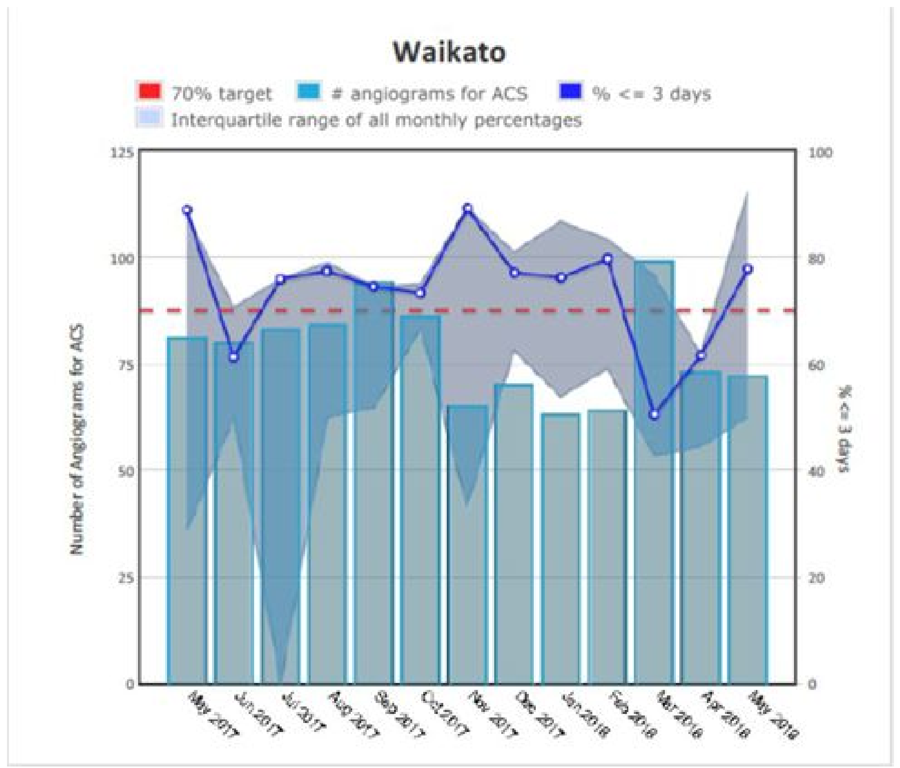
Access to Acute and Emergency Surgery

Over the last month access to surgery for acute and emergency patients has been better than normal based on a restriction of elective services in preparation for nursing strike conditions.



ACS Target

Our performance against the ACS target did not meet the standard in March and April but has improved again in May with fewer angiograms being performed.

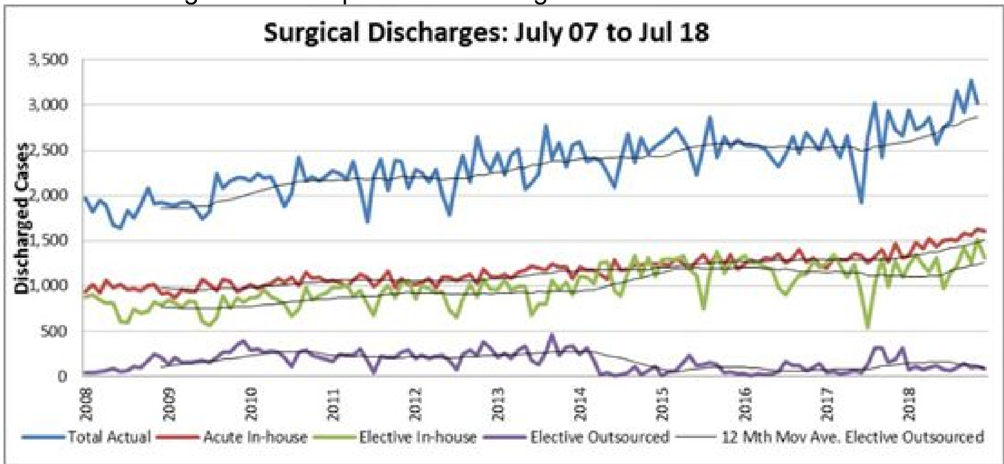


Elective Services

- Relevant performance indicators:
  - "Quantitative" – volume of patients treated
  - "Qualitative" – ESPI framework.

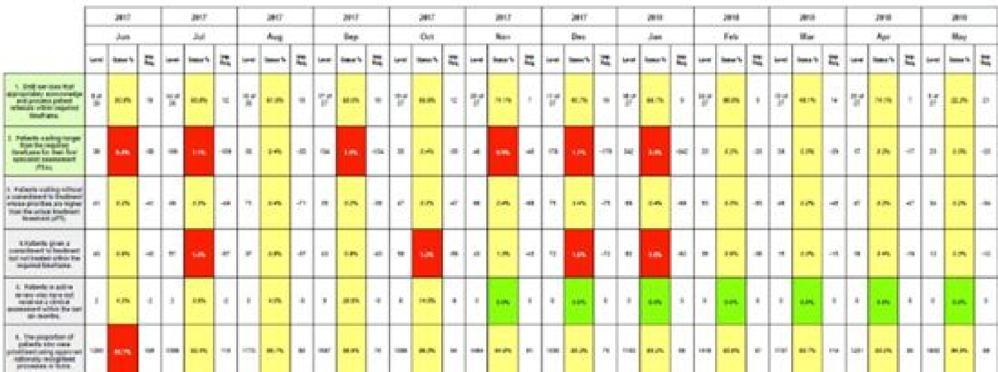
Quantitative

We have delivered the required volume of elective services for 2017/18 at about 104% of the target washed up across all categories.



Qualitative Measures

The DHB has been compliant for ESPI 2 and 5 for 4 months and we believe the results for June will be similarly so.



Additional commentary on surgical performance is included in the Chief Executive's report with reference to the Surgical Reinvention (KEEZZ) Project.

Regional and Community Based Services[1]

Waikato DHB continues to meet the Faster Cancer Treatment targets.

Staffing and Capacity

Measures to usefully comment on capacity and staffing related issues are being developed. At present, as at the end of the financial year, two observations are warranted.

- The hospital group has accrued a major liability with regard annual leave earned but not taken across both medical and nursing staff groups.
- Nursing workloads remain high across the in-patient areas (wards, theatres etc) of the hospital group.

Two significant developments with regard capacity are planned:

- A third evening acute operating theatre has been commissioned from 16 July 2018.
- The acute surgical admission unit will be commissioned in early August addressing a long standing gap between the bed plan and staffed beds.

Date	Forecast	Required Beds	Planned Beds	Hosp Beds Over/ Under
Mon-16-Jul-18	569	651	617	-34
Tue-17-Jul-18	561	651	617	-34
Wed-18-Jul-18	560	651	617	-34
Thu-19-Jul-18	565	651	617	-34
Fri-20-Jul-18	544	651	617	-34
Sat-21-Jul-18	524	651	617	-34
Sun-22-Jul-18	540	651	617	-34
Mon-23-Jul-18	568	651	617	-34
Tue-24-Jul-18	578	651	617	-34
Wed-25-Jul-18	564	651	617	-34
Thu-26-Jul-18	559	651	617	-34
Fri-27-Jul-18	552	651	617	-34
Sat-28-Jul-18	537	651	617	-34
Sun-29-Jul-18	545	651	617	-34
Mon-30-Jul-18	555	651	643	-8
Tue-31-Jul-18	565	651	643	-8
Wed-01-Aug-18	559	651	643	-8
Thu-02-Aug-18	556	651	643	-8
Fri-03-Aug-18	559	651	643	-8

[1] Note this section currently only refers to cancer services. The intention is to broaden this set to include diabetes, renal services and other related service groups.

Expenditure

At the time of compiling this report the hospital group is approximately $13 million dollars unfavourable for the full year against a budgeted expenditure of $460,596,603. The major contributors to this variance are:

- $4 million liability for annual leave earned but not taken for nursing staff.
- $4 million liability for annual leave earned but not taken for medical staff.
- Approximately $4 million dollars over budget for clinical supplies, in particular treatment disposables.

Revenue

The hospital group is favourable year to date in revenue earned from Waikato DHB ($13,693,358) and non-Waikato DHB sources ($681,644). For the purposes of District Health Board consideration the former number is a transfer from funder to provider arm.

Contribution

The Hospital Group delivered a contribution as budgeted of $158,759,018 or 30%.

Planning for 2018/19 year and beyond

Clinical Service Planning

The majority of clinical units have had their first round of meetings to advance clinical service planning and a number have almost completed the process.

As expected some clinical units are in need of immediate support (eg: respiratory) although there also appears to be a genuine need to invest across a wide range of clinical areas if we are to pursue a DHB-wide strategy of increases access to healthcare across the spectrum, whilst coping with growing acute demand.

Nursing

The hospital group has committed to staffing the right number of beds to meet demand notwithstanding a commitment to avoid admissions where we can, and to avoid unnecessary delays in providing the necessary treatment.

In addition we have committed to staffing inpatient care areas in a manner consistent with the appropriate acute workload measures, and have already addressed this issue in some wards while rolling out to the rest of the wards.

These two measures will increase the number of nurses required and will cost substantially more, albeit there should be offset benefit in terms of dollars, and in other areas more detrimental to long term sustainability. If we don’t correct the current issues, for example the inability to send staff on leave, and the drive to staff more beds than initially budgeted for, something which has characterised the last few years, we will incur further liability in terms of leave not taken, and staff burn out.

Recommendation
THAT
The Board receives the report.

GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER, WAIKATO HOSPITAL SERVICES

MEMORANDUM TO THE BOARD
25 JULY 2018

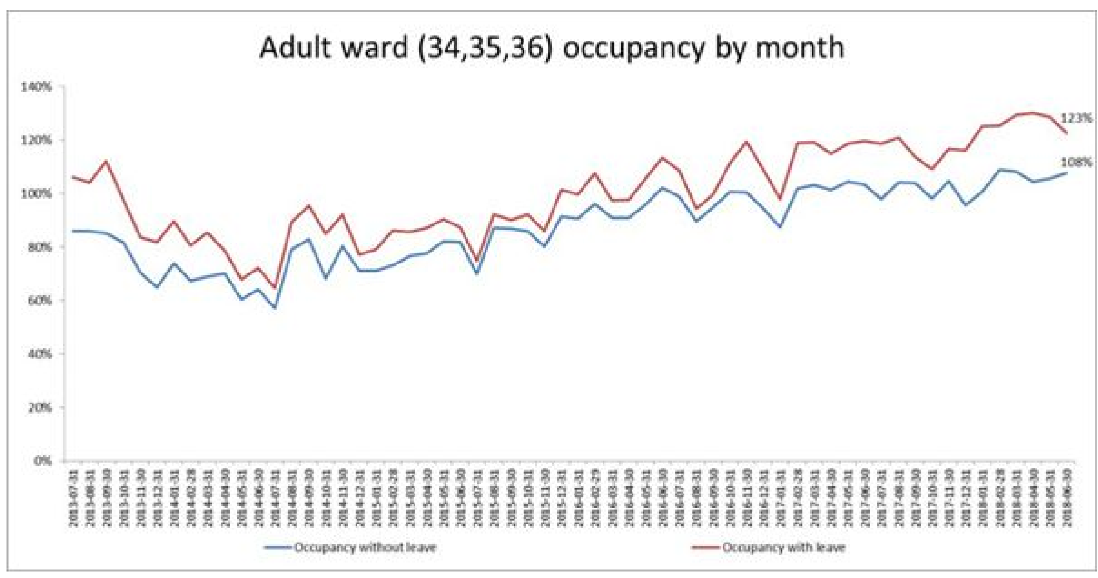
AGENDA ITEM 9.2

MENTAL HEALTH & ADDICTIONS SERVICES

Purpose	For information.

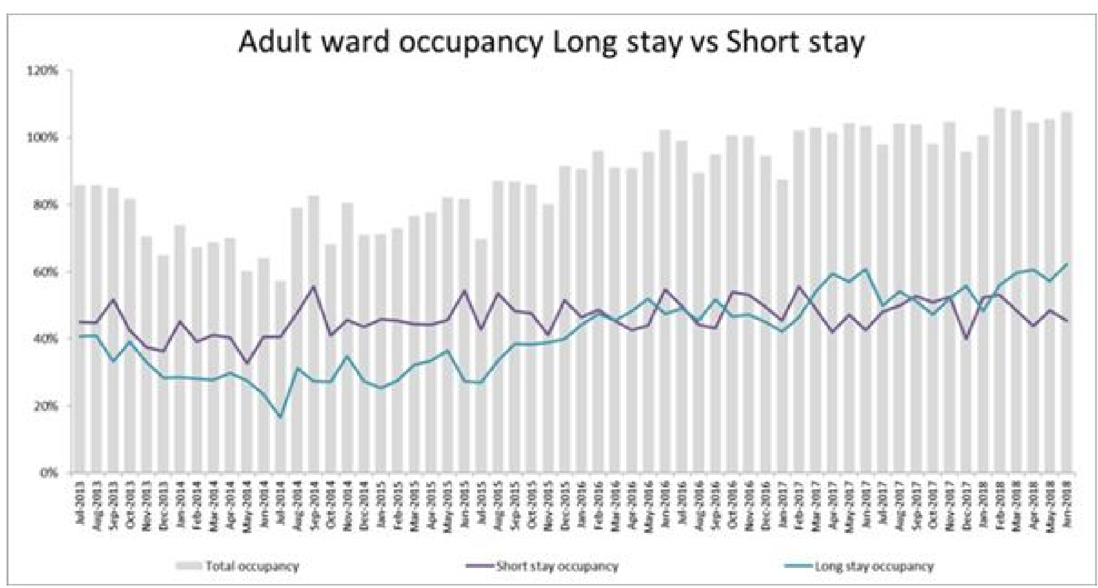
SERVICE OVERVIEW

Over the last year (and longer) there has been a significant increase in demand right across Mental Health and Addictions services, which culminates in an inordinate amount of pressure on the adult inpatient unit (HRBC). This ranges from being on numbers (53) to regularly being 12+ over numbers. From January 1st 2018 to June 12th 2018 an additional 667 bed nights were occupied. This has an impact on both the service user experience of effective care and treatment, and on our staff who are working with high levels of occupancy and acuity. The numbers of those requiring acute inpatient care has risen, as well as the complexity and acuity of presentations. The risk of increasing levels of aggression and potential for assaults on staff is being mitigated by a detailed contingency and escalation plan.



The plan involves collaboratively working with Waikato Hospital, once the adult beds reach 100% occupancy. Longer term solutions have been proposed to Strategy and Funding and

include the funding of an increase in beds from 53 to 59, as well as finding a sustainable solution for the 7-10 service users who require individualised packages of care. At the end of July, 31 service users had been an inpatient for more than 21 days, with seven service users staying between 73 and 238 days.



Work is underway to scope the inpatient bed requirements to meet current volumes and demand until a new facility is on stream.

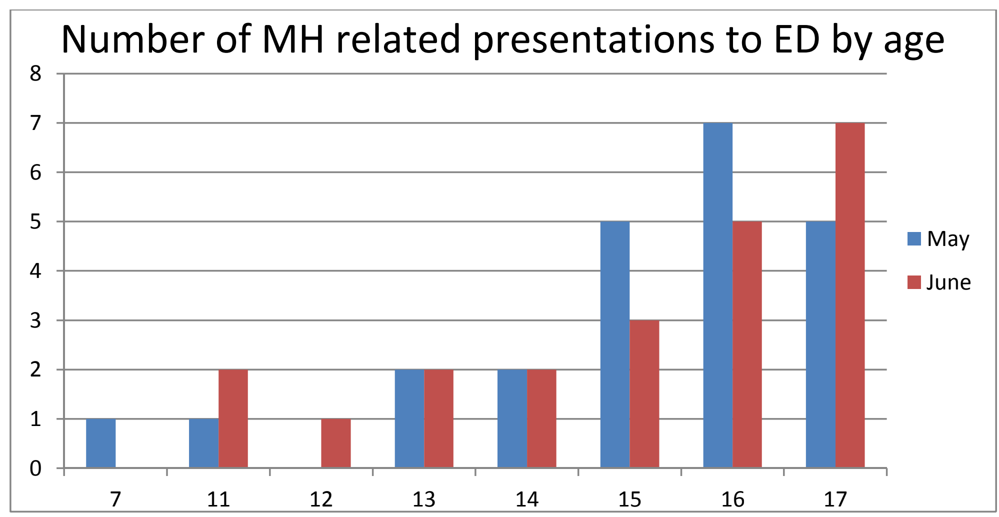
Emergency Department

With the appointment of a Nurse Practitioner in Mental Health, planning is underway to support a small team of mental health practitioners to be based in the Emergency Department of Waikato Hospital. Once the service pressures process is finalised clinicans will be recruited and be based in the Emergency Department outside of hours, particularly in the afternoons, seven days a week. The Emergency Department has confirmed this week that they can make space for mental health practitioners to be based in the department and work is underway to prepare the necessary documentation for approval of service pressures to be released both into the Price Volume Schedule and then the HRIS/ Finance system to be able to recruit staff. This is an exciting initiative which will free up the crisis assessment home treatment team to be able to respond in a more timely manner to referrals from outside of Waikato Hospital and deploy their finite resources to meet demand. The data below demonstrates the demand being placed on Waikato Hospital Emergency Department presentations where mental health as a specialty is being recorded.

Summary of Emergency Department (ED) presentations for June 2018

- A total of 104 ED attendances, included in the measure, with 18 discharges occurring six hours or more after arriving at ED – representing 82.7% achievement of being seen and discharged within six hours. This equates to 86 of 104 presentations meeting the target.
- The total number of Mental Health presentations was 148, although not all required, or were discharged by, Mental Health.
- 105 of the 148 presentations had an arrival time after hours (between 5pm and 8am) equalling 70.95%. During this time there is one registrar on duty for all mental health related work (including inpatient).
- Individuals presenting to ED do so with a range of reasons including anxiety, suicidality, psychosis and behavioural changes.
- Whilst the busiest days of the week in June were Friday and Saturday, in May the busiest days were Tuesday and Thursday. There does not appear to be a consistent pattern to presentations.
- Of the 18 breaches, five of them occurred on a weekend.
- The highest number of Mental Health presentations in one day was 11 (this was a Saturday).

- There were 45 presentations to ED of children and youth in May and June.



Recovery Planning

Work has occurred looking at recovery planning and to improve performance in two key areas:

- Compliance with the national KPI for recovery plan completion.
- Using a staff led project to improve the quality of recovery plans within the service.

KPI for recovery planning

Background

KPI data on completion rates is reported monthly to the Mental Health clinical governance forum and the Board. The national target for recovery plan completion is 90% for people within the service 1 year or over.

The Mental Health and Addictions service has consistently been performing under the target for completion rates of recovery plans.

Current actions

- A daily report on recovery planning is provided to team leaders on expired, about to expire plans, or non-existent plans.
- Team leaders are reviewing the report and following up with individual clinicians.
- Systems analyst working to increase visibility of status of recovery plan; HoNOS; comprehensive assessment, when a progress note is created / opened in clinical workstation in response to feedback from clinicians.

The data at the commencement of the daily reporting had overall performance as 70.4%. The initial aim was to reach 90% by the 30th June. Achievement was 94.3%. Ongoing updates comparing team progression have been provided to all team leaders which highlights the teams that have reached the target, improved, or declined in performance.

The operations manager has been monitoring progress with team leaders, and has reviewed the data being sent out by the business analyst.

Recovery Project

A workshop was held with 18 staff – nursing, occupational therapy, social workers in senior clinical leadership positions and expert clinicians from across the Mental Health and Addictions service and the recovery advisor (consumer position) who are involved in the design and delivery of the recovery planning education within the service.

The purpose of this workshop was to engage staff involved in the provision of clinical care on the quality process for recovery planning. Key themes were identified that prioritise a move to more person centred care across the patient journey.

<u>Intended Actions</u>

An action plan is in place to support best practice and ensure consistent performance in this area. Two new developments will further support changes in practice:

1. Clinical Workstation changes to improve performance

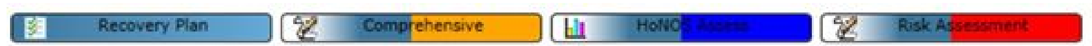
It is proposed to modify the standard progress note so that clinicians are reminded of outstanding activities while recording notes – this will prompt them to resolve out of date or overdue activities while they are in the person's record and recording information for that person.

The five dimensions of focus:

- Recovery Plan status
- Comprehensive status
- HoNOS collection (and ADOM)
- IMI status
- Risk Assessment status.

A row of buttons will be added to the progress note form with icons and title of the measure – in addition the *colour of the button will indicate urgency*.

Should the clinician select any of the buttons the outstanding form (or a new form) will open allowing immediate investigation or resolution of the outstanding activity – the outstanding form will open in a separate window – therefore and importantly, content of the progress note will not be lost.



2. Qlik Sense Mental Health pilot

Six dashboards have now been developed within the Qlik pilot project.

While there is further use testing required and allocation of licenses, there are a number of dashboards that will assist clinicians to better understand and manage their caseloads:

<u>Community caseload</u> –The Qlik application has a number of features including recovery plan status, risk assessment, IMI tracking, housing status, and engagement with primary care. It also has the added function of allowing users to understand the level of engagement MH has with the service users.

Readmission, Inpatient and Outcomes – Understanding trends within the inpatient area of Mental Health.
Seclusion – Monitors seclusion and analyses historical trends.
Post discharge care – Day to day management of clients who have been discharged from the inpatient area that require follow up. Analyse of post discharge performance of Mental Health.

INITIATIVES AND HIGHLIGHTS

Collaborative partnerships

In response to occupancy and flow issues - a governance and operational group has been established with key non government organisations who provide residential and supported accommodation. The purpose of these forums is to collaboratively explore every opportunity to create solutions to support this current climate of high demand. A weekly forum is held with multiple providers - sharing current status of vacancy, impending residents and issues for those that they are trying to transition from their residential support service.

A governance group is also meeting to look at the systemic issues that need addressing across the care continuum.

This has highlighted that while there is pressure to obtain placements for those needing supported residential options, provider flow is also impacted for those who are suitably ready to transition to independent options. While work with other providers occurs including Housing NZ and Link People - residential support facilities currently host service users, with capacity to function independently given the dificulty in accessing independent housing options. Narratives include individuals repeatedly being declined housing options, as the rental market is currently highly competitive. Financial disincentives are also identified, as individuals recognise the value of the accommodation provider support - and the realities of independent costs of living. That said, the forums are a new initiative, demonstrating the commitment of those involved in delivering services, to addressing broader continuum issues that impact on occupancy and flow, and directly affect individual lives and recovery.
This is unprecedented as the competitive climate amongst providers has been a feature in the past.

As a direct result of this forum - a service user was successfully identified as being well suited to another provider and transitioned quickly and efficiently, enabling the same day transfer of an awaiting inpatient to the provider vacancy.

Recruitment and retention issues have featured over the last quarter, particularly in the community sector teams. This has resulted from a combination of high workload demand, compounded by vacancies in teams. A significant piece of work has been in progress in conjunction with HR, to identify the issues and work to generate some resolution. A recruitment project team has been established, with regular advertisements and interviewing occurring. This has successfully resulted in attracting some good applicants for a “buffer pool” of health professionals for the community sector. The buffer pool is a direct feeder to ensure vacancies are filled immediately. With time we anticipate that this will alleviate some of the pressure arising with staff in the community teams, having to carry additional caseload responsibilities when colleagues resign. Resignations have slowed, and work has been a priority in responding to staff concerns.

Psychiatry recruitment to PHOs has been completed, with two 0.6 FTE positions established in each of the respective PHOs. Dr. Andrew Darby has joined the Pinnacle team, and remains with Waikato DHB in a 0.4 capacity. Dr Darby will provide an interface between primary and specialist services (in dual roles). As part of the 0.4 FTE work, Andrew has agreed to lead a project, exploring existing community sector caseloads of those in service for two years and over, to review and identify those who may be suitable to transition beyond specialist services, and back to primary care.

Consumer roles - reinstatement of a second on-staff consumer recovery advisor role has been in progress. This role will have a focus on quality initiatives, to support and enhance service user outcomes. The incumbent has been selected to participate in a national quality scholarship, and we understand, is the first consumer role to participate in this training opportunity. As the face of “real time feedback” and “zero seclusion” interviews, this is an outstanding opportunity for a well deserving quiet leader with a keen and passionate interest in the work that he does.

Integrated Safety Response - now fully staffed after a recruitment drive, this team is exploring how they can progress from response, to intervention opportunities. Engagement with the broader DHB has been occurring, as it is critical to have wider health representation at the panel addressing family violence. While the panel representation remains with mental health and addictions, communication channels across the DHB are in place; with health social workers identified as a key stakeholder.

Integrated Recovery Service

The existing IRS service, since its inception as Malcom House and Mahi Tahi, has been through significant changes and review. However its core business has essentially remained the same.

IRS is a generic community rehabilitation service that offers a number of personal and skill development responses with an emphasis on fostering opportunities for recreation, with and through other community agencies and networks. As a recovery focused health employment and education, working service, it strives to support people to build bridges to the communities outside of a mental health service.

The team have realigned their approach to focus on these key areas and programmes and interventions are structured around:

a) Vocational (employment)
b) Social and recreational (leisure)
c) Independent living (life skills).

The pathways follow evidence informed socially inclusive approaches, and are time-limited with commencement and graduation dates. There is a high degree of engagement in the wider community and away from mental health specific services, truly promoting social inclusion and a strengths-based approach.

Creating our Futures

Significant community engagement has occurred with communities to inform both Creating our Futures and Te Pae Tawhiti. This engagement process has been branded “Lets Talk” and has seen Mental Health and Addictions staff fronting over 50 hui. A number of hui have been Māori specific and in populations with significant health and social deprivation. A high proportion of Māori have attended these engagements and local Māori providers have worked with us to enhance Māori participation.

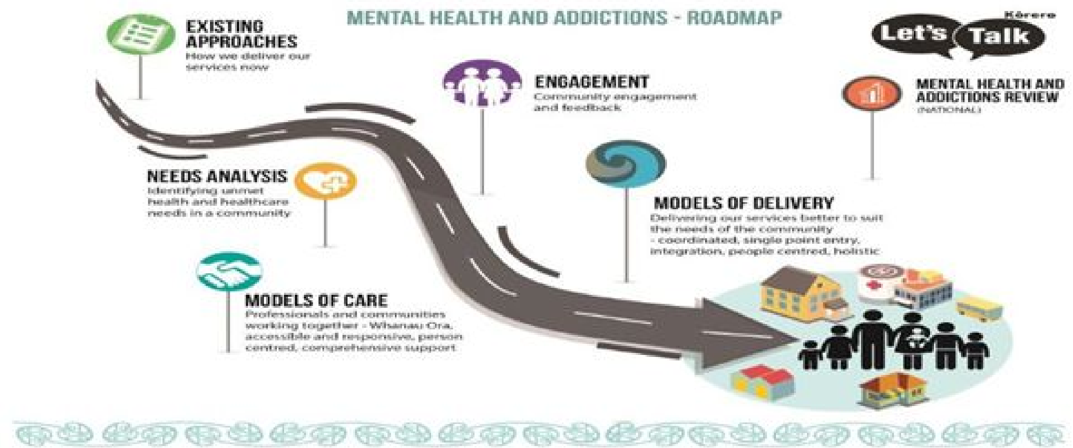
Examples of key themes include:

- Support for whānau
- Local services
- Local points of entry to services
- Whānau ora as a model for MH&A services
- Integrated – better joined up care
- Improved access to crisis care

- Transport issues in rural communities
- Support for GPs in rural communities
- Alternative treatments to medication
- People who listen.

All feedback is typed verbatim and is collated and will be analysed by a diverse group to inform the development of change programme.

The generosity of people sharing their stories has been both compelling and challenging to those attending the hui. The service has a strong commitment to honouring the feedback and voices of those who have contributed. Those involved should be acknowledged for the remarkable effort that has gone into this process. I am not aware of anything occurring of this magnitude before in an open and genuine attempt to improve services.



The recommended preferred way forward for the Waikato DHB Mental Health and Addictions service (MH&AS) Facilities and Service Redevelopment Case will be presented for the Board's review in August. The community engagement and workshops with key stakeholders have now concluded. Once the preferred options are approved a more detailed economic assessment as part of the Detailed Business Case can commence.

Recommendation
THAT
The Board receives the report.

VICKI AITKEN
EXECUTIVE DIRECTOR (INTERIM) MENTAL HEALTH & ADDICTIONS SERVICES

Decision Reports

Equity Focussed Reporting: report due in October.

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 10.2

PHO SERVICES AGREEMENT – HAURAKI PHO

Purpose	For approval.

This PHO Services Agreement - Version 5 is the standard national PHO Service variation for all Primary Health Organisations (PHOs) and covers the period 2017/18. The Chair of the Board is required to sign this agreement on behalf of the Board or delegate authority to the Chief Executive, as the contracted value is over $10m per annum.

This variation updates all the changes to the National PHO Services Agreement that were negotiated and agreed nationally including:

- Increase to the capitation funding in line with PHO Service Agreements; and
- The 2017/18 Flexible Funding plan that was agreed at the Hauraki Hauora Alliance Leadership Team in April 2018.

Funding

The total Funding for this agreement with Hauraki PHO for 2017/18 is as follows:

Funding Streams (Waikato)	2017/18
Capitation	$26,837,047
Health Promotion	$353,008
Care Plus	$2,055,281
Management Fee	$2,624,845
System Level Measures	$722,332
Total	**$ 33,522,602**

Radical Improvement in Māori Health Outcomes by Eliminating Health Inequities for Māori

Hauraki PHO has three Māori Health provider organisations that are members of the PHO – Raukura Hauora o Tainui, Te Kohao Health, and Te Korowai Hauora o Hauraki. These providers operate a Whanau Ora model of care and are key partners in the PHO. The Board is made up of 50% Māori membership. Hauraki PHO's Strategic Goals are:

1. Wai Ora – Quality Health Care;
2. Whai Mana – Health Equity; and
3. Whai Rangatiratanga – Sustainability of Service Provision.

Recommendation
THAT
The Board:

1) Gives approval for the Chair to sign the 2017/18 Hauraki PHO Services Agreement; or
2) Delegates authority to the Chief Executive to sign the agreement.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR STRATEGY AND FUNDING

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 10.3

PHO SERVICES AGREEMENT – MIDLANDS HEALTH NETWORK

Purpose	For approval.

This PHO Services Agreement - Version 4 is the standard PHO Service variation for all Primary Health Organisations (PHOs) and covers the period 2016/17. The Chair of the Board is required to sign this agreement, or delegate authority to the Chief Executive, as the contracted value is over $10 per annum.

The previous Agreement, Version 3, was signed by the CEO of Midlands Health Network (MHN) in March 2016 and subsequently signed by our former Chief Executive on behalf of the Board in January 2017.

This Agreement, Version 4, was signed by the Chief Executive Officer of MHN on 7 June 2018.

Whilst the 2016/17 agreement period is well past and MHN has been paid fully for services for this period including any nationally prescribed price increases, we are required to get this document signed in order to progress their next PHO Services Agreement.

These Agreements are negotiated nationally through PHOs Services Agreement Protocol process and include first level services (usual general practice services) and all related payment mechanisms such as capitation, immunization payments, System Level Measures and Flexible Funding Plans. It is essentially an evergreen contract with annual changes to reflect, in the main, payment increases.

We sign the MHN agreement as the lead DHB on behalf of Tairawhiti, Lakes and Taranaki DHBs. However all these DHBs have separate payment processes, have a discrete enrolled patient register, and have a direct relationship with MHN.

We have had challenges in getting the PHO Services Agreement signed given the MHN Alliance Leadership Team (ALT) struggled to reach agreement on the use of flexible funding and the strained relationship between Waikato DHB and MHN at that time.

Funding

The overall funding for this Agreement for 2016/17 with MHN is approximately $83.7 million per annum for Waikato, Taranaki, Lakes and Tairawhiti DHBs.

The funding for Waikato DHB is as follows:

Funding Streams (Waikato)	16/17 Funding
Capitation	$39,813,527
Flexible Funding	$7,883,410
Care Plus	$3,296,307
Health Promotion	$572,495
Management Fee	$1,533,256
Services to improve Access	$2,481,352
System Level Measures	$1,299,466
Total	**$48,996,404**

Radical Improvement in Māori Health Outcomes by Eliminating Health Inequities for Māori

As this Agreement is for 2016/17 it includes the standard PHO Services Agreement clause which is the development and implementation of a Māori Health Plan.

The new 2018/19 agreements we have with MHN, which are outside the PHO Services Agreement, includes a clause on radical improvement for Māori, and are being signed now by MHN. The standard clause will be incorporated into the 2018/19 PHO Services Agreement.

Recommendation
THAT
The Board:
1) Gives approval for the chair to sign this agreement; or
2) Delegates authority to the Chief Executive to sign this agreement.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

MEMORANDUM TO THE BOARD
25 JULY 2018

AGENDA ITEM 10.4

REQUEST FOR CHANGE APPROVAL – PATIENT FLOW MANAGER INFRASTRUCTURE

Purpose	For approval.

Radical Improvement in Maori Health Outcomes by Eliminating Health Inequities for Maori
The implementation and use of Patient Flow Manager will make it much easier for Kaitiaki staff to receive, prioritise and respond to requests for support of Māori patients on the wards. It will enable instant communication of requests and include the comments from the Kaitiaki in the nursing handover documentation ("comments for ward (KT)").

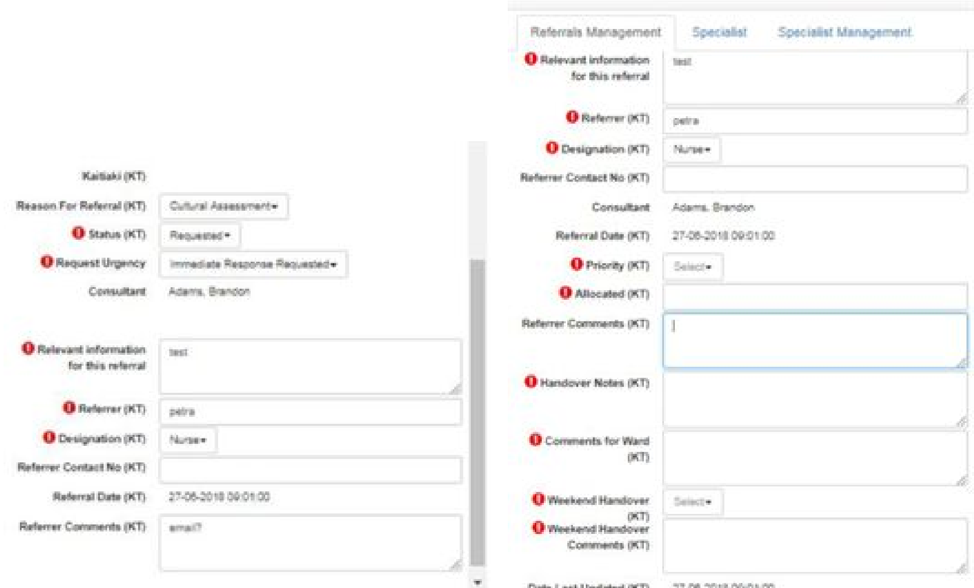


Figure 1: Request for Kaitiaki support **Figure 2: Notes from Kaitiaki**

Background
Patient Flow Manager is the information system that is being implemented in Waikato DHB as the replacement for current paper based and stand-alone clinical whiteboards and nursing handover reports on all patient wards. The system also provides workflow functionality for staff groups who are responsible for completing patient related tasks (i.e. RMOs, Allied Health, Food & Nutrition, Kaitiaki, etc). Electronic Clinical Task Management (CTM; part of the Patient Flow Manager

solution) for RMOs is being implemented to address one of the recommendations to be satisfied for the Medical Council training accreditation.

The project's aim to provide transparency and visibility of each patient's journey, combined with the roll-out of approximately 900 hand-held devices, has the potential to transform how work is completed on the wards. Improved communication through increased speed and accuracy of information flow will enable timely and effective prioritisation, contributing to dramatically shortened wait-times for completion of tasks.

The business case for this project (IS 1410-001-02 iMPACT Patient Flow Tool) was approved by the DHB Board in February 2017 and by the Minister in June 2017. Required endorsements were obtained at regional level (Regional Capital Committee and eSPACE project), and National level (MoH Digital Advisory Board and Ministry of Health).

The scope for the solution is all inpatient wards, and roll-out is commencing in the Southern Rural Hospitals in August 2018, followed by Thames and Waikato Hospital later this year.

Currently the project is in the testing phase, with User Acceptance Testing by 100+ staff from a range of disciplines scheduled to commence by 30 July.

Request for Change and Rationale
Additional capital funding is requested to complete essential building works related to the installation of large screens in all wards in scope, to develop additional functionality for Mental Health, and to extend the project by 2 months.

Additional funding is sought to deliver a solution that is acceptable to the users, and to accommodate additional building and health and safety requirements that were not identified during the development and review of the original business case. Specific details are included in the Request For Change (RFC-006) document.

Alternatives and Benefits
Two alternatives were considered to reduce cost. The first to utilise existing smaller screens on wards where these are installed. The second alternative considered was to exclude the additional Mental Health functionality. Both alternatives were discounted as patient safety would be compromised and user satisfaction severely compromised.

Financial Evaluation
The financial evaluation of the original business case was:

Net Present Value	millions	$18,893	(Interest Rate:	8.0%
Payback		1.5	Years	
Internal Rate of return		259.5%		

With the revised capital requirements, the revised financial evaluation is

Net Present Value	millions	$18,232	(Interest Rate:	8.0%
Payback		1.7	Years	
Internal Rate of return		186.0%		

Thus, there is no doubt that had we factored in the latest expected project costs, the recommendation to proceed would still have been made.

Next steps
The Request for Change requires approval by the Minister, and a request for this has been sent to the Ministry. It is imperative to have approvals for the funding in place by end of July as otherwise the project implementation will be delayed further and compromise time commitments made to Medical Council and the delivery of long awaited benefits to the organisation.

Recommendation
THAT
The Board approves a Request for Change RFC-006 for additional Capex of $661,402 for the project.

MARC TER BEEK
CHIEF DATA OFFICER

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

Request for Change

RFC number:	RFC006	Date:	20/06/2018
Project manager:	Philippus Roos	Project code:	IS1410-001
Project name:	iMPACT – Patient Flow Manager		
Change title:	Patient Flow Manager Functional Changes		

Change request details

Description of the proposed change

Summary

- Within the IS project delivery framework there is a key milestone review where the project is re-validated. This is after the design phase is completed. This RFC is to re-align the project after re-validation
- Changes from the original business case are to be addressed and this include:
  1. Solution Change – key off-specification requirements to be included in product scope
  2. Integration Change - de-scoping integration product scope not functionally possible.
  3. Infrastructure & Building work – The requirement for additional screens with the associated build and electrical work is a critical requirement
  4. Time – Request adjustment of time to complement the plan of completing the project
  5. Total Budget in this RFC - Request approval for the additional CAPEX & OPEX associated with points 1-3 above

Change Detail:

1. Solution Change: Mental Health Functionality – New Dashboard, Bed configuration within HRBC and MH legal status functionality to be included into the scope of the Patient Flow Solution. This will primarily be vendor specific cost. Total cost associated with **Section 1: $50,000 CAPEX**
2. Integration Change – Removing Amion integration from the solution. The integration with Amion was planned in late 2017. The vendor modified the base product base on the DHB requirements received. Once actual feeds were enabled between Amion and PFM (Patient Flow Manager) the data displayed didn't produce the expected outcome. After further investigation it was determined that the original required data cannot be displayed in PFM without major integration development and maintenance going forward. There is no further cost associated with the de-scoping of this functionality.

Change request details

Description of the proposed change

3. Infrastructure & Building work

Detailed information regarding the large screen requirements:

Approved in Business Case	Current Requirement
60 X Screens (55"/65")	107 X Screens (65" only)
No budget for Desktops	Desktop required for Screens
Assumption to repurpose existing screens	Repurpose of existing screens not possible
Limited Building work assumed	Detail requirement for Building Work now defined (Electric, network and wall re-enforcement)
No budget for Network	Budget requirement for Network
	31 X New Locations identified
	39 X Locations with replacement screens

3.1. Considerations

- Increased numbers of screens are now identified during the detailed design process
- This resulted in the reuse of existing screens not being possible due to clinical risk from information not being visible on smaller screens
- Detailed planning identified deferred building maintenance and health & safety hazards that need to be addressed as part of installing the screens
- The original business case budgeted for non-commercial (not 24x7) screens but these are not suitable for 24/7 use as required.
- Desktops (For Journey board view on large screens) were not considered in the business case
- Network capacity (insufficient network switches) was not considered in the business case
- External labour for Property & Infrastructure was not considered in the business case
- In order to keep the project moving
  - The screen installation and building work has been split into 2 phases.
    - Phase 1 is for locations where there are no current screens
    - Phase 2 to cover the replacement of existing screens
  - The existing approved budget of $160,000 will cover the cost for building work in Phase 1
- CAPEX Budget

Item	Qty	Total	Comment
Screens	107	$278,791	Brackets included
Desktops	45	$54,000	Keyboard/Mouse, HDMI cables included
Network	7	$70,000	Additional access switches
Building	70	$296,686	Labour (Building/Electrical), materials, screen delivery included
Total budget :		$699,478 required	
Approved BC budget:		$160,000.00 available	
Section 3 Budget:		**$539,478 additional CAPEX required**	

Description of the proposed change

4. Time – The current baseline completion date for the project is: 18 Sept 2018
   - The forecast completion date for the project is now Nov 2018. This is based on the following assumptions
     - The Change plan is completed and accepted by Business
     - The business (Nursing, Allied Health & RMO) is available for UAT (User Acceptance Testing
     - The business is available prior to Go-Live for training on the PFM system
     - The business is preparing the PFM system for Go-Live
     - The business is available to Go-Live
     - The business is available to maintain (Super Users model implemented) and support of the PFM system in BAU (Business as usual)

   - The project request the **re-baseline the project for completion end November 2018**
   - CAPEX Budget (Required with an end November 2018 baseline)

Resource	Qty	Total	Comment
Project Manager	320	$21,280	Full time for 2 months
Programme Manager	64	$6,144	At 0.2 FTE for 2 month
Application Support	320	$19,040	Full time for 2 months
Change Agent	380	$25,460	1.2 X FTE for 2 months
Section 4 CAPEX Budget: $71,924 additional required			

5. Total Budget in this RFC - Request approval for the additional CAPEX & OPEX associated with points 1-4 above

Section	Total	Comment
1	$50,000	CAPEX - Solution Change
2	$0	De-scoping Integration
3	$539,478	Infrastructure & Building Work
4	$71,924	Cost of time extension
RFC Total Budget: $661,402 CAPEX additional required		

Impact analysis

Impact on time		
The overall project will be extended with 7 weeks.		
Milestone name	Baseline date	Revised date
Go-Live – Tokoroa	10 Sept 2018	10 Sept 2018
Go-Live – Te Kuiti/Taumarunui	10 Sept 2018	17 Sept 2018
Go-Live – Thames	16 Aug 2018	24 Sept 2018
Go-Live – Mental Health	06 Aug 2018	22 Oct 2018
Go-Live – Hamilton Campus	06 Aug 2018	29 Oct 2018
Project closure	01 Oct 2018	21 Nov 2018

Impact on Opex Budget				
It No impact on OPEX budget				
Task/Activity	Original budget	Extra budget	Contingency amount	Estimated budget to complete
Total				

Impact on Capex Budget				
Task/Activity	Original budget	Extra budget	Contingency amount	Estimated budget to complete
Internal Services	$269,190	$71,924		$341,114
Vendor	$580,000	$589,478		$1,169,478
Training	$38,000	$0		$38,000
Contingency	$169,838	$0		$169,838
Hardware (Tablets)	$750,000	$0		$750,000
Total	$1,807,028	$661,402		$2,468,430

Note: The One-off Capex budget is increased by $661,402.

The request is to approve the additional budget for completion of the project.

Impact on scope
1. Solution Change - off-specification requirements to be included in product scope 2. Integration Change - de-scoping integration product scope not functionally possible 3. Infrastructure Change – Additional large screens & building/electrical work

Impact on risk
1. Potential hidden cost not identified as part of the Request for Change that may result in a further budget shortfall 2. Change fatigue after the 2018 Waikato flu season can result in poor system uptake

Impact on resources
IS Project Manager - Full time for 2 months IS Programme Manager - 0.2 FTE for 2 month IS Application Support - Full time for 2 months Change Agent - 1.2 X FTE for 2 months

Impact on benefits
No impact on benefits

Impact on other streams/Projects/BAU if this change is approved	
Area of impact	Impact details
BAU	None
Business requirements	None
Other projects	Committed project resources for the additional time will not be able to continue with other project delivery work
Procurement	None
Testing	None
Training	None
Media & Communications	There will be specific requirements for wall posters
IS Operations	This project will continue close to the Brown-out & Black-out period at the end of 2018
Waikato DHB	None
Vendor/Supplier	The vendor contract/scope will increase with the additional work to be done
Other	None

Impact on other streams/Projects/BAU if this change is not approved
None

Other alternatives evaluated

Option 1		
Exclude Mental Health Functionality	Time impact	Yes
	Cost impact	Yes
	Scope impact	Yes
	Risk impact	Yes
	Resource impact	Yes
	Benefit impact	Yes
Reason this option is not recommended		

- Current Dashboard not functionally viable,
- Bed configuration within HRBC vital for Mental Health to achieve the required benefits of patient flow management
- And MH legal status is critical for patient care within Mental Health

Option 2		
Use existing screens. Do not replace or purchase additional infrastructure. Thus, 62 less screens will be purchased	Time impact	Yes
	Cost impact	Yes
	Scope impact	Yes
	Risk impact	Yes
	Resource impact	No
	Benefit impact	Yes

Reason this option is not recommended

Cost: The CAPEX cost requirement will be reduced by $376,265

Increased Risk:

- Clinical risk due to data not fitting in single view and needing to scroll
- Limited adoption of system by staff as doesn't meet needs
- Poor use of the system

Negative Benefits:

- No improved staff morale
- Increased clinical risk
- Reduced performance on already constrained workforce

Project Manager's comments

It is recommended that this Request for Change is approved to include the vital functionality for Mental Health.

Additional resources required for the extended time to complete the project.

Change request decision

Decision approvers	Signature	Decision	Date
Marc ter Beek Project Executive	[signature]	☑ Approved ☐ Rejected	27/06/18
Geoff King Chief Information Officer	[signature]	☑ Approved ☐ Rejected	

Decision approvers' comments / caveats

Functionality enhancements required for Mental Health processes to work.

Investment in large screen infrastructure required to safely operate the whiteboard functionality in the wards. Additional costs for building works not anticipated during business case costing work, some of these are due to new health and safety requirements.

Significant Programmes/Projects

Medical School: no report.

Creating Our Futures: refer item 9.2.

Papers for Information

Presentations

Next Board Meeting: 22 August 2018.