Board Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	22 August 2018	**Time:**	1pm

Board Members:	Ms S Webb (Chair) Professor M Wilson (Deputy Chair) Ms S Christie Ms C Beavis Mr M Gallagher Mrs MA Gill Ms T Hodges Mr D Macpherson Mrs P Mahood Ms S Mariu
In Attendance:	Mr K Whelan, Crown Monitor Ms T Thompson-Evans, Chair Iwi Maori Council Mr D Wright, Interim Chief Executive and other Executives as necessary

Next Meeting Date:	26 September 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: 25 July 2018
   - 3.2 Committees Minutes:
     - 3.2.1 Iwi Maori Council: 2 August 2018
     - 3.2.2 Maori Strategic Committee: 15 August 2018
     - 3.2.3 Hospitals Advisory Committee: 8 August 2018
     - 3.2.4 Community and Public Health Advisory Committee: 8 August 2018

4. **INTERIM CHIEF EXECUTIVE REPORT**

5. **QUALITY AND PATIENT SAFETY**
   - 5.1 Quality and Patient Safety – Patient Experience

6. **FINANCIAL PERFORMANCE MONITORING**
   - No Financial report this month

7. **HEALTH TARGETS**

8. **HEALTH AND SAFETY**
   - 8.1 Health and Safety Service Update (report due in October)

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

10. **DECISION REPORTS**
    - 10.1 Equity Focussed Reporting (report due in October)
    - 10.2 Reappointment of the New Zealand Health Partnerships Independent Directors

11. **SIGNIFICANT PROGRAMMES/PROJECTS**
    - 11.1 Medical School (no report this month)
    - 11.2 Creating our Futures – Mental Health and Addictions Service Facilities and Service Redevelopment Preferred Way Forward

12. **PAPERS FOR INFORMATION**
    - No papers

Board Agenda

13. PRESENTATIONS

No presentations

14. BOARD MEMBER ITEMS

14.1 Car Parking Pay Stations (report due in September)
14.2 Living Wage (report due in September)

NEXT MEETING: 26 September 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) Midland Regional Governance Group to be received: Friday 3 August 2018 (All items)

Item 16: Replacement of Linear Accelerator – Public Excluded

Item 17: CBD Accommodation Project – Scope Change Proposal – 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:	Replacement of Linear Accelerator – Public Excluded	Negotiation with suppliers will be required	Section 9(2)(j)
Item 17:	Change of scope proposal for CBD accommodation – 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: 25 July 2018
To be confirmed: Items taken with the public excluded

15.2 Midland Regional Governance Group: 3 August 2018
To be received: All items

16. REPLACEMENT OF LINEAR ACCELERATOR – PUBLIC EXCLUDED

Alex Gordon to attend at 3.30pm

17. CBD ACCOMMODATION PROJECT – SCOPE CHANGE PROPOSAL – 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 AUGUST 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.

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			

Sharon Mariu

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

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

Member, 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	

Professor Margaret Wilson

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

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 25 July 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
Ms M A Gill
Ms T Hodges
Mr D Macpherson
Mrs P Mahood
Ms Mariu
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 S Hayward (Chief Nursing and Midwifery Officer)
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 M ter Beek (Chief Data Officer)
Dr R Tapsell (Clinical Services Director, Mental Health and Addictions Services)
Ms V Aitken (Executive Director (Interim) Mental Health and Addictions Services)
Mr I Wolstencroft (Director, Strategic Processes)

ITEM 1: APOLOGIES FOR ABSENCE

An apology for absence was received from Mr M Gallagher.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

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

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 27 June 2018

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 27 June 2018 taken with the public present was confirmed as a true and accurate.

3.2 Committee Meeting Minutes

3.2.1 Iwi Maori Council: 5 July 2018
3.2.2 Maori Strategic Committee: 18 July 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:

- Mental Health Services are working under pressure as occupancy is in excess of 100%. A reason for this being that some patients cannot be discharged as they require a higher level of care than community NGOs can provide. A different solution is required for these patients.
- NZ Nurses Organisation – negotiations were continuing.
- Changes have been made to report on improved performance in the Health Targets report.
- A meeting had been held to consider the whole issue of transport and how people arrive at the campus. Board members were keen to find a suitable solution that would negate the need for building another car parking building.
- Interviews for the Executive Director Human Resources and Organisational Development position had been held. The General Manager, Human Resources, at Auckland DHB was the external advisor on the interview panel.
- Interviews for the Chief Advisor Allied Health, Scientific and Technical positon were still to take place. The Executive Director, Allied Health, Scientific and Technical from Bay of Plenty would to be the external advisor on this interview panel.

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:

- The national dashboard now in use. Focus would be on child ASH rates as the results from the last national inpatient survey had shown deterioration.
- Local quality improvement initiatives were in place for sepsis, early detection of deteriorating patients and end of life as these were areas where local data shows there were issues.
- Work was happening to prevent avoidable readmissions. Readmission may become an indicator.

Resolved
THAT
The Board noted the report and action outlined:

1) Improved reporting and monitoring of service quality (national dashboard/atlas of variation/health round table etc) and prioritising work according to this with input from out Consumer Council.
2) Supported the quality improvement projects on deteriorating patients and sepsis.
3) Prioritised the effort to develop the quality improvement capability and capacity framework.

ITEM 6: FINANCIAL PERFORMANCE MONITORING

6.1 Finance Report

Mr A McCurdie attended for this agenda item. The report for the month of June 2018 was taken as read noting that June had an unfavourable variance to budget of $27.5m with exception of savings achieved against the savings plan.

Resolved
THAT
The Board received this report.

6.2 Year End Matters

Mr A McCurdie attended for this agenda item. The report was taken as read noting that the provisional consolidated result for the year to 30 June 2018 was $37.5m deficit.

Resolved
THAT

1) The Board received this report.
2) Nominated 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.

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. It was acknowledged there was still a lot of work to do. It was noted that Tokoroa Hospital's Emergency Department had recorded some good results. The Board members asked management to look at how these results were achieved and report back to the Board next meeting.
- Increase in 8 month olds being fully immunised – performance is still poor. It may take 2/3 months for an improvement in results to flow through.
- Raising healthy kids – Quarter 4 result showed that the DHB had maintained the 100% result.

Resolved
THAT
The Board received the report.

ITEM 8: HEALTH AND SAFETY

8.1 Health and Safety Services Update.

Mr I Wolstencroft attended for this item. The report was taken as read. It was noted:

- Waikato DHB had met tertiary level requirements in ACC's accredited employer program audit. The audit highlighted the key hazards/risks that employees were exposed to. These were:
  - violence and assaults on staff
  - exposure to blood and body fluids
  - chemicals/hazardous substances
  - moving and handling
  - slips, trips and falls
- Employee Influenza Vaccination – 66% of staff had received the flu vaccination. Noting that the influenza season had now commenced the Board were concerned that unvaccinated staff could pass the virus on to vulnerable patients.

Resolved
THAT
The Board received the report.

ITEM 9: SERVICE PERFORMANCE MONITORING

9.1 Interim Chief Operating Officer

Dr G Howard attended for this item. The report was taken as read. It was noted:

- Emergency Department - the overload score was still an issue and needed to be kept down.
- Acute and emergency services – some initiatives to improve flow within ED and flow out of ED are being implemented.
- Elective Services -
    - Quantitative – delivered the required volumes of elective services for 2017/18 at approx. 104% of the target.
    - Qualitative - ESPI performance –the DHB has been complaint for ESPI 2 and 5 for 4 months.
- Expenditure – 13 million unfavourable for year against a budgeted expenditure of $460,596,603. Variances were:
    - $4m for annual leave earned but not taken – nursing staff
    - $4m for annual leave earned but not taken – medical staff
    - $4m over budget for clinical supplies.
- Revenue – favourable year to date at $13,693,358 and non- Waikato sources $681.644
- Contribution as budgeted $158,795,018

Resolved
THAT
The Board received the report.

9.2 Mental Health and Addictions Service

Dr R Tapsell and Ms V Aitken attended for this item. The report was taken as read. It was noted:

- A significant increase in demand across the whole Mental Health and Addictions Service was causing pressure on the adult inpatient unit. The rising numbers of acute and complex presentations were being managed with contingency planning. Board members requested a paper updating them on this matter including a proposal for additional bed capacity.
- Nurse Practitioner for the Emergency Department – the appointment process is underway and will be finalised in the near future.
- Recovery Planning - looking 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.
- Creating our Futures – there had been significant community engagement including over 50 hui with over 700 consumers attending. Feedback will be analysed and used to inform the development of change programme. The recommended preferred way forward would be presented at the August Board meeting.

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)

ITEM 10: DECISION REPORTS

10.1 Equity Focussed Reporting (report due in October)

10.2 PHO Services Agreement – Hauraki PHO

Ms T Maloney attended for this item. The PHO Services Agreement – Version 5 national PHO service variation for the period 2017/18 was required to be signed. The Agreement had been negotiated and agreed nationally.

Resolved
THAT
The Board:

1) delegated authority to the Interim Chief Executive to sign the 2017/18 Hauraki PHO Services Agreement; and
2) resolved that in future, including for the 18/19 contract, that if the contract is not signed within three months of being issued to the PHO, then funding would be withheld until the contract is signed.

10.3 PHO Services Agreement - Midland Health Network

Ms T Maloney attended for this item. The PHO Services Agreement – Version 5 National PHO service variation for the period 2016/17 required signing. The Agreement had been negotiated and agreed nationally.

Resolved
THAT
The Board:

1) delegated authority to the Interim Chief Executive to sign both the 2016/17 and 2017/18 Midland Health Network PHO Services Agreements; and
2) resolved that in future, including for the 2018/19 contract, that if the contract is not signed within three months of being issued to the PHO, then funding would be withheld until the contract is signed.

10.4 Request for Change Approval – Patient Flow Manager Infrastructure

Mr M ter Beek and Ms D Nelson attended for this item. The paper was taken as read. It was noted that the implementation and use of the Patient Flow Manager would make it easier for Kaitiaki staff to receive, prioritise and respond to requests for support for Māori patients on wards.

Resolved
THAT
The Board approved a Request for Change RFC-006 for additional Capex of $661,402 for the project.

ITEM 11: SIGNIFICANT PROGRAMMES/PROJECTS

11.1 Medical School (no report this month)

11.2 Creating our Futures (refer to item 9.2)

ITEM 12: PAPERS FOR INFORMATION

There were no papers for information this month.

ITEM 13: PRESENTATIONS

There were no presentations this month.

ITEM 14: BOARD MEMBER ITEMS

1) Car Parking Ticketing Machine Problems – it was noted that patients and visitors to the hospital were experiencing problems at the pay stations. The Chief Executive responded to say that the DHB does have a solution in mind and he would provide a report on this solution at the next meeting.

2) Living Wage – a discussion about DHB employees. The Board members would like to receive information on the cost implications to the DHB if all staff were to receive the living wage or moving in step with other government agencies. The Chief Executive agreed to provide a paper to the October Board Meeting.

NEXT MEETING

The next meeting is to be held on Wednesday 22 August 2018 commencing at 1.00 pm at in the Board Room in the Hockin Building, Waikato hospital.

BOARD MINUTES OF 25 JULY 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 27 June 2018 (Items taken with the public excluded).**
- **(ii) Audit & Corporate Risk Management Committee: Wednesday 23 May 2018 to be adopted: (All items)**

Item 16: FY18/19 Operating Budget and Future Year End Projections – Public Excluded

Item 17: Replacement of Radiology Angiography equipment – 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-ii): 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: FY 18/19 Operating Budget and Future Year Projections – public excluded	Negotiations will be required	Section 9(2)(j)
Item 17: Replacement Angiography Equipment – public excluded	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 Māori Council (or their proxy) is allowed to remain after the public has been excluded because of their knowledge of the aspirations of the Iwi Māori Council specifically and Māori 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 7 – a paper on Wait Times in the Emergency Department at Tokoroa Hospital	Grant Howard	September 2018
• Item 9.2 – a paper from Mental Health setting out their proposal for coping with additional bed capacity	Vicki Aitken	August 2018
• Item 10.3 – update on 2018/19 PHO services agreements generated by Sector Services	Tanya Maloney	September 2018
• Item 14- Board Member Items – paper on the problems with the car parking pay stations	Chris Cardwell	September 2018
• Item 14 – Board Member Items – Living Wage – a paper to be provided on the DHB paying the Living Wage or moving in step with other Government agencies.	Derek Wright	October 2018

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Māori Council

Held: Thursday 2nd August 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 McClintock	Waikato-Tainui
	Ms C Brears	Whanganui
	Ms T Ake	Tūwharetoa Māori Trust Board
	Ms L Elliot	Executive Director – Māori Health
	Ms P Mahood	Waikato DHB Board
	Ms T Hodges	Waikato DHB Board
	Mr T Turner	Chair Kaunihera Kaumātua
	Ms S Greenwood	Minute taker

In Attendance: Janise Eketone, Jade Sewell

ITEM 1 KARAKIA: Mr T Turner

ITEM 2 MIHIMIHI: T Thompson-Evans

ITEM 3 APOLOGIES

Ms S Webb (Acting Board Chair), Ms K Hodge (Raukawa), Ms M Balzer (Maata Waka), Ms S Hetet & Mr T Bell (Ngati Maniapoto), Mr A Chase & Mr G Tupuhi (Hauraki), Ms P Taiaroa (Whanganui), Ms K Gosman (Tūwharetoa)

ITEM 4 CHAIR REPORT

ITEM 5 WHAKAPAKARI TE WHARE

5.1 Conflicts of Interest Register/Declarations

K McClintock - Employee of Te Rau Matatini
G Tupuhi - Trustee of Hauraki Māori Trust Board
G Tupuhi - Te Rūnanga o Kirikiriroa Trustee
G Tupuhi - Iwi Māori Justice Panelist
K Hodge – Raukawa Charitable Trust Deputy Chair
K Hodge – Waikato Regional Council – Ngā Tai ki Uta
K Gosman – New Zealand Institute of Rural Health
K Gosman – New Zealand Rural General Practice Network Committee Member
K Gosman – Lake Taupo Hospice Trust Board member
K Gosman – Lakes DHB Iwi Governance Board member
T Bell – Chair of Maniapoto Māori Trust Board
B Bryan – resigned

S Hetet – CEO, Maniapoto Māori Trust Board
C Brears – Te Ngira Whānau Ora Collective

5.2 Mandates, alternative representatives

ITEM 6 MINUTES AND ACTIONS

6.1 – IMC Meeting: 5 July 2018

- **Amendments:**
  - Ms K Hodge appeared twice in the apologies.

- MOU to be signed by Raukawa week commencing 6th Aug 2018.
- Letter sent to Hauraki Māori Trust Board Chair for MOU signing

Kaituku Mōtini/Moved: Te Rūnanga o Kirikiriroa
Kaitautoko Mōtini/Seconded: Waikato-Tainui

ITEM 7 GOVERNANCE

7.1 – Māori Strategic Committee Minutes and Verbal Update: 18th April and 16th May

- DNA programme of work is under action
- Puna Waiora – 3 new candidates accepted roles, on track to start 17th August.
- KPI's for level 1 – 5 out for discussion, tabled with ED's, TPO, Board.

ITEM 8 STRATEGIC AGENDA ITEMS

8.1 – Defining Whānau Ora workshop

- Two workshops - Joint Board/IMC May 3rd and the MSC had workshop (pg 32). Question was asked at workshops: what does oranga look like for whānau? Information from Care in Community wananga. If this is what whānau health looks like then what does the service look like? There has been no position on this previously.
- What is whānau ora philosophy that differs from others? Explanation given around the vision of whānau ora.
- How do we prevent the Māori world perspective from being colonised and turned into a contract? We are being shaped in a particular way to fit mainstream models.
- Iwi are able to commission these services ourselves, if DHB are talking Whanau Ora then they need to be understanding of what that means and can DHB actually do this.
- Iwi wananga workshops 'By Māori-For Māori', giving the tools to make choices and decisions.
- Fundamental shift to be made is around giving the health/whānau ora needs to be given back to whānau. Discussion currently is around entities 'doing to' whānau instead of whānau 'doing' for themselves. How do we as a system help enable whānau? Are we more responsive to their needs than we have been previously? Prioritising highest needs, focus on wellbeing than services. Rongoa, mirimiri, karakia – it's okay to do all these things as well as utilising mainstream health systems/services.

- Pulling funding out and allowing Māori to look after Māori themselves rather than trying to rely on smaller contracts or whoever is in power.
- Taking a whānau ora model and moving health to where it needs to be – with Māori otherwise someone else always has control.
- There are no choices, doctors / hospitals / other health services are geared to mainstream and Māori get what everyone else gets which doesn't work for Māori.
- What are the things that services around whānau ora and whānau - what are the greatest values?
    - It values the whānau being connected with all services within and outside of the current health model in isolation. Values of housing, financial and social needs.
    - Interested in relationships with other services.
- Whānau ora is about having a voice to be heard, and to feel confident that family will be treated well and services can demonstrate they can listen.
- No change in the mainstream delivery of services which is where the bulk of Māori are
- Māori do not have the life expectancy and services that we have a right to.
- We have a right to medical care to keep us alive.
- DNA's are not a Māori problem they are a systems problem. The system is set up to meet the needs of people who are not Tangata Whenua.
- There is no whānau ora service delivery concept. What does the service need to do, look like etc to work around the concept of whānau ora. How to apply the kaupapa.
- Govt agencies in the Waikato are involved around an Iwi regional plan. We should go wider than health, housing, social.
- Ongoing challenge between the Crown/Govt needing to show value for money and what whānau ora means and what whānau want.
- If whānau/whānau ora had the power, what would the services look, feel and behave like within set parameters?
- Could this look like whānau ora having the funding as opposed to the DHB?
- Only a small portion of health and wellness in the holistic Māori sense are able to be controlled by health services.
- Key characteristics that we would expect all services to be able to demonstrate effectively and that contribute to whānau wellness.
- Need more education in services such as financial, budgeting, life skills rather than things they already know.

8.2 – HSP update

- Noted two wānanga still to have with Iwi being Huntly and Tokoroa.
- Noted that there needs to be far greater input than just wānanga and furthermore that wide variety of actions toward ensuring Māori input must be had – especially to engage rangatahi voices.
- Need to also employ wide medium resources such as social media platforms and view the communications strategy.
- Māori citizens are used to not being heard and not having a voice and being invisible. Do we just want the feedback or do we want to empower Māori to have a voice now and in the future?

8.3 – Māori equity KPI's discussion

KPI's from Board level 1 to Managers at level 5. Input has come from Te Puna Oranga, Māori Strategic Committee, Executive Directors and now Iwi Māori Council. To be rolled out across the DHB region with measurable KPI's.

National survey for Māori workforce has just gone out. Northland and Waitemata are currently leading, Waikato need to improve. Workforce is largely nursing and an Aging workforce.

8.4 – Preparation for joint IMC/Board hui

- Joint meeting to take place on 6th September 2018 at Turangawaewae Marae.
- Chair noted that four Board members are unable to attend the joint Board meeting in September: P Mahood, C Wade have apologies; D Macpherson and M Gallagher will attend Council hui the same day.
- Chair noted efforts of IMC to locate an alternative date with no success.
- Discussion at Board around the racism workshop that it was a good start. Discussion around Heathers presentation and that action needed to be taken. Looking at potential recommendations from TPO around this to be presented back to the Board and IMC and then endorsed.

8.5 Creating our Futures – update and "Let's Talk" raw data

- Noted that whole parts of Te Reo was translated, and considered transcripts to be incomplete whereas they should have been analysed as they are
- Considered that Māori mental health context needs are holistic and need to be considered as such not purely clinical.
- How is the review influencing our service models? The business case is due to go to the Board in October.
- Equity Assessment still to occur

Motini/Motion: That IMC:

- Have confidence in Te Puna Oranga (TPO) to analyse the raw data from Māori hui to compare with COF analysis for alignment and to locate discrepancies to be clarified and agreed.
- Considers that the Business case with preferred options to be incomplete until such time that such analysis is undertaken
- IMC recommends that the business case not proceed until the data has been reconciled and Māori equity assessment has been completed.

Kaituku Mōtini/Moved: Te Rūnanga o Kirikiriroa
Kaitautoko Mōtini/Seconded: Waikato-Tainui

ITEM 9 TE PUNA ORANGA UPDATE REPORT

9.1 Service performance reports

- Hapu Wananga (HW) is going to grow. Currently seeing 450 wahine annually, these numbers need to reach 1600 and include more access for mamas in rural locations.
- Strategic intent for HW is that within an 18month timeframe – Communities will drive this kaupapa
- Strategy and Health to remain with Te Puna Oranga and services to be handed back to the community.

- Noted that for Hui Mana Wāhine, measurable outcomes must be gained and noted where wāhine were linked with services.
- Need to consider value added information, how this is captured and how this contributes to make radical changes to Māori health inequities.
- S&F had discussed whether Mama/pepi funding should be handled by rural communities.
- Whare Ora continues to grow and have welcomed two new staff on board, Whetu Balzer-Horo and Ezra Dixon. Whare Ora is another service delivery programme of work that will go back to the community eventually.

ITEM 10 IMC WORK PLAN

ITEM 11 GENERAL BUSINESS

ITEM 12 APPENDIX

Hui Whakakapi: Meeting closed at 11.50pm

Next meeting held on: Thursday 6th September 2018 at Rangiriri (this is a joint Board/IMC meeting).

	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 Deputy 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 alternative representative to the Statutory Committees.		IMC Chair
5.	Request confirmation of data around specific engagement facilitated along with the Board around the business case approval.		IMC Chair
6.	Flag/banner to say “hui” that can be seen and makes the venue visible.		TPO

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Māori Strategic Committee held on Wednesday 15 August 2018 commencing at 10:00am in the Board Room, Hockin Building

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

In Attendance:
Mr D Wright
Ms L Elliott
Mr N Hablous
Mr H Curtis
Ms N Te Ahu
Ms P Ormsby
Ms J Crittenden (Minutes)

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Mr H Curtis.

ITEM 2: APOLOGIES

Apologies were received from Ms J Eketone.

ITEM 3: MINUTES OF 18 MAY 2018

Minutes accepted as true and correct.

Moved: Mr C Wade
Seconded: Ms T Moxon

ITEM 4: MATTERS ARISING

4.1 MSC TERMS OF REFERENCE

- Travel reimbursement was discussed.
- It was noted that iwi representatives can be paid including travel.

- Progress on Consumer Council being paid at the same rates as IMC members – max 5 people could be attending so not a large expense.
    - It was suggested by two members that only 2-3 attend and that this will be taken to the next Consumer Council meeting.
- Amendments requested by Ms T Thompson-Evans haven't been included – to be followed up.
- Payment of members
    - Ms L Elliott to update to Neville
        - Board vs IMC vs Consumer Council
- All changes done/circulated by tomorrow to go the Board
    - No response is agreement.

ITEM 5: MSC UPDATES

CCP / HSP Wananga

It was noted that:

- LE acknowledged good turnout of waananga, and quality of information gathered.
- The Chair asked why themes seemed health service specific, not holistic / aspirational / radical?
- JC acknowledged the numbers of providers present.
- TTE the detail would be helpful and about the analysis being the important step.
- Matua H Curtis discussed the value of the consumer wananga and separate provider hui in the evenings.
- GT cautioned about the way youth engagement is framed
    - Giving good context is vital
    - Gave cautionary tale re AOD and youth residential facility.
- NTAH said we have to be better at promoting wananga to rangitahi (and to everyone – these wananga were ambiguous about whether providers were welcome or not).
- TTE noted the inspiring korero, especially the whanau at Hamilton who shared their story about how they managed their Koro's health.
    - Started networking with other whanau present.at the conclusion of the hui

Puna Waiora

It was noted that:

- 1 Rangitahi has declined our offer of employment we have 3.4 FTEs starting Friday 17th August 2018

DNAs

It was noted that:

- DM discussed his personal difficulties navigating the health system with recent appointments
- Communication improvements with letter and forms would be a good step.
- 0800 numbers can't be rung with cell phone?
    - Mr D Wright rang the number and got through to voicemail.

- Paper from Auckland / Waitemata is good starting point.
- Deputy Chair noted that we need to look at system changes to communications to make rapid, high level change.
- Deputy Chair also noted that better auditing is important
    - Navigators may be a band aid not a solution.
- Mr D Macpherson noted that there is no text reminder and can this be fixed soon?
- Mr G Tupuhi requested the number of output appointments, number of Maori, number of DNAs, wrong phone number etc be circulated.
- CW scepticism of texting – Does it make a difference? Do people change phone number too often?
    - Follow up with Auckland to see what worked and what didn't.
        - Low hanging fruit.
- A suggestion was made regarding using Facebook messaging to get hold of patients.
    - Can this be added to National Register?
- GNAs with immunisations register – TPO / Director Maori Health Strategy helped identify families that Immunistion Register couldn't find.
- Consumer Council willing to help with developing messages / finding families.
- Could we focus on Tamariki DNAs
- Could we ask whanau "are you likely to turn up?" and prioritise families that answer "no"?
- Could we have an update from Auckland?
- Outpatient structure is clearly a contributing barrier – more standardisation is better.
    - DNAs are costly
    - Can we survey both people who come and those who DNA to see what works and what doesn't?
    - Centralised approach to DNA management?
- LE and Chair agreed that it is unsustainable for kaitiaki to do this for everyone going forward.
    - What is the system-level fix? Strategic?
    - Flexible appointments? Work with GPs?

Equity focused KPIs

Creating our Futures

It was noted that:

- Concerns raised regarding Programme Board becoming advisory only (esp once new Maori members begin to challenge the team).
    - Derek reassured the meeting that the COF Programme Board reports to the DHB Board so it has a lot of decision making power.
- Loraine to circulate equity framework to MSC (HEAT was/is a tool that originated from Tumu Whakarae)

Draft Employee KPIs

- To be updated with feedback from Executive Directors
- Needs clear, measurable and link to radical improvement in Māori Health inequities, not simply attending meetings regarding Maori with other management.
- Should connect to strategy and values.

Puna

- Recruitment of additional Maori strategic leaders is subject to budget approval, CE says budget and monetary review should be done by the end of the month.

Community projects

Discussion:

- Similar to Hapu Wananga Event – community fun day with opportunistic health stands.
    - Partner sporting events and set up health stalls where the community is already gathered.
    - This has been done before (with free food) and was very successful
    - Whanau/children's day by Runanga was also successful
    - Good organisation ensures the day is free from gang-wear and alcohol.
    - Netball courts in Enderley are a good venue but be aware that whanau supporting kids in sport are not our highest need target group.
    - Need longer term, sustainable community project with locals not DHB led.
    - High need communities take the lead (not local Maori providers).
    - TPO can enable but not do it for them.
    - Community centres are good for locals but they are struggling and need more resources - DHBs and Councils could help.

ITEM 6: GENERAL BUSINESS

- Hearings at Turangawaewae 15th-19th October 2018 for claim WAI-1315
    - Claim for Maori providers and PHOs is WAI-1315
- Question regarding the impact of the newly appointed Crown monitor?
    - CE advised Crown monitor to sit at Board and sub-committees and report back to the Ministry/Minister.
    - Sally Webb confirmed as Chair of Board
    - Margaret Wilson confirmed as Deputy Chair of Board
- Te Whare Taurima is full, difficult to find accommodation, whanau travelling from far away.
    - Concerns include:
        - Whanau can't stay on the ward
        - Whanau can't be housed in on-site accommodation.
    - This may turn into a media issue.
    - Local motels are an option for low cost stay – we should investigate
    - Is there an accommodation coordinator?
    - LE to work with TTEs to follow up with manager of accommodation.
- Model of care in HRBC doesn't promote whanau engagement even though building originally had a room for whanau hui but it is never used.
    - Maori Health Plans required on all wards.

ITEM 7: DATE OF NEXT MEETING

Wednesday 19th September 2018, Board Room, Level 1, Hockin Building

ITEM 8: KARAKIA WHAKAMUTUNGA

Karakia whakamutanga by Mr H Curtis.

Chairperson: _____

Date: _____

Meeting closed at: 11.40am

ACTION POINTS

	Action List	Completed	Who
1.	Agenda Item 4: Terms of reference updates will be circulated as an electronic document through the Committee for presentation and approval at the next Committee meeting	Completed. See Agenda Item 4.1.	Ms L Elliott
2.	Agenda Item 5.3: Identify an approach to target the DNA issues and present at the next Māori Strategic Committee meeting.	In progress. See Agenda Item 4.2	Ms L Elliott Mr D Wright
3.	Agenda Item 6: 1. That Te Puna Oranga consider: a. How He Pikinga Waiora can be implemented and actioned within Waikato DHB. b. Identify the steps for implementation.	To be initiated.	Ms L Elliott
	1. That Dr N Scott present to Iwi Māori Council with a view of testing the tool with Iwi. 2. That Dr N Scott liaises with the Consumer Council Māori Caucus for presentation of this tool to their group for equity focused work programmes they are currently undertaking. 3. That is any groups interested in using He Pikinga Waiora can contact Dr N Scott.	Completed.	Dr N Scott

The August Hospitals Advisory Committee minutes will be published on 20 August.

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Community and Public Health Advisory Committee held on 8 August 2018 commencing at 1.00pm

Present: Dr C Wade (Chair)
Mr M Arundel
Ms C Beavis
Mrs P Mahood
Ms S Mariu
Mr J McIntosh
Mr D Slone
Ms TP Thompson-Evans

In Attendance: Ms T Maloney, Executive Director, Strategy & Funding
Dr D Tomic, Clinical Director Primary and Integrated Care
Mr W Skipage, Strategy and Funding
Mrs MA Gill, Waikato DHB Board member
Mr M Gallagher, Waikato DHB Board member
Ms M Neville, Director Quality and Patient Safety
Ms L Elliott, Executive Director Maori Health

IN THE ABSENCE OF DELEGATED AUTHORITY ALL ITEMS WERE FOR RECOMMENDATION TO THE BOARD

The Community and Public Health Advisory Committee and Disability Support Advisory Committee currently have three community representatives in addition to the Consumer Council representative. The Waikato DHB Board has recently agreed to reorganise community representation to ensure there is one non-Board member for each statutory committee. As a result, Mr F Mhlanga will now be the representative on the Health Advisory Committee and no longer a CPHAC/DSAC Committee member. The chair acknowledged Mr Fungai's contribution to the CPHAC/DSC committee.

The chair also congratulated Mr J McIntosh for being the recipient of the Paul Keesing award for his contribution to community health.

The Chair tabled a memo from Tania Hodges outlining her comments on a number of items on the agenda.

ITEM 1: APOLOGIES

Apologies from Ms S Webb, Ms T Hodges, Ms J Small, Mr Rob Vigor Brown and Mr F Mhlanga were received.

Resolved
THAT
The apologies were received.

ITEM 2: INTERESTS

2.1 Register of Interests

Mr M Arundel has supplied an update to his interests which would be reflected in the next agenda.

2.2 Conflicts Relating to Items on the Agenda

No conflicts of interest relating to items on the agenda were foreshadowed.

ITEM 3: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

The chair highlighted that Lakes DHB were undertaking a media campaign regarding smoking cessation and suggested that there may be opportunities for Waikato DHB to collaborate on this venture.

Resolved
THAT

1) The minutes of a meeting of the Waikato DHB Community and Public Health Advisory Committee held on 13 June 2018 be confirmed as a true and correct record.
2) The minutes of a meeting of the Lakes DHB Community and Public Health Advisory Committee held on 11 June 2018 be noted.

ITEM 4: DISABILITY SERVICES

4.1 Waikato DHB Disability Responsiveness Plan Terms of Reference

The updated Terms of Reference (TOR) for the Waikato DHB Disability Responsiveness Plan were provided to the Committee. The TOR now included a link to the national Whai Te Ao Marama Plan. A direction setting workshop with the wider sector will be convened where details around specific actions would be determined.

Resolved
THAT
The Committee noted the Terms of Reference

4.2 Committee Representation on the Disability Responsiveness Plan Reference Group

Whilst it was agreed that it was opportunistic to have a Committee representative that was part of the Consumer Council, the Committee highlighted that there were also benefits of having a non-Consumer Council representative. Accordingly it was decided that there would be two CPHAC representatives.

Resolved
THAT
The Committee approved Ms J Small and Mr D Slone as the Committee representatives on the Disability Responsiveness Plan Reference Group.

ITEM 5: PAPERS FOR DECISION

5.1 2018-21 Suicide Prevention and Postvention Plan

Ms M Neville and Ms J Hudson attended for this agenda item. An updated 2018-21 Waikato Suicide Prevention Plan was brought to the Committee which now included a zero suicide aspiration. The intention was for the Plan to remain a living document. The first intersectoral workshop had received positive feedback, however Committee members emphasised the importance of having the right people in attendance which needed to include connecting with the group of people who were not currently under any services if a zero suicide rate was to be achieved. Increased engagement with the Iwi Māori Council was also required to ensure attendance reflects the communities where the wananga are being held.

Resolved
THAT
The Committee endorsed the 2018-21 Waikato Suicide Prevention Plan.

ITEM 6: PAPERS FOR INFORMATION

6.1 Proposal for Change to Strategy, Funding and Public Health

Presented by Ms T Maloney, members discussed and provided feedback on the change proposal with a focus on the commissioning approach. It was noted that the Public Health Unit would now be subject to a separate review and would not be part of the current Strategy and Funding review.

Resolved
THAT
The Committee provided feedback on the Proposal for Change.

6.2 Health Improvement Settings Approach

An overview was presented by Ms D Penjueli, Ms R Black and Ms C Dargaville of the Health Improvement service activities.

Mrs P Mahood left the meeting.

Resolved
THAT
The Committee noted the Health Improvement Settings Approach update.

6.3 Ki Te Taumata o Pae Ora Update

Resolved
THAT
The Committee noted the update progress report.

6.4 Waikato DHB Tobacco Control Action Plan

An updated Waikato DHB Tobacco Control Action Plan was submitted to the Committee for noting. It was highlighted that submission of the plan was a Ministry requirement and met the minimum requirements; however the intention was to do further work over the coming months, with a stronger focus on Māori and on reducing smoking initiation.

It was noted that the maternal smoking rate differed between the Plan and the Strategy Paper.

A paper will be brought to a future committee by the Public Health Unit in respect to a position statement on vaping.

Resolved
THAT
The Committee noted the content of the report.

ITEM 7: PRESENTATIONS

7.1 Oral Health Services Update

Presented by Ms J Dibble, Dr K Ayers and Ms D Pevreal, members were provided with an overview of Waikato oral health services.

Committee members requested a breakdown of the presented data by ethnicity.

Members also suggested an oral health review and plan for adults could be beneficial, albeit was noted that if oral health care for 0-18 year olds succeeded in 100% coverage, long term adults would be covered.

Resolved
THAT
The Committee noted the presentation.

Ms TP Thompson-Evans left the meeting.

7.2 Project Energize, Update from Sport Waikato

Presented by Mr M Cooper, Mr R Batersby, Ms J Scott, Ms M Nightingale-Pene, and Mr A Corkill from Sport Waikato, members were provided with an update of the Project Energize programme.

Sport Waikato will be undertaking a full evaluation of the Project Energize programme in 2019. Accordingly the data presented was based from the last evaluation in 2011. It was suggested that the evaluation should include a longitudinal element, determining the long term success of the programme for those who started the programme in the early years and were now adults.

Resolved
THAT
1) The Committee noted the report and presentation.
2) The Committee noted the evaluation currently being developed.
3) The Committee noted the gaps in the current approach and opportunities for increased impact through expansion of the programme.

ITEM 8: GENERAL BUSINESS

There were no general business items raised.

ITEM 9: DATE OF NEXT MEETING

10 October 2018

Meeting finished at 4:15 pm

Chief Executive Report

MEMORANDUM TO THE BOARD
22 AUGUST 2018

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

Summary of Board Meeting

The Board discussed last month the need for adequate information about Board proceedings to be available to the Community Health Forums (CHFs). I am proposing that information in the form below is completed after every Board meeting and made available for this purpose.

The style would be "snappy" but without requiring additional information to be understandable.

This will ensure that irrespective of the attendance of Board members there is a sound flow of information to the CHFs. The summary can of course be used for other forums as well.

I would envisage that "public excluded" matters would be covered to an extent possible without compromising their confidentiality.

SUMMARY OF BOARD MEETING: 25 JULY 2018

PUBLIC PART OF AGENDA

Chief Executive Report

- Board agreed to develop a wide-ranging transport strategy.
- 2017/18 surgical discharges increased by 12 %.
- Compliant with ESPI (elective services performance indicators) for five months – first time; better-positioned than comparable district health boards.
- Ian Wolstencroft (who oversaw our building programme) is retiring at the end of August.

Monitoring Reports

- For year to 30 June 2018 – unfavourable variance to budget of $27.5M.
- Total deficit $37.5M.
- Nursing $9.7M above budget including $4M accrued for current negotiation cost.
- Continuing to fall short of six hour ED treatment target.
- Immunisation rates stubbornly remaining below 90%.

- 66% of staff vaccinated against influenza by 20 June – remains below previous year where masks were required for staff not vaccinated.
- Waikato DHB retained tertiary status as an ACC accredited employer in their partnership programme (basically reduces our ACC costs because we are fairly good at looking after health and safety).
- Acute surgical unit is about to be commissioned which will help alleviate pressures in ED.
- Significant increase in demand within mental health and addictions services.
- About to start locating mental health staff permanently in ED outside of normal hours.

PUBLIC EXCLUDED PART OF AGENDA

- Significant expenditure on radiology equipment.

External Committee Members

The Board has external committee members derived from four different sources, i.e. those proposed by the Consumer Council, those proposed by the Iwi Maori Council, those proposed by other Midland District Health Boards and those proposed by a public process which last occurred after the 2013 elections.

In respect of the last category (i.e. those appointed following a public process ("the public appointees") a number have resigned and there are now only three left. All of these are presently on the Community and Public Health Advisory Committee.

Earlier this year the Board agreed that the three public appointees should remain on committees through until after the 2019 election, when inevitably there would be another review of committee membership.

However a re-balancing of membership was required because of all the public appointees being on one committee.

The Committee chairs have now completed that process and it has been agreed as follows:

1) Mr Fungai Mhlanga to be on the Hospitals Advisory Committee.
2) Messrs David Slone and John McIntosh to remain on the Community and Public Health Advisory Committee.

Recommendation
THAT

1) Messrs David Slone and John McIntosh are formally advised that their appointment to the Community and Public Health Advisory Committee will continue until early 2020.
2) Mr Fungai Mhlanga is formally appointed to the Hospitals Advisory Committee until early 2020 subject to (re)submission of advice as to conflicts of interest to be reviewed by the Board Chair and Chair of the Hospitals Advisory Committee.

It is noted in passing that the attendance of the public appointees at the August committee meetings anticipated the above arrangements.

Terms of Reference: Maori Strategic Committee

The Maori Strategic Committee has reviewed its terms of reference and an amended version is attached for consideration by the Board.

Those who attend meetings either come as members of the Board, members appointed on Iwi Maori Council nomination, or by invitation from the Consumer Council. This has implications for the payment regime which we have spelled out in some detail to avoid confusion.

Recommendation
THAT
The reviewed terms of reference for the Maori Strategic Committee are adopted.

Month End Financial Report

Due to the change over to the National Oracle System and challenges around the extraction and reporting of financial information there is no Financial report this month.

Andrew McCurdie will give a verbal update to the Board.

Mental Health Bed Capacity

The Board has been made aware of the current significant pressure on mental health inpatient services and the resultant significant over occupancy of the wards.

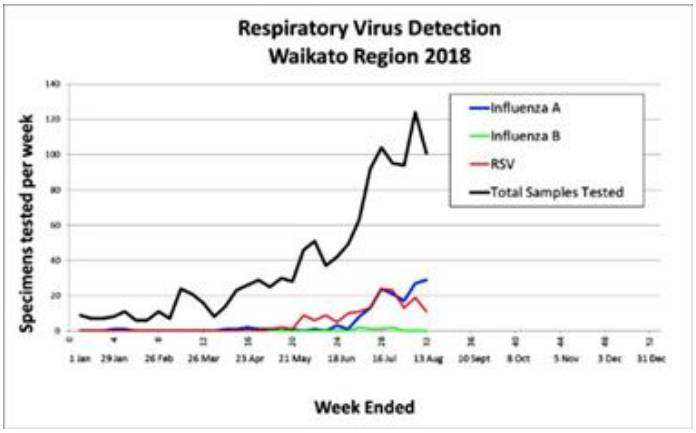
The following option is being pursued to address the need for additional acute capacity and placement of patients with very complex needs.

The transfer of eight forensic longer term rehabilitation patients is being negotiated with another provider. This option will free eight beds for acute capacity within the Henry Bennett Rongomau Centre. This arrangement should continue until new facilities are commissioned.

The additional costs associated with increasing the number of mental health beds will be met within the approved 2018/19 budget.

Emergency Department and Acute Medicine

The Emergency Department continues to be under significant pressure to see and treat presenting patients within a reasonable and safe period of time, as reflected by our performance relative to the six hour benchmark. This has been exacerbated by the prevalence of influenza A in the last weeks.



We have worked with the Francis Group on implementing a different model of care to see and treat patients in the Emergency Department and to increase the presence and involvement of senior clinicians in early decision making. The arrival of additional geriatricians from 6 August will allow us to increase the early involvement of specialist geriatricians in caring for at risk elderly patients, as well as free up general medical specialists to augment the amount of time available to see presenting medical patients.

The Acute Surgical Assessment Unit opened on 14 August for patients and will have been formally opened by the Minister of Health just prior to this Board meeting.

There is no question that the issue of access to acute and timely care is problematic in all the large health services at this time, and will remain a significant challenge for the foreseeable future.

Acute Surgery

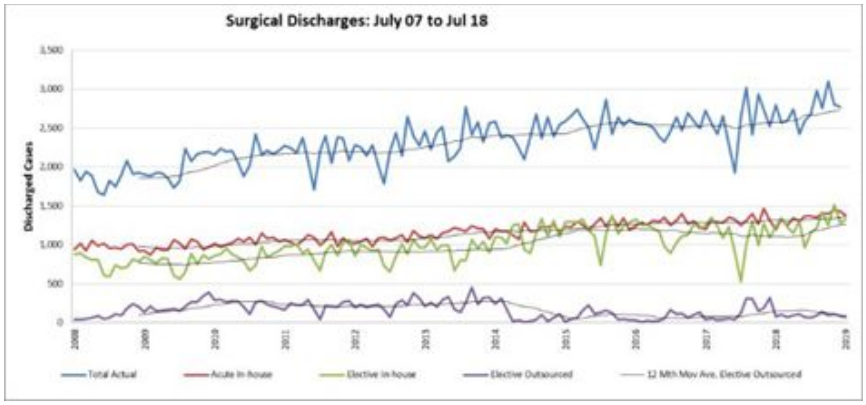
Our performance in terms of getting acute patients to theatre without delay has been much improved. We have been more consistently meeting the 24 hour and 48 hour targets for 80% and 100% of waiting patients being operated on, respectively.

Elective Surgery

Industrial action by the NZ Nurses Organisation meant the first half of the month was difficult to coordinate in terms of elective surgery.

The systems put in place by the surgical reinvention project, although still needing further maturation, meant we were able to increase elective volumes by substituting short turnaround patients for more complex patients.

Month and Year	***Acute Surgical Discharges***	***Elective Surgical Discharges (in-house)***	***Total***
July 2016	1199	1256	2505
July 2017	1196	1236	2527
July 2018	1374	1328	2775



For the same reason, we have maintained ESPI 2 and 5 compliance for 6 consecutive months, including this July, although this will need confirmation from the Ministry in the usual way.

Report and Monitoring of Risks

With the restructure complete in the Waikato Hospital services, a new process of reporting and monitoring risk is being discussed with the Interim Chief Operating Officer but will clearly involve the medical, nurse and service directors in each directorate upward to the hospital services executive.

Within Mental Health and Addiction services, risk is managed through their clinical governance forum with the risk register reviewed regularly. A similar approach will be taken with Strategy and Funding once their restructure is complete. The DHB executive group continues to oversee the high and extreme risk monthly (identified on the risk register >12), with any extreme risks then reported through to the Board in the relevant Executive Director's reports.

It is proposed to have the assurance framework presented to the Board in September.

Audits and Accreditation Visits

Attached is a schedule of known external audits and accreditation visits during 2018/19. This is provided as information to the Board.

Reporting on Suicide Pre and Postvention

The Ministry of Health's has provided feedback on Waikato DHB's Q4 report on suicide pre and postvention. Their feedback follows and is provided as information to the Board.

> ***Ministry Feedback***
> Thank you for your report, which indicates that Waikato DHB continues to provide an outstanding, evidence-informed, collaborative and responsive programme of suicide prevention work. Waikato DHB is to be commended also for their Suicide Prevention planning process, which has made considerable efforts to access the voices of specifically vulnerable populations. Suicide prevention activities carried out address multiple risk and protective factors, are well documented, resourced and their impact is evident. We look forward to watching further progress in these areas
>
> ***Initial Rating:*** Achieved.

Smoking Cessation Data

At a previous Board meeting, a query was raised on the measures the DHB routinely collects with regard to smoking cessation. In addition to the Ministry's target around smoking advice provided, the DHB also collects data on:

1) Quarterly smoking prevalence of PHO enrolled population, by ethnicity.
2) Monthly smoking prevalence of patients admitted to Waikato DHB hospital.

Without doing extensive research, and collecting new data from patients, we have no way to track whether 'smoking advice provided' correlates with changes in smoking prevalence of our patients.

Discussions with Counties Manukau DHB

On 6 August Sally Webb and I met with the Chair, Acting Chief Executive and recently appointed Chief Executive for Counties Manukau DHB. The purpose of the meeting was to develop a closer working relationship between the two DHBs. With the projected increase in the population for our Northern and their Southern Corridor it is important that we are working in partnership on how best to provide services to this area.

We also identified there are other synergies between the two organisations, such as equity issues, diverse populations etc. We agreed building a stronger collaboration between the DHB's would be advantageous.

We discussed a number of opportunities to collaborate:

- Joint planning
- Board to Board meeting
- Executive to Executive meeting
- Enhancing Iwi relationships, especially with Tainui.
- Maori Provider development

- Climate Change issues.

We are looking at possibly a joint Board/Executive meeting before the end of this calendar year.

Executive Recruitment

I am pleased to advise that the following positions have been recruited to:

- Executive Director, Human Resources and Organisational Development. Ms Gil Sewell has accepted this position. Her commencement date with the DHB is being negotiated.
- Chief Advisor Allied Health, Scientific and Technical. Ms Claire Tahu has accepted this position and will commence in late November 2018.

DHB 2018/19 Budget

As the DHB, along with many other DHBs, is forecasting a deficit for this year, we have invited the Ministry of Health and two DHB Chief Executives to attend a workshop with us on 30 August to undertake a peer review of our budget. We are continuing to refine our budget but believe having an external peer review would be beneficial.

Recommendation
THAT
The Board receives this report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

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

MĀORI STRATEGIC COMMITTEE

Terms of Reference

1. To drive strategic governance of the Waikato DHB to ensure radical improvement in Māori health outcomes by eliminating health inequities for Māori.

2. To oversee the development of the Ki Te Taumata o Pae Ora, Iwi Māori Health Strategy to radically improve Māori health outcomes by eliminating health inequities for Māori noting that Ki Te Taumata o Pae Ora will be developed by staff in conjunction with a working group including representation from outside Waikato DHB.

3. To oversee the implementation of the Ki Te Taumata o Pae Ora, Iwi Māori Health Strategy to radically improve Māori health outcomes by eliminating health inequities for Māori.

4. To identify and consider other areas of the Waikato DHB that could contribute towards radical improvements in Māori health outcomes by eliminating health inequities for Māori.

Delegation

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

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

Meeting Frequency

1. The committee meets every month, and otherwise as needed.

Committee Membership

1. The committee comprises eight members, four of whom are from the Board and four of whom are appointed on recommendation from the Iwi Māori Council. These members have the sole decision-making authority.
2. The Board appoints the chair of the committee.
3. The Consumer Council Māori Caucus has an open invite to meetings for attendance and advisory input.

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

Payment of Members

1. Payment of the Board members of the committee is not within the discretion of the Waikato DHB. Approval for it needs to be given by the Minister of Health. Based on previous requests it is considered unlikely that such approval would be given.
2. Non-Board members on the committee are, pursuant to Board resolution, paid at the same rate as members of the statutory committees, such as the Hospital Advisory Committee, including mileage reimbursement.
3. Members of the Consumer Council who attend meetings of the committee are paid under the auspices of the Consumer Council at the same rate as non-Board members of the committee, including mileage reimbursement.

Waikato DHB – External audit schedule 2018 - 2019

External audits	Manager	HDSS Standard	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Notes	Frequency
Waikato DHB & HRBC Certification audit	QPS	All									X				MoH (Surv Oct2020)	3 yearly
Baby Friendly Hospital Initiative (BFHI)	tbc									X					NZBA - date tbc	
HQSC Patient experience survey	Chris Chandler	1.2.3		X			X			X			X		Q&PS	Quarterly
IANZ hospital laboratory	Kay Stockman					Taum/Tok / Te Kuiti	Waikato						Thames			Annual
Food Act, MPI: Food Control Plan	Wendy Dodunski	1.3.13		Rural Hosp						Waikato					Business Support and Rural and Community	Annual
ACC Accredited Employer Programme	Greg Peploe	1.2.3; 1.2.4;1.2.7	X												Wkto Theatres/ Te Kuiti	Annual/biennial
Community Oral Health	Jill Dibble				X											Annual
Hazardous substance compliance	Mark Whatnall														tbc under new legislation, policy & Procedure	Annual
Property & Infrastructure	Colin Hearnden	1.4.1			Taum	Thames	Wkto (Med Gas)				Wkto (Deisel)	Te Kuiti	Tokoroa/ Wkto (VIE)			Annual
Pharmacy Audit: Retail (align with main pharmacy audit)	Jan Goddard														Should occur 18/19 year	Random
Medicines control – Pharmacy license	Jan Goddard														Audited 2013. Should be this year	3-5 yearly
NZ Blood Service	Aileen McGowan		Wkto Hosp												Rural Hospitals 2020	2 yearly
Crimes of Torture Act Ombudsman's audit (MH)	Rees Tapsell	2.2.2; 2.2.3;2.2.4; 2.2.5; 2.3.1; 2.3.2	X	X	X	X	X	X	X	X	X	X	X	X	Unscheduled	
Building Compliance – Warrant of fitness (HCC) inc. lift inspection	Colin Hearnden	1.2.2; 1.4.3	X	X	X	X	X	X	X	X	X	X	X	X		Annual
Internal audit programme	Ian Cowley		X	X	X	X	X	X	X	X	X	X	X	X	Internal audit	Annual
National Endoscopy Quality Improvement Programme - Thames & Hospitals							X								Thames Nov 17 Report Rec'd Feb 18	TBC
IANZ – Waikato Drinking Water Assessment Service (WaDWAS)	Deryl Penjueli		Lost accreditation; doubtful audit will take place 2018/2019												Population Health	Annual
National Cervical Screening Programme – Colposcopy services	Joanne Clarke		Due Late 2019												Audited Oct 2015	4 yearly
National Radiation audits	Sally McMillan		Have not been notified of next C5 & C3 audit dates.												C5 audited 2016	2-yearly
Breastcare Midland: BSA National Policy & Quality Standards	Shona Duxfield		MoH considering moving to a certification programme - external audit suggested for 2019. tbc													
NZ Blood Service	Aileen McGowan		Thames, Tokoroa, Te Kuiti, Taumarunui due 19/20												audited 2017/18	2 yearly
Tumor Standards reviews	Jan Smith		Reviews against national tumor standards of service provision: Lung (Jun14), Bowel (Nov14), Gynae (Mar15), Breast (Dec15), Lymphoma (Aug16), Sarcoma (Jan16), Myeloma (Dec16), Revised Lung Stds (in draft Sept17); Melanoma (May18); Upper GI (Sept18). No further reviews planned at this stage.												Midland Cancer Network/ National Cancer Programme	
Universal Newborn Hearing Screening & Early Intervention Programme	Barb Garbutt		Due May 2020												Audited 2017	3 yearly
Disability Support Link Evaluation	Graham Guy		Due May 2020												Audited 2017	3 yearly
Public Records Act audit	Glenda Morrisey		Standards Revised 2016. Not sure when audit will take place												Archive NZ	5 yearly
Radiation Safety (Oncology)			National Codes of Practice being developed. Licences to be applied for. Auditing will start after that.													tbc

* in conjunction with Waikato DHB service audit calendars

Waikato DHB – External (Colleges/Accreditation) audit schedule 2018-2019

External audits	Manager	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Notes	Frequency
Medical Council NZ Accreditation - Provision of Intern clinical attachments	Helen Clark											X		Accredited until May 2019	
Royal Australasian College of Physicians Advanced Training in general Paediatrics	Hamish McCay			X										1 year accreditation subject to CARs	1 year
Royal Aust and NZ College of Obstetricians and Gynaecologists accreditation	Narena Dudley								X					Re-accredited Feb 2018. Next accreditaton visit?	Annual
Plastic Reconstruction Surgery - training post accreditation	Dean Blake/Simon Chong						X								
Royal Australasian College of Physicians advanced training in general Paeds)	Hamish McCay			X										Sept17 : accredited 12 months	
Royal College of Pathologists of Australasia	Daniel Ninin														
Royal Aust College of Surgeons : Accred'n of Surgical Education and Training	Rob Blaikie/Linus Wu													03/03/2017: review one post Mar 2018	5 yearly
NZ Orthopaedic Association	Rob Blaikie/Neville Strick													14/03/2017 - Review Due June 2018?	5 yearly
Royal Australasian College of Ophthalmologists	Michael Merriman	Due October 2019												No CARs	3 yearly
Paediatric Surgical Accreditation	Askar Kukkady	college visit 21/5/18 - outcome awaited													
Advanced Training in Neonatology	David Bourchier	Accred visit 5/6/18 - awaiting outcome													
College of Intensive Care Medicine accreditation of training (neurology / neurosurgery & trauma)	Geoff McCracken	Accred visit Jun18 - awaiting outcome												Awaiting outcome	tbc
Royal Australasian College of Physicians Respiratory & Sleep Medicine Training	Janice Wong	Aug-19												Reviewed Aug2017	2 yearly
Royal Australian and New Zealand College of Psychiatrists	Aletsa Stephan	Due Feb 2020												Upper Central North Island training prog -	
Australasian College fof Physical Scientists and Engineers in Medicine	Koki Mugabe	15-Jul-20												Medical Physics trainees	5 yearly
Royal Australasian College of Physicians (Paed basic training)	Penny Brandt	Due Nov 2020												3 recommendatons to be addressed	3 yearly
Medical Services Council of NZ - Anaesthetic Technicians	Mark Tumai	Valid to 31/11/2020													
RACS Board of Vascular Surgery - training post	Vasu Vasudevan	Due 31/12/2020												No CARs	5 yearly
Australasian College for Emergency Medicine *ED credentialling	Tonia Nicholson	Due 2020												3 recommendations - response sent Nov2015	5 yearly
RACP Gastroenterology Accreditation	Andrea Coxhead/Frank Weilert	Due by August 2020												Recommendations but no corrective actions.	3 yearly
RACP Dermatology Accreditation	Rob Blaikie / Amanda Oakley	Due 2021												last site visit 2016. Standards achieved. 2 recommendations	5 yearly
Royal Australasian College of Dental Surgeons - Oral & MaxFax surgery	Simon Lou	Due 2021												Five recommendations: theatre time, nursing support, admin support, clinic space, research	5 yearly
Royal Australasian College of Physicians (Basic Physician Training)	Paul Huggan	Due 2021												Accredited 2016, conditional re trainee protected time	5 yearly
Neurosurgical Society of Australasia: Education and Training in Neurosurgery	Zakier Hussain	Due 2021												accredited 1 training post Jul18	4 yearly
Advanced Training in Communithy Child Health	Dave Graham	Due 2022												Accred Nov17	4 years
Australian Dental Council & Australia Medical Council Ltd; Dental Council (NZ) & Medical Council NZ Accreditation of OMS education and training programs of RACDS	Simon Lou	Due 2023												One rec for NZ: training oppor-tunities be assured for dental implants (not funded at Waikato).	5 yearly
Royal Australasian College of Surgeons and The Urological Society of Australia & NZ (SET Accreditation /training)	Adam Davies	Due by 31/12/2021												3 recommendatons to be addressed	5 yearly
Aust & NZ College of Anaesthetists accreditation	Cam Buchanan	Due 2022												Oct 2015 last audit - some recs	7-yearly
Royal Australasian College of Surgeons Trauma Verification	Grant Christey	Verfication Audit Feb 2017													4-yearly
Medical Lasers	Koki Mugabe													Standard AS/NZS 4173:2004	
Anaesthetic Technicians Board															
Clinical physiologist registration Board														cardiopulmonary and physiology techs	
Medical Laboratory Technologists														cervical cytology	
Australian Society for Ultrasound on Medicine														ultrasonography and echosonography trainees	
Health Research Council														radiotherapy trainees	
GP College of Rural Hospital Medicine															
Pain Medicine - if we apply to be a training facility															
Royal Australian and New Zealand College of Radiologists (Radiology Registrar Training)	Glenn Coltman													Level A Accred to 31/12/16. Visit booked 3/11/16.	5 yearly

Quality and Patient Safety

MEMORANDUM TO THE BOARD
22 AUGUST 2018

AGENDA ITEM 5.1

QUALITY AND PATIENT SAFETY – PATIENT EXPERIENCE

Purpose	For information.

There are three national patient/ client experience feedback mechanisms in place for the DHB – Inpatient adult survey, primary care survey and mental health and addictions real time feedback. Only the high level adult inpatient survey results are available for public access.

Key findings from the latest adult inpatient survey are attached. Waikato results when compared with the national figures are as follows:

	Waikato	National	Median 2014-18
Response rate	34%	25%	
Response rate Māori*	20.1%	11%	
Communication domain	8.3	8.5	8.4
Partnership domain	8.4	8.6	8.4
Coordination domain	8.4	8.6	8.5
Physical and emotional needs domain	8.6	8.8	8.6

* *17 replies from 81 invitations sent via email and post*

Only four DHBs had a response rate higher than 30% with West Coast DHB achieving 58%. Of note they use their consumer council to raise awareness of the survey.

The lowest rated areas of the four domains nationally (and for Waikato), remain as

- Staff informing patients about medication side effects
- Including family / whānau in discussions about care
- Receiving sufficient information on managing condition at home.

Additionally there were three other areas rated low, including a lack of privacy for Waikato in this quarter.

Work is underway to ensure that services have access to their own results and to ensure focus on the low scoring areas.

Recommendation
THAT
The Board notes the results and the activity underway.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

1.0 Background to the feedback approach

Inpatient survey
The national adult inpatient survey began in August 2014 developed by the Health Quality and Safety Commission (HQSC) based on the Picker model. The patient experience survey runs quarterly in all district health boards and covers four key domains of patient experience:

- communication
- partnership
- co-ordination
- physical and emotional needs.

A selection of 400 adult patients who spent at least one night in hospital are sent an invitation via email (a rising number) or post (majority and better response) inviting them to participate in the national survey. The survey responses are anonymous unless patients choose to provide their contact details.

The results remain broadly consistent across all 16 survey rounds with little variation to date.

The results are available on the HQSC website for the public to access

Primary care survey
The Ministry of Health (the Ministry) and the Health Quality & Safety Commission (the Commission) have also introduced patient experience measures for primary care using an online patient survey in 2016. This is administered quarterly to all patients who visited the practice during the designated 'survey week'.

Unfortunately these surveys (primary care and inpatient) are administered differently so the results are not seen as 'a whole'. The results are not available on the HQSC website for the public to access.

The system level measure group is working on improving visibility of the Waikato DHB patient experience results and developing system wide actions to improve patient experience, as well as ensuring local GP practices and inpatient directorates are using the information to improve their systems.

Mental health survey
The Mental Health Commissioner of the Health and Disability Commission (HDC) commissioned the development and implementation of an electronic, real-time system to capture feedback from people interacting with mental health and addiction services (the RTF system). The aim was to develop a system that ensures that the voices of consumers, family/whānau are heard and contribute to quality improvement.

This was introduced as a pilot at Waikato DHB in late 2014 and this approach continues, with results seen by the Board of Clinical Governance and used within the mental health and addiction services to drive service improvement.

The results are not available currently for the public to access.

2.0 Adult Inpatient results

National and DHB level results can be found at https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3425/ and are attached for ease.

Waikato results when compared with the national figures are as follows:

	Waikato	National	Median 2014-18
Response rate	34%	25%	
Response rate Māori*	20.1%	11%	
Communication domain	8.3	8.5	8.4
Partnership domain	8.4	8.6	8.4
Coordination domain	8.4	8.6	8.5
Physical and emotional needs domain	8.6	8.8	8.6

* 17 replies from 81 invitations sent

Only four DHBs had a response rate higher than 30% with West Coast DHB achieving 58%. Of note they use their consumer council to raise awareness of the survey.

The lowest rated areas of the four domains:

	Waikato	National
Staff informing patients about medication side effects	51	52
Including family / whānau in discussions about care	57	59
Receiving sufficient information on managing condition at home	59	62

Note: The four domains show as a score out of 10 and the individual items within the domains show as a score out of 100.

It is disappointing that these areas have been consistently rated low by our patients since the start of the surveys in 2014.

Additionally Waikato's other low scores this quarter were

- Not feeling listened to by doctors (69) or nurses (62)
- Not given enough privacy when discussing condition / treatment (59)
- Cleanliness of room / ward (62).

A qualitative analysis of respondent comments from the inpatient survey 1 July 2014 – 31 May 2016 (seven survey rounds) was presented to the Board of Clinical Governance in July 2016.

This analysis found that many survey respondents had issues with the lack of information they received about medication side-effects at discharge, lack of adequate discussions with family/whānau about their care while in hospital and lack of information about managing their condition after discharge. This was clear by the volume of comments that noted these issues specifically, with lack of information about managing one's care after discharge being the most significant area of concern. Respondents commented passionately at times about the impacts of these issues on them personally or the impacts they witnessed on loved ones which also indicated their level of frustration and gave insight into why they felt the way they did.

The importance of qualitative information and analyses should not be underestimated and where possible, should be undertaken in combination with quantitative analyses

especially when thinking about service improvement. The services need to review their own results and comments to assist them, alongside other feedback such as complaints / Facebook comment to get a picture of where the service / staff get it right and where we can improve.

3.0 Action underway or proposed

- The co-ordination of the discharge process and communication - the introduction of the safer bundle and recent work by the Francis group in medicine should assist this, if consistently applied and sustained.

- The timing of when medical information is conveyed to patients is important - a recent nudge project in A2 (supported by Quality and Patient Safety / HQSC) has developed a discharge checklist that could assist. Work is underway to try and merge this with some of the Francis group work and to test more widely. This piece of work is being monitored by the System Level Measure (SLM) working group.

- Work with the consumer council to raise awareness of the survey and also discuss getting involvement from consumers in the areas where we perform less well.

- QPS to work with the services to ensure they see and understand their results and the areas they need to be focusing on for improvement.

- The Quality Forum recently set up by clinical support services (attendants, nutrition, cleaners, P&I staff) with senior nursing staff, QPS and consumer council member has a key role in overseeing the results and agreeing areas of DHB focus such as cleaning, privacy.

- System Level Measures continue to use the results as a focus of improvement.

Patient experience survey: Results for patients treated in May 2018

Key findings

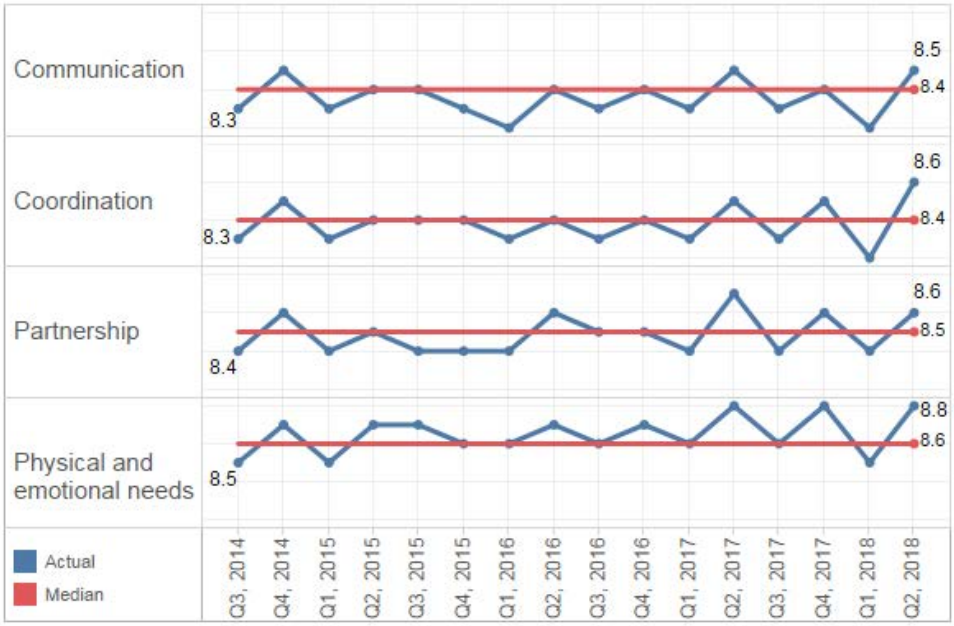
- National results for the four domains (communication, partnership, coordination, and physical and emotional needs) have remained broadly consistent across all 16 survey rounds.
- There was little variation between district health boards (DHBs).
- The national response rate was consistent with previous rounds at 25 percent.
- We have undertaken weighting, as before, in line with the methodology and procedure document: methodology and procedure document.
- Note: In the national results webpage, we display run charts to monitor statistically significant trends. Figures 1, 2, 3 and Table 1 have run charts. The run chart for Table 1 allows the user to select DHB.

National results

Compared with quarter 1, 2018, scores for quarter 2, 2018 increased significantly for all domains, after remaining consistent since quarter 2, 2015. These results are within the bounds of previous results.

Figure 1: National average scores for the four domains, 2014–18

Figure 1a: Run chart of the national average scores for the four domains, 2014–18



The physical and emotional needs domain rated the highest in all survey rounds. It includes the ‘humanitarian’ questions shown in Figure 2, which continuously score highest.

The three questions shown in Figure 3 continuously scored the lowest of all the survey questions.

Figure 2: Highest-rating questions of the four domains, 2014–18 (percent of patients answering most positively)

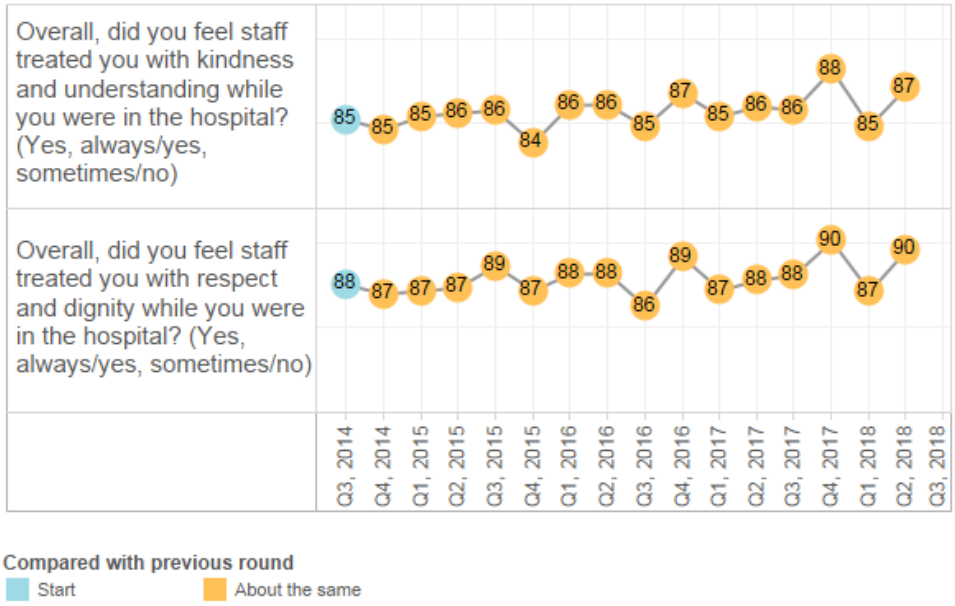


Figure 2a: Run chart of the highest-rating questions of the four domains, 2014–18 (percent of patients answering most positively)

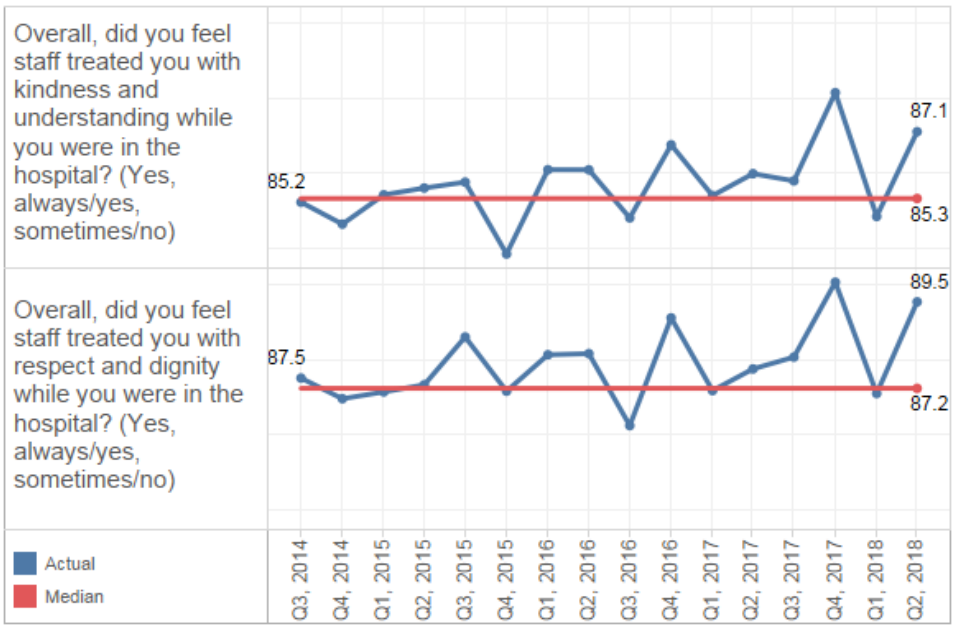


Figure 3: Lowest-rating questions of the four domains, 2014–18 (percent of patients answering most positively)

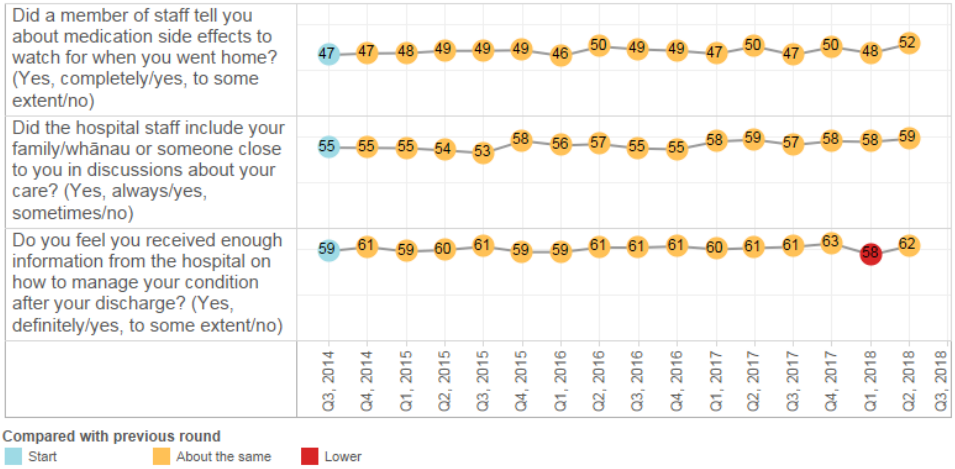
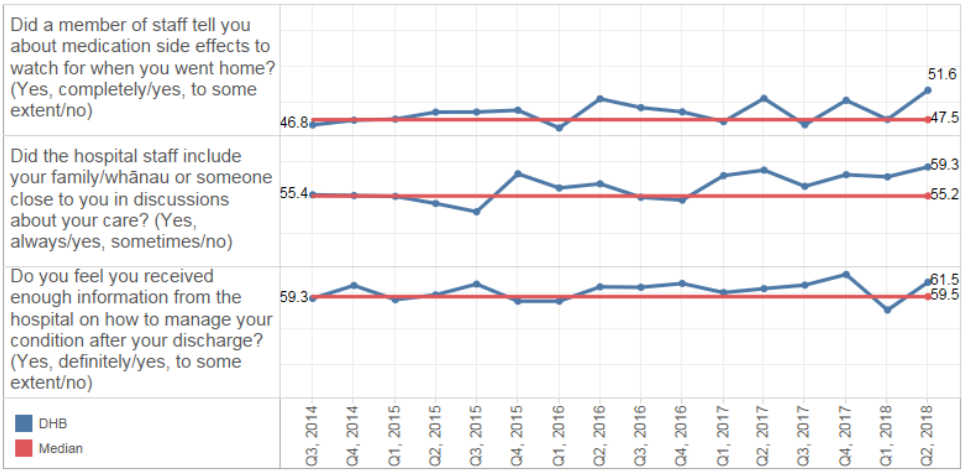


Figure 3a: Run chart of the lowest-rating questions of the four domains, 2014–18 (percent of patients answering most positively)

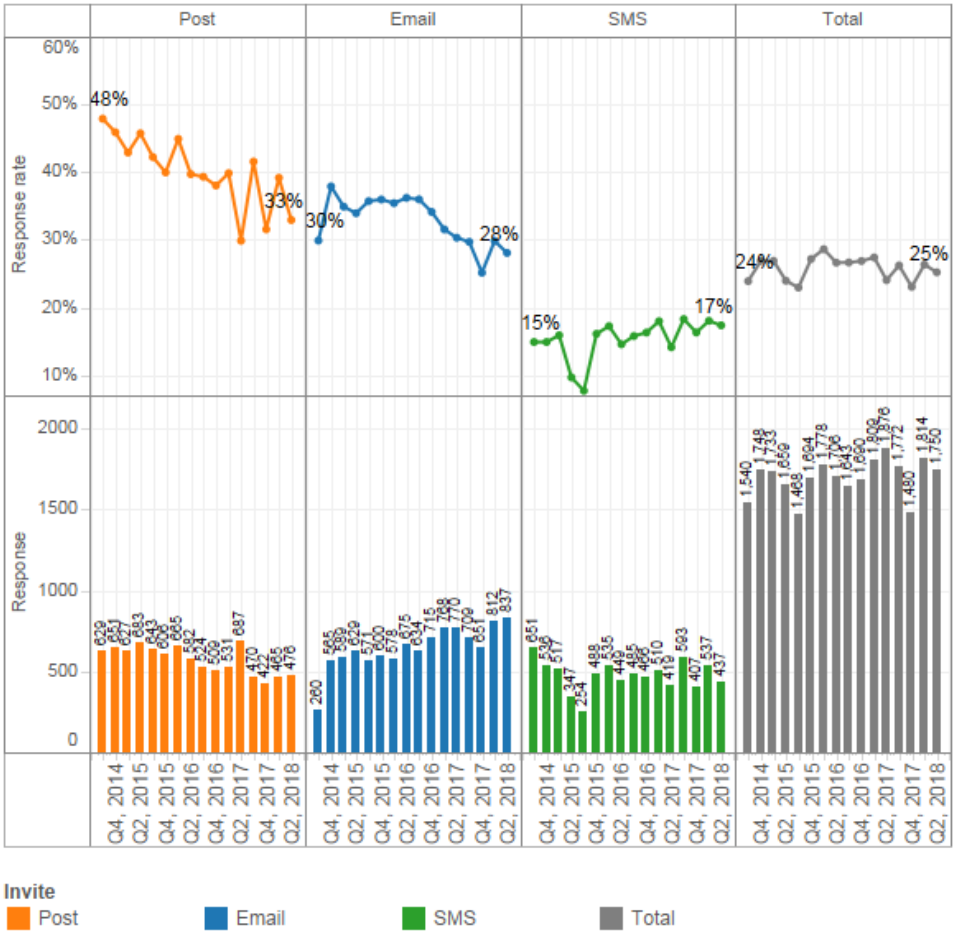


Response rates

The national response rate was consistent with previous rounds at 25 percent.

Figure 4 shows the breakdown of response rates by survey distribution method. Postal surveys have a high processing cost, so we encourage DHBs to undertake surveys via email or SMS where possible.

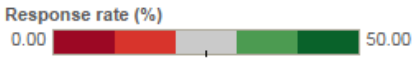
Figure 4: Response rates by survey distribution type, 2014–18



Response rates per DHB varied from 14 percent to 58 percent (see Table 1). Four DHBs achieved a 30 percent response rate or above in the current survey round. DHBs are required to have at least 30 responses for results to be meaningful. Due to a technical issue in the survey data processing, no result was provided for Southern DHB for this quarter. (See also Appendix 1 for per-DHB scores for each of the four domains.)

Table 1: Response rates by DHB (%), 2014–18

	Q3, 2014	Q4, 2014	Q1, 2015	Q2, 2015	Q3, 2015	Q4, 2015	Q1, 2016	Q2, 2016	Q3, 2016	Q4, 2016	Q1, 2017	Q2, 2017	Q3, 2017	Q4, 2017	Q1, 2018	Q2, 2018
Auckland DHB	16	12	19	13	20	15	17	17	9	21	26	28	15	26	29	26
Bay of Plenty DHB	20	20	24	24	22	25	25	24	25	23	25	20	24	23	31	25
Canterbury DHB	20	26	26	17	16	27	30	37	34	33	23	16	29	22	23	24
Capital & Coast DHB	28	33	33	32	38	34	31	37	32	30	31	34	29	13	28	29
Counties Manukau Health	15	21	23	15	17	26	19	13	13	17	18	22	16	12	22	21
Hauora Tairawhiti	9	9	18	4	6	22	19	15	16	17	24	16	13	17	20	18
Hawke's Bay DHB	26	25	20	17	16	20	25	21	25	21	20	22	22	24	18	14
Hutt Valley DHB	25	29	31	25	20	23	32	25	28	28	25	24	23	29	28	28
Lakes DHB	38	22	25	23	14	25	26	21	22	24	16	22	24	19	26	18
MidCentral DHB	49	49	44	46	49	45	46	46	49	44	44	37	40	39	39	38
Nelson Marlborough DHB	27	35	35	37	26	38	33	38	35	35	40	33	36	33	27	28
Northland DHB	14	17	15	18	14	14	20	21	20	20	18	18	18	17	17	18
South Canterbury DHB	29	30	35	22	27	28	33	31	22	36	32	18	28	14	18	26
Southern DHB	21	20	23	18	12	22	19	19	25	16	25	8	23	18	26	
Taranaki DHB	28	28	22	19	14	26	29	13	26	14	24	26	29	20	26	28
Waikato DHB	14	31	24	34	35	40	45	41	42	44	37	31	38	35	40	34
Wairarapa DHB	40	41	36	34	30	33	36	27	26	30	33	28	25	32		17
Waitemata DHB	17	43	35	39	30	38	37	34	32	38	37	30	32		35	31
West Coast DHB	11	14	32	27	33		31	35	27	30	30	28	29	11	26	58
Whanganui DHB	30	25	27	28	21	25	28	19	24	24	29	27	35	27	23	26
New Zealand	24	27	27	24	23	27	29	27	27	27	28	24	26	23	26	25



Representation of respondents

Nationally, respondents were reasonably representative of all ages and genders.

The under-representation of people continued for people in the 15–24 and 25–44 age groups and for people in Māori, Pacific and Asian ethnic groups. Table 2 gives a demographic breakdown of respondents.

Table 2: Representativeness by demographic group, May 2018

Respondents by age group

Group	Patients discharged (%)	Respondents (%)
Age 15–24	9	3
Age 25–44	27	20
Age 45–64	25	28
Age 65–74	17	23
Age 75–84	15	18
Age 85+	8	8

Respondents by gender

Group	Patients discharged (%)	Respondents (%)
Female	58	58
Male	42	42

Respondents by ethnicity

Group	Patients discharged (%)	Respondents (%)
NZ European	71	79
Māori	16	11
Pacific peoples	5	3
Asian	7	6
Other	1	2

Appendix 1: Scores for all domains by DHB

Table 3: Communication scores by DHB, 2014–18

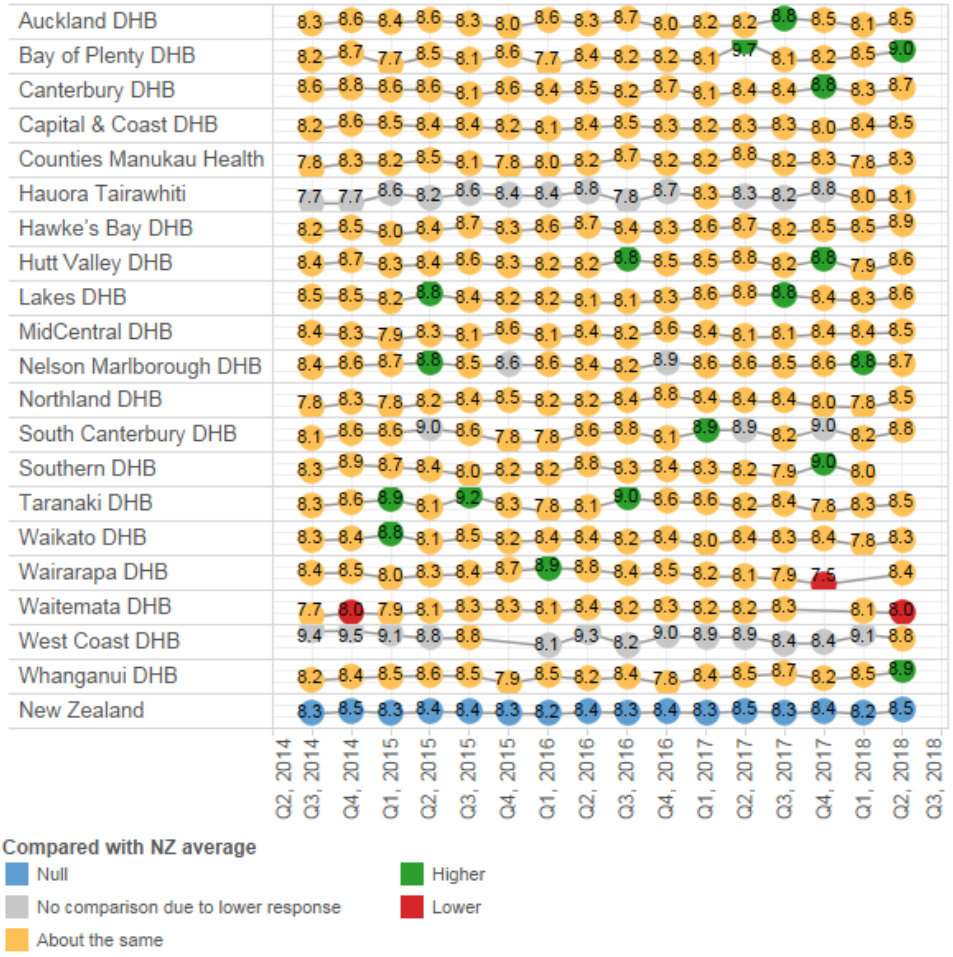


Table 4: Partnership scores by DHB, 2014–18

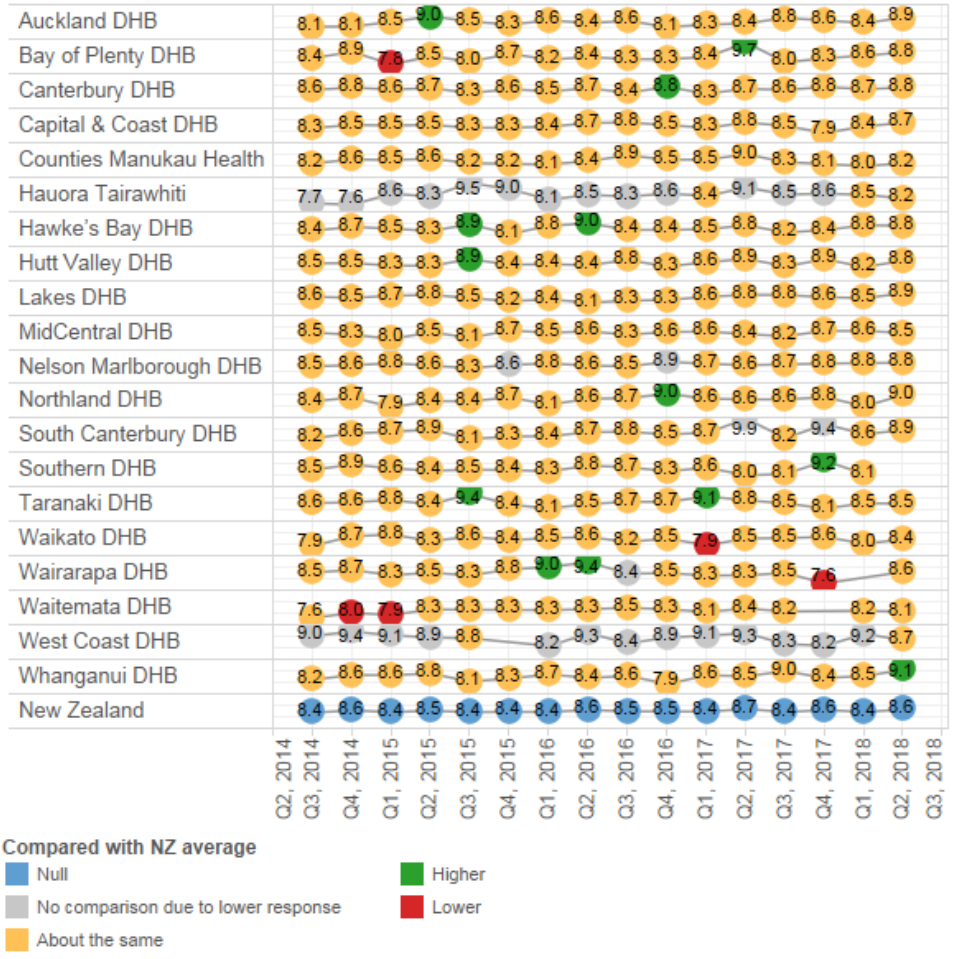


Table 5: Coordination scores by DHB, 2014–18

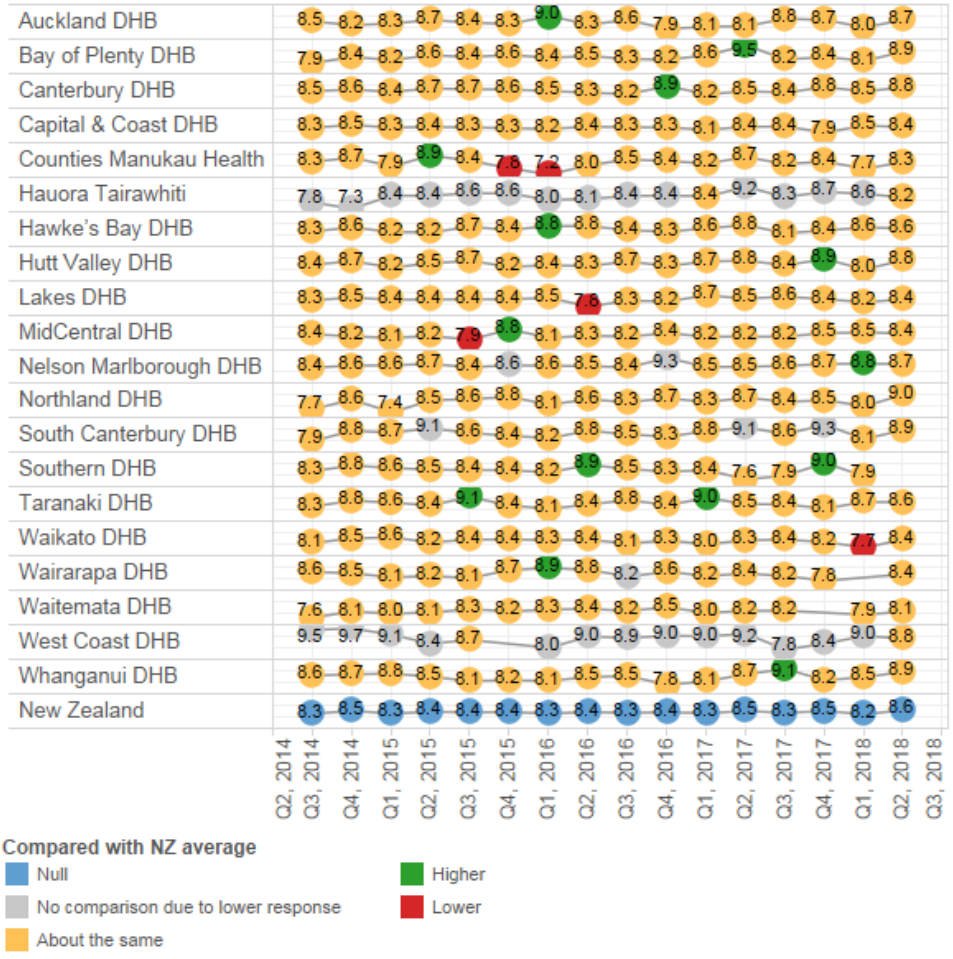
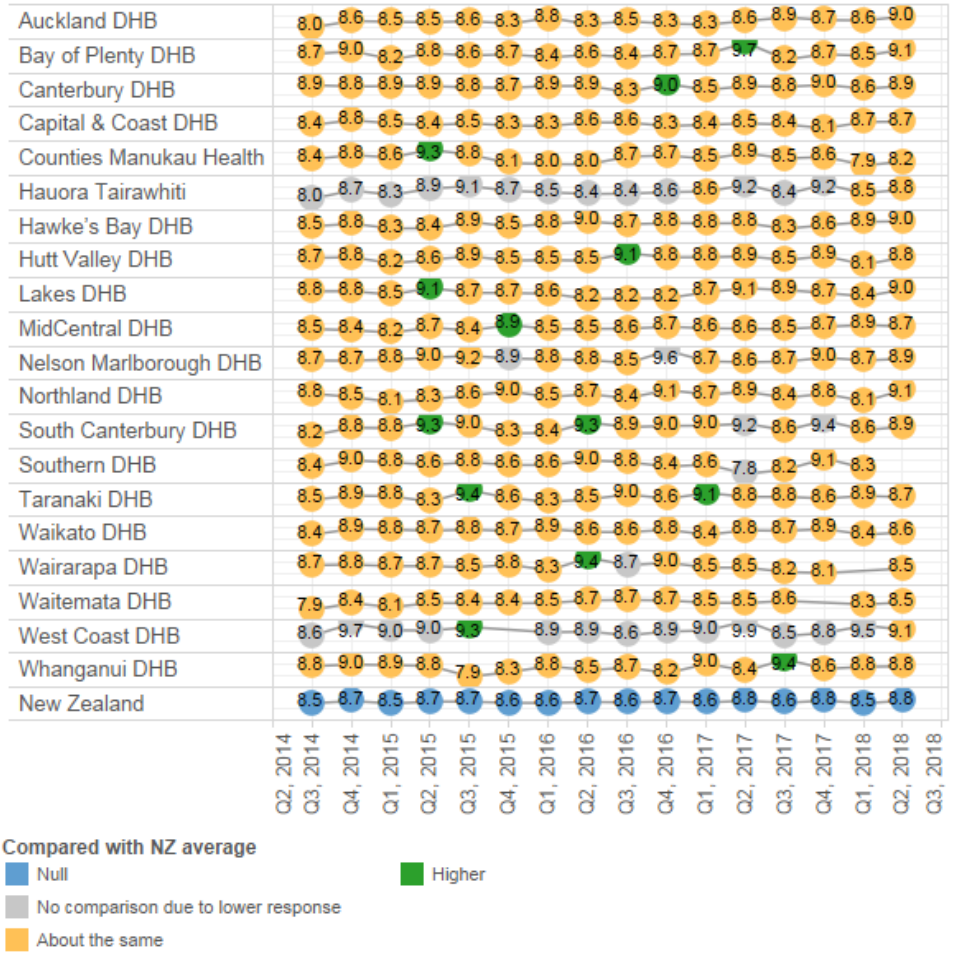


Table 6: Physical and emotional needs scores by DHB, 2014–18



Finance Performance Monitoring

No Financial report this month. Verbal update to be given by Andrew McCurdie.

Health Targets

MEMORANDUM TO THE BOARD
22 AUGUST 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. 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	2017/18 Q4 result	Target achieved	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 ✗	**Expected 09/08/2018**	X	83% Jul-18 YTD
Improved access to elective surgery		**100%**	108% 7th ★	106% 10th ●	110% 3rd ★	114% 2nd ★	**100%**	111% 5th ★	104% 8th ●	105% 6th ★	105% 7th ★	√	105% Q4 17/18 result*
Faster Cancer Treatment (FCT)	Achievement	**85%**	81.4% 5th ★	85.9% 4th ★	86.1% 5th ★	86% 2nd ★	**85%**	98% 1st ★	98% 2nd ★	97% 3rd ★	96% 3rd ★	√	92% June -18 Provisional
Better Help for Smokers to quit	Primary Care	**90%**	87% 12th ●	86% 13th ●	87% 12th ●	88% 15th ✗	**90%**	88% 14th ●	89% 12th ●	88% 14th ●	87% 16th ✗	X	87% 17/18 Q4 result
	Maternity	**90%**	93% 12th ●	96% 4th ★	98% 4th ★	95% 8th ●	**90%**	94% 8th ●	97% 4th ★	99% 3rd ★	87% 14th ●	X	87% 17/18 Q4 result
Increased immunisation (8 months)		**95%**	92.3% 13th ●	92% 15th ✗	90% 16th ✗	89% 15th ✗	**95%**	88% 15th ✗	90% 15th ✗	89% 14th ✗	88% 14th ✗	X	88% Jul 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% 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

*Finalised plan yet to be agreed with MOH for 18/19 so no July result

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2017/18

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
82.1%	88.8%	85.8%	83.6

Table 3 - Emergency Department Q4 results by site and by clinical unit

Total		
Numerator: Number of Patient Presentations to ED with Length of Stay < 6 Hours		Percentage of Patient Events Admitted, Discharged or Transferred from ED within 6 hours
23,968	28,653	83.6%
16,214	20,323	79.8%
3,613	4,049	89.2%
2,868	2,962	96.8%
1,273	1,319	96.5%

		Maori			Pacific		
DHB	Individual ED Facilities	Numerator: Number of Patient Presentations to ED with Length of Stay < 6 Hours	Denominator: Number of Patient Presentations to the ED	Percentage of Patient Events Admitted, Discharged or Transferred from ED within 6 hours	Numerator: Number of Patient Presentations to ED with Length of Stay < 6 Hours	Denominator: Number of Patient Presentations to the ED	Percentage of Patient Events Admitted, Discharged or Transferred from ED within 6 hours
Waikato DHB	Combined DHB	7,541	8,845	85.3%	643	751	85.6%
	Waikato	4,984	6,157	80.9%	480	581	82.6%
	Thames	662	735	90.1%	10	10	100.0%
	Tokoroa	1,300	1,342	96.9%	57	62	91.9%
	Taumarunui	595	611	97.4%	96	98	98.0%

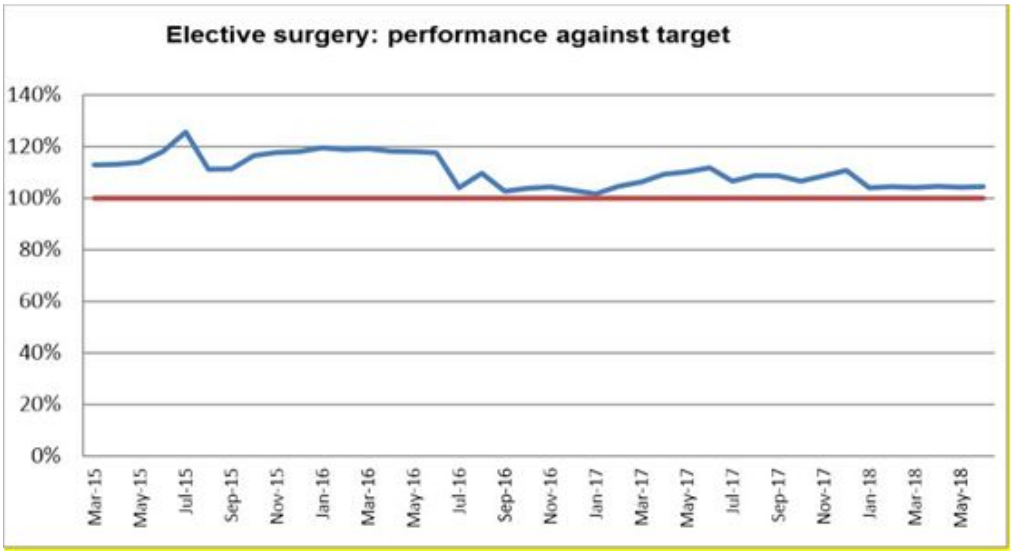
Target: Elective Surgery

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
Result	102.6%	103.1%	106.3%	111.8%	111%	104%	105%	105%
Ranking	7	10	3	2	5	8	6	7

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 June 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**
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	92% Provisional
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**
25%	17%	19%	19%	22%	14%	14%	14%	19% Provisional

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

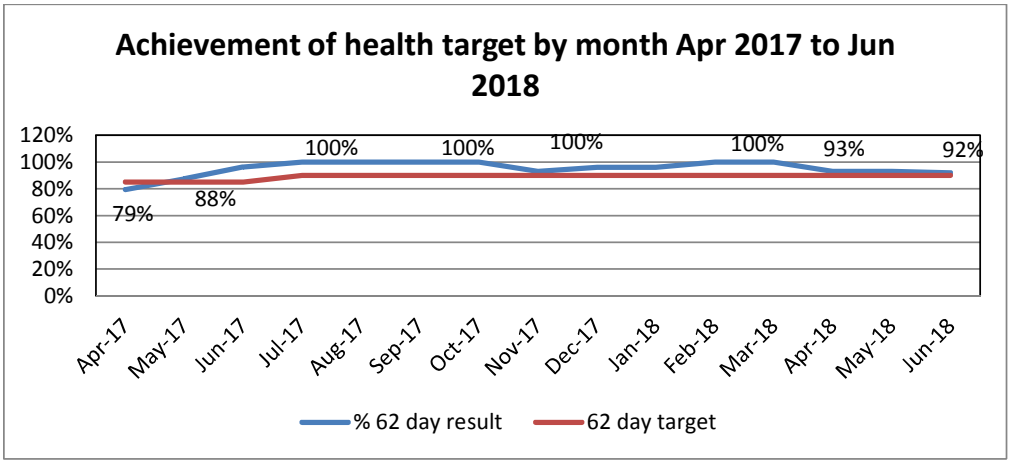


Table 6

Local FCT Database	Apr-18	May-18	Jun-18	Total
Number of records submitted	27	41	25	93
Number of records within 62 days	25	38	23	86
% 62 day Target Met (90%)	93%	93%	91%	92%
% Volume Target Met (15%)	17%	26%	16%	19%

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
Result	**90%**	**89%**	**88%**	**90%**	**89%**	**88%**
Māori	**89%**	**86%**	**82%**	**86%**	**83%**	**82%**
Ranking	**16**	**15**	**15**	**15**	**14**	**14**

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

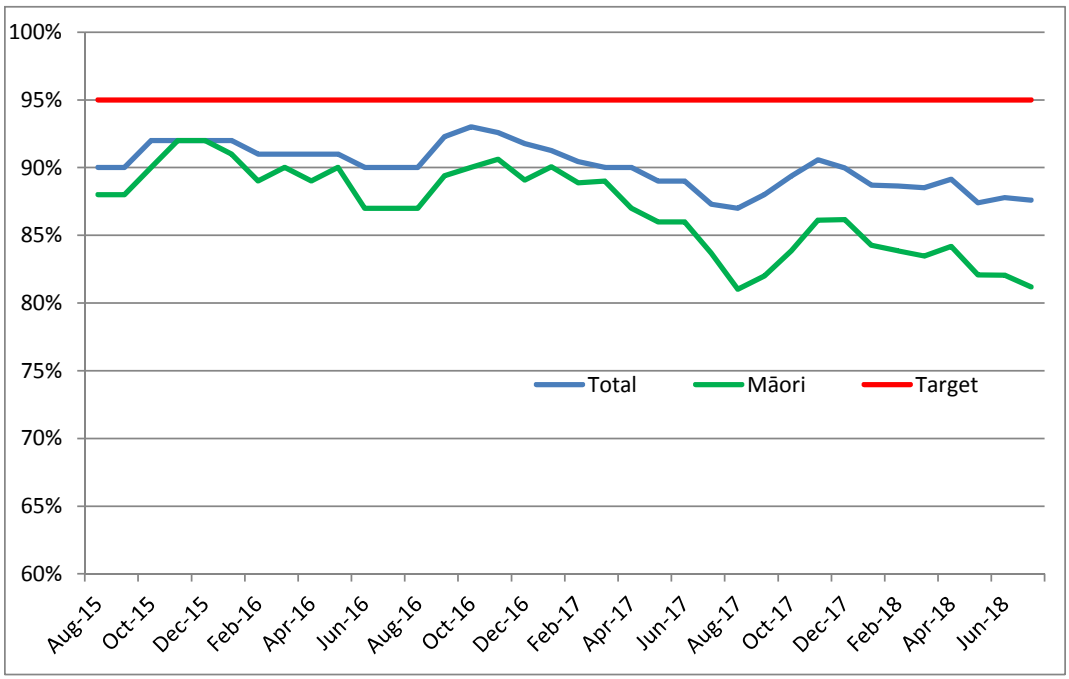


Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from May 2018 to Jul 2018

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	599	547	91%	23
Māori	547	444	81%	76
Pacific	51	46	90%	3
Asian	163	154	94%	1
Other	83	73	88%	6
Total across ethnicities				109
Total	1,443	1,264	88%	107

Target: Better help for smokers to quit - primary care

Table 9 – Quarterly Results

	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Total	87%	86%	88%	88%	89%	88%	87%
Total Ranking	12	13	15	14	12	14	16
Māori						87%	85%
Māori Ranking						13	15

Ethnicity splits only provided from Q3 17/18

Target: Better help for smokers to quit - maternity

Table 10 – Quarterly Results

	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Total	98%	96%	95%	94%	97%	99%	87%
Total Ranking	4	12	8	8	4	3	14
Māori	99%	95%	96%	93%	97%	98%	83%
Maori Ranking	5	12	10	10	8	2	13

Caution must be exercised when interpreting results as the sample population is extremely small

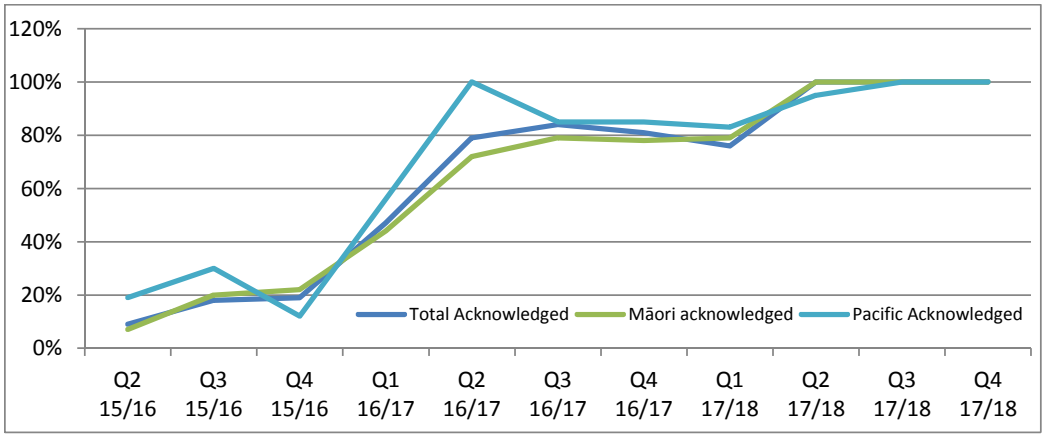
Target: Raising healthy kids

Table 11 – 2017/18 Q4 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	2017/18 Q4
		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 4 - 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

DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER

Health and Safety

Health and Safety Service report due in October.

Service Performance Monitoring

MEMORANDUM TO THE BOARD
22 AUGUST 2018

AGENDA ITEM 9.1

STRATEGY AND FUNDING UPDATE

Purpose	For information.

This report provides an overview of the priority work areas for the Strategy and Funding team over last three months.

A New Approach to Commissioning

The strategy, planning and funding functions of a District Health Board (DHB) are critical levers in achieving the DHB's responsibilities to improve population health outcomes and ensure the provision of effective healthcare services. Most importantly, these functions can, when appropriately configured and supported, play a critical role in the DHB's key responsibilities to improve Māori health and reduce health inequities.

In March 2018, the Interim Executive Director, Strategy & Funding commissioned a review of the Strategy and Funding team which identified limitations in the capacity and capability of the team. In essence these limitations related to the team being inadequately resourced and poorly configured for effective commissioning, and to provide the leadership and system transformation that is required to address the significant challenges that the health system is experiencing, particularly with respect to health equity. Subsequent to the review, the Executive Director has released a consultation document that proposes a new approach to commissioning and a restructure of the Strategy and Funding team.

The proposed commissioning approach is outlined in the appendix. The foundation of the approach is strong partnerships, community and consumer participation (and co-design), effective leadership and shared accountability for outcomes. The approach will be underpinned by a new prioritisation framework that is under development and yet to be presented to the Executive Team.

Health System Plan and Care in the Community Plan

Numerous stakeholder engagement events have taken place over the last couple of months which will inform the Care in the Community and the Health System Plan. More than 200 people have participated in a series of wānanga across seven locations to share their views on what our future health system should be configured.

The project team is currently exploring further opportunities to engage with and hear the views of Māori rangatahi. Additionally, a consumer engagement process (undertaken through a series of interviews and focus groups) has been undertaken to better understand the experiences and aspirations of a broad range of consumers.

The stakeholder feedback, alongside feedback from previous sector engagements, will inform the plan's development. A working draft of the Care in the Community Plan will be shared and discussed at a strategic options workshop in late September. This will subsequently contribute to the development of a road map of actions addressing a mix of emergent themes:

- How to accelerate new models of care that will eliminate inequities particularly for Māori;
- How to promote continuous service improvements as the future model of care is implemented;
- How to future-proof the system with the flexibility, capacity and capability to meet the expected demand from population growth, aging and complexity.

Review of Primary Options Service

'Primary Options' is a $1.4 million per annum programme which includes a range of services provided by PHOs to reduce the need for secondary care. We have recently commissioned an external review of the programme to ascertain the effectiveness of this programme, particularly in light of growing demand on secondary services. The review concluded this month and a number of recommendations have been made to improve the effectiveness of this programme. We will be working with PHOs to give effect to these recommendations over the next couple of months.

Review of Urgent and Emergency Care

Effective community based urgent and emergency care services are critical to the DHB being able to stem Emergency Department demand across the District. Strategy and Funding is in the final stages of commissioning a review of these services. This will be a comprehensive review across the District, to determine the effectiveness of current models of delivery and the opportunities for improvement.

It is anticipated that this piece of work, alongside the (hospital) Acute Flow project, and Primary Options review, will inform new models of service delivery to better meet health needs within the community and to stem acute demand. This work is anticipated to begin in September and be completed by December 2018.

Child Health Services Improvement

As reported to the Board in previous months, we have been particularly concerned about our performance with respect to child health improvement. Whilst the DHB invests considerable discretionary funding in a PHO Child Health Coordination service, we have continued to perform poorly with respect to the percentage of new borns enrolled in general practice, children receiving all their well child checks in their first year, and having early childhood immunisation on time. Most importantly, the equity gap between Māori and non-Māori for immunisations at 6 month, 8 months and 15 months had increased 5 percentage points over the last two years.

We are currently reviewing the way we deliver these services. We are also planning to review our outreach immunisation services to ascertain the effectiveness and value of this significant investment of approximately $750k per annum.

System Performance Measures

The Government has recently announced that a new suite of measures focusing on system performance and population health outcomes will be developed to replace National Health Targets.

There have also been discussions with the Board and the Community and Public Health Advisory Committee (CPHAC) over the last few months with respect to the need for a new dashboard to report and monitor system outcome measures across the district. These measures need to identify the equity gap between Māori and non-Māori in order that we are able to target approaches to eliminate health inequities.

The groundwork for this dashboard has been undertaken in the analytical profile we have developed for the Care in the Community Plan. One of the high level outputs from this work is attached which shows our performance on (previous) Health Targets and 'System Level Measures'.

Priority areas for our new system performance dashboard will include:

- Māori health
- Mental health and addictions
- Child and youth health
- Long term conditions and health of older people
- Social determinants and population health risk factors.

We intend to present a draft System Performance Framework to the Executive Group for endorsement in late September with an update to the Community and Public Health Advisory Committee in October. It is envisaged that reporting on the agreed dashboard will commence in late 2018.

New Pharmacy Agreement

The current Community Pharmacy Services Agreement is a national agreement that has been in place since 2012 and expires on 30 September 2018.

The process of negotiating and agreeing the new national agreement has been long and challenging, with negotiations between DHB contract representatives and community pharmacy sector representatives breaking down in December 2017. As a result DHBs went to the sector with a proposal that was not supported by the sector representatives. Further consultation with the sector occurred across the country in March and April 2018, with the parties finally reaching agreement on the new Integrated Community Pharmacy Services Agreement on 16 July 2018. The new Agreements will come into effect on 1 October 2018.

Mental Health Pay Equity

In June 2018 the Government announced the extension of the Care and Support Workers Pay Equity Settlement to New Zealand's estimated 5,000 mental health and addiction support workers. In an agreement with unions and employers, the Government has agreed to extend the Care and Support Workers (Pay Equity) Settlement Act to include mental health and addiction support workers. This Settlement Agreement was signed by all parties to the settlement at Parliament on 25 July 2018.

The settlement delivers a new pay scale that reflects workers' qualifications and experience and improves access to training to support reduced turnover in the sector. Nearly half of all Mental Health and Addiction support workers will get an increase of more than $3 per hour which means that full-time workers will be paid approximately an extra $120 gross per week. A further 20 percent of support workers will get an increase of more than $5 per hour, or approximately an additional $200 per week (full time equivalent). The $173 million settlement extension will be implemented over a five-year term and funded through an increase to Vote Health. Waikato DHB's share of this funding is approximately $1.9m for 2018/19.

There is considerable work ahead for the Strategy and Funding Team in implementing these changes.

Recommendation
THAT
The Board receives this report.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

Appendix 1

Commissioning for Healthy People, Excellent Care & Health Equity

Waikato DHB's proposed approach to planning, developing and procuring health services

This document forms part of the Strategy, Funding and Public Health Proposal for Change

Author: Tanya Maloney, Executive Director, Strategy, Funding and Public Health

Contents

1.0 Introduction

Waikato District Health Board ('the DHB') faces significant challenges to meet its responsibility and commitment to improve Māori health and reduce health inequities. It is also struggling to meet the growing demand on health services which has resulted in significant growth in ED presentations and hospitalisations over the past decade. The district faces further pressures with significant population growth, and an aging population which will inevitably further increase the demand on primary and secondary care services.

In order to address the challenges above, we need a significant change in how we plan, fund and provide services. The 10 year Health System Planning process that is currently underway, will describe a future health system that is likely to look quite different to the current one, and will require a shift in resources and investment. Implementation of such changes requires an effective commissioning process, along with strong relationships between communities, provider organisations and the DHB Strategy and Funding Directorate.

It is apparent that the DHB's current approach to planning and funding services is lacking in numerous areas that are essential to effective commissioning in complex public sector environments. Many of the gaps in the current approach were outlined in the recent review of Strategy and Funding which highlighted that the current focus is on contract management, with limited capacity for system leadership and service development.

This document outlines a proposed new approach to commissioning for Waikato DHB.

2.0 Waikato DHB – Population Overview

The Waikato is a unique region within New Zealand with respect to its geography and population profile. It is the largest DHB by geographical area, incorporates 10 Territorial Local Authorities, and has a broad mix of large urban, small urban, rural and significantly isolated communities. These unique characteristics present unique challenges in providing appropriate mixes of services that meet the needs of our population.

Additionally, as a DHB with one of New Zealand's largest proportional Māori populations, we have a particular need to reduce health inequities amongst Māori. Māori health in the Waikato still lags woefully behind that of non-Māori; thus Māori health gain is therefore necessarily the primary focus of all of the DHB's planning, service delivery and investment approaches.

This section provides an overview of population health need across the District, with a particular focus on Māori Health inequities.

2.1 Māori Health Needs

Demography

In 2018/19, 95,640 Māori live in the Waikato District Health Board area, 23% of the District's total population. The Waikato Māori population is currently youthful but showing signs of ageing. Over a third (37%) of the District's children under 15 years of age and 30% of those aged 15–24 years are Māori.

The Waikato Māori population is projected to experience a significant increase (30 per cent) between 2018/19-2033/34. The Māori population aged under 15 is set to rise by 14%, and the 15-24 age group of the Māori population is set to rise by 33% over the same period.

Social Determinants of Health

In 2013, 12% of Māori adults aged 15 years and over were unemployed, more than twice the non-Māori rate (5%). Two in five children and one in three adults in Māori households (defined as households with at least one Māori resident) were in households with low equivalised household incomes (under $15,172), compared to one in five children and adults in other households.

Using the NZDep2013 index of small area deprivation, 26% of Waikato Māori lived in the most deprived decile areas (decile 10) compared to 9% of non-Māori. Conversely, only 6% of Māori resided in the two least deprived decile neighbourhoods compared to 17% of non-Māori.

Waikato residents living in Māori households were 3 times as likely as those living in other households to be in crowded homes (i.e. requiring at least one additional bedroom) (20% compared to 7%).

Life Expectancy and Mortality Rates

In 2012–2014, life expectancy at birth for Māori in the Waikato Region was 76.5 years for females (7.5 years lower than for non-Māori females) and 72.2 years for males (8.1 years lower than for non-Māori). The all-cause mortality rate for Waikato Māori was twice as high as the non-Māori rate during 2008–2012.

Potentially avoidable mortality and mortality amenable to health care were 2.6 times and 2.7 times as high for Māori as for non-Māori in Waikato during 2007–2011.

Hospitalisation

During 2011–2013, among Māori children there were on average 136 admissions per year for serious skin infections (with the rate more than twice that of non-Māori children). The rate of hospitalisation due to injury was 19% higher for Māori than for non-Māori.

2.2 Rurality

The Waikato DHB region has a high proportion of rurality including Independent Urban Areas which are the most deprived areas and have the most health needs. People who live in rural areas have the highest incidence of cardiovascular disease, malignancy, renal and respiratory disease as well as the highest levels of potentially avoidable mortalities (amenable deaths - those occurring before 75 years of age). This populations constitutes a large percentage of secondary care activity.

2.3 Ageing

The overall population in Waikato is projected to rise by 13% from 419,890 in 2018/19 to 474,990 in 2033/34. The proportion of those 65+ among the DHB's resident population is projected to increase from 16% in 2018/19 to 22% by 2033/34. The age group between 65 and 74 is projected to increase by 34% and the age group over 75 is projected to increase by 86%. The Māori population aged 65 years and over will increase by 50% between 2013 and 2020.

More than two-thirds of the Waikato District's projected growth will be at 65+ years, while decline is expected at 45-59 years of age as the baby boomer cohort ages. Future population growth is centred around specific localities - Hamilton and surrounds, Matamata, and the Northern Corridor. The other localities are expected to experience varying population decline across most age groups, though the total population for Thames is projected to be flat through to 2033. All localities will experience growth in the number and proportion of those 65+ in the population.

The population groups described above must be the focus for more targeted and innovative investment approaches.

3.0 The Responsibilities of District Health Boards

District Health Boards are responsible for the health of their population. The statutory objectives and functions of District Health Boards are set out in the Public Health and Disability Act (the Act) 2000. The Act is clear that DHBs have a much broader role than the planning and provision of health services; the objectives of the DHBs include (inter alia) the following:

- To improve, promote and protect the health of people and communities;
- To reduce health disparities by improving health outcomes for Māori and other population groups;
- To promote the inclusion and participation in society, and the independence of people with disabilities; and
- To foster community participation in health improvement, and in service planning.

Amongst the statutory functions of DHBs, the following are the most relevant to the Strategy and Funding directorate:

- Investigate the health status and health needs of the population;
- Plan and co-ordinate for the most effective and efficient delivery of health and disability services;
- Enable Māori to participate in and contribute to strategies for Māori health improvement;
- To collaborate with relevant organisations in the planning and coordination of services;
- Ensure the provision of services (either through DHB Provider Arm services or by contracting with other providers); and
- Monitor the delivery and performance of services by the DHB and other providers.

The Strategy and Funding Directorate plays a critical role in ensuring that at a macro level the organisation is configured in a way that meets the legislation's objectives. Waikato DHB drives its contribution to these objectives through its overarching strategy and strategic imperatives, its 10 year health system plan (under development) and its annual planning process.

In undertaking its statutory functions, the DHB's Strategy and Funding Directorate must be configured and resourced appropriately to ensure effective system investment, and performance management. Complex adaptive systems (such as health), often need to be nimble and to flex over time with respect resource and skill-sets to support service development and integration. The proposed commissioning approach recognises the changes in the health services environment and will ensure the DHB has the right people and right approaches to continually improve performance against its statutory obligations.

4.0 Waikato DHB's Current Strategy and Funding Directorate

A recent review of Strategy and Funding identified that the fundamental structure and approach to the development procurement of services had not fundamentally changed since the DHB's inception. Whilst there is deep health sector knowledge within the team, there are also some fundamental gaps in terms of system and service planning, service design, and engagement.

Whilst many DHB's have grown their teams both in terms of adding different skill-sets and overall capacity, Waikato DHB's Strategy and Funding team has largely operated a traditional portfolio approach to contracting services that is not in line with more contemporary approaches to the commissioning of services and achieving health outcomes. The focus on only the contracted services side of the health system continuum has left the Strategy and Funding Directorate largely disconnected from its own Provider Arm services with respect to decisions about service development and responding to the challenges of increasing demand. This has resulted in a fragmented system of delivery, where opportunities have been missed in respect to sustainable hospital service development, and the adoption of horizontally integrated models of care.

The DHB has embarked on the development of a strategic Health System Plan alongside its Māori Health Strategy, Ki te Taumata o Pae Ora. These significant pieces of work will define a 2030 integrated system of health services delivery, and will outline implementation pathways that will guide service development over the next 10 years. It is the expectation of the Board and Executive that these plans will enable transformation of our Waikato health system, redirecting investment to areas that will drive progress against its strategic imperatives.

To implement the direction set by the Health System Plan, Strategy and Funding is currently being reconfigured to ensure it has the skills and capacity to accelerate change and manage the DHB's investment in health outcomes.

Fundamentally this will require a significant refocus of approach to ensure it:

- engages consumers, community, clinicians, providers and other stakeholders in co-design;
- enables change in the health system to improve Māori Health and reduce health inequities; and
- ensures system and service development is a key feature of the commissioning approach.

5.0 From Contracting to Commissioning

Despite DHBs being established with a structural purchaser/provider split, there has been recognition for some time that the adopted contracting and performance management approaches have done little to improve health outcomes, particularly for Māori and other disadvantaged communities.

Much of this can be attributed to the way services have been developed and performance managed. There has, in general, been a distinct lack of system thinking with respect to social determinants, and providers have been encouraged to deliver services strictly aligned to service contracts, which in effect, has stifled innovation. This has meant that opportunities for health improvement and service sustainability through innovation and better integration have not been exploited to the advantage of local populations.

There has been some significant learning from across New Zealand and the world in respect to effective commissioning approaches. The U.K has had mixed success, but in general the literature demonstrates that all successful models of commissioning should incorporate the following elements:

- Planning that is clearly linked to a **population's health needs**. This seems so simple, and yet so often the linkage between what is delivered to what is needed is tenuous. Unless a DHB fully understands what the needs (and the drivers of those needs) are, it has little chance of success in eliminating health inequities amongst its most vulnerable communities.

- The planning and design of services should involve **effective engagement** of the public, service users and clinicians. From listening to communities about their particular needs through to co-designing services – a well-functioning system of commissioning should be inclusive and responsive to stakeholder perspectives.
- Services should cascade from a clear **strategic direction**. For a DHB, this direction is best established within a Health System Plan, where health service and social service delivery intersect, and services are integrated in such a way to ensure people stay well in their community. Key priorities (such as Radical Māori Health Improvement) should be well embedded in this strategic direction setting.
- An embedded culture of **collaboration and cooperation** (e.g. alliancing) ensures providers from across the sector have a stake in and commitment to a future vision of sustainable and outcome focussed service delivery.
- Ensuring programmes of work are built on sound intervention logic and robust **monitoring and evaluation**. In turn this ensures the funder and the provider are working together to ensure the services provided are supported by **continuous quality improvement** to achieve the outcomes sought.
- A strong commissioning approach is based on a **partnership model** with shared leadership and accountability, rather than a blunt and punitive contract management approach.

6.0 Proposed Waikato Commissioning Approach

The DHB's commissioning approach will be founded on the DHB's commitment to working in partnership to improve population health and eliminate health inequities. Genuine partnership with consumers, communities, clinicians and providers is the goal in respect to developing services that maximise health gain.

The principles that guide our approach to commissioning are:

- equity for vulnerable populations: focus on reducing and if possible eliminating inequities in health;
- shared leadership: all the actors in the local health system share leadership in achieving health gain for the population;
- accountability: while each organisation has its own accountability mechanism, there will be shared accountability in Waikato for achieving health improvement; and
- whole of system, end to end care: commissioning of services will take into account the impact of any changes on the whole system of care. When commissioning new services or service changes, the principle will be to assess the improvement any service will bring to the end-to-end health experience of patients.

A number of commissioning models have been examined and as a result, we have developed the 'Commissioning Koru' below as our proposed approach for Waikato.

Figure 1: Waikato Commissioning Koru

6.1 The Commissioning Koru Components

DHB Strategy Development

The DHB developed its Strategy in 2016 which has a clearly articulated vision and set of strategic imperatives. Typically these are only reviewed every ten years unless there is a significant direction change signalled by Government. Developing an overarching strategic framework is an important first step in the commissioning process, as it grounds all future decisions within a priority hierarchy.

Health Needs Assessment

Knowing where to invest in services to maximise health gain and reduce inequities is wholly dependent on understanding the health needs of a population. Typically DHBs have undertaken Health Needs Assessments on a 3-5 year cycle.

Within the Waikato commissioning approach, the DHB will run an active Health Needs Assessment Programme where aspects will be updated as new data becomes available. The DHB may publish a regular report, but Planners and Service Development Managers will have access to as up-to-date analysis as possible through this approach.

Strategic Position Statements

Good planning requires clear definitions and descriptions of activities and areas of focus.

In order to ensure clarity about particular programmes of work, clear position statements are critical to the planning and wider commissioning processes.

Position statements are driven by our principles and rationale relating to areas of proposed strategic development. They provide a solid foundation upon which further engagement with wider stakeholder groups take place, and guide service development work.

Health System Design

The DHB has embarked on the development of its Waikato Health System Plan, which is another critical step in the Commissioning Process. A Health System Plan provides a schematic that outlines what a connected system of health services looks like at a future point in time. The DHB's schematic is focussed on its vision of a 2030 Waikato service mix.

A health system schematic represents what changes will take place, where people access their care, where DHB resources are deployed, and the role of social services in impacting social determinants of health. The health system plan also provides a mix of implementation pathways. This provides clear direction for on-going service planning and change management activity.

Engagement is a critical aspect in designing a system of delivery that is effective, and has the commitment of communities and stakeholders. To this end, a comprehensive whole of DHB approach to engagement is currently being developed which will ensure multiple stakeholders across communities, services users, provider organisations and clinicians are engaged. Additionally, Strategy and Funding will ensure sufficient opportunity for the Board, its Committees, Iwi Māori Council and the Consumer Council to drive the on-going system design.

Investment Prioritisation

This DHB is clear about its strategic direction and its intent to actively invest in services that maximise health gain and eliminate inequities.

There will always be nationally driven contracts and service specifications that the DHB must manage. But additionally, there are always opportunities to think more creatively about service provision and where flexible funding will make the most difference. Strategy and Funding will use a mix of tools to transparently identify where investment is most likely to have the greatest impact, and to prioritise our investments based on clear evidence and rationale.

Business cases for change will be evidence based and will clearly identify how population outcomes are to be tracked over time. With intervention logic underpinning investment choices, decision makers will maintain a long term view around how and when planned outcomes will occur. Because this approach also allows for continuous review and service adaptation through shared accountability and leadership, it fosters confidence across executive and governance groups in respect to the investment's long term contribution to strategic imperatives.

Prioritising investment is intended to drive a people centred approach, and to ensure inequities are eliminated. As a result, our population will become healthier.

Service Development

It is an intention to adopt a more collaborative approach to developing services, creating better connections across the sector to ensure services are more people centred and are focussed on reducing inequities, particularly for Māori.

Co-design will be Strategy and Funding's preferred method of engaging stakeholders in the on-going development of services. The DHB has access to a rich network of stakeholders including its communities, its Board and Committees, its Iwi Māori Council and those in the Consumer Council who have a lived experience of current health services. Harnessing this knowledge and input will significantly improve how the DHB's services are configured, where they are located, and how they respond to people and their whanau.

Greater service design expertise will be employed within the Strategy and Funding Directorate, and district-wide alliancing through a Health System Leadership Group will ensure there is collective buy-in to a more integrated and outcome focussed mix of services.

Contracting for Outcomes

Adopting different frameworks (such as intervention logic) and reorienting contracts to be clearly linked to desired outcomes is a key means of ensuring the DHB is partnering with providers to deliver the right service to achieve the desired outcomes. Shared accountability and leadership will enable greater flexibility and allow for services to be developed around people and their families, rather than simply ticking boxes around interventions.

That said, contracts remain the key mechanism for measuring provider performance and the DHB must still operate within the Government's Rules of Sourcing in procurement of services. Ensuring the DHB operates in a transparent and collaborative approach with providers will be imperative to ensuring contracts work for both parties.

Monitoring and Managing Performance

With the DHB's contracts having stronger linkages to outcomes, and greater collaboration between the DHB and providers in respect to on-going service development - there will be a strong focus on monitoring performance and working together to remediate issues and exploit opportunities.

A stronger evaluation presence inside the Strategy and Funding Directorate will further strengthen the DHBs assurance around programmes of services and the impact they have against our strategic imperatives.

Outcome / VFM Measurement

As a precursor to the decision to re-commission or decommission, consideration will be given to all the performance and evaluation information to determine the relative value and outcomes of the service and investment.

Commission or Decommission Services

The relative value and contribution to outcomes is a critical aspect in the decision to re-commission or decommission a service. It is not the only consideration however. Changes in organisational priorities as determined by Government or Board will be considered, as will the emergence of opportunities to deliver services in a more effective way.

7.0 The Role of the Health System Leadership Group

This group has previously been referred to as the "Waikato District Alliance".

Representatives from the Inter-Alliance and DHB Strategy and Funding Directorate recently met to discuss the creation of a Health System Leadership Group (HSLG). This would comprise a core group of senior health system leaders who were well placed to oversee and advise on the development of a new integrated health system focussed on people centred care, the elimination of health inequities for Māori and sustainability across all services.

The HSLG would also be responsible for advancing key integrative projects, and identifying opportunities to better target health investment.

A Terms of Reference is under development, and will bring together a core group of management and clinical expertise from across the sector to ensure broad support for the Health System and Care in the Community Plans under development. Moving forward, this group will support the development of programmes of work that will underpin change through the DHB's commissioning work. Membership may change as areas of focus require additional sector expertise relating to particular projects or strategic programmes. Through this activity, the HSLG will become a key informer to the Waikato Commissioning approach.

8.0 The Role of the Board and the Community & Public Health Advisory Committee

The DHB's Board is inextricably linked to the commissioning process through its participation and decision making in respect to strategic and organisational planning, its engagement in Strategy and Funding's work programme development, and its approval of significant service change. Regular system performance reporting will be provided through revised performance dashboards and specific reporting on programmes of work.

The Community and Public Health Advisory Committee (CPHAC) meets regularly to hear presentations and discuss those DHB investments in services and activities that are aimed at improving health outcomes and eliminating health inequities. CPHAC advises the Board on the progress being made by the DHB with respect to its commissioning of services across the health continuum, and the DHB's investment in preventative and early intervention approaches.

Appendix 2

Waikato DHB System Performance

					Waikato			National		
Indicator	Target (Total Population)	Period	Rank (Total)	Rank (Māori)	Māori	Pacific	Other	Māori	Pacific	Other
PHO enrolment	100%	Jul-18	12	8	94%	94%	95%	91%	100%	93%
Newborn enrolment	100%	Apr-Jun 18	19	13	60%	62%	65%	62%	62%	70%
Breast Screening (50-69 years)	70%	Jan-Mar 18	18	19	58%	61%	71%	65%	73%	73%
Cervical Screening	80%	Jan-Mar 18	11	10	68%	73%	78%	67%	71%	75%
Primary Care Smoking	90%	Apr-Jun 18	16	15	85%	83%	88%	87%	90%	91%
Maternity Smoking*	90%	Apr-Jun 18	14	13	87%			89%		
8 month Immunisations	95%	Apr-Jun 18	14	14	82%	93%	91%	86%	94%	93%
ASH (0-4) - per 100,000	7254	12 mnths Mar 18	19	20	10159	9638	8009	7741	11793	5650
Acute Bed Days - per 1,000	484	12 mnths Mar 18	18	19	687	500	424	557	685	352
Amenable Mortality - per 100,000	123	5 years June 14	13	16	247	204	85	215	192	79

Key: DHB position: **Top third** , **Middle third** , **Bottom third**

3% or more worse than target | 1% worse than target | Target achieved

*For ASH, Acute Bed Days and Amenable Mortality: Results for Waikato and National are coloured by performance against the Waikato ethnicity specific milestones
Source: MOH quarterly reports, StatsNZ Population Projections (2017) update, NSU coverage data, MOH Access to Primary Care by Ethnicity (April 2018)

Waikato District Health Board

Decision Reports

Equity Focussed Reporting: report due in October.

MEMORANDUM TO THE BOARD
22 AUGUST 2018

AGENDA ITEM 10.2

REAPPOINTMENT OF THE NEW ZEALAND HEALTH PARTNERSHIPS INDEPENDENT DIRECTORS

Purpose	For decision.

At the National DHB Chairs meeting held in June there was discussion on the process for reappointing independent directors to New Zealand Health Partnerships.

Please find attached in this regard a letter from Jenny Black the Chair of District Health Boards together with a paper from NZ Health Partnerships for discussion at the August Board meeting.

Recommendation
THAT
The Board:

1) Receives the report.
2) Provides feedback on the reappointment or otherwise of NZ Health Partnerships' independent directors and the process for appointing independent directors moving forward.

SALLY WEBB
CHAIR

All District Health Boards

Jenny Black MNZM
Chairman
West Coast & Nelson Marlborough
District Health Boards

3 August 2018

National Chairs
20 District Health Boards

Dear Colleagues

Re: the reappointment of the New Zealand Health Partners Independent Directors

At our last meeting in June we agreed that we were in favour of the process of reappointment of Independent Directors recommended by the four DHB appointed directors, as there was no clear process noted in the constitution.

We also agreed to roll over the reappointment of the present independent directors until the September AGM. To enable this to occur, and in order to ensure that issues in relation to a quorum for Director meetings do not arise, please ensure that you come to the September AGM with the right authorities from your DHB Board in place.

The option recommended at the June meeting was to reappoint each of the independent directors for staggered terms. (The paper presented to us in June is attached, for your reference).

If your Board proposes a different course of action it would be helpful to have that discussion before the AGM. You will recall that the NZHPL constitution requires that each independent director be appointed jointly by all of the DHBs.

If anybody has any questions about this issue, please contact me.

Regards
Jenny

Jenny Black MNZM
Chairman
West Coast & Nelson Marlborough
District Health Boards
jenny.black@nmdhb.govt.nz

16 May 2018

Reappointment of NZ Health Partnerships' Independent Directors

Dear Shareholders,

As your regional representatives on NZ Health Partnerships' Board we are writing to all DHB Chairs about two key governance-related recommendations:

1. Reappointment of NZ Health Partnerships' Independent Directors
2. Process for appointing Independent Directors moving forward.

1. Reappointment of Independent Directors

At the DHB Chairs' Forum in Wellington on 8 March it was decided that the Independent Directors of NZ Health Partnerships would be re-appointed only until the full Shareholders' Meeting in September 2018.

Those that remained at the meeting indicated that there are a number of new DHB Chairs that would not know the Independent Directors well enough to support their reappointment for the recommended terms.

The matter was discussed at the NZ Health Partnerships Board meeting in late-March. It was agreed that we would provide you with further information about our Independent Directors, as well as the skills mapping and Director evaluation processes that were undertaken prior to making the re-appointment recommendations.

Reappointment Terms

The unanimous recommendation of your four regional Directors is that the current Independent Directors should be reappointed beyond September 2018 for terms as follows:

Director	Appointment type	Director since	Reappointment Recommendation
Peter Anderson (Chair)	Independent	1 October 2015	30 September 2020
Jo Hogan	Independent	31 March 2016	30 September 2022
Terry McLaughlin	Independent	1 October 2015	30 September 2021
Rabin Rabindran*	Northern Region	22 March 2017	21 March 2020
Kevin Atkinson	Central Region	22 March 2017	21 March 2020
Ron Luxton	Southern Region	1 August 2017	31 July 2020
Deryck Shaw**	Midlands Region	1 July 2015	Retiring 30 June 2018

* Recently stood down as Counties Manukau DHB Chair. Northern Region to appoint replacement Director.
** Pauline Lockett is Director-Elect for the Midlands Region

These recommendations are made with our collective knowledge of the experience they bring to the Board. Specifically, we feel Peter's leadership experience with co-operatives; Terry's strong finance, risk and audit knowledge; and Jo's practical project director's skillset and broader public sector knowledge are the ideal mix for effective governance of NZ Health Partnerships for the next few years. This skill set complements the health sector governance knowledge we bring as DHB Chairs.

Their individual contributions to the Board have also been assessed through peer review. In each case the three Independent Directors received very positive reports. Common phrases used to describe all three, which we endorse, include: extremely professional, astute, adds a lot of value, committed, focused, insightful, respectful, not afraid to challenge, knowledgeable and thoughtful leader.

More information on Directors' experience and capabilities are included in **Appendices 1** and **2**.

We also feel strongly that there is a need for both certainty and continuity on the Board, beyond the next round of triennial DHB elections and Chair appointments in late-2019.

This is of particular importance as the only current foundation Director, Midlands-regional representative Deryck Shaw, will step down and be replaced by Pauline Lockett in July 2018. We will also shortly lose Rabin Rabindran as he has stood down from Counties Manukau DHB.

2. **Recommendations on the process for appointing Independent Directors moving forward**

NZ Health Partnerships' Constitution provides for the Board to make recommendations to its shareholders on the appointment and reappointment of its Independent Directors. This is in line well-accepted governance principles and recognises that your Directors are best placed to provide an accurate view of the value, or otherwise, that the Independent Directors add to the governance of the organisation.

However, we acknowledge that there are improvements to be made to the reappointment process, particularly in ensuring all of our shareholders have the appropriate information on which to base their decisions. Moving forward we recommend the process as follows:

I. Independent Director recommendations are considered by a Board subcommittee, comprising of the Board Chair (where his reappointment is not involved) and the four DHB regionally appointed Directors.

II. That at least six months prior to an Independent Director's term expiring the other Directors conduct a structured peer-review of their performance and of their skills compatibility against the strategic needs of the organisation.

III. That the subcommittee makes a recommendation to the full Board and then Shareholders **at least four months prior** to expiry of the Director's term.

IV. In the event that the retiring Director is not to be reappointed this leaves sufficient time for the Board subcommittee to identify and recommend a new Independent Director candidate to be voted on by shareholders at the annual meeting.

V. A spokesperson for the Board subcommittee will introduce the new Independent Director candidates to shareholders at the annual meeting, along with their CV and reasons for their appointment.

If you wish to discuss any of these matters, please call your regional Director. Otherwise, please indicate your acceptance of these recommendations by signing the Resolution in **Appendix 3** and returning it to NZ Health Partnerships' Chief Executive Megan Main (megan.main@nzhealthpartnerships.co.nz) by 31 July 2018.

Yours Sincerely

Kevin Atkinson	**Deryck Shaw**	**Ron Luxton**	**Rabin Rabindran**
Director	Director	Director	Director

List of Appendices:

- **Appendix 1**: Directors' Biographies (short-form)
- **Appendix 2**: Directors' Skills Map
- **Appendix 3:** Resolution

Appendix 1 – Directors' Biographies

Independent Directors

 **Peter Anderson** Chair; Chair Remuneration Committee	Peter's skills as a Chair are well honed in a co-op environment where shareholding Directors are closely engaged in the business on a day-to-day basis. Peter has over 20 years' experience at Foodstuffs in a customer and consumer focused environment. Prior to that he had nearly 30-years in the primary sector with Wrightsons, where he worked in a variety of sales and executive roles. After six years as a Director he was appointed Chair of Foodstuffs Wellington in 2012 and then led a successful merger with Foodstuffs Auckland to create Foodstuffs North Island, one of NZ's largest companies. He worked with all stakeholders to ensure member support culminating in a 100% vote in favour of the merger and was appointed Board Chair of Foodstuffs North Island and Foodstuffs New Zealand in 2013. He retired from both roles in 2017. Peter is known for developing strong and trusted relationships with his down to earth leadership style.
 **Terry McLaughlin** Director; Chair of Finance, Risk, Audit Committee	Terry is an experienced finance executive with particular strengths in Audit and evaluation of contracts and performance (value for money). Originally qualified as an accountant he started in public practice with EY; then joined the office of the Auditor General rising to Assistant AG working across all of Government, in particular Treasury and SSC. His work involved a number of in depth investigations and performance audits of major transactions and contracts which involved both the public and private sector. As CEO of the NZ Institute of Chartered Accountants (NZICA) he led major reforms to the governance and structure of NZICA which culminated in their merger with Australia to form CAANZ. Terry is currently CEO of a national law firm, Duncan Cotterill.
 **Jo Hogan** Director; Remuneration Committee	Jo is an experienced executive who has lead major transformational change in large organisations across a range of industry sectors and countries. Starting her career in Technology, Jo's career progressed to large enterprise-wide change projects that impacted on all aspects of large companies in the Health, Manufacturing, Property and Waste processing industries. Jo has built a reputation for managing end to end change and delivering on business improvements with significant financial and operational improvements. Prior to her appoint to the Board, Jo was the interim Chief Executive of NZ Health Partnerships in its first seven months of operations. Jo is now Director, New Zealand Business Number at MBIE.

NZ HEALTH PARTNERSHIPS

DHB Directors

 **Rabin Rabindran** Former Chair Counties Manukau DHB Northern Region Director	Alongside his roles in health, Rabin has been a Director of Auckland Transport, a Director of Solid Energy New Zealand and is Chair of Bank of India (NZ) Limited. Rabin is a commercial barrister specialising in major project negotiation and documentation. He has worked on projects throughout New Zealand and in Asia, Africa, the West Indies and the Pacific acting for Governments, international companies and the World Bank.
 **Kevin Atkinson** Chair Hawkes Bay DHB Central Region Director	Kevin has been a director of Hawkes Bay DHB since 1998. He is also the Chair of Unison Network, which owns the electricity distribution networks in Hawke's Bay, Taupo and Rotorua, and Director of the Hawke's Bay Rugby Union. Kevin's professional life has centred on the technology sector. He founded the software company Information Management Services Ltd (IMS) in 1983, which provided payroll software to a large number of New Zealand and Pacific Islands customers. IMS was sold to MYOB in October 2015. In the 2010 Queens Birthday honours list Kevin received the New Zealand Order of Merit (MNZM), for services to Business and the Community.
 **Ron Luxton** Chair South Canterbury DHB Southern Region Director	Ron is a pharmacist by profession and has more than 40-years of experience as a frontline primary healthcare worker. Ron is currently Chair of the Aoraki MRI Charitable Trust and his previous Directorship includes as International Director at Lions Clubs International and over three years as Chair of the South Canterbury Endowment Fund.
 **Deryck Shaw** Chair Lakes DHB Midlands Region Director	Alongside Deryck's health role which include Board membership of TAS (shared services health organisation, he is President of New Zealand Football and Deputy Chair of Te Puia (New Zealand Maori Arts and Crafts Institute). Deryck is currently the Owner and Director of APR Consultants Ltd, a Chartered Director of NZ Institute of Directors, Associate Fellow of the New Zealand Institute of Management, and Foundation Member of the Royal Society of New Zealand. He is also a Member of the NZ Research Association, New Zealand Association of Economists and New Zealand Planning Institute.

 **Pauline Lockett** Chair Taranaki DHB Midland Region Director Elect	Pauline was a partner with PwC for twenty years. She has had seven years on the Board of the Taranaki District Health Board with four of these as the Chair. Her commercial directorship experience has been as a Director of Landcorp Farming Limited (LFL), a State-Owned Enterprise, for six years. Pauline received a recent appointment from the Maori Land Court (MLC) to Ngati Te Whiti Whenua Topu Trust. She was advised that this appointment was made after the MLC had satisfied themselves as to Pauline having integrity, commercial acumen and professionalism from the local hapu members' perspective.

Appendix 2 – Directors' Skills Map

Background

In November 2017 the Board undertook a strategic Directors' skills mapping exercise. It was agreed that there were 39 qualities, skills and competencies required around the Board table to maximise its effectiveness and ability to meet the strategic objectives of NZ Health Partnerships and its shareholders. These were broken into four broad categories: Behavioural Qualities (10), Directorial and Governance Skills (12), Technical Skills and Experience (11) and Health Sector Knowledge (6).

The minimum level of competency and the desired or aspirational number of Directors holding this competency was determined for each of the 39 qualities, skills and competencies. The ratings of each Director were determined by a mixture of self and peer assessment, added to by the Chief Executive's assessment of all Directors.

In the behavioural qualities and governance skills areas a full peer and self-assessment was undertaken by all Directors, added to by a CE assessment of all Directors. Director self-rating was excluded from these sections and each director was rated as:

Expert: If five or more of their seven peers, including the CE, rated a director as expert and the other two rated them as competent.

Competent: If five or more of their seven peers rated a director as competent or higher.

Limited: If three or more of their seven peers rated a director as limited or below.

None: If three or more of their seven peers rated a director as none.

In the technical skills and industry knowledge areas it was decided that a self-rating, and no peer-rating, would be conducted as directors considered they were unable to provide meaningful, accurate peer assessments in all areas.

Skills Map Summary

The Board has a very strong competency profile versus its desired or aspirational state as highlighted in the Overall Competency Profile attached below.

This shows that it has sufficient, and in many cases a surplus, in 36 of the 39 identified qualities, skills and competencies. The collective competency mix across the four broad categories was assessed as:

Behavioural Qualities: Directors were peer-assessed as having strong competency in this area where 9 of the 10 competencies were at the desired level. All directors were peer-rated as competent or expert in every

category. Listening skills was the only category that did not meet the required standard where only one director was peer-rated as expert against a desired level of 5.

Directorial and Governance Skills: Directors were peer-assessed as having good competency in this area with all directors rated as expert or competent in every category. The desired competency level was met in 10 of the 12 categories and in most categories the Board has a much stronger overall competency than is required. There were however gaps apparent in Strategic and Governance Leadership and Effective Decision Making (including risk). All directors were peer-rated as competent or expert.

Technical Skills and Experience: The self-assessments undertaken indicates that the Board has an abundance of skill and experience in nine of the eleven categories and a minor shortfall in the Finance and Legal categories, where we have one expert in each category versus a desired number of two.

Health Sector Knowledge: The Board has an abundance of skill in this area with all six categories being self-assessed as having substantially more knowledge that the minimum required levels.

While it is not appropriate to disclose individual Director's assessments, the overall Board Competency Assessment is copied below.

NZ HEALTH PARTNERSHIPS

NEW ZEALAND HEALTH PARTNERSHIPS LTD

Director Competency Assessment

Board View of Desired v Current State

Competency		Importance	Minimum Strength Required	Breakdown of Ratings					
				Desired	Current	E	C	L	N
Behavioural Qualities	Team player / Collaborative	Extreme	Competent	5	7	3	4	0	0
	Integrity and High Ethical Standards	Extreme	Expert	5	7	7	0	0	0
	Common Sense and Sound Judgement	Extreme	Competent	5	7	4	3	0	0
	Interpersonal Relations	Extreme	Competent	5	7	4	3	0	0
	Verbal Communications	Extreme	Competent	5	7	2	5	0	0
	Listening Skills	Extreme	Expert	5	1	1	6	0	0
	Courage Willing / Able To Challenge And Probe	Extreme	Competent	5	7	2	5	0	0
	Energy /Time for the Role and Reliability	Extreme	Competent	5	7	2	5	0	0
	Emotional Agility And Resilience	Important	Competent	5	7	3	4	0	0
	Capacity to learn and grow	Important	Competent	5	7	0	7	0	0
Director/ Governance Skills	Strategic and Governance Leadership	Extreme	Expert	5	1	1	6	0	0
	Effective Decision Making Including Risk	Extreme	Expert	5	2	2	5	0	0
	Stakeholder Communication	Extreme	Expert	2	2	2	5	0	0
	Finance	Extreme	Expert	2	1	1	6	0	0
	CEO Selection / Monitor / Evaluation	Extreme	Expert	2	1	1	6	0	0
	Project Governance	Extreme	Expert	2	2	2	5	0	0
	Focus On Delivering Value	Extreme	Expert	2	1	1	6	0	0
	Mentoring Skills	Important	Competent	2	7	0	7	0	0
	Monitoring	Important	Competent	2	7	2	5	0	0
	Compliance	Important	Competent	2	7	1	6	0	0
	Policy Frameworks	Important	Competent	2	7	0	7	0	0
	Networking	Important	Competent	2	7	1	6	0	0
Technical Skills & Experience	Commercial / Business Experience And Acumen	Extreme	Expert	3	6	6	1	0	0
	Strategic Development And Implementation	Important	Expert	2	2	4	3	0	0
	Finance	Important	Expert	2	1	1	4	1	0
	Law	Important	Expert	2	1	1	3	3	0
	Information Technology	Important	Expert	2	2	2	4	1	0
	Risk Management	Important	Competent	2	7	3	4	0	0
	Human Resource Management	Important	Competent	2	7	2	5	0	0
	Management Experience In Substantial Orgs	Important	Competent	2	4	3	1	3	0
	Contemporary Corporate Governance	Important	Expert	2	3	3	4	0	0
	Procurement And Supply Chain	Moderate	Competent	2	4	1	3	3	0
	Data Analytics	Important	Competent	2	5	2	3	3	0
Industry	Health Management / Administration	Important	Limited	1	7	2	2	3	0
	Consumer Advocacy / Stakeholder Engagement	Important	Competent	1	6	3	3	1	0
	Outsourcing And Shared Services	Important	Competent	1	6	2	4	1	0
	Government & Stakeholder Management Lobbying	Important	Expert	1	3	3	2	2	0
	Financial Services Industry	Moderate	Competent	1	4	0	4	3	0
	Electronic Commerce	Moderate	Competent	1	3	1	2	4	0

Key:

(Expert - of 7 peers, 5 rated expert and 2 as competent
(Competent - of 7 peers, 5 rated competent or above
((Limited - of 7 peers, 3 rated as limited or below
(None - not applicable
Each Director self-rated, no peer-assessment was conducted

Appendix 3 – Resolution:

On behalf of my DHB, I approve the reappointment of NZ Health Partnerships' Independent Directors for the terms outlined in the attached letter.

Signed for and on behalf of:

AUCKLAND District Health Board by:

Gwen Tepania-Palmer

OR

_____

Signature
Position: Director

Signed for and on behalf of:

AUCKLAND District Health Board by:

Patrick Snedden

_____

Signature
Position: Chair

Signed for and on behalf of:

BAY OF PLENTY District Health Board by:

Sally Webb

_____

Signature
Position: Chair

Signed for and on behalf of:

CANTERBURY District Health Board by:

John Wood

_____

Signature
Position: Chair

Signed for and on behalf of:

CAPITAL & COAST District Health Board by:

Andrew Blair

_____

Signature
Position: Chair

Signed for and on behalf of:

COUNTIES-MANUKAU District Health Board by:

Hon Vui Mark Gosche

_____

Signature
Position: Chair

Signed for and on behalf of:

HAWKE'S BAY District Health Board by:

Kevin Atkinson

_____

Signature
Position: Chair

Signed for and on behalf of:

HUTT VALLEY District Health Board by:

Andrew Blair

_____

Signature
Position: Chair

Signed for and on behalf of:

LAKES District Health Board by:

Deryck Shaw

_____

Signature
Position: Chair

Signed for and on behalf of:

MIDCENTRAL District Health Board by:

Dorothy McKinnon

_____

Signature
Position: Chair

Signed for and on behalf of:

NELSON MARLBOROUGH District Health Board by:

Jenny Black

_____

Signature
Position: Chair

Signed for and on behalf of:

NORTHLAND District Health Board by:

Sally Macauley

_____

Signature
Position: Chair

Signed for and on behalf of:

SOUTH CANTERBURY District Health Board by:

Ronal Luxton

_____

Signature
Position: Chair

Signed for and on behalf of:

SOUTHERN District Health Board by:

Kathy Grant

_____

Signature
Position: Commissioner

Signed for and on behalf of:

TAIRAWHITI District Health Board by:

David Scott

_____

Signature
Position: Chair

Signed for and on behalf of:

TARANAKI District Health Board by:

Pauline Lockett

_____

Signature
Position: Chair

Signed for and on behalf of:

WAIKATO District Health Board by:

Sally Webb

_____

Signature
Position: Acting Chair

Signed for and on behalf of:

WAIRARAPA District Health Board by:

Sir Paul Collins

_____

Signature
Position: Chair

Signed for and on behalf of:

WAITEMATA District Health Board by:

Kylie Clegg

_____

OR

Signature
Position: Deputy Chair

Signed for and on behalf of:

WAITEMATA District Health Board by:

Professor Judy McGregor

_____

Signature
Position: Chair

Signed for and on behalf of:

WEST COAST District Health Board by:

Jenny Black

_____

Signature
Position: Chair

Signed for and on behalf of:

WHANGANUI District Health Board by:

Dorothy McKinnon

_____

Signature
Position: Chair

Significant Programmes/Projects

Medical School: no report.

MEMORANDUM TO THE BOARD
22 AUGUST 2018

AGENDA ITEM 11.2

MENTAL HEALTH & ADDICTIONS SERVICE (MH&AS) FACILITIES AND SERVICE REDEVELOPMENT PREFERRED WAY FORWARD

Purpose	For approval.

A series of business case documents have or are being developed using the NZ Treasury (National Infrastructure Unit) Better Business Case requirements of a Five Case Model. This being the New Zealand Government accepted good practice standard for investment and understanding of the need for change to something different. Progress to date includes:

i. The Creating Our Futures Programme Strategic Assessment was approved by the Waikato DHB Board and submitted to the Ministry of Health for presenting at the 8 June 2017 Capital Investment Committee meeting [endorsed to proceed to the next stage].

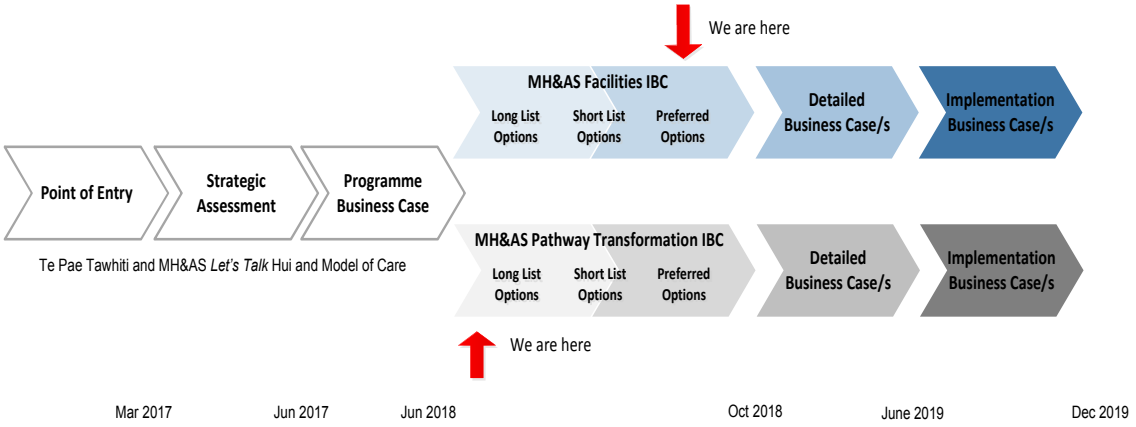
ii. The Creating Our Futures Programme Business Case was approved by the Waikato DHB Board and submitted to the Ministry of Health for presenting at the 17 May 2018 Capital Investment Committee meeting [awaiting feedback].

iii. The Waikato DHB MH&AS Facilities and Service Redevelopment Indicative Business Case is in draft as it requires the Waikato DHB Board to consider and approve the preferred way forward option/s. The purpose of this Memorandum.

iv. The business case indicative financial information was provided to the Ministry of Health for their collation and presentation to the Capital Investment Committee national assessment management plan, 21 June and 12 July 2018 meetings [awaiting decision regarding outcome of discussion].

v. The Waikato DHB MH&AS Pathway Transformation Indicative Business Case is in the discovery phase, with the long list options process being undertaken on 16 August 2018 with a wide and varied group including service users, whanau, service providers and other experts.

Business case progress to date.



Waikato DHB MH&AS Facilities and Service Redevelopment Project – Business Case

The Waikato DHB's Mental Health and Addictions service has implemented a number of significant changes since the *A Time for Change* 2009 review. The desire for services to reflect recovery best practice and deliver safe and effective therapeutic care is an ongoing tension. The ability to fully implement and sustain change is fundamentally limited by the physical structure of the existing Henry Rongomau Bennett Centre (HRBC) building. The facility is described as providing an environment which is institutional, is dark and depressing, and does not meet contemporary standards. The Ministry of Health Section 99 (s99) inspection team believe that a contemporary service model involving the construction of new purpose built hospital and community facilities should be considered. This should provide a more efficient use of recurrent funds and provide a greater array of inpatient treatment options for service users who present with increasingly complex and diverse needs.

> *"… despite considerable effort to improve the HRBC environment, [the facility] did not meet a significant number of basic contemporary standards. Further, it was the view of the review team that the capacity of the service to develop new and potentially more efficient and effective models of service was being constrained by the need to deliver services in the existing facility (MoH s99 report, 2016)."*

To date a series of workshops (refer appendix 1) have been undertaken to identify and assess the investment requirements for the Waikato DHB MH&AS Inpatient Infrastructure. Key stakeholders developed a long list of possible options for addressing the change requirements for Acute Mental Health, Multiple and Variable Needs (including specialty services) and Regional Forensic Puawai services. These options have been assessed against the Model of Care principles and the investment Critical Success Factors to determine a short list of options.

Prior to 9 July 2018 workshop, eleven (11) acute mental health options were identified by stakeholders for examination, discussion and a final recommendation to the DHB's Board.

The eleven options can be catagorised as

- 1 x Base Case or status quo (refurbishment undertaken) option.
- 3 x Waiora Hospital campus options.

- 3 x Strategic Alliances with other DHBs (Auckland & Midland) options.
- 2 x Green Field (including a rebuild of Tokanui) options.
- 2 x Externally provided options.

A facilitated workshop with key stakeholders was held on 9 July 2018 with the purpose of amalgamating the short list options (refer appendix 2) for each of the service areas into a single option for consideration by the Waikato DHB Board. In order to ensure improvements for equity of access and outcomes for Māori health this amalgamation included an assessment of each of the short list options against Māori Equity Dimensions (initially developed by Te Puna Oranga) and progressed by the workshop participants.

A traditional base case / do nothing option is not feasible for the Waikato DHB as all credible options required a new fit-for-purpose facility/s to be provided to care for service users. As such, an option of *do minimum* refurbishment of current facilities was examined in the long list assessment process (the do minimum option was the lowest ranking score and was scored *no benefit* for each of the five investment benefits).

Key stakeholders reduced the long list of 11 Acute Mental Health options down to three variants to be considered in relation to the Multiple and Variable Needs (or specialty services) and Puawai increased capacity requirements.

On the basis of this assessment and having regard to the recommendations of workshop participants the following is recommended for Board approval.

Recommendation
THAT
The Board:
Approve the MH&AS Facilities and Service Redevelopment preferred way forward recommendations for inclusion within the Indicative Business Case:

1) Agreement to progress an onsite Main Waiora Hospital Campus for acute inpatient service development.
2) Agree Multiple and Variable need inpatient and rehabilitation specialty services occur closer to home, and alternatives to inpatient and specialist development/s be explored, these include: Potential regional solutions and onsite facilities adjacent to proposed acute inpatient facilities.
3) Agree that community based sub acute and outreach options are developed based on the principles of closer to home, better partnerships with Non-Government Organisations and other providers (more detail on Greenfields, Private Public Partnership [PPP] and Public Private Iwi Partnership [PPIP] need to be explored as procurement options).
4) Agree that additional Forensic Psychiatric beds will be required within HRBC, given the increased prison population.

NB: The Department of Corrections have already indicated early plans for a 100 bed Mental Health Facility in the region. While there has been no confirmation (yet) of the specific services the facility will deliver, there are both significant risks and opportunities for MH&AS. It is essential local Forensic and Mental Health and Addiction services remain engaged and involved in the planning process for this unit. The possibility of an inter-sectoral strategic alliance between

Corrections and Waikato DHB to support mental health services to patients within Corrections custodial services is on the horizon and is being worked through with Corrections. Any future relationship between the parties will be brought back to each entities governance levels for approvals.

VICKI AITKEN
EXECUTIVE DIRECTOR (INTERIM) MENTAL HEALTH & ADDICTIONS SERVICES

IAN WOLSTENCROFT, EXECUTIVE DIRECTOR, WAIKATO DHB STRATEGIC PROJECTS

- Detail of the engagement Hui is attached as Appendix 1.
- Detail of Short List Development is attached as Appendix 2.
- Detail of Capex and Opex costing is attached as Appendix 3.
- Next steps in preparing Indicative Business Case (IBC) is attached as Appendix 4.

Appendix 1

Let's Talk – Engagement Hui

Let's Talk is the description the Waikato DHB Mental Health & Addiction service (MH&A service) and the Strategy and Funding service have used for community engagement to inform improvements to MH&AS service. The Iwi Māori Council provided advice on engagement with Māori and specifically in five key regions:

- North Waikato
- Hauraki
- South Waikato
- Maniapoto
- Ruapehu.

The engagement team has worked in partnership with Māori service providers in each of these regions to ensure the best and most appropriate methods were used to reach and encourage Māori participation.

Personal invitations to attend engagement hui were sent to:

- Waikato DHB Regional and local Mayors and District Councillors
- Members of the Iwi Māori Council and the Waikato DHB Board.

Notifications and invitations were also emailed to GP practices, medical centres, police, schools and other agencies.

Fifty six community hui have been held around the Waikato DHB region where 1,004 people (43% of attendees who identified as Māori) have shared their experiences of using MH&AS service. These hui were conducted jointly by the Creating our Futures and Te Pai Tawhiti programmes. The information from these hui will become a key contributor to informing improvements to MH&AS service.

From this feedback there are several key themes that stand out, for example:

- better support for whānau looking after loved ones
- the need for local services
- whānau ora as a model for MH&AS service delivery
- integrated and better joined up care with NGOs and the wider public sector
- improved access to crisis care and alternative options in rural communities. (e.g. local points of access)
- recognition of the pressure on rural whānau taking their loved ones to hospital and visiting them
- support for GPs to be local leads in supporting and treating tangata whaiora
- alternative treatments to medication
- te whare tapa wha be investigated as a framework.

Engagement hui statistics:

- Over 1,000 people have participated in the engagement process. As at today's date 226 completed online surveys have been received, 148 people gave feedback on butcher paper at hui events and 742 tangata whaiora and whānau have provided feedback on their service experience via Real Time Feedback[1].
- 56 hui meetings have been held. As well as the community hui, this figure includes 19 meetings for staff of the MH&AS service, and meetings for focus groups representing tangata whaiora, rangatahi and the LGBTIQ+ community
- 450 people attended Iwi Māori Council directed hui
    - 41% of these attendees identified themselves as Māori[1]
- 1,004 people attended all hui overall
- 43% of total attendees at all hui identified themselves as Māori.

Alternative options to provide feedback were available for people who were unable to attend or speak at an organised hui. For example: an online survey (226 completed surveys received), record their comments on butchers paper at engagement hui, provide feedback via one-on-one or smaller group discussion and a Let's Talk email for written feedback/submissions.

A significant amount of feedback data has been received and in many cases includes general feedback on health services. All information and feedback gathered with this engagement process will be included within the analysis.

Feedback analysis

A robust qualitative analysis will be undertaken at the conclusion of the hui. The analysis will include narratives from the hui and MH&AS Real Time feedback. This analysis will include a naturalistic inquiry methodology using grounded theory and thematic analysis. In order to offset bias and to validate and sort the data, a diverse group of individuals with a range of perspectives will analyse the raw data.

Appendix 2

Short List Development

Option Summary	Description
Waiora Main Campus New Acute MH Build	New fit-for-purpose holistic build on Waikato Hospital campus. Purpose built holistic, flexible and modular build on Waikato Hospital campus Ryburn site or other identified site.
Waiora Main Campus and Out Reach Sub-Acute New MH Builds	New fit-for-purpose Acute build on Waikato Hospital campus and new out-reach Sub-Acute builds - Purpose built holistic, flexible and modular acute facility build on Waikato Hospital campus Ryburn site or other identified site. - Purpose built sub-acute community facilities in Hamilton and main rural north and rural south locations.
New Acute MH Green Fields Build/s	- Development of a holistic, flexible and modular build on green field site/s.
Multiple and Variable Needs Colocation with Acute MH in New Build	New holistic Main Waikato Hospital (option 1) footprint includes capacity to meet requirements for service provision. - alcohol and other drugs - cognitive impairment - high and complex needs - youth - eating disorders - peri-natal
Multiple and Variable Needs Repurpose of HRBC(on existing adult footprint)	Rebuild of existing adult HRBC ward to meet the service needs. - alcohol and other drugs - cognitive impairment - high and complex needs - youth - eating disorders - peri-natal
Multiple and Variable Needs Joint Ventures with Midlands Regional DHBs	Development of new joint venture/s with regional Midlands DHB(s) for specialty services. - alcohol and other drugs - cognitive impairment - high and complex needs - youth - eating disorders - peri-natal
Puawai HRBC Rebuild (on existing adult footprint)	Rebuild of existing adult HRBC ward to meet the increased prison muster capacity.
Puawai Joint Venture with NZ Corrections	Joint venture with co-locating MH&AS service facilities within NZ Corrections prison/s sites.

Key stakeholders undertook a further assessment of three multiple and variable needs (or specialty services) and three Puawai increased capacity options were undertaken separately. On the basis of the above analysis, the short-listed options were assessed against the Critical Success Factors to rule out impractical and uneconomic options. The Critical Success Factors include:

- Strategic Fit: the likely success of the facility and the alignment of the option with DHB and MH&AS Strategic Plans, mental health guidelines and other requirements and directives.
- Service User Outcomes: how well the option facilitated meaningful service user engagement and outcomes.
- Integration; how well the facility integrated with existing service provision locally and regionally and the new Model of Care.
- Adaptability and Sustainability: how quickly and efficiently the option can adapt to future demand, values and need.
- Transitional Feasibility: how much disruption is caused to staff and service users during implementation?
- Workforce engagement: how well the option increases staff engagement, retention and performance.
- Value of for money: how well the option achieves economy, effectiveness, and efficiency and is financially viable and sustainable.
- Equity for Maori: how well the option achieves equity of access, engagement and outcomes for Maori

The following table presents the short list of options Critical Success Factors Assessment to determine the options that achieve the investment objectives in a way that is likely to achieve the Project Benefits.

Short List Options Critical Success Factors Assessment

	Waiora Main Campus New Acute MH Build	Waiora Main Campus and Out Reach Sub-Acute New MH Builds	New Acute MH Green Fields Build/s	Multiple and Variable Needs Colocation with Acute MH in New Build	Multiple and Variable Needs Repurpose of HRBC	Multiple and Variable Needs Joint Ventures with Midlands Regional DHBs	Puawai HRBC Rebuild (Adult)	Puawai Joint Venture with NZ Corrections
Unweighted score	243	428	271	288	266	242	279	186
Unweighted ranking	3	**1**	2	**1**	2	3	**1**	2

The preferred way forward

On the basis of the above analysis, the recommended preferred way forward was arrived at.

It is proposed that these options are also taken to Detailed Business Case, noting that each/some of these options has/have additional costs related to the need to relocate services and also replacement of current staff car parking at the Waiora Waikato Hospital main campus.

Appendix 3

The tables below summarises the indicative CAPEX costings and OPEX projected operating costs based on the total Waikato DHB inpatient service:

Indicative CAPEX summary costings

	Inpatient Beds	$ millions
Acute MH Beds (inclusive of subacute outreach)	90 Beds	$96 m
Acute MH Bed	70 Beds	$80 m
Rural Outreach	20 Beds	$31 m
Acute MH and High and Complex needs	82 Beds	$88 m
Multiple and Variable Needs – Specialty services (HRBC Refurbishment)	22 Beds	$21 m
Multiple and Variable Needs – Specialty and High and Complex Needs (HRBC Refurbishment)	34 Beds	$25 m
Puawai	20 Beds	$13 m
Greenfields Site (excludes outreach)	104 Beds	$150 m

Indicative inpatient service operating costs to 2043

	2018	2022	2028	2035	2043
Total Inpatient Beds*	119	183	192	197	214
Total FTEs	355.7	551.4	575.9	589.2	641.7
Total OPEX Costs	$42,944,493	$77,188,300	$81,860,183	$82,257,336	$87,253,289

* Includes Acute MH (and proposed outreach), Multiple and Variable Needs, Puawai, MHSOP, and Internal Bureau

All figures are preliminary at this stage and will be subject to detailed testing and analysis to be presented in the Detailed Business Case stage further through the process. One level of detail yet to be revealed is the hurdle costs of change from one practice and service model to the preferred model/s currently under consultation.

Affordability remains a significant issue for the Waikato DHB, given the current financial outlook. However, the alternative of no investment in these services would have a significant negative impact on the population with regard to access to services, matters of equity, Maori health gain, societal risks, clinical risk, service user safety and outcomes, as well as the broader health system and population health.

Codicils on the Indicative CAPEX summary costings:

1. The summaries in the table are based on scope and estimated costs of the Counties Manukau facility as tendered last year.
2. It was based on a January 2019 construction start which will now not occur and hence further escalation will be a factor.
3. The Strategic Projects Office office is aware of additional scope (particularly security) being demanded by Counties Manukau staff that has increased costs by several millions.

4. If the preferred way forward is designated on the Waiora Campus as a single storey structure, it is extremely likely that the existing Renal Service building will need relocation, and their current building demolished. These costs are not included in the current summary.
5. If the Rheumatology Service is to be relocated to its own designated facility, this cost is not included.
6. Relocation and removal of the IT service and it's building are not included.
7. The provision of replacement car parks to maintain resource consent provisions (up to 100 parks) are not included.
8. Implications of the current Waikeria Prison announcement is not assessed or included.
9. Other costs either of a Capital or Opex nature are not included in this Report but should be the subject of cost noted in other Creating our Futures Business Cases. These are:
    a. Management of bow-wave as the service converts from current practice to future.
    b. New service configuration yet to be tested and completed.
    c. Commissioning of services yet to be tested Note: Building commissioning is included.
    d. Future staffing requirements.
    e. IT application costs and infrastructure outside the norm.
10. There is no capital costing for construction that maybe leased to an NGO other than what is termed *Rural Outreach.*
11. Escalation costs that arise in initiating the whole programme of works i.e. the costs related to having resources engaged while not actually executing the developments of construction and transformational development of services due to delays in the business case approvals, procurement of contractors and project resources.

Appendix 4

Next steps in preparing the Indicative Business Case (IBC)	Completed
Waikato DHB Board confirmation and approval of the Preferred Way Forward	August 2018
Review and propose Creating Our Futures Programme Board membership; principles of governance; and, structure to ensure a partnership model	September 2018
Māori Equity Group commenced (indicative phase) a) progress the equity dimensions framework b) review and provide input into the MH&AS Facilities & Service Redevelopment IBC from a Māori equity perspective c) review and provide input into the MH&AS Pathways Transformation deliverables from a Māori equity perspective	Ongoing
Let's Talk hui analysis in partnership with Te Puna Oranga	Ongoing
Continue the mental health and addictions Pathway Transformation work effort	November 2018
Progress the MH&AS Facilities & Service Redevelopment IBC and ensure its alignment and fit with the future pathway transformation destination	IBC draft completed November 2018
Presentation of the Pathway Transformation and Facilities Indicative Business Case to Waikato DHB Board	28 November 2018

Papers for Information

No Information papers.

Presentations

No presentations.

Board Member Items

Car Parking Pay Stations (report due in September).

Living Wage (report due in September).

Next Board Meeting: 26 September 2018.