DISTRIBUTION

Board Members

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

Executive Management Team

- Mr D Wright, Interim Chief Executive
- Mrs V Aitken, Interim Executive Director, Mental Health & Addictions Service
- Ms L Aydon, Executive Director, Public and Organisational Affairs
- Mr C Cardwell, Executive Director, Facilities and Business
- Ms M Chrystall, Executive Director, Corporate Services
- Ms L Elliott, Executive Director, Maori Health
- Mr N Hablous, Chief of Staff
- Mr D Hackett, Executive Director, Virtual Care and Innovation
- Mrs S Hayward, Chief Nursing & Midwifery Officer
- Dr G Howard, Interim Chief Operating Officer, Waikato Hospital
- Prof R Lawrenson, Clinical Director, Strategy and Funding
- Ms T Maloney, Interim Executive Director, Strategy and Funding
- Ms M Neville, Director, Quality & Patient Safety
- Mr M Spittal, Executive Director, Community & Clinical Support
- Dr R Tapsell, Acting Chief Medical Advisor
- Mr M ter Beek, Executive Director, Operations and Performance
- Dr D Tomic, Clinical Director, Primary and Integrated Care
- Mr I Wolstencroft, Executive Director, Strategic Projects

Contact Details:
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Next Meeting Date: Tuesday 24 April 2018

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

Agenda

Board

Date: **28 March 2018**

Time: **2pm**

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

Meeting of the Waikato District Health Board

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

AGENDA

Item

1. Apologies

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

3. **MINUTES AND BOARD MATTERS**
- 3.1 Board Minutes: 28 February 2018
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 1 March 2018
  - 3.2.2 Maori Strategic Committee: 21 March 2018
- 3.3 Terms of Reference and Agendas of Committees

4. **INTERIM CHIEF EXECUTIVE REPORT**

5. **QUALITY AND PATIENT SAFETY**

6. **FINANCIAL PERFORMANCE MONITORING**
- 6.1 Finance Report

7. **HEALTH TARGETS**

8. **HEALTH AND SAFETY**

9. **SERVICE PERFORMANCE MONITORING**
- 9.1 Waikato Hospital Services
- 9.2 Mental Health and Addictions Service
- 9.3 Community and Clinical Support (report due in April)
- 9.4 Strategy and Funding (report due in April)
- 9.5 Operations and Performance (report due in May)
- 9.6 People and Performance (report due in May)
- 9.7 Infrastructure (report due in May)
- 9.8 IS (report due in May)

10. **DECISION REPORTS**
- 10.1 Delegations of Authority Policy Renewal
- 10.2 Waikato DHB Demographic Model for the 10 Year Health Systems Plan
- 10.3 Ethnicity Based KPI Reporting

11. SIGNIFICANT PROGRAMMES/PROJECTS

- 11.1 Virtual Health (no report this month)
- 11.2 Medical School (no report this month)
- 11.3 Creating our Futures
  - 11.3.1 Programme Business Case – Strategic Assessment
  - 11.3.2 Additional Programme Resourcing

12. PAPERS FOR INFORMATION

- 12.1 2018 Influenza Season

13. PRESENTATIONS

No presentations this month

14. NEXT MEETING: Tuesday 24 April 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 28 March 2018 (Items taken with the public excluded)**
- **(ii) Sustainability Advisory Committee – to be adopted: Wednesday 28 February 2018 (All items)**
- **(iii) Remuneration Committee – to be adopted:**
  Wednesday 28 June 2017 (All items)
  Tuesday 4 July 2017 (All items)
  Wednesday 12 July 2017 (All items)
  Friday 4 August 2017 (All items)
- **(iv) Midland Regional Governance Group – to be received: Friday 2 March 2018**

Item 16: Risk Register – Public Excluded
Item 17: Interim Chief Executive's Report – Public Excluded
Item 18: Options for Moving Forward with the HealthTap System – Public Excluded
Item 19: Current Status of Issues Identified in Relationship to Previous Chief Executive's Expenditure – Public Excluded
Item 20: Contemporary Challenges in Cardiology and the Genesis of Complaint – Public Excluded
Item 21: FY 2018/19 Capital Plan – Public Excluded
Item 22: Execution of Provider Agreements Exceeding Delegation – 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-iv): Minutes – Public Excluded		Items to be adopted / confirmed / received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 16:	Risk Register – Public Excluded	Avoid inhibiting staff advice about organisational risks	Section 9(2)(ba)
Item 17:	Interim Chief Executive's Report – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 18:	Interim Chief Executive's Report – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 19:	Status of issues with regard to the previous Chief Executive's expenditure – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 20:	Challenges in Cardiology and associated complaint – Public Excluded	Protect the privacy of the complainant	Section 9(2)(a)
Item 21:	FY 2018/19 capital plan – Public Excluded	Negotiation will be required	Section 9(2)(j)

Item 22:	**Provider agreements exceeding delegation – Public Excluded**	**Negotiation will be required**	**Section 9(2)(j)**

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

Item

15. MINUTES – PUBLIC EXCLUDED

15.1 Waikato District Health Board: 28 February 2018
To be confirmed: Items taken with the public excluded

15.2 Sustainability Advisory Committee: 28 February 2018
To be adopted: All items

15.3 Remuneration Committee: 28 June 2017, 4 July 2017, 12 July 2017, 4 August 2017
To be adopted: All items

15.4 Midland Regional Governance Group: 2 March 2018
To be received: All items

16. RISK REGISTER – PUBLIC EXCLUDED

17. INTERIM CHIEF EXECUTIVE'S REPORT – PUBLIC EXCLUDED

18. OPTIONS FOR MOVING FORWARD WITH THE HEALTHTAP SYSTEM – PUBLIC EXCLUDED

19. CURRENT STATUS OF ISSUES IDENTIFIED IN RELATIONSHIP TO PREVIOUS CHIEF EXECUTIVE'S EXPENDITURE – PUBLIC EXCLUDED

20. CONTEMPORARY CHALLENGES IN CARDIOLOGY AND THE GENESIS OF COMPLAINT – PUBLIC EXCLUDED

21. FY 2018/19 CAPITAL PLAN – PUBLIC EXCLUDED

22. EXECUTION OF PROVIDER AGREEMENTS EXCEEDING DELEGATION – PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

THAT:

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

Apologies.

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO MARCH 2018

Sally Webb

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

Crystal Beavis

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

Sally Christie

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

Note 1: Interests listed in every agenda.

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

Martin Gallagher

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

Mary Anne Gill

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

Tania Hodges

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

Note 1: Interests listed in every agenda.

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

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

Dave Macpherson

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

Pippa Mahood

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

Sharon Mariu

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

Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived
Director/Shareholder, Asher Group Ltd	Pecuniary	Perceived
Director, Hautu-Rangipo Whenua Ltd	Pecuniary	Perceived
Owner, Chartered Accountant in Public Practice	Pecuniary	Perceived
Daughter is an employee of Puna Chambers Law Firm, Hamilton	Non-Pecuniary	Potential
Daughter is an employee of Deloitte, Hamilton	Non-Pecuniary	Potential

Clyde Wade

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

Note 1: Interests listed in every agenda.

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

Conflicts related to items on the agenda.

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 28 February 2018 commencing at 2.00pm in the Board Room, in the Hockin Building at Waikato Hospital

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

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

ITEM 1: APOLOGIES FOR ABSENCE

There were no apologies for absence.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

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

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 24 January 2018

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 24 January 2018 taken with the public present were confirmed as a true and accurate record.

3.2 Committee Meeting Minutes

3.2.1 Iwi Maori Council: 1 February 2018

Resolved
THAT
The Board noted the minutes of this meeting.

3.3 Structure and Operation of the Board's Committees

Mr N Hablous attended for this item.

Mr Hablous explained that the Board members had attended a workshop on 14 February 2018 to discuss the structure and operation of DHB committees and frequency of meetings. The key recommendations reached at this workshop are set out in the recommendations shown below.

It was acknowledged that it would take time to implement some of the agreed changes.

Recommendation
THAT

1. The Waikato DHB maintains the existing non-statutory committees (Maori Strategic Committee, Sustainability Advisory Committee, Remuneration Committee and Audit and Corporate Risk Management Committee) and their existing membership subject to the change at 2 below.
2. The Remuneration Committee is retitled the Chief Executive Performance Review Committee.
3. The Performance Monitoring Committee is replaced with a Hospital Advisory Committee[1] (with terms of reference to be adopted at the March meeting).
4. The Health Strategy Committee is replaced with a Community and Public Health Advisory Committee (with terms of reference to be adopted at the March meeting).
5. The Community and Public Health Advisory Committee includes on each agenda a dedicated disability section which concentrates

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

on matters falling within the scope of a Disability Support Advisory Committee as stated in the legislation.

6. The terms of reference to be provided in March are broadly as outlined at the workshop in that they are modified version of the legislative purpose but incorporating the decisions that follow below.
7. The Hospital Advisory Committee and the Community and Public Health Advisory Committee meet every second month as at present.
8. The membership of the Hospital Advisory Committee (including chair and deputy chair) is as for the current Performance Monitoring Committee, and the membership of the Community and Public Health Advisory Committee (including chair and deputy chair) is as for the current Health Strategy Committee, noting that further discussion will occur on consumer representation or otherwise.
9. Monitoring (defined as reports for information and achievement against targets and KPIs) no longer occurs at the Hospital Advisory Committee and the Community and Public Health Advisory Committee.
10. The preferred suite of monitoring information is broken down into a number of segments and one is provided to the Board each month to achieve a complete cycle every three months.
11. Monitoring reporting is reduced in total volume.
12. The Chief Executive for the Board and the supporting executives for the Hospital Advisory Committee and Community and Public Health Advisory Committee respectively report by exception on what is bothering them in their portfolios to supplement the reduced monitoring reporting (style can be idiosyncratic; intent is to share/explore issues with a view to helping resolve them and allow the committee to provide support).
13. The Board's strong preference is to remain strategic at both committees and the Board noting the approach to monitoring/reporting described above.
14. Without attempting to define exhaustively what the content of strategic reporting will be the Board envisages it will cover dimensions such as:
    a. Integration between Waikato DHB services and services delivered by others;
    b. Implementation of our strategy;
    c. Risk.
15. As a proxy for defining the strategic content of committee agendas and the Board agenda in the short term, the executives supporting the committees and the Chief Executive in relation to the Board, will as soon as possible meet with their chairs and convene workshops with their committees/Board to determine (working drafts for) the content of agendas for the next 18 months through to the 2019 elections (the committees should perhaps go first and the Board conclude the process with the results of the committee exercise to hand).
16. The chairs of the main committees (including of those committees not explicitly required by statute) meet regularly to help ensure alignment (Chief Executive PA to provide appointments).
17. The Board's agenda in general covers the following:
    a. The Chief Executive's report as "real-time" assessment of present issues;

b. Adoption or otherwise of committee advice;
c. Monitoring as described above;
d. High level Quality and Patient Safety reporting as the raison d'etre of the delivery part of the organisation;
e. Health and Safety reporting;
f. Global financial performance;
g. Workshopping unformed issues;
h. External relationships, stakeholder management and understanding the aspirations of key sector players;
i. Any issues whose timing precludes committee review;
j. Waikato Medical School;
k. SmartHealth/Virtual Health Strategy;
l. Significant multi-dimensional business cases.

18. The assumption is that items go to the committees unless there is good reason for them to go to the Board rather than the other way around.
19. The committees do not have delegated authority.
20. It is noted that executive support for the statutory committees will flow from the Chief Executive's restructure proposal and will be advised as soon as possible.
21. The Board determines oversight of which specific programmes and projects will fall within the scope of each of the three statutory committees either at the present meeting or over time.
22. The quality assurance framework (Director Quality and Patient Safety) comes to the Board as soon as possible.
23. The Board of Clinical Governance develops an approach to anticipating and maximising the chance of achieving the various (main) forms of accreditation and external compliance to which the organisation is subject and to ensuring the Board is kept informed on these matters.

3.4 Board Policies

Mr N Hablous attended for this item.

Two Board policies were presented to the Board member for their approval:

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

Board Remuneration and Expenses - an Amendment was suggested to one of the bullet points listed under 4.1 Payment of Board members and payment of expenses with this suggested amendment made the Board adopted the policies.

Training and Familiarisation for Board Members – it was noted that appraisals had not been carried out for Board members for quite some time. It was agreed that they should be done at least once per term.

It was noted that induction is carried out on a regional or national level and not locally.

It was agreed that before the term of the next Board commences a formal induction process should be established for new Board members. A timeline would be agreed.

Resolved
THAT
The two Board policies "Board Remuneration and Expenses" and "Training for Board Members" were adopted for the current term of the Board.

3.5 Appointment of Directors to NZ Health Partnership Limited (NZHPL)

This was a new item and not shown on the Agenda.
Mrs Webb explained that at the next National Chairs' Meeting to be held on 8 March 2018, the Chairs would be asked to re/appoint directors to NZHPL. Mrs Webb asked that the Board provide their authority in advance of this meeting for her to reappoint directors to NZHPL.

Resolved
THAT
The Board gave their approval for Mrs Webb to reappoint directors to NZHPL.

ITEM 4: INTERIM CHIEF EXECUTIVE REPORT

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

- **HealthTap** – Ernst & Young had been appointed to undertake the evaluation. The review will involve:
  - a series of feedback and surveys from patients and clinicians; and
  - 20 dedicated stakeholder interviews from across the community, partner organisations and clinical staff.

  The outcome of the review will be presented to the May board Meeting.

- **Virtual Health Care Strategy Refresh Project Update**
  A refresh project began in October 2017. A new draft strategy would be presented to the Board in May 2018 ready for adoption by the Board in June 2018.

- **Planning for 2018/19** – still awaiting the Minister's letter of expectations. It is likely to be after the budget.

  Mr Macpherson expressed his dissatisfaction with regard to how Treasury calculate population figures and suggested the DHB seek an opportunity to challenge this. With regard to the census, Mr Macpherson noted there could be an issue with the statistical information if the population have problems completing the census forms electronically.

- **Coronial Support Services** – Waikato DHB is part of a joint bid to provide coronial services under a new contract that is due to commence in the first quarter of 2018/19.

- **Executive Restructure** – the Interim Chief Executive had received a significant amount of feedback concerning the restructure and is taking it into consideration before finalising the new executive structure.

- **Ten Year Services Plan** – a ten year services plan is to be developed by the end of this year.

- **Chief Medical Officer** – the vacant role has been advertised. Applications have been received from internal and external candidates.

- **Audit of the Universal Newborn Hearing Screening and Early Intervention Programme** – the Ministry of Health has confirmed that all corrective actions from the audit had been completed. The DHB has now achieved all the standards that were assessed during the audit.

Resolved
THAT
The Board received the report.

ITEM 5: QUALITY AND SAFETY REPORT

There was no report this month.

ITEM 6: DECISION REPORTS

6.1 Banking Services Supplier

Mr A McCurdie attended for this agenda item.

Waikato DHB will move its banking services supplier from Westpac to BNZ after the implementation of the National Oracle Solution (NOS). This means that an extension of the current Westpac contract was required from 28 March 2018 until 21 December 2018.

Resolved
THAT
The Board:

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

6.2 Replacement of Heart Lung Machines

Dr Grant Howard, Dr Gary Hopgood, Dr Nicholas Barnes and Joanne MacDonald attended for this item.

Approval was sought for two core critical heart lung machines and four arterial pumps to be replaced from capital expenditure.

Resolved
THAT
The Board:
1) Received the report.
2) Noted that $680k was on the approved capital expenditure plan.
3) Approved an increase in budget from $0.7m to $1.5m for 2017-18 noting that this could be managed within the overall capital plan.
4) Approved the capital expenditure of $1.5m to replace the three heart lung machines and four arterial pumps.
5) Approved that cash flow be from the current year.

6.3 Business Case: Surgical Assessment Unit at Level 8, Menzies Building Waikato Hospital

Dr G Howard attended for this agenda item.

A business case was tabled to approve the proposed redevelopment of level 8 of the Menzies Building to get the area to a usable standard and configured for 26 beds. It is intended that this ward be used as an Acute Surgical Assessment Unit and operational by July 2018 in time for the anticipated winter increase in bed demand.

Resolved
THAT
The Board approved the proposed redevelopment of level 8 of the Menzies Building and implementation of the linked model of care costed at:

- $1,561,254.00 - capital investment
- $5,214,585.00 - per annum for direct operational expenditure

Ms Hodges expressed concerns about this project and voted against the resolution.

6.4 Suicide Prevention and Postvention Intersectoral Workshop

Ms M Neville attended for this item.
The Board were updated on the current situation regarding suicide prevention and postvention in the Waikato District Health Board area.

Recent discussions held within the SPPHAG about setting a target that the DHB should work towards had settled on a zero suicide concept being considered.

It was proposed that a workshop would be held in April 2018 with local partners. Following discussion it was agreed that a way to create a different dynamic and bring more information into the group might be to widen the group of attendees so that it is not just government

agencies in attendance. Ms Neville said she would look at widening the group of local partners invited to the workshop.

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

ITEM 7: FINANCE MONITORING

7.1 Finance Report

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

- A total spend of $42 million was forecasted
- $66 million working capital facility

Resolved
THAT
The financial statements of the Waikato DHB to 31 January 2018 were received.

7.2 FY 18/19 Operating Budget and Capital Plan

Mr A McCurdie attended for this agenda item.

The first submission of the FY18/19 budget was due with the Ministry of Health on 2 March 2018.

The Board discussed and decided that the figure of $18.6 million was on the low side and they wanted to ensure that there was enough money to implement the strategy. It was agreed that $25 million was more realistic and this figure should include a list of caveats of what has not been included.

Resolved
THAT
The Board:
1) Received the report.
2) Approved the first budget submission to the Ministry of Health on 2 March of $25 million and to also include caveats of what has not been included in this figure.

7.3 Capital Charge Invoice Approval

Mr D Wright attended for this item.
A capital charge invoice for $18.6 million, received in early December was payable by 20 December 2017. In the absence of an available Board meeting, the Chief Executive contacted the Chair of the Board

to gain approval to pay the invoice. The invoice was paid after receiving approval.

Resolved
THAT
The Board:

1) Note the pre-approval given by the Chair outside an available board meeting to pay the December 2017 capital charge invoice.
2) Retrospectively approve the payment of the December 2017 capital charge invoice for $18,640,646.00
3) Provide the standing approval of full payment of all future capital charge invoices payable to Ministry of Health, subject to approval of the calculated amount charged by the Chief Financial Officer or Treasurer.

ITEM 8: PRESENTATIONS

8.1 Creating our Futures

Mrs V Aitken and Ms V Endres gave a presentation to update Board members on the Creating our Futures project.

Resolved
THAT
The Board received the presentation.

ITEM 9: PAPERS FOR INFORMATION

9.1 Health Targets

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

- Immunisation rates for 8 month olds had not been achieved for the quarter. A revised action plan showing proposed new work streams had been agreed. The action plan would be sent to the Ministry of Health.
- Raising Healthy Kids – Waikato DHB had been rated as an outstanding performer by the Ministry of Health this quarter.

Resolved
THAT
The Board received the report.

9.2 Provider Arm Key Performance Dashboard

The high level provider arm performance dashboards for January 2018 were tabled.

The Board asked if the health target measures could include an ethnicity indicator. Dr Howard said he would follow up on this and

look into the usefulness of providing this information on a regular basis.

Resolved
THAT
The Board received the report.

9.3 Provider Arm Key Performance Dashboard

The Strategy and Funding KPI Dashboard was tabled for the Board members information.

It was noted that Julie Wilson, Executive Director for Strategy and Funding had resigned from her position. The Board members requested that a letter be sent to Julie offering their thanks and acknowledging her service to the DHB.

Resolved
THAT
The Board received the report.

ITEM 10: NEXT MEETING

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

BOARD MINUTES OF 28 FEBRUARY 2018

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

THAT:

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

Item 11: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 24 January 2018 (Items taken with the public excluded).**
- **(ii) Sustainability Advisory Committee: 28 February 2018 (Verbal update all Items taken with the public excluded).**
- **(iii) Audit and Corporate Risk Management Committee: Wednesday 28 February 2018 (Verbal update all Items taken with the public excluded).**
- **(iv) Midland Regional Governance Group – Friday 2 February 2018 (All items to be received).**

Item 12: Risk Register – Public Excluded
Item 13: Interim Chief Executive Report – Public Excluded
Item 14: Proposal to conduct an expression of interest process – Public Excluded
Item 15: Mobile X-Ray Unit and Image Intensifiers – Public Excluded
Item 16: Ronald McDonald House – family and whanau – Public Excluded

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER	SECTION OF THE ACT
Item 11 (i-iv): Minutes	Items to be adopted/ confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 12: Risk Register	Avoid inhibiting staff advice about organisaitonal risks	Section 9(2)(c)
Item 13: Interim Chief Executive's Report	Negotiations will be required	Section 9(2)(j)
Item 14: Proposal to conduct an expression of interest process	Negotiations will be required	Section 9(2)(j)
Item 15: Mobile X-Ray Unit and Image Intensifiers	Negotiations will be required	Section 9(2)(j)
Item 16: Ronald McDonald House – family and whanau	Negotiations will be required	Section 9(2)(j)

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

Item 11:	**As shown on resolution to exclude the public in minutes.**
Item 12:	**Section 9(2)(a) of the Official Information Act 1982 – to Protect the Privacy of naural persons including that a deceased natural person**
Item 13 - 16	**Section(9)(2)(j) of the Official Information Act 1982 – to enable the Waikato DHB to carry on negotiations without prejudice or disadvantage**

ACTION LIST

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

	ACTION	BY	WHEN
	• Agenda item 3.2.1 Minutes of Iwi Maori Council – Tania Hodges suggested having a Board and Executive session/workshop on the Treaty of Waitangi. Will look at having an external facilitator.	Interim CE	
	• Agenda item 3.4 Board Policies – Training for Board Members – Appraisals for Board members will be organised to occur this year. • Establish a formal induction process for new Board members before the term of the next Board commences	Board Chair Interim CE	
	• Agenda Item 4 – Interim Chief Executive's Report – Planning for 2018/19 – on methodology to create a population model	Strategy & Funding	
	• Agenda Item 9.2 – Provider Arm Key Performance Dashboard – look at including ethnicity in the health target indicators	Interim CE	
	• 9.3 – Strategy & Funding Key Performance Dashboard – letter to Julie Wilson thanking her for her service to the DHB	Interim CE	
	• Agenda Item 17 – Ministerial Advisory Group – Dr Wade to email Derek Wright a list of Bullet Points – these points to be added as discussion points to the Committee agendas.	Dr Wade and Interim CE	

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Maori Council

Held: Thursday 1st March 2018 at 9.30am

Venue: Board Room, Hockin Building, Waikato Hospital

Present:	Mr H Mikaere	Chair
	Ms T Moxon	Deputy Chair
	Ms T Thompson-Evans	Waikato Tainui Te Whakakitenga o Waikato Inc
	Mr G Tupuhi	Hauraki Māori Trust Board
	Ms M Balzer	Te Rūnanga o Kirikiriroa
	Ms K Gosman	Tuwharetoa Māori Trust Board
	Mr B Bryan	Raukawa Charitable Trust
	Mr T Bell	Maniapoto Māori Trust Board
	Ms S Hetet	Maniapoto Māori Trust Board
	Ms T Hodges	Waikato DHB Board
	Ms P Mahood	Waikato DHB Board
	Ms L Elliott	Executive Director Maori Health
	Matua H Curtis	Pou Herenga Te Puna Oranga
	Ms S Greenwood	Minute taker

ITEM 1 **KARAKIA:** Matua H Curtis

ITEM 2 **MIHI:** H. Mikaere

ITEM 3 **APOLOGIES**

D. Wright, G. Roberts, Dr K. McClintock, K. Hodge

ITEM 4 **PRESENTATIONS**

4A **MENTAL HEALTH PRESENTATION –** V Aitken, R Lawrenson, R Tapsell, J Wilson, M Berryman

Te Pai Tawhiti

- First time for different approach and representations.
- **Key messages conveyed:** 1.) two processes started separately; 2.) good alignment and engagement at present.

Improvement Projects

- A new way of thinking around the system as a whole.
- Need something fit for purpose and meeting community needs.

IMC Advice

- Strong Maori engagement across five regions.
- More engagement from Maori providers
- Community advice – ask the community, reduce confusion.

Creating Our Futures

- Planned engagement meetings across five regions.
- Feedback around lack of coordination.

- Gaps in funding.
- Staff feedback.
- Online survey.
- Meeting with other community health networks.
- Advisory and focus groups and advisory meetings.
- Engagement to inform service and make improvements.
- Recognising issues in growth and adolescent groups.
- Need to make this work for Maori.
- A living document being referred to and revised.

Q1. *T Hodges asked what the essentials are given that funding is limited?*

A V Aitken replied that the whole focus should be around the community and model of care is an important part of the business case.

Q2. *M Balzer asked how can the mind set of staff be changed and what is the associated cost?*

A Through prevention and consultation; Primary versus community care; a shift in culture.

Q3. *H Mikaere asked what is the timeframe around this programme?*

A R Lawrenson replied that it will be 2-3 months before consolidation of the document, when they will bring it back to IMC for further consultation.

It was **NOTED:**

- Concern in development and lack of resources at community and primary level.
- Access is a huge area, resourcing communities.
- An investment strategy is needed.
-

H Mikaere **RESOLVES:**

- IMC carry out its role with the MOU, the WDHB and to promote and advocate.

4B **MAORI NURSING WORKFORCE PRESENTATION –** S Hayward, C Baker, F Blossom

- Majority graduates from Wintec.
- Retention has improved.
- Challenges include the number of students graduating (completing study).
- Strategies to prevent the number of graduates from decreasing.
- As a DHB the challenge is for Iwi Providers to provide new graduate places.
- New graduates are largely going to Tokoroa.
- Involved with employment partnerships with Wintec.
- Working to provide an end to end process.
- Hauora partnership group. Looking at how education is delivered and how we increase success for Maori students as registered nurses and how we support them culturally.

Members made the following comments:

- Recognising that a large potential workforce exists in rural communities.
- Concerns there is no integrated, multiple strategy.
- Can iwi providers carry all the risk and training without DHB support?

- Need a strategy that targets populations.
- Why Ora, starting with year 8/9 students and supporting and mentoring them through High School and into careers in health; currently 7000+ Maori students in 47 High Schools and Kura throughout the DHB Region ; whilst mentoring the students, the health and wellbeing of whanau is addressed.
- Raukawa don't have a huge workforce but they are all Maori and an aging workforce.

Q1. *T Thompson-Evans - how are we supporting Maori nurses and how is this monitored?*

A S Hayward responded with, self-review and to provide opportunities for nurses. Currently no solid cultural support. Will start to look at both qualitative and quantitative measures.

Q2. *T Hodges – how are you currently connecting with Kia Ora Hauora and what is the current volume of Maori nurses?*

A C Baker responded: We currently have an aging workforce so this is challenging.

Q3. *T Hodges - how are we proactive around recruiting Maori nurses, are we doing all we can do or are we the barrier to recruiting more Maori nurses?*

A S Hayward responded: All successful Maori candidates are offered a job however we aren't always the first choice for the candidate. We are currently losing 50% of candidates to their preferred choice.

4C HAUORA iHUB PRESENTATION – N Scott

Name chosen, builder appointed and location chosen for new Hauora iHub.

- A space with a Māori feels launching at the end of May 2018.
- Holistic model of care.
- There will be a clinical nurse specialist who will be developing models of care and assessing needs.
- To capture whanau who are visiting patients who would otherwise not receive health care, engaging those people in virtual healthcare and other services they may need.

Bowel Screening :

- Increase life expectancy
- Decrease inequities for Maori
- Aim to pilot a screening programme that screens Maori at a younger age.

ITEM 4 MINUTES OF LAST MEETING

- Nga Mangaru presentation in Feb 2018, clarify the speaker was Griff and not the WDHB or its representatives except where noted.

Minutes Passed
Received by: T. Thompson-Evans
Seconded by: M. Balzer

ITEM 5 GOVERNANCE

MSC meeting due to be held in Feb 2018 was cancelled.

ITEM 6 GENERAL BUSINESS

- Privacy Commissioner wanting to meet with IMC members on March 15th 2018 at 3.15 – 4.00pm.
- M.B would like to put her name forward as a replacement member of the MSC. In support: All. Objections: None.
- Hyperbaric chambers services opened on 27th February 2018. Awaiting contract with PHO. Copy of media statement presented to members.
- Recommended that the WDHB purchase a further hyperbaric chamber to prevent the removal of limbs or death from diabetes.
- Conflicts of interest register noted. Members to pass any conflicts to the minute taker to include in the next meeting.
- Think Tank. If we are putting models to the Crown what does this look like?

Resolved
THAT
Mere Balzer to replace Janise Eketone on the Māori Strategic Committee

ITEM 7 **Hui Closed:** Matua H Curtis at 12.25pm

Next IMC Hui: 9.30am 5th April 2018

	Action List	Completed	Who

1.	Summary of HSC agenda for commentary for IMC.		Te Pora
2.	A letter to be written on behalf of IMC Chair in support of the Treaty of Waitangi Tribunal Claim: Wai 1350. To cc: Health Minister and Sally Webb.		Harry/Glen
3.	Is there already a mental health nurse in ED?		Loraine
4.	Submit letter to Ministry from IMC on Maori Mental Health		Glen, Harry
5.	Dr N Scott requested from IMC who should we invite to the launch of the new Hauora iHub.		IMC members
6.	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 from diabetes.		IMC

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Māori Strategic Committee held on Wednesday 21 March 2018 commencing at 10:00am in the Board Room, Hockin Building

Present: Ms T Hodges (Chair)
Dr C Wade (Deputy Chair)
Ms S Christie
Ms T Thompson-Evan

In Attendance: Ms L Elliott
Mr D Wright
Mr H Curtis
Ms J Eketone
Mrs R Walker (Minutes)

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Mr Hemi Curtis

Ms T Hodges welcomed all attendees, with particular acknowledgement of Ms S Christie whose name would be presented at the next Waikato District Health Board meeting as a new Māori Strategic Committee Member.

Ms M Balzer was also a new committee member (appointed by Iwi Māori Council) who had replaced the vacancy left by Ms J Eketone who would now attend the Committee in her new role as Director Māori Health Strategy.

Action
Māori Strategic Committee Chair to table new membership (S Christie, M Balzer) to full Board for approval.

ITEM 2: APOLOGIES

Apologies were received from Mr D Macpherson, Ms T Moxon, Ms M Balzer, Mr G Tupuhi

ITEM 3: MINUTES OF 15 NOVEMBER 2017

Minutes moved and accepted.

ITEM 4: MATTERS ARISING FROM MINUTES OF 15 NOVEMBER 2017

No matters arose; however it was acknowledged that since the last meeting a number of areas had been positively progressed.

ITEM 5: PRIORITY 1.1 PROPOSED PROGRAMME OF WORK

Ms J Eketone provided an overview of the Proposed Programme of Work which was split into two areas:

- Seven priority areas that were new projects and would require new funding to proceed
- Seven priority areas that were or could be included as part as business as usual or work already under way that should not require new funding but may require funding redirected

Part Two

1. Tikanga best practice

The intention was this new one-day training (which would include a pōwhiri, Treaty of Waitangi, whanaungatanga, values which would also build in tikanga), would replace the induction programme. It would likely run about five times a year with a maximum of 250 staff per session at the university. The Business Case was well advanced with The University of Waikato. The initial focus would be for all new staff with current staff given a time frame to have signed up to induction day training within a 12 – 18 month period, and this will need to be negotiated with their respective Managers. Further consideration needed to be given to the delivery of the programme for staff not based in Hamilton with on line training and video conferencing as options of appropriate delivery methods or whether an interactive hands on approach was required. It was agreed that a pilot of the members of the Board, IMC, Consumer Council and executives would be a positive starting place once programme approved.

2. Ethnicity Data

Whilst the collection and reporting of ethnicity data was already mandatory, further work was required around ensuring the data was collected correctly and that consideration still needed to be given to the timing/location of the question (i.e. page 1 or page 3 as it currently is).

3. DNAs (Did Not Attends)

A co-ordinated system for the follow up and report for patients who did not attend outpatient appointments

Mr C Wade arrived at 10:10am.

4. Māori Health Plans

Services having Māori health plans are part of the current Māori policy, but have not been actioned.

5. Audit

Internal monitoring processes against Maori Health accountabilities. That is Māori Health plans, ethnicity data, induction training, and recruitment policies

6. HR policy, procedures, workforce leadership and KPIs

This was linked to PPP 1.4. Work was underway to change the language in the PPP so that when the Health Strategy was approved it can be reviewed and changed.

7. Proactive recruitment of Māori

Enabling the recruitment process and sitting KPIs to attract and employ Māori staff in all areas including medical, nursing, allied health, management. These staff would be supported with empowered career pathways.

Part One
*Community Development Projects (*two initiatives)
These projects are to be led by the community and should include not just primary health but should focus on wellbeing (environment, whanau), and should be focussed on prevention.

*WhyOra – Māori ran*gatahi and whanau

Puna – Māori strategic capability

Oranga Kaimahi

Harti Hauroa –Stage 2 implementation
Initial thinking in four priority areas.

Special projects
As the Māori Health Plan is developed, there will be projects identified for implementation. The intention is to tag some funding for special projects, yet to be identified, but contribute towards making radical improvements in Māori health.

General Discussion
- Business cases for "Tikanga Best Practice" and "WhyOra" projects were being finalised to be put forward to the DHB approval process at the beginning of April.
- The CE reminded members that the proposed programme of work needed to be discussed at the Executive Group prior to going to the Board for approval. Given the significant amount of proposed new funding required for Part One programmes, this will need to be considered as part of the 2018/19 budget planning where the Board will need to consider what things at a high level need to be stopped if they wish to approve any new funding. The programmes under Part 2 would also need to be "fleshed out" to ensure they could all be made operative within existing resources.
- A greater understanding was required as to why 42% of Māori (and 31% of non-Māori) were not attending their clinic appointments. Ms L Elliott, & Ms J Eketone will work with Dr C Wade and Ms T Thompson-Evan to see if they can be involved in a survey of patient's clinic attendance experiences. Whilst these may sit under Māori Health Plans consideration could be given to making it a new programme of work under Special Projects.
- Members were in favour of pilots of programmes being trailed prior to full programme roll outs.
- Measures of programme success need to be completed, recognising that overall success may not be seen in many programmes for a number of years.
- A number of the proposed services would require a wraparound service in order for them to be successful. It was suggested that consideration be given to a standalone wrap around service programme under the Special Projects heading.

Mr D Wright left the meeting at 10:55 am.

Resolved
THAT

The Committee:

1. Endorses the proposed programme of work for the Waikato DHB (led by Te Puna Oranga)
2. Supports the bid for funding of Part One activities for the 2018/19 year and beyond
3. In principle support Part Two activities to be actioned within existing resources and part of the core business of the DHB.
4. Notes the business cases for the proposed activities will be vetted via the organisational prioritisation framework P3M3 and the Executive Group

ITEM 6: PROGRESS UPDATE ON PRIORITY PROGRAMME PLAN FOR MAKING RADICAL IMPROVEMENTS IN MĀORI HEALTH

Ms L Elliot provided a progress update on this standard agenda item.

The chair reminded members that the plan needed to reflect radical improvements in Māori Health and should not be held back by existing templates, and the proposed programmes of work should then form *part* of that plan.

An update would be provided at the next meeting of plan progress.

PROGRESS UPDATE OCTOBER 2017 WORKSHOP

All three key ideas identified at the October 2017 workshop aligned with the Programmes of work and would be progressed once the Programmes of Work had been approved.

It was highlighted that Māori Health Plans had already been approved and that thinking should now be around how to move behaviour. The Chief Nursing and Midwifery Officer was supportive and would help progress if resourcing capacity was made available.

ITEM 7: GENERAL BUSINESS

<u>Consumer Council</u>
A request had been received from the newly formed Consumer Council to work with the Māori Strategic Committee. The chair was to advise the Consumer Council that once the Waikato DHB Board had discussed, she would clarify how in practice the two identities could work together

<u>Items for discussion at next meeting</u>
It was agreed to have a conversation at the next meeting on “How do we get radical improvement items rising to the top”.

ITEM 8: DATE OF NEXT MEETING

8.1 Date of Next Meeting

Wednesday 18 April 2018

ITEM 9: KARAKIA WHAKAMUTUNGA

Karakia by Mr Hemi Curtis.

Chairperson: _____

Date: _____

Meeting closed at 11:45 am

Programme of work – PART ONE		Timeline				Alignment				
	Proposed Activity	Mar 2018	Jun 2018	Nov 2018	Mar 2019	Waikato DHB Strategy Priority Clusters	System Level Measures (SLMs)	National Health Targets	Waikato DHB & IMC MOU	October 2017 Workshop
1	**Community Development Projects - Hauora/Wellness focus** Community development projects with a specific focus on hauora/wellness in Māori communities. Two projects developed and implemented in 2018/19 increasing number of projects and learnings each year.					1, 3, 6	1, 2, 3, 5, 6	4, 5, 6	1, 2, 3, 4,	--
2	**Community Development Projects - High need community focus** Community development projects with a specific focus on high need Māori communities. Six projects developed and implemented in 2018/19 increasing number of projects and learnings each year.					1, 3, 6	1, 2, 3, 5, 6	4, 5, 6	1, 2, 3, 4,	--
3	**WhyOra - Māori rangatahi and whānau** Targeted programme to pipeline Māori rangatahi into health workforce. This is complemented wrap around services to support rangatahi and their whānau.					1, 3, 5, 6	3, 6	--	1, 2, 3, 6, 7	--
4	**Puna - Māori strategic capability** Securing high level Māori strategic capacity and capability to support the leadership required to drive the implementation of the Māori strategic plan.					1, 2, 3, 4, 5, 6	--	--	1, 2, 3, 6, 7	--
5	**Oranga Kaimahi** A support for Māori health workforce across the Waikato DHB.					1, 5, 6	--	--	1, 2, 3, 6	--
6	**Harti Hauora – Stage 2 implementation** Targeted wrap-around service for priority groups accessing Waikato DHB services. For example, frequent flyers and those with chronic conditions. This programme links patients and whānau with the appropriate primary and community services.					1, 3, 6	1, 2, 3, 5, 6	4, 5, 6	1, 2, 3, 5	3
7	**Special projects** Projects to be determined as strategy is developed.					TBD	TBD	TBD	TBD	TBD

Programme of work – PART TWO		Lead Partners	Alignment				
	Proposed Activity		Waikato DHB Strategy Priority Clusters	System Level Measures (SLMs)	National Health Targets	Waikato DHB & IMC MOU	October 2017 Workshop
1	**Tikanga best practice** In partnership with the University of Waikato, this is a specific compulsory training for all Waikato DHB employees to be actioned at induction. The training package will enable high quality culturally appropriate and clinically effective services as stipulated by the Waikato DHB Māori health policy and as required by national practicing bodies. The training will also be open to other providers for their staff. It is envisioned that this activity will: • Provide baseline tikanga best practice knowledge across all staff. • Strengthen key stakeholder engagement: Strategic relationship building with both University of Waikato and other health providers. • Link with existing funding and development schemes such as Māori Provider Development Scheme, Kia Ora Hauora.	HR (link to PPP 1.4, cultural competency framework)	1, 2, 3, 6	3, 4	--	1, 2, 3, 6	--
2	**Ethnicity data** Mandatory collection and reporting of ethnicity data across the organisation.	Hospital Services, Community Health	1, 2, 6	1, 4, 6	1, 2, 3, 4, 5, 6	1, 2, 3	--
3	**DNAs (Did Not Attend)** A coordinated system for the follow up and support for patients who do not attend an outpatient appointment. Possible models: a. Centralisation at the Waiora Waikato Hospital with booking clerks. b. Locality/community based Equity Clinical Nurse Specialists. c. Te Puna Oranga managed service.	Hospital Services	1, 3, 4	2, 3, 4	2, 4, 5, 6	1, 2, 3	1
4	**Māori health plans** Every ward and service has a dedicated Māori health plan specific to their service contributing toward radical Māori health improvement.	Hospital Services, Community Health (link to PPP 1.4, service and team WOF)	1, 3, 6	1, 2, 3, 4, 5,6	1, 2, 3, 4, 5, 6	1, 2, 3, 5	2
5	**Audit** a. Internal monitoring processes against Māori accountabilities (i.e, Māori health plans, ethnicity data, induction training, hiring policies) b. External auditing to ensure alignment with strategic priorities, specifically as they pertain to Māori and radical Māori health improvement (Māori auditors with te reo Māori).	Hospital Services	1, 2, 3	3	--	1, 2, 3, 4	--
6	**HR policy, procedures, workforce leadership, and KPIs** Improve responsiveness in the organisation and workforce.	HR (link to PPP 1.4, Staff WOF)	1, 2	3	--	1, 2, 3, 6, 7	--
7	**Proactive recruitment of Māori** Enabling the recruitment process and setting KPI's to attract and employ Māori staff in all areas including medical, nursing, allied health, management. These staff would be supported with empowered career pathways.	HR, Medical, Clinical, Allied Health, Management etc	1, 2, 5	3, 4	--	1, 2, 3, 6, 7	--

* This proposed activity is in the Priority Programme Plan 1.4 – Enable workforce to deliver culturally appropriate services. Wording changes required in 1.4 PPP for alignment.

KEY: Waikato DHB Strategy Priority Clusters

1. Health equity for high need populations.
2. Safe, quality health services for all.
3. People centred services.
4. Effective and efficient care and services.
5. A centre of excellence in learning, training, research and innovation.
6. Productive partnerships.

System Level Measures

1. Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds (keeping children out of hospital).
2. Acute hospital bed days per capita (using health resources effectively).
3. Patient experience of care (person-centred care).
4. Amenable mortality rates (prevention and early detection).
5. Babies living in smokefree homes (a healthy start).
6. Youth access to and utilisation of youth appropriate health services (youth are healthy, safe and supported).

National Health Targets

1. Shorter stays in emergency department.
2. Improved access to elective surgery.
3. Faster cancer treatment.
4. Increased immunisation.
5. Better help for smokers to quit.
6. Raising health kids.

Waikato DHB & IMC MOU

1. Radical improvement in Māori health outcomes by eliminating health equities for Māori.
2. Promoting the implementation of the philosophy of Whānau Ora.
3. Radical improvement of mainstream responsiveness to Māori health needs.
4. Ensure the growth of sustainable Kaupapa Māori health services.
5. Remove barriers for Māori experiencing disabilities.
6. To increase and build a sustainable Māori workforce to contribute to the delivery of excellent culturally appropriate services.
7. To grow future Māori leadership in the Health and Disability Sector at governance, and service delivery levels.

October Workshop 2017

1. Improving attendance at clinical appointments
2. Māori health plans
3. Navigator service

Key	Colour
Development stage	
Implementation stage	

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 3.3

TERMS OF REFERENCE AND AGENDAS OF COMMITTEES

Purpose	For approval.

In February the Board held a workshop on how its committees should function. This was followed by the adoption of the attached report (Appendix 1) at the February Board meeting.

In essence the report proposed a reversion to the framework for committee operation required by legislation with some refinements to meet Waikato DHB needs.

A further workshop was held with Board chairs and other interested Board members in March at which terms of reference for the proposed committees were discussed along with the work plans to pertain to each.

The terms of reference agreed by the March workshop are attached as Appendix 2. They align with the original concept of a return to the framework for committee operation required by legislation.

The primary purpose of the meeting was to identify the main matters for discussion at the next few meeting(s) of the various committees. Attached as Appendix 3 are the results of this exercise.

It was envisaged that these matters would be placed on the agendas of the committees at the next meeting, be validated, refined and/or expanded in that forum and would then form the basis of the work plan for that committee. This would occur in conjunction with the executives appointed to support each committee consequent upon the Interim Chief Executive's restructure proposal currently in progress.

The meeting also canvassed a range of other matters. For the sake of simplicity they are outlined in the recommendation below as they seem relatively self-evident.

Recommendation
THAT

1. The attached terms of reference for the Board committees are adopted (Appendix 2) and included in the governance manual.
2. In order to ensure adequate focus is given to disability issues the "disability items" always appear first in the Community and Public Health Advisory Committee agenda.

3. The Chair of the Hospital Advisory Committee is appointed to the Maori Strategic Committee to ensure adequate engagement between the two committees.
4. The Board appoints a chair to the Chief Executive Performance Review Committee and considers someone other than the Chair or Deputy Chair of the Board for this role given the desirability of a relative degree of detachment.
5. The Board schedules the following workshops over the next few months:
    a. Virtual Health Strategy Refresh: March 2018.
    b. Assurance Framework: May 2018.
    c. Maori Health/Inequities: June 2018 (Board member Hodges to suggest presenter).
6. Once the assurance framework is developed the risks identified through that process are allocated to the various Board committees (according to relevance of scope) for the purposes of ensuring mitigation.
7. In developing and reporting KPIs the Waikato DHB always considers how they drive radical improvement in Maori health and how they quantify whether this has occurred.
8. “Creating Our Futures” is a programme to be monitored by the Board.
9. The matters raised in Appendix 3 (incorporating any amendments arising from the present meeting) are submitted to the relevant committee meeting for discussion and adoption as the basis for the committee work plan

NEVILLE HABLOUS
CHIEF OF STAFF

Appendix 1

MEMORANDUM TO THE BOARD
28 FEBRUARY 2018

AGENDA ITEM 3.3

STRUCTURE AND OPERATION OF THE BOARD'S COMMITTEES

Purpose	For approval.

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

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

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

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

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

Recommendation
THAT

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

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

Appendix 1

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

Appendix 1

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

NEVILLE HABLOUS
CHIEF OF STAFF

Appendix 2

TERMS OF REFERENCE

COMMUNITY & PUBLIC HEALTH COMMITTEE TERMS OF REFERENCE

1) In accordance with the NZ Public Health and Disability Act, the Board shall establish a Community & Public Health Advisory Committee whose members and chairperson shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Community & Public Health Advisory Committee shall be to consider and advise the Board on:

   a) The needs of the population;

   b) Any factors that may adversely affect the health status of the population;

   c) Priorities for use of health funding across both externally funded services and services delivered by Waikato DHB, including decisions on the adoption or otherwise of particular technologies, procedures and degrees of complexity associated with services delivered by Waikato DHB;

   d) The initiation, monitoring and termination of contracts by which health funding is delivered including related procurement processes;

   e) The monitoring of externally funded providers to ensure probity and effectiveness;

   f) Strategic planning processes for Waikato DHB;

   g) Its findings on detailed investigation of particular problems, challenges or issues coming within the Committee's scope;

   h) Issues that the Committee is directed by the Board to examine including mitigation of particular risks;

   i) Progress in implementing specific programmes and projects; and

   j) When opportunities to advocate and make submissions on matters coming within the scope of the Committee should be taken up, and on the content of such advocacy/submissions.

4) The Committee's advice may not be inconsistent with the New Zealand Health strategy.

5) The Community and Public Health Advisory Committee shall hold meetings as frequently as the Board considers necessary. Six meetings are normally held annually.

Appendix 2

HOSPITAL ADVISORY COMMITTEE TERMS OF REFERENCE

1) In accordance with the NZ Public Health and Disability Act, the Board shall establish a Hospital Advisory Committee, whose members and chairperson shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Hospital Advisory Committee shall be to consider and advise the Board on:

   a) Strategic issues relating to the provision of hospital services and other services directly delivered by Waikato DHB;

   b) Other issues arising from oversight of hospital and other services as presented in executive reports;

   c) Its findings on detailed investigation of particular problems, challenges, or issues coming within the Committee's scope;

   d) Issues that the Committee is directed by the Board to examine, including mitigation of particular risks;

   e) Progress in implementing specific programmes and projects; and

   f) When opportunities to advocate and make submissions on matters coming within the scope of the Committee should be taken up, and on the content of such advocacy/submissions.

4) The Hospital Advisory Committee shall hold meetings as frequently as the Board considers necessary. Six meetings are normally held annually.

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Appendix 2

DISABILITY SUPPORT ADVISORY COMMITTEE TERMS OF REFERENCE

1) In accordance with the NZ Public Health and Disability Act, the Board shall establish a Disability Support Advisory Committee whose members and chairperson shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Disability Support Advisory Committee shall be to consider and advise the Board on:

   a) The disability support needs of the population;

   b) The priorities for use, of the disability support funding agreed by the Board to be within the Committees scope;

   c) Practical improvements the Waikato DHB could make across the breadth of its activities to promote the inclusion and participation in society, and maximise the independence of people with disabilities;

   d) Its findings on detailed investigation of particular problems, challenges, or issues coming within the Committee's scope;

   e) Issues that the Committee is directed by the Board to examine, including mitigation of particular risks;

   f) Progress in implementing specific programmes and projects; and

   g) When opportunities to advocate and make submissions on matters coming within the scope of the Committee should be taken up, and on the content of such advocacy/submissions.

4) The Committee's advice may not be inconsistent with the New Zealand disability strategy.

5) The Disability Support Advisory Committee shall hold meetings as frequently as the Board considers necessary. This will be determined by work flow (see the note below)

NOTE: DSAC will convene for items within scope as listed on the CPHAC agenda and the membership will be the same for both committees. There will be no formality associated with this transition.

Appendix 2

AUDIT AND CORPORATE RISK MANAGEMENT COMMITTEE TERMS OF REFERENCE

1) The Board shall establish an Audit and Risk Management Committee whose members and chair person shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Audit and Corporate Risk Management Committee shall be:

   a) Internal Audit and Control:

      i) to evaluate whether management is setting the appropriate "control culture" by communicating the importance of internal control and the management of risk and by ensuring that all employees have an understanding of their roles and responsibilities;

      i) to monitor the security of computer systems and applications and the contingency plans for processing information in the event of a systems break down;

      ii) to monitor the implementation by management of recommendations made by internal auditors; and

      iii) to ensure that both fraud and sensitive expenditure are adequately addressed by relevant policy and control processes.

   b) Financial Reporting:

      i) to gain an understanding of the current areas of greatest financial risk and how management is managing those effectively;

      ii) to review with the internal and external auditors any fraud, illegal acts, deficiencies in internal control or other similar issues;

      iii) to review significant accounting and reporting issues, including recent professional and regulatory pronouncements, and understand their impact on the financial statements;

      iv) to review any legal matters which could significantly impact the financial statements or which are significant in their own right; and

      v) to review the financial statements and the result of the audit.

   c) External Audit:

      i) to make recommendations to the Board regarding the reappointment of the external auditors;

      ii) to meet separately with external audit to discuss any matters that the Committee or auditors believe should be discussed privately; and

      iii) to monitor the implementation by management of recommendations made by external auditors.

   d) Compliance:

      i) to review the findings of any examination by regulatory agencies where these are not clinically-focussed; and

      ii) to review the Draft Annual Plan and Draft Annual Report.

Appendix 2

e) State Services Standards of Integrity and Conduct:

i) To assess whether based on the totality of the information being placed before the Committee and the Board more generally, management is setting a tone for the organisation that reinforces the State Services Commission Standards of Integrity and Conduct;

ii) To determine whether any additional reporting is required to establish that point; and

iii) To recommend actions that are considered necessary to ensure that the management and staff of the Waikato DHB meet the Standards.

f) Advocacy:

i) To advise the Board when opportunities to advocate and make submissions on matters coming within the scope of the Committee should be taken up, and on the content of such advocacy/submissions.

4) The Audit and Risk Management Committee shall hold meetings as frequently as the Board considers necessary. Four meetings are normally held annually.

Appendix 2

CHIEF EXECUTIVE PERFORMANCE REVIEW COMMITTEE TERMS OF REFERENCE

1) The Board shall establish a Chief Executive Performance Review Committee whose members and chairperson shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Chief Executive Performance Review Committee shall be:

   a) To provide advice to the Board on employment issues pertaining to the Chief Executive, including recruitment, conditions of employment and annual performance review;

   b) To prepare the performance agreement with the Chief Executive for adoption by the Board;

   c) To undertake the Chief Executive performance review on behalf of the Board and make recommendations regarding at-risk pay, increases in remuneration and associated matters;

   d) On behalf of the Board to deal with any personal issues pertaining to the Chief Executive and recommend to the Board actions relating to them;

   e) To consider issues that the Committee is directed by the Board to examine, including mitigation of particular risks; and

   f) On behalf of the Board to ensure that the Chief Executive completes any compliance requirements (legislative or otherwise) pertaining to their role including disclosure of conflicts of interest, notification of secondary employment and submission of expense returns to the State Services Commission.

4) The Chief Executive Performance Review Committee shall hold meetings as frequently as the Board considers necessary. Meetings are held as required.

NOTE: Notwithstanding privacy issues associated with the Chief Executive's performance, minutes of the Committee must be adopted by the Board.

Appendix 2

SUSTAINABILITY ADVISORY COMMITTEE TERMS OF REFERENCE

1) The Board shall establish a Sustainability Advisory Committee whose members and chair person shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Sustainability Advisory Committee shall be:

   a) To monitor the development, implementation and success of existing projects intended to ensure the financial sustainability of the Waikato DHB;

   b) To monitor the financial performance of the Waikato DHB with a view to advising the Board on the urgency to be given to initiatives to ensure the sustainability of the Waikato DHB;

   c) To assess and prioritise any new proposals intended to ensure the financial sustainability of the Waikato DHB;

   d) To ensure the Board is kept informed of the activities coming within the scope of the Committee and their success or otherwise; and

   e) To consider issues that the Committee is directed by the Board to examine, including mitigation of particular risks.

4) The Sustainability Advisory Committee shall hold meetings as frequently as the Board considers it necessary. Six meetings are normally held annually.

Appendix 2

MAORI STRATEGIC COMMITTEE TERMS OF REFERENCE

1) The Board shall establish a Maori Strategic Committee whose members and chairperson shall be as determined by the Board from time to time.

2) None of the Committees of the Board have delegated authority and all have an advisory role to the Board. The Committee's scope of action outlined below should be read with this important qualification in mind. This advisory role will normally be discharged by way of the Board adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Maori Strategic Committee shall be:

   a) to oversee the development of the Plan to radically improve Maori health outcomes by eliminating health inequities for Maori;

   b) to oversee the implementation of the Plan to radically improve Maori health outcomes by eliminating health inequities for Maori;

   c) to identify and consider other areas of the Waikato DHB that could contribute towards radical improvements in Maori health outcomes by eliminating health inequities for Maori;

   d) To consider issues that the Committee is directed by the Board to examine, including mitigation of particular risks; and

   e) When opportunities to advocate and make submissions on matters coming within the scope of the Committee should be taken up, and on the content of such advocacy/submissions.

4) The Maori Health Committee shall hold meetings as frequently as the Board considers necessary. Meetings are held monthly normally.

Appendix 3

Key Task for Discussion at Next Committee Meetings

Disability Support Advisory Committee

To assess the following in terms of their priority and alignment with the Waikato DHB strategic imperatives and frame the committee work plan on that basis:

- Continuity in primary care (including pharmacy) for those experiencing disability including issues of access, ongoing relationships with particular health professionals and time provided;
- Implementation or otherwise of the Health Passport;
- "Enabling Good Lives" and the evolution of the national direction;
- Stock take of disability funding including that provided by Waikato DHB for national programmes; and
- Equitable access for Maori to disability services.

Community and Public Health Advisory Committee

To assess the following in terms of their priority and alignment with the Waikato DHB strategic imperatives and frame the committee work plan on that basis:

- Improving access to primary care (including access for Maori);
- The model for primary and community care;
- Needs analysis and comparative intervention rates;
- Assessment of whether we have sufficient focus on prevention work;
- Stock take of external providers and the programmes for which they are funded;
- Midwifery;
- Future demand and planning for it;
- Last thousand days.

Hospital Advisory Committee

To assess the following in terms of their priority and alignment with the Waikato DHB strategic imperatives and frame the committee work plan on that basis:

- Quality of the services we provide including services under challenge; and
- Culture of the organisation particularly within clinical services and how it can be improved.

Note: the thinking was that at the April meeting the committee should go into some depth into the quality of our clinical services notwithstanding that we have agreed that ordinarily monitoring of relevant KPIs will go to the Board. It was considered the Director: Q&PS would take some time to present on current status using whatever approach was considered appropriate. This would be supplemented by reporting from the relevant executive directors under the auspices of their regular report on what services they considered to be under challenge and what was occurring to address them. CMO, DON&M, and Director of People and Performance requested to report (in conjunction with executive management as appropriate) on current organisational culture and how we should drive improvement if required.

Appendix 3

Other Committees

Considered to be under control with the Sustainability Advisory Committee to concentrate on the budget and savings in the near term with a particular eye to avoiding the “drift” that occurred around our approach to the budget for 2017/18, and the Maori Strategy Committee to concentrate on improving capacity and funding to ensure that speed in planning and implementation can be picked up. The Audit and Corporate Risk Management Committee may take a more active role in risk subject to development of the assurance framework.

Chief Executive Report

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

Board Member Orientation

At the February Board meeting the Board discussed the need to put in place some firm guidelines around orientation of new Board members. While we are presently mid-cycle there is no reason to delay so we suggest what follows. Our view is that a formal policy is probably not required but that these guidelines are included in the Governance Manual.

Board Member Orientation Guidelines

Orientation of new Board members is intended to achieve the following requirement of the NZ Public Health and Disability Act: "A board that has elected or appointed to it a member or members not already familiar with the obligations and duties of a member of a board, Maori health issues, Treaty of Waitangi issues, or Maori groups or organisations in the district of the DHB concerned must fund and, to the extent practicable, ensure the member or members undertake and complete, training approved by the Minister relating to whichever of those matters the member or members are not familiar with".

It is anticipated that national and regional orientation will generally cover the obligations and duties of a member of the board and Treaty of Waitangi issues.

Orientation of new Board members at the Waikato DHB will include at least the following components:

- An opportunity for elected Board members to attend all Board and committee meetings (including at the discretion of the Chair the public excluded part of the meetings) between the date of the election and the commencement of their term in early December.
- Attendance at any national orientation organised by the Ministry of Health for all new Board members.
- Attendance at any regional orientation organised for all new Board members in the region.
- Sessions with the Chief Executive and other senior executives of the Waikato DHB at which roles are explained, strategies are outlined and key challenges and opportunities are identified.
- An opportunity to undertake familiarisation tours of the Hamilton, Thames, Tokoroa, Te Kuiti and Taumarunui campuses before the end of March in the year following the election.

- Workshops on Maori health issues in the Waikato and Maori groups or organisations within the district of the Waikato DHB, to be completed before the end of March in the year following the election.
- Review of the Board's Code of Conduct and specific explanation of Board policies and particular legislative provisions such as those pertaining to conflicts of interest.

Drinking Water

The DHB's Public Health Unit has made good progress on resolving five of the six corrective actions required before seeking re-accreditation of the drinking water assessment service. The core issue, the mismatch between staffing and workload, remains unresolved.

Since the assessment visit the Ministry have confirmed that our two trainee assessors who are ready to be fully certified cannot be certified until the service is accredited. The service itself cannot be accredited without more assessors. The DHB has approached all other drinking water assessment services in New Zealand for assistance. All services have indicated that they are unable to assist due to their own operational issues. Given this catch-22, the DHB has formally written to the Ministry of Health requesting the closer involvement of senior officials as there are both structural policy constraints as well as practical operational issues to be overcome. The Ministry are currently working up an options paper and plan to meet with the DHB in late April.

For clarity the Board should note that the DHB has a contractual, but not statutory, responsibility for assessing drinking water suppliers. The Havelock North Enquiry recommended significant structural and operational reform across most aspects of the supply and assessment of drinking water.

Waikato Health System Plan

A Programme Director has started to lead a programme of work to bring together a 10 year Waikato Health System Plan (HSP) with actions to deliver on the priorities outlined in the strategy; Healthy People Excellent Care.

The approach will bring together feedback and strategies from recent internal and external engagements, in-flight clinical service planning with hospital specialty services, yet to be commenced care in the community service planning and non-clinical strategies and plans. Priorities within the resourcing available, dependencies, regional alignment and strategic investment will be part of the output. The participation of Maori and consumers will feature in the Care in the Community planning process.

The HSP is scheduled to be completed by December 2018 but a draft prior to developing the action plans is expected to be available by October 2018.

The draft HSP will be used to engage the wider sector, staff, the Board and subcommittees (including the Iwi Maori Council) with the engagement process also used as an input into action planning and implementation.

The HSP and Action Plan will inform the DHB's Long Term Investment Plan and wider regional DHB investments.

We will present the proposed Plan Framework to the April board meeting.

DHB Revenue

At a previous Board meeting there was a request for information on the sources and quantum of DHB revenue. Information can be found in the March Finance report, agenda item 6.1.

Funding Envelope for 2018/19

We are still awaiting the funding envelope for the DHB for the upcoming year.

Medical Council of NZ Review

Planning is underway for the Medical Council of New Zealand accreditation visit for prevocational medical training. The accreditation will be undertaken on 17 and 18 April. We are confident that we can demonstrate considerable progress towards addressing the standards that we failed to meet in August 2017. The areas that have not been fully addressed (the management of interns' leave and the implementation of the electronic task management system) have clear plans in place and we expect these two outstanding required actions to be fully achieved by the end of July 2018.

DHB Accreditation Calendar

The attached is supplied for information, as requested by Board.

Recommendation
THAT
The Board receives the report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

Waikato DHB – External (Colleges/Accreditation) audit schedule 2017-2018

External audits	Manager	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Notes	Frequency
Neurolsurgical Society of Australasia: Education and Training in Neurosurgery	Zakier Hussain	X												Trainee for 2017 allocated to Waikato DHB.	Annual
Australasian College for Emergency Medicine *ED credentialling	Tonia Nicholson		X												2 years
Medical Council NZ Accreditation - Provision of Intern clinical attachments	Helen Clark	X												Audited July17….CARs?	3 yearly
FRACP General Paediatric Advanced Training	Claire West			X										26/09/2017	
Royal Aust and NZ College of Obstetricians and Gynaecologists accreditation	Tony Stock				X									Training Accreditation withdrawn late 2015. Project underway to address issues	Annual
Plastic Reconstruction Surgery - training post accreditation	Winston McEwan						X								
Royal Australasian College of Physicians (Physician Training training & Advanced)	Paul Huggan	X					X							25 July visit.	
NZ Orthopaedic Association	Leigh Singers									X				14/03/2017 - Review Due June 2018?	5 yearly
Royal Aust College of Surgeons : Accred'n of Surgical Education and Training	Rob Blaikie/Linus Wu									X				03/03/2017: review one post Mar 2018?	5 yearly
Royal Australasian College of Physicians Respiratory & Sleep Medicine Training	Janice Wong												X	Andrea Coxhead: 23/6 or 30/6	
Royal Australasian College of Physicians (Paed basic training)	Claire West	Visit April 2016. Provisional report received, comments returned. Awaiting final report due August												Claire W asking college re final report.	3-5 yearly
RACP Gastroenterology Accreditation	Aileen McGowan													tbc Jul/Aug 2017??	
Royal Australasian College of Physicians advanced training in general Paeds)	Hamish McCay													Completed questionnaire Nov 2015	up to 5 yearly (tbc)
Advanced Training in Neonatology	Claire West														
Advanced Training in Communithy Child Health	Dave Graham				X										
Royal Australian and New Zealand College of Psychiatrists	Aletsa Stephens													Upper Central North Island training prog -	
College of Intensive Care Medicine	Geoff McCracken													Training accreditation	
Royal College of Pathologists of Australasia	Daniel Ninin														
Royal Australasian College of Surgeons: Gen Surg	Rowan French	2017													5 yearly
Australasian College fof Physical Scientists and Engineers in Medicine	Koki Mugabe	15-Jul-20												Medical Physics trainees	5 yearly
Medical Services Council of NZ - Anaesthetic Technicians	Mark Tumai	Valid to 31/11/2020													
Australia and New Zealand Society for Vascular Surgery - training post	Vasu Vasudevan	Due 31/12/2020												certified 1/1/16-31/12/20	5 yearly
Aust & NZ College of Anaesthetists accreditation	Cam Buchanan	Due 2022													7-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	Mark Spittal														
Pain Medicine - if we apply to be a training facility															
Royal Australasian College of Dental Surgeons - Oral & MaxFax surgery	Angus Colquhoun	Due 2021													5 yearly
Royal Australasian College of Surgeons and The Urological Society of Australia & NZ (SET Accreditation /training)	Adam Davies	Due by 31/12/2021													5 yearly
Royal Australasian College of Ophthalmologists	Michael Merriman	Audit Oct 2016…..													3 yearly
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
Royal Australasian College of Surgeons Trauma Verification	Grant Christey	Verfication Audit Feb 2017													

The following section from the Interim Chief Executive's report in public excluded has been moved to the public section of the March board agenda and will be discussed under item 4.

Update on Legal Matters

Over the last few months the workload for our legal services has been significant. There has been a large amount of legal work associated with the State Services Commission review, the Office of the Auditor General review and the numerous OIA requests with regard to the previous Chief Executive.

The above has also created significant extra work for staff in the Chief Executive's office and staff in Finance and IT.

Quality and Patient Safety

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 5

QUALITY AND PATIENT SAFETY REPORT

Purpose	For information.

This paper aims to assure the Board that the systems and processes in place across the organisation are established and being further developed, in order to monitor and improve the quality of services for patients across the DHB.

Recommendation
THAT
The Board receives the report.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

Quality and Patient Safety report - March 2018

This paper aims to assure the Board that the systems and processes in place across the organisation are established and being further developed, in order to monitor and improve the quality of services for patients across the DHB

Update on the structures in place to help assure the Board of the quality of care

- Board of Clinical Governance (BoCG) – *TOR / membership currently under review*
    - Medicines and Therapeutics Committee (medication safety program, blood management program)
    - Infection Prevention and Control Committee
    - Clinical Records Committee
    - Patient Safety Program Group (PSPG)
    - Operational Executive Director governance / leadership groups

- Patient Safety Program Group (PSPG)– oversees the patient safety programs and projects (advance care planning, end of life, early detection of deteriorating patient, sepsis / Early Warning Score (EWS), mental health improvement program) and recommends where new patient safety work might be needed from themes from mortality reviews / serious events/ incidents/ complaints / Health Round Table (HRT) data etc.
    - Mortality Committee
    - Serious event panel
    - Releasing Time to Care (RTC)

- Quality and Patient Safety team (consumer engagement, clinical effectiveness, patient safety, risk management, certification)

Quality indicators

The indicators identified here should enable the Board to measure achievement against the strategic objectives and annual work programme. Work continues to increase the use of the health round table (HRT) data and the business support unit have committed to reporting the key safety markers within HRT monthly to the Board of Clinical Governance. It is important to note that these high level indicators should be viewed as a 'summary report' as it is not a substitute for the detailed papers which inform its content and which are presented at various committees and groups in the DHB.

Indicator	Tolerance per Month	Quarter 1	Quarter 2	February
HDSMR (mortality)	<100	Amber (103)	Amber (108)	Amber (108)
Attributable Grade 3 & 4 Pressure Ulcers	Zero	Green (0)	Amber (1)	Green (0)
Patients with a fractured hip as a result of a fall	<2	Green (0)	Amber (2)	Green (0)
Staph Aureus Bacteraemia (SAB) per 1000 bed days	< 0.1	Amber (0.15%)	Amber (0.15%)	Red (0.2%)
Complaints (responded to within 20 working days)	70%	Amber (68%)	Amber (66%)	Amber (64%)
National Patient Survey response	> 30%	Green (38%)	Green (35%)	n/a
Policy / guideline compliance	> 95%	Red (76%)	Red (74%)	Red (73%)
Always report event (previously known as never events)	Zero	Red (2 in Q)	Red (1)	Red (1)
Hand hygiene	> 85%	Amber (82.3%)	Green (85.8%	Green (85.2%)

Staph Aureus Bacteraemia (SAB) – variable performance

Action - An action plan has been developed and approved by the infection control committee and BoCG which includes reviewing all reported SAB cases to understand the contributory factors so that improvement work can be focused. Over 30% of the infections are due to peripheral lines and an audit is currently underway across the DHB to check compliance against best practice guidance

Policy and guideline currency - a stubborn red

A key requirement of surveillance and certification audit standards is to have up to date policies and guidelines – we are not achieving this and have a further corrective action following the surveillance audit. As at the end of February 2018 our compliance was –

Waikato DHB Wide

Document Type	Currency	Number	
Policies	74%	100/136	■
Guidelines	90%	28/31	■
Procedures	90%	53/59	■
Protocols	98%	44/45	▲
Drug Guidelines	55%	40/73	▲
Standing Orders	51%	35/68	▼
Total	73%	300/412	▼

Clinical Management

Business Area	Currency	Number	
Community and Clinical Support	85%	398/469	▲
Medicine and Oncology	63%	271/430	■
Mental Health and Addictions	82%	37/45	▲
Older Persons and Allied Health	96%	87/91	▼
Surgery, Critical Care	62%	206/334	■
Women's and Children's Health	69%	171/247	▼
Other*	100%	18/18	■
Total	73%	1188/1634	▲

* **Other** includes: ADT, Clinical Equipment, Infection Prevention and Control, Information Services, Procurement and Security

▼ **Decrease from previous quarter** ▲**Increase from previous quarter** ■ **No change**

Action - work ongoing to reduce duplicate policies and guidelines and to get the email alert system working to remind staff 3 months prior to document going out of date. Work is underway with the corporate policies to realign and ensure the updated policies are easy to read and linked to source documents commencing with the HR policies.

Always report event (previously known as never events)
See under serious events

Complaints
Performance has remained below target for the last 12 months.

Action - the complaints team are running reports and sending emails to services where they have responses due. These emails are tailored to each service/dept.

Mortality

Hospital Diagnosis Standardised Mortality Ratio (HDSMR) is where mortality data is adjusted to take account of some of the factors known to affect the underlying risk of death. The HDSMR is calculated as the ratio of the actual number of deaths within 30 days of admission to hospital (irrespective of place of death) to the expected number of deaths.

Action being taken

- All deaths continue to be reviewed centrally and escalated to local M&M review / Serious event as necessary (no serious events triggered this month)
- Clinical Director QPS is working with teams to address documentation issues
- As an additional assurance a weekly crude mortality report is being developed from the DHB mortality database as HDSMR rate has a delay and only reported 6 monthly
- Thames clinicians are in discussion with the clinical coders, in regard to documentation and codes being taken solely from discharge summaries

Gap

- Standard of clinical documentation poor – clinical audits show little improvements
- Lack of real time clinical coders (at service level)

National quality and safety marker (QSM) report

The October – December 2017 report has yet to be published by the Health Quality Safety Commission(HQSC). It is hoped the new HQSC online dashboard will be available shortly

Health and Disability Complaints (HDC)

During February, there were no breach decisions against the DHB. There was one adverse comment

(Women's Health) Concerns: Little support or counselling offered following stillbirth. Family still do not feel they know what had caused death of baby. Inadequate pain relief during labour.
Final decision following investigation: Adverse comment.

New complaints / review

(Tokoroa / ED Waikato) Anonymous complaint: concerns about care provided to patient (dec) at Waikato Hospital in 2017. Patient was transferred from Tokoroa Hospital and was treated in ED/A4. Care was subsequently withdrawn and patient passed away.
M&M review at the time showed no clinical issues. QPS to lead review and response to HDC

Nine investigations are currently underway, three of which were notified in February – none of these have been the subject of a serious event review. There is a rise in the number of complaints from HDC - In calendar year 2017 we had a total of 7 investigations, in the first two months of 2018 we already have 4 investigations underway.

A teleconferences have been set up three times a year between Anthony Hill (HDC Commissioner) and QPS (Director and clinical lead) to enable discussion re trends and concerns. The recent conversation in February highlighted

- 30 % of our HDC complaints are around access and prioritisation and we are seen as an outlier. Our local complaints do not reflect this trend.
- High number of open investigations – DHB is aware of this and concerned locally but in discussion we are not an outlier nationally

Serious events
We currently have 32 serious events being reviewed, led by the QPS team with support from clinicians from various services.
9 events were notified in February 2018 as follows:

- 1 Suspected Community Suicide
- 6 Healthcare acquired infections
- 2 Clinical incidents

Including one Always report event – wrong side nephrostomy tube inserted.

One SAC1 – Woman's health

Coroner / inquest recommendations
Nothing to report

Patient Safety Program

When the themes from serious events, complaints, trigger tools along with areas of concern in the health round table data are reviewed, a number of areas for improvement have been identified. These are outlined in the quality account priority areas

The following programs are currently underway, led by QPS patient safety facilitators. Progress is reported 6 monthly through the patient safety program group and onward to the BoCG
End of life program

- Advance care planning
- Bereavement service
- Last days of life

Early Detection of deteriorating patients

- 'Sepsis 6' bundle
- National Early Warning Score and observation chart
- Family / Whanau escalation

Pressure Injury prevention

- Pilot site for HQSC with the new quality safety marker – seen as an exemplar

Scoping for possible next program
A hydration / fluid balance program to include projects on preventing peripheral line infection, catheter associated infection, pre-operative fasting etc.

Bright Spots

- Critical incident e-book action research project in Mental Health – there is evidence that staff suffer as 'second victims' when involved in a serious event and although EAP is offered, there is currently no robust debrief process or wider information available for staff. This project is based on work done at Auckland Woman's hospital for maternity services
- Feedback from leadership walk AMU – engaged and enthusiastic team still implementing improvements after the Rapid Improvement Event (ED and medicine) earlier in the year
- Sepsis patient safety project with strong clinical engagement in obstetrics, paediatrics, ED and ICU. A new Sepsis NZ Trust has been formed from Waikato DHB https://www.sepsis.co.nz/
- Consumer council in place and met for the first time in March

Areas of future focus

- Governance processes across operational executives (Floor to Executive) – how are they monitoring quality indicators / mortality / Health Round Table (HRT) / clinical audit processes and results / risk register and improving?

- Risk register practice – little attention paid to the risks identified and how to mitigate them. Discussion on refreshed approach scheduled for March BoCG

- Lack of governance / transparency with national clinical databases (NZ/Australia) - data available to services / clinicians but not known by DHB, for example -
    - Cardiac surgery
    - Intensive care
    - Neonatal

- External audit program / college accreditation process to enable transparency of program and ensuring strong govern acne processed to implement recommendations. This is in place for most external audits but not the college visits

Areas of concern

- Woman's Health – number of HDC complaints and serious events currently underway
  QPS have put in a facilitator for 3-4 months to assist with volume and work through governance processes

- Systems adding to staff burden - process for equipment repair / replacement is bureaucratic, slow and non transparent

- Infection rate - particularly cardiac surgery, staph aureous bacteramia (SAB). Whilst there work is underway in both these elements, concern remains over the slowness to show any improvement

- Reactionary system operation – ' daily firefighting' versus time for improvement.

Finance Performance Monitoring

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 6.1

FINANCE REPORT

Purpose	For information.

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

Recommendation
THAT
The Board receives the report.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD

YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Group Result for February 2018	Year to Date			Group Budget
	Group Actual $m	Group Budget $m	Variance $m	Jun-18 $m
Funder	25.9	27.7	(1.8) U	34.0 F
Governance	0.2	0.1	0.1 F	0.2 F
Provider	(29.7)	(29.0)	(0.7) U	(44.7) U
Waikato Health Trust	(0.2)	0.1	(0.3) U	0.5 F
DHB Surplus/(Deficit)	**(3.8)**	**(1.1)**	**(2.7) U**	**(10.0) U**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

Episodes	February 2018 YTD				
Acute	Actual Feb 2018	Plan	Variance to Plan %	Actual Feb 2017	Variance to Prior year %
Surgical & CCTVS	11,655	11,747	-0.8%	11,457	1.7%
Medicine & Oncology	14,735	13,708	7.5%	13,529	8.9%
Child Health	3,606	3,339	8.0%	3,233	11.5%
Women's Health	5,894	6,253	-5.7%	5,978	-1.4%
TOTAL	35,890	35,047	2.4%	34,197	5.0%
Elective	Actual Feb 2018	Plan	Variance %	Actual Feb 2017	Variance to Prior year %
Surgical & CCTVS	9,908	10,182	-2.7%	8,779	12.9%
Medicine & Oncology	467	703	-33.6%	691	-32.4%
Child Health	451	492	-8.3%	462	-2.4%
Women's Health	751	771	-2.6%	777	-3.3%
TOTAL	11,577	12,148	-4.7%	10,709	8.1%
Total Episodes - Acute plus Electives	**47,467**	**47,195**	0.6%	**44,906**	5.7%

CWDS	February 2018 YTD				
Acute	Actual Feb 2018	Plan	Variance to Plan %	Actual Feb 2017	Variance to Prior year %
Surgical & CCTVS	20,029	20,052	-0.1%	19,814	1.1%
Medicine & Oncology	14,014	13,080	7.1%	13,028	7.6%
Child Health	4,618	4,185	10.3%	3,964	16.5%
Women's Health	3,306	3,303	0.1%	3,073	7.6%
TOTAL	41,967	40,620	3.3%	39,879	5.2%
Elective	Actual Feb 2018	Plan	Variance %	Actual Feb 2017	Variance to Prior year %
Surgical & CCTVS	13,962	14,461	-3.5%	12,194	14.5%
Medicine & Oncology	356	410	-13.1%	434	-18.0%
Child Health	374	445	-16.0%	390	-4.2%
Women's Health	707	754	-6.3%	701	0.8%
TOTAL	15,399	16,070	-4.2%	13,719	12.2%
Total CWDS - Acute plus Electives	**57,366**	**56,690**	1.2%	**53,598**	7.0%

February 2018	Actual	Prior year	Change
ED Attends	77,926	73,382	6.2%
Beddays	150,185	143,554	4.6%

MONTHLY COMMENTS

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

Delivery Plan Performance

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

Financial Performance Monthly Comment:

For February 2018 we have an unfavourable YTD variance to budget of $2.7m. However this result includes $1.4m one off favourable variances so a normalised result is $4.1m unfavourable. Furthermore, $11.2m of the centrally held savings plan, which contains high risk initiatives, is phased in the budget to take effect over the balance of the year.

Provider:

The Provider is unfavourable to budget $0.7m - see detail for explanations. Variances include:

1. Revenue $11.4m favourable to budget due mainly to favourable internal revenue (eliminates against Funder), a favourable acute volume variance, IDF in and the reimbursement of NOS costs.
2. Employed personnel costs favourable to budget $10.6m - analysis below.
3. Outsourced Personnel costs unfavourable $9.7m, the dominant variances relate to medical locums ($4.5m partly offset by savings in medical personnel costs), nursing personnel ($1.5m) and Management and Administration $3.5m ($2.5m NOS costs recovered in other government revenue).
4. Outsourced Services favourable $4.2m.
5. Clinical supplies unfavourable to budget $5.3m.
6. Infrastructure & Non Clinical supplies are unfavourable to budget $11.9m.
7. Interest, depreciation and capital charge close to budget.
8. Loss on disposal of fixed assets unbudgeted $0.1m

Funder and Governance:

The results for the Funder is $1.8 unfavourable to budget. This mainly as a result of unfavourable internal provider payments (eliminates against Provider). This is partially offset by higher additional funding received across a number of areas. Governance is on budget.

Waikato Health Trust

The result for the Waikato Health Trust is unfavourable to budget mainly due to unfavourable grants variance arising from increased grants paid against budget assumptions.

Budget Update

As per report below.

Ministry of Health funding aspects

As per report below.

Cost splits and FTE comparisons

As per report below.

RECOMMENDATION(S):

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

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD

YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Group Result:		
The Waikato DHB YTD Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$6.1 F**	
CFA Revenue		
● CFA revenue $0.9m favourable to budget which includes increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year). Current year funds are on-paid to providers (offset in NGO payments).	$0.9 F	Neutral
Crown Side-Arm Revenue		
Side-arm contracts revenue close to budget	$0.4 F	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is favourable to budget mainly due to:		
● Reimbursement of costs associated with the implementation of National Oracle Solution (NOS) $2.5m favourable (offset in Outsourced Personnel $2.8m).	$4.8 F	Neutral
● ACC income $0.4m favourable which includes increases in income as a result of a change to a new annual contract.		
● Return to Employment project income $0.5m unfavourable due to lower referrals from MSD for enrolment. This variance is offset by lower outsource, clinical supplies and infrastructure costs.		
● Inter District Flow (IDF) income from other DHBs $0.5m favourable. High volume specialities compared to budget for the year to date include haematology, neurosurgery and neo natal.		
● Inter District Flow (IDF) income relating to 2016/17 $1.8m favourable. This as a result of the annual wash up of IDF activity across all DHBs. The final adjustment is not known until coding of all activity across all DHBs is completed. This variance is partly offset by an unfavourable variance on the IDF outflow wash up ($0.8m), which is included in NGO payments.		Favourable
Other Revenue		
Other revenue is on budget.	$0.0 F	Neutral

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($8.8) U**	
Personnel (employees and outsourced personnel total)	**$0.9 F**	
Employed personnel are favourable to budget mainly due to:	$10.6 F	Neutral
● Medical costs are favourable to budget by $7.2m. This includes a higher than expected vacancy level, partly offset by an unfavourable annual leave movement for the year to date. This favourable variance is partly offset by outsourced personnel unfavourable variance $4.5m.		
● Nursing costs are unfavourable to budget by $0.5m. This variance, along with the unfavourable outsourced personnel cost for nursing $1.5m, is due to higher patient numbers entering ED (6.2% above plan), and a higher level of mental health inpatient services and acuity. An unfavourable annual leave movement for the year to date and higher than budget overtime are both offsetting variances.		
● Allied Health costs are favourable to budget by $1.1m. Variances continue to be mainly as a result of higher than expected vacancy levels. The net favourable variance of $1.0m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.9% of total allied health personnel budget to date.		
● Management, Administration and Support costs are favourable to budget by $2.8m. Variances are spread across the DHB including clinical support, and are mainly as a result of higher than expected vacancy levels. Partially offset in Outsourced Personnel ($0.7m).		
Outsourced personnel are unfavourable to budget mainly due to:		
● Medical personnel $4.5m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $7.2m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.	($9.7) U	Neutral
● Nursing personnel $1.5m unfavourable. As for employed nursing personnel this is due to higher patient numbers entering ED (6.2% above plan), and higher level of mental health inpatient services and acuity and higher than budgeted patient watches.		
● Allied health $0.1m unfavourable. The net favourable variance of $1.0m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.9% of total allied health personnel budget to date.		
● Management, Administration and Support costs are $3.6m unfavourable largely due to contractor costs of $2.8m for the implementation of the new NOS ERP solution (to date $2.5m of this cost is offset by additional other government revenue) and $0.7m to cover management, administration and support vacancies (offset in favourable employed personnel variance).		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$4.2 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced clinical service costs are $3.4m favourable as facility lists run through external providers did not reach full capacity. This is reflected in total elective episodes being 4.7% below plan, despite in house throughput being to plan. There continues to be a recovery plan in place to meet the elective services target.	$4.2 F	Neutral
• Outsourced corporate service costs are $0.8m favourable to budget due mainly to a delay in commencing Information Systems outsourcing including a new national IS infrastructure.		
Clinical Supplies	**($5.3) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Instruments & equipment - favourable to budget by $0.6m. These particular supplies are not volume related, and instead the variance is due to timing of ordering.	$0.6 F	Neutral
• Implants & prosthesis - favourable to budget by $0.3m. Reduced costs include high cost cardiothoracic devices for procedures that are no longer being completed on behalf of other DHB's.	$0.3 F	Neutral
• Treatment disposables - unfavourable to budget by $4.1m (10.4% of budgeted costs). High cost areas include theatres (mix including high cost specialities of orthopaedics and neurosurgery), blood services (high product demand within the hospital), renal dialysis (10% up on budget), and respiratory patients (case weights for 10% up on plan).	($4.1) U	Unfavourable
• Pharmaceuticals - unfavourable to budget by $2.1m. Relates mainly to $1.5m unbudgeted increase in oncology drug costs. The initial Pharmac forecast included a lower usage assumption for new melanoma drugs. The variance includes a favourable offset of $0.3m in December due to a rebate adjustment for the increase in costs in 2017/18.	($1.9) U	Unfavourable
• Pharmaceuticals rebate adjustment relating to 2016/17 $0.2m favourable to budget. This is a wash up amount relating to prior year costs that we were notified of in December 17.		Favourable
• Diagnostic Supplies & Other Clinical Supplies are close to budget.	($0.2) U	Unfavourable
Infrastructure and non-clinical supplies	**($11.8) U**	
• Infrastructure and non clinical supplies - $1.9m favourable variance includes as a result of delays in moving in to new buildings. The net variance includes ongoing additional costs due to extended leases in existing buildings.	($11.8) U	Neutral
• Savings plan - $13.7m unfavourable variance in infrastructure relates to centrally held savings plan not specifically allocated. We continue to monitor closely actual savings achieved across the organisation.		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$3.3 F**	
External Provider payments are favourable to budget mainly due to:		
• Payments to providers are $3.0m favourable. Payments to mental health providers are favourable to budget by $2.2m due to a delay in commencement of NGO contracts. Other variances arise due to timing, with payments not matching CFA revenue received, MoH and accrual adjustments relating to prior year funding and costs arising from additional targeted revenue from MoH.	$3.3 F	Neutral
• IDF out payments for 2017/18 are $1.1m favourable. This relates mainly to lower volumes for personal health services.		
• IDF out payments for 2016/17 are $0.8m unfavourable. As for IDF in receipts, this relates to the annual wash up of IDF activity across all DHBs. This final adjustment is not known until coding of all activity across all DHBs is completed. Variance is offset by a favourable variance on the IDF inflow wash up ($1.8m), which is included in Other Government and Crown Agencies Revenue.		
Interest, depreciation and capital charge	**$0.0 F**	
Interest charge is close to budget.	$0.1 F	Favourable
Capital charge is close to budget.	($0.1) U	Unfavourable
Depreciation is on budget.	$0.0 F	Neutral
Extraordinary costs	($0.1) U	
Loss on disposal of fixed assets - not budgeted.	($0.1) U	Unfavourable

TREASURY

Opinion on Group Result:

Cash flows are unfavourable to budget as detailed below.

YTD Actuals Feb-17 $'000	Waikato DHB Cash flows for year to February 2018	Year to Date Actual $'000	Year to Date Budget $'000	Year to Date Variance $'000	Budget Jun-18 $'000
	Cash flow from operating activities				
895,014	Operating inflows	961,705	955,876	5,828	1,438,154
(858,828)	Operating outflows	(933,792)	(914,169)	(19,623)	(1,396,156)
36,186	**Net cash from operating activities**	**27,913**	**41,707**	**(13,795)**	**41,998**
	Cash flow from investing activities				
1,080	Interest income and proceeds on disposal of assets	979	779	199	1,170
(15,107)	Purchase of assets	(25,677)	(36,688)	11,011	(55,056)
(14,027)	**Net cash from investing activities**	**(24,698)**	**(35,909)**	**11,210**	**(53,886)**
	Cash flow from financing activities				
0	Equity repayment	0	0	0	(2,194)
(5,379)	Interest Paid	(520)	(526)	6	(810)
(142)	Net change in loans	(246)	2,380	(2,626)	12,700
(5,521)	**Net cash from financing activities**	**(766)**	**1,854**	**(2,620)**	**9,696**
16,638	**Net increase/**(decrease) in cash	**2,449**	**7,652**	**(5,204)**	**(2,192)**
856	Opening cash balance	9,577	9,577	(0)	9,577
17,494	**Closing cash balance**	**12,026**	**17,229**	**(5,204)**	**7,385**

Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Total Net cash flow from Operating Activities	**($13.8) U**	
Operating inflows	**$5.8 F**	
Operating inflow is favourable to budget mainly due to:	$5.8 F	
o Unbudgeted IDF 2016/17 wash-up revenue received in December $1.8m.		Favourable
o Inter District Flow (IDF) income from other DHBs $0.5m favourable. High volume specialities compared to budget for the year to date include haematology, neurosurgery and neo natal.		Neutral
o ACC income $0.4m favourable which includes increases in income as a result of a change to a new annual contract.		
o CFA revenue $0.9m favourable to budget which includes increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year).		
o Return to Employment project income $0.5m unfavourable due to lower referrals from MSS for enrolment.		
o Other operating inflow variance is due to timing of cash received compared to budget phasing.		

Cash flow variances resulted from:	Variance $m	Impact on forecast
Operating outflows	**($19.6) U**	
Operating cash outflows for payroll costs are favourable mainly due to:		
○ Personnel costs are favourable against budget mainly due to higher than planned vacancies. Vacant positions are in many instances filled by outsourced personnel. Offset in unfavourable non payroll cash flows.	$5.1 F	Neutral
Operating cash outflows for non-payroll costs are unfavourable largely as a result of:	($26.9) U	
○ Unfavourable operating costs including outsourced personnel (offset in personnel cost), outsourced services, clinical supplies, infrastructure & non clinical supplies and provider payments (net -$19.3m).		Neutral
○ Higher prepayment balance due to timing of payments $0.2m.		
○ The timing of vendor payments against budget assumptions as the budget is evenly phased.		
○ GST cash movement is favourable due to timing variances on GST transacted.	$2.2 F	Neutral
Net cash flow from Investing Activities	**$11.2 F**	
○ Interest received is close to budget.	$0.2 F	Favourable
○ Capital spend is slower than planned YTD. This is as a result of deferred timing of spend.	$11.0 F	Neutral
Net cash flow from Financing Activities	**($2.6) U**	
○ Cash flow from financing activities is unfavourable due to the deferment of planned finance leases.	($2.6) U	Neutral

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

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

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

As at 28-Feb-18	Feb-18 Actual	Mar-18 Forecast	Apr-18 Forecast	May-18 Forecast	Jun-18 Forecast	Jul-18 Forecast	Aug-18 Forecast	Sep-18 Forecast	Oct-18 Forecast	Nov-18 Forecast	Dec-18 Forecast	Jan-19 Forecast	Feb-19 Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	2,372	4,340	4,116	4,564	4,228	6,764	4,708	4,366	5,855	4,594	4,468	6,650	3,252
Funder inflow (MoH, IDF, etc)	127,209	137,915	125,303	125,303	129,983	131,880	131,880	136,560	131,880	131,880	136,750	131,880	131,880
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	2,997	2,527	2,297	2,757	2,412	2,642	2,757	2,412	2,642	2,642	2,297	2,415	2,185
Rents, ACC, & HealthPac (General Accou	3,099	2,685	2,518	2,765	2,654	2,736	2,820	2,645	2,760	2,818	2,658	2,676	2,562
	135,677	147,466	134,234	135,389	139,277	144,022	142,164	145,983	143,136	141,933	146,173	143,621	139,879
Cash was applied to:													
Personnel Costs (incl PAYE)	(48,123)	(44,418)	(44,726)	(49,875)	(47,207)	(45,794)	(58,622)	(45,684)	(51,500)	(48,275)	(54,857)	(45,746)	(48,659)
Other Operating Costs	(26,836)	(37,200)	(33,900)	(34,100)	(37,900)	(36,026)	(34,924)	(36,222)	(31,124)	(35,826)	(36,328)	(30,720)	(30,620)
Funder outflow	(48,583)	(49,837)	(45,599)	(46,617)	(45,700)	(46,808)	(50,807)	(46,148)	(47,037)	(46,808)	(45,818)	(46,478)	(46,047)
Interest and Finance Costs	(11)	(10)	(10)	(10)	(10)	(20)	(15)	(20)	(15)	(15)	(15)	(20)	(20)
Capital Charge	0	0	0	0	(18,483)	0	0	0	0	0	(18,483)	0	0
GST Payments	(8,611)	(7,711)	0	(15,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(13,710)	(9,000)
	(132,165)	(139,176)	(124,235)	(145,812)	(156,511)	(135,859)	(151,579)	(135,285)	(136,887)	(138,135)	(155,502)	(136,675)	(134,347)
OPERATING ACTIVITES	**3,513**	**8,290**	**9,998**	**(10,423)**	**(17,233)**	**8,163**	**(9,414)**	**10,698**	**6,249**	**3,799**	**(9,329)**	**6,946**	**5,532**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	88	90	90	90	90	75	75	75	75	75	75	75	75
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
	88	90	90	90	90	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(3,751)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(4,000)	(4,000)	(5,000)	(3,500)	(5,500)	(3,500)	(5,000)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(3,751)	(3,500)	(3,500)	(3,500)	(3,500)	(3,500)	(4,000)	(4,000)	(5,000)	(3,500)	(5,500)	(3,500)	(5,000)
INVESTING ACTIVITIES	**(3,663)**	**(3,410)**	**(3,410)**	**(3,410)**	**(3,410)**	**(3,425)**	**(3,925)**	**(3,925)**	**(4,925)**	**(3,425)**	**(5,425)**	**(3,425)**	**(4,925)**
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance Lease received	0	0	0	0	0	2,600	2,600	2,600	2,600	2,600	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	2,600	2,600	2,600	2,600	2,600	0	0	0
Cash was applied to:													
Capital Repayment	0	0	0	0	(2,194)	0	0	0	0	0	0	0	0
Finance lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)
Working capital facility repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
	(26)	0	0	(26)	(2,194)	0	(26)	0	0	(26)	0	0	(26)
FINANCING ACTIVITIES	(26)	0	0	(26)	(2,194)	2,600	2,574	2,600	2,600	2,574	0	0	(26)
Opening cash balance	5,431	5,254	10,134	16,722	2,863	(19,974)	(12,636)	(23,401)	(14,028)	(10,104)	(7,156)	(21,910)	(18,389)
Overall increase/(decrease) in cash	(176)	4,880	6,588	(13,859)	(22,838)	7,338	(10,765)	9,373	3,924	2,948	(14,754)	3,521	581
CLOSING CASH BALANCE	5,254	10,134	16,722	2,863	(19,974)	(12,636)	(23,401)	(14,028)	(10,104)	(7,156)	(21,910)	(18,389)	(17,808)
Closing Cash Balance represented by:													
General Accounts													
Cheque Account	0	0	0	0	0	0	0	0	0	0	0	0	0
NZ Health Partnerships Ltd	5,254	10,134	16,722	2,863	(19,974)	(12,636)	(23,401)	(14,028)	(10,104)	(7,156)	(21,910)	(18,389)	(17,808)
Long-term Loans													
Finance Leases	0	0	0	0	0	(2,600)	(5,200)	(7,800)	(10,400)	(13,000)	(13,000)	(13,000)	(13,000)
EECA Loan	(195)	(195)	(195)	(169)	(169)	(169)	(143)	(143)	(143)	(117)	(117)	(117)	(91)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	5,059	9,939	16,527	2,695	(20,143)	(15,404)	(28,744)	(21,971)	(20,647)	(20,273)	(35,027)	(31,505)	(30,898)
Working capital facility	(70,937)	(70,937)	(70,937)	(70,937)	(70,937)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(70,937)	(70,937)	(70,937)	(70,937)	(70,937)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)

BALANCE SHEET

Opinion on Result:

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

Prior Year June 2017 $'000	Waikato DHB Group Financial Position	As at February 2018 Actual $'000	Budget $'000	Variance $'000	Budget Jun-18 $'000
88,517	Total current assets	87,415	84,073	3,342 F	65,434
(181,405)	Total current liabilities	(177,476)	(179,465)	1,989 F	(160,570)
(92,888)	**Net working capital**	**(90,061)**	**(95,392)**	**5,332 F**	**(95,136)**
736,618	Term assets	729,094	740,221	(11,127) U	739,628
(21,053)	Term liabilities	(20,249)	(23,239)	2,990 F	(34,411)
715,565	**Net term assets**	**708,845**	**716,982**	**(8,137) U**	**705,217**
622,677	**Net assets employed**	**618,784**	**621,590**	**(2,806) U**	**610,081**
622,677	**Total Equity**	**618,784**	**621,590**	**(2,806) U**	**610,081**

Prior Year June 2017 $'000	Waikato DHB Group Ratios	As at February 2018 Actual $'000	Budget $'000	Achieved	Trend
63,670	Borrowing facilities available at month end	70,627	65,344	✓	⇧
0.5	Current ratio	0.5	0.5	✓	⇔
75.5%	Equity to total assets	75.8%	75.4%	✓	⇧
0.3%	Return on equity	0.0%	0.0%	✓	⇩

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is favourable to budget mainly due to:		
Current Assets		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $5.2m due mainly to the unfavourable variance relating to operating activities($13.8m) and financing activities ($2.6m) offset by favourable variance from investing activities ($11.2m) .	**$3.3 F**	Neutral
• Total accounts receivable and accrued debtors is higher than budgeted by $8m mainly due to the accrual of $7m capital charge funding not yet received from the MoH and $3.0m unbudgeted accrual for recovery of NOS costs. The remaining $2.0 unfavourable variance is largely as a result of timing of cash received compared with budget assumptions.		
• Prepayments are higher than planned by $0.2 mainly due to the timing of annual IS spend.		
• Other favourable variances across a number of areas $0.3m.		
Current Liabilities		
• Payroll liabilities are $4.6m favourable mainly due to the timing of pay runs (PAYE & leave) as compared with the phasing of the budget.	**$2.0 F**	Neutral
• Income in Advance $2.4m unfavourable to budget mainly due to quarterly unbudgeted pay equity settlement and Public Health Contract funds received in December.		
• GST $2.2m unfavourable to budget mainly due to the timing of processing of vendor invoices and unbudgeted income received.		
• Other Current Liabilities are favourable to budget $2m mainly due to the variances arising from the actual timing of transactions compared with budget assumptions.		
Net Fixed Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $11.1m. Please see attached for latest forecast of capital spend for the year for further detail.	**($11.1) U**	Neutral
Non Current Liabilities:		
Non Current Liabilities are favourable due to deferment of budgeted finance leases.	**$3.0 F**	Neutral
Equity:		
Driven mainly by variance in overall results.	**($2.8) U**	Neutral

CAPITAL EXPENDITURE AT 28 February 2018 ($000s)

Capital Plan					Cash Flow Forecast					Full Project Forecast		
Activity	Total Prior year Board Approvals	New Approvals FY17/18	Transfers During 17/18	Total Board Approved Capital Plans	Prior year expenditure for active Projects	Total Expenditure Forecast FY 17/18 (Actual + Planned)	Actual Expenditure YTD from 1 Jul-17 to 28 Feb 18	Approved and Planned Expenditure 01 Mar 18 - 30 Jun 18	Approved and Planned Spend Subsequent Years	Total Planned Expenditure (Actual + Forecast to Project completion)	Total Planned Expenditure Versus Total Board Approved	Commitments
Under $50K Subtotal		3,000		3,000		3000	1,660	1,340	0	3,000	0	520
Clinical Equipment Subtotal	12,668	20,354	1,237	34,259	2,566	9,569	7,546	2,023	17,696	29,831	4,428	3,161
Property & Infrastructure Subtotal	44,031	7,803	-657	51,177	18,255	14,881	8,017	6,864	15,930	49,066	2,111	2,020
IS Subtotal	19,758	7,729	109	27,596	8,314	7,052	4,416	2,636	7,642	23,008	4,587	1,486
Corporate Systems & Processes Subtotal	3,326	8,325	68	11,719	450	3,671	2,770	901	7,436	11,557	162	90
Regional Subtotal	9,419	798	-109	10,108	270	8,513	4,060	4,453	824	9,607	501	795
MOH Subtotal	0	0	0	0	0	0	0	0	0	0	0	0
Trust Funded Subtotal	0	0	0	0	0	0	0	0	0	0	0	12
Savings to be manged during 17/18 approval process						-4,691		-4,691		-4,691	4,691	
REPORT TOTALS	89,202	48,009	649	137,859	29,855	41,996	28,470	13,526	49,528	121,379	16,480	8,085

Waikato DHB
CAPITAL EXPENDITURE AT 28 February 2018 ($000s)

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
CT Machine Replacement Waikato x3	3,828	3,740	77	10
CT Machine Replacement Waikato x1	725	73	652	(0)
Ventilators (Critical Care)	400	-	400	-
Endoscopes	300	-	300	-
Replacement Theatre Lights OT 20-25	286	235	51	(0)
Glucose meters	275	-	275	-
Renal Dialysis (CCD) machines x4 Prismaflex	601	589	12	1
Other items - identfied per Clinical asset review	781	-	781	-
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	75	1,238	(0)
Mobile Dental Unit Replacements - level 2	600	-	600	-
Bed Replacement Programme	400	-	400	-
Digital Mobile X-Ray	351	-	351	(0)
Digital Mobile X-Ray Project	1,246	-	1,246	0
X-ray general (Radiology ED Room 1)	350	-	350	-
X-ray general (Radiology MCC Room 5)	350	-	350	-
Mobile Image Intensifier - Waikato	300	-	300	-
Microscope - Platics- Plastics Theatre	300	-	300	-
Linear Accelerator (replacement)	4,000	-	4,000	-
Anaesthetic machine - Aisys Carestation	380	-	380	-
Heart Lung Machines	680	-	680	-
Vascular & Interventional Replacement	1,750	-	1,750	-
General X-Ray replacement Thames	700	-	700	-
Biochemistry main Analysers	300	-	300	-
Liquid Chromatography Mass Spectometry Analyser	600	438	162	0
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	20	805	(0)
Trauma Gantry (radiology)	350	-	350	-
Projects Removed to be Capitalised	4,880	4,507	-	373
Other Clinical Services Projects Budgeted <$250K	9,669	2,095	7,519	55
Adjustment to reflect capacity to deploy			(3,990)	3,990
Clinical Equipment Subtotal	37,259	11,772	21,059	4,428
Property and Infrastructure				
Mental Health Facility - scoping	606	201	405	0
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Gallagher Build - Fitout	4,238	3,826	98	314
Gallagher Building - Med Store & CSES Clinic	406	402	4	(0)
Gallagher Building - Racking System	362	500	-	(138)
Gallagher Building - Converyor System	348	351	-	(3)
SCEP racking - hospital wide	400	-	400	-
Hamilton Consolidation of CBD facilities - 9th Floor	850	850	-	-
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	1,519	7,605	0
Hamilton CBD - Collingwood Street Development - First Floor	5,584	101	5,483	0
ED - Reconfiguration of entry / Front of House (Potential substitution for ED Expansion)	400	-	400	-
Menzies L3 development (Potential substitution for ED Expansion)	450	-	450	-
Pain Clinic to L8 Menzies (Potential substitution for ED Expansion)	450	-	450	-
Hilda Ross - Phase 1	2,801	2,896	-	(95)
Hilda Ross - Remediation	3,683	2,348	231	1,105
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	-	550	-
Hague road carpark - Seismic and Beam support	375	-	375	-
Urology to L8 Menzies	320	6	314	0
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Waikato Hauora iHub	321	25	220	76
Waikato switchboard upgrades core buildings	675	7	667	1
Infrastructure Replacement Pool (17/18)	510	79	286	145
Infrastructure Replacement Pool (15/16)	600	725	20	(145)
Infrastructure Replacement Pool (16/17)	641	175	25	441
OCB Replacements	350	-	350	-
Waikato Distribution Boards	250	213	67	(30)
Lift car upgrades (Stage 1)	1,835	2,059	-	(224)
Electrical Systems Improvement	6,714	5,969	745	0
Food & Nutrition Software	921	26	895	(0)
Projects Removed to be capitalised	3,165	3,175	-	(10)
Projects no longer in flight with expenditure	274	-	-	274
Other P&I Projects Budgeted <$250K	3,424	729	2,502	193
Property & Infrastructure Subtotal	**51,177**	**26,271**	**22,794**	**2,111**
Regional				
HSL - eSpace Programme	4,885	2,773	2,256	(144)
National Oracle Solution - Elevate	4,399	1,557	2,197	645
Other Regional Projects Budgeted <$250K	824	-	824	-
Regional Subtotal	**10,108**	**4,330**	**5,277**	**501**
MOH & Trust Funded				
Telestroke Pilot	449	49	272	128
16/17 Trust Account	303	303	-	(0)
Other MOH & Trust Funded Projects Budgeted <$250K	(752)	(352)	(372)	(28)
MOH & Trust Subtotal	0	0	(100)	100
Information Systems				
Platform	2,688	667	2,472	(451)
Storage & Reporting	1,125	438	686	1
Network & Communications	3,735	1,770	1,984	(19)
IAAS	1,686	745	941	0
Devices	2,253	636	1,274	343
Licensing	1,154	217	937	-
Enterprise Service Business	937	276	693	(32)
Tools	3,254	1,542	1,734	(22)
Security	817	101	708	8
Clinical Systems	6,862	3,822	3,239	(198)
Other Projects	422	118	305	(1)
CORPORATE SYSTEMS & PROCESSES	11,719	3,220	8,337	162
Projects to be Capitalised	2,663	2,399	-	263
Adjustment to reflect capacity to deploy			(4,694)	4,694
IS Subtotal	39,315	15,951	18,615	4,749
Savings to be managed during 17/18 approval process			(4,691)	4,691
Grand total	**137,859**	**58,325**	**62,954**	**16,580**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
February 2018

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

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

Travel costs - Executive Group	Month			Year to Date			
Feb-18	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AYDON LYDIA HELEN MS	-	-	-	610.70		610.70	
AITKEN VICKI ANN	-	-	-	538.83		538.83	
CHRYSTALL MAUREEN MS	-	-	-	493.49		493.49	
ELLIOTT LORAINE	-	-	-	316.69		316.69	
HABLOUS NEVILLE MR	-	-	-	557.25		557.25	Detail below
HACKETT DARRIN MR	-	-	-	126.35		126.35	
HAYWARD SUSAN MRS	812.67	-	812.67	3,292.87	3,144.68	6,437.55	Training related $3,145
LAWRENSON ROSS PROF	-	-	-	353.63		353.63	
MALONEY TANYA	-	534.43	534.43	280.12	3,546.40	3,826.52	Training related $3,546.40
MURRAY NIGEL MR	-	-	-	6,478.89	(499.90)	5,978.99	Detail below
NEVILLE MAUREEN MS	-	-	-	1,574.46		1,574.46	
PARADINE BRETT MR	-	-	-	312.26		312.26	
SPITTAL MARK MR	-	-	-	1,358.21		1,358.21	
TER BEEK MARC MR	-	-	-	607.67		607.67	
TOMIC DAMIAN MR	-	-	-	2,939.34		2,939.34	
WATSON TOM MR	-	-	-	1,292.58		1,292.58	
WILSON JULIE MS	-	-	-	3,010.40		3,010.40	
WOLSTENCROFT IAN	-	-	-	146.96		146.96	
WRIGHT DEREK MR	455.00	-	455.00	2,896.22	63.48	2,959.70	Detail below
Taxi	-	-	-	350.63		350.63	Largely N Murray
Grand Total	1,267.67	534.43	1,802.10	27,537.55	6,254.66	33,792.21	

CE Travel Expenditure: Nigel Murray

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

Acting CE Travel Expenditure Neville Hablous

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

Interim CE Travel Expenditure Derek Wright

Travel charges for the year to	February 2018			
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
October YTD	1,365.84	Prior to CE appointment	Prior to CE appointment	
November 2017	69.57	Conference cost	Nga Tumanako Conference	Ngaruawahia
November 2017	77.83	Mental Health and Addictions Services NGO Commissioning workshop	Mileage and parking expenses	Auckland
December 2017	702.42	DHB CE Meeting & MoH DG Health	Airfare (return), taxi	Wellington
December 2017	471.44	DHB CE Meeting - RMO bargaining strategy	Airfare (return)	Wellington
December 2017	73.48	Meeting with NZRDA (Union) and meeting with National Hauora Coalition	Mileage and parking expenses	Auckland
February 2018	199.13	Midlands DHBs regional meetings	Accommodation	Auckland
	2,959.70			

Budget update

The budget process is tracking to plan. The volume schedule is now being run through into the downstream models and costing aspects are being worked through. The first service pressure discussion is scheduled for 23 March. Whilst we do not yet have an overall budgeted cost and we have no information regarding the MoH funding envelope, the one aspect that is clear is that the budget will be under extreme pressure.

Response to Board queries:

The Board has requested

1. Analysis of our Ministry of Health (MoH) funding and clarity of our dominant concerns regarding such funding.
2. Cost splits and FTE comparisons.

These are outlined below.

1. Ministry of Health (MoH) Funding aspects

Funding table

	$'000		$'000			$'000			$'000			$'000		
	2014	% of total	2015	% of total	% change to prior year	2016	% of total	% change to prior year	2017	% of total	% change to prior year	2018 Forecast	% of total	% change to prior year
FUNDER REVENUE														
MoH - PBFF revenue	940,410	76.8%	962,947	76.7%	2.4%	1,006,698	77.2%	4.5%	1,052,140	77.4%	4.5%	1,099,093	76.2%	4.5%
Additional Funder MoH contracts	71,745	5.9%	76,645	6.1%	6.8%	87,447	6.7%	14.1%	92,257	6.8%	5.5%	120,555	8.4%	30.6%
Inter district Flows	121,983	10.0%	126,689	10.1%	3.9%	125,433	9.6%	-1.0%	129,030	9.5%	2.9%	138,227	9.6%	7.1%
Other Government	73	0.0%	627	0.0%	753.5%	655	0.1%	4.5%	584	0.0%	-10.9%	534	0.0%	-8.5%
Total Funder revenue	**1,134,211**	**92.7%**	**1,166,909**	**92.9%**	**2.9%**	**1,220,233**	**93.6%**	**4.6%**	**1,274,051**	**93.8%**	**4.4%**	**1,358,410**	**94.1%**	**6.6%**
PROVIDER EXTERNAL REVENUE														
Revenue MoH side-arm contracts	37,059	3.0%	30,125	2.4%	-18.7%	21,918	1.7%	-27.2%	22,479	1.7%	2.6%	21,992	1.5%	-2.2%
ACC	10,667	0.9%	14,389	1.1%	34.9%	16,459	1.3%	14.4%	13,903	1.0%	-15.5%	15,551	1.1%	11.9%
Health Workforce NZ	10,712	0.9%	10,571	0.8%	-1.3%	11,083	0.9%	4.8%	11,357	0.8%	2.5%	11,716	0.8%	3.2%
Other Revenue	31,100	2.5%	33,941	2.7%	9.1%	33,510	2.6%	-1.3%	36,767	2.7%	9.7%	35,653	2.5%	-3.0%
Total Provider external revenue	**89,539**	**7.3%**	**89,026**	**7.1%**	**-0.6%**	**82,969**	**6.4%**	**-6.8%**	**84,506**	**6.2%**	**1.9%**	**84,911**	**5.9%**	**0.5%**
TOTAL REVENUE	**1,223,750**	**100.0%**	**1,255,935**	**100.0%**	**2.6%**	**1,303,203**	**100.0%**	**3.8%**	**1,358,557**	**100.0%**	**4.2%**	**1,443,321**	**100.0%**	**6.2%**

MoH funding

The MoH funds DHBs through various channels, as follows

- Predominantly DHBs are funded through a Population Based Funding Formula (PBFF) that is applied to the relevant Vote Health allocation. The basis for this formula is outlined below. Value for Waikato DHB for 17/18 is $1,099m.
- Top-sliced funding for aspects such as Forensics, Primary Maternity, School Based Health, Hospice support and capital adjustors. Value for 17/18 is $33m.
- Other specifically contracted service lines or adjustments, such as Additional Electives, Aged Residential Care Pay Equity, Primary Health Organisation Low cost access subsidy, etc. Value for 17/18 is $88m.
- DHB Provider side-arm contracts with MoH, such as breast screening. Value for 17/18 is $22m.
- Total MoH funding for 17/18 is $1,242m (86% of total funding).

Population-based funding formula (PBFF) basis

The formula takes into account the number of people who live in each DHB catchment, their age, socio-economic status, ethnicity, and sex. It also has mechanisms to compensate DHBs who service rural communities and areas of high deprivation. According to the PBFF, each DHB's share of health and disability funding is determined by:

1. its share of the projected New Zealand population, weighted according to the national average cost of the health and disability support services used by different demographic groups
2. an additional policy-based weighting for unmet need that recognises the different challenges DHBs face in reducing disparities and access to health services between population groups
3. a rural adjustment and an adjustment for eligible overseas visitors and refugees, each of which redistribute a set amount of funding between DHBs to recognise unavoidable differences in the cost of providing certain health and disability support services to these population groups.

The Waikato **DHB will receive $1,099m in PBFF allocation** for the 17/18 financial year. Unfortunately the Ministry does not provide a detailed breakdown of PBFF calculations for different population groups, only our total funding.

Other funding

Dominant other funding sources are

- Inter District Flows (IDF) which includes a Tertiary Adjustor aspect – $138m
- ACC – $16m
- Health Workforce New Zealand – $12m
- Other, including Research, non resident charges, food sales, parking fees, etc - $36m
- Total Other Funding total is $201m (14% of total revenue – very little of which is able to be influenced as part of daily activities).

Funding concerns

There are a number of concerns regarding our funding, as follows

- When considering the pressure that most DHBs seem to be under, it would **seem** that the quantum of Vote Health shared under the PBFF formula is inadequate and isn't sufficient to address population growth, population demographic changes, increased patient complexity, the increasing scope of clinical practice in the interests of improving quality of life and life expectancy, the disproportionately growing acute demand and the unavoidable escalation (MECA and other general inflationary impacts).
- Revenue growth is lagging demographically driven demand growth.
- The PBFF formula lags some aspects of demographic growth.
- IDF events are settled at the National Price, which is lower than the cost of service delivery.
- The Tertiary Adjustor formula has shown high volatility which suggests the basis for determination may be flawed.

These aspects are covered in more detail below.

Vote Health quantum

The Ministry of Health receives costing information from a high percentage of total DHB volume. They use this data to define a National Price for a secondary Caseweight (a common unit of clinical service delivery). This National Price is calculated for a financial year based on costing data that is 3 years old with adjustment applied – thus for the 18/19 National Price, the cost base for 15/16 is taken, adjusted for 3 years of inflation at a MoH determined rate (2.21% for 15/16 to 16/17, 2% for 16/17 to 17/18 and uplift from 17/18 to 18/19 still to be defined), an efficiency adjustor is then applied (average of 1.5% per annum) as well as an "affordability" adjustor (the quantum of which is not clarified). The result is a National Price for 18/19 set in 17/18. However, I have not been able to gain clarity re what such National Price is purporting to represent. I thus asked for and received a comparison from the MoH reflecting the comparison between the prospectively set National Price and the retrospectively calculated actual costs. For the last four years for which this is available, the National Price average is 7.1% below the average actual cost of DHB service delivery at a secondary Caseweight level. **IF** the National Price was meant to represent the average cost of secondary Caseweight services, then the DHBs are being underfunded by this average 7.1% - or $298m based on the total of Casemix priced volumes of $4.2bn for 17/18. I'm trying to progress clarity of what the National Price is designed to represent with the National Costing Collection and Pricing Programme Technical Reference Group (NCCP TRG).

Revenue Growth vs Cost Growth

The table below reflects population and revenue over the last 5 years. In order to recognise demographic change over the years, the "weighted" population has been derived by factoring in the "expected" health costs for the various demographic groups in order to estimate increased demand over time as the demographics change. The revenue line has also been discounted to 2014 money in order to remove the inflationary impact.

Population and Revenue growth	2014	2015	% change	2016	% change	2017	% change	2018	% change	% change to 2014
Population	383,520	390,640	1.9%	399,550	2.3%	408,690	2.3%	417,130	2.1%	8.8%
Weighted population	383,520	392,400	2.3%	403,497	2.8%	415,748	3.0%	427,148	2.7%	11.4%
PBFF revenue	$940,410	$962,947	2.4%	$1,006,698	4.5%	$1,052,140	4.5%	$1,099,093	4.5%	16.9%
PBFF Revenue discounted by inflation	$940,410	$952,470	1.3%	$983,290	3.2%	$1,005,553	2.3%	$1,030,504	2.5%	9.6%

The % change since 2014 of 11.4% for the weighted population compared to the PBFF revenue discounted % change of 9.6% is the most relevant aspect and demonstrates that "real" revenue has not kept pace with the expected demand from population growth and demographic changes.

Another way of looking at this is to review revenue growth split between inflationary and demographic aspects. The table below reflects an attempt to do this. Please note that I have used an inflationary factor for each year that is the average between SMO MECA, NZNO MECA and CPI. This demonstrates a cumulative funding shortfall of around $44m which is based on funding for 2014 being fairly aligned to our cost based driven by demand (which isn't necessarily correct).

Inflationary vs Demographic growth	2014	2015	% change	2016	% change	2017	% change	2018	% change	% change to 2014
Weighted population	383,520	392,400	2.3%	403,497	2.8%	415,748	3.0%	427,148	2.7%	11.4%
PBFF revenue	$940,410	$962,947	2.4%	$1,006,698	4.5%	$1,052,140	4.5%	$1,099,093	4.5%	16.9%
DHB total costs	$1,219,903	$1,258,862	3.2%	$1,299,770	3.2%	$1,357,626	4.5%	$1,465,159	7.9%	20.1%
NZNO MECA increases			2.0%		2.0%		2.8%	assumed	2.0%	
SMO MECA increases			0.6%		0.0%		2.0%		2.0%	
CPI			0.7%		1.8%	assume flat	1.8%		1.8%	
Average			1.1%		1.3%		2.2%		1.9%	
Calculated inflation on 76% of cost base		$10,198	0.8%	$12,119	1.0%	$21,732	1.7%	$19,948	1.5%	5.2%
Derived revenue for demographic growth		$12,339	1.0%	$31,632	2.5%	$23,710	1.8%	$27,005	2.0%	7.8%
Demographic growth derived shortfall			1.3%		0.3%		1.2%		0.8%	3.6%
Calculated $ impact of under-funding		$15,906		$3,968		$15,756		$10,223		$44,088

PBFF formula lags

The PBFF formula uses population estimates created every year by Stats NZ for the MoH. We have a concern that some population segments or localities are changing and the Stats NZ process doesn't get to this level of detail. An example would be the Northern Corridor growth. The Funder is developing a new demographics model to help highlight this. Where population growth is missed in the current process there is a delay in compensation for these DHBs. In addition the annual pricing is subjected to a minimum and maximum revenue increase – termed transitional funding – most currently a minimum of 2.5% and a maximum of 5%. The reality of this is that a DHB with a declining population still receives the 2.5% minimum increase which is then smoothed over a period negotiated with that DHB – this has a flow on impact on other DHBs as this minimum funding increase impacts of the balance of Vote Health to be distributed. By the same token a DHB that has a high population growth has its revenue increase capped at 5% which is then smoothed over subsequent years. Thus DHBs with declining populations benefit for some time and DHBs with growing populations suffer.

IDF events

Of relevance too is that IDF volumes are settled at the National Price, thus the Waikato DHB would under recover on IDF In and benefit from a price lower than cost for IDF Out. Our net balance for 17/18 is net IDF In of $78m. The marginal costing argument would only be relevant for clinical services where the IDF in volumes were extremely small – most clinical services would resource for IDF volumes. Reality is that almost all costs are variable in the long term, thus I believe the most relevant comparison should be against full cost. Thus a calculated under recovery (or other DHB subsidy) of $5.5m for 17/18 ($78m x 7.1%).

Tertiary adjustor

The Tertiary Adjuster is a price premium that all DHBs pay to ensure that there is tertiary-level hospital capacity available for their populations. The tertiary adjuster calculation compares tertiary DHB costs of producing secondary cases with the costs based on secondary DHB costs. This is based on the assumption that while the costs of tertiary cases is properly accounted for in tertiary case-mix funding, the costs of doing secondary cases in a tertiary setting incurs a diseconomy cost due to staff capacity, capability and mix and advanced diagnostics that is not addressed in casemix funding.

My concern here relates to the volatility in this adjustor. The initially proposed pricing for 17/18 reflected a 2.33% increase in Casemix pricing and a 23.61% decrease in the Tertiary Adjustor – there was a high degree of discomfort in this Tertiary Adjustor change so the outcome was that the Tertiary Adjustor was rolled over from 16/17 with a 2% increase. An initial cut of the 18/19 pricing reflected a reduction of the Tertiary Adjustor pool from $142m to $64m – a 55% reduction. However, it was discovered that some Waitemata data was incorrect. Once this was adjusted the pool was revised to $78m – a 22% increase from the previous calculation – a 45% decrease from 17/18. The final outcome is a reduction in the Tertiary Adjustor pool from $142m to $79m – a 44% decrease. I have not been able to obtain any logical explanation as how/why this pool is so volatile. The 18/19 pricing advise acknowledges that the "tertiary pool result is very sensitive to the quality and quantity of information provided". My view is that the mechanics (which are complex) may well be illogical and thus should be carefully reviewed. I'm trying to progress this perspective with the NCCP TRG.

2. <u>Cost Splits and FTE comparisons</u>

The Board has also requested clarity re change over time to

- The cost split between External Providers and our internal DHB Provider
- FTE numbers by resource type

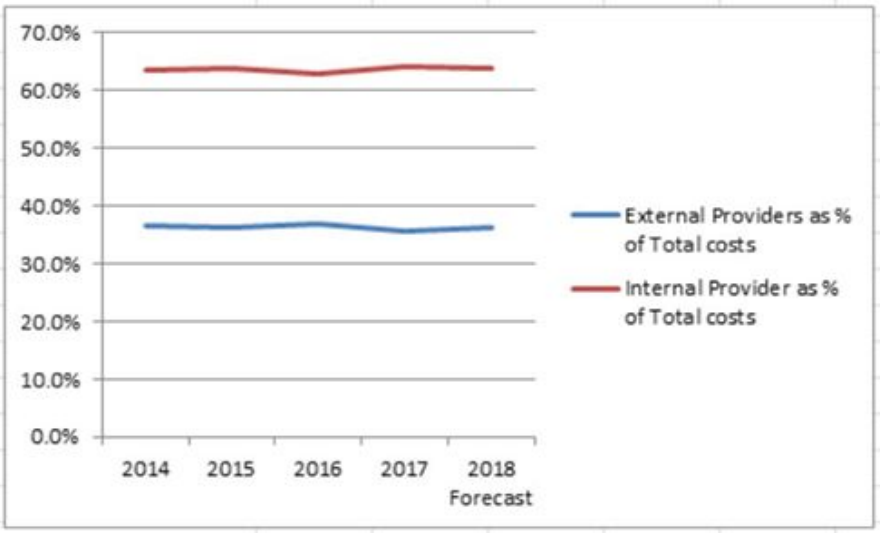
These aspects are reflected below

Cost split between External Providers and our internal DHB provider:

The split of our cost base between External Providers and our Internal Provider over the last 5 years has been very consistent.

External Providers/Internal Provider split

	2014	2015	2016	2017	2018 Forecast
External Providers as % of Total costs	36.5%	36.3%	37.0%	35.7%	36.1%
Internal Provider as % of Total costs	63.5%	63.7%	63.0%	64.3%	63.9%



More detailed cost splits, which reflects a generally consistent pattern with some key exceptions, such as

- Disability Support Services increase in 2018
- Outsourced personnel increase in 2017
- Outsourced services from 2016 onwards mostly due to theatre outsourcing

	$'000		$'000			$'000			$'000			$'000		
		% of 2014 total		% of 2015 total	% change to prior year		% of 2016 total	% change to prior year		% of 2017 total	% change to prior year	2018 Forecast	% of total	% change to prior year
FUNDER EXTERNAL EXPENSES														
Laboratory	19,501	1.7%	18,292	1.5%	-6.2%	19,416	1.6%	6.1%	19,948	1.5%	2.7%	20,498	1.5%	2.8%
Pharmaceuticals	89,453	7.7%	87,407	7.3%	-2.3%	92,054	7.5%	5.3%	91,448	7.0%	-0.7%	93,670	6.8%	2.4%
Primary Practice Srv	70,140	6.1%	76,873	6.5%	9.6%	79,764	6.5%	3.8%	83,258	6.4%	4.4%	87,238	6.3%	4.7%
Personal Health other	53,486	4.6%	53,678	4.5%	0.4%	59,430	4.8%	10.7%	57,505	4.4%	-3.2%	55,864	4.1%	-2.9%
Mental Health	42,846	3.7%	43,796	3.7%	2.2%	44,606	3.6%	1.8%	45,546	3.5%	2.1%	48,337	3.5%	6.1%
Disability Support Services	97,859	8.5%	100,300	8.4%	2.5%	103,521	8.4%	3.2%	109,362	8.4%	5.6%	131,527	9.6%	20.3%
External Provider - Excluding IDF outflow	**373,285**	**32.3%**	**380,347**	**31.9%**	**1.9%**	**398,791**	**32.3%**	**4.8%**	**407,106**	**31.4%**	**2.1%**	**437,134**	**31.8%**	**7.4%**
IDF Outflow	48,895	4.2%	51,345	4.3%	5.0%	58,284	4.7%	13.5%	56,643	4.4%	-2.8%	59,954	4.4%	5.8%
Total Funder External Expenses	**422,180**	**36.5%**	**431,692**	**36.3%**	**2.3%**	**457,075**	**37.0%**	**5.9%**	**463,749**	**35.7%**	**1.5%**	**497,088**	**36.1%**	**7.2%**
PROVIDER EXPENSES														
Personnel	482,822	41.8%	497,880	41.8%	3.1%	515,996	41.8%	3.6%	537,041	41.4%	4.1%	565,705	41.1%	5.3%
Outsourced Personnel	14,299	1.2%	12,900	1.1%	-9.8%	14,737	1.2%	14.2%	23,364	1.8%	58.5%	26,664	1.9%	14.1%
Outsourced Services	38,666	3.3%	39,032	3.3%	0.9%	46,978	3.8%	20.4%	55,055	4.2%	17.2%	62,357	4.5%	13.3%
Clinical Supplies	127,367	11.0%	132,377	11.1%	3.9%	128,997	10.5%	-2.6%	135,538	10.4%	5.1%	143,431	10.4%	5.8%
Infrastructure & Non Clinical Supplies	70,050	6.1%	76,610	6.4%	9.4%	70,104	5.7%	-8.5%	82,735	6.4%	18.0%	80,845	5.9%	-2.3%
Total Provider Expenses	**733,204**	**63.5%**	**758,798**	**63.7%**	**3.5%**	**776,813**	**63.0%**	**2.4%**	**833,733**	**64.3%**	**7.3%**	**879,003**	**63.9%**	**5.4%**
TOTAL EXPENSES excl IDCC	1,155,384	100.0%	1,190,490	100.0%	3.0%	1,233,887	100.0%	3.6%	1,297,483	100.0%	5.2%	1,376,091	100.0%	6.1%

FTE numbers by resource type:

The table below reflects dominant FTE growth in clinical resources which aligns to continued patient demand growth.

	Full Year							YTD Feb-18		
Accrued FTE's	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**16/17 Change since 2010/11**	**17/18 Change since 2010/11**
Medical Personnel	702.58	723.8	715.53	702.58	714.75	723.01	767.93	801.03	9.3%	14.0%
Nursing Personnel	2377.14	2472.07	2438.41	2377.14	2438.41	2467.24	2586.2	2624.35	8.8%	10.4%
Allied Health Personnel	970.01	1058.33	1004.95	970.01	1004.95	1030.24	1073.59	1068.91	10.7%	10.2%
Support Personnel	345.39	342.76	344.65	345.39	344.65	345.21	348.64	342.22	0.9%	-0.9%
Management / Administration Personnel	1077.88	1131.69	1091.26	1077.88	1048.32	1046.8	1086.08	1090.21	0.8%	1.1%
Total	**5473.00**	**5728.65**	**5594.80**	**5473.00**	**5551.08**	**5612.50**	**5862.44**	**5926.72**		

Increase %	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Medical Personnel	3.0%	-1.1%	-1.8%	1.7%	1.2%	6.2%	4.3%
Nursing Personnel	4.0%	-1.4%	-2.5%	2.6%	1.2%	4.8%	1.5%
Allied Health Personnel	9.1%	-5.0%	-3.5%	3.6%	2.5%	4.2%	-0.4%
Support Personnel	-0.8%	0.6%	0.2%	-0.2%	0.2%	1.0%	-1.8%
Management / Administration Personnel	5.0%	-3.6%	-1.2%	-2.7%	-0.1%	3.8%	0.4%
Total	**4.7%**	**-2.3%**	**-2.2%**	**1.4%**	**1.1%**	**4.5%**	**1.1%**

% of Total	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Medical Personnel	12.8%	12.6%	12.8%	12.8%	12.9%	12.9%	13.1%	13.5%
Nursing Personnel	43.4%	43.2%	43.6%	43.4%	43.9%	44.0%	44.1%	44.3%
Allied Health Personnel	17.7%	18.5%	18.0%	17.7%	18.1%	18.4%	18.3%	18.0%
Support Personnel	6.3%	6.0%	6.2%	6.3%	6.2%	6.2%	5.9%	5.8%
Management / Administration Personnel	19.7%	19.8%	19.5%	19.7%	18.9%	18.7%	18.5%	18.4%

Some Other key stats :

We have extracted some key stats for the last 5 years, as per below.

Key stats	2014	2015	% change	2016	% change	2017	% change	2018	% change	% change to 2014
Population	383,520	390,640	1.9%	399,550	2.3%	408,690	2.3%	417,130	2.1%	8.8%
Weighted population	383,520	392,400	2.3%	403,497	2.8%	415,748	3.0%	427,148	2.7%	11.4%
FTE	5,473	5,551	1.4%	5,613	1.1%	5,862	4.4%	5,927	1.1%	8.3%
CWD - Acute & Elective only	77,748	80,403	3.4%	79,281	-1.4%	83,006	4.7%	85,758	3.3%	10.3%
Bed days - Acute & Elective only	211,557	205,999	-2.6%	203,529	-1.2%	212,802	4.6%	217,036	2.0%	2.6%
Total bed days	296,729	297,465	0.2%	298,685	0.4%	310,131	3.8%	314,886	1.5%	6.1%
ALOS - acute	3.76	3.60	-4.3%	3.59	-0.3%	3.60	0.3%	3.56	-1.1%	-5.3%
ALOS - elective	1.66	1.60	-3.6%	1.43	-10.6%	1.42	-0.7%	1.53	7.7%	-7.8%
Inflationary aspect			1.1%		1.3%		2.2%		1.9%	
PBFF revenue	$940,410	$962,947	2.4%	$1,006,698	4.5%	$1,052,140	4.5%	$1,099,093	4.5%	16.9%
PBFF Revenue discounted by inflation	$940,410	$952,470	1.3%	$983,290	3.2%	$1,005,553	2.3%	$1,030,504	2.5%	9.6%
Total revenue	$1,223,750	$1,255,935	2.6%	$1,303,203	3.8%	$1,358,557	4.2%	$1,443,321	6.2%	17.9%
Revenue discounted by inflation	$1,223,750	$1,242,270	1.5%	$1,272,900	2.5%	$1,298,402	2.0%	$1,353,250	4.2%	10.6%
DHB total costs	$1,219,903	$1,258,862	3.2%	$1,299,770	3.2%	$1,357,626	4.5%	$1,465,159	7.9%	20.1%
DHB costs discounted by inflation	$1,219,903	$1,245,165	2.1%	$1,269,547	2.0%	$1,297,513	2.2%	$1,373,726	5.9%	12.6%
DHB cost/CWD	$15,690	$15,657	-0.2%	$16,394	4.7%	$16,356	-0.2%	$17,085	4.5%	8.9%
Discounted DHB cost/CWD	$15,690	$15,486	-1.3%	$16,013	3.4%	$15,632	-2.4%	$16,019	2.5%	2.1%
DHB cost/population	$3,181	$3,223	1.3%	$3,253	0.9%	$3,322	2.1%	$3,512	5.7%	10.4%
Discounted DHB cost/population	$3,181	$3,188	0.2%	$3,177	-0.3%	$3,175	-0.1%	$3,293	3.7%	3.5%
Discounted DHB cost/weighted population	$3,181	$3,173	-0.2%	$3,146	-0.8%	$3,121	-0.8%	$3,216	3.0%	1.1%
CWD/population	0.203	0.206	1.5%	0.198	-3.6%	0.203	2.4%	0.206	1.2%	1.4%
CWD/weighted population	0.203	0.205	1.1%	0.196	-4.1%	0.200	1.6%	0.201	0.6%	-1.0%
CWD/FTE	14.206	14.485	2.0%	14.125	-2.5%	14.160	0.3%	14.469	2.2%	1.9%
Bed days/FTE	54.217	53.588	-1.2%	53.213	-0.7%	52.905	-0.6%	53.127	0.4%	-2.0%
DHB/cost per bed day	$4,111	$4,232	2.9%	$4,352	2.8%	$4,378	0.6%	$4,653	6.3%	13.2%
DHB/discounted cost per bed day	$4,111	$4,186	1.8%	$4,250	1.5%	$4,184	-1.6%	$4,363	4.3%	6.1%

Health Targets

MEMORANDUM TO THE BOARD
28 MARCH 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 including 2017/18 quarter one and two results. These results are still provisional as the Ministry of Health has not yet obtained final approval from the Minister to publish them. The most recent results in the last column give the most up to date picture of performance using local data where available.

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	Target achieved	2017/18 Most recent result
Shorter stays in emergency departments		95%	89.3% 19th ✗	87.6% 20th ✗	88.4% 20th ✗	86% 20th ✗	95%	82% 20th ✗	89% 20th ✗	X	86% Feb-18 YTD
Improved access to elective surgery		100%	108% 7th ★	106% 10th ●	110% 3rd ★	114% 2nd ★	100%	111% 5th ★	104% 8th ●	√	105% Feb-18 YTD
Faster Cancer Treatment (FCT)	Achievement	85%	81.4% 5th ★	85.9% 4th ★	86.1% 5th ★	86% 2nd ★	85%	98% 1st ★	98% 2nd ★	√	98% Feb-18
Better Help for Smokers to quit	Primary Care	90%	87% 12th ●	86% 13th ●	87% 12th ●	88% 15th ✗	90%	88% 14th ●	89% 12th ●	X	89% 17/18 Q2 result
	Maternity	90%	93% 12th ●	96%	98% 4th ★	95% 8th ●	90%	94% 8th ●	97% 4th ★	√	97% 17/18 Q2 result
Increased immunisation (8 months)		95%	92.3% 13th ●	92% 15th ✗	90% 16th ✗	89% 15th ✗	95%	88% 15th ✗	90% 15th ✗	X	89% Feb 18 3 mth rolling
Raising Healthy Kids[1]		95%	47% 11th ●	79% 6th ★	84% 9th ●	81% 14th ●	95%	76% 19th ✗	100% 1st ★	√	100% Q2 provisional result

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

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2017

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

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

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

Quarterly Results – by DHB total population

	Numerator: The number of ED presentations with a length of stay of less than six hours	Denominator: Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	25298	28473	88.8%
Waikato	16961	19582	86.6%
Taumarunui	1410	1447	97.4%
Thames	3948	4380	90.1%
Tokoroa	2979	3064	97.2%

Quarterly results – by ethnicity

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

	Māori Ethnicity			Pacific Ethnicity		
	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	6977	7727	90.3%	570	777	73.4%
Waikato	4547	5205	87.4%	436	621	70.2%
Taumarunui	579	590	98.1%	10	12	83.3%
Thames	625	672	93.0%	29	39	74.4%
Tokoroa	1226	1260	97.3%	95	105	90.5%

Thames, Tokoroa and Taumarunui Hospitals

Summertime is the peak period for Thames hospital due to the increase in domestic and international tourist numbers to the Coromandel. Two percent more people presented in the first two months of 2018 compared to the same period the prior year. A proposal to introduce a CNS pilot into the Thames ED is currently under evaluation. A formal EOI seeking respondents who are willing to establish a primary care centre within the Thames hospital facility was approved by the DHB board in late February and will be conducted over March/April.

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

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

Collaborative work involving the Waikato DHB, the Auckland Westpac helicopter trust, and the Waikato Phillips helicopter trust to improve the clinical management of patients who are urgently retrieved between the district's rural EDs and the base hospital in Hamilton is underway.

Waikato Hospital

Waikato Hospital's ED continues to experience significant monthly year on year increases in presentations. February 2018 experienced a 5.3% increase on February last year, whilst there has been a staggering 9.8% increase in attendances year to date. The target performance was slightly down from January, but was much higher than in Q1.

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

Actions currently being taken in Waikato Hospital:

- General Medicine has moved to a ward based model of care on 26 February, with the stated aim of further enhancing patient flow on the Medical wards. Early indications are that this is having a beneficial impact on patient flow, and more timely discharges.

- OPR5's opening enables a new improved frail elderly pathway of care and sorely needed additional bed capacity.

- Electronic SBARR handover sheets to Medicine and Respiratory go live on 01st March

- The Francis Group have been engaged to support the patient flow process from ED to the Medical and OPR wards.

- GP enrolments continue to be actively promoted in the ED, through designated resource, in an attempt to reduce repeat presentations.

- Recruiting into 2 MOSS position into ED to broaden the skill mix and improve senior cover out of hours.

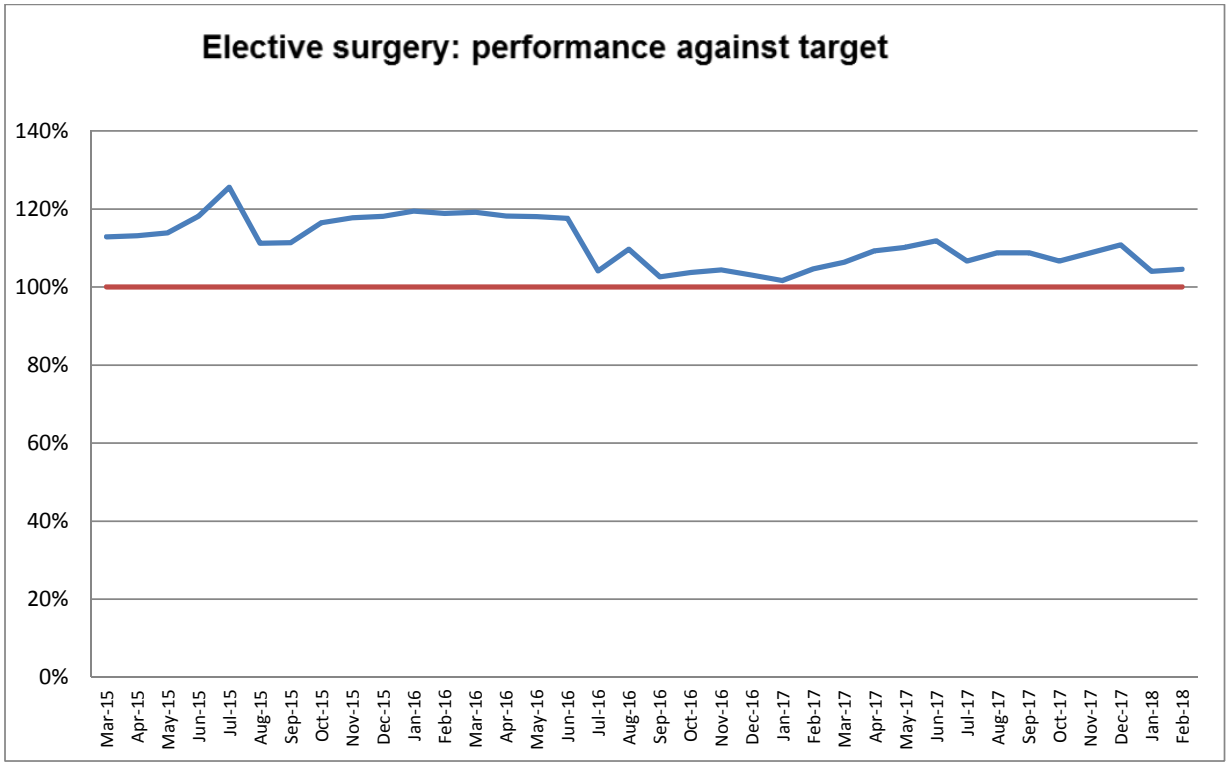
Target: Elective Surgery

Table 4 – Elective Surgery Results by Quarter

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

Graph 1 below provides the most recent result of 105%.

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



Target: Faster Cancer Treatment (FCT)

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

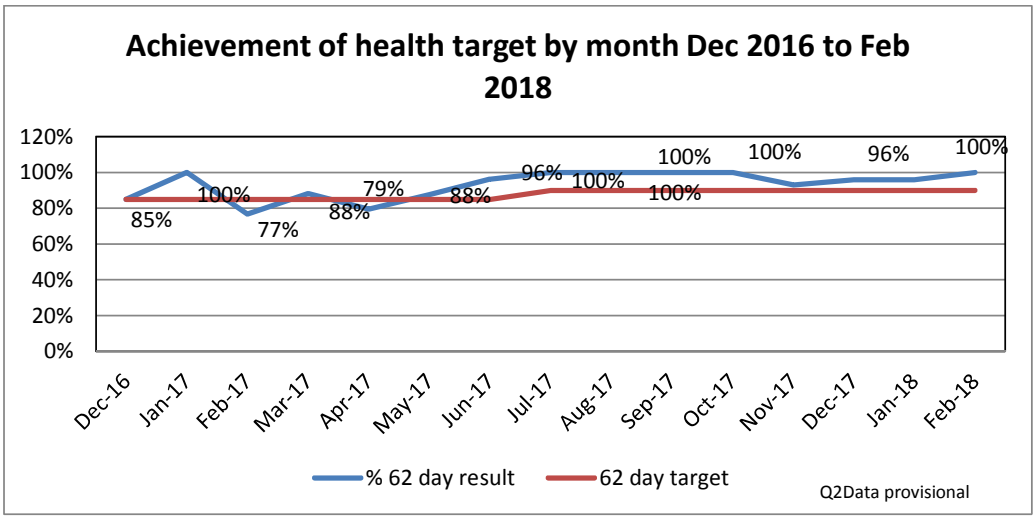
FCT 62 DAY HEALTH TARGET								
DHB Current Target	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	**DHB Preliminary Q3 Result**
90%	72.6% 14th ranking	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 3rd equal ranking	96.6% 2nd ranking	98.0%
FCT VOLUME TARGET								
DHB Current Target	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	**DHB Preliminary Q3 Result**
25%	14%	17%	19%	19%	22%	14%	14%	**13%**

Waikato has continued to deliver sustained achievement against the 90% FCT health target. We are pleased to be able to report that we are currently ranked second nationally for this metric for 2017/18.

2017/18 Quarter 2 is the second quarter for achievement against the new health target of 90%, which includes the newly excluded breach reasons of patient choice and clinical considerations. Our final result of 96.6% shows that Waikato continues to strongly deliver on this key national target.

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

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



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

- FCT Business Manager and FCT Nurse Tracker are working very closely with cancer care coordinators and clinical nurse specialists to monitor patient pathways from initial date of referral
- Improving the timeliness of gynaecology triaging and first specialist appointment.
- Weekly coordinated meeting with the gynaecology clinical nurse specialist and cancer care coordinator to discuss individual patients and tracking pathways to ensure patients are discussed at Auckland multi-disciplinary meetings in a timely manner.
- Ongoing monitoring of respiratory triaging and time to FSA.
- Weekly coordinated meeting with upper gastro-intestinal surgeons and upper gastro-intestinal cancer nurse coordinator to discuss and track individual patients to ensure patients proceed along the pathway in a timely manner.
- Liaising with interventional radiologists to ensure patients receive their CT biopsy in a timely manner.
- Weekly urology waitlist meeting to discuss any patients triaged onto 62 day pathway.
- Monitoring and collaborative approach between breast care and plastics for women requiring immediate breast reconstruction.
- Engagement with Te Puna Oranga to minimise inequity in FCT, including addressing DNAs and identifying barriers.
- Daily reports are now being generated to highlight any DNAs for FCT patients.
- Early detection of lung cancer - A small working group is being established to look at identifying and supporting patients with early lung cancer to reduce admissions into ED and poor outcomes.

Table 6

Local FCT Database	**Jan-18**	**Feb-18**	**Q3 Preliminary Total**
Number of records submitted	26	17	43
Number of records within 62 days	25	17	42
% 62 day Target Met (90%)	96%	100%	98%
% Volume Target Met (15%)	16%	10%	13%

Target: Increased immunisations for 8 months

Table 7 – 8mth Milestone Immunisation Results by Quarter

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

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

We have not achieved the target this quarter as has been the case since the inception of this tartget.

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

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

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

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

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

Proposed new work streams

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

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

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

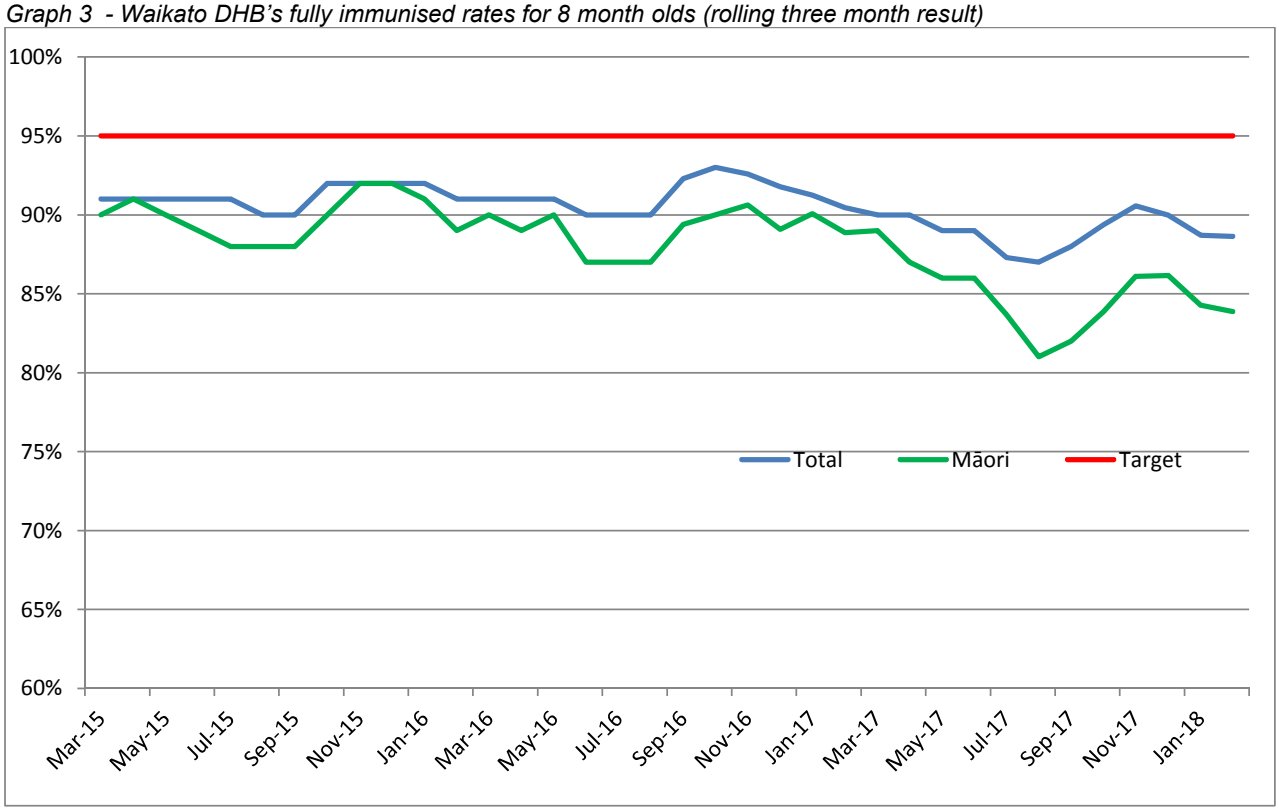


Table 8 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 87 additional children needed to be immunised to meet the 95% target.

Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from Dec 2017 to Feb 2018

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	561	512	91%	21
Māori	508	426	84%	57
Pacific	57	52	91%	3
Asian	159	154	97%	0
Other	79	65	82%	11
Total across ethnicities				92
Total	1,364	1,209	89%	87

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

Table 9 - Waikato DHB's PHO level results for 8 month old immunisation from Dec 2017 to Feb 2017

	Total population			Maori population		
PHO	No eligible population	No fully immunised population	Percent immunised	No eligible population	No fully immunised population	Percent immunised
Hauraki PHO	492	447	91%	218	187	86%
Midlands Health Network – Waikato	765	691	90%	248	214	86%
National Hauora Coalition	25	21	84%	13	10	77%
Enrolled with a PHO outside of Waikato	26	23	88%	10	9	90%
Unenrolled Waikato population	56	27	48%	19	6	32%
DHB Total	1,364	1,209	89%	508	426	84%

Target: Better help for smokers to quit - primary care

Table 10 – Quarterly Results

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

Graph 4 showing data up to the quarter two 17/18 result of 89% shows Waikato DHB has maintained the results from the previous quarters.

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

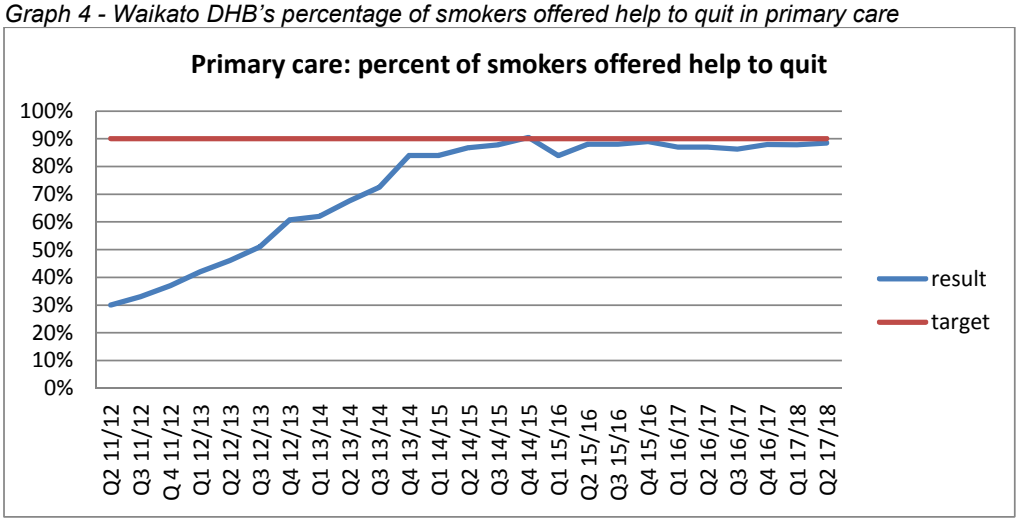


Table 11 shows a breakdown of primary care smoking results by PHOs up to 2017/18 quarter two.

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

PHOs	**Tobacco Numerator**	**Tobacco Denominator**	**2017/18 Q2 result**	**2017/18 Q1 result**	**2016/17 Q4 result**	**2016/17 Q3 result**
Midlands Health Network	25,857	28,714	90%	89%	**87%**	88%
Hauraki PHO	20,066	23,192	87%	86%	**89%**	86%
National Hauora Coalition	1,126	1,280	88%	88%	**94%**	87%
Total	47,049	53,186	**89%**	**88%**	**86%**	**86%**

Target: Better help for smokers to quit - maternity

Table 12 – Quarterly Results

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

Graph 5 quarter two result of 97% shows we continue to met this target.

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

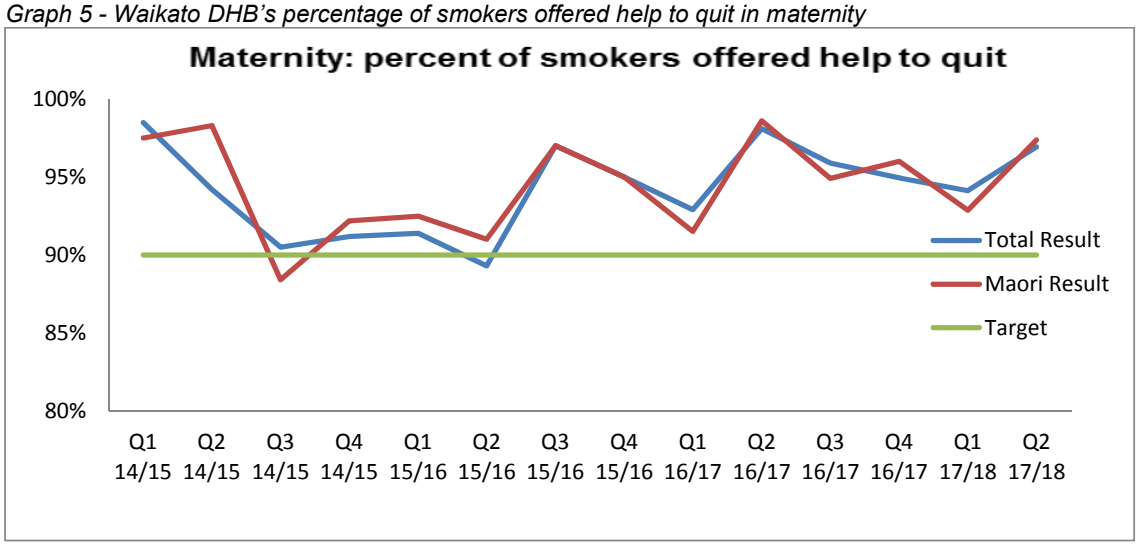


Table 13 shows our quarter three results provided by the Ministry for our total and Maori population.

Table 13 – 2016/17 Q4 maternity smoking status and advice results (target 90%)

	No. women registered	No. of women identified as smokers	No. people given advice	Smoking prevalence	Percent of smokers offered advice
Maori	83	38	37	46%	97.4%
Total	383	65	63	17%	96.9%

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

The information for this measure is received directly from the Ministry of Health.

Target: Raising healthy kids

As reported last month the Waikato DHB has been rated as an outstanding performer by the Ministry of Health last quarter.

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

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

2

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

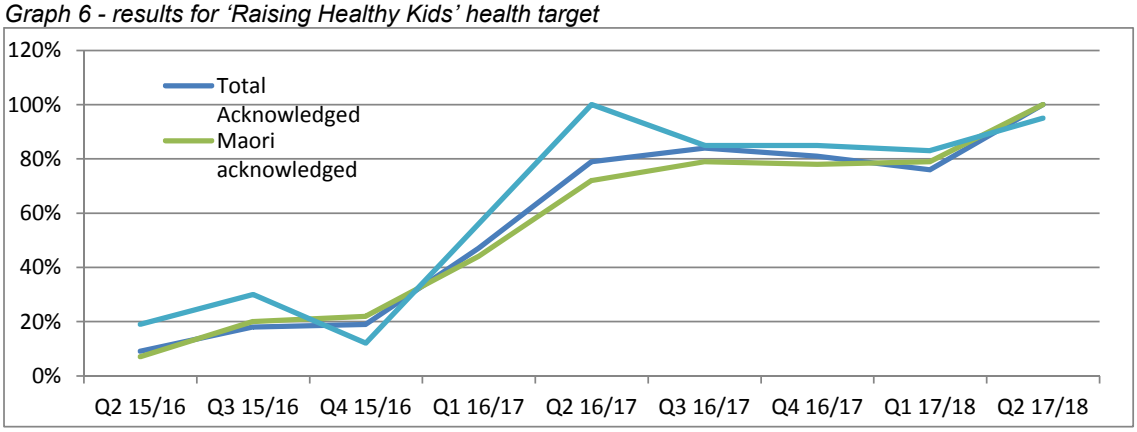
Waikato DHB, The Psychology Centre and Sport Waikato is setting up new options for community regional wide approach to support families with young children identified as having an unhealthy weight. This will be an extension of our current active families programmes offered by Sport Waikato. We are in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

Table 14 – 2017/18 Q2 Raising Healthy Kids Results (target 95%)

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

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

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



Data for a 6 month rolling period up to Nov 2017

Recommendation
THAT
The Board receives this report.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY AND CLINICAL SUPPORT

Health and Safety

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 8

HEALTH AND SAFETY UPDATE REPORT

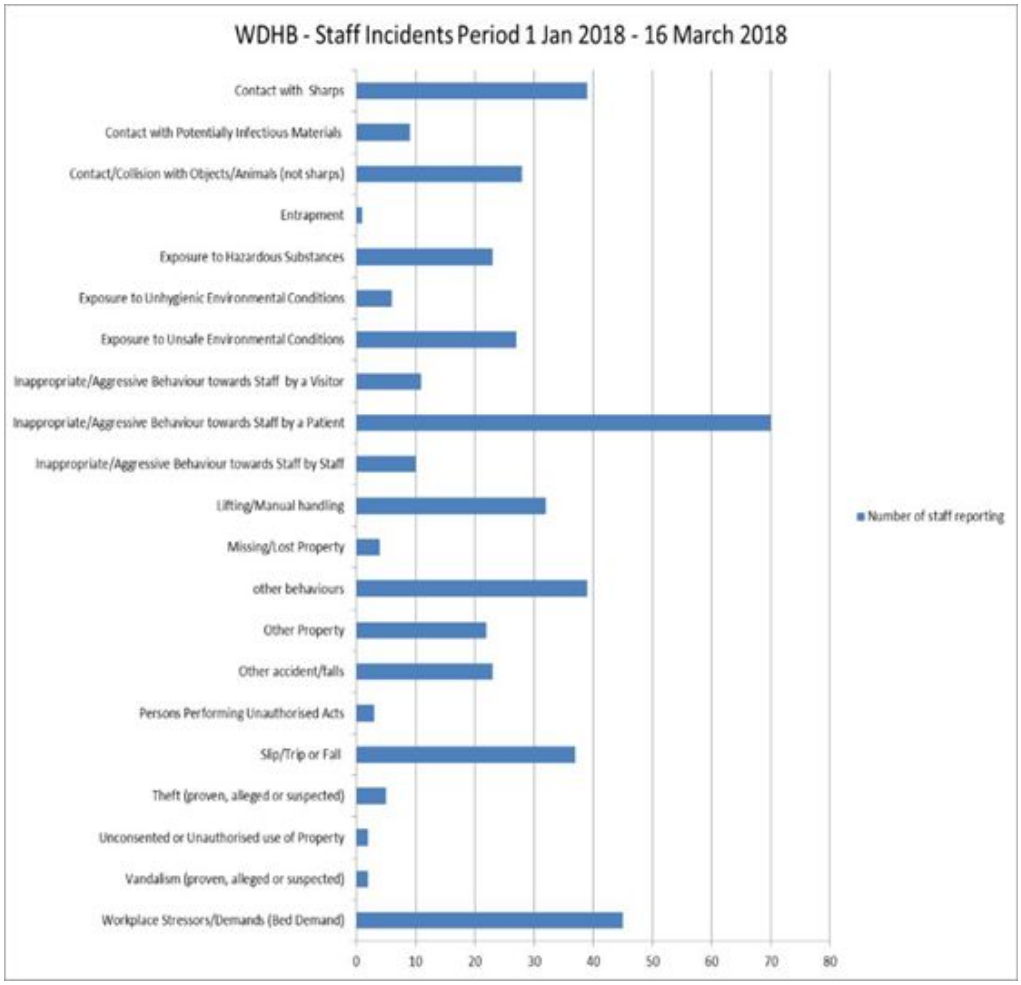
Purpose	For information.

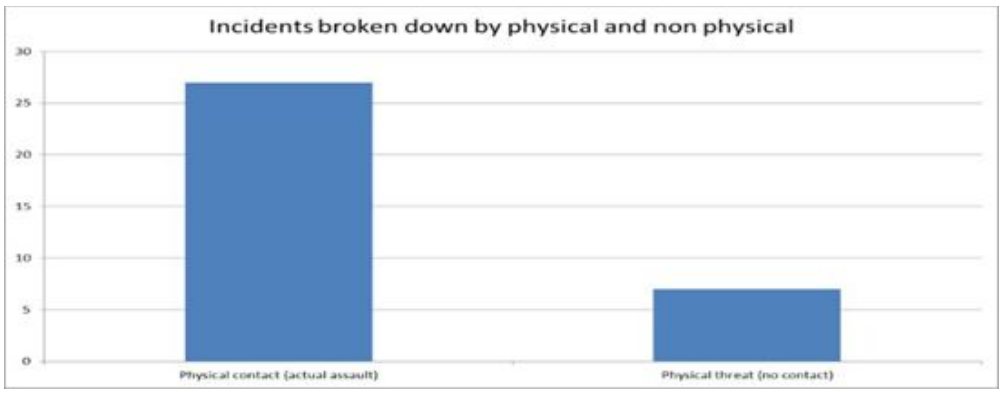
There are four branches to Principles of Due Diligence in Health and Safety Governance:

- Policy and Planning
- Monitor
- Delivery
- Review.

Incidents Reported to WorkSafe NZ year to date (1 January 2018)

	Year to date
Total Incidents reported	**0**


WDHB - Staff Incidents Period 1 Jan 2018 - 16 March 2018
Contact with Sharps
Contact with Potentially Infectious Materials
Contact/Collision with Objects/Animals (not sharps)
Entrapment
Exposure to Hazardous Substances
Exposure to Unhygienic Environmental Conditions
Exposure to Unsafe Environmental Conditions
Inappropriate/Aggressive Behaviour towards Staff by a Visitor
Inappropriate/Aggressive Behaviour towards Staff by a Patient
Inappropriate/Aggressive Behaviour towards Staff by Staff
Lifting/Manual handling
Missing/Lost Property
other behaviours
Other Property
Other accident/falls
Persons Performing Unauthorised Acts
Slip/Trip or Fall
Theft (proven, alleged or suspected)
Unconsented or Unauthorised use of Property
Vandalism (proven, alleged or suspected)
Workplace Stressors/Demands (Bed Demand)
0
10
20
30
40
50
60
70
80
Number of staff reporting


Incidents broken down by physical and non physical
30
25
20
15
10
5
0
Physical contact (actual assault)
Physical threat (no contact)

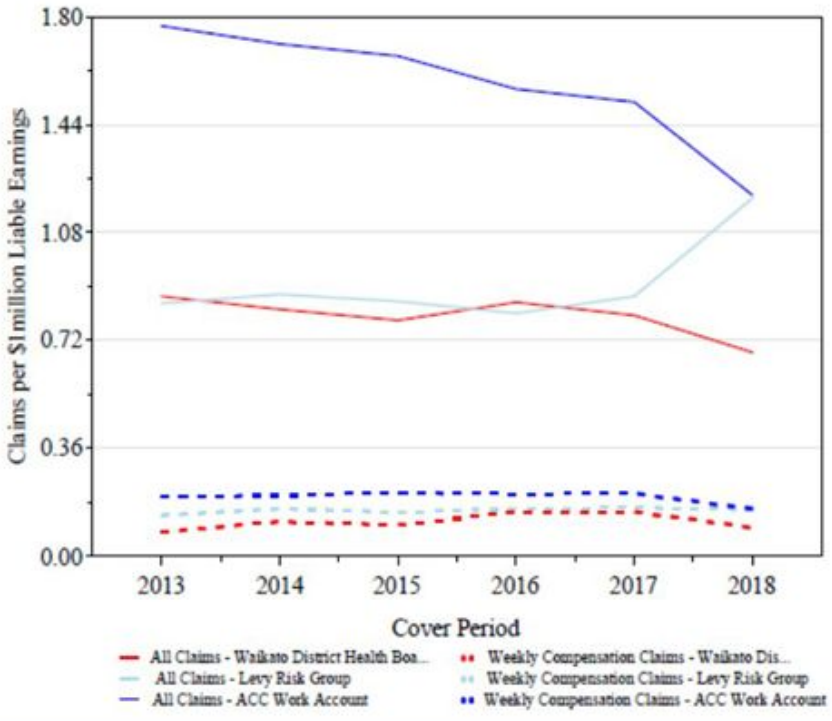
Work Injuries (Period 1 April 2017 – 31 March 2018)

ACC Partnership Programme

Claim Data Summary Report

Waikato District Health Board

Claims per $1million Liable Earnings		Cover Period					
		2013	2014	2015	2016	2017	2018
Total Liable Earnings ($million)		$384.96	$400.13	$414.13	$433.64	$444.87	$452.43
All Claims	Waikato District Health Board	0.87	0.82	0.79	0.85	0.80	0.68
	Levy Risk Group	0.84	0.87	0.85	0.81	0.87	1.20
	ACC Work Account	1.77	1.71	1.67	1.56	1.52	1.21
Weekly Compensation Claims	Waikato District Health Board	0.08	0.11	0.10	0.15	0.15	0.10
	Levy Risk Group	0.14	0.16	0.15	0.16	0.16	0.16
	ACC Work Account	0.20	0.20	0.21	0.21	0.21	0.16



ACC Partnership Programme

The data represents claims per $1M liable earnings. Waikato DHB is the red line and the Levy Risk Group (LRG) is the pale blue line. Looking at the overall five year trend between 2013 and 2017 (the last full year of comparative data - updated) it can be seen that the DHB is still tracking well against the LRG average with overall claims showing a marked declining trend in number. The LRG overall claim rate has remained fairly static. Waikato DHB's entitlement claims indicate an increasing trend in the claim rate. The LRG also indicates an increasing trend in claim numbers in this category. Overall, Waikato DHB is experiencing fewer claims than the associated Levy Risk Group in both categories.

ACC renewal analysis assessment
Currently conducting an ACC renewal analysis assessment which will recommend a combination of options that provides the organisation with the best value for money taking into account the premium charged by ACC and their inherent claims risk.

Contractor Activity

- 4 induction training sessions
- 40 contractors inducted
- 2 event reviews involving contractors
- 26 audits/assessments
- 21 plan or work method approvals for moderate to high risk work
- 4 pre qualification evaluations).

Manual Handling Orientation

Three hundred and ninety eight staff have now completed this module. Work with staff training the trainer continues. Additional focus is on non-clinical manual handling to assist with decrease of preventable strains.

ACC Partnership Audit

Booked for July 2018.

Health and safety representative training

Currently, we have 144 Health and Safety representatives in place.

- Revamped training rollout this quarter
- Focus on Health and Safety Rep training at rural hospitals.

Campaigns and Innovations

Scoping a new project – Waikato DHB 2018 5 Star Safety Rating Awards. It's aim is to:

- Promote Health and Safety culture within Waikato DHB by making safety a way of working not an added extra.
- Promote use of reporting systems, key people within departments and functions of Health and Safety.

Needle Sticks

An awareness campaign re prevention of needle stick injuries is being rolled out.

Calculations have been made regarding the cost of each needle stick injury within Waikato DHB. Further investigations to be carried out regarding how many of these needle sticks could have been prevented if using a safety lock syringe.

Once full investigation complete, findings will be presented to Health and Safety Manager and then to PDU to propose purchase of safety lock syringes.

Staff Safety

Request for medical representation on Staff safety action group is gaining momentum expressions of interests being received. Resources uploaded onto intranet and identification of hot spots trough Datix reporting occurring to support additional training.

Continued uptake to Personal Safety online course developed as part of the staff mandatory orientation. Also available on line is a Staff Safety Manager Briefing and a de-escalation course called CALM. Ongoing identification of potential workplace champions is also being scoped to support embedding of 'safety being our concern' at the service/ department level.

Workplace Support Person

Waikato DHB staff have concerns about bullying; mostly found to be rude, disrespectful or discourteous behaviour (otherwise known as uncivil behaviour) in the workplace.

We are addressing this concern through a workplace support person (WSP) initiative**,** which links staff to a trained colleague who can provide unbiased support for them in finding ways to resolve their concern(s).

The WSP initiative was launched October 2017 and the 29 WSP completed training.

Workplace Support people:

- Can be approached by other staff in their service, or staff who work in a different area, and by email or face-to-face;
- Are familiar with relevant Waikato DHB policies, and with options for escalating the concern if appropriate.

Employee Assistance Programme (EAP)

Period of report 1 October to 31 December 2017.

A promotional campaign for EAP was conducted in November-December 2017 by email to selected staff group, intranet promotion, and through the People & Performance newsletter.

Programme usage is based on an approximate employee headcount of 6700 employees. The National Usage Rate is shown as a percentage for a 12 month period however the Usage Rate percentage is for the period of this report i.e. quarterly or six monthly.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
111	2	6	107	1.60%	8.20%

Session Data

The following table details the number of sessions each client has attended, within the report period.

Total Clients	Total Sessions	Sessional Average	National Average
107	207.5	1.94	2.60

Clients by Session

The following table details the number of sessions each client has attended, within the report period.

No. of Clients	No. of Sessions
48	1.00
34	2.00
20	3.00
1	4.00
4	5.00

The following table identifies the programme status of clients accessing the programme at the end of the report period.

Client Programme Status	Number of Clients
Ongoing	60
Completed	47
Referred On	0

Impact Level Assessments

The graph and table shows impact levels as determined by the EAP Professional when the client first presents. The purpose of the 'impact level' is to assist in determining any health and safety risks resulting from clients' issues.

Levels	No. of Clients	Description of Levels
Level 1	7	Practical assistance required
Level 2	26	Work could be impacted if issues not dealt with
Level 3	54	Work performance is affected
Level 4	17	Work performance is affected and starting to take days off
Level 5	3	Client severely affected and unable to function in the workplace

Referral Source

The following information indicates the source of referrals to the programme.

Please note most referrals were self-referrals; however we acknowledge that some referrals indicated as self-referral, may have been prompted by managers.

Self-Referral	Management Suggested	Management Formal
84	23	0

Recommendation
THAT
The Board receives the report.

GREGORY PEPLOE
DIRECTOR PEOPLE AND PERFORMANCE

Service Performance Monitoring

MEMORANDUM TO THE BOARD
28 MARCH 2018

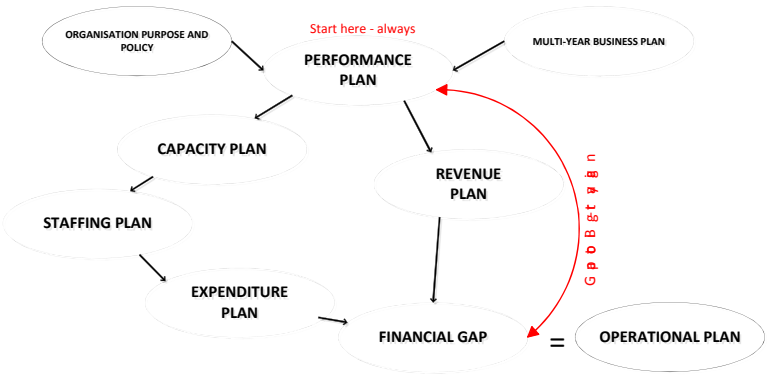
AGENDA ITEM 9.1

WAIKATO HOSPITAL SERVICES REPORT

Purpose	For information.

For the purposes of consistency this report will follow an operational planning format. i.e.

The Operational Plan Development Process



The reason for following this format is that the various parts of the operational reality ought to be aligned and congruent. The following sections approximate the headings of the above planning process as a mapping tool.

PERFORMANCE

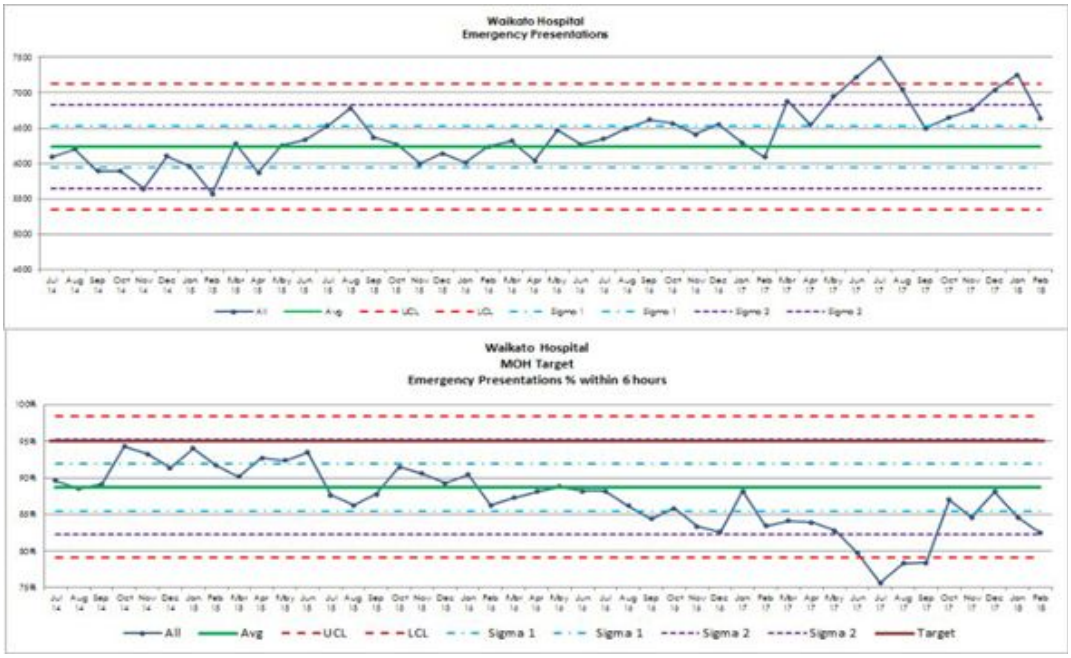
For the purposes of examining performance, Waikato Hospital Services comprise three groups, acute (rescue) services, elective services where the aim is to help people deal with long term health problems, and services that are hospital based to a greater or lesser extent, but where the service delivery is in the community or on a regional scale.

Acute Services

- Relevant performance indicators:
  - Emergency Department 6 hour target.
  - Acute theatre access percent (80% in 24 hours, 100% in 48 hours).
  - Acute Coronary Syndrome (ACS) pathway (diagnostic coronary angiography within 72 hrs of presentation to a medical facility in the Midland Region).

Emergency Department

Performance at Waikato Hospital against the 6 hour target was 82.4% during February, below the target of 95%. Attendance for February 2018 was 9% higher than the same time period February 2017 last year. The percentage of patients meeting the 6 hour target was lower than February 2017 (82.4% vs 83.4%) .



Actions currently being taken in Waikato Hospital:

- The Francis Group have been engaged to support the patient flow process from ED to the Medical and OPR wards.
- General Medicine has moved to a ward based model of care on 26 February, with the stated aim of further enhancing patient flow on the Medical wards. Early indications are that this is having a beneficial impact on patient flow, and more timely discharges.
- The permanent opening of the OPR5 ward has enabled an improved frail elderly pathway of care and provided additional bed capacity.
- Electronic "SBARR" handover sheets to Medicine and Respiratory go live on 01st March
- Recruiting into 2 MOSS position into ED to broaden the skill mix and improve senior cover out of hours.
- GP enrolments continue to be actively promoted in the ED, through designated resource, in an attempt to reduce repeat presentations.

It should be noted that these measures, with the possible exception of the last, will not stop people attending the emergency department but relate more to organisational capability to deal with the increasing number of presentations.

Major tactical solutions are required to address the number of people presenting, and to deal with the number (and more) currently presenting. There is a paucity of these evident across New Zealand and internationally.

As a predictor of probable future tracking the NHS has introduced all the things we are planning to do, in fact we are planning to do them because they have worked,

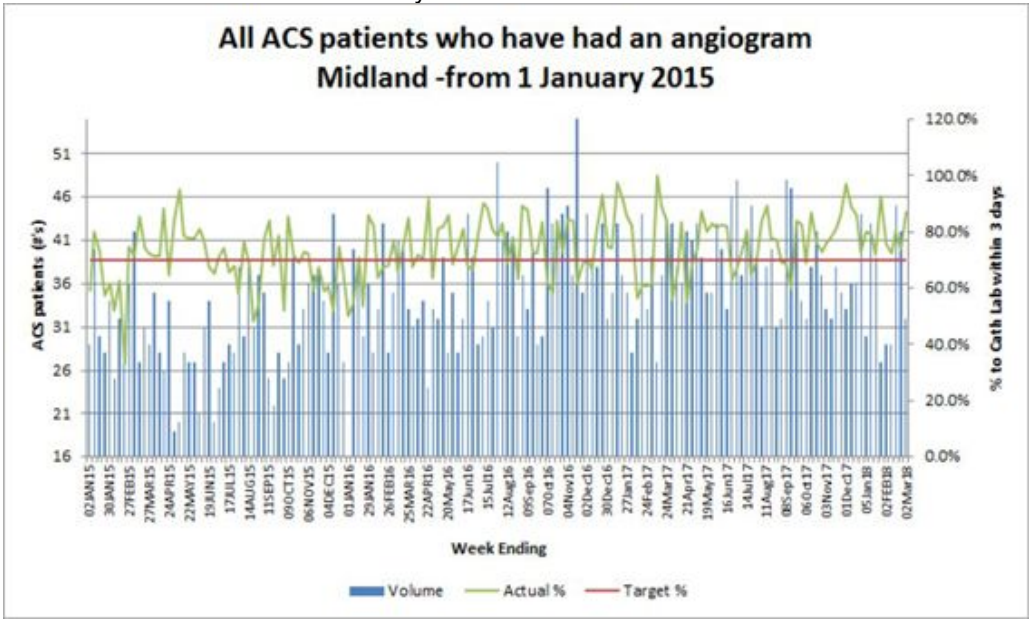
however there is a significant risk we are “kicking the can down the road”. At present it appears the NHS as a whole is tracking at the lowest compliance rate for ED targets since 2015.

Access to Acute and Emergency Surgery

Metrics relevant to this section will be covered under the surgical reinvention project below.

Acute Coronary Syndrome Target

Performance against the ACS target for all Midland patients was above the target of 70% for February with 77% of patients receiving an angiogram within the timeframe across the whole month of February.



Elective Services

- Relevant performance indicators:
  - “Quantitative” – volume of patients treated
  - “Qualitative” – ESPI framework.

Quantitative

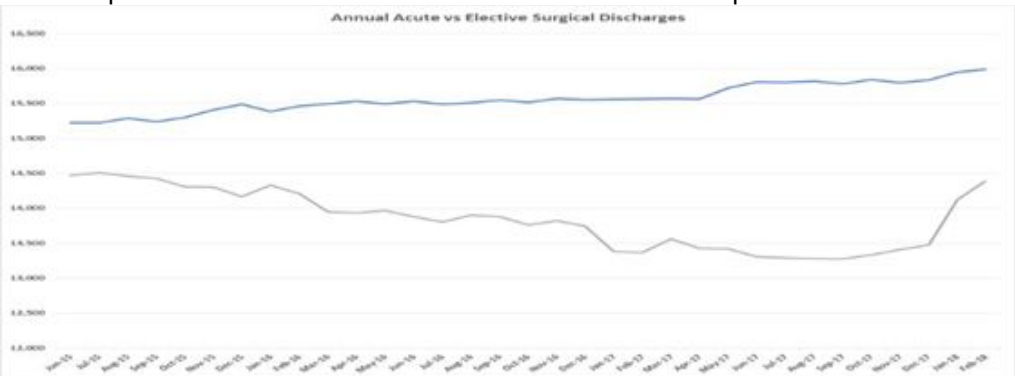
We remain above the volume of elective surgery agreed with the Ministry of Health, by about 4%. This is less than the trend of the last several years.

Health Waikato
Elective Health Target Performance - YTD 28 Feb 2018

PUC	Description	Actual Discharges	Health Target Discharges	%
S00001	General Surgery - Inpatient Services (DRGs)	1,446	1,541	94%
MS02016	Skin Lesion	1,331	935	142%
S05001	General Surgery Anaesthesia - Inpatient Services (DRGs)	103	93	111%
S15001	Cardiothoracic Surgery - Inpatient Services (DRGs)	123	126	98%
S25001	Otorhinolaryngology (ENT) - Inpatient Services (DRGs)	1,125	1,177	96%
S30001	Gynaecology - Inpatient Services (DRGs)	762	774	98%
S35001	Neurosurgery - Inpatient Services (DRGs)	138	120	115%
S40001	Ophthalmology - Inpatient Services (DRGs)	1,192	1,103	108%
S40007	Intraocular injections	767	981	78%
S45001	Orthopaedics - Inpatient Services (DRGs)	1,153	1,091	106%
S55001	Paediatric Surgery - Inpatient Services (DRGs)	329	346	95%
S60001	Plastic & Burns - Inpatient Services (DRGs)	1,319	1,194	110%
S70001	Urology - Inpatient Services (DRGs)	481	476	101%
S75001	Vascular Surgery - Inpatient Services (DRGs)	438	400	110%
Surgical Discharges from a Surgical PUC - Elective (Previous HT)		**10,707**	**10,357**	103.4%
	Surgical Discharges from a Surgical PUC - Arranged	826	762	108%
	Surgical Discharges from a Non-Surgical PUC - Elective	245	198	124%
	Surgical Discharges from a Non-Surgical PUC - Arranged	194	138	141%
Elective Health Target Total		**11,972**	**11,455**	104.5%

Nonetheless the total volume of surgical admission and discharges has increased significantly in tandem with the surgical reinvention project.

This composite measure is reflected in acute and elective components as follows:



There is currently a recovery in elective volumes of surgery delivered “in-house” back to the same level as 3-5 years ago while continuing to meet the rising acute demand.

Assisted by the Keezz team, the focus of the surgical reinvention program is at present:

- Continuing to embed the management roles related to the adopted operating model (day surgery, elective surgery, acute surgery, cardiovascular surgery).
- Building the tools to manage these processes (16 week elective planning tool).
- Simplifying and standardising referral and outpatient aspects of elective surgical (and medical) processes.
- Adding important aspects of new models of care:
    - Surgical admission unit
    - Increased after hours acute operating capacity
    - Integrated geriatric-orthopaedic care pathways.

Qualitative Measures

At the time of writing this report Waikato appeared to be non-compliant in ESPI 2 (3 months) and ESPI 5 (4 months) at the end of January 2018. This risk was escalated to the Board in February in the context of the National Burns Unit relying on Waikato to treat major burns patients, and the requirement to provide outreach to other regional providers for basic acute services.

ESPI 2 and ESPI 5 are generally considered the most significant indicators for patient flow in elective services and draw penalties for non-compliance greater than 4 months.

We have confirmed with the Ministry that it is likely we will be compliant for both ESPI 2 and 5 in February 2018, this could not be confirmed beyond doubt at the time of reporting to the Board.

It is interesting to note the national ESPI dashboard as at January 2018 for comparison of Waikato against other centres.

MoH Elective Services Online

National comparison of DHBs for January 2018

Auckland																		
Bay of Plenty																		
Canterbury																		
Capital and Coast																		
Counties Manukau																		
Hawkes Bay																		
Hutt Valley																		
Lakes																		
MidCentral																		
Nelson Marlborough																		
Northland																		
South Canterbury																		
Southern																		
Tairawhiti																		
Taranaki																		
Waikato																		
Wairarapa																		
Waitemata																		
West Coast																		
Whanganui																		
Total:																		

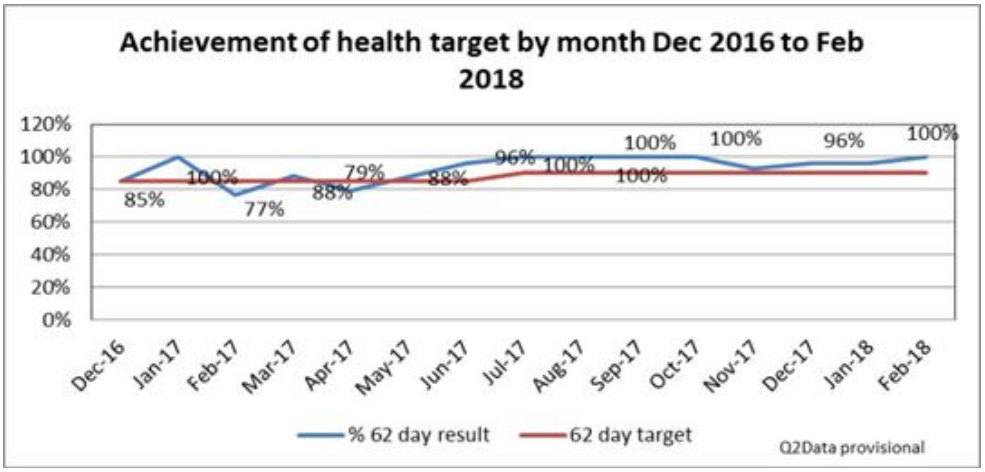
Regional and Community Based Services[1]

- Relevant performance indicators:
  - Faster cancer treatments.

Waikato has continued to deliver sustained achievement against the 90% FCT health target. We are pleased to be able to report that we are currently ranked second nationally for this metric for 2017/18.

2017/18 Quarter 2 is the second quarter for achievement against the new health target of 90%, which includes the newly excluded breach reasons of patient choice and clinical considerations. Our final result of 96.6% shows that Waikato continues to strongly deliver on this key national target.

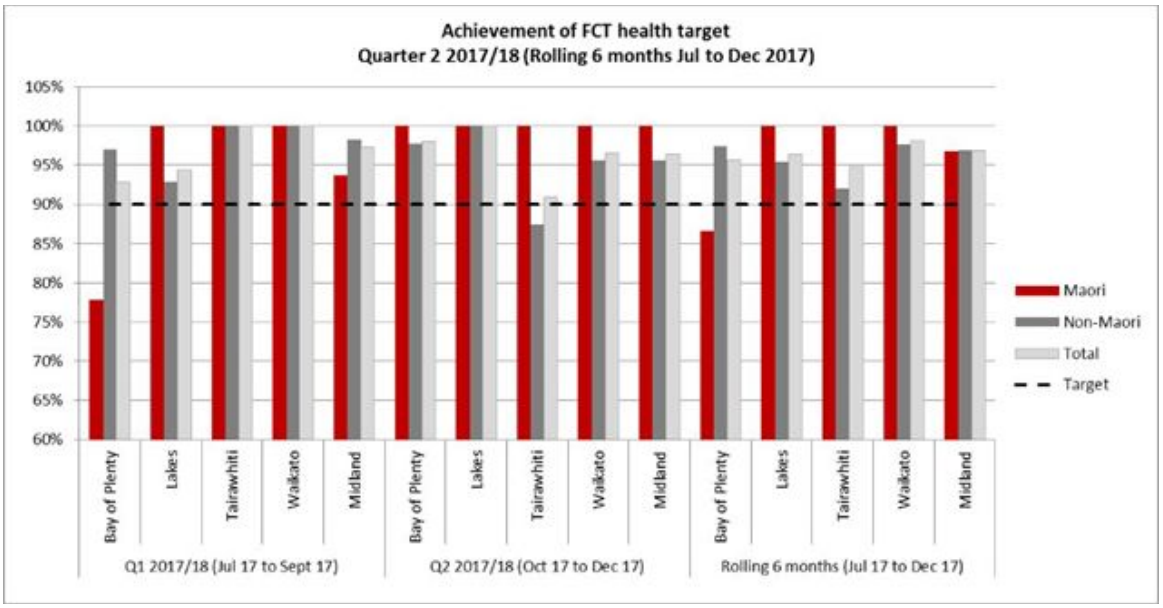
The chart below shows the historical monthly percentage performance against the target.



[1] Note this section currently only refers to cancer services. The intention is to broaden this set to include diabetes, renal services and other related service groups.

Addressing Inequity

Achievement against 62 day health target



All four Midland Cancer Network DHBs achieved the FCT health target for the quarter 2 reporting period of July to December 2017. The combined Midland achievement of the health target is 96.8% (up from 94.8% for the previously reported quarter).

Performance of DHBs show improvement in reducing the equity gap. In fact, performance for October to December 2017 period shows that Māori are achieving better than non-Māori for the 62 day health target for the Midland Cancer Network DHBs. This data should be celebrated but also interpreted cautiously as it records progress following diagnosis, and may not reflect barriers to access.

STAFFING AND CAPACITY

Measures to usefully comment on capacity and staffing related issues are being developed.

At present, as at the end of February, two observations are warranted.

- The hospital group has accrued a major liability with regard annual leave earned but not taken across both medical and nursing staff groups.
- Nursing workloads remain high across the in-patient areas (wards, theatres etc) of the hospital group.

CLINICAL SERVICE PLANNING

Clinical Service planning has started, using the ENT service as a trial group. The purpose of this activity is to establish what each clinical group wants to do and ought to do, whether this is in line with the DHB direction, whether each clinical unit is fit for purpose, and where the DHB needs to intervene or support units that are at risk.

In turn the planning activity will inform medium and long run investment strategies.

EXPENDITURE

- The hospital group is $1,656,154 unfavourable.
- The major unfavourable variances are in both nursing and medical groups with regard the valuation of annual leave earned but not taken ($2.3 and $2.5 million respectively).

REVENUE

- The hospital group is favourable year to date in revenue earned from Waikato DHB ($7,001.012) and non-Waikato DHB sources ($1,421.954).
- For the purposes of District Health Board consideration the former number is a transfer from funder to provider arm.

CONTRIBUTION

- When contribution is considered against budgeted non-DHB sourced revenue relative to actual expenditure, the hospital group is unfavourable by $234 000.
- When the full funding envelope under a funder – provider split is considered, the hospital group has made a contribution to the DHB of $111,295,221 which is favourable to budget by $6.5 million dollars.

Recommendation
THAT
The Board receives and provides comment on the report.

DR GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER, WAIKATO HOSPITAL SERVICES

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 9.2

MENTAL HEALTH AND ADDICTIONS SERVICE PERFORMANCE DASHBOARD

Purpose	For information.

The high level key performance dashboard for Mental Health and Addictions Service for February 2018 is attached for the Board's information.

Recommendation
THAT
The Board receives the report.

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

Key Performance Dashboard

Mental Health

February 2018

Waiting Times

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department < 6 Hours	% of patients	84.1	95.0	(10.9)	86.3	95.0	(8.7)		1

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health seclusion hours	Hours	944	736	(208)	4,320	5,887	1,567		
Mental health recovery plans	% Cases	79.3	95.0	(15.7)	84.4	95.0	(10.6)		2
Mental health HoNos matched pairs	% Cases	88.1	95.0	(6.9)	96.3	95.0	1.3		
Mental health inpatient bed occupancy	%	101.3	85.6	15.7	96.6	49.0	47.6		
Mental health GP methadone cases	Cases	79.0	76.0	3.0	86.5	76.0	10.5		

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Mental health post discharge follow up - % seen in 7 days	%	82.7	90.0	(7.3)	86.0	90.0	(4.0)		
Mental health follow up - numbers seen in 7 days	Number of Cases	67	73	(6)	74	77	(3)		
Mental health community contract positions filled	% FTEs	98.6	95.0	3.6	97.8	95.0	2.8		
Mental health 28 day readmission rate	%	15.1	15.0	(0.1)	11.3	15.0	3.7		

Health target measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Better help for smokers to quit	% of smokers	100.0	95.0	5.0	98.8	95.0	3.8		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints resolved within 20 wd (1 month lag)	% for Jan-18	57	70	(13)	305	70	235		
Falls Resulting in Harm	Numbers	1	1	0	10	11	1		

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Expenditure vs Budget ($000s)	$000s	5,960	5,821	(138)	50,433	49,856	(577)		
Actual FTEs vs Budget	FTEs	764.7	753.9	(10.8)	751.0	750.4	(0.7)		
Sick Leave	% of paid hours	2.7	1.7	(1.1)	3.4	3.1	(0.4)		3
Overtime $'s	$000s	108	78	(30)	1,081	617	(464)		4
Annual Leave Taken	% of Budget	Rolling 12 month measure			86.2	100.0	(13.8)		5

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

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

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

KPI Report: Mental Health & Addictions Services February 2018

The following is a current state KPI dashboard for the directorate (Year to 28 February 2018).

Note	Indicator	Commentary
1	Emergency Hours <6 hours	Overall 111 Mental Health (MH) related presentations for February: • 88 of these were included in the MH 6 hour target • 14 people breached the 6 hour target – 84.1% • The highest number of MH presentations on a single day was 7 on both the 11th and 23rd of February. The highest number of presentations in a single day in January was 10. 81 of the 111 presentations occurred after hours (17:00 pm to 08:00 am) – 72.97%. In January this figure was 70.66% 14 breached the target (a reduction on the 23 target breaches which occurred in January). The nature of those presentations included: • 8 x suicidal intent/overdose attempts • 1 x arthritis - psychosocial and environmental complexities • 1 x anxious/hearing voices • 1 x post-natal psychosis • 1 x paranoid/psychosis • 1 x overall body pain (Hx Bipolar Disorder) • 1 x Self-harm threats.
2	Recovery Plans	A continued focus on recovery plans is occurring across the service. There has been little change in the overall percentage completed since the data set changes. This is an area we are looking at a quality collaborative approach for improvement. Of note, however, the child and youth service regularly meet their target, with 95.5% this month.
3	Sick Leave	The 12-month sick leave trend is favourable, despite the unrealistic sick leave target of 1.7% for February. The overall sick leave for the entire service was 2.7%. Of note, in acute services where there is consistently high occupancy, acuity, service demand and overtime required to meet service need, sick leave was at 2.5% for the month of February.
4	Overtime	Whilst overtime moved closer to the annual target this month and is in the green, actual overtime use particularly in our inpatient unit and in the crisis team continues to be a significant issue. Overtime in general is monitored by name and by ward, as well as reviewing where double shifts have needed to be worked to maintain staff and service user safety.

		With the over-occupancy of the adult acute beds, additional staff are required to be deployed daily, this depletes the internal bureau quickly, along with agency and overtime use being high. Inpatient adult vacancies are virtually filled, although due to a number of internal senior nurse moves, opportunities for secondments and permanent appointments may mean this position is not sustained.
5	Annual Leave taken	The service continues to have strong plans in place to manage annual leave. Annual leave in the service has been budgeted at a flat rate across the year, despite there being a consistent seasonal pattern. In the 18/19 year annual leave will be phased according to historical patterns and the KPI will be more meaningful at this point.

Decision Reports

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 10.1

DELEGATIONS OF AUTHORITY POLICY RENEWAL

Purpose	For approval.

Introduction

Under clause 39 of Schedule 3 of the New Zealand Public Health and Disability Act, Waikato DHB is required to have a Delegations of Authority Policy for the purpose of exercising its powers of delegation, and any amendments to this policy are required to be approved by the Minister of Health subject to any conditions the Minister specifies.

Where there is a conflict between this policy, and any other Waikato DHB policy, this policy takes precedence.

The following process has been undertaken to renew Waikato DHB's Delegation of Authority Policy:

- Specific consultation with relevant department areas that the policy covers.
- Alignment to national financial delegations developed under the National Oracle Solution (NOS) project.
- Organisation-wide consultation.
- CFO final review.
- Policy Committee approval.
- Endorsement at the Audit & Corporate Risk Management Committee meeting on 28 February 2018.
- Review by Audit New Zealand at the request of ACRMC (attached).

The following significant changes have been incorporated into the renewal:

- Add spend limits to align with those available under the proposed National Oracle Solution.
- Note that delegation levels held by staff are now maintained in the Human Resource Information System.
- Clarify how budget accountability is managed, to align with Position Descriptions refresh already completed.
- Update position titles for new management structures.
- Adjust delegation levels following consultation with managers of the relevant areas covered by the Delegations Policy.
- Specify Pharmaceutical spend delegations managed outside of Oracle as noted in the Audit New Zealand management letter.
- Add where a DHB contractual template is not used for entering into an agreement, that the Legal department should be consulted.

- Note that electronic delegation forms can be accepted with an electronic signature in Taleo to align with new electronic recruitment process.
- Policy exclusions clarified:
  - Minimum and maximum inventory level ordering from scanners.
  - Externally imposed approvals required that are subject to change outside of Waikato DHB's internal delegations policy and timing of renewal.

Delegations to Chair (Late Insert to Report)

Over recent weeks questions have been raised about the extent of delegations to the Chair to commission external services. In order to ensure some clarity for the future it is suggested that the following be added to the Waikato DHB Delegation Policy:

"The Chair of the Board has no specific delegations beyond those pertaining to the Board generally. As such any expenditure proposed solely at the initiative of the Chair should ordinarily be placed before the Board for approval. In extraordinary circumstances which are likely only to apply where the Chair is dealing with highly confidential and significant issues relating to the performance or behaviour of the Chief Executive, the Chair may after taking advice from the Chair of the Audit and Corporate Risk Management Committee directly commission independent external advice or support of up to $10,000.00 per supplier so long as this expenditure is ratified by the full Board at its next meeting."

Recommendation
THAT
The Board:

1) Note that the clause suggested above in relation to the Chair is not in the attached copy of the Delegations of Authority Policy submitted to the Board.
2) Approve the updated Delegations of Authority Policy subject to the inclusion of the clause relating to the Chair.
3) Approve that the Delegations of Authority Policy be passed to the Minister of Health to gain his approval.

DEREK WRIGHT
CHIEF EXECUTIVE

Feedback from Audit New Zealand (by email) regarding draft Delegations of Authority Policy, received 14/3/18

We have completed a high level review to ensure the delegations policy contains key elements that we would expect to see in a Delegations of Authority policy. We checked if any best practice or guidelines in the Office of the Auditor General (OAG) publications that we could compare the policy to. There is no specific OAG guidance or best practice in this regard as delegations are captured as part of other guidance material. We therefore focused on areas that are of importance from an audit perspective. Based on our high level review, we are satisfied that overall the policy is adequate.

We considered and confirmed:

- The policy processes are clearly defined;
- the approval of the various delegations are done on appropriate levels;
- the standing delegations are clear but the policy also caters for specific (sole purpose) delegations;
- it is clear when delegations should be periodically reviewed, being after each triennial DHB elections;
- per the policy, delegation is based on the whole cost of the contract including the term of the contract and not on an annual or split cost basis (this is covered in appendix A and B of the policy); and
- the policy covers and is clear about statutory delegations and legislative requirements.

We also checked if our recommendations made in the 2016/17 management reports regarding the Delegations of Authority policy has been addressed in the updated policy. Our previous recommendation was that the Delegations of Authority policy be updated to reflect the delegations of pharmacy staff and to specifically cover the limits these individuals have. Also that staff whose purchase orders do not require one up approval and the reasons why this is allowed for by the DHB. We are pleased that this has been addressed in the new policy and will clear this matter in our next management report.

General comments and things that you may want to consider:

- Delegations with respect to statutory powers need to be treated with care. Some may not be capable of delegation and may have to reside with the office holder referred to in the legislation.

Management comment:
This point is covered in the last paragraph regarding “Exclusions” (section 1.4, copied below). This recognises that the policy can’t define changing external requirements, but that delegations must be exercised taking external statutory powers into consideration, and meeting any and all internal and external approval requirements.

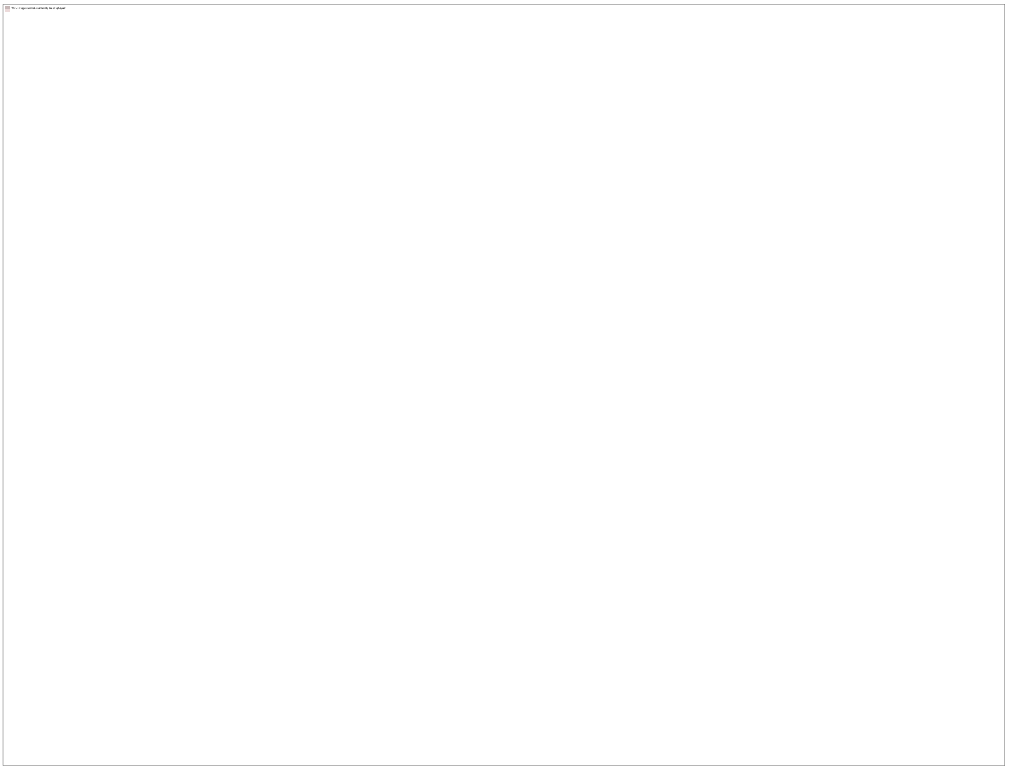
Delegations Policy Extract (section 1.4):
“This policy excludes approval requirements imposed on Waikato DHB by external organisations, as Waikato DHB has no control over the approvals required with regards to limits and timing of the changes (i.e. they may change outside of this policy). This exclusion does not negate Waikato DHB’s obligation to meet external approval requirements where imposed by organisations with the legislative right to develop such requirements. Spend may only be incurred where all internal and external approval requirements have been met.”

- Something that we are interested in relation to procurement, is whether it is possible that the delegations for approving payments to be higher than the delegations for approving the award of the contract. We noted that in the delegations that an individual is unable to approve more than the approved contract amount. For example the CEO can approve a contract up to $10m however for operational expenditure (not sure if this includes payments on that contract) they can approve $5m per purchase order.

  This raises the question whether contract payments are also included in this operational expenditure line as the delegations is silent on this. I have snipped a copy of those delegations in the policy. If not, then maybe this is something that you may consider to be included in the policy.

Management comment:
We don't manage delegations over release of individual payments to suppliers and employees. If a contract and purchase order have been approved, an invoice has been received that matches the purchase order, and confirmation has been logged that goods and services have been received in a satisfactory condition, then it is then assumed that payment can be released in accordance with the contractual terms and conditions regarding timing of payment.

Purchase Orders are not limited to one per contract. So an individual is able to approve multiple Purchase Orders for a single contract, to cover a total contract amount.



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

POLICY

Delegation of Authority

Policy Responsibilities and Authorisation

Department Responsible for Policy	Finance
Position Responsible for Policy	Director Finance Operations
Document Owner Name	Rowan Cramond
Sponsor Title	Chief Executive Officer
Sponsor Name	Derek Wright
Target Audience	Managers and staff
Committee Approved	
Date Approved	
Committee Endorsed	
Date Endorsed	
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Policy Review History

Version	Updated by	Date Updated	Summary of Changes
05		March 2017	Add spend limits to align with those available under the proposed National Oracle Solution. Add units and maximum time limits to spend limits.
			Add that delegation levels held by staff are now maintained in the HRIS system.
			Clarify how budget accountability is managed, to align with Position Descriptions refresh.
			Update position titles for new management structures.
			Amend general delegation levels following consultation with managers. Remove Business Resource Review Group (BRRG) and replace with the Portfolio Governance Group (PGG) in the relevant areas of this policy.
			Add specific delegations for pharmaceutical spend via Pharmacy Services department
			Note that where a DHB contractual template is not used for entering into an agreement, that Legal should be consulted.
			Note that electronic delegation forms can be accepted with electronic signatures in Taleo to align with a new/planned electronic recruitment process.
			Policy exclusion added, regarding Min/max inventory level ordering from scanners, and external approval required.
			Add definitions to give clarity.

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POLICY

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1. Introduction

1.1 Purpose

On 1 January 2001, Health Waikato Limited was succeeded by the Waikato District Health Board (Waikato DHB), a publicly-owned health and disability statutory corporation established by section 19 of the New Zealand Public Health and Disability Act 2000 (the Act). Under clause 39(1) of Schedule 3 of the Act the board is required to formulate a policy for the exercise of its powers of delegation.

This policy has been formulated by the Board as its policy for the exercise of its powers of delegation under the Act and replaces any previous delegation policies of the Board. Every exercise by the Board of a power of delegation must comply with this policy.

1.2 Preface

This Policy contains the following parts:

- The Policy statement, processes and associated information as approved by the Minister of Health, in accordance with the Act.
- A summary of Delegation Levels 1 to 9 (Appendix A).
- Detailed standing delegations for Levels 1 to 8 and the notification to be given to staff on commencement (Appendix B).

1.3 Policy

- This policy and any subsequent variations or changes must be approved by the Board of Waikato DHB (the Board) and the Minister of Health.
- All decisions made by the Board or staff holding delegated authority must comply with this policy. Failure to comply may be considered as serious misconduct.
- Every delegation of any function, duty or power of the Board must be in writing.
- All staff with delegations must accept their standing delegations in writing and by signing the delegation document (as per Appendix B).
- Any sub-delegation must be confirmed in writing by a person holding the proper authority to sub-delegate.
- Any person who considers that they have or will have a conflict of interest with Waikato DHB in the exercise of any delegation must immediately disclose such conflict to their manager (as per Waikato DHB Conflict of Interest Policy).
- Delegation of a function, duty or power is revocable and does not prevent the Board from performing its function or duty by exercising its power.
- Staff shall have their levels of delegation noted in their position descriptions and recorded in the Human Resource Information System (HRIS).

1.4 Exclusions

This policy excludes the systematic purchase of inventory items such as stock increase orders driven from scanners detecting ordering required, based on pre-determined min/max quantities that are managed centrally through system limits such as min/max ordering derived from stocktakes using scanning capability.

This policy excludes approval requirements imposed on Waikato DHB by external organisations, as Waikato DHB has no control over the approvals required with regards to

limits and timing of the changes (i.e. they may change outside of this policy). This exclusion does not negate Waikato DHB's obligation to meet external approval requirements where imposed by organisations with the legislative right to develop such requirements. Spend may only be incurred where all internal and external approval requirements have been met.

2. Abbreviations

CEO	Chief Executive Officer
CFO	Chief Financial Officer
CIMS	Coordinated Incident Management System
DHB	District Health Board
ED	Executive Director
ED Corp. Serv.	Executive Director Corporate Services
FTE	Full time equivalent
HRIS	Human Resource Information System
IEA	Individual Employment Agreement
PGG	Portfolio Governance Group
P&I	Property & Infrastructure
P&P	People & Performance
RC	Responsibility Centre
SLA	Service Level Agreements
S&F	Strategy & Funding
The Act	New Zealand Public Health and Disability Act 2000
The Board	The Board of Waikato District Health Board

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3. Definitions

Clinical Service Contract	A clinical service contract is a contract for provision of clinic based specialised assessment and treatment services for patients.
Commitment	A commitment when referred to in a notice of delegation is an obligation (usually with a financial aspect) that requires the Waikato DHB to do something or refrain from doing something. Depending on the monetary value of the commitment or the degree of risk to the Waikato DHB, the commitment shall be evidenced by varying levels of documentation ranging from a leave application form to individual employment contracts or from simple purchase orders to complex commercial contracts and deeds.
Delegated Authority	Refers to the delegation level that a person holds and the authority assigned to each delegation level as set out in this policy.
Documents	The generic term "documents" when referred to in a notice of delegation includes formal agreements, contracts, letters of intent, memorandum of understanding, and heads of agreement.
FTE	An FTE (full time equivalent) is the hours worked by one employee on a full-time basis. The concept is used to convert the hours worked by several part-time employees into the hours worked by full-time employees.
Funding contract	A revenue contract managed by the Strategy and Funding department.
Levels of Delegation	The levels of delegation detailed in the notice of delegation shall be as follows:

Level	**Levels of Delegation** *
1	Waikato DHB Board
2	CEO
3	Staff Designated by the CEO
4	Staff Designated by Level 2 and 3 Delegates
5	Staff Designated by Level 2 to 4 Delegates
6	Staff Designated by Level 2 to 5 Delegates
7	Staff Designated by Level 2 to 6 Delegates
8	Staff Designated by Level 2 to 6 Delegates

	9 | Staff Designated by Level 2 to 6 Delegates **The Levels shown from 3 down are not determined by reporting lines but by nomination by the persons who hold appropriate delegation levels. That is, a direct report to the CEO, such as the CEO's personal assistant, is not necessarily at Level 3 for the purposes of this policy.* The Authorised Delegate when referred to in a notice of delegation is that person authorised (either by a standing delegation or sub-delegation) to exercise their delegation.
Revenue contract	A revenue contract is a contract for the supply of goods or services from Waikato DHB to an external party (including Ministry of Health).
Standing delegations	Standing delegations of authority are those permanent delegations specified in this notice of delegation that have been delegated by the Board to the CEO, and further permanently delegated by delegated authority holders to lower level delegated authority holders. Standing delegations shall be created, changed and withdrawn only in writing. Standing delegations shall apply to specified persons within the different management levels of the organisation.
Special leave	Includes discretionary sick leave, long service leave, employment relations education leave, union delegates leave, NZ sports and cultural representative leave.
Staff	Anyone to whom this policy applies to, such as where they are placed in a position that holds a delegated authority.
Sub-delegation	Sub-delegation is the ability to delegate (pass on) a standing authority, in whole or in part, to individuals holding other specified positions. Also, where permitted in accordance with the notification of delegation, a sub-delegation may be further sub-delegated. These sub-delegations may be permanent to an employee whilst holding the specified position or temporary for the duration of a specific event or period. Authority to sub-delegate is outlined in Clause 13.
The Act	The Act refers to the New Zealand Public Health and Disability Act 2000.
Variation	A variation is a document or addendum that varies or amends an existing agreement.

4. Objectives

The objectives of this Policy are to:

- promote and maintain the highest service and ethical standards in the contractual relationships between the Waikato DHB and all external organisations;
- protect the Waikato DHB from loss or damage as a result of mis-management, financial failure, default, improper dealings or undue influence by other parties;

- ensure that decisions made by the Board, and directives issued in the name of the Board, are properly implemented, and that decisions made and instructions issued by the CEO or Senior Management are properly actioned;
- clarify the level of delegated authority that a position has;
- protect staff from being involved in conflicts of interest situations detrimental to the Waikato DHB, or themselves, individually or as staff members; and to
- ensure staff observe the highest levels of propriety, fairness and equity in their dealings with contractors, suppliers, customers, providers and other staff members.

4.1 Guidance for Staff

All staff delegations are contained in Appendix B. For staff with delegated authority levels from 2 to 8, staff should be provided with a copy of the appropriate standing delegation level notification on commencement of their role (contained in Appendix B). The delegation authority notification in Appendix B should be reviewed, any sub-delegations written on the notification, the notification signed (or electronically approved) and a copy held by the staff member and manager. The original is retained on the employee's file. A staff member's delegation level will be outlined on their position description and entered in the HRIS.

All staff need to read and understand this Policy itself before exercising the delegations shown in the schedules. If there is any uncertainty as to how any delegation is to be exercised, then the staff member must refer the matter to their manager for guidance before proceeding to exercise the delegation. Where there are any contradictions in the standing delegations compared to other Waikato DHB policies, the Delegations of Authority Policy will take precedence.

All staff must apply and abide by the most recent and live version of this policy. Staff must disregard any signed delegation of authority form from previous policy versions, and apply the policy limits for their level of delegation against the current policy.

Staff with zero delegation in the previous version of this policy (level 7) will continue to have zero delegation in accordance with this policy version (level 9), unless they (and a higher delegation level holder to approve) sign a delegation authority form for level 2 to 8.

5. Policy Processes

5.1 Review of Policy

This policy must be reviewed after each triennial DHB election. No delegation made prior to any review of this policy is invalidated by such review and every delegation shall remain in force until such time as it is revoked in writing.

Changes made to this policy while in effect, shall be approved by the Board of Waikato DHB and approved by the Minister of Health.

5.2 Resolution to Precede Written Notice of Delegation

Every written notice, pursuant to clause 39 of Schedule 3 of the Act, delegating a function, duty or power by the Board, shall be preceded by a resolution to that effect. To be effective, such resolution shall not require all delegates and the terms of their delegations to be recorded in the minutes of the Board. It shall be sufficient if the resolution refers to a named and dated schedule of delegations that is available for subsequent perusal in its adopted form.

5.3 Giving Written Notice of Delegation

Any written notice by the Board delegating a function, duty or power to any person or class of persons that is formally agreed by the Board, will be conveyed to the delegate by the Board.

5.4 Coming into Force of Delegations

A delegation comes into force on the date set out in the instrument of delegation (approved delegation form).

5.5 Revocation of Delegations

A delegation shall be revoked in the following circumstances:

- At the expiry of the delegation instrument, or
- When the delegation is revoked by the Board or a higher delegated authority holder before its expiry date.

5.6 Change in Membership of Committee

A delegation to a committee shall not be revoked or be deemed to have been revoked only because of a change to the membership of the committee.

5.7 Change to position description of delegate

As long as the relevant function, duty or power remains the responsibility of a position, a delegated authority shall not be revoked or deemed to have been revoked only because the position description is in some other way modified through either formal amendment or informal agreement - in such cases, any changes to delegation levels will be noted in the position description.

5.8 Powers, Duties and Functions Retained by the Board

Waikato DHB operates in accordance with the principles of good governance. This means that irrespective of delegations made there will be occasions when a matter should be referred to the Board that might otherwise be dealt with under delegated authority. The following clauses refer to the functions, duties and powers the Board wishes to retain and the situations in which a matter otherwise delegated must be referred to the Board.

The Board shall make all decisions in respect of revenue and expenditure as follows:

- Revenue contract (including funding contracts) above the financial limitation delegated to the CEO;
- Capital expenditure above the financial limitation delegated to the CEO;
- Expenditure for major maintenance above the financial limitation delegated to the CEO;
- Financial delegations above the financial limitation delegated to the CEO and
- Property matters above the financial limitation delegated to the CEO.

The Board shall make all decisions on the following:

- All new ventures and changes of policy or practice that are likely to significantly affect outputs or change access to a service.

- Any proposal that might attract significant adverse publicity or can with reasonable foresight be predicted to result in legal action of material consequence being taken against Waikato DHB;

The Board must ensure that any matter that requires Ministerial approval, including those described in section 24 (co-operative agreements and arrangements) and section 28 (shares in bodies corporate or interests in associations) and the giving of a notice under section 88 (notice of terms and conditions of payments) of The Act shall only be made in accordance to the procedures and requirements of The Act.

The Board shall not delegate to the CEO:

- Any function, duty or power of the Board which the Board has specifically indicated it wishes to exercise itself; or
- Any function, duty or power delegated to a committee of the Board pursuant to clause 39(4) of Schedule 3 of the Act (Committee delegations).

5.9 Limitation principles

Under this Policy the only persons/bodies to whom functions, duties or powers shall be delegated to shall be:

- A committee or member of the Board,
- Staff of Waikato DHB, or
- An individual or class of persons approved by the Minister of Health under clause 39 (5) of Schedule 3 to the Act.
- Staff not engaged through an employee contract, but are instead engaged through a 'contract for service' (contractor) relationship with Waikato DHB to operate within and represent Waikato DHB in business matters (i.e. be given a DHB email address and ID badge), may be given a delegated authority level. Such delegated level will relate to an appropriate level as per Appendix B.

A Waikato DHB staff member shall not commit Waikato DHB to any obligation or incur any liability included in this Policy unless:

- They are one of the staff authorised to do so in accordance with the actual delegation, or
- they have the required authority properly sub-delegated to them by a person so authorised as per this policy.

A person who holds a delegated authority shall not sub-delegate the authority except in accordance with the provisions of the delegation of authority policy or with the written consent of the Board (clause 40(1)(b) of Schedule 3 of the Act).

All delegated authority holders shall be held accountable for their actions in exercising their delegations. If an employee is unclear of their delegated authority, they should check with their line manager.

A person with delegated authority can make a decision, but this decision could have far-reaching implications (across other departments) with wider impacts. In these cases the decision-maker should consult with the managers of the other departments affected. I.e. the

fact that a person has delegated authority to make a decision does not mean that the position holder should make such a decision without first seeking input from relevant experts/managers.

All delegated authorities are exercised on the Board's behalf and shall be exercised in accordance with other relevant policies and procedures set by the Board from time to time.

Authorised delegates shall familiarise themselves with and follow any relevant policies, standard procedures, protocol and guidelines and departmental processes.

No individual may approve time sheets, leave, any business expenses or benefits which relate to that individual or which result in personal benefit to the approving individual. Examples are:

- an expense claim for a meal consumed by the authorising manager but paid for by another employee.
- an expense claim for a family member with whom you share a bank account that the reimbursement of funds will ultimately be paid into.

Managers are required to understand and be accountable for the content of their capital and operating budgets, monitoring and managing spend, including personnel and other costs, and complying with financial rules.

Waikato DHB has developed a range of contract templates. Where a contract template has been developed by a third party (other than the Ministry of Health), it is expected that the Waikato DHB Legal department will be given the opportunity to review the contract or agreement prior to signing.

Executive Directors may choose to impose further restrictions on managers in order for the organisation to respond to external requirements or constraints. For example, capping expense claims, invoking controls on staff recruitment or overtime payments, or minimising travel spend.

5.10 Delegation to CEO

In accordance with section 26(3) of the Act, the Board shall delegate to the CEO the power to make decisions on management matters relating to the Board on such terms and conditions, as the Board thinks fit.

5.11 Conditions

Delegations shall be limited to the categories and scope shown in the notification of delegation, so that:

- any proposed action that exceeds the delegated authority upper limits specified in the notification of delegation shall require the specific approval of a higher authorised level, where such action is within their limit; and
- prior to making a commitment on behalf of the Board in areas not specified in their notification of delegation, staff members shall obtain the concurrence of a Line Manager able to make such a commitment in terms of their delegation. Should there be any

doubt as to authority to make the commitment; the matter shall be referred to the CEO for action.

Other than in an emergency situation, staff shall only use their delegated authority within their own area of responsibility. In a hospital or DHB emergency situation (i.e. a CIMS event) the incident controller is deemed to have the necessary delegations to enable cross service emergency responses.

5.12 Temporary sub-delegations

All temporary sub-delegations shall be in writing, specifying the time period, any limits, any special conditions or restrictions. Copies shall be retained by the person authorising the sub-delegation and by the person receiving the sub-delegation. Any person acting on a sub-delegation must be able to provide written evidence of the sub-delegation being provided to them. Sub-delegations initiated directly by employees in systems that maintain a clear audit trail of the sub-delegations systematically given may be used in lieu of writing (e.g. Oracle vacation rules).

No sub-delegation shall diminish the responsibility of the person holding a standing delegation for the way such authority is exercised.

Prior to any significant planned absence from the Board, the CEO shall make arrangements, approved by the Chair of the Board, for exercising the authorities delegated to the CEO. The CEO may put in place sub-delegations that may be exercised for a limited period, under special circumstances such as his/her unplanned absence.

In all other cases where an employee holding a sub-delegated authority is absent that authority shall revert to the officer from whom it was delegated, and the manager of the next level higher than the officer with the standing delegation may action further sub-delegations necessary to maintain operations.

Temporary position sub-delegations should not remain permanent. If a position requires a permanent change then a change in the permanent delegation level attached to that position should be requested from the relevant P&P consultant.

5.13 Changes in delegations

Authorities vested in the Board shall not be altered without the Board's approval. Only the CEO shall have the authority to approve changes to the standing delegations in Appendices A and B.

5.14 Contradictions of Delegations of Authority policy

If there is any contradictions in relation to the approval limits set, which is also specified within other Waikato DHB policies, the limits set within the current Delegations of Authority policy will override other contradictions and take preference. This excludes any extra limits imposed by Executive Directors as described in clause 5.9.

Where this policy makes reference to an employee's position, but the position is renamed or disestablished (e.g. as the result of a restructure), an equivalent position created will be deemed to hold the delegation level from that point forward. Where an equivalent position is not clear following a restructure, the equivalent position will be determined by the CEO.

5.15 Conflict of interest

Where a person (other than a member of the Board, or of a committee of the Board, given that such matters are covered directly by requirements around management of interests specifically related to the Board or Board committee) is to perform a function or duty, or exercise a power delegated by the Board, that person must, before performing the function or duty, or exercising the power consider whether or not he or she has (or, as the case requires, will have) on that day any conflicts of interest with Waikato DHB. If he or she has, then he or she must give to their manager a statement completed in good faith that discloses those conflicts of interest, together with any other such conflicts of interest that the person reasonably believes are likely to arise in future in connection with that particular delegation. The Board will consider and make such decisions as appropriate for the management of those interests or potential interests (clause 39(8) of Schedule 3 of the Act).

6. Notice of Delegation

Notices of delegation shall be in the form of Delegation levels and shall cover the following areas of accountability:

- Staff;
- Contracts;
- Capital expenditure;
- Finance;
- Property;
- Legal;
- Supplies and services;
- Research;
- Communication matters;

6.1 Staff

For all people matters the principle of "Once Removed' shall be followed. This means that individuals who have delegated authorities shall not use these authorities in their own case or for their own benefit or for the benefit of a person with whom they have a close personal relationship with. For example, an employee shall not approve their own (or a family member's) expenses, salary, leave, etc. An Authorised Delegate above the person to whom the decision relates shall always perform this function.

The Board Chair shall approve the CEO's expenses. When the Chair is unavailable approval can be made by the Deputy Chair (in the first instance) or the Chair of the Audit & Risk Management Committee (in the second instance).

Formal secondments must be actioned through the formal recruitment process, including signing a fixed term employment agreement relating to the seconded role to recognise

temporary change in role responsibilities and reporting lines during the period of secondment.

6.2 Procurement of Goods and Services

Staff shall follow the instructions in the Waikato DHB Procurement and Contracts Policy when entering into contracts with parties outside of Waikato DHB.

For the purposes of this clause contracts are agreements entered into by the Waikato DHB. The delegations referred to in this clause relate to:
1. A revenue contract is a contract for the supply of goods or services from Waikato DHB to an external party (including Ministry of Health).
2. Expenditure contracts entered into with private suppliers of clinical and other related services.

Staff will take a principled approach in the procurement of goods and services, which means:

- observing the responsibilities of spending public money;
- having a detailed understanding of what is to be purchased, the value and risk of the procurement and how important the procurement is to achieving Waikato DHB's overall goals and business strategy;
- procurement decisions will be based upon the "best value" for the money being spent over the total expected life of the goods or services. Best value may involve the consideration of a range of criteria, not only price;
- considering national and regional health procurement initiatives and 'All-of-Government' contract arrangements;
- using Waikato DHB's standard procurement processes and systems;
- dealing with suppliers in a fair and consistent manner.

6.3 Capital Expenditure

The Capital Expenditure Policy contains full details of the capital expenditure definition, capital expenditure planning process and capital expenditure approval process. The approval process supports the delegation amounts listed in this policy. Capital expenditure includes the purchase of assets with an economic useful life of over one year and costing more than $2,000 (excluding GST), and specific assets less than $2,000 (excluding GST) when collectively purchased as a pool.

The Portfolio Governance Group (PGG) is a mechanism for approval of large new capital expenditure and new positions on behalf of the CEO and Chief of Staff, but the CEO and Chief of Staff are not obligated to use this mechanism in exercising their delegation. Capital Expenditure is defined in the Capital Expenditure Policy.

External capital approvals required by Waikato DHB, but not controlled by Waikato DHB must be adhered to, before capital expenditure is incurred. These are not listed in this policy, as they can be changed outside of this policy by the entity controlling the requirement. Examples of entities with further requirements include:

- Regional capital board

- National Health IT Board
- Ministry of Health

Where a Project Manager is assigned to deliver the project expenditure (capital or operating expenditure) associated with the approval given in accordance with this policy (e.g. at a PGG meeting), the Project Manager may exercise the purchase of supplies or services on behalf of the initial authoriser of a project.

6.4 Finance

The CFO is responsible to the CEO for all financial matters of Waikato DHB. Delegations for specific Treasury management aspects are further defined in the Treasury Management policy.

6.5 Property

The categories in any notice of delegation relating to property may include:

- Acquisition and Disposal of Land and Buildings
- Internal Landlord and Tenancy Matters
- External Landlord and Tenancy Matters

All proposals for the purchase, sale, lease or other disposition of real estate shall be approved by the Board.

6.6 Legal: Execution of Documents

In general, the CEO should be advised of all legal action prior to it being initiated by the person with delegated authority.

Where any decision of the organisation is required to be formalised by the execution of an agreement as a deed, that document shall be executed by two witnessed signatures of two staff, who is either the CEO or who directly report to the CEO and have appropriate authorised delegation. The exception to this, is where the other party to the agreement as a deed is the Ministry of Health, in which case the document shall be executed by one witnessed signature of one manager who has the delegation authority.

“Deed” for the purposes of this clause shall include deeds, (and renewals, assignments and terminations thereof), land transfer documents, sale and purchase agreements for real estate, residential tenancy agreements and other documents so designated by the Waikato DHB Solicitor.

6.7 Purchasing Supplies and Contracting for Services

These delegations relate to the external acquisition of all classes of supplies and services.

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These delegations shall enable staff at all delegated levels to acquire the equipment, supplies and services allowed for in the approved, annual budgets of the Responsibility Centres (RCs) that they have the delegated authority to incur expenditure for.

Catalogue items shall be obtained using internal requisitions that require the purchasing support and inventory teams in the Purchasing and Distribution Department to obtain and deliver the required items to the requested delivery point.

Staff shall follow the instructions in the Waikato DHB Procurement and Contracts Policy when obtaining any requirements from sources outside the Waikato DHB. Requisitions and requests for non-catalogue items shall be processed in accordance with the Procurement and Contracts Policy. This may further require Expressions of Interest (EOIs), Requests for Proposals (RFPs), Quotes (RFQs) or Tenders (RFTs) from potential suppliers in order to complete the requisition.
For critical items and those goods or services that have been the subject of a tender, providers may be contracted to supply the goods or services using the Waikato DHB's standard contracting documents facilitated by the Legal Department.

Operating costs can only be approved for departments within the hierarchy that the staff member is accountable for, or has delegation from the responsibility centre owner to incur costs for.

Specialist approvals will exist for certain categories of spend or product items. In these cases, a Manager approval will need a further specialist approval being accepted by the Board. The purpose of the specialist approvals is to ensure good management of the relevant categories or products by involving people who have high expertise and knowledge of the DHB's current and required spend for these areas (e.g. legal fees, insurance). These will be applied as necessary in response to meet varying business requirements.

Exceptions to approvals are provided where necessary, to ensure the smooth operations of inventory and distribution capability. Exceptions apply where suitable process and system controls are in place to ensure the ordering of inventory remains within appropriate operational parameters (such as stock increase orders driven from scanners detecting ordering required based on pre-determined min/max quantities to be held). Exceptions to the standard approval processes for inventory will be managed by the Supply Chain team.

Due to the nature of pharmaceuticals purchased through the Pharmacy Services Department, specific approval limits are listed by Position Title in this policy. This ensures delegation rights for direct ordering of Pharmaceuticals by suitably qualified staff. In this case, manual approval mechanisms and approval limits specific to pharmacy staff and pharmacy systems (e.g. ePharmacy) shall be relied on. Waikato DHB Pharmacy staff are defined as Pharmacy Administrators, Pharmacists, Pharmacy Technicians, Pharmacy Assistants, the Pharmacy Dispensary Team Leader, and the Pharmacy Manager. Non-standard or new products must be approved by either the Pharmacy Dispensary Team Leader or the Pharmacy Manager.

Note where a Project Manager is assigned to deliver the project expenditure (which may contain capital and/or operating expenditure) associated with the approval given in accordance with this policy (e.g. at a PGG meeting), the Project Manager may exercise the purchase of supplies or services on behalf of the initial authoriser of a project.

6.8 Research

Delegations relating to research shall apply to all research projects undertaken by Waikato DHB, or that Waikato DHB participates in.

6.9 Communication

Communication delegations predominantly relate to ensuring appropriate delegations for activities that could have an effect on the public relations and reputation of Waikato DHB.

7. Statutory Delegations

The Board holds other regulatory functions, duties and powers under other statutes and specific functions, duties and powers under the New Zealand Public Health and Disability Act 2000 not falling within the previous categories mentioned above. Such functions, duties and powers may be delegated in accordance with this policy.

The categories in any notice of delegation shall be stated with reference to the relevant statute or regulation and may include:

- Injury Prevention, Rehabilitation and Compensation Act 2001
- Health Act 1956
- Public Records Act 2005
- Charitable Trusts Act 1957
- Children, Young Persons and Their Families Act 1989
- Civil Defence Emergency Management Act 2002
- Contraception, Sterilisation and Abortion Act 1977
- Disabled Persons Community Welfare Act 1975
- Education Act 1989
- Electoral Act 1993
- Health and Disability Services (Safety) Act 2001
- Land Transport Act 1998
- Medicines Act 1981
- Mental Health Commission Act 1998
- Misuse of Drugs Act 1975
- Local Government (rating) Act 2002
- Subordinate Legislation (Confirmation and Validation) Act 2015
- Social Security Act 1964
- Tuberculosis Act 1948
- Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999
- Cremation Regulations 1973

- Health (Burial) Regulations 1946
- Health Entitlement Card Regulations 1993
- Health (Infectious and Notifiable Diseases) Regulation 2016
- Health (Infirm and Neglected Persons) Regulations 1958
- Health (Needles and Syringes) Regulations 1998
- Health (Retention of Health Information) Regulations 1996
- Medicines Regulations 1984
- Venereal Diseases Regulations 1982
- Water Supplies Protection Regulations 1961
- New Zealand Public Health and Disability Act 2000
- Health Practitioners Competency Assurance Act 2003

8. Success Factors

- All staff have a level of delegation noted in their position descriptions
- Delegation levels are accurately recorded in the HRIS
- Appropriate delegations are used for DHB activities
- Relevant policies are referenced prior to decision making
- All staff with a delegated authority above level 9 have completed a delegation notification as per Appendix B
-

9. Legislative Requirements

9.1 Legislation

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

- New Zealand Public Health and Disability Act 2000
- Health and Safety at Work Act 2015
- Human Rights Act 1993
- Privacy Act 1993
- Employment Relations Act 2000
- Treaty of Waitangi Act 1975

9.2 External Standards

- Ministry of Health Operational Policy Framework
- Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS)

10. Associated Documents

10.1 Associated Waikato DHB Documents

- Waikato DHB Financial Accounting Policy (1813)
- Waikato DHB Capital Expenditure Policy (0034)
- Waikato DHB Treasury Management Policy (0042)
- Waikato DHB Project Management Policy (1044)
- Waikato DHB Procurement and Contracts Policy (0170)
- Waikato DHB Conflict of Interest Policy (0006)
- Waikato DHB Research Policy (0142)
- Waikato DHB Managing Behaviour and Performance Policy (5250)
- Waikato DHB Media and Communications Policy (1816)
- Waikato DHB Non-Employee Engagement Policy (1042)
- Waikato DHB Incident Management Policy (0104)
- Waikato DHB Recruitment and Selection Policy (0021)
- Waikato DHB Code of Conduct (5674)
- Waikato DHB Leave Policy (0009)

10.2 References

- Schedule of National Financial Delegation Authority Levels

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Appendix A Summary of Standing Delegations

Below is a high level summary of Waikato DHB's standing delegations.
Level 1 delegation is at Governance level and is expressed in Appendix B.
Level 9 has no delegations (except for specific Pharmacy Services department staff).

with P&P input $ with Finance input ^ with Legal input + with Procurement input (except for S&F)
with Property and Infrastructure (P&I) input with Public and Org. affairs input

Input means that you must consult and consider advice/direction from the relevant department.

		Level 2	Level 3	Level 4	Level 5	Level 6
Staff	Approve a new role (additional FTE) – within existing Personnel Cost Budget	Yes	Yes	Yes	No	No
	Approve a Personnel budget increase for a new role (additional FTE and cost)	Yes – via PGG (customarily)	Yes – Chief of Staff only. Via PGG (customarily)	No	No	No
	Approve a budgeted new role	Yes	Yes	Yes	Yes	No
	Approve replacement of an existing role	Yes	Yes	Yes	Yes	Yes
	Approve a temp/non-employee vacancy	Yes	Yes	Yes	Yes	No
	Approve outsourced personnel	Yes	Yes	Yes	Yes	No
	Approve leave	Yes	Yes	Yes	Yes	Yes
	Approve special leave	Yes	Yes	Yes	Yes (only discretionary sick leave up to 5 days p.a. per employee)	No
	Make and sign an offer of employment/ secondment for an Individual Employment Agreement (IEA)	Yes	Yes	Yes	No	No
	Make and sign an offer of employment/ secondment (excl. IEA)	Yes	Yes	Yes	Yes	Yes
	Vary the Individual Employment Agreement template	Yes#	Yes# – ED Corp. Serv. only	No	No	No
	Issue first and final warnings	Yes	Yes	Yes	Yes	Yes

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		Level 2	Level 3	Level 4	Level 5	Level 6
Staff (cont.)	Suspend an employee	Yes#	Yes#	Yes#	Yes#	Yes#
	Dismiss an employee	Yes	Yes#	Yes#	Yes#	Yes#
	Approve a redundancy	Yes#	Yes#	No	No	No
	Approve a gratuity/lump sum payment	Yes#	Yes#	No	No	No
	Approve expenses/allowances outside the applicable employment agreement	Yes#	Yes#	No	No	No
	Approve a timesheet /hours of work	Yes	Yes	Yes	Yes	Yes
	Approve a variation to hours of work or contracted FTE	Yes	Yes	Yes	Yes	Yes
	Approve an increase in salary outside auto increments	Yes#	Yes#	No	No	No
	Approve tertiary education fees	Yes	Yes	Yes	No	No
	Approve a Collective Employment Agreement	Yes	No	No	No	No
	Approve an employee settlement	Yes	No	No	No	No
Clinical Service Contracts	Negotiate a clinical service contract	Yes	Yes	Yes	Yes	No
	Approve/sign a clinical service contract	Yes – up to $10m p.a. (max. 5 years)	Yes – up to $1m p.a. (max 5 years)	Yes – up to $500k p.a. (max 5 years)	No	No
	Terminate a clinical service contract	Yes	Yes	Yes	Yes	No
Revenue Contracts	Negotiate a new revenue and funding contract	Yes – up to $10m p.a. (max. 5 years)	Yes – up to $5m p.a. (max. 5 years)	Yes – up to $1m p.a. (max. 3 years)	Yes, S&F Portfolio Managers only up to $100k p.a. (max. 3 years)	No
	Approve/sign/ extend a revenue and funding contract	Yes – up to $10m p.a. (max. 5 years)	Yes – up to $5m p.a. (max. 5 years)	Yes – up to $1m p.a. (max. 3 years)	Yes, S&F Portfolio Managers only up to $100k p.a.	No

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		Level 2	Level 3	Level 4	Level 5	Level 6
Revenue Contracts (cont.)	Terminate a revenue and funding contract	Yes – up to $10m p.a. (max. 5 years)	Yes – up to $5m p.a. (max. 5 years)	Yes – up to $1m p.a. (max. 3 years)	No	No
Inter District Flows (IDFs)	Approve establishment of new inter-district service (budgeted)	Yes –up to $10m p.a. (max. 5 years)	Yes – ED S&F up to $10m p.a. (max. 5 years)	No	No	No
	Approve establishment of new inter-district service (non-budgeted)	Yes –up to $10m p.a. (max. 5 years)	No	No	No	No
Service Level Agreement (SLA)	Approve Waikato DHB Internal Service Level Agreement (SLA)	Yes	Yes – up to $10m p.a.	Yes – up to $5m p.a.	No	No
Capital Expenditure	Approve capital under $50,000	Yes+	Yes+$	Yes+$	No	No
	Approve replacement of existing capital over $50,000 and under $100,000	Yes+$	Yes+$	Yes+$	No	No
	Approve replacement of existing capital over $100,000 and under $500,000	Yes+$	Yes+$	No	No	No
	Approve new capital over $50,000 and under $100,000	Yes+$ – via PGG (customarily)	Yes +$ – Chief of Staff only. Via PGG (customarily)	No	No	No
	Approve new capital over $100,000 and under $500,000	Yes+$ – via PGG (customarily)	Yes +$ – Chief of Staff only. Via PGG (customarily)	No	No	No
	Approve capital over $500,000 and under $1m (excl. information systems software)	Yes+$ – via PGG (customarily)	Yes +$ – Chief of Staff only. Via PGG (customarily)	No	No	No

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		Level 2	Level 3	Level 4	Level 5	Level 6
Finance	Approve internal transfer of funds from one budget line to another	Yes	Yes	Yes	No	No
	Approve credit notes for revenue invoices	Yes	Yes	Yes – Finance only	Yes – Finance Manager Payments only	No
	Initiate debt recovery	Yes	Yes	Yes	No	No
	Alter default system provisions for doubtful debts	Yes	Yes – ED Corp. Serv. Only	Yes – Finance only	No	No
	Write off bad debts (amounts by invoice)	Yes	Yes – ED Corp. Serv. only up to $100k	Yes – Finance only up to $2k. CFO only up to $100k.	No	No
	Approve new banking arrangements	Yes	Yes – ED Corp. Serv. only	Yes – CFO or Treasurer only	No	No
	Rollover existing borrowing or investing arrangements	Yes	Yes – ED Corp. Serv. only	Yes – CFO or Treasurer only	No	No
	Borrow or invest within existing arrangements	Yes	Yes – ED Corp. Serv. only	Yes – CFO or Treasurer only	Yes - Treasury Dealers only	No
	Enter into a Guarantee or Indemnity	Yes^	Yes^ – ED Corp. Serv. only	Yes^ - CFO only	No	No
	Destroy financial records	No	Yes – ED Corp. Serv. only	Yes - Finance only	No	No
	Acquire securities, shares or other interests	Yes - with Ministerial approval	Yes – ED Corp. Serv. only with Ministerial approval	Yes - CFO only with Ministerial approval	No	No
	Arrange new or vary national insurance policies	Yes$	Yes$	Yes$	No	No

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		Level 2	Level 3	Level 4	Level 5	Level 6
Finance (cont.)	Agree to insurance settlements (excl. motor vehicles)	Yes^	Yes^	Yes^ – Legal Advisor only	No	No
	Submit a claim for insurance	Yes	Yes	Yes	Yes	Yes
	Enter into a Finance Lease	Yes $	Yes – ED Corp. Serv. only	Yes – CFO only	No	No
Property	Approve Building Project contingency	Yes – up to 5% of specific project budget	Yes – up to 2% of specific project budget	No	No	No
	Approve Building Project letters of intent and engagement	Yes – up to $1m	Yes – up to $250,000	No	No	No
	Approve maintenance costs in own RCs	Yes	Yes	Yes	Yes	No
	Approve disposal of property including leases over 5 years	No	No	No	No	No
	Approve lease of property from other parties	Yes^	Yes^	Yes^ - P&I only	No	No
	Approve purchase of land	Yes^	No	No	No	No
	Approve tenancy agreements (for and from DHB)	Yes $	Yes $,	Yes $ - P&I only	No	No
	Approve lease of Waikato DHB property to other parties for periods up to 5 years	Yes ^	No	No	No	No

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		Level 2	Level 3	Level 4	Level 5	Level 6
Legal	Initiate legal proceedings	Yes^#	Yes^# (refer s. 6.6 of Delegations policy)	Yes ^# – Director P&P and Legal only (refer s. 6.6 of Delegations policy)	No	No
	Sign other legally binding documents on behalf of Waikato DHB that are not otherwise specified in this document	Yes^	Yes^	Yes^	No	No
	Approve purchase of joint ventures	Yes^	Yes^	No	No	No
	Sign documentation for the Registrar of Companies	Yes^	Yes^ – Chief of Staff only	No	No	No
Supplies and Services	Negotiate supplies and services (on behalf of approving manager)	Yes+	Yes+	Yes+	Yes+	Yes+
	Approve/sign a contract for supplies and services	Yes+ - up to $10m total value (max. 8 years)	Yes+ - up to $5m total value (max. 8 years)	Yes+ - up to $1m total value (max. 8 years)	Yes+ - up to $100k total value (max. 8 years)	No
	Terminate a contract for supplies and services	Yes+	Yes+	Yes+	Yes+	No
	Approve operational expenditure (excluding pharmaceutical products via Pharmacy Services Dept.)	Yes – up to $5m per Purchase Order	Yes – up to $3m per Purchase Order	Yes – up to $500k per Purchase Order	Yes – up to $100k per Purchase Order	Yes – up to $25k per Purchase Order
	Approve pharmaceutical products via Pharmacy Services Dept.	No	ED Community & Clinical Support only	Pharmacy Manager only – Up to $100k per order	No	Dispensary Team Leader only - Up to $50k per order
Research	Approve a research proposal or funding	Yes	Yes	Yes	No	No

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		Level 2	Level 3	Level 4	Level 5	Level 6
Communication	Respond to an Official Information Act request	Yes^	Yes^	Yes^	Yes^	No
	Respond to Ombudsman Request	Yes^	Yes^	Yes^	No	No
	Respond to complaints/ compliments	Yes	Yes	Yes	Yes	Yes
	Initiate an CIMS emergency team	Yes	Yes	Yes	Yes	No
	Seek and approve inwards sponsorship	Yes - up to $100k p.a.	Yes - up to $40k p.a. – ED Public & Org. Affairs only	Yes - up to $2k p.a.	No	No
	Approve sponsorship spend	Yes - up to $100k p.a. only	Yes - up to $100k p.a. – ED Public & Org. Affairs only	Yes - up to $2k p.a.	No	No
	Release information to media	Yes	Yes	Yes	Yes	No
	Be a media spokesperson	Yes	Yes	No	No	No
	Approve outwards gifts	Yes	Yes	Yes	Yes	Yes

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Additional delegation levels

There are additional levels for the sole purpose of managing approval of the purchase of minor supplies and services. These are:

Level 7 has Nil delegation except:

		Level 7
Supplies and Services	May approve operational expenditure (excluding pharmaceutical products via Pharmacy Services dept.)	Yes – up to $10k per Purchase Order

Level 8 has Nil delegation except:

		Level 8
Supplies and Services	May approve operational expenditure (excluding pharmaceutical products via Pharmacy Services dept.)	Yes – up to $2k per Purchase Order

Level 9 has Nil delegation except:

		Level 9
Supplies and Services	Approve pharmaceutical products within the Pharmacy Services Department	Only: Pharmacy Technicians – up to $10k per order Pharmacy Assistants – up to $10k per order Pharmacy Administrator – up to $5k per order Pharmacists – up to $2k per order

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Appendix B Standing Delegations – Level 1 and Delegation Levels 2 to 8

Below are the standing delegations for Level 1 and Delegations levels 2 to 8. These standing delegations outline your delegation levels in detail. For delegation levels 2-8 staff should be provided with a copy of the appropriate standing delegation level notification on commencement (as per Appendix B). A staff member's delegation level will be outlined on their position description. The notification should be reviewed and any changes noted, then signed with a copy held by the staff member and manager. The original delegation notification should be held on the employee's file.

Level 1- Waikato DHB Board

The Board shall make all decisions in respect of major expenditure as follows:

- revenue and funding contracts above the financial limitation delegated to the CEO;
- capital expenditure above the financial limitation delegated to the CEO;
- expenditure for major maintenance above the financial limitation delegated to the CEO;
- financial delegations above the financial limitation delegated to the CEO;
- property matters above the financial limitation delegated to the CEO.

The Board shall make all decisions on the following:

- all new ventures and changes of policy or practice that are likely to significantly affect outputs or change access to a service.
- any proposal that might attract significant adverse publicity or can with reasonable foresight be predicted to result in legal action of material consequence being taken against Waikato DHB;
- any matter that requires Ministerial approval including those described in section 24 of the Act (Co-operative agreements and arrangements) and section 28 (Shares in bodies corporate or interests in associations) and the giving of a notice under section 88 (arrangements relating to payments).

A Board member shall not delegate, and shall not be deemed to have delegated to the CEO:

- any function, duty or power of the Board which the Board has specifically indicated it wishes to exercise itself; or
- any function, duty or power delegated to a committee of the Board pursuant to clause 39(4) of Schedule 3 of the Act (Delegations).

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Delegation Level 2 – Chief Executive

with P&P input $ with Finance input ^ with Legal input + with Procurement input

with Property and Infrastructure (P&I) input with Public and Org. affairs input

Input means that you must consult and consider advice/direction from the relevant department.

Staff	Approve a new role (additional FTE) – within existing Personnel cost budget	Yes
	Approve a Personnel budget increase for a new role (additional FTE and cost)	Yes – via PGG (customarily)
	Approve a budgeted new role	Yes
	Approve replacement of an existing role	Yes
	Approve a temp/non-employee vacancy	Yes
	Approve outsourced personnel	Yes
	Approve leave	Yes
	Approve special leave	Yes
	Make and sign an offer of employment/ secondment for an Individual Employment Agreement (IEA)	Yes
	Make and sign an offer of employment/ secondment (excl. IEA)	Yes
	Vary Individual Employment Agreement template	Yes#
	Issue first and final warnings	Yes
	Suspend an employee	Yes#
	Dismiss an employee	Yes
	Approve a redundancy	Yes#
	Approve a gratuity/lump sum payment	Yes#
	Approve expenses/allowances outside the applicable employment agreement	Yes#
	Approve a timesheet/hours of work	Yes
	Approve a variation to hours of work or contracted FTE	Yes
	Approve an increase in salary outside auto increments	Yes#
	Approve tertiary education fees	Yes
	Approve a Collective Employment Agreement	Yes
	Approve an employee settlement	Yes
Clinical Service Contracts	Negotiate a clinical service contract	Yes
	Approve/sign a clinical service contract	Yes – up to $10m p.a (max. 5 years)
	Terminate a clinical service contract	Yes
Revenue Contracts	Negotiate a new revenue and funding contract	Yes – up to $10m p.a. (max. 5 years)
	Approve/sign/extend a revenue and funding contract	Yes – up to $10m p.a. (max. 5 years)
	Terminate a revenue and funding contract	Yes – up to $10m p.a. (max. 5 years)

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Inter District Flows (IDF)	Approve establishment of new inter-district service (budgeted)	Yes – up to $10m p.a. (max. 5 years)
	Approve establishment of new inter-district service (non-budgeted)	Yes – up to $10m p.a. (max. 5 years)
Service Level Agreement (SLA)	Approve Waikato DHB internal Service Level Agreement (SLA)	Yes
Capital Expenditure	Approve capital under $50,000	Yes+
	Approve replacement of existing capital over $50,000 and under $100,000	Yes+$
	Approve replacement of existing capital over $100,000 and under $500,000	Yes+$
	Approve new capital over $50,000 and under $100,000	Yes+$ – via PGG (customarily)
	Approve new capital over $100,000 and under $500,000	Yes+$ – via PGG (customarily)
	Approve capital over $500,000 and under $1m (excl. information systems software)	Yes+$ – via PGG (customarily)
Finance	Approve internal transfer of funds from one budget line to another	Yes
	Approve credit notes for revenue invoices	Yes
	Initiate debt recovery	Yes
	Alter default system provisions for doubtful debts	Yes
	Write off bad debts (amounts by invoice)	Yes
	Approve new banking arrangements	Yes
	Rollover existing borrowing or investing arrangements	Yes
	Borrow or invest within existing arrangements	Yes
	Enter into a Guarantee or Indemnity	Yes^
	Destroy financial records	No
	Acquire securities, shares or other interests	Yes - with Ministerial approval
	Arrange new or vary national insurance policies	Yes$
	Agree to insurance settlements (excl. motor vehicles)	Yes^
	Submit a claim for insurance	Yes
	Enter into a Finance Lease	Yes$
Property	Approve Building Project contingency	Yes – up to 5% of specific project budget
	Approve Building Project letters of intent and engagement	Yes – up to $1 million
	Approve maintenance costs in own RCs	Yes
	Approve disposal of property including leases over 5 years	No
	Approve lease of property from other parties	Yes^
	Approve purchase of land	Yes^
	Approve tenancy agreements (for and from	Yes$

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	DHB)	
	Approve lease of Waikato DHB property to other parties for periods up to 5 years	Yes^
Legal	Initiate legal proceedings	Yes^ #
	Sign other legally binding documents on behalf of Waikato DHB that are not otherwise specified in this document	Yes^
	Approve purchase of joint ventures	Yes^
	Sign documentation for the Registrar of Companies	Yes^
Supplies and Services	Negotiate supplies and services (on behalf of approving manager)	Yes+
	Approve/sign a contract for supplies and services	Yes+ - up to $10m total value (max. 8 years)
	Terminate a contract for supplies and services	Yes+
	Approve operational expenditure (excluding pharmaceutical products via Pharmacy Service Dept.)	Yes – up to $5m per Purchase Order
	Approve pharmaceutical products via Pharmacy Service Dept.	No
Research	Approve a research proposal or funding	Yes
Communication	Respond to an Official Information Act request	Yes^
	Respond to Ombudsman Request	Yes^
	Respond to Health and Disability Commissioner requests	Yes^
	Respond to complaints/compliments	Yes
	Initiate an CIMS emergency team	Yes
	Seek and approve inwards sponsorship	Yes - up to $100k p.a.
	Approve sponsorship spend	Yes - up to $100k p.a. only
	Release information to media	Yes
	Be a media spokesperson	Yes
	Approve outwards gifts	Yes
	Approve patient travel and accommodation	Yes

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Delegation agreement:

Approval Name (Board Chair)	Signature	Date
Accepted by [Name] (Level 2 CEO)	Signature	Date

The above delegations are effective from the date of this policy until either the delegation is withdrawn by the standing delegation holder or the recipient is no longer employed in the position.

Delegation level 2 may sub-delegate all of the above standing delegations by recording this in writing.

When exercising delegations, the employee will ensure they have familiarised themselves with the Delegations of Authority Policy, understands they will be held accountable for their actions under the policy and as needed, will reference other appropriate related accountability processes/policy, committee approvals, and other relevant agreements.

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Delegation Level 3 – Designated by CEO

with P&P input $ with Finance input ^ with Legal input + with Procurement input

with Property and Infrastructure (P&I) input with Public and Org. affairs input

Input means that you must consult and consider advice/direction from the relevant department.

Staff	Approve a new role (additional FTE) – within existing Personnel cost budget	Yes
	Approve a Personnel budget increase for a new role (additional FTE and cost)	Yes – Chief of Staff only. Via PGG (customarily)
	Approve a budgeted new role	Yes
	Approve replacement of an existing role	Yes
	Approve a temp/non-employee vacancy	Yes
	Approve outsourced personnel	Yes
	Approve leave	Yes
	Approve special leave	Yes
	Make and sign an offer of employment/ secondment for an Individual Employment Agreement (IEA)	Yes
	Make and sign an offer of employment/ secondment (excl. IEA)	Yes
	Vary Individual Employment Agreement template	Yes# - ED Corp. Serv. only
	Issue first and final warnings	Yes
	Suspend an employee	Yes#
	Dismiss an employee	Yes#
	Approve a redundancy	Yes#
	Approve a gratuity/lump sum payment	Yes#
	Approve expenses/allowances outside the applicable employment agreement	Yes#
	Approve a timesheet/hours of work	Yes
	Approve a variation to hours of work or contracted FTE	Yes
	Approve an increase in salary outside auto increments	Yes#
	Approve tertiary education fees	Yes
	Approve a Collective Employment Agreement	No
	Approve an employee settlement	No
Clinical Service Contract	Negotiate a clinical service contract	Yes
	Approve/sign a clinical service contract	Yes – up to $1m p.a. (max 5 years)
	Terminate a clinical service contract	Yes
Revenue Contracts	Negotiate a new revenue and funding contract	Yes – up to $5m p.a. (max. 5 years)
	Approve/sign/extend a revenue and funding contract	Yes – up to $5m p.a. (max. 5 years)
	Terminate a revenue and funding contract	Yes – up to $5m p.a. (max. 5 years)

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Inter District Flows (IDFs)	Approve establishment of new inter-district service (budgeted)	Yes – ED S&F up to $10m p.a. (max. 5 years)
	Approve establishment of new inter-district service (non-budgeted)	No
Service Level Agreement (SLA)	Approve Waikato DHB internal Service Level Agreement (SLA)	Yes – up to $10m p.a.
Capital Expenditure	Approve capital under $50,000	Yes+$
	Approve replacement of existing capital over $50,000 and under $100,000	Yes+$
	Approve replacement of existing capital over $100,000 and under $500,000	Yes+$
	Approve new capital over $50,000 and under $100,000	Yes +$ – Chief of Staff only. Via PGG (customarily)
	Approve new capital over $100,000 and under $500,000	Yes +$ – Chief of Staff only. Via PGG (customarily)
	Approve capital over $500,000 and under $1m (excl. information systems software)	Yes +$ – Chief of Staff only. Via PGG (customarily)
Finance	Approve internal transfer of funds from one budget line to another	Yes
	Approve credit notes for revenue invoices notes	Yes
	Initiate debt recovery	Yes
	Alter default system provisions for doubtful debts	Yes – ED Corp. Serv. Only
	Write off bad debts (amounts by invoice)	Yes – ED Corp. Serv. only up to $100k
	Approve new banking arrangements	Yes – ED Corp. Serv. Only
	Rollover existing borrowing or investing arrangements	Yes – ED Corp. Serv. Only
	Borrow or invest within existing arrangements	Yes – ED Corp. Serv. Only
	Enter into a Guarantee or Indemnity	Yes^ – ED Corp. Serv. Only
	Destroy financial records	Yes – ED Corp. Serv. Only
	Acquire securities, shares or other interests	Yes – ED Corp. Serv. only with ministerial approval
	Arrange new or vary national insurance policies	Yes$
	Agree to insurance settlements (excl. motor vehicles)	Yes^
	Submit a claim for insurance	Yes
	Enter into a Finance Lease	Yes
Property	Approve Building Project contingency	Yes – up to 2% of specific project budget

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	Approve Building Project letters of intent and engagement	Yes – up to $250,000
	Approve maintenance costs in own RCs	Yes
	Approve disposal of property including leases over 5 years	No
	Approve lease of property from other parties	Yes^
	Approve purchase of land	No
	Approve tenancy agreements (for and from DHB)	Yes$
	Approve lease of Waikato DHB property to other parties for periods up to 5 years	No
Legal	Initiate legal proceedings	Yes^# (refer s. 6.6 of Delegations policy)
	Sign other legally binding documents on behalf of Waikato DHB that are not otherwise specified in this document	Yes^
	Approve purchase of joint ventures	Yes^
	Sign documentation for the Registrar of Companies	Yes^ - Chief of Staff only
Supplies and Services	Negotiate supplies and services (on behalf of approving manager)	Yes+
	Approve/sign a contract for supplies and services	Yes+ -up to $5m total value (max. 8 years)
	Terminate a contract for supplies and services	Yes+
	Approve operational expenditure (excluding pharmaceutical products via Pharmacy Services Dept.)	Yes – up to $3 million per Purchase Order
	Approve pharmaceutical products via Pharmacy Services Dept.	Yes – ED Community & Clinical Support only
Research	Approve a research proposal or funding	Yes
Communication	Respond to an Official Information Act request	Yes^
	Respond to Ombudsman Request	Yes^
	Respond to Health and Disability Commissioner requests	Yes^
	Respond to complaints/compliments	Yes
	Initiate an CIMS emergency team	Yes
	Seek and approve inwards sponsorship	Yes - up to $40k p.a. – ED Public & Org. Affairs only
	Approve sponsorship spend	Yes - up to $100k p.a. – ED Public & Org. Affairs only
	Release information to media	Yes
	Be a media spokesperson	Yes
	Approve outwards gifts	Yes
	Approve patient travel and accommodation	Yes

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POLICY

Delegation of Authority

Delegation agreement:

Approval Name (CEO – Level 2)	Signature	Date
Accepted by [Name] (Level 3 Manager)	Signature	Date

The above delegations are effective from the date of this policy until either the delegation is withdrawn by the standing delegation holder or the recipient is no longer employed in the position shown below.

Delegation level 3 may sub-delegate all of the above standing delegations by recording this in writing.

When exercising delegations, the employee will ensure they have familiarised themselves with the Delegations of Authority Policy, understands they will be held accountable for their actions under the policy and as needed, will reference other appropriate related accountability processes/policy, committee approvals, and other relevant agreements.

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Delegation of Authority

Delegation Level 4 – as designated by Level 3 Managers

with P&P input $ with Finance input ^ with Legal input + with Procurement input

with Property and Infrastructure (P&I) input with Public and Org. affairs input

Input means that you must consult and consider advice/direction from the relevant department.

Staff	Approve a new role (additional FTE) – within existing Personnel cost budget	Yes
	Approve a Personnel budget increase for a new role (additional FTE and cost)	No
	Approve a budgeted new role	Yes
	Approve replacement of an existing role	Yes
	Approve a temp/non-employee vacancy	Yes
	Approve outsourced personnel	Yes
	Approve leave	Yes
	Approve special leave	Yes
	Make and sign an offer of employment/ secondment for an Individual Employment Agreement (IEA)	Yes
	Make and sign an offer of employment/ secondment (excl. IEA)	Yes
	Vary Individual Employment Agreement template	No
	Issue first and second warnings	Yes
	Suspend an employee	Yes#
	Dismiss an employee	Yes#
	Approve a redundancy	No
	Approve a gratuity/lump sum payment	No
	Approve expenses/allowances outside the applicable employment agreement	No
	Approve a timesheet/hours of work	Yes
	Approve a variation to hours of work or contracted FTE	Yes
	Approve an increase in salary outside auto increments	No
	Approve tertiary education fees	Yes
	Approve a Collective Employment Agreement	No
	Approve an employee settlement	No
Clinical Service Contracts	Negotiate a clinical service contract	Yes
	Approve/sign a clinical service contract	Yes
	Terminate a clinical service contract	Yes
Revenue Contracts	Negotiate a new revenue and funding contract	Yes – up to $1m p.a. (max. 3 years)
	Approve/sign/extend a revenue and funding contract	Yes – up to $1m p.a. (max. 3 years)
	Terminate a revenue and funding contract	Yes – up to $1m p.a. (max. 3 years)
Inter District Flows	Approve establishment of new inter-district	

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(IDF)	service (budgeted)	
	Approve establishment of new inter-district service (non-budgeted)	
Service Level Agreement	Approve Waikato DHB internal Service Level Agreement (SLA)	Yes – up to $5m p.a.
Capital Expenditure	Approve capital under $50,000	Yes+$
	Approve replacement of existing capital over $50,000 and under $100,000	Yes+$
	Approve replacement of existing capital over $100,000 and under $500,000	No
	Approve new capital over $50,000 and under $100,000	No
	Approve new capital over $100,000 and under $500,000	No
	Approve capital over $500,000 and under $1m (excl. information systems software)	No
Finance	Approve internal transfer of funds from one budget line to another	Yes
	Approve credit notes for revenue invoices	Yes – Finance only
	Initiate debt recovery	Yes
	Alter default system provisions for doubtful debts	Yes – Finance only
	Write off bad debts	Yes – Finance only up to $2k. CFO only up to $100k.
	Approve new banking arrangements	CFO or Treasurer only
	Rollover existing borrowing or investing arrangements	Yes – CFO or Treasurer only
	Borrow or invest within existing arrangements	Yes – CFO Or Treasurer only
	Enter into a Guarantee or Indemnity	Yes^ - CFO only
	Destroy financial records	Yes – Finance only
	Acquire securities, shares or other interests	Yes – CFO only with Ministerial approval
	Arrange new or vary national insurance policies	Yes$
	Agree to insurance settlements (excl. motor vehicles)	Yes^ – Legal Advisor only
	Submit a claim for insurance	Yes
	Enter into a Finance Lease	Yes
Property	Approve Building Project contingency	No
	Approve Building Project letters of intent and engagement	No
	Approve maintenance costs in own RCs	Yes
	Approve disposal of property including leases over 5 years	No
	Approve lease of property from other parties	Yes^ - P&I only
	Approve purchase of land	No
	Approve tenancy agreements (for and from DHB)	Yes $ - P&I only

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	Approve lease of Waikato DHB property to other parties for periods up to 5 years	No
Legal	Initiate legal proceedings	Yes ^# - Director P&P, and Legal only (refer s. 6.6 of Delegations policy)
	Sign other legally binding documents on behalf of Waikato DHB that are not otherwise specified in this document	Yes^
	Approve purchase of joint ventures	No
	Sign documentation for the Registrar of Companies	No
Supplies and Services	Negotiate supplies and services (on behalf of approving manager)	Yes+
	Approve/sign a contract for supplies and services	Yes+
	Terminate a contract for supplies and services	Yes+
	Approve operational expenditure (excluding pharmaceutical products via Pharmacy Services Dept.)	Yes – up to $500,000 per Purchase Order
	Approve pharmaceutical products via Pharmacy Services Dept.	Yes – Pharmacy Manager only, up to $100k per order
Research	Approve a research proposal or funding	Yes
Communication	Respond to an Official Information Act request	Yes^
	Respond to Ombudsman Request	Yes^
	Respond to Health and Disability Commissioner requests	Yes^
	Respond to complaints/compliments	Yes
	Initiate an CIMS emergency team	Yes
	Seek and approve inwards sponsorship	Yes - up to $2k p.a.
	Approve sponsorship spend	Yes – up to $2k p.a.
	Release information to media	Yes
	Be a media spokesperson	No
	Approve outwards gifts	Yes
	Approve patient travel and accommodation	Yes

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POLICY

Delegation of Authority

Delegation agreement:

Approval Name (Level 2 or 3 Manager)	Signature	Date
Accepted by [Name] (Level 4 Manager)	Signature	Date

The above delegations are effective from the date of this policy until either the delegation is withdrawn by the standing delegation holder or the recipient is no longer employed in the position shown below.

Delegation level 4 may sub-delegate all of the above standing delegations by recording this in writing.

When exercising delegations, the employee will ensure they have familiarised themselves with the Delegations of Authority Policy, understands they will be held accountable for their actions under the policy and as needed, will reference other appropriate related accountability processes/policy, committee approvals, and other relevant agreements.

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POLICY

Delegation of Authority

Delegation Level 5 – as designated by Level 2 to 4 Managers

with P&P input $ with Finance input ^ with Legal input + with Procurement input

with Property and Infrastructure (P&I) input with Public and Org. affairs input

Input means that you must consult and consider advice/direction from the relevant department.

Staff	Approve a new role (additional FTE) – within existing Personnel cost budget	No
	Approve a Personnel budget increase for a new role (additional FTE and cost)	No
	Approve a budgeted new role	Yes
	Approve replacement of an existing role	Yes
	Approve a temp/non-employee vacancy	Yes
	Approve outsourced personnel	Yes
	Approve leave	Yes
	Approve special leave	Yes – (only discretionary sick leave up to 5 days p.a. per employee)
	Make and sign an offer of employment/ secondment for an Individual Employment Agreement (IEA)	No
	Make and sign an offer of employment/ secondment (excl. IEA)	Yes
	Vary Individual Employment Agreement template	No
	Issue first and final warnings	Yes
	Suspend an employee	Yes#
	Dismiss an employee	Yes#
	Approve a redundancy	No
	Approve a gratuity/lump sum payment	No
	Approve expenses/allowances outside the applicable employment agreement	No
	Approve a timesheet/hours of work	Yes
	Approve a variation to hours of work or contracted FTE	Yes
	Approve an increase in salary outside auto increments	No
	Approve tertiary education fees	No
	Approve a Collective Employment Agreement	No
	Approve an employee settlement	No
Clinical Service Contracts	Negotiate a clinical service contract	Yes
	Approve/sign a clinical service contract	Yes
	Terminate a clinical service contract	Yes
Revenue Contracts	Negotiate a new revenue and funding contract	Yes, S&F Portfolio Managers only – up to $100k p.a. (max. 3 years)

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	Approve/sign/extend a revenue and funding contract	Yes, S&F Portfolio Managers only – up to $100k p.a. (max. 3 years)
	Terminate a revenue and funding contract	No
Inter District Flows (IDF)	Approve establishment of new inter-district service (budgeted)	No
	Approve establishment of new inter-district service (non-budgeted)	No
Service Level Agreement (SLA)	Approve Waikato DHB internal Service Level Agreement (SLA)	No
Capital Expenditure	Approve capital under $50,000	No
	Approve replacement of existing capital over $50,000 and under $100,000	No
	Approve replacement of existing capital over $100,000 and under $500,000	No
	Approve new capital over $50,000 and under $100,000	No
	Approve new capital over $100,000 and under $500,000	No
	Approve capital over $500,000 and under $1m (excl. information systems software)	No
Finance	Approve internal transfer of funds from one budget line to another	No
	Approve credit notes for revenue invoices	No
	Initiate debt recovery	No
	Alter default system provisions for doubtful debts	No
	Write off bad debts (amounts by invoice)	No
	Approve new banking arrangements	No
	Rollover existing borrowing or investing arrangements	No
	Borrow or invest within existing arrangements	Yes – Treasury dealers only
	Enter into a Guarantee or Indemnity	No
	Destroy financial records	No
	Acquire securities, shares or other interests	No
	Arrange new or vary national insurance policies	No
	Agree to insurance settlements (excl. motor vehicles)	No
	Submit a claim for insurance	Yes
	Enter into a Finance Lease	No
Property	Approve Building Project contingency	No
	Approve Building Project letters of intent and engagement	No
	Approve maintenance costs in own RCs	Yes
	Approve disposal of property including leases over 5 years	No
	Approve lease of property from other parties	No

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	Approve purchase of land	No
	Approve tenancy agreements (for and from DHB)	No
	Approve lease of Waikato DHB property to other parties for periods up to 5 years	No
Legal	Initiate legal proceedings	No
	Sign other legally binding documents on behalf of Waikato DHB that are not otherwise specified in this document	No
	Approve purchase of joint ventures	No
	Sign documentation for the Registrar of Companies	No
Supplies and Services	Negotiate supplies and services (on behalf of approving manager)	Yes+
	Approve/sign a contract for supplies and services	Yes+ – up to $100k per Purchase Order
	Terminate a contract for supplies and services	Yes+
	Approve operational expenditure (excluding pharmaceutical products via Pharmacy Services Dept.)	Yes – up to $100,000 per Purchase Order
	Approve pharmaceutical products via Pharmacy Services Dept.	No
Research	Approve a research proposal or funding	No
Communication	Respond to an Official Information Act request	Yes^
	Respond to Ombudsman Request	No
	Respond to Health and Disability Commissioner requests	No
	Respond to complaints/compliments	Yes
	Initiate an CIMS emergency team	Yes
	Seek and approve inwards sponsorship	No
	Approve sponsorship spend	No
	Release information to media	Yes
	Be a media spokesperson	No
	Approve outwards gifts	Yes
	Approve patient travel and accommodation	Yes

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POLICY

Delegation of Authority

Delegation agreement:

Approval Name (Level 2 to 4 Manager)	Signature	Date
Accepted by [Name] (Level 5 Manager)	Signature	Date

The above delegations are effective from the date of this policy until either the delegation is withdrawn by the standing delegation holder or the recipient is no longer employed in the position shown below.

Delegation level 5 may sub-delegate all of the above standing delegations by recording this in writing.

When exercising delegations, the employee will ensure they have familiarised themselves with the Delegations of Authority Policy, understands they will be held accountable for their actions under the policy and as needed, will reference other appropriate related accountability processes/policy, committee approvals, and other relevant agreements.

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Delegation of Authority

Delegation Level 6 – as designated by Level 2 to 5 Managers

with P&P input $ with Finance input ^ with Legal input + with Procurement input

with Property and Infrastructure (P&I) input with Public and Org. affairs input

Input means that you must consult and consider advice/direction from the relevant department.

Staff	Approve a new role (additional FTE) – within existing Personnel cost budget	No
	Approve a Personnel budget increase for a new role (additional FTE and cost)	No
	Approve a budgeted new role	No
	Approve replacement of an existing role	Yes
	Approve a temp/non-employee vacancy	No
	Approve outsourced personnel	No
	Approve leave	Yes
	Approve special leave	No
	Make and sign an offer of employment/ secondment for an Individual Employment Agreement (IEA)	No
	Make and sign an offer of employment/ secondment (excl. IEA)	Yes
	Vary Individual Employment Agreement template	No
	Issue first and final warnings	Yes
	Suspend an employee	Yes#
	Dismiss an employee	Yes#
	Approve a redundancy	No
	Approve a gratuity/lump sum payment	No
	Approve expenses/allowances outside the applicable employment agreement	No
	Approve a timesheet/hours of work	Yes
	Approve a variation to hours of work or contracted FTE	Yes
	Approve an increase in salary outside auto increments	No
	Approve tertiary education fees	No
	Approve a Collective Employment Agreement	No
	Approve an employee settlement	No
Clinical Service Contracts	Negotiate a clinical service contract	No
	Approve/sign a clinical service contract	No
	Terminate a clinical service contract	No
Revenue Contracts	Negotiate a revenue and funding contract	No
	Approve/sign/extend a revenue and funding contract	No
	Terminate a revenue and funding contract	No

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Inter District Flows	Approve establishment of new inter-district service (budgeted)	No
	Approve establishment of new inter-district service (non-budgeted)	No
Service Level Agreement (SLA)	Approve Waikato DHB internal Service Level Agreement (SLA)	No
Capital Expenditure	Approve capital under $50,000	No
	Approve replacement of existing capital over $50,000 and under $100,000	No
	Approve replacement of existing capital over $100,000 and under $500,000	No
	Approve new capital over $50,000 and under $100,000	No
	Approve new capital over $100,000 and under $500,000	No
	Approve capital over $500,000 and under $1m (excl. information systems software)	No
Finance	Approve internal transfer of funds from one budget line to another	No
	Approve credit notes for revenue invoices	No
	Initiate debt recovery	No
	Alter default system provisions for doubtful debts	No
	Write off bad debts	No
	Approve new banking arrangements	No
	Rollover existing borrowing or investing arrangements	No
	Borrow or invest within existing arrangements	No
	Enter into a Guarantee or Indemnity	No
	Destroy financial records	No
	Acquire securities, shares or other interests	No
	Arrange new or vary national insurance policies	No
	Agree to insurance settlements (excl. motor vehicles)	No
	Submit a claim for insurance	Yes
	Enter into a Finance Lease	No
Property	Approve Building Project contingency	No
	Approve Building Project letters of intent and engagement	No
	Approve maintenance costs in own RCs	No
	Approve disposal of property including leases over 5 years	No
	Approve lease of property from other parties	No
	Approve purchase of land	No
	Approve tenancy agreements (for and from DHB)	No
	Approve lease of Waikato DHB property to other parties for periods up to 5 years	No

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Legal	Initiate legal proceedings	No
	Sign other legally binding documents on behalf of Waikato DHB that are not otherwise specified in this document	No
	Approve purchase of joint ventures	No
	Sign documentation for the Registrar of Companies	No
Supplies and Services	Negotiate supplies and services (on behalf of approving manager)	No
	Approve/sign a contract for supplies and services	No
	Terminate a contract for supplies and services	No
	Approve operational expenditure (excluding pharmaceutical products via Pharmacy Services Dept.)	Yes – up to $25,000 per Purchase Order
	Approve pharmaceutical products via Pharmacy Services Dept.	Yes – Dispensary Team Leader only – Up to $50k per order
Research	Approve a research proposal or funding	No
Communication	Respond to an Official Information Act request	No
	Respond to Ombudsman Request	No
	Respond to Health and Disability Commissioner requests	No
	Respond to complaints/compliments	Yes
	Initiate an CIMS emergency team	No
	Seek and approve inwards sponsorship	No
	Approve sponsorship spend	No
	Release information to media	No
	Be a media spokesperson	No
	Approve outwards gifts	Yes
	Approve patient travel and accommodation	Yes

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POLICY

Delegation of Authority

Delegation agreement:

Approval Name (Level 2 to 5 Manager)	Signature	Date
Accepted by [Name] (Level 6 Manager)	Signature	Date

The above delegations are effective from the date of this policy until either the delegation is withdrawn by the standing delegation holder or the recipient is no longer employed in the position shown below.

Delegation level 6 may sub-delegate all of the above standing delegations by recording this in writing.

When exercising delegations, the employee will ensure they have familiarised themselves with the Delegations of Authority Policy, understands they will be held accountable for their actions under the policy and as needed, will reference other appropriate related accountability processes/policy, committee approvals, and other relevant agreements.

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POLICY

Delegation of Authority

Delegation Level 7 – as designated by Level 2 to 6 Managers

with P&P input $ with Finance input ^ with Legal input + with Procurement input

with Property and Infrastructure (P&I) input with Public and Org. affairs input

Input means that you must consult and consider advice/direction from the relevant department.

Staff	Approve a new role (additional FTE) – within existing Personnel cost budget	No
	Approve a Personnel budget increase for a new role (additional FTE and cost)	No
	Approve a budgeted new role	No
	Approve replacement of an existing role	No
	Approve a temp/non-employee vacancy	No
	Approve outsourced personnel	No
	Approve leave	No
	Approve special leave	No
	Make and sign an offer of employment/ secondment for an Individual Employment Agreement (IEA)	No
	Make and sign an offer of employment/ secondment (excl. IEA)	No
	Vary Individual Employment Agreement template	No
	Issue first and final warnings	No
	Suspend an employee	No
	Dismiss an employee	No
	Approve a redundancy	No
	Approve a gratuity/lump sum payment	No
	Approve expenses/allowances outside the applicable employment agreement	No
	Approve a timesheet/hours of work	No
	Approve a variation to hours of work or contracted FTE	No
	Approve an increase in salary outside auto increments	No
	Approve tertiary education fees	No
	Approve a Collective Employment Agreement	No
	Approve an employee settlement	No
Clinical Service Contract	Negotiate a clinical service contract	No
	Approve/sign a clinical service contract	No
	Terminate a clinical service contract	No
Revenue Contracts	Negotiate a revenue and funding contract	No
	Approve/sign/extend a revenue and funding contract	No
	Terminate a revenue and funding contract	No

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Delegation of Authority

Inter District Flows(IDF)	Approve establishment of new inter-district service (budgeted)	No
	Approve establishment of new inter-district service (non-budgeted)	No
Service Level Agreement (SLA)	Approve Waikato DHB internal Service Level Agreement (SLA)	No
Capital Expenditure	Approve capital under $50,000	No
	Approve replacement of existing capital over $50,000 and under $100,000	No
	Approve replacement of existing capital over $100,000 and under $500,000	No
	Approve new capital over $50,000 and under $100,000	No
	Approve new capital over $100,000 and under $500,000	No
	Approve capital over $500,000 and under $1m (excl. information systems software)	No
Finance	Approve internal transfer of funds from one budget line to another	No
	Approve credit notes for revenue invoices	No
	Initiate debt recovery	No
	Alter default system provisions for doubtful debts	No
	Write off bad debts (by invoice amount)	No
	Approve new banking arrangements	No
	Rollover existing borrowing or investing arrangements	No
	Borrow or invest within existing arrangements	No
	Enter into a Guarantee or Indemnity	No
	Destroy financial records	No
	Acquire securities, shares or other interests	No
	Arrange new or vary national insurance policies	No
	Agree to insurance settlements (excl. motor vehicles)	No
	Submit a claim for insurance	No
	Enter into a Finance Lease	No
Property	Approve Building Project contingency	No
	Approve Building Project letters of intent and engagement	No
	Approve maintenance costs in own RCs	No
	Approve disposal of property including leases over 5 years	No
	Approve lease of property from other parties	No
	Approve purchase of land	No
	Approve tenancy agreements (for and from DHB)	No
	Approve lease of Waikato DHB property to other parties for periods up to 5 years	No

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Delegation of Authority

Legal	Initiate legal proceedings	No
	Sign other legally binding documents on behalf of Waikato DHB that are not otherwise specified in this document	No
	Approve purchase of joint ventures	No
	Sign documentation for the Registrar of Companies	No
Supplies and Services	Negotiate supplies and services (on behalf of approving manager)	No
	Approve/sign a contract for supplies and services	No
	Terminate a contract for supplies and services	No
	Approve operational expenditure (excluding pharmaceutical products via Pharmacy Services Dept.)	Yes – up to $10,000 per Purchase Order
	Approve pharmaceutical products via Pharmacy Services Dept.	No
Research	Approve a research proposal or funding	No
Communication	Respond to an Official Information Act request	No
	Respond to Ombudsman Request	No
	Respond to Health and Disability Commissioner requests	No
	Respond to complaints/compliments	No
	Initiate an CIMS emergency team	No
	Seek and approve inwards sponsorship	No
	Approve sponsorship spend	No
	Release information to media	No
	Be a media spokesperson	No
	Approve outwards gifts	No
	Approve patient travel and accommodation	No

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POLICY

Delegation of Authority

Delegation agreement:

Approval Name (Level 2 to 6 Manager)	Signature	Date
Accepted by [Name] (Level 7)	Signature	Date

The above delegations are effective from the date of this policy until either the delegation is withdrawn by the standing delegation holder or the recipient is no longer employed in the position shown below.

Delegation level 6 may sub-delegate all of the above standing delegations by recording this in writing.

When exercising delegations, the employee will ensure they have familiarised themselves with the Delegations of Authority Policy, understands they will be held accountable for their actions under the policy and as needed, will reference other appropriate related accountability processes/policy, committee approvals, and other relevant agreements.

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POLICY

Delegation of Authority

Delegation Level 8 – as designated by Level 2 to 6 Managers

with P&P input $ with Finance input ^ with Legal input + with Procurement input

with Property and Infrastructure (P&I) input with Public and Org. affairs input

Input means that you must consult and consider advice/direction from the relevant department.

Staff	Approve a new role (additional FTE) – within existing Personnel cost budget	No
	Approve a Personnel budget increase for a new role (additional FTE and cost)	No
	Approve a budgeted new role	No
	Approve replacement of an existing role	No
	Approve a temp/non-employee vacancy	No
	Approve outsourced personnel	No
	Approve leave	No
	Approve special leave	No
	Make and sign an offer of employment/ secondment for an Individual Employment Agreement (IEA)	No
	Make and sign an offer of employment/ secondment (excl. IEA)	No
	Vary Individual Employment Agreement template	No
	Issue first and final warnings	No
	Suspend an employee	No
	Dismiss an employee	No
	Approve a redundancy	No
	Approve a gratuity/lump sum payment	No
	Approve expenses/allowances outside the applicable employment agreement	No
	Approve a timesheet/hours of work	No
	Approve a variation to hours of work or contracted FTE	No
	Approve an increase in salary outside auto increments	No
	Approve tertiary education fees	No
	Approve a Collective Employment Agreement	No
	Approve an employee settlement	No
Clinical Service Contracts	Negotiate a clinical service contract	No
	Approve/sign a clinical service contract	No
	Terminate a clinical service contract	No
Revenue Contracts	Negotiate a revenue and funding contract	No
	Approve/sign/extend a revenue and funding contract	No
	Terminate a revenue and funding contract	No
Inter District Flows (IDFs)	Approve establishment of new inter-district service (budgeted)	No
	Approve establishment of new inter-district service (non-budgeted)	No
Service Level Agreements (SLAs)	Approve Waikato DHB internal Service Level Agreement (SLA)	No

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

POLICY

Delegation of Authority

Capital Expenditure	Approve capital under $50,000	No
	Approve replacement of existing capital over $50,000 and under $100,000	No
	Approve replacement of existing capital over $100,000 and under $500,000	No
	Approve new capital over $50,000 and under $100,000	No
	Approve new capital over $100,000 and under $500,000	No
	Approve capital over $500,000 and under $1m (excl. information systems software)	No
Finance	Approve internal transfer of funds from one budget line to another	No
	Approve credit notes for revenue invoices	No
	Initiate debt recovery	No
	Alter default system provisions for doubtful debts	No
	Write off bad debts (by invoice amount)	No
	Approve new banking arrangements	No
	Rollover existing borrowing or investing arrangements	No
	Borrow or invest within existing arrangements	No
	Enter into a Guarantee or Indemnity	No
	Destroy financial records	No
	Acquire securities, shares or other interests	No
	Arrange new or vary insurance policies	No
	Agree to insurance settlements	No
	Submit a claim for insurance	No
	Enter into a Finance Lease	No
Property	Approve Building Project contingency	No
	Approve Building Project letters of intent and engagement	No
	Approve maintenance costs in own RCs	No
	Approve disposal of property including leases over 5 years	No
	Approve lease of property from other parties	No
	Approve purchase of land	No
	Approve tenancy agreements (for and from DHB)	No
	Approve lease of Waikato DHB property to other parties for periods up to 5 years	No
Legal	Initiate legal proceedings	No
	Sign other legally binding documents on behalf of Waikato DHB that are not otherwise specified in this document	No
	Approve purchase of joint ventures	No
	Sign documentation for the Registrar of Companies	No

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

POLICY

Delegation of Authority

Supplies and Services	Negotiate supplies and services (on behalf of approving manager)	No
	Approve/sign a contract for supplies and services	No
	Terminate a contract for supplies and services	No
	Approve operational expenditure (excluding pharmaceutical products via Pharmacy Services Dept.)	Yes – up to $2,000 per Purchase Order
	Approve pharmaceutical products via Pharmacy Services Dept.	No
Research	Approve a research proposal or funding	No
Communication	Respond to an Official Information Act request	No
	Respond to Ombudsman Request	No
	Respond to Health and Disability Commissioner requests	No
	Respond to complaints/compliments	No
	Initiate an CIMS emergency team	No
	Seek and approve inwards sponsorship	No
	Approve sponsorship spend	No
	Release information to media	No
	Be a media spokesperson	No
	Approve outwards gifts	No
	Approve patient travel and accommodation	No

Delegation agreement:

Approval Name (Level 2 to 6 Manager)	Signature	Date
Accepted by [Name] (Level 8)	Signature	Date

The above delegations are effective from the date of this policy until either the delegation is withdrawn by the standing delegation holder or the recipient is no longer employed in the position shown below.

Delegation level 6 may sub-delegate all of the above standing delegations by recording this in writing.

When exercising delegations, the employee will ensure they have familiarised themselves with the Delegations of Authority Policy, understands they will be held accountable for their actions under the policy and as needed, will reference other appropriate related accountability processes/policy, committee approvals, and other relevant agreements.

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 10.2

WAIKATO DHB DEMOGRAPHIC MODEL FOR THE 10 YEAR HEALTH SYSTEM PLAN

Purpose	For Approval.

Purpose
To inform the 10 Year Health System Plan and its components a robust and agreed picture of the Waikato DHB population (and the Midland Region at a higher level) is required. This will enable each of the plan components to be based on one best "source of the truth" for population numbers and demographic profiles. The model will also be used across the organisation wherever population metrics are required.

Currently there is potential for confusion when interpreting or comparing different population numbers from different sources or organisations. This approach will help rectify that by building one agreed picture of the DHB population utilising the best sources of information available. The model will also have the ability to be updated at agreed timeframes as new sources of information are released and the impacts of this identified.

The model will need to have the capacity to be updatable as new data becomes available over time (e.g. 2018 Census results).

Methodology
Current population projections and demographic models do not meet all the DHB's requirements. Various parts of the DHB and other external agencies hold pieces of information to inform different parts of this picture. For example the WISE model used by Councils to inform their plans and the Waikato Plan based on Territorial Local Authority – which does not match the Waikato DHB boundaries.

Therefore a small group led by Regan Webb (Strategy and Funding), involving Strategy and Funding analysts, Public health analysts and NIDEA with oversight from Gary Jackson (EY), Polly Atatoa-Carr (NIDEA), and Public Health Specialist from the DHB's Public Health Unit has been formed to complete this piece of work.

The group first met on Friday 23 February 2018 to refine the methodology outlined in this paper and to perform a stocktake and cross-matching exercise of the information sources each of the participants has access to.

Please see Appendix One for a detailed definition of requirements and methodology.

Due to the tight timeframes required to meet the expectations of the 10 Year Health System Plan this work will be undertaken in two phases. Phase one will only be based on developing the initial model requirements in Appendix One. Following that a phase two cycle of development will be implemented to:

- Explore the possibility of a health needs index to weight need in localities at a Ethnicity level relative to each other

- Develop a “health population” using PHO registers, pharms, Labs, hospital and ED data etc to find an accurate picture of people in the DHB

Output

1. An interactive data model able to be used by other workstreams and parts of the organisation for population and demographics requirements;
2. A population profile document which can then be used as a section of the 10 Year Plan report.

Timeframe

- Phase one model available for use in May 2018.
- 1st draft of population numbers to be presented at Board meeting in May 2018.
- Phase two development to begin in June 2018.

Recommendation
THAT
The Board notes the content of this report and endorsed the proposed methodology for creating a Waikato DHB population model.

TANYA MALONEY
EXECUTIVE DIRECTOR
STRATEGY & FUNDING

REGAN WEBB
SENIOR FUNDING MANAGER
STRATEGY & FUNDING

Appendix One – Detailed Requirements and Methodology

Minimum Requirements of the Model:

For the Waikato DHB area:

- five years ago, Current, five year, ten year, and fifteen year projections
- Population modelling by locality (utilising the recently developed sub-DHB Locality Framework –see appendix two), split in combination by:
    - five year age bands (at a total level), and life stage age groups when used in combination with the below factors – this will help to alleviate some concerns of very low numbers in some combinations
    - Sex
    - Ethnicity (Maori//Other, with Pacific available at total level only)
    - Overlaid with the latest NZ Deprivation Index Quintile
- Special areas of interest:
    - Northern Corridor
    - Waikeria prison expansion impact

For Midlands Region:

- five years ago, Current, five year, ten year, and fifteen year projections
    - Population modelling by DHB, split by as per above

Known data sources to be incorporated into development:

1. Stats NZ population projections produced for the MoH at a DHB level used in determining DHB funding levels
2. Stats NZ projections at Census Area Unit (CAU) by age and sex (medium projection criteria)
3. Stats NZ subnational projections by age, sex and ethnicity (non prioritised) at Territorial Authority (TA) level (medium projection criteria)
4. WISE (Waikato Integrated Scenario Explorer) model of land area usage commissioned by the Waikato Projections Working Group (used by Councils to complete their Plans ad as a basis for the Waikato Plan)
5. PHO registers, pharms, labs, hospital data sets

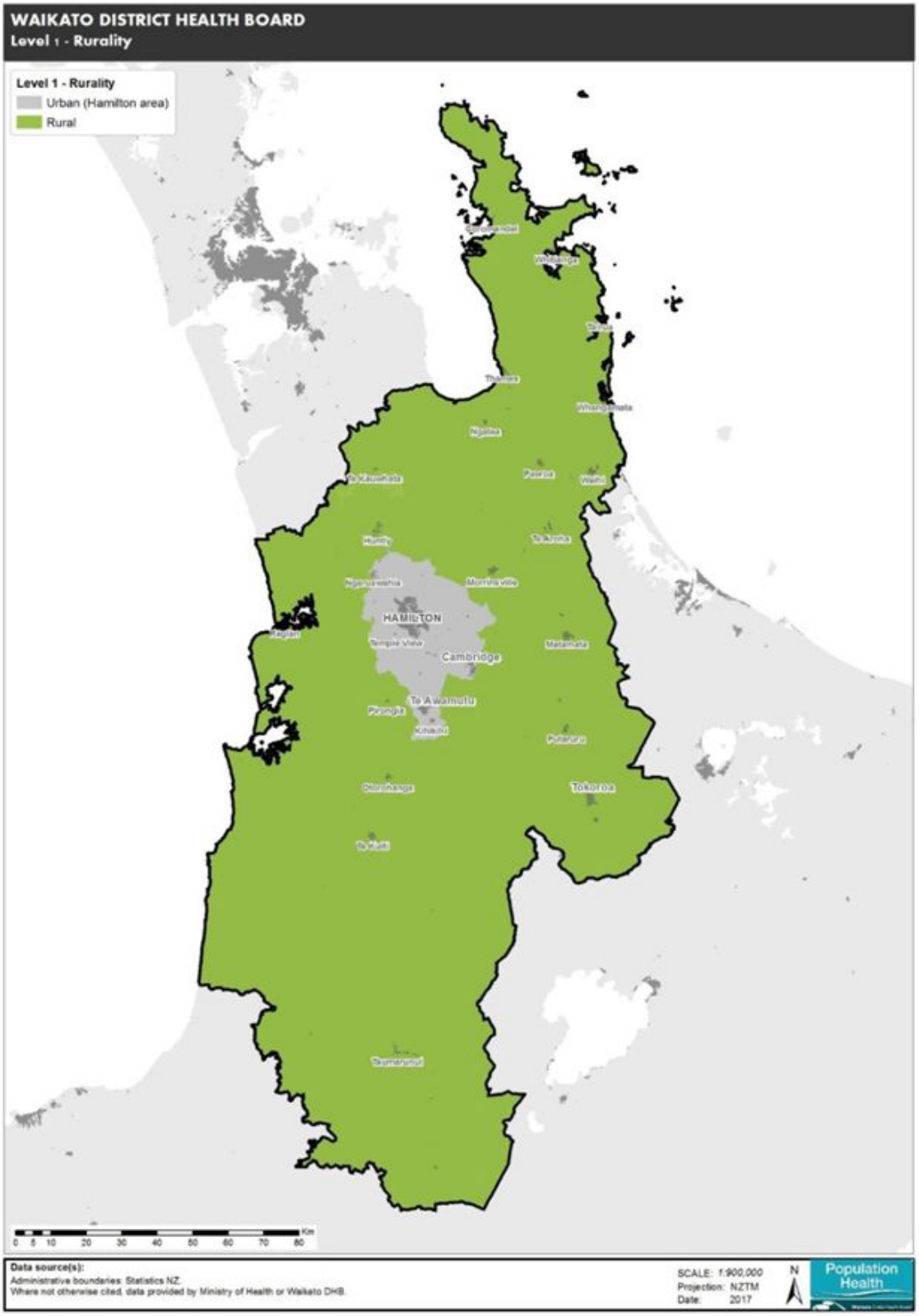
For the population and demographic model:

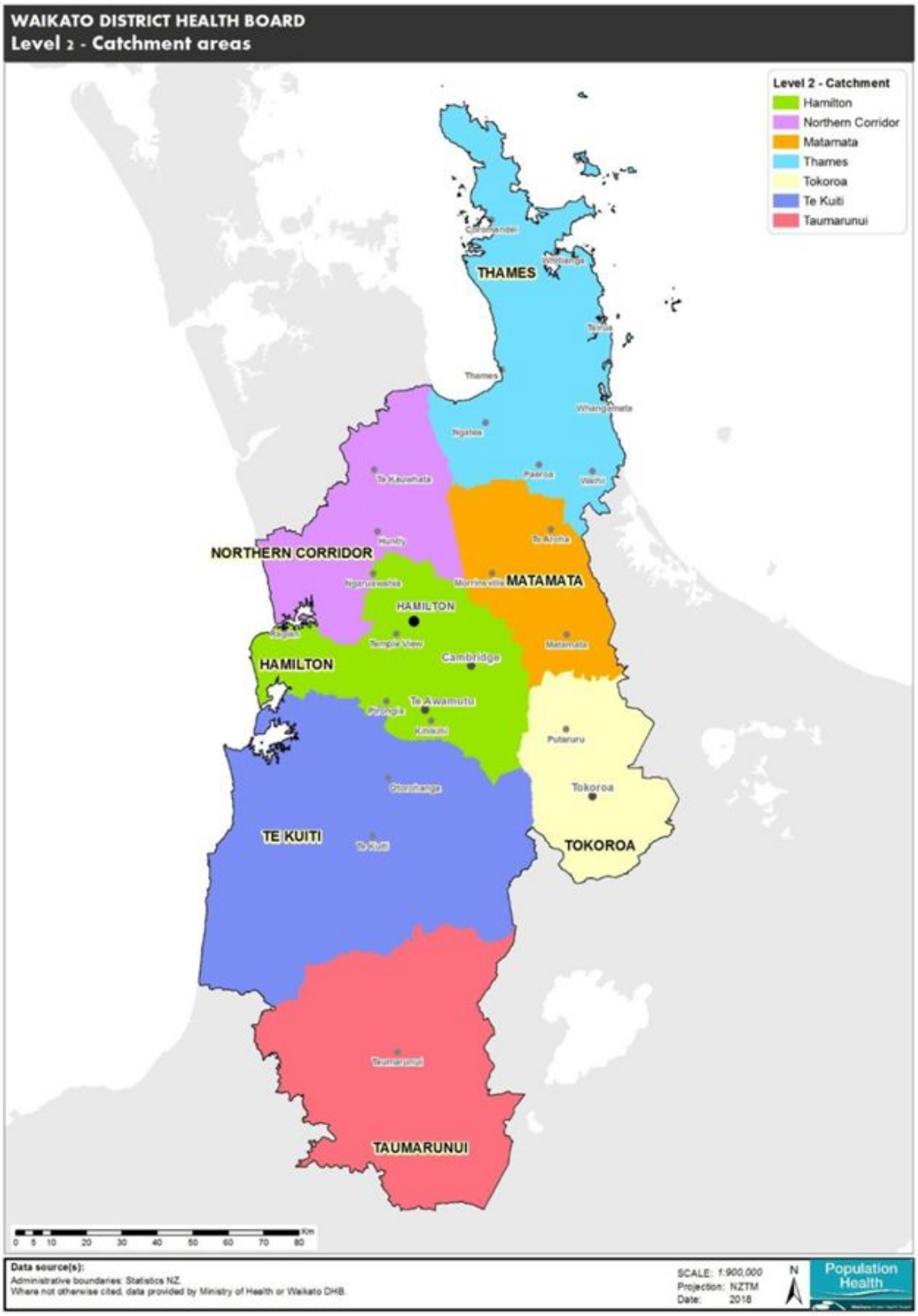
- Base file will be the Stats NZ projections at CAU by age and sex (2 above)
- For each age/sex combination a Maori/Non-Maori split will be applied based on the ethnicity split for the age/sex split within the subnational TLA level file (3 above).
- All age/sex/ethnicity calculations will be rounded to whole people
- Totals for CAUs by ethnicity will have a mathematical factor applied so that the sum of CAU will match the total annual MoH projections (1 above), but not necessarily by age and sex categories
- Increases for high growth areas using the WISE model (e.g. Northern Corridor)

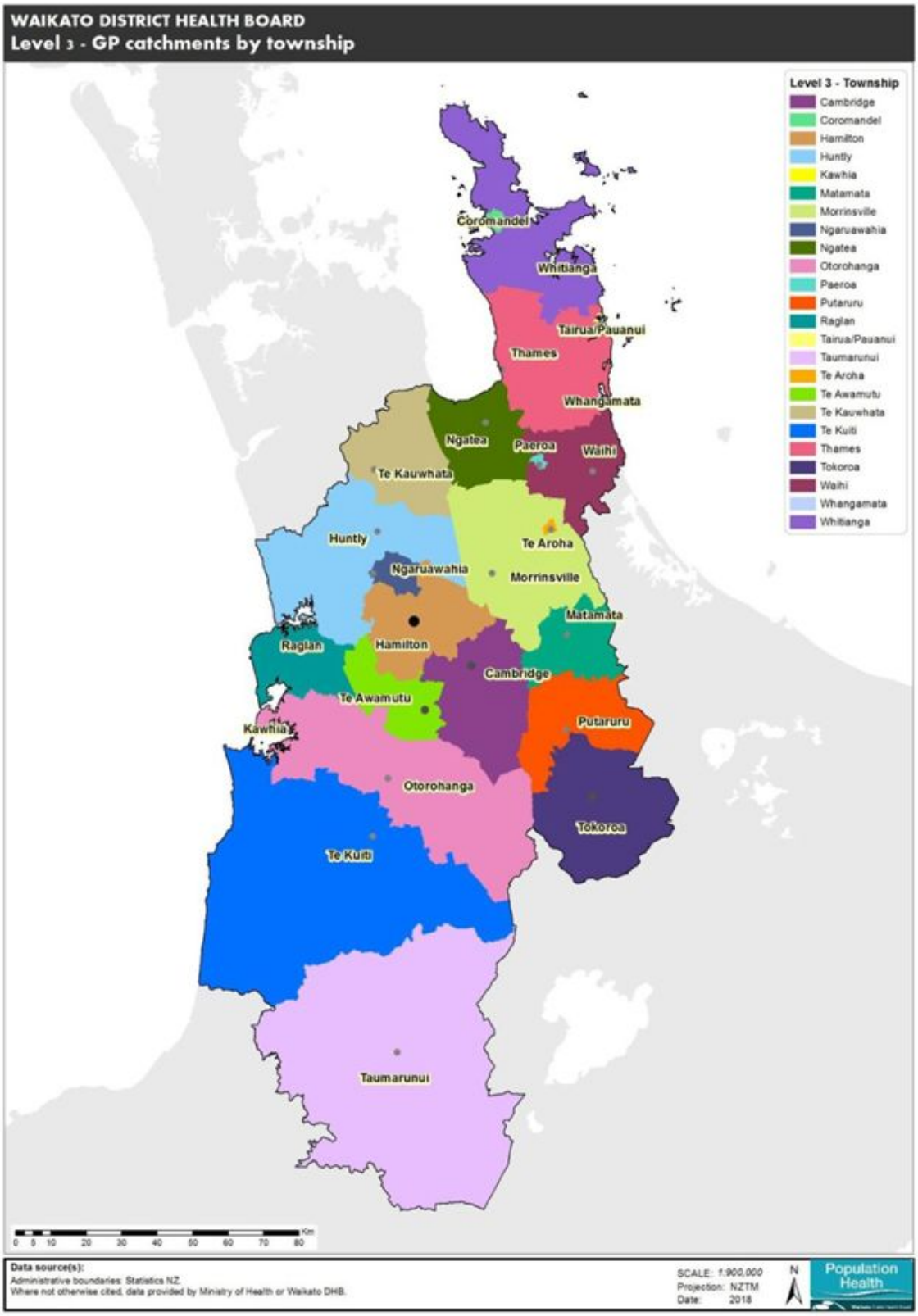
Weakness/limitations:

- Stats NZ subnational projections by age, sex and ethnicity do not include prioritised ethnicity. Therefore, the sum of all counted ethnicities is greater than the population as a whole as people have the ability to list multiple ethnicities. The projections for Maori are broadly in line with the MoH projections at a DHB level. All other ethnicities are over stated compared with the prioritised ethnicity data. The most robust approach is to present a Maori and Non-Maori split of the population, though this has clear limitations for visibility of other ethnicities when combining with other dimensions.
- Applying a TLA wide ethnicity profile to each CAU within the TLA does not reflect the true distribution of ethnicities within communities. The result is that at a CAU level there will be some significant differences in projected ethnicity makeup. The projections become more reliable as CAU are combined into larger geographical groupings. This will be mitigated by using our locality framework.

Appendix Two – Locality Framework




WAIKATO DISTRICT HEALTH BOARD
Level 2 - Catchment areas
Level 2 - Catchment
Hamilton
Northern Corridor
Matamata
Thames
Tokoroa
Te Kuiti
Taumarunui
THAMES
NORTHERN CORRIDOR
MATAMATA
HAMILTON
HAMILTON
TE KUITI
TOKOROA
TAUMARUNUI
Cambridge
Te Awamutu
Tokoroa
Thames
Ngatea
Paeroa
Te Aroha
Matamata
Putaruru
Te Kuiti
Taumarunui
Data source(s):
Administrative boundaries: Statistics NZ.
Where not otherwise cited, data provided by Ministry of Health or Waikato DHB.
SCALE: 1:900,000
Projection: NZTM
Date: 2018
N
Population Health


WAIKATO DISTRICT HEALTH BOARD
Level 3 - GP catchments by township
Level 3 - Township
Cambridge
Coromandel
Hamilton
Huntly
Kawhia
Matamata
Morrinsville
Ngaruawahia
Ngatea
Otorohanga
Paeroa
Putaruru
Raglan
Tairua/Pauanui
Taumarunui
Te Aroha
Te Awamutu
Te Kauwhata
Te Kuiti
Thames
Tokoroa
Waihi
Whangamata
Whitianga
Coromandel
Whitianga
Tairua/Pauanui
Thames
Whangamata
Ngatea
Paeroa
Waihi
Te Kauwhata
Huntly
Te Aroha
Ngaruawahia
Morrinsville
Matamata
Raglan
Hamilton
Cambridge
Te Awamutu
Putaruru
Kawhia
Otorohanga
Tokoroa
Te Kuiti
Taumarunui
0 5 10 20 30 40 50 60 70 80 Km
Data source(s):
Administrative boundaries: Statistics NZ.
Where not otherwise cited, data provided by Ministry of Health or Waikato DHB.
SCALE: 1:900,000
Projection: NZTM
Date: 2018
N
Population Health

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 10.3

ETHNICITY BASED KPI REPORTING

Purpose	For information and feedback.

Background

The Board requested in the February Board meeting, that performance on key performance measures be reported to the Board by ethnicity, in particular split by Māori and Non-Māori. This request supports the DHB's key strategic priority 1.1 radical improvement in Māori health outcomes by eliminating health inequities for Māori.

This interim report provides a brief update on the work undertaken since the February meeting. A comprehensive report will be included on the April Board meeting.

Current Situation

The DHB collects ethnicity information for all its patients and this information is frequently validated when reception staff interacts with patient in an outpatient or inpatient setting. There is a range of regular performance and operational reports produced by various departments in the organisation, most notably Operational Performance and Support (OPS), Strategy and Funding (S&F) and Information Services (IS). Performance reporting does not consistently split out performance between Māori and non-Māori.

Progress

Since the February Board meeting, the OPS team have reviewed our ethnicity data and implemented the September 2017 ethnicity data protocol of 'priority ethnicity' as used by the Ministry of Health (*HISO 10001:2017 Ethnicity Data Protocols*). The 'priority ethnicity' is determined by using a ranked list of ethnic groups, and when a person has selected multiple ethnicities, the highest ranked ethnicity is set as the 'priority ethnicity' and subsequently used in analysis and reports. The priority ranking used is included in annex 1. This definition is the same as used in reports produced by Strategy & Funding from GP data.

It is proposed that a core set of 22 key performance indicators are reported to the April Board, split by Māori and non-Māori. The selection will be made from the measures currently included on the KPI reports for Waikato Hospital, Community and Clinical Support and Mental Health. Not all measures currently included on these reports are able to be split by ethnicity as the core data for some measures does not

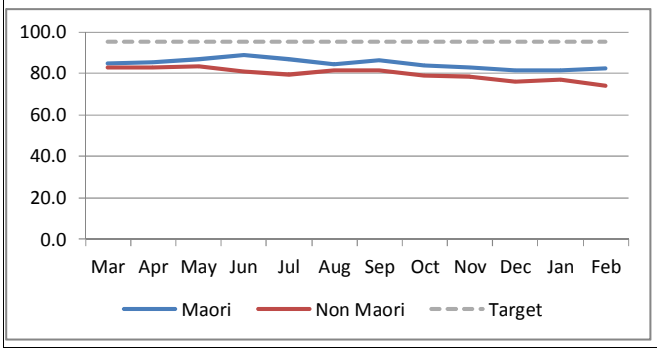
provide this breakdown. For measures included, analysis will be included to provide insight whether any observed differences are statistically relevant.

The proposed measures to be included on the initial performance report are a mixture of health targets and other key measures:

Section	Measure	Unit
Waiting Times	Emergency Department < 6 Hours	% of patients
Waiting Times	Faster Cancer Treatment - Referral received to first treatment <= 62 days	% of patients
Waiting Times	Faster Cancer Treatment - DTT to first treatment <= 31 days	% of patients
Waiting Times	Number of long wait patients on outpatient waiting lists	# > 4 mths
Waiting Times	Number of long wait patients on OPRS outpatient waiting lists	Patients
Waiting Times	Number of long wait patients on inpatient waiting lists	# > 4 mths
Theatre Productivity	Waiting Time for acute theatre < 24 hrs	%
Theatre Productivity	Waiting Time for acute theatre < 48 hrs	%
General Throughput Indicators	Mental health seclusion hours	Hours
General Throughput Indicators	Mental health recovery plans	% Cases
General Throughput Indicators	Mental health HoNos matched pairs	% Cases
General Throughput Indicators	Mental health inpatient bed occupancy	%
General Throughput Indicators	Outpatient DNA Rate	%
Discharge Management	Number of long stay patients (>20 days length of stay)	Discharges
Discharge Management	Number of long stay patient bed days (>20 days los)	Bed Days
Discharge Management	Mental health average length of stay	Days
Discharge Management	Average length of stay (Specialty excl AoD)	Days
Discharge Management	Mental health post discharge follow up - % seen in 7 days	%
Discharge Management	Mental health follow up - numbers seen in 7 days	Number of Cases
Discharge Management	Mental health community contract positions filled	% FTEs
Discharge Management	Mental health 28 day readmission rate	%
Health target measures	Better help for smokers to quit	% of smokers

The proposed reporting format is shown below (sample data only).

Emergency Department < 6 Hours



	Maori	Non-Maori
Feb-18	74.2	74.2
Target	95.0	95.0
Variance	-20.8	-20.8
YTD	79.6	66.6
Target	95.0	95.0
Variance	-15.4	-28.4

Next steps and future

Following feedback from the Board, the report will be prepared for the April Board meeting, including further analysis on a few key performance indicators. The report will also be provided to the Iwi Māori Council for their April meeting. In the future, any new performance reports that are produced using the DHB's new reporting toolset *QlikSense* will have ethnicity as a standard parameter to be used by staff in filtering and drill-down of performance measures online. This objective is already included in the Operations & Performance team objectives document.

Recommendation
THAT
The Board:

1) Receives the report.
2) Notes the proposal for ethnicity based reporting of performance measures.
3) Provides feedback on the proposed measures and reporting format.

MARC TER BEEK
EXECUTIVE DIRECTOR OPERATIONS AND PERFORMANCE

5.5.2 Prioritised output

One of the main criteria stipulated in the definition of ethnicity is that a person can belong to more than one ethnic group. The ethnicity question caters for multiple responses. However, the question does not ask people to indicate the ethnic group with which they identify the most strongly.

In prioritised output, each respondent is allocated to a single ethnic group using the prioritisation tables below. There are prioritisation orders for both level 1 and level 2 of the classification. The aim of prioritisation is to ensure that where some need exists to assign people to a single ethnic group, ethnic groups of policy importance or of small size, are not swamped by the New Zealand European ethnic group. Prioritisation is a reduction process for output and analysis purposes and does not assume this is the ethnic group that a respondent identifies most strongly with.

For example, if a data provider has indicated four ethnicities and these have been aggregated to level 2 as 40 – Asian, 21 – Māori, 51 – Middle Eastern and 11 – New Zealand European, the prioritised responses would be:

1. 21 – Māori
2. 40 – Asian
3. 51 – Middle Eastern
4. 11 – New Zealand European.

The following tables are available on http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/ethnicity-code-tables.

Table 2: Prioritisation for level 1 codes

Priority order	Ethnic group code (Level 1)	Ethnic group code description
1	2	Māori
2	3	Pacific Peoples
3	4	Asian
4	5	Middle Eastern/Latin American/African (MELAA)
5	6	Other Ethnicity
6	1	European
9	9	Residual Categories

Table 3: Prioritisation for level 2 codes

Priority order	Ethnic group code (Level 2)	Ethnic group code description
1	21	Māori
2	35	Tokelauan
3	36	Fijian
4	34	Niuean
5	33	Tongan
6	32	Cook Island Māori
7	31	Samoan
8	37	Other Pacific Peoples
9	30	Pacific Peoples not further defined
10	41	Southeast Asian
11	43	Indian
12	42	Chinese
13	44	Other Asian
14	40	Asian not further defined
15	52	Latin American
16	53	African
17	51	Middle Eastern
18	61	Other Ethnicity
20	12	Other European
21	10	European not further defined
22	11	New Zealand European

Priority order	Ethnic group code (Level 2)	Ethnic group code description
94	94	Don't know
95	95	Refused to answer
97	97	Response unidentifiable
99	99	Not stated

This output type is the one most frequently used in Ministry of Health statistics and is also widely used in the health and disability sector for funding calculations, monitoring changes in the ethnic composition of service utilisation and so on. It produces data that is easy to work with, as each individual appears only once. This means the sum of the ethnic group populations will add up to the total New Zealand population. Denominator data must also be prioritised to ensure numerator denominator consistency.

Limitations with prioritised output include that it places people in specific ethnic groups (high priority because of policy importance), which simplifies yet biases the resulting statistics as it over-represents some groups at the expense of others in ethnic group counts because of the order of prioritisation. It is also an externally applied single ethnicity which is inconsistent with the concept of self-identification including multiple ethnicities and should therefore not be used in processes of data collection or recording.

Significant Programmes/Projects

Virtual Health: no report this month.

Medical School: no report this month.

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 11.3.1

CREATING OUR FUTURES PROGRAMME BUSINESS CASE – STRATEGIC ASSESSMENT

Purpose	For information and approval.

The Creating Our Futures (COF) Programme Business Case document is attached for the Board's review and endorsement. The purpose of the Programme Business Case is to seek approval from Capital Investment Committee members to commence the preferred programme of work and to proceed with developing future business cases for the specified projects within the proposed tranches. The Programme Business Case:

- confirms the strategic context and how the proposed investment fits within that strategic context
- confirms the need to invest and the case for change
- recommends a preferred programme and a preferred way forward for further development of the investment proposal
- identifies the key asset and non-asset based projects and activities that will support the programme outcomes, including proposed programme tranches, and
- seeks the approval of decision-makers to develop subsequent project business cases.

Recommendation
THAT
The Board:

1) Receives the Creating Our Futures Programme Business Case.
2) Endorses the Creating Our Futures Programme Business Case.
3) Endorses the Creating Our Futures Programme Business Case for submission to NZ Treasury, the Ministry of Health and Investment Ministers.

VICKI AITKEN
INTERIM EXECUTIVE DIRECTOR, MENTAL HEALTH AND ADDICTIONS

IAN WOLSTENCROFT
EXECUTIVE DIRECTOR, STRATEGIC PROJECTS

Better Business Cases

Waikato DHB Mental Health and Addictions

Creating Our Futures

Programme Business Case

Prepared by:	Waikato DHB Mental Health and Addictions
Prepared for:	
Date:	19 March 2018
Version:	v0.04
Status:	DRAFT

Better Business Cases
Programme Business Case

Document Control

Document Information

	Position
Document ID	
Document Owner	Vicki Aitken, Executive Director
Issue Date	
Last Saved Date	19/03/2018
File Name	Waikato DHB MH&AS Creating Our Futures

Document History

Version	Issue Date	Changes
v0.01	05/03/2018	Programme Document Initiation
v0.02	13/03/2018	Amendments following Ministries feedback
v0.03	19/03/2018	Amendments following Executive Group feedback

Document Review

Role	Name	Review Status
Approval	MH Clinical Governance Board	27/02/2018
Review	Ministry of Health	05/03/2018
Approval	MH&AS Creating Our Futures PB	12/03/2018
Approval	Waikato DHB Executive Group	16/03/2018
Approval	Waikato DHB Board	

Document Sign-off

Role	Name	Sign-off Date
Senior Responsible Owner	Vicki Aitken	
Senior Supplier	Ian Wolstencroft (Facilities Redevelopment)	
Senior User	Vicki Aitken	
Project Director	Dr Virginia Endres	

Contents

Executive Summary

Introduction

This Waikato District Health Board (DHB) programme business case seeks formal approval from the Capital Investment Committee to obtain Ministerial approval to proceed with developing the Facilities Redevelopment and Transformational Pathway indicative business case/s to ensure Mental Health and Addictions (MH&AS) service provision is safe, effective and efficient without compromising outcomes for service users and their family whānau; and for staff; and, supports the regions' growing population needs, values and aspirations, now and into the future.

This programme business case follows the NZ Treasury Better Business Cases guidance and is organised around the five case model.

Strategic Case

The strategic context

The strategic case outlines the strategic context for the investment proposal and makes a robust and compelling case for change. While the Waikato DHB MH&AS service has progressed service delivery, growing numbers of people accessing services for mental health and addictions issues is placing the service under pressure, and there is increasing potential for unmet need. Often people present once their condition deteriorates, and the dominant reactive treatment option (medication and therapy) does not address the broader social factors that help people to be well and support their recovery.

The case for change

Key stakeholders identified three investment objectives for this investment proposal.

Table 1: The case for change is summarised for each investment objective below.

Investment Objective 1	**To transform service delivery in order to improve safety, effectiveness and efficiency.**
Existing Arrangements	Growing numbers of Waikato people are accessing health services for mental health and addictions issues; MH&AS is under pressure. Often services are reactive and available to people only once their condition has deteriorates, and the dominant treatment option (medication and therapy) do not address the broader social factors that help people to be well and support their recovery.
Business Needs	Broaden the focus of service delivery from mental illness and addiction to mental well-being and recovery. Improve the quality of mental health and addiction services, supported by evidence based practice and information about changing levels of need. Improve access [front gate] to early intervention before the impacts of mental health and addictions reach a more severe stage.
Potential Scope	Non-capital strategies required to fully integrate services:

	- MH&AS community, inpatient and specialty services (whole system pathway) - Regional Forensic services pathway
Potential Benefits	- Improved access and health outcomes - Improved experience and engagement
Potential Risks	New model of care does not bring about transformational change. Challenges and breakdown in key stakeholder confidence and lack of collaboration in the change programme Inability of the wider sector to understand and support the implementation of the model of care
Constraints and Dependencies	Any changes to Government policy direction that followed the 2017 election may impact on the investment scope of the business case. For planning and management proposes it is assumed that regardless of Government, there will be a need for sustainable integrated service delivery across the continuum of care. The proposed model of care and business case describes a broader approach to mental health and addictions and assumes a collaborative and sector wide engagement to actioning a response.

Investment Objective 2	**To create safe and therapeutic environments that support holistic care at all times.**
Existing Arrangements	HRBC footprint is out-dated and is based on institutional design, significant deficiencies; include lack of space and privacy, lack of natural lighting, congestion, ventilation. Institutional layout is inflexible and unable to support interventions and future demand.
Business Needs	Contemporary fit-for-purpose inpatient facilities, with the necessary therapeutic space to manage and deliver holistic care. Spaces that are modular and flexible in order to meet changing demand, needs and values; now into the future. Health Professionals have the necessary space to manage clinical risk, safety and de-escalation, and appropriate co-location, freeing up time to enable staff to focus on care.
Potential Scope	Capital Infrastructure investment into fit-for-purpose environments: - Acute MH Inpatient - Multiple and Variable Needs Inpatient (needs (including, high and complex, MH older 65 years, youth, eating disorders, cognitive impairment, peri-natal, AoD – SA(ACT) requirements) - Puawai Inpatient
Potential Benefits	- Therapeutic and safe environments
Potential Risks	Affordability issues. Protracted approval and development sequencing / timelines exacerbate current service issues and increase's the potential interim solution risk. Competition of market supply and demand – a number of large builds occurring during this period (NZ Corrections; PPP Waikato Schools). New infrastructure becomes out-dated in 20 years' time.
Constraints and Dependencies	Government health funding and mental health policy direction (capital infrastructure cot and competing investment).

	Any changes to the forensic model of care or programme may impact on the scope of this business case. Ongoing close engagement with regional corrections will need to occur.

Investment Objective 3	**To build sustainable capacity and capability of services to meet future demand, values and need.**
Existing Arrangements	Increasing demand and zero growth in resources (eg, people and funding) which threatens access to services for mental health and addictions issues. Services are under pressure and there is a potential for many needs being unmet.
Business Needs	Implement a workforce strategy that enables the service and the broader sector to deliver better, more accessible services. Achieve change through collaborative leadership, supported by transparent outcome information.
Potential Scope	- Professional Practice, and Cultural Responsiveness - Leadership - Culture and Values - Engagement - Technologies
Potential Benefits	- Operational efficiencies and effectiveness gains - Workforce gains
Potential Risks	Demand continues to overwhelm capacity. Unplanned future clinical risk/s or challenges on the horizon. Competition between programme delivery and BAU.
Constraints and Dependencies	The ability to continue to deliver at current (or enhanced) levels to the growing Waikato population is subject to funding constraints. Not managing BAU alongside the change programme

Economic Case

Potential programme options

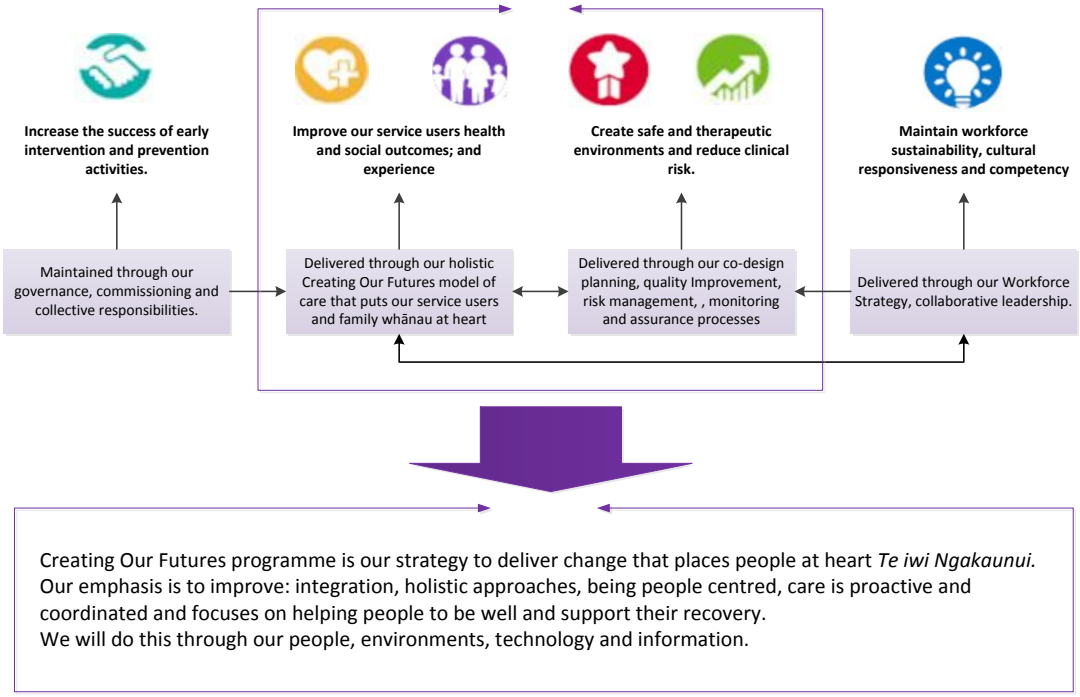
Within the potential scope of this proposal, the main programme options were identified by key stakeholders at a series of facilitated workshop held throughout 2017. On the basis of the above, the recommended preferred way forward for the Creating Our Futures programme is described below.

The project mix

On the basis of a series of facilitated stakeholder workshops held throughout 2017, the following mix and sequencing of projects is recommended for progressing the preferred programme which includes:

- MH&AS Transformational Pathway Project
- MHA Whole Approach to Wellbeing and Recovery
- Waikato DHB MH&AS Facilities Redevelopment Project

- MH&AS Capacity and Capability Initiatives



Indicative costs and benefits

The estimated rough-order costs and benefits for the preferred programme over the period to 2022 are between $100 - $200 million (capital infrastructure – any opex costs are yet to be determined). The whole of life and operational costs will be assessed in the indicative cases.

Commercial Case

The commercial case outlines the proposed deal in relation to the preferred way forward is conventional (where Waikato DHB manages the design and construction of any facilities redevelopment; and, delivers clinical, non-clinical and facilities management service in-house). This will be confirmed and finalised in the next stages of the business case development.

Financial Case

Affordability remains a significant issue for the Waikato DHB, given the current funding outlook. However, the alternative of no investment in mental health and addictions services would have a significant negative impact on access to services, clinical risk and service user safety and outcomes, as well as on the broader Waikato community health system and population health.

Management Case

The programme governance structure and initial project milestones are provided below.

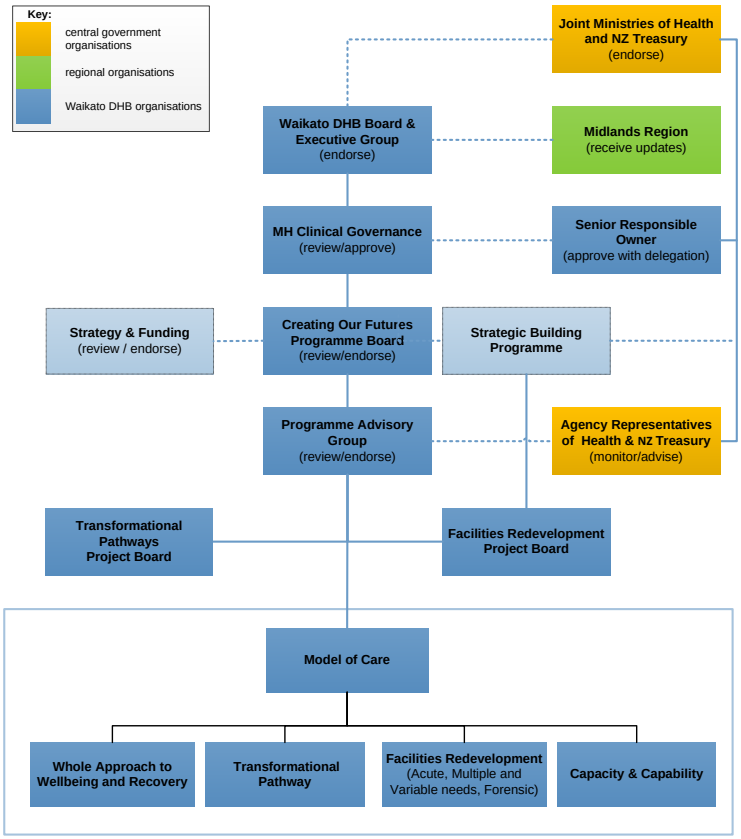


Table 2 Programme key milestones below.

Proposed key milestones	Estimated timing
Discovery and Indicative	Jan 2017 – Apr 2018
Programme Business Case	May 2017 – Mar 2018
Indicative Business Case (Facilities Redevelopment Project)	Jan 2018 – May 2018
Single Stage Business Case (Transformational Pathway Project)	Apr 2018 – Sept 2018
Transformation System Changes	Jan 2018 – Jan 2020
Detailed Business Case (Facilities Redevelopment Project)	May 2018 – Sept 2018
Stage 1 Facilities Implementation	May 2018 – Dec 2021
Continuous Improvement	Jan 2017 – Dec 2020
Stage 2 Facilities Implementation	Jan 2021 – Dec 2022
PIR and Continuous Improvement	Jan 2021 – ongoing

Next Steps

The Programme Business Case also seeks approval from Capital Investment Committee members to commence the preferred programme of work and to proceed with developing future business cases for the specified projects within the proposed tranches.

Introduction

1. This Waikato District Health Board (DHB) programme business case seeks formal approval from the Capital Investment Committee to obtain Ministerial approval to proceed with developing the Facilities Redevelopment Project and Transformational Pathway Project business case/s to ensure Mental Health and Addictions (MH&AS) service provision is safe, effective and efficient without compromising outcomes for service users and their family whānau; and for staff; and, supports the regions' growing population needs, values and aspirations, now and into the future.

2. In response to the identified constraints, the Waikato DHB Mental Health and Addictions service is committed to undertaking a major project of work. This Creating Our Futures Programme 2016 - 2019 is aligned to our Waikato DHB Strategic Plan and Mental Health and Addictions (MH&AS) service new Model of Care. Both the programme and the strategic plan set the agenda for investment in the environment needed to support contemporary and best practice service delivery. This programme business case provides an opportunity to assess and justify MH&AS service change.

3. The recommended programme changes include:

   - Transforming service delivery in order to improve safety, effectiveness and efficiency.

   - Creating safe therapeutic environments that support holistic care at all times.

   - Building sustainable capacity and capability of services to meet future demand, values and need.

The Strategic Case – Making the Case for Change

Strategic Context

4. Mental Health and Addictions provides services to people with a severe mental illness and/or addiction disorder/s who are experiencing an episode of such severity that they require secondary / tertiary service level assessment and intervention. Research confirms that early and holistic approaches to recovery improves' overall health and wellbeing for the service user and their family whānau. To this end, we are focused on ensuring that our service users receive the care at the **right time**, **right place**, by the **right person** and in the **right way**.

5. More broadly, MH&AS service want to improve the experience and engagement of those who interact with us, including service users; family whānau; staff; and, professionals and other agencies across the sector. This has been highlighted by our community through our engagement and feedback processes (in particular the development of our new Model of Care and '*Let's Talk*' engagement). We are also focused on ensuring that our services reflect the diversity of our Waikato community and ways to ensure equity of access tin ways that meet their needs.

6. Improving our inpatient facilities will require significant investment in the next five years. The Waikato DHB has prioritised investment into Mental Health and Addictions

services to ensure they are safe, effective and efficient through people, systems, processes and technology for the future.

Organisational Overview – MH&AS

7. Waikato DHB Mental Health and Addictions (MH&AS) service provides mental health, addictions and speciality services to the population of the Waikato and regional forensic services to the Midlands population. We collaborate with other health and Non-Government Organisations, stakeholders and our communities to identify what mental health and addictions services are needed and how best to deliver these services. As at 30 June 2015, the Waikato DHB MH&AS services had 745 full time equivalents (FTE). These employees are central to the DHBs ability to deliver mental health and addictions services to the Waikato communities.

8. MH&AS services are for people experiencing an episode of mental health and/or addiction difficulty of such severity that they require secondary / tertiary service level assessment and intervention. Services are delivered through the Waikato DHB's district by geographical sectors (North, Central, North Rural, South Central and South Rural). Henry Rongomau Bennett Centre (HRBC) is a mental health facility located on Waiora Waikato Hospital Campus, Hamilton. Adult inpatient services include low stimulus and secure inpatient services of 53 beds based in HRBC.

9. Puawai provides regional forensic psychiatric services to the Midland health region, covering the courts, prisons, and general mental health services within Waikato, King Country, Bay of Plenty, Whakatane, Rotorua, and Taranaki areas. Essentially forensic psychiatry is about legal issues pertaining to people who have or are thought to have a mental disorder. The services provided by Puawai include a secure inpatient service of 44 beds based in Hamilton (HRBC) [plus, co-location of Detox 2 beds, and High and Complex 3/4 beds]. Its community forensic service includes services to the prisons and courts in the region, as well as community mental health follow-up to community-based forensic services users living in Hamilton.

10. Mental Health Services for Older People (MHSOP) is a specialist team offering assessment, interventions for people aged 65 years and over who are experiencing serious mental health disorders, dementia and serious behavioural and/or psychological symptoms and signs. MHSOP service is provided in both an inpatient and community setting. The Older Persons and Rehabilitation Building facility was purpose built for health services related to older people and for rehabilitation. The building includes four wards and an outpatient clinic for the Older Persons and Rehabilitation service, as well as a ward and clinic area for Mental Health Services for Older People.

Mental Health and Addictions Funding Arrangements

11. Acute Mental Health and Addictions is part of a continuum that supports wellbeing and recovery aspirations to enable people with long term and episodic conditions to stay well in their communities and at home. The Waikato DHB plans to spend $137.4 million in the 17/18 financial year on mental health and addictions services. The funds are allocated as follows:

Waikato DHB Provider Arm[1]	$85.0m
External Providers	$50.0m
Inter-District Flows (IDF)	$2.4m
Forecast Total 17/18 Year	$137.4m

12. Waikato DHB presently spends $137.4 million per annum on acute mental health and addictions, with provider arm hospital delivered inpatient services accounting for 30% (or $40.2m) of that expenditure. Each quarter, the Mental Health and Addictions service have a total caseload of approximately 5,000 service users (total appointments 50,000) with about 350 inpatient admissions in the Waikato district. Many more individuals access primary and community based services.

The Waikato – Geography and Demography

13. Waikato DHB covers eight percent of New Zealand's population, From Northern Coromandel to close to Mt Ruapehu in the South, and from Raglan on the West Coast to Waihi on the East. It takes in the city of Hamilton and towns such as Thames (including the Coromandel Penninsula), Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngaruawhia, Te Kuiti, Tokoroa and Taumarunui.

14. Key Demographics:

- For 2015/2016, our population was 394,340
- Our population is getting proportionately older
- The Māori population (estimated to be 23 percent of our population) is growing
- Pacific people represent almost 3 percent of our population
- Approximately 60 percent of our population live outside the main urban areas
- We have a larger proportion of people living in areas of high deprivation than in areas of low deprivation.

Existing Arrangements

15. People with lived experience[2], clinical staff members, community, and social and health providers, have provided feedback on how the Mental Health and Addictions service can improve delivery of services in the Waikato.

[1] Waikato DHB Provider Arm funds are used for providing acute adult, older persons and forensic inpatient care; and a range of community based services.

16. Through a series of Investment Logic Mapping workshops (see annex 2) stakeholders identified three problems that challenge our Mental Health and Addictions service delivery.[3]

    a. Lack of an integrated and holistic model is resulting in significant barriers to timely and appropriate care.

    b. Current building, designed to fit an outdated institutional model, does not provide a safe, therapeutic and effective environment for service users and staff.

    c. Existing service capacity is not meeting the increasing acuity / complexity and demand, which at times results in compromised and unsafe care.

Problem One – Model of Care ***Lack of an integrated and holistic model results in significant barriers to timely and appropriate care.***

17. The implementation of a contemporary mental health and addictions model of care is, and has been, challenging, where systemic issues have hindered the implementation of the Integrated Care Pathway. This issue is confounded by increasing demand for mental health and addictions services, in terms of numbers, acuity and complexity of need. Specific contributing factors include:

    - sub-optimal integration of mental health and addictions across the sector
    - delivery of care is unplanned and reactive
    - lack of predicable transition and transfer of care (push system of care)
    - variable approaches and stigma resulting in inequity and lack of engagement.

18. Recent evidence based model of care reviews include:

    a. **Section 99 Inspection of Waikato DHB Mental Health and Addictions Services** (Crawshaw, 2016). In early 2015, there were a number of very difficult and serious events at Waikato DHB Mental Health and Addictions services. Following these events, Dr Crawshaw, Director of Mental Health, used his statutory powers under section 99 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 to inspect the services to ensure they were providing a good quality of care to people in the Waikato region. The purpose of the inspection was to examine how the services were functioning, and to enable the Director of Mental Health to determine whether any systemic issues contributed to those events.

       The inspection team acknowledged the direction of travel of the change as appropriate, and that it showed good strategic thought as to contemporary models

[2] People with lived experience/s – includes service users and family whānau who are or who have had mental health and addictions experience/s both indirectly or directly. Mental health refers to any form of mental health condition (including, organic or functional), severe mental illness refers to conditions involving psychosis or very high levels of need, and wellbeing as a more general term capturing emotional and psychological state and resilience.

[3] Refer to annex 2 for the full Investment Logic Map.

of practice. The shift in the model/s of care through this time has been significant, and it needed to be - acknowledging that the transformational change is yet to be completed.

b. **Time for Change: evaluation of Health Waikato Adult Mental Health and Addictions Services** (Fjeldsoe, Aimer, Clapham-Howard and Kidd, 2009). In 2009, an independent review committee evaluated the standard of acute adult inpatient and community care services and provided 74 practical recommendations to improve the care provided. The *A Time for Change* programme was undertaken to reset the service model of care 2009-2013.

Problem Two – Environments and Infrastructure *Current building, designed to fit an outdated institutional model, does not provide a safe, therapeutic and effective environment for service users and staff*

> *…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.*
>
> *The review team believes 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 [consumers] with increasingly complex and diverse needs (Fjeldsoe, 2015).*

19. Despite considerable effort to implement potentially more safe, effective and efficient models of care (and improve space), implementation is being constrained by the need to deliver services within the outdated institutional design of the existing Waikato DHB Henry Rongomau Bennett Centre (HRBC) facility. Essentially, the service has been trying to make the service model fit within environments which cannot support contemporary standards. A number of independent inspections[4] and reviews[5] of the Waikato DHB Henry Rongomau Bennett Centre (HRBC) acute inpatient service found the current facilities do not meet contemporary standards of privacy, security and safety; and provide challenges to staff providing care to acutely unwell service users.

    a) **Section 99 Inspection of Waikato DHB Mental Health and Addictions Services** (Crawshaw, 2016). A focus of the section 99 inspection was the examination and assessment of the Henry Rongomau Bennett Centre (HRBC) capital infrastructure. Overall, the findings of the inspection team were (in line with the Waikato 2013 DHB Business Case) that the current facilities do not

[4] In early 2015, there were a number of serious events (SAC1 and SAC2) at the Waikato DHB Mental Health and Addictions service. Dr Crawshaw, alongside colleagues from the Ministry of Health and a consumer leader from Te Kupenga Net Trust, carried out this inspection in August 2015.

[5] In 2015 (and 2009) an independent review of the Henry Rongomau Bennett Centre (HRBC) Models of Care and Facility Infrastructure Review (Fjeldsoe, Meehan and Kingswell, 2015) was commissioned. The review noted a number of serious facility deficiencies.

meet contemporary standards, and therefore pose challenges to the teams providing care to acutely unwell service users; and, the confusing physical layout and lack of good sight-lines posed safety risks. The inspection team also remarked on the difficulty the service would face in effectively addressing these issues, given the physical structure of the unit and the constraints this posed. For instance, the narrowness of the corridors and the placement of bedroom doors present the real possibility of an effective barricading of corridors, as well as the potential for a service user to harm themselves or another person, out of sight.

The inspection team did not undertake a detailed analysis of the facilities, because the Waikato DHB had already commissioned a full review of its adult mental health facilities in 2015. The Fjeldsoe (2015) report was completed during the s99 inspection; and made similar findings.[6]

b) **Waikato DHB Mental Health and Addictions HRBC Improvement Plan** (Aitken, 2015). Following incidents at Henry Rongomau Bennett Centre (HRBC), the service made some alterations to the security and fencing, reconfigured the acute adult ward to an acuity step down model, Plan-Do-Study-Action quality audits undertaken, and changes to the Leave and AWOL processes.

c) **Waikato DHB Mental Health and Addictions Models of Care and Facility Infrastructure Review** (Fjeldsoe, Meehan and Kingswell, 2015). The primary focus of the independent review was the assessment of the Henry Rongomau Bennett Centre (HRBC) capital infrastructure. The assessment was aimed at determining the facility's suitability for development and its capacity to respond effectively and efficiently to existing and emerging models of service delivery for adults requiring acute inpatient care. The review found that advances in models of care was impeded, as the changing needs of those admitted becomes increasingly difficult to treat in facilities which were not designed for their current purpose. Specific contributing factors include:

- HRBC facilities do not meet a significant number of basic contemporary standards
- capacity of the service to develop new and potentially more efficient and effective models of service is being constrained by the need to deliver services in the existing facility
- fundamental problems with layout and insufficient space result in problems with privacy, safety and security
- inability to meet service user expectations: i.e., provision of single rooms with ensuite, natural light, indoor / outdoor access
- population growth without commensurate increase in beds

[6] See annex 3

- extended length of stay for high and complex service users reduces the service's capacity to respond to acute demand and limits the rehabilitation focus

- lack of specific facilities for service users who, as a result of trauma or cognitive impairment, have challenging behaviours

- inability to effectively transition service users through supported accommodation at a sustainable rate.

Fjeldsoe etal (2015) concluded that a redevelopment of the existing Henry Rongomau Bennett Centre (HRBC) acute unit would not address problems and would be unlikely to achieve significant improvements to the safe and effective treatment of those with the highest and most complex needs. The basic layout would still provide an institutional ambience and restrict the delivery of new and potentially more effective and efficient service options.

d) **Waikato DHB Functional HRBC Ward Design: Business Case** (Aitken, 2013). A business case was accepted by the Waikato DHB in principle subject to the ability of the organisation to realise the necessary capital funding.

20. It is almost 20 years since the Henry Rongomau Bennett Centre (HRBC) acute adult inpatient service was designed and built. The characteristics, needs and expectations of those who use the inpatient service have changed significantly since that time. International evidence shows that advances in models of care are commonly impeded through existing outdated institutionally designed facilities unable to meet current purpose.

Problem Three – Capacity and Capability *Existing service capacity and capability is not meeting the increasing acuity/complexity and demand which at times results in compromised and unsafe care*

21. People with lived experience[7], clinical staff members, community, and social and health providers, have provided feedback on how the Mental Health and Addictions service can improve delivery of services in the Waikato. Models of service delivery that are shown to be most effective and efficient are those that respond to dynamic population values and needs. Emerging issues for Waikato DHB's Mental Health and Addictions service delivery include relative levels of acuity and the complexities associated with co-morbidities / co-existing problems of individuals referred to the service. With these issues come increasing cost and significant expensive resource requirements. Specific contributing factors:

    - key working functions are genericising multidisciplinary approaches and diluting professional practice; and, impacting on the ability to deliver best practice interventions

[7] People with lived experience/s – includes service users and family whānau who are or who have had mental health and addictions experience/s both indirectly or directly. Mental health refers to any form of mental health condition (including, organic or functional), severe mental illness refers to conditions involving psychosis or very high levels of need, and wellbeing as a more general term capturing emotional and psychological state and resilience.

- low staff morale through workload pressures (static resourcing – people and funding)

- inability to forecast demand and plan resources (disparate tools and information systems)

- increasing demand, acuity and complexity of need confounded by a static resource capacity.

a. **Section 99 Inspection of Waikato DHB Mental Health and Addictions Services** (Crawshaw, 2016). The section 99 inspection found that Mental Health and Addictions Service and its leadership team has made significant improvement to the service since 2009, and that Mental Health and Addictions service is well managed and led. Staff, despite the problems of morale and increased pressure, is dedicated to doing their best for people accessing the service. People accessing the services and their family whānau can be assured that they can expect to receive good care.

   Like all mental health and addictions services nationally, Waikato DHB's Mental Health and Addictions service faces significant pressures as it changes its model of care and responds to increased community demand and needs. In some respects, pressures on the service are to be expected as the Mental Health and Addictions moves towards more accessible and timely care. There are some obvious issues that the Mental Health and Addictions service and the Waikato DHB need to address within the Creating Our Futures programme:

   - Mental Health and Addictions service needs to secure adequate resources to meet staffing gaps, and support a redefined [transformational] change timeline.

   - Mental Health and Addictions service needs to further strengthen leadership to support clinical change capability and capacity.

   - Waikato DHB needs to provide increased oversight and support to the Mental Health and Addictions service leadership team driving the transformational change.

22. The current model for delivery is primarily *Keyworking.*[8] A number of reviews have found that this model has genericised clinical practice and roles, and results in the keyworker functioning as the [*only*] care provider for the service user. This model has also inhibited multidisciplinary functioning, and resulted in a lack of progressive transition; integration; and unplanned and reactive response to care

23. The latest staff satisfaction survey[9] showed staff members felt pressured and concerned about caseload acuity, complexity and numbers; and low staff recruitment and retention rates.

24. Currently the service has limited visibility of a number of factors needed to effectively match capacity to demand.[10] [,11] The service information is gathered across a

[8] Waikato DHB Keyworker Procedure 5241

[9] MH&AS Staff Satisfaction Surveys Reports undertaken in 2016 and 2017

multitude of systems, which involves time-consuming recording of clinical documentation, duplication of information into manual systems, and an inability to plan end-to-end care. There is also a lack of ability to undertake production and capacity planning in the short or long term, and no way of determining resource requirements. Over the last 20 years, despite increasing demand and change in need, there has been no significant change in resource capacity.

25. Significant investment is required to address these current state problems. The Waikato DHB MH&AS service is committed and currently working to respond to the need to change and challenge the status quo. 2018 will see the development of a whole systems approach and integrated service delivery model.

Business Needs – Meeting the Investment Objectives

Creating Our Futures Programme

26. Over the past 20 years (since deinstitutionalisation), Waikato DHB has evolved its model of care to enable the majority of mental health services to be delivered in the community, in line with national and regional mental health strategies. A number of the aforementioned reviews found evidence of improved service delivery over time. However, with the growing number of people accessing services for mental health and addiction issues, the MH&AS service is under pressure and there is increasing potential for unmet need. Often services are available to people only once their condition deteriorates, and the dominant treatment option (medication and therapy) do not address the broader social factors that help people be well and support recovery.

27. Action is required to relieve pressure on existing mental health and addictions service. The Creating Our Futures programme is underway to transform our whole system pathway, with appropriate fit-for-purpose facilities, as more of the same will not deliver the wellbeing and recovery oriented system that is required.

28. The focus of the Creating Our Futures programme is to progress and regain traction on improving our mental health and addictions model of delivery (as described in the MH Commission 2018 monitoring report p10) through taking on:

- broaden the focus of service delivery from mental illness and addiction to mental well-being and recovery
- increase access to health and other support services
- ensure that we have timely information about changing levels of need, current services and support, and evidence about best practice
- implement a workforce strategy that enables the service to deliver better, more accessible services

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[10] MH&AS Community Demand Report 2014- 2018; KPI Performance Dashboards

[11] MH&AS Preliminary Post Implementation Review Report, 2013

- achieve the required changes through collaborative leadership, support by robust structures and accountabilities to ensure successful, transparent results.

29. The programme of work sets the action plan for responding to the need to change and forms the basis for the investment. The objectives described within the Creating Our Futures programme are based on the investment objectives:

    Investment Objective One: To transform service delivery in order to improve safety, effectiveness and efficiency.

    Investment Objective Two: To create safe and therapeutic environments that support holistic care at all times.

    Investment Objective Three: To build sustainable capacity and capability of services to meet future demand, values and need.

30. This is not a programme that can be run in isolation inside the confines of the Waikato DHB. Indeed, implementing a new model of care that does not engage the sector and community and take into account the varying needs, desires and requirements and would be destined to fail. The Creating Our Futures programme is underpinned by a service users and family whānau centred care approach, which means working with service users and their family whānau to co-design project deliverables, facilities function and form, incorporating our values and strategies. We are committed to transforming our culture so that working within a partnership model becomes a way of life.

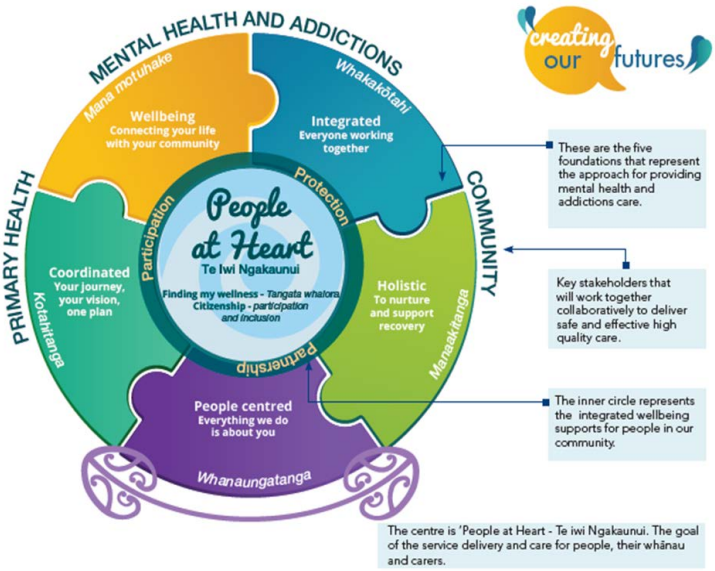
New Model of Care – *Te iwi Ngakaunui*

31. Our strategic vision, values and outcomes are intended to remain constant over time, while our strategic intentions reflect the areas that our community identified as needing the most focus during this period during the Creating Our Futures programme.

32. We are embarking on a transformation of MH&AS services to improve the services we provide to our Waikato community. Our *Creating Our Futures* programme is all about us looking through the eyes of our service users and family whānau to make MH&AS service more safe, effective and efficient.

33. Our vision, values and outcomes are intended to remain constant over time, while our strategic intenti0ns reflect the areas that we have identified as needing the most focus during the period of this programme.

Figure 1 Proposed COF Model of Care



People-centred – care is focused and organised around the service user and whānau needs (including, mental, physical, social and cultural), aspirations and resources.
Coordinated and joined up – the care journey is coordinated across care settings. People will know where to get help, what to expect and by whom.
Integrated – one recovery plan. Service users and whānau, professionals, and service providers are partners-in-care, everyone working together to respond early and support self-managed wellness.
Holistic – care will nurture and support the service user recovery needs and aspirations. At all times care will reflect a mana protecting and mana enhancing approach.
Wellbeing – enabling self-managed wellbeing through good connections with the services and community, no matter where an individual is at in their care journey.

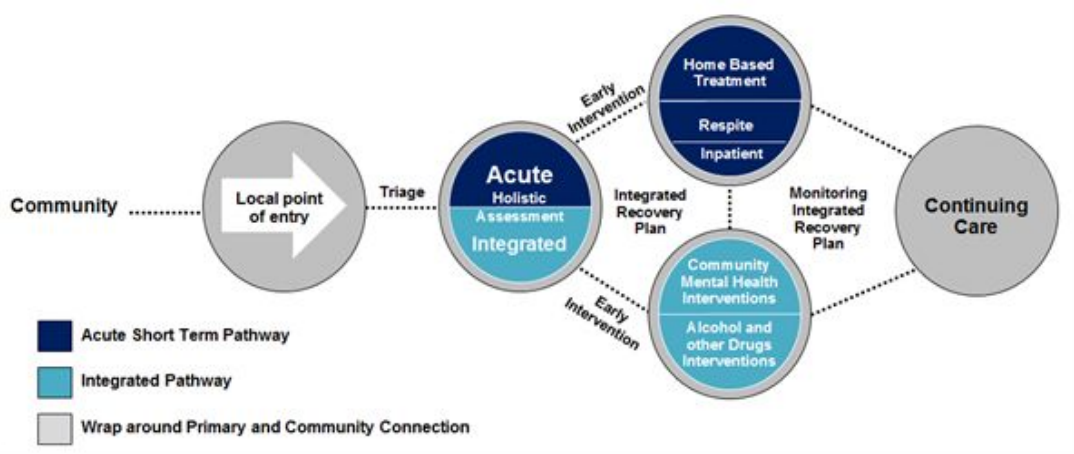
34. Waikato DHB is embarking on a transformation of Mental Health and Addictions to improve the services we provide to the Waikato. The Creating Our Futures new model of care is all about us looking through the eyes of our service users and family whānau in order to make MH&AS service more safe, effective and efficient. Mental Health and Addictions vision of *Te iwi Ngakaunui* people at heart and values reflect the service we want to be.

35. As a service, we need to invest in early, proactive and holistic interventions well before the impacts of mental illness and co-existing problems reach a more severe stage to reduce harm to service users and family whānau, and long term costs. With support from other agencies, providers and other health professionals that span across the sector, we intend to engage and work together to develop a systematic approach to health and social factors that will establish a clear view of what interventions are best used in each situation, informed by all agencies with responsibility for the relevant interventions.

36. Our ability to work with others to provide early and proactive care will have positive impacts, and will reduce the severity and long term burden.

37. Figure 2 depicts a conceptual model of care of what we want to achieve.[12]

Figure 2 Proposed Whole System of Care Pathway



38. We want to work more effectively with our partners across the sector to help deliver our vision. We are focused on building effective long term relationships to deliver benefits for Waikato. Partnerships to help us reach our vision include agencies such as: NZ Police. Ministry of Education, Ministry of Health, St John, WINNZ, Child and Youth People Service, Primary Health Care, Non-Government Organisations, Hamilton City People's Project and Housing NZ.

39. To enable the implementation of this whole system pathway, Waikato DHB Mental Health and Addictions service are proposing greater flexible funding models to support strong and viable family whānau and community with increased resources and support. It makes sense that Mental Health and Addictions service has greater advocacy and monitoring of the commissioning and funding of early interventions and packages of care across the end-to-end system. A number of new ways of working as part of the system transformation required increased advocacy and funding[13] for:

- integration across organisational boundaries
- increasing investment in community-based services
- strengthening primary care

Alignment to existing strategies

40. The NZ Government has four key priorities. They are:

- responsibly managing the Government's finances

[12] The detailed development of this pathway will be delivered within the transformational Pathway Project.

[13] Further and ongoing discussions with Strategy and Funding; other Midlands DHBs; Hauora Waikato and other key stakeholders are required to enable this deliverable. These discussions will inform the whole approach to wellbeing and recovery change.

- building a more competitive and productive economy
- delivering better public services
- rebuilding Christchurch

41. Responsibly managing the Government's finances – we aim to improve early and proactive interventions to reduce the burden on costly secondary and tertiary services; and, maintain an appropriate perspective of inpatient admission avoidance and/or appropriate inpatient length of stay.

42. Building a more competitive and productive economy – we aim to help to build a more productive economy by improving the degree of recovery and return to daily activities, lifting our workforce and productivity, and reducing clinical risk.

43. Delivering better public services – we are focussed on improving the health and social system through greater integration. We are also on investing in our values, leadership and cultural responsiveness to improve our capability to engage early and proactively

44. Rebuilding Christchurch – we support a safe rebuild, and continue to support anyone who has migrated to the Waikato requiring our services.

Other existing strategies

45. The Creating Our Futures programme case for change remains compelling. Change is still required to address the operational and infrastructure pressures to improve outcomes now and into the future.

46. The Creating Our Futures programme of work is closely aligned to addressing many of the areas of concern identified within the *New Zealand's Mental Health and Addictions Service: the monitoring and advocacy report of the Mental Health Commissioner* (MH Commission, 2018). Alignment in terms of addressing:

- a lack of early interventions options
- low commitment by services to shared planning with [consumers] and their family and whānau
- coordination challenges within and between services
- high uses of compulsory treatment, especially for Maori
- stagnation in seclusion reduction
- poorer physical health outcomes for people with serious mental health and/or addictions issues
- disparity in outcomes for Māori and other populations

47. While the MH Commissioner's report has just been released (March, 2018), we too have listened to our Waikato community and they have told us similar concerns. Our programme of work will ensure the accelerator is pushed to gain traction on ensuring action is taken to deliver the required change.

48. The Waikato DHB Mental Health and Addictions serviced have recently refreshed their long term goals, in the context of the wider health and social sector system. The *New Zealand Health Strategy 2016 – 2026* (MoH, 2016) outlines the high-level direction for our mental health and addictions system: all Waikato individuals live well, stay well, get well, in a system that is people-powered, provides services close to home, is designed for value and high performance, and works as one team in a smart system.

49. The *Commissioning Framework for Mental Health and Addiction: a New Zealand guide* (MoH, 2016) sets out an ideal approach to using available resources to achieve best outcomes in the most efficient, effective and sustainable way (including, mental, psychological, physical, social and cultural). The refresh of the Waikato DHB's Mental Health and Addictions strategy (MH&AS, 2017) and new model of care (MH&AS, 2017) aims to place people at the heart of their care to achieve equitable access and outcomes. In addition, the Creating Our Futures programme involves a systematic focus on productivity and professional practice in response to intensifying complexity and acuity of need; and, workload demands.

50. The *Rising to the Challenge: the Mental Health and Addictions Service Development Plan 2012-2017* (MoH, 2012) is the keystone for service development. The key themes in the document are better use of resources, improved locality and hospital services integration; cementing and building gains for the most vulnerable; intervening early in the lifecycle to prevent later problems; seclusion and restrain elimination. The Creating Our Futures programme involves a focus on an integrated and joined up response to care to ensure best use of resources and early intervention before the impact of mental illness and co-existing problems reaches a more severe stage. Delivery of care and support will be planned, proactive and holistic in the least restrictive environment.

51. A guiding principle of *Rising to the Challenge* is that a whānau ora approach will be undertaken when working with Māori, with it emphasised that priority actions must contribute to whānau ora initiatives. Whānau ora and whānau-centred best practice maximises all opportunities to facilitate sustainable change for whānau, recognises the value and validity of Māori concepts and frameworks in practice, and transcends sectors and weaves resources together into an integrated approach or pathway of care.

52. To support the development of new models of care, the Waikato DHB Strategy and Funding service *Te Pae Tawhiti*; Older Persons; Child and Adolescent; and, Alcohol and Other Drugs is currently under development. A Waikato region needs assessment has been undertaken to inform model development.

Table 1 Summary of the existing arrangements and business needs

Investment Objective 1	**To transform service delivery in order to improve safety, effectiveness and efficiency.**
Existing Arrangements	Growing numbers of Waikato people are accessing health services for mental health and addictions issues; MH&AS is under pressure. Often services are reactive and available to people only once their condition has deteriorates, and the dominant treatment option (medication and therapy) do not address the broader social factors that help people to be well and support their recovery.
Business Needs	Broaden the focus of service delivery from mental illness and addiction to mental well-being and recovery. Improve the quality of mental health and addiction

	services, supported by evidence based practice and information about changing levels of need. Improve access [front gate] to early intervention before the impacts of mental health and addictions reach a more severe stage.
Potential Scope	Non-capital strategies required to fully integrate services: - MH&AS community, inpatient and specialty services (whole system pathway) - Regional Forensic services pathway
Potential Benefits	- Improved access and health outcomes - Improved experience and engagement
Potential Risks	New model of care does not bring about transformational change. Challenges and breakdown in key stakeholder confidence and lack of collaboration in the change programme Inability of the wider sector to understand and support the implementation of the model of care
Constraints and Dependencies	Any changes to Government policy direction that followed the 2017 election may impact on the investment scope of the business case. For planning and management proposes it is assumed that regardless of Government, there will be a need for sustainable integrated service delivery across the continuum of care. The proposed model of care and business case describes a broader approach to mental health and addictions and assumes a collaborative and sector wide engagement to actioning a response.

Investment Objective 2	**To create safe and therapeutic environments that support holistic care at all times.**
Existing Arrangements	HRBC footprint is out-dated and is based on institutional design, significant deficiencies; include lack of space and privacy, lack of natural lighting, congestion, ventilation. Institutional layout is inflexible and unable to support interventions and future demand.
Business Needs	Contemporary fit-for-purpose inpatient facilities, with the necessary therapeutic space to manage and deliver holistic care. Spaces that are modular and flexible in order to meet changing demand, needs and values; now into the future. Health Professionals have the necessary space to manage clinical risk, safety and de-escalation, and appropriate co-location, freeing up time to enable staff to focus on care.
Potential Scope	Capital Infrastructure investment into fit-for-purpose environments: - Acute MH Inpatient - Multiple and Variable Needs Inpatient (needs (including, high and complex, MH older 65 years, youth, eating disorders cognitive impairment, peri-natal, AoD – SACACT) requirements) - Puawai Inpatient
Potential Benefits	- Therapeutic and safe environments
Potential Risks	Affordability issues. Protracted approval and development sequencing / timelines exacerbate current service issues and increase the potential interim solution risk. Competition of market supply and demand – a number of large builds occurring

	during this period (NZ Corrections; PPP Waikato Schools). New infrastructure becomes out-dated in 20 years' time.
Constraints and Dependencies	Government health funding and mental health policy direction (capital infrastructure cot and competing investment). Any changes to the forensic model of care or programme may impact on the scope of this business case. Ongoing close engagement with regional corrections will need to occur.

Investment Objective 3	**To build sustainable capacity and capability of services to meet future demand, values and need.**
Existing Arrangements	Increasing demand and zero growth in resources (eg, people and funding) which threatens access to services for mental health and addictions issues. Services are under pressure and there is a potential for many needs being unmet.
Business Needs	Implement a workforce strategy that enables the service and the broader sector to deliver better, more accessible services. Achieve change through collaborative leadership, supported by transparent outcome information.
Potential Scope	- Professional Practice, and Cultural Responsiveness - Leadership - Culture and Values - Engagement - Technologies and Information
Potential Benefits	- Operational efficiencies and effectiveness gains - Workforce gains
Potential Risks	Demand continues to overwhelm capacity. Unplanned future clinical risk/s or challenges on the horizon. Competition between programme delivery and BAU.
Constraints and Dependencies	The ability to continue to deliver at current (or enhanced) levels to the growing Waikato population is subject to funding constraints. Not managing BAU alongside the change programme

Potential Business Scope and Key Service Requirements

53. The potential business scope and key service requirements were identified and assessed by stakeholders at the facilitated Model of Care series of workshops held throughout 2016 - 2017.

Table 2 Potential business scope and key service requirements

Service Requirements	Scope Assessment	
	In Scope	**Out of Scope**
System Transformation	- MH&AS community, inpatient and specialty services (whole system pathway) - Regional Forensic services	- Continuous Quality Improvement initiatives (activities must be ongoing and not contingent on programme timeframes)
Inpatient Facilities (includes HBT / respite options)	- Acute MH - Multiple and Variable needs (including, high and complex, MH older 65 years, youth, eating disorders, cognitive impairment, peri-natal, AoD) - Puawai Increased capacity	- MHSOP facilities (OP&R1) - Waikato DHB strategic build
Capacity & Capability	- Professional Practice (and interventions) - Leadership - Culture and Values - Engagement - Information and Technology	- Business as Usual

54. Further and ongoing discussions with other national and local DHBs and Hauora Waikato are required to support understanding of the in scope inpatient services across the Midlands region. In particular, arrangements regarding localities, acuity and specialty and sub-specialty service planning.[14] Discussions with NZ Corrections in relation to developing and progressing the model of care are also required.

Meeting the Need for Māori - Wellbeing

55. Both Waikato DHB and MH&AS service recognise that the Treaty of Waitangi is a founding document of government in New Zealand and established the country as a nation. We aim to support the Crown in its Treaty of Waitangi relationships and deliver our service in ways that enable equitable outcomes for Māori.

56. Māori are over represented in mental health services relative to non-Māori, and are more likely to be diagnosed with a psychotic illness, and admitted to the acute inpatient service under the Mental Health Act 2012. Māori subsequently experience more readmissions than non-Māori with high exposure to the use of seclusion and restraint by mental health staff while in acute care (MoH, 2015).[15]

57. As a process of service delivery and a principle of wellbeing, the Mental Health and Addiction services: best practice framework will draw on the *Te Whare Tapa Whā* as a model with its four cornerstones of health and wellbeing. Te Whare Tapa Whā

[14] For example, the repatriation of youth beds from Auckland DHB – implications and arrangements for both MH&AS and Medical Paediatric services.

[15] Te Rau Matatin (2015).Kaupapa Māori Mental Health and Addiction Services: Best Practice Framework. Ministry of Health.

endorses a Māori world view and an ecological approach to health which is congruent with indigenous philosophies: *Taha Wairua, Taha Hinengaro, Taha Tinana, and Taha Whānau*.[16]

58. The Waikato DHB Mental Health and Addictions services remain cognisant of the specific needs and service settings for Māori; and will use Māori frameworks and models of care that encompass a holistic approach to health and wellbeing. Underpinned by the concepts of mana, tapu and mauri.

Main Benefits

59. Delivering the change required will not be a trivial exercise. Careful planning and consideration will be required to continue to explore and confirm the core components for understanding what it is the service delivers; and the environments required to support that delivery. Working together with our stakeholders and those with lived experience will be important as we focus on a system-wide approach to health and recovery related outcomes and aspirations.

60. The Waikato DHB is committed to working closely with other Ministries and District Health Boards who can assist in the delivery. The timing is right to improve how we deliver services through to 2045 (and beyond).

61. Stakeholders have identified the following benefits of the proposed investment.

Table 3 Analysis of potential benefits that can be expressed in monetary terms

Main Benefits	Who Benefits	Direct / Indirect	Description
Improved access and health outcomes	DHB Community	Direct Indirect	Reduced lifetime costs per capita and burden on secondary and tertiary services due to earlier intervention Increased access to services before the impacts of mental health and addiction reach a more severe stage (sustainable population costs)
Improved experience and engagement	DHB Community	Direct Indirect	Reduced lifetime service costs due to sustained wellbeing and recovery. Reduction in costs associated with barriers to transition and length of stay
Therapeutic and safe environments	DHB	Direct	Avoids the burden and risk of disutility serious adverse events and complaints Reduction in costs associated with maintaining substandard facilities
Operational efficiencies and effectiveness gains	DHB	Direct	Increased i clinical productive hours and reduction in cost of non-clinical productive hours
Workforce gains	DHB	Direct	Reduction of staff turnover

[16] Te Rau Matatini (2015). Kaupapa Māori Mental Health and Addiction Services: Best Practice Framework. Ministry of Health (pp 8 – 9; adapted from http://www.hauoratane.co.nz/te-whare-tapa-wha-health-whare/)

Table 4 Analysis of potential benefits that cannot reliably expressed in monetary terms

Main Benefits	Who Benefits	Direct / Indirect	Quantitative / Qualitative	Description and Possible Measures
Improved access and health outcomes	Service users Family whānau Community	Direct Direct Indirect	Both Both Both	Functional status; Productivity; Wellbeing and healthy years of life; quality of life Family whānau wellbeing; reduced carer hours; productivity; community participation
Improved experience and engagement	Service users Family whānau	Direct Direct	Qualitative Qualitative	Engagement and positive experience maximising the potential of service users and family whānau
Therapeutic and safe environments	Service users Family whānau Clinicians	Direct Indirect Direct	Both Both Both	Admission is an intervention and is planned as part of recovery oriented care
Operational efficiencies and effectiveness gains	Service users Clinicians DHB	Direct Direct Direct	Both Both Both	Positive health outcomes Increased clinical face-to-face time Enable holistic interventions to be delivered
Workforce gains	Service Users Clinicians	Direct Indirect	Both Qualitative	Workforce satisfaction Health Professional working at the top of their scope of practice

Main Risks

62. This programme business case provides a compelling value proposition for actioning the current pressures on our mental health and addictions services. Without addressing the concerns raised here, we will continue to see more of the same challenges. The table below presents an initial risk analysis.

Table 5 Initial Risk Analysis

Main Risks	Consequence (H/M/L)	Likelihood (H/M/L)	Comments and Risk Management Strategies
The absence of dedicated resources (project, clinical input and working groups) impacts on the achievement of the investment objects	H	L	Secure dedicated additional resources within PBC.
New model of care does not bring about transformational change	H	M	Transformational change processes are evaluated and monitored. Continued use of co-design in propose / initiate / plan / develop phases.
Not managing BAU alongside the change programme	H	H	Monitoring for alignment with BAU risk within service 30, 60, 90 plan/s.
Changes to health and social policy at a national level, impact on MH&AS service delivery	H	H	Engage and influence policy proposals. Remain focussed on provision of holistic service user centred care.
Loss of key personnel during the life of the programme (5 years)	H	L	Flexible working conditions, mentoring and leadership development opportunities, skill development, good sequencing and documentation management.
Challenges and breakdown in key stakeholder confidence and collaboration in the change	H	M	Engage key stakeholders in co-design in an emotion and intelligent way (trust,

programme			integrity and honesty)
Failure of Strategy and Funding to deliver early intervention services.	H	H	Ensure funding targeted to the provision of early intervention services in the community and where possible alignment with social sector initiatives.
Inability to provide a culturally responsive service.	H	L	Implementation of a parallel Māori model of care into services. Advocate and lobby for change at a national level, reducing stigma, locally, regionally and nationally.
Inability of the wider sector to understand and support the implementation of the model of care	H	M	Opportunities for ongoing education, support, communication, partnerships, engagement for all.

63. A risk register has been developed and is being progressively updated. Considerable monitoring of changes to practice and workflow, and trust in transformative change, will be required. Ensuring the programme is undertaken in a way where risks are transparent and carefully managed, issues are quickly identified and resolved and benefits realisation is apparent and readily able to be understood by all, is key.

Optimism bias

64. Based on the nature of the investment proposal, the expected net benefits are currently unknown and will be reviewed in the respective business cases.

Key Constraints and Dependencies

65. The proposal is subject to the following constraints and dependencies, which will be carefully monitored during programme.

Table 6 Key constraints and dependencies

Constraints	Notes
Government health funding	The ability to continue to deliver at current (or enhanced) levels to the growing Waikato population is subject to funding constraints.
Re/location of the build/s	Onsite Waiora Hospital site constraints (availability of adequate space, soft fill, implications for current facilities, car parking) Offsite green fields – timely consent processes, land lock, considerations of institutional model, access to medical services
Current market competition	Competition of market supply and demand – a number of large builds occurring during this period (NZ Corrections; PPP Waikato Schools)
Dependencies	**Notes and Management Strategies**
Government policy direction	Any changes to Government policy direction that followed the 2017 election may impact on the investment scope of the business case. For planning and management proposes it is assumed that regardless of Government, there will be a need for sustainable integrated service delivery across the continuum of care.
Broader sector engagement	The proposed model of care and business case describes a broader approach to mental health and addictions and assumes a collaborative and sector wide engagement to actioning a response.
NZ Corrections Capacity programme	Any changes to the national forensic model of care or programme may impact on the scope of this business case. Ongoing close engagement with regional corrections will need to occur.
SA(CAT)	The SA(CAT) legislation was introduced in 2018 and the impact now and into the future is unknown. Any changes to demand may impact on the scope of this business case. Ongoing close engagement regionally and nationally will need to occur.

The Economic Case – Exploring the Preferred Way Forward

Critical Success Factors

66. The following critical success factors were identified by stakeholders at the facilitated options workshops held May – October 2017. Stakeholders agreed to use the generic benefits descriptions as a preliminary process for exploring the way forward. A more detailed assessment of the possible options will be undertaken in the indicative and detailed business case/s processes.

Table 7 Critical Success Factors

Critical Success Factors	How well the option
Improved access and health outcomes	- improves the degree of recovery - improves time to recovery aspirations / return to daily activities - improves recovery aspirations achieved and sustained over time - improve end-to-end recovery aspirations
Improved experience and engagement	- improves communication and information sharing - encourages and supports participation and collaboration in recovery decision making - improves coordination/transition of care between and across service providers - treats service users and whānau with dignity and respect
Therapeutic and safe environments	- improves holistic care disutility[17] (SAC1/SAC2, accreditation, clinical audit) - engage proactive participation in managing risk - allows service user and whānau lead co-design, safety and quality - assists sustainable therapeutic environments
Operational efficiencies and effectiveness gains	- care is coordinated across the system (shared recovery plan) - allows care to delivered at the appropriate location - evidence based practice throughout the care trajectory
Workforce gains	- increases staff wellbeing - increases the capability and capacity of the consumer, peer-led, family / whānau workforce - increases the cultural competency of the workforce

Programme Options Identification

67. Under the five dimensions, stakeholders have identified a comprehensive and overarching long list of in-scope options as follows.

Table 8 Possible programme options classified by the five dimension of choice

Dimension	Description	Options within each Dimension
Scale, scope and location	In relation to the proposal, what levels of coverage are possible?	• Acute Mental Health • Addiction services • Mental Health Services for Older People (transformation) • Multiple and Variable needs • Regional forensic prison muster

[17] Disutility refers to the adverse or harmful effects associated with a particular activity or process

Service solution	How can services be provided?	• Inter-sectorial / Fully Integrated Care Model • Multi-Community providers (MCP) • Primary and Acute Care Systems (PACs) • Wrap Around Reach • Urgent and Emergency Care • Acute Care Collaboration
Service delivery	Who can deliver the services?	• Out-sourced (PHOs, NGOs and providers) • Out-sourced – NZ Corrections • Midlands Joint Ventures • Auckland DHB Joint Ventures
Implementation	When can services be delivered?	• Big Bang service transformation and capital infrastructure implementation • Agile service delivery model transformation and phased capital infrastructure implementation • Agile service delivery model transformation and deferred capital infrastructure
Funding	How can it be funded?	• Waikato DHB free cash flow • Waikato DHB capital growth funded • Crown funded debt

Programme options assessment

Model of Care Options

68. The assessment of the service delivery model (or way we work) was a multifactorial process. In order to understand the blueprint for the Creating Our Futures a series of workshops were held over a six month period January – June 2017. These workshops were facilitated by the service MH Professional Leads / MH Nurse Director and included a range of stakeholders (people with lived experience; clinical staff; community; and social and health sector had an opportunity to provide feedback and tell us their stories).

69. Each work stream produced an options document that was presented to the Creating Our Futures advisory group for feedback and consideration. The information gathered has been developed into an implementation plan which will be managed as business as usual (BAU) and monitored through 30, 60 90 day plan/s.

70. The detailed assessment and preferred way forward will be presented in the Waikato DHB MH&AS Transformational Pathway Single Stage Business Case.

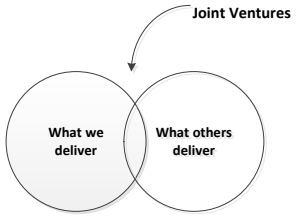
Facilities Redevelopment Options

71. A number of stakeholders from the aforementioned working groups then generated a wide range of options that could influence service delivery; workshops were held between May – October 2017. The scope of the options include Acute Mental Health, Multiple and Variable Needs; and Puawai change requirements.

72. The detailed assessment and preferred way forward will be presented in the Waikato DHB MH&AS Facilities Redevelopment Indicative and Detailed Business Case.

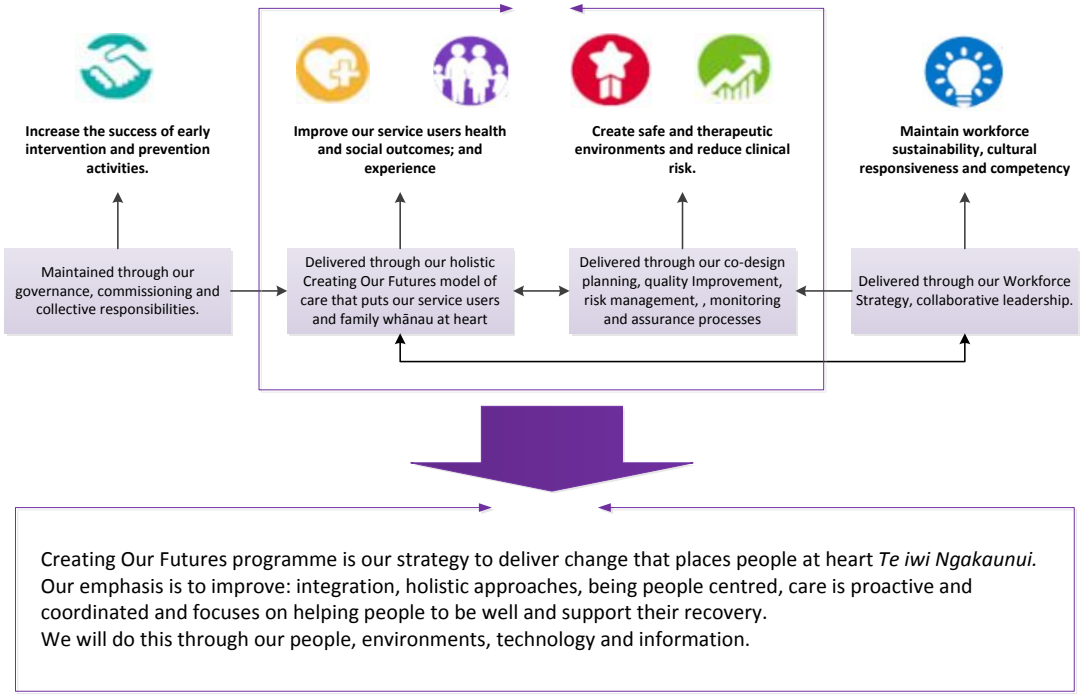
Diagram 1 What will the change look like?

Table 9 Long List Investment Options

Mental Health and Addictions Long List Options - initial summary							
	1	2	3	4	5	6	7
	Key Worker	Integrated Care Pathway	Multispecialty Community Providers (MCPs)	Primary and Acute Care Systems (PACs)	Wrap Around Reach	Urgent and Emergency Care	Acute Care Collaboration
Location Summary	'Key worker' service delivery is a method of service delivery involving a person who works in a guide role with service user and their whānau. The key worker acts as a single point of contact, supporting the service user to coordinate their care. The main concept of the key worker's role is to empower service users by providing them with support, resources and information tailored to meet their individual needs.	An integrated care pathway (or ICP) is an outline of anticipated care, where community based multidisciplinary teams use the pathway to co-ordinate inputs from a wide variety of professionals. Care is holistic, with professional's co-ordinating and often directly providing the care to meet the person's needs. Professionals would not always employed by the MH&AS.	Primary practices in local areas are grouped into a number of geographical clusters. In each cluster multi-disciplinary teams are established to allow GPs to work together with other health, mental health, addiction and social care professionals to provide more integrated services outside of secondary and tertiary services.	A single entity or group of providers takes responsibility for delivering a full range of primary, community, mental health and inpatient services for their local population, to improve co-ordination of services and move care out of secondary services where appropriate. The PACs delivery is fundamentally similar to the MCP model but is wider in scope.	Wraparound is a strength-based and individualised approach to service delivery that is based on service users and whānau identifying what support they need in their home and community. Service users are paired with care co-ordinators to assist them in identifying personal, community and professional resources to meet those needs and to "wrap" those services around them and their whānau. Wraparound is designed to increase parent choice in selecting resources and service providers. Wraparound promotes family independence by acknowledging families or caregivers know what is best for their youth and family	These focus on improving the co-ordination of urgent and emergency care services and reducing pressure on A&E departments.	This involve linking services together to improve their clinical and financial viability, reducing variation in care and improving efficiency.
Key Consider-ations	• Close multidisciplinary working with primary and community through locality integrated networks • Requires the need for integrated working with local government and community to co-deliver services. • Coordination and integration of a range of health and care activities: o Urgent and acute care collaboration o Risk-sharing agreements o Packages of Care • Investment and active involvement in primary and community care development • New professional roles spanning organisational and service boundaries • Co-design and co-production - break down barriers between health and social care. • A common value base: safety, effectiveness, assurance and user engagement, with quality at the core • Sustainable governance and management. • Integrating health and social care outcomes across agency boundaries. • A quality dataset to inform interventions and demonstrate outcomes. • Build in sustainability with providers, and reinforcing accountability for quality. • Change management processes and ongoing quality improvement cycles. • Identification of the outstanding issues, opportunities for shared agreements and partnerships, and consequential impacts coming out of this process				 Consideration of the potential collective impact for service delivery is required.		

The Recommended Preferred Way Forward

73. On the basis of the above initial assessment, the preferred way forward is for the Creating Our Futures programme is described below.



The mix of projects

74. With a focus on system integration, a number of projects and improvement initiatives are taking place. Each initiative has a specific goal, and all have the needs of the service users and family whānau at its core. The outline of the programme of work includes:

- MH&AS Transformational Pathway Project
- MHA Whole Approach to Wellbeing and Recovery
- Waikato DHB MH&AS Facilities Redevelopment Project
- MH&AS Capacity and Capability Initiatives

75. The Creating Our Futures Programme Logic is presented overleaf.

Diagram 2 Programme Logic

Creating Our Futures – Programme Logic 2018

Waikato DHB Story

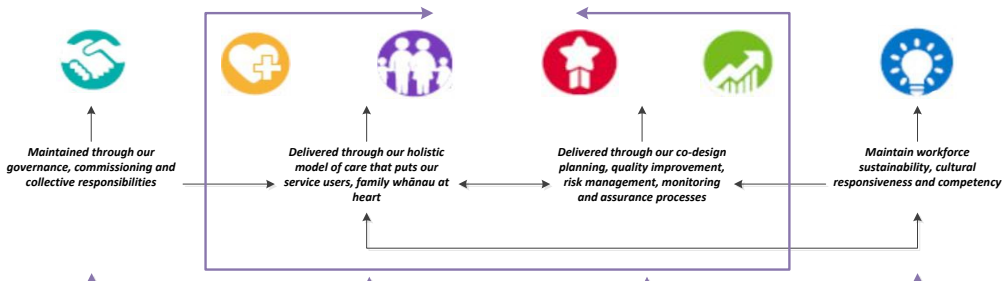
Vision	***Healthy People, Excellent Care***					
Strategic Outcome	*Productive partnerships* ***Whanaketanga***	*Health equity for high need populations* ***Oranga***	*People centred services* ***Manaaki***	*Safe, quality health services for all* ***Haumaru***	*Effective and efficient care and services* ***Ratonga a iwi***	*A centre of excellence in learning, training, research and innovation* ***Pae taumata***
Strategic Objective	• Incorporate te Tiriti o Waitangi in everything we do • Authentic collaboration with partner agencies and communities • Focus on effective community interventions using community development and prevention strategies • Work towards integration between health and social care services	• Radical improvement in Māori health outcomes by eliminating health inequities for Māori • Eliminate health inequalities for people in rural communities • Remove barriers for people experiencing disabilities • Enable a workforce to deliver culturally appropriate services	• Utilise the expertise of communities, providers, agencies and specialists in the design of health and care services • Provide care and services that are respectful and responsive to individual and whānau needs and values • Enable a culture of professional cooperation to deliver services • Promote health services and information to our diverse population to increase health literacy	• Deliver high quality, timely, safe care based on a culture of accountability, responsibility, continuous improvement and innovation • Prioritise for-for-purpose care environments • Early intervention for service users in need • Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives	• Live within our means • Achieve and maintain a sustainable workforce • Redesign services to be effective and e∃fficient without compromising the care delivered • Enable a culture of innovation to achieve excellence in health and care services	• Build close and enduring relationships with local, national and international education providers • Attract doctors, nurses and allied health staff to the Waikato through high quality training and research • Cultivate a culture of innovation, research, learning, and training across the organisation • Foster a research environment that is responsive to the needs of our population

Mental Health and Addictions Story

Vision	***Strengthened Communities, Through Trust and Partnership***				
Long term impacts	Wellbeing **Mana Motuhaka**	Holistic **Manaakitanga**	People Centred **Whanaungatanga**	Integrated **Whakakōtahi**	Coordinated **Kotahitanga**
Our Model of Care will be driven together through collective impact partnerships with multiple sector groups.					

Creating Our Futures Story

Vision	***People at Heart Te iwi Ngakaunui***



Long term Impacts	Increase the success of early intervention and prevention activities	Improve our service users health and social outcomes, and experience	Create safe and therapeutic environments and reduce clinical risk	Maintain cultural responsiveness and competency
Outputs	• connect with our community; and, across our organisation, service, teams and disciplines • enable seamless integration to enable best health outcomes • achieve changes through collaborative leadership and collective responses to the needs of our community	• create a coordinated and more visible service user journey • increase access to mental health and addictions services (including a proactive 'front gate' approach and rapid local response to urgent need) to ensure a timely response to service user need • enable services to work more efficiently through the use of technology (single common recovery plan) • integrate with primary and community providers to improve service user and family whānau outcomes and sustain self-managed wellbeing • teams will be mobile, multi-skilled and well equipped to work together to enable the first best response for our service users	• create functional, safe and comfortable environments that reflects daily living and is responsive to the needs and values of service users and their family whānau • extend the capacity of the current footprint to meet current and future need • enable delivery of holistic, therapeutic and rehabilitation interventions • integrate with community and primary services to enable efficient transition (through the use of technology, processes, systems and space)	• enable holistic approaches to care, that are culturally responsive • improve the quality of mental health and addictions care (where care is informed by evidence based practice) through continuous improvement • broaden the focus of mental health and addictions to mental well-being and recovery • become a national leader in mental health and addictions care delivery • ensure all clinicians practice in accordance with Health and Disability Standards and Health Practitioners Competence Assurance Act 2003

Output Classes

Output Classes	MHA Whole Approach to Wellbeing and Recovery	Transformational Pathways	Facilities Redevelopment	Capacity and Capability

Stewardship

Stewardship	Culture and Values, Leadership	Co-Design Processes	Continuous Quality Improvement Cycle	Technology and Information Sharing

MH&AS Transformational Pathway Project

76. Waikato DHB has committed to investing in transforming the service pathway and make changes to the way we work. Stakeholders have told us that they feel services could be organised, located and carried out differently, a greater focus on the coordination and interventions, enabling clinicians to spend more time with service users. Currently community teams operate in isolation of one another, this can create a lack of equity of access to services, barriers to transition that is not always proactive or well-coordinated. This combined with our current antiquated forms and siloed information systems and can lead to inefficiencies in our process and a service user journey that is hard to coordinate and track.

77. The Transformational Pathway Project aims to achieve:

    a. create a coordinated and more visible service user journey

    b. increase access to mental health and addictions services (including a proactive 'front gate' approach and a rapid local response to urgent need) to ensure a timely response to service user need

    c. enable services to work more efficiently through the use of technology (single common recovery plan)

    d. integrate with primary and community providers to improve service user and family whānau outcomes and sustain self-managed wellbeing

    e. teams will be mobile, multi-skilled and well equipped teams to work together to enable the first best response for our service users

78. In order to deliver a better experience for our service users and whānau, and to offer them more choices in their interactions with us, we need to ensure that our systems and technology enable us to this. It is vital that we have simple pathways, automated information systems, consistent service user experience across the pathway.

Mental Health and Addictions Whole Approach to Wellbeing and Recovery Initiatives

79. Mental Health and Addictions is committed to the Waikato community and improve the standard for how we work together. We are committed to transforming our culture and leadership so that we are working in a partnership model.

80. The whole approach to mental health and addictions aims to achieve:

    a. connect with our community; and across our organisation, service, teams and disciplines

    b. enable seamless and integration to enable best health outcomes

    c. achieve changes through collaborative leadership and collective responses to the needs of our community

81. Mental Health and Addiction's culture and values underpin our ability to deliver on our programme. We want to develop and sustain wellbeing and recovery focused teams. Additionally, given our focus on mental health and addictions, it is important to us that our service demonstrates leadership and excellence within the sector.

MH&AS Facilities Redevelopment Project

82. The Waikato DHB is committed to building new Acute Mental Health Facilities, Multiple and Variable Needs Facilities; and, increased Puawai capacity. The build project will reflect advances in the understanding of optimal environments for care, advances in assessment, intervention/treatment, rehabilitation, recovery and changing practices in the delivery of mental health and addictions services.

83. The Facilities Redevelopment Project aims to achieve:

    a. create functional, safe and comfortable environment that reflects daily living and is responsive to the needs and values of services users and their family whānua

    b. extend the capacity of the current footprint to meet the current and future need

    c. enable delivery of holistic, therapeutic and rehabilitation interventions

    d. integrate with community and primary services to enable efficient transition (through the use of technology, processes, systems and space)

84. The build project has significant interdependencies with the transformation project, where design processes will be underpinned by the principle co-design - function before form.

85. The building will be constructed in two stages with Stage 1 Acute Mental Health build planned for 2019. Project completion is schedule for 2021. Stage 2 Multiple and Variable Needs and increased Puawai capacity planned for 2021. Project completion is scheduled for 2023.[18]

MH&AS Initiatives

86. The programme of work also includes a mix of initiatives to ensure earlier delivery of the objectives. These initiatives will be delivery as BAU.

MH&AS Capacity and Capability Initiatives

87. Mental Health and Addictions is committed to implementing a workforce strategy that enables the service to deliver more effective care, and essential skills to the wider community.

[18] The rationale for the current focus on the acute and integrated services is due to the staging of the programme and requirement to provide an acute inpatient solution by 2021 to release Henry Rongomau Bennett Centre (HRBC) footprint to enable the Puawai solution to be implemented (should this be a preferred way forward).

88. The Capacity and Capability initiatives aim to achieve:

    a. enable holistic approaches to care, that are culturally responsive

    b. improve the quality of mental health and addictions care (where care is informed by evidenced based practice) through continuous improvement

    c. broaden the focus of mental health and addictions to mental well-being and recovery

    d. became a national leader in mental health and addictions care delivery

    e. ensure all clinicians practice in accordance with Health and Disability Standards and Health Practitioners Competence Assurance Act 2003

89. What we want to achieve is a diverse and high performing workforce, who are empowered to deliver a consistently great service user experience. We want our staff members to feel proud to work here, and that we are an exemplar in recovery and wellbeing.

Quality Improvement - Inpatient

90. We are currently introducing a number of inpatient quality improvement initiatives aimed at better supporting service users need and reducing clinical risk.

91. Proactive Care Interventions - Our focus is on achieving *proactive*, rather than reactive care for our service users. This includes knowing the potential risks that might contribute to service user's deterioration and more importantly how to predict and avoid these risks. Interventions include visual tools to monitor and manage proactive care (Acuity tool – assignment and workload manager; and, electronic ePatient Journey Boards).

92. Service User Engagement - Engagement with our service users and their family whānau is at the heart of what we do. This supports the overall aim of delivering *proactive* care to our service users, therefore their involvement is crucial. Interventions include: Mutual Expectations; and, Intentional Rounding.

93. Team Work – Bringing together all members of the multidisciplinary team is crucial to achieving proactive care for our service users. Clear, service user focused and task oriented communication between all members will ensure continuity of care and better service user outcomes. Interventions include: SBARR communication; escalating risk; and plan of the day / handover / Multidisciplinary Meetings.

94. Environments – Exploring external and internal factors within the environments that may have an impact on violence and putting plans in place to remove or minimise these. Interventions include: Len Bowers Safewards Interventions; and, DATIX mapping of incidents.

Quality Improvement - Community

95. We are currently introducing a number of inpatient quality improvement initiatives aimed at better supporting service users need and reducing clinical risk.

96. Achieving *proactive*, rather than reactive care for our service users. Interventions include visual tools to monitor and manage caseloads (Qilksense business intelligence toolset) and reduce barriers to transition. In addition, the development of a tool that enables clinicians to understand caseloads and caseload acuity to avoid clinical risk.

97. Team Work – Bringing together all members of the multidisciplinary team is crucial to achieving proactive care for our service users. Clear, service user focused and task oriented communication between all members ensures continuity of care and better service user outcomes. Interventions include: SBARR communication; escalating risk; and plan of the day / handover / Multidisciplinary Meetings.

98. Environments - Urban Relocation Project – Hamilton London Street community services are relocating to the Hamilton CBD in 2019. With this relocation brings the opportunity to consider environmental factors and to introduce more efficient ways of working. We are undertaking a significant future state mapping process to design the functional requirements and introduce new efficiencies.

Indicative costs and benefits

99. The programme cost profile is unknown at this stage due to the agile approach to development and delivery. The Tranche Two cost of resourcing is $1.4 million for 2018, and is made up of additional project FTE, and Stage 1 facilities design and co-design / engagement costs. The composition of the costs will change once the operating resources required become known. The resource cost continues to be funded from Waikato DHB internal cash resources. It is expected that the programme resourcing will be completed by 2022.

100. It is assumed that the whole of life costs of the programme will be detailed in the mix of business cases. Where any productivity improvements will be based on clinical safety, effectiveness (delivery of interventions, increased face-to-face time and outcomes) and efficiencies through smoother transition through services. It is important to note that while there is increasing demand on services, our MH&AS resourcing has remained static over the past 20 years (and the current model was developed at the time of deinstitutionalisation).

101. It is proposed for the mix of project Business Cases to provide analyses to assess the longitudinal operating costs on a whole-of-life, Net Present Costs basis over a 27 – 30 year period.

102. The Waikato DHB Board and Waikato Interim Chief Executive have signified agreement to the preferred way forward outlined in this proposal.

Outlining the Commercial Case

103. This section outlines the proposed deal in relation to the preferred way forward

104. On the basis of the relative value of the procurement and the potential risk to the organisation, the preferred supply position and approach to the supply market is conventional.

105. Subject to approval, the Waikato DHB proposes to approach the market with a request for further information, based on the preferred way forward.

106. Any procurement processes will comply with the Waikato DHB Procurement and Contracts Policy (0170) that uses the five Principles of Government Procurement as a guide to making good procurement decisions. Additionally, any procurement (over $100,000) will comply with the Government Rules of Sourcing, Ministry of Business, Innovation & Employment (endorsed by Cabinet CAB Min (13) 10/4A) as set out in the policy.

Programme Procurement Model Options

107. Following the identification of programme characteristics and risks, a range of potential procurement options has been identified. The range of procurement models was complied with reference to application of models previously used in the health sector, including projects and programmes with similar requirements, and national and international infrastructure project experience.

Public-Private Partnerships ('PPPs')

108. Public-Private Partnerships can generally be defined in terms of the extent of risk that the procuring consortia is prepared to accept during design and construction and pre and post occupancy. Where investments have a significant specific-purpose component, a choice is required between conventional procurement and a Public Private Partnership (PPP). This is largely dependent on whether the service is *durable*, i.e. how likely it is that the service requirement will change over time in unpredictable ways, requiring costly contract variations. Common to both is the need for a credible project director, architectural practice and construction company who have demonstrated experience and success in designing and delivering complex, large scale health infrastructure projects.

109. The project build is large and complex and there are a number of specific project risks needing to be taken into account of including the size of the build; build sequencing; and, timeframes. Consideration is needed for lead time for certain materials and supplies (e.g., any offshore fabrication, precast concrete and structural steelwork). Any construction project and procurement methodology will need to take account of these market conditions.

110. Local experience of PPP is limited to Education and Corrections. The conceptual contracting and conceptual issues have been well worked through. A PPP requires a very clear functional specification and a negotiation rather than a tender. Local experience with a hospital Public-Private Partnership is nil but on the other hand, there are no known full scale hospital rebuilds of this sort.

111. The first PPP hurdle assessment criterion is Project Size. The estimated capital cost of the short listed possibilities is between $100 million to $200 million. Based on this capital amount, the project will not be of sufficient size to ensure that the procurement costs of a PPP are not disproportionally large in comparison to conventional models. Market soundings indicated that a minimum project size of $100 million in capital cost is required.

112. At this stage, this programme does not meet the first PPP hurdle assessment criterion; it has not been assessed against the four additional criteria (timetable, durability of requirements, whole of life service need and market appetite and competition). As a result, the PPP procurement option is not currently considered a viable option, and is not assessed in this Commercial Case.

Shortlisted Procurement Models

113. Prior[19] to confirmation of the requirement to undertake a programme business case, an initial registration of interest (ROI) was undertaken to request information that may be used to identify potential suppliers for concept design.

114. Although a market sounding process has been undertaken to assess potential market participants' views, the scope and specification of the project was not known at that point, and was not directly tested. This process will be conducted as part of the Detailed Business Case.

115. It is proposed that further qualitative assessment of the procurement models is required. With that in mind, the range of a procurement models will be subject to a detailed qualitative assessment[20] to ensure a robust process. To facilitate this, a workshop is planned with representative stakeholders to evaluate the possible short list of procurement options in February 2018

Alternative procurement

116. At this stage the project on a standalone basis does not meet the Public-Private Partnership hurdle criteria. It is possible that, depending on when the project enters the procurement phase, it could be bundled with other Waikato DHB capital investment projects. In this circumstance, the Public-Private Partnerships hurdle criteria would be revisited to assess the bundled project's suitability for Public-Private Partnerships procurement

[19] In 2016

[20] The possible short list of options will be evaluated using the Counties Manukau procurement criteria see annex.

117. This option will be assessed in the Detailed Business Case when the timeframes of other Waikato DHB projects are known with greater certainty.

Implications for other Waikato DHB sites

118. Should the facilities redevelopment project proceed, it would result in the new build and relocation of some services from their current site. Consideration of the impacts of the displacement will need to be considered within the campus strategic plan. There is potential impacts on staff car parking that would trigger the need for construction of a new multi-storey car park, and decanting and provision of facilities for displaced services.

119. The current Henry Rongomau Bennett Centre (HRBC) acute inpatient facility is expected to be demolished when new facilities are developed for the service. This site is expected to be used for the extension of the Puawai footprint to meet the NZ Corrections capacity programme requirements.

120. If the project requires rural outreach developments on Waikato DHB land requirements will need to be considered.

121. Key consideration to joint ventures across the DHBs within the Midlands is required. In particular the specialty and sub specialty services and how that aligns to our Waikato DHB model of care (e.g., SA(CAT), eating disorders, cognitive impairment). Furthermore, any repatriation of services will need to be considered (e.g., youth beds, ECT services). The detail of these key considerations will be included within the following cases.

122. Should the NZ Corrections Capacity programme proceed, it would result in an increased regional prison muster. Consideration of the interdependencies of timelines and any agreements will need to be considered.

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Outlining the Financial Case

Financial Costing Approach

123. The financial funds Waikato DHB needed to provide safe, effective and efficient mental health and addictions services without compromising outcomes for service users and their family whānau; and for staff; and, supports the regions' growing population needs, values and aspirations, now and into the future. The MH&AS service has experienced static people and resource capacity with increasing demographic demand over time for almost all services, since 1997. To this end, we need investment to help offset the clinical risk and safety issues presented here.

124. Currently we manage our funding with the objective of obtaining the best possible balance of return and risk:

- continue to review strategy funding allocations to ensure that the allocations provide the best possible balance of risk

- actively manage our portfolio with the objective of obtaining best economic and social value for money

125. It is expected that further analysis and consultation with Ministry of Health and NZ Treasury representatives will be undertaken regarding the design and delivery of the programme (including its performance) and funding structure of free cash flow and crown funded debt. At this indicative stage the funding structure is based on a 100% percent crown funded debt.

Proposed Funding Arrangements

126. Investing in our future is needed. Evaluation of investment performance should be by looking at the extent to which the Waikato DHB and other Partners has achieved the visions of enhancing early and proactive care returns and reducing risk. We should measure the MH&AS service contribution to our Waikato community is organised around community economic and social value. Mental Health and Addictions will create that value through the following categories of measures that enable us to assess our performance in delivering value.

- Reach – the proportion of Waikato population proactively served (early well before the impacts of mental health and co-existing disorders reach a more severe stage).

- Service User and Family Whānau – the quality and effectiveness of the services provided

- Impact – how effective we are at delivering the desired outcomes

- Cost effectiveness – value for money (economic and social value) and financial sustainability

- appropriate perspective of inpatient admission avoidance and/or appropriate inpatient length of stay
- delivering evidence based recovery interventions and programmes focused on recovery for all that improves wellbeing for service user and family whānau
- providing safe and efficient support transitions that support sustainable wellbeing

Overall Affordability

127. The estimated facility cost of the preferred possible shortlisted options range between $100 million and $200 million. Affordability remains a significant issue for Waikato DHB given the current funding outlook. However, the alternative of no investment in these services would have an ongoing significant negative impact on access to services, clinical risk and service user safety and outcomes, as well as on the broader Waikato community health system and population health. Given the nature of Mental Health and Addictions services and issues with current facilities, the driver for this investment is clinical need rather than financial return.

128. The continued tightening of the fiscal position and the funding forecast means that Waikato DHB has to accelerate the implementation pace of the model of care needed for future sustainability. Decisions have been made that will continue to be required to maintain access in a time of having to reprioritise spending to achieve whole-system transformational change. Mental Health and Addictions service remains committed to achieving a surplus financial position, as planned for the 2017/2018 financial year.

129. This capital infrastructure investment has been prioritised by Waikato DHB as part of the 20-year Strategic Planning Programme.

130. The next few years are anticipated to be increasingly challenging and Mental Health and Addictions service will continue to focus on non-capital strategies via the model of care with our locality and Midland region partners to continuously improve and innovate service delivery as a way of living within our means.

Efficiency gains

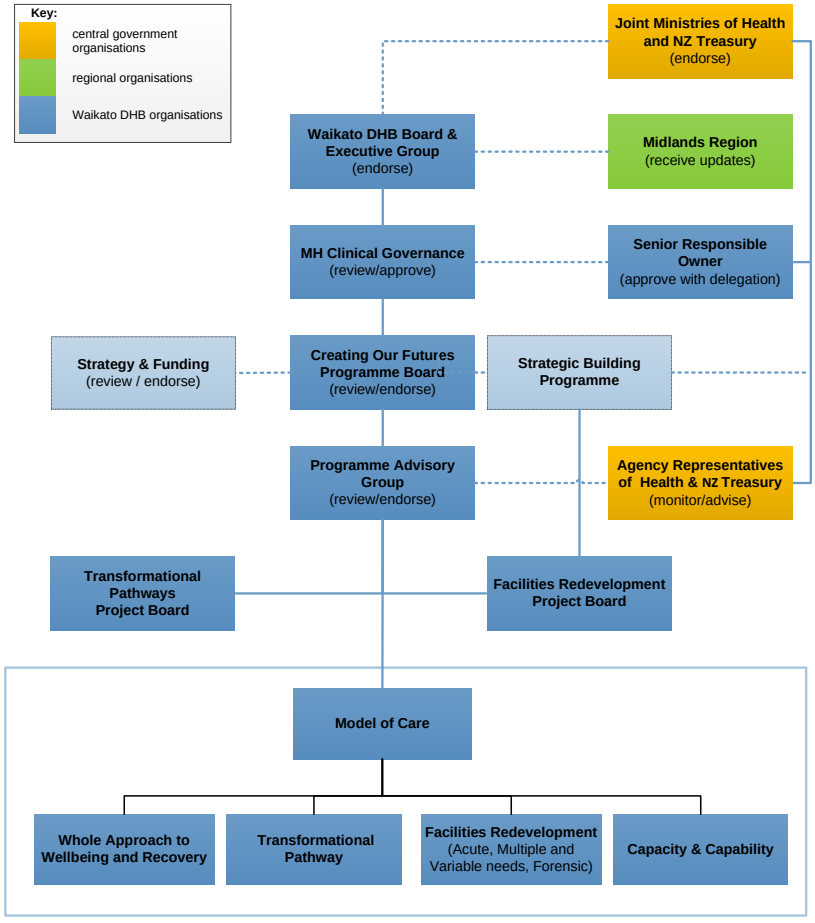
131. The Waikato DHB Creating Our Futures programme will realise efficiency gains and cost savings, as a result of whole system transformation. In addition to the new capital infrastructure, the model of care focuses on early and proactive care that is planned and coordinated, with greater integration across organisational boundaries supporting wrap around and transfer of care. By transforming the way in which Mental Health and Addictions services are organised, and how they integrate with primary care, the service can realise the benefits of improved service user flow, improved ability to deliver more effective evidence based care, improved service user and staff safety which will result in increased efficiency of service delivery.

132. In developing the design a number of scenarios for each of the build options will be undertaken to understand cost savings.

Outlining the Management Case

133. The Creating Our Futures programme scope will be guided by the detailed assessment and preparation of the Business Cases. The detailed preparation of the business case document will be developed using the NZ Treasury (National Infrastructure Unit) Better Business Case Model, and the New Zealand Government's accepted good practice standard. The programme business case is a living document and will be revised at the end of each tranche, updated to reflect material changes, and used as the basis for seeking confirmation to continue to invest in the mix of projects and activities within the programme.

Diagram 3 Programme Structure



Programme Management Strategy and Framework

134. In October 2016, the MH&AS engaged key stakeholders who told us that they wanted change. Their feedback confirmed that despite the improvements in recent years, action is still required to relieve pressures on the current system. As a result, MH&AS looked hard at how it could improve its service provision. This led to MH&AS developing a programme to re-orient the system.

135. The Better Business Case Strategic Assessment presented a compelling case for change, which was endorsed by Ministers in June 2017. The changes required to take action include:

    a) To transform service delivery in order to improve safety, effectiveness and efficiency.

    b) To create safe and therapeutic environments that support holistic care at all times.

    c) To build sustainable capacity and capability of services to meet future demand, values and need.

136. The programme is to be delivered three stages (tranches) over a five year period to enable MH&AS to meet the delivery objectives while ensuring minimal disruption to BAU. MH&AS is taking a steady, incremental approach where all significant products and initiatives will fully tested before going live with appropriate assurance (including independent quality assurance where appropriate) in place.

    1) Discovery and Indicative

    2) Design, Planning and Delivery Transformation System Changes; and, Stage 1 MH Acute Inpatient Facilities Design, Planning and Delivery;

    3) Continuous improvement and Stage 2 Facilities Planning and Delivery

137. Between October 2016 and December 2017 the programme focused on understanding the *problem* and discovery of solutions that can be delivered through a series of workshops.[21]

    - Care Coordination
    - Culture and Values
    - Leadership
    - Professional Practice
    - Productivity

    Significant progress has been made on the discovery phase, where implementation plans have been developed for 30, 60, and 90 DAY management and monitoring. Note alongside this work effort, input into cultural responsive has been ongoing and continues to be weaved through all project deliverables.

138. The second tranche focuses on solutions that can be delivered in 2018 / 2020 and includes:

    - refocusing of service delivery to provide integration and collective impact across the social and health sector

[21] Each work stream has developed a possible options assessment and an implementation plan (including a 30, 60 and 90 DAY plan).

- mental health and addictions quality improvement initiatives
- initiating the acute Mental Health facilities solution
- implementing the Professional Practice workforce strategy, cultural responsiveness and best practice informed care
- implementing the required changes to achieve care coordination

139. Delivery of the third tranche starts in 2021. It builds on enhancing the first tranche ensuring sustainability and quality improvement cycles; and, includes Puawai; and, Multiple and Variable needs facilities solution delivery.

Programme Team

140. A programme team is being established and will have authority to run the programme and mix of projects on a day-to-day basis on behalf of the Programme Board within the constraints laid down by the Board. The programme team will include a programme director / business case writer, engagement specialist, consumer and family whānau representation, and a mix of project managers, change agents (clinicians), fiscal advisor and business analysts (and any other resources as required).

141. A change management plan will be developed to guide MH&AS in realising the key changes to ensure the provision of safe, effective and efficient delivery of care. The plan will aim to drive change by ensuring that teams share a clear sense of purpose. The change process will be supported by seconded clinician who will be responsible for change leadership and accountabilities for assisting the transformational co-design and transition process.

142. Mental Health and Addictions service is working with other agencies and providers as it delivers the programme. Discussions are being held to ensure collaboration opportunities are maximised, including synergies to improve integration and collective impact within the health and social sector.

143. The programme is invested in taking a co-design and human centred approach (see annex for the programme Communication and Engagement Strategy). Our process offers the opportunity for people that live within the Waikato DHB region to have a voice in helping guide the direction of health and social system of care.

Outline project plan

144. The anticipated key milestones for the programme business case are outlined below. It is important to note that the below dates are aligned to the NZ Corrections Capacity programme timeline, and therefore maybe unrealistic. Refer to the annex for the detail of the programme tranches plan.

Table 10 Programme milestones

Proposed key milestones	Estimated timing
Discovery and Indicative	Jan 2017 – Apr 2018
Programme Business Case	May 2017 – Mar 2018
Indicative Business Case (Facilities Redevelopment Project)	Jan 2018 – May 2018
Single Stage Business Case (Transformational Pathway Project)	Apr 2018 – Sept 2018
Transformation System Changes	Jan 2018 – Jan 2020
Detailed Business Case (Facilities Redevelopment Project)	May 2018 – Sept 2018
Stage 1 Facilities Implementation	May 2018 – Dec 2021
Continuous Improvement	Jan 2017 – Dec 2020
Stage 2 Facilities Implementation	Jan 2021 – Dec 2022
PIR and Continuous Improvement	Jan 2021 – ongoing

145. Readiness for service; and, operational review and benefits realisation timeframes are yet to be determined.

Risk management

146. Risks to the Creating Our Futures programme are commensurate with its scope, size and magnitude. Mental Health and Addictions has adopted a strong risk management framework which is firmly embedded. Risks and Issue registers for the Programme are updated and regularly reported to governance forums including the Creating Our Futures Programme Board and Advisory Group.[22]

147. Managing risk is instrumental in maintaining our Waikato DHB and MH&AS service delivery on our investment objectives. Our approach to assessing and managing risk is based on international best practice (ISO 31000), which emphasises the ongoing dynamic nature of risk, and risk management.

148. A *three lines of defence* model supports our approach (staff, risk and compliance, and assurance). Staff members are primarily responsible for identifying and managing risks within their business groups, and ensuring that risk management is fully integrated in all business activities, support by our Quality and Patient Safety service.

149. The MH Clinical Governance Forum, chaired by the Director of Clinical Services, provides management oversight of the risk system. Reports on the status and management of MH&AS service are provided to the Waikato DHB Board.

[22] From this point forward, MoH and NZ Treasury will receive reporting on the high level risks as part of the programme dashboard reports.

150. Creating Our Futures reports the programme risk profile monthly to the MH Clinical Governance Forum. Our latest risk profile five critical areas of risk to successful implementation of the programme include:

Table 11 Programme risks

Key areas of risk	Management Actions under way or considered
Risk to programme resourcing – getting the right people at the right time in a challenging Waikato labour market.	Access to appropriate skilled and experienced resources is a constant focus. Programme resourcing is also discussed with other DHBs to identify approaches to resources
Complexity of the underlying business requirements unique to MH&AS could drive up implement timings and costs	MH&AS is engaging with other services to understand and mitigate the likelihood and impact of this occurring A constant focus one ensuring we are developing solutions for the future rather than duplicating current functionality and process is also in place (Change Agent - process mapping).
Future capabilities of MH&AS staff – MH&AS workforce will need to have different capabilities after the transformation	Implementation of the Values and Culture initiatives, Cultural Responsive framework to enable the required essential, discipline and specialist competency and cultural capabilities to put in place is underway. In addition MH&AS is seeking funding to create a Workforce Development role to ensure the smooth alignment and management of resources.
Maintaining business performance during the transformation could at times be challenging	The implementation of the operational community and inpatient dashboards to enable monitoring is underway. The implementation of a series of quality initiatives related to improved [patient] is underway (e.g. safer discharge, safewards)
Risk of delays related to clinical risk, BBC processes, affordability and market capacity	A constant focus on ensuring we are monitoring risk and developing mitigating solutions. Consideration is needed for lead time for certain materials and supplies (e.g., any offshore fabrication, precast concrete and structural steelwork). Any construction project and procurement methodology will need to take account of these market conditions.

151. The Creating Our Futures programme acknowledges that this is a complex programme that requires tight management over a long period of time. There are significant timeline interdependencies with the NZ Corrections Capacity programme, and the mix of facility redevelopment carries significant delivery risk that requires specific monitoring.

Project Assurance

152. This programme investment proposal has been assessed as medium risk using the Gateway Risk Profile Assessment tool. On the basis of this risk assessment, the basis

for on-going engagement as part of the business case has been agreed. Key aspects of this approach are to engage with Ministry of Health and NZ Treasury at all key phases of the programme. It would be timely for MH&AS to invite representation from these agencies onto the programme board as members.

153. Throughout the delivery phase of the programme, deliverables and outcomes are validated:

- through the Creating Our Futures Advisory Group to ensure delivery is aligned to the model of care and the values and needs of our community
- the programme benefits, to ensure benefits are realised and programme objectives are met
- the budget (at this stage this is being set) to ensure actual spend is within budget
- MH&AS and Creating Our Futures vision and values, to ensure deliverables and outcomes support the desired culture

154. Continued co-design and engagement with the people with lived experience, staff and the sector will continue through a series of workshops across the Waikato to discuss *"Let's Talk" what matters* to explore the co-design of mix of projects.

155. Lessons Learned are taken as work progresses and after completion of projects and initiatives. Key learnings are recorded and are available to the programme team. In addition, lessons learned are being picked up from other DHBs who have undergone or are undergoing a similar transformational process.

Effective governance and assurance arrangements are in place

156. The Executives for this programme will ultimately be responsible for the programme, supported by the Project Director and Health and NZ Treasury representatives. The Executive must ensure that the programme gives value for money, ensures a cost conscious approach to the programme, and balances the demands of the programme with expectations of the Ministry of Health and NZ Treasury, and the Waikato DHB Board, Health Strategic Committee and Strategic Building Programme. Throughout the business case development and programme, the Senior Responsible Owner *owns* the programme.

157. Governance arrangements ensure that an appropriate level of oversight and reporting occurs to the Waikato DHB Board, Executive Group and senior programme levels.

158. Measures in place to support effective oversight, monitoring and management of Ministerial interests include;

a) Quarterly meetings between the programme team and the Advisory Group.

b) Ministry of Health and NZ Treasury reviews at key points in the programme with the purpose of confirming the need for the programme and the likelihood of it achieving the desired outcomes.

The measures in place will become more robust once the full scope and size of the transformation becomes known.

159. Engagement with MH&AS transformation programme has been transparent. The programme provides effective signalling of where the complexities exist, with the consistent description of progress and key risks across multiple levels from Board to Senior Responsible Owner to Strategy and Funding.

160. Independent Quality Assurance (IQA) activities will be undertaken throughout the Detailed Business Case and Procurement processes.

161. There are cost pressures and issues that are apparent within the programme but these are appropriately flagged for management and governance oversight. Creating Our Futures overall programme rating is AMBER to reflect the issues being managed (slippage in time tolerance).

Service User and Family Whānau Rights

162. To date, this programme business case has not raise any issues or inconsistencies with the New Zealand Health and Disability Commissioner Act 1994 and 2003, Code of Health and Disability Services Consumers Right Act 1994, Bill of Rights Act 1990, Human Rights Act 1993 or New Zealand. If progressed well, the programme will result in substantial improvements towards helping our Waikato community to be well.

163. In principle Creating Our Futures can be implemented without legislative change. Regulatory impact analysis requirements (at this stage) do not apply to this business case.

Next Steps

164. The Programme Business Case also seeks approval from Capital Investment Committee members to commence the preferred programme of work and to proceed with developing future business cases for the specified projects within the proposed tranches.

165. It is recommended that:

    i. That the Waikato DHB continues to fund the programme related work.

    ii. That is programme business case is presented for noting by Ministry of Health and NZ Treasury to Investment Ministers, and that this Programme Business Case is accepted and endorsed to proceed with developing future business cases.

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Annexes

1. Commissioners Letter
2. Investment Logic Map
3. Model of Care
4. Programme Brief
5. Programme Communication and Engagement Strategy
6. Programme Business Case 1 Pager
7. Programme Tranches

Annex One: Commissioner's Letter

This template is the basis for developing the letter for a Government department and may be customised and individualised to meet the requirements or to address proposal-specific issues.

[date]

[To whom it may concern]

Creating Our Futures Programme Business Case

This Programme Business Case is a significant deliverable of a strategic project by …….. to investigate value for money options to meet its future …….. requirements.

I confirm that:

i I have been actively involved in the development of the attached investment proposal through its various stages

ii I accept the strategic aims and investment objectives of the investment proposal, its functional content, size and services

iii the indicative cost estimates of the proposal are sound and based on best available information, and

iv suitable contingency arrangements are in place to address any current or unforeseen affordability pressures.

This letter fulfils the requirements of the current Better Business Cases guidance. Should either these requirements or the key assumptions on which this case is based change significantly, revalidation of this letter of support should be sought.

Yours sincerely

……..

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

creating OUR futures

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12 March 2018

TO WHOM IT MAY CONCERN

Creating our Futures Programme Business Case

The Creating our Futures Programme Business case is a significant deliverable of a transformational change programme by the Waikato DHB Mental Health & Addictions Services to investigate value for money options to meet the Waikato region's future mental health and addictions service delivery requirements.

As current Chair of the Creating our Futures Programme Board and the Senior Responsible Owner of the Programme, I confirm that the Programme Board has been actively involved in the development of the attached investment proposal through its various stages.

The Creating our Futures Programme Board unanimously endorsed the investment proposal at its 12 March 2018 meeting, and approves its presentation to the Waikato DHB Board.

Yours faithfully

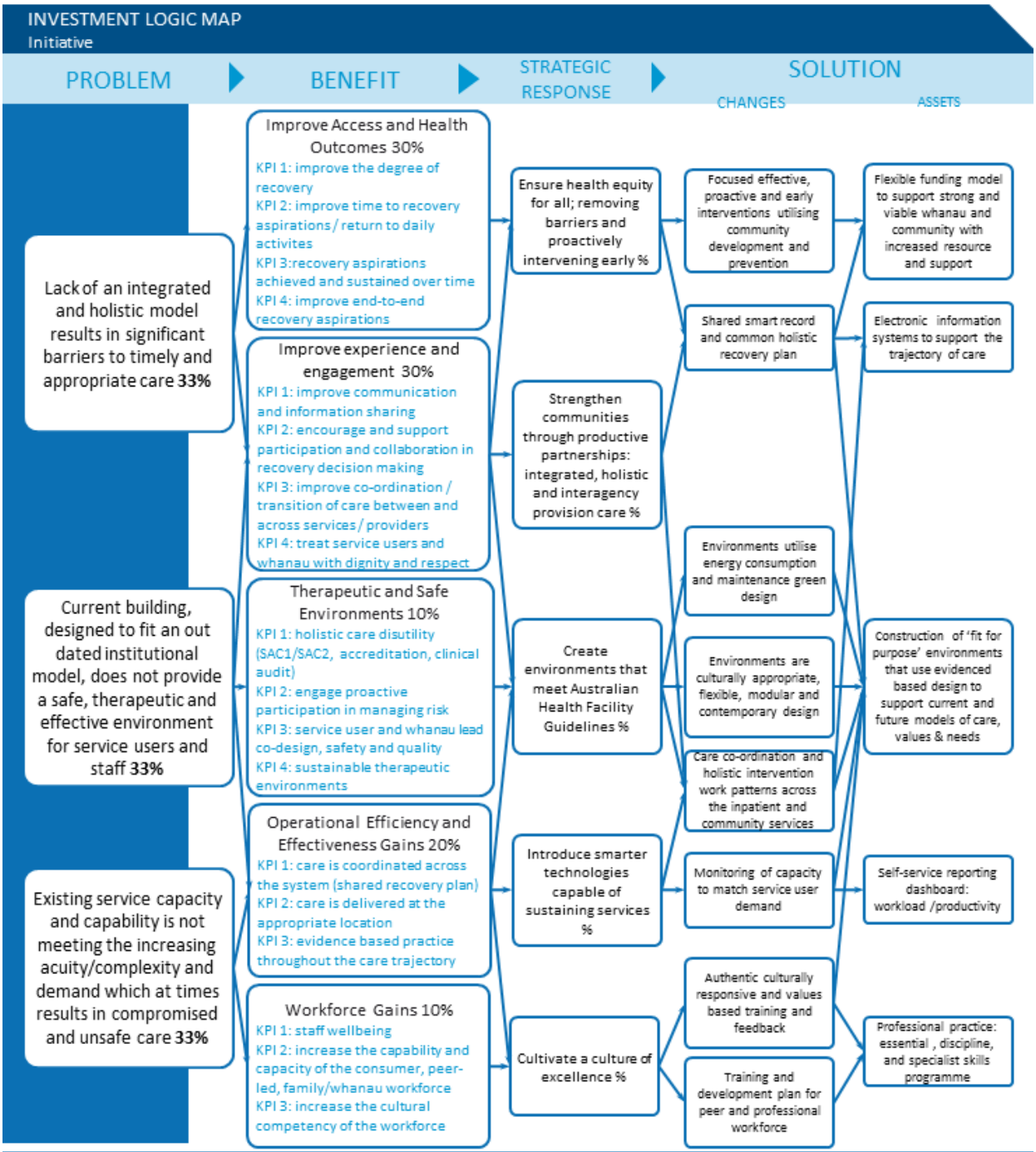
Vicki Aitken
Interim Executive Director
Mental Health & Addictions Services

Annex Two: Investment Logic Map

Waikato District Health Board

People at Heart *Te iwi Ngakaunui*: strengthened communities, through trust and partnership

Mental Health and Addictions service



Annex Three: New Model of Care

DRAFT

creating our futures

Mental Health and Addictions Service
PROPOSED MODEL OF CARE

May 2017

This document introduces the proposed Waikato District Health Board (DHB) Mental Health and Addictions service proposed model of care. The new model has been developed in partnership with key experts and lived experience stakeholders.

'Creating Our Futures' is part of a larger Waikato DHB Mental Health and Addictions services continuous quality improvement programme.

Waikato District Health Board

INTRODUCTION

Over recent years demand for mental health and addictions services has increased in terms of numbers, acuity and complexity of need. The need to transform the way the service does things is necessary to ensure safe, effective and efficient service delivery without compromising outcomes for service users and their whānau, and staff now and into the future.

People who require mental health and addictions services should expect early and appropriate holistic care well before the impacts of mental illness and co-existing problems reach a more severe stage. The goal of this model of care is to join holistic care with the service users and their whānau aspirations, to support the recovery journey and achieve self-managed wellness.

This new model of care document outlines the needs-led, strengths-based and outcomes-focused recovery pathway, to be achieved and strengthened through advocacy and partnerships.

People with lived experience, staff, community and social and health providers have provided feedback on the how the Mental Health and Addictions service can improve delivery of services:

- Commit adequate support and resources to service users and whānau that enable them to be safe, well informed and engaged as partners-in-care.
- Support whānau to provide effective early and post-acute care.
- Be part of strengthening communities to ensure early and proactive response/s.
- Improve progressive flow through services supporting recovery, realistic goals and wellbeing.
- Ensure service provision priorities reflect the needs of our community (e.g., co-existing problems, specific populations and groups of people with unique cultural and/or vulnerabilities, age specific, gender, intellectual, spiritual and geographical location needs).

Key stakeholders identified three core constraints that currently impede the service's ability to deliver safe, effective and efficient holistic care:

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

The Waikato DHB Mental Health and Addictions service is committed to undertaking a major programme of work to respond to the need to challenge the status quo. The Creating Our Futures programme offers the opportunity to support a recovery approach to holistic care, by creating a model that places emphasis on putting recovery at the heart of people's care: People at Heart Te iwi Ngakaunui. It also offers the opportunity to significantly enhance the integration and coordination of health and social support and services.

OUTLINE TO THE NEW MODEL OF CARE

The proposed model of care places the emphasis on putting the wellbeing of people at heart throughout their care journey.

If progressed well, in the model people will receive care that is:

People-centred – care is focused and organised around the service user and whānau needs (including, mental, physical, social and cultural), aspirations and resources.

Coordinated and joined up – the care journey is coordinated across care settings. People will know where to get help, what to expect and by whom.

Integrated – one recovery plan. Service users and whānau, professionals, and service providers are partners-in-care, everyone working together to respond early and support self-managed wellness.

Holistic – care will nurture and support the service user recovery needs and aspirations. At all times care will reflect a mana protecting and mana enhancing approach.

Wellbeing – enabling self-managed wellbeing through good connections with the services and community, no matter where an individual is at in their care journey.

WHAT TO EXPECT

Our Waikato community should expect early and appropriate holistic care that is prioritised appropriately and agreed between the service user and their whānau and the care team. Delivery of holistic care will be proactive, planned, coordinated and delivered in the most appropriate environment.

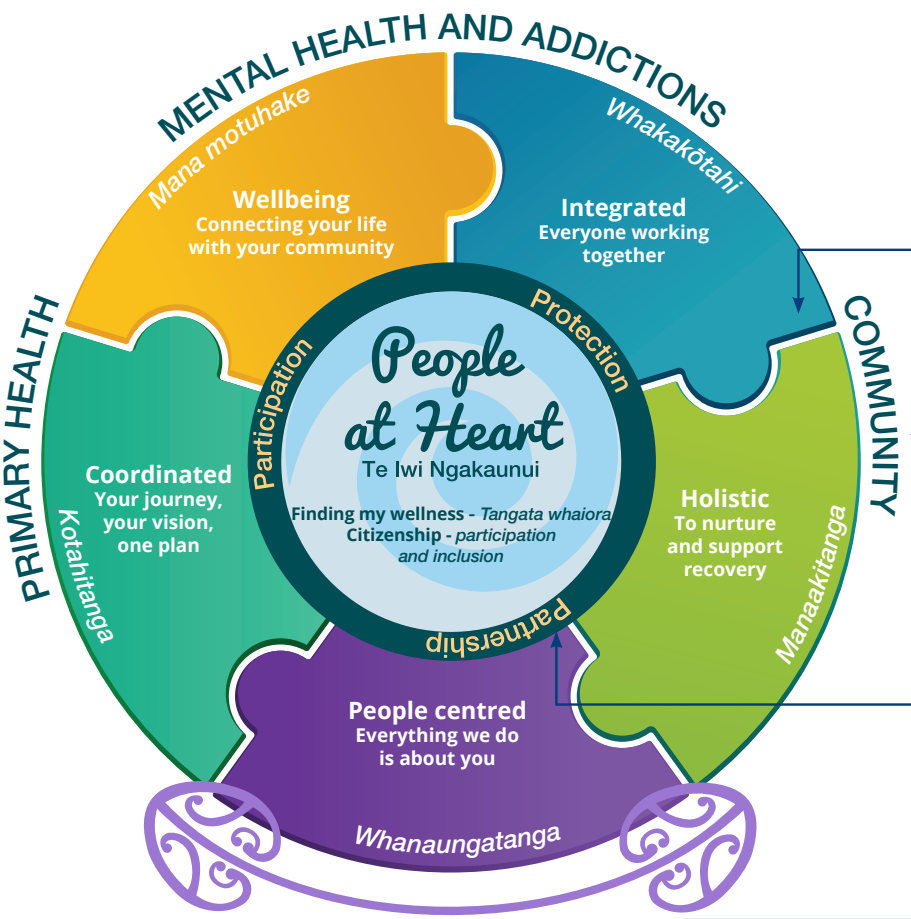
Individuals and whānau will transition from our service with a shared, common and integrated recovery plan in place that enables them to access the support they need in their community or with access to appropriate residential services that meet's their individual needs and aspirations.

RECOVERY AND WELLBEING

The recovery journey components promote holistic care, support and respect. Implementing holistic and people-centred recovery strategies are a means to address the impacts of a range of health and social problems. The Mental Health and Addictions service will incorporate the principles of the recovery model and mana enhancing practice as part of fostering a values-based culture and mana protecting partnerships so that services are delivered on the same track as service users and whānau needs.

Underpinning recovery is wellbeing. An individual may experience many shades of wellbeing throughout their journey including hope, healing, empowerment and connection. Recovery and mana enhancing practice will be one that aspires to wellbeing and self-managed care.

PROPOSED MODEL OF CARE



creating our futures

These are the five foundations that represent the approach for providing mental health and addictions care.

Key stakeholders that will work together collaboratively to deliver safe and effective high quality care.

The inner circle represents the integrated wellbeing supports for people in our community.

The centre is 'People at Heart - Te iwi Ngakaunui. The goal of the service delivery and care for people, their whānau and carers.

IMPROVEMENTS FOR PEOPLE ENGAGING WITH OUR SERVICE

- They will know where to get help and what to expect.
- They will be actively involved in their wellbeing plan.
- They will have access to advocacy and support.
- They will have equitable access to care no matter where they live.
- They will have an ongoing voice in improving services.
- They will receive early and proactive care.
- They will be actively involved in their recovery plan as partners-in-care.
- They will have equitable access to effective and appropriate advocacy and support.
- They will receive care that is coordinated: right place, at the right time, recognising the recovery journey and that there is no set way.
- They will be holistically supported, in terms of their physical, mental, social and cultural circumstances.

IMPROVEMENTS FOR FAMILY/WHĀNAU AND SIGNIFICANT CARERS ENGAGING WITH OUR SERVICE

- They will know where to get help for their whānau member.
- Information on what they can expect will be easily available.
- They will know where to get support for themselves.
- They will be actively involved in recovery planning as partners-in-care.
- They will offered good access to information and resources that ensure they are able to access support for themselves.

The Mental Health and Addictions service will be part of a wider system of care. The service will need to work together with our Waikato service providers to improve the way the system currently works locally – sharing information, simplifying structures where appropriate, and finding innovative ways to share resources and deliver service. There will also need to be investment into accountability, financial flexibility, parity of esteem, and having stronger partnerships. Fundamentally communities will be strengthened so that everyone can play their part.

"Strengthened Communities, through Trust and Partnership"

DRAFT

THE RECOVERY JOURNEY

The model of care focuses on the following initiatives to improve integration, partnership, participation, and protection of the health and wellbeing of our Waikato service users and their communities.

THE CARE JOURNEY

All individuals will experience the same prompt access to quality care. Individuals will receive holistic care at the **right time**, **right place**, by the **right person** and in the **right way**. Every individual receiving care from our service will have an experienced care coordinator who is responsible for advocating and ensuring the seamless coordination of holistic interventions and integrated transition throughout their journey.

THE PROPOSED CARE JOURNEY FOR MENTAL HEALTH AND ADDICTIONS SERVICES

Capable Community	Assessment & Early Intervention	Integrated Recovery Plan	Care Coordination – care interventions	Ongoing Monitoring & Adaptation of Plan	Continuing Care – capable community
• Enhanced community and primary sectors providing brief interventions (feedback, advice and linkage). • Establishing screening and protection pathways for high risk populations. • Engaging person and their whānau through listening, understanding and respecting cultural differences and potential protective factors.	• Initial focus on engagement, safety and prevention. • Assessment is inclusive of the family/whānau or family voice. • Involvement of community and primary linkages. • Comprehensive assessment and integrated brief planning and intervention guided by complexity. • Advice and education provided to family and carers. • Psychosocial support and carer respite for carers and families. • Cultural assessment is inclusive of a wairua perspective.	• Maximised inter-sectorial and multidisciplinary function. • Access to a care coordinator or case manager will ensure treatment integration and follow up. • Valuing the contribution of whakapapa and cultural narratives as healing processes through generations.	• Best practice interventions. • Access to functional and therapeutic programmes including evidence based Tikanga Maori approaches to recovery. • Integrated practice is guided by the person's integrated wellbeing plan. • Movement through the journey of care will be a negotiated and guided process. • Reaffirming the ability and capacity of whānau to engage and provide support.	• Enhanced monitoring to ensure relapse prevention is in place. • Opportunities to include carers, and other community supports into the review of plans and transition points through the journey of care. • Asking the person and whānau whether the outcome of manaakitanga has been achieved for them.	• Active linking to opportunities and naturally occurring support systems. • Evaluation of social inclusion and quality of life. • Identifying the needs of whānau and carer ensuring access to support and respite.

THE RECOVERY PLAN

For all people who are requiring support there will be one shared, common integrated recovery plan. People should expect to be involved in decision-making and wellbeing planning throughout their journey. Care will be proactive and people will know at the start of their journey what to expect when, and by whom.

The recovery plan will:

- describe the needs and aspirations of the individual; and the steps needed to address the aspirations
- be continually reviewed and developed in partnership with the individual, whānau and significant carers, professionals and other agencies across the sector
- appropriately span across community, primary, secondary, tertiary and other sectors (e.g. Police; ambulance; General Practitioners; schools).

CARE COORDINATION

Care coordination involves the management and coordination between a range of care providers including, the service user, whānau and significant carers and health professionals and other agencies across the sector. Care coordination includes:

- a person or persons who has responsibility for initiating and coordinating the processes, services and resources that assist the objectives of the recovery plan
- care coordination is based on a holistic wellbeing plan
- working with a variety of agencies and sectors
- continuity of care supported through the use of evidence-based pathways recognising that there is *no set way.*

Care coordination requires someone to manage the provision of care.

WHAT IS JOINED UP?

People want their journey to be as simple as possible, and not to be passed 'from pillar to post' before their needs are met - not limited by boundaries, location, contract service etc. This relies on different services working together in a well-coordinated way that is not limited by boundaries.

WHAT IS INTEGRATED CARE?

Intregrated care is an approach in which all people representing health and social support services will actively be involved as partners-in-care all working together towards a common wellbeing goal for someone requiring mental health and addictions support.

ABOUT WAIKATO DHB MENTAL HEALTH AND ADDICTIONS SERVICES

creating our futures

For people requiring support from Mental Health and Addictions service, our service will actively work with other services in an integrated way.

To ensure our Mental Health and Addictions service is part of a wider health and social system, the service is committed to the development and implementation of a model of care through the *'Creating Our Futures'* programme.

OUR COMMUNITY SERVICE

There will need to be investment in community services to ensure that where possible people are cared for in their own environments, which is usually where they want to be, and in most instances, is where they should be.

Examples of community services that you may see include:

- home-based and carer support
- peer-led services
- integrated community and DHB triage and early intervention services
- community agencies capable of mental health first aid (people have knowledge and skills to manage wellbeing)
- acute care pathway developed across home treatment, crisis resolution, alternatives to admission to ensure crisis care can be delivered closer to home in the least restrictive setting
- care coordination and multidisciplinary allocation of holistic interventions
- investment in technologies and shared information, all focus on shared outcomes

OUR INPATIENT FOCUSED SERVICE

For the small percentage of people who do require an inpatient stay then there are some changes to the types of care they will receive.

The main difference to inpatient care is that the service will have a therapeutic focus based on function, flexibility and safety. This will be needs-led, strengths-based and outcomes-focussed so that an individual's physical, mental, social and cultural circumstances are identified to deliver the right interventions. Individuals will be assessed and regularly reviewed on a daily basis which will allow them to be directed to other services, to support linkage and wrap-around-care.

NEW BUILDINGS - ENVIRONMENT

The aim is to make people's experience a positive one and as short as possible. This will be achieved by creating the right environment to deliver the right holistic interventions.

In order to support the new model there will need to be some environmental changes; these may include for example:

- welcoming and reassuring, within a culturally functional environment
- warm and safe
- comfortable and homely (high standard accommodation)
- calming colours
- indoor – outdoor flow
- privacy and sound proofed
- sensory throughout
- accessible (a number of welcoming entry points to accommodate choice; and access to outdoor areas)
- caters for needs
- reconfigurable, flexible and multi-use rooms
- spaces which support whānau and community involvement
- promotes therapeutic alliance, social inclusion and optimum independence
- security that enables freedom of movement
- accommodation needs and social circumstances
- enables everyday living (e.g. laundry, dining options), facilities (café, music, advocacy office, library, gym, natural light, cultural, workshop, relaxation, recreational areas and designation areas to connect with others)
- office, training and workforce development.

Ideally people should receive care from our service in a way which creates the least disruption to their lives with access to the most appropriate programmes. It is recognised that being admitted to hospital can at times, be a frightening and daunting experience, so the aim is to create a culturally welcoming and reassuring environment. The right environment needs to be created in the right way to achieve the delivery of the right care.

WHAT DOES THIS ALL MEAN

All key stakeholders who represent integrated health and social care and support in the model will need to actively participate to support people's care journeys through services.

The Mental Health and Addictions service will work to provide:

- Linkage and wrap-around-care which primarily focuses on forming therapeutic relationships with community.
- Citizenship to maximise participation and inclusion within community.
- Invested and capable community which easily recognises signs and symptoms; can provide early and brief interventions; and has an agenda that is oriented to advancing recovery and anti-stigma.
- Visible, proactive and engaging care where everyone can play their part.

OUR WORKFORCE

As well as the environment the staffing model, staff training and workforce development are key to delivering our model of care. The priority areas include:

- Person-centred and compassionate culture.
- Early career professionals.
- Values-based recruitment.
- Cultural competence.
- Promotes leadership development.
- Collaborative workforce that shares learnings and experiences.
- Empowering staff to work safe and well.
- Ability to challenge the norm.

IMPROVEMENTS FOR HEALTH PROFESSIONALS (including those from mental, physical and/or other services)

- They will know what is expected of them.
- They will be clear about the sorts of interventions and tools that are required.
- They will easily be able to access advice and consultation.
- They will have strong and cohesive relationships.
- They will have access to upskilling, refreshers and succession planning.

SERVICE USER AND WHĀNAU

Service users and whānau are enabled to play an even greater role in service design, provision, monitoring and governance. An expert service user and whānau group will be established to guide and to realise the model of care and continuous improvement throughout the programme.

ANY QUESTIONS?

We hope that this summary document has provided you with an understanding of our future plans for better mental health and wellbeing for those requiring our care.

Please get in touch with any questions that you have. Your queries will be used to create a selection of frequently asked questions to share with others.

Please send your questions to: creatingourfutures@waikatodhb.health.nz

Annex Four: Programme Brief

Waikato District Health Board

Mental Health and Addictions Creating Our Futures

Programme Brief

Purpose

The focus of the Creating Our Futures programme is on the development and implementation of a new model of care that will inform what it is the service delivers; the acute environment/s and capital infrastructure needed; and, the resrouces required to support that delivery. The programme of work sets the agenda for responding to the need to change and forms the basis for the investment.

The system-wide transformation is characterised by more convenience, better outcomes, higher quality, better value, and greater performance than could ever be achieved under the current systems. The aim described within the Creating Our Futures programme inlcudes:

a) Transforming service delivery in order to improve safety, effectiveness and efficiency.

b) Creating safe and therapeutic environments that supprot holistic care at all times.

c) Building sustainable capacity and capability of services to meet future demand, values and need.

Author: Dr V Endres

Last Updated: 2018-03-05

Document Name: MH&AS Creating Our Futures

Version: v0.01

Revision history

Date	Author	Summary of Changes	Version
2017-11-07	Virginia Endres	Draft of first version	v0.01
2018-03-05	Virginia Endres	Alignment to PBC	v0.02

Distribution

Name	Title	Issue Date	Version
Dr Rees Tapsell (chair)	MH Clinical Governance	14/12/2017	v0.01

Approvals

Approver	Signature	Issue Date	Version
Derek Wright Waikato DHB Interim Chief Executive			
Vicki Aitken Interim Executive Director of Mental Health & Addictions			
Dr Rees Tapsell Director of Clinical Mental Health & Addictions Services			
Ian Wolstencroft SPO Executive Director			

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1. Background

Over the past 20 years (since deinstitutionalisation), Waikato DHB has evolved its model of care to enable the majority of mental health services to be delivered in the community, in line with national and regional mental health strategies. A number of the aforementioned reviews found evidence of improved service delivery over time. However, with the growing number of people accessing services for mental health and addiction issues, the MH&AS service is under pressure and there is increasing potential for unmet need. Often services are available to people only once their condition deteriorates, and the dominant treatment option (medication and therapy) do not address the broader social factors that help people be well and support recovery.

Action is required to relieve pressure on existing mental health and addictions service. The Creating Our Futures programme is underway to transform our whole system pathway, with appropriate fit-for-purpose facilities, as more of the same will not deliver the wellbeing and recovery oriented system that is required.

2. Programme definition

2.1. Programme purpose

The focus of the Creating Our Futures programme is to progress and regain traction on improving our mental health and addictions model of delivery (as described in the MH Commission 2018 monitoring report p10) through taking on:

- broaden the focus of service delivery form mental illness and addiction to mental well-being and recovery
- increase access to health and other support services
- ensure that we have timely information about changing levels of need, current services and support, and evidence about best practice
- implement a workforce strategy that enables the service to deliver better, more accessible services
- achieve the required changes through collaborative leadership, support by robust structures and accountabilities to ensure successful, transparent results.

2.2. Programme objectives

The programme of work sets the action plan for responding to the need to change and forms the basis for the investment. The objectives described within the Creating Our Futures programme are based on the investment objectives:

Investment Objective One: To transform service delivery in order to improve safety, effectiveness and efficiency.

Investment Objective Two: To create safe and therapeutic environments that support holistic care at all times.

Investment Objective Three: To build sustainable capacity and capability of services to meet future demand, values and need.

2.3. Programme ILM

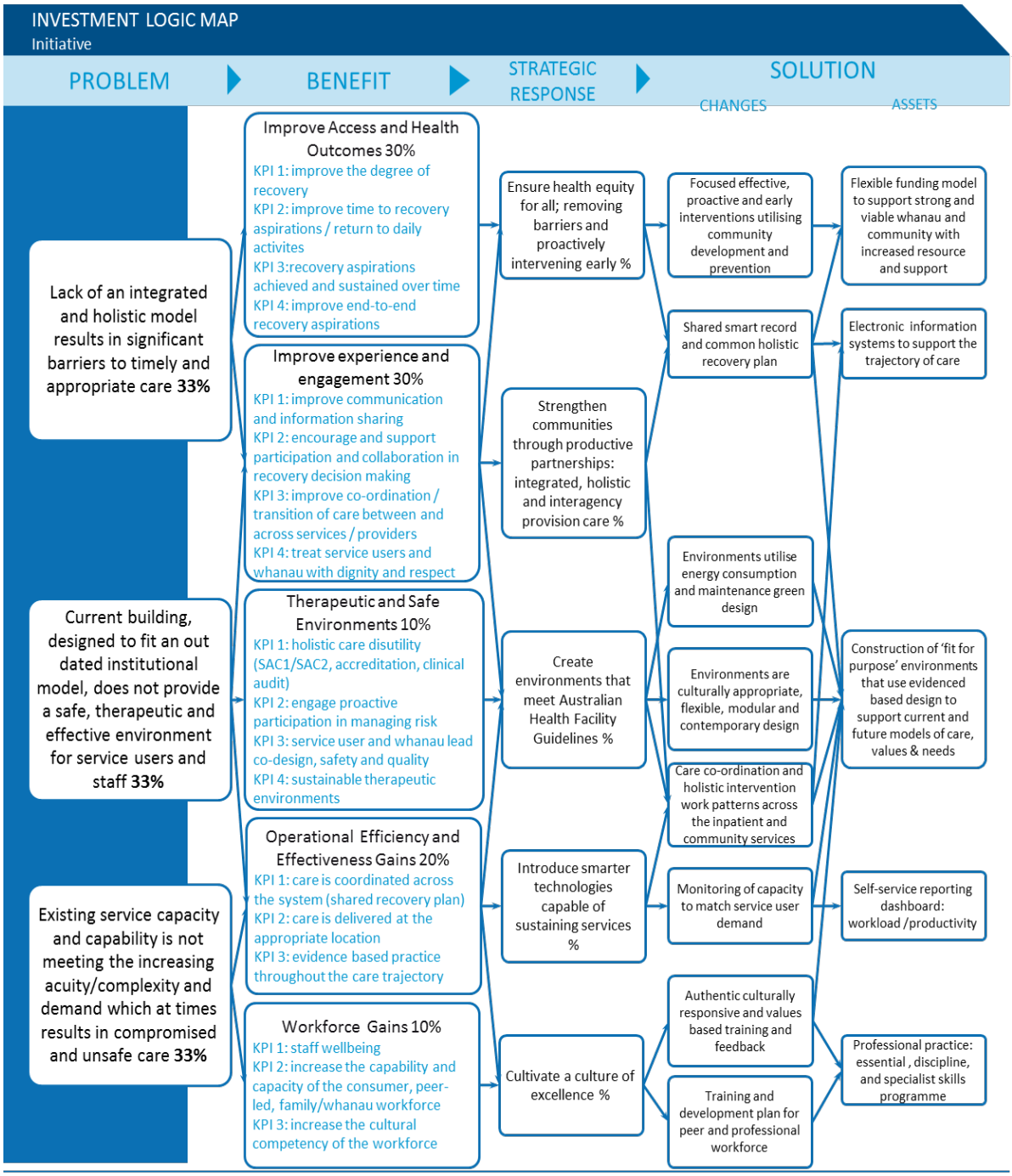
People with lived experience[1], clinical staff members, community, and social and health providers, have provided feedback on how the Mental Health and Addictions service can improve delivery of services in the Waikato. Through a series of Investment Logic Mapping workshops (see annex 2) stakeholders identified three problems that challenge our Mental Health and Addictions service delivery.

[1] People with lived experience/s – includes service users and family whānau who are or who have had mental health and addictions experience/s both indirectly or directly. Mental health refers to any form of mental health condition (including, organic or functional), severe mental illness refers to conditions involving psychosis or very high levels of need, and wellbeing as a more general term capturing emotional and psychological state and resilience.

Waikato District Health Board

People at Heart *Te iwi Ngakaunui*: strengthened communities, through trust and partnership

Mental Health and Addictions service



Investor:	Derek Wright, MH&AS Executive Director	Initial Workshop:	18/01/2017
Facilitator:	Andrew McCurdie	Version no:	v 0.7
Accredited:	Yes	Last modified by:	Dr Virginia Endres
		Template version:	-

3. Programme scope deliverables

The potential business scope and key service requirements were identified and assessed by stakeholders at the facilitated Model of Care series of workshops

Table 1 Business scope and key service requirements

Service Requirements	Scope Assessment	
	In Scope	**Out of Scope**
System Transformation	- MH&AS community, inpatient and specialty services (whole system pathway) - Regional Forensic services	- Continuous Quality Improvement initiatives (activities must be ongoing and not contingent on programme timeframes)
Inpatient Facilities	- Acute MH - Multiple and Variable needs (including, high and complex, MH older 65 years, youth, eating disorders, cognitive impairment, peri-natal, AoD) - Puawai Increased capacity	- MHSOP facilities - Waikato DHB strategic build
Capacity & Capability	- Professional Practice - Leadership - Culture and Values - Engagement - Technologies	- Business as Usual

The Creating Our Futures is a significant programme of health system transformation in terms of redesigning of the model of care that will inform what it is the service delivers; the acute environment/s and capital infrastructure needed; and the resources required to support that delivery. Fundamentally, the redesign is focused on the system which involves better integration of care across organisational and service boundaries, increased investment in community-based services, and strengthening primary care.

3.1. In Scope Deliverables

With a focus on system integration, a number of projects and improvement initiatives are taking place. Each initiative has a specific goal, and all have the needs of the service users and family whānau at its core. The outline of the programme of work includes:

- MH&AS Transformational Pathway Project
- MHA Whole Approach to Wellbeing and Recovery
- Waikato DHB MH&AS Facilities Redevelopment Project
- MH&AS Capacity and Capability Initiatives

The Creating Our Futures programme scope will be guided by the detailed assessment and preparation of the Programme Business Case. The detailed preparation of a programme business case document will be

developed using the NZ Treasury (National Infrastructure Unit) Better Business Case Five Case Model, the New Zealand Government's accepted good practice standard. The programme business case is a living document and will be revised at the end of each tranche, updated to reflect material changes, and used as the basis for seeking confirmation to continue to invest in the mix of projects and activities within the programme.

4. Testing and Quality Checks

The programme business case Risk Profile Assessment indication – **MEDIUM** (no Gateway Review required).

This programme investment proposal has been assessed as medium risk using the Gateway Risk Profile Assessment tool. On the basis of this risk assessment, the basis for on-going engagement as part of the business case has been agreed. Key aspects of this approach are to engage with Ministry of Health and NZ Treasury at all key phases of the programme. Throughout the delivery phase of the programme, deliverables and outcomes are validated:

- through the Creating Our Futures Advisory Group to ensure delivery is aligned to the model of care and the values and needs of our community
- the programme benefits, to ensure benefits are realised and programme objectives are met
- the budget (at this stage this is being set) to ensure actual spend is within budget
- MH&AS and Creating Our Futures vision and values, to ensure deliverables and outcomes support the desired culture

Continued co-design and engagement with the people with lived experience, staff and the sector will continue through a series of workshops across the Waikato to discuss *"Let's Talk" what matters* to explore the co-design of mix of projects.

Lessons Learned are taken as work progresses and after completion of projects and initiatives. Key learnings are recorded and are available to the programme team. In addition, lessons learned are being picked up from other DHBs who have undergone or are undergoing a similar transformational process.

5. Assumptions

The following assumptions have been noted:

- ✓ We will utilise approaches like co-design to make efforts to reach out to all groups enabling them to participate, and will respect their contribution.
- ✓ We will utilise national and international experiences and solutions completed and/or underway so as to use learnings and also reduce rework on problems that may have already been solved.
- ✓ We will explore all options for solutions in the proposed programme business case including those described in the *NZ's Mental Health and Addictions services: monitoring and advocacy report of the MH Commissioner* (HDC, 2018) MoH section 99 inspection (Crawshaw etal, 2016) and the independent Facilities Infrastructure Review (Fjeldsoe etal, 2015).
- ✓ We will work closely with other key transformation projects that are under way.

- ✓ We will engage early and consistently with the Ministry of Health to make sure that the key elements of the best interests of people we serve are designed into any potential solution, from the outset.
- ✓ We will work closely with Central Agencies through the review process and through regular briefings with updates to key stakeholders and monitoring agencies.
- ✓ We will communicate widely and take account of the communication needs, advice required and journey that needs to be taken hand-in-hand with the sector.

6. Programme tolerances

All products produced by the programme will be peer reviewed and quality checked by the Creating Our Futures Steering Group.

All Products	**Cost**	To be determined
	Time	+/- 1 month
	Quality	Stakeholder engagement
	Scope	Waikato DHB Mental Health and Addictions service
	Financial	Programme Business Case
	Risks	Risks and issues to be included in project server site and escalated to the project director via the programme manager

7. Risks and issues

7.1. Known risks faced by the programme

The following risks for the programme business case have been noted:

#	Risk Description	Mitigation / Comment	Likelihood	Impact
1.	The absence of dedicated resources (project, clinical input and working groups) impacts on the achievement of the investment objects	Secure dedicated additional resources within PBC.	L	H
2.	New model of care does not bring about transformational change	Transformational change processes are evaluated and monitored. Continued use of co-design in propose / initiate / plan / develop phases.	M	H
3.	Not managing BAU alongside the change programme	Monitoring for alignment with BAU risk within service 30, 60, 90 plan/s.	H	H
4.	Changes to health and social policy at a national level, impact on MH&AS service delivery	Engage and influence policy proposals. Remain focussed on provision of holistic service user centred care.	H	H
5.	Loss of key personnel during the life of the programme (5 years)	Flexible working conditions, mentoring and leadership development opportunities, skill development, good sequencing and documentation management.	L	H
6.	Challenges and breakdown in key stakeholder confidence and collaboration in the change programme	Engage key stakeholders in co-design in an emotion and intelligent way (trust, integrity and honesty)	M	H
7.	Failure of Strategy and Funding to deliver early intervention services.	Ensure funding targeted to the provision of early intervention services in the community and where possible alignment with social sector initiatives.	H	H
8.	Inability to provide a culturally responsive service.	Implementation of a parallel Māori model of care into services. Advocate and lobby for change at a national level, reducing stigma, locally, regionally	L	H

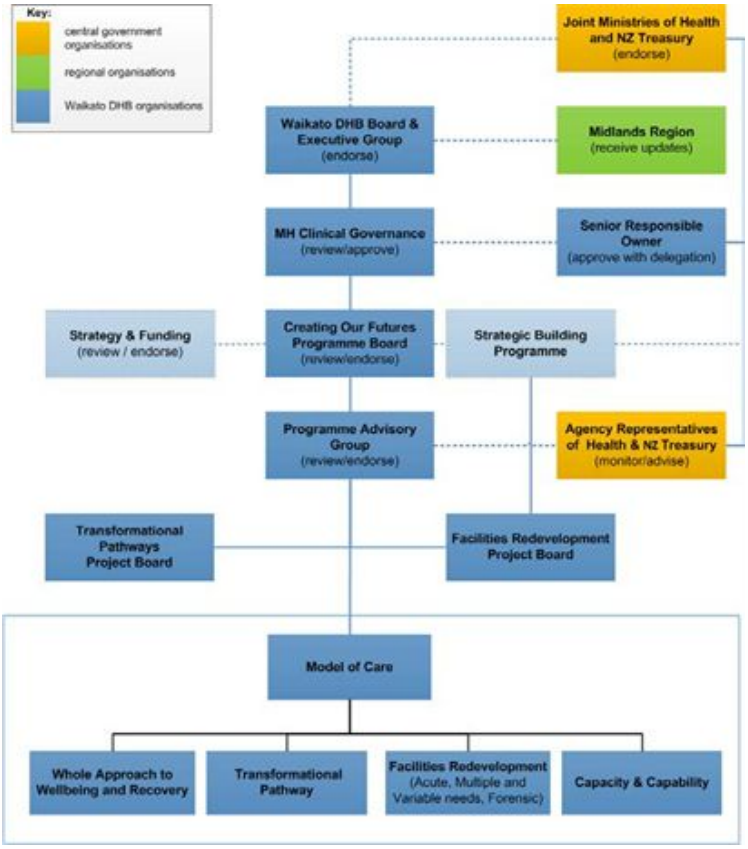
		and nationally.		
9.	Inability of the wider sector to understand and support the implementation of the model of care	Opportunities for ongoing education, support, communication, partnerships, engagement for all.	M	H

7.2. Known issues faced by the programme

The Creating Our Futures programme acknowledges that this is a complex programme that requires tight management over a long period of time. There are significant timeline interdependencies with the NZ Corrections Capacity programme, and the mix of facility redevelopment carries significant delivery risk that requires specific monitoring.

8. Programme structure and responsibilities

The following programme structure chart depicts the proposed structure for the governance of the programme, defining the levels of responsibility and approval, communication channels and roles and responsibilities.



Roles	Name
Programme Sponsor	Derek Wright, Waikato DHB Interim Chief Executive
Programme Executive	Vicki Aitken, MH&AS Interim Executive Director
Senior Users	Dr Rees Tapsell, MH&AS Director of Clinical Services
Senior Suppliers	Ian Wolsterncroft, SPO Executive Director (infrastructure)
Senior Suppliers	Trish Smith (MoH); Davin Hall (NZ TSY); Emily Irwin (NZ TSY)
Programme Director	Dr Virginia Endres

Roles	Responsibility
Programme Executive	The Executive for this project will be the Senior Responsible Owner, who is ultimately responsible for the project namely, the business case development process; delivery of the project, and the realisation of the benefits. The Senior Responsible Owner, supported by the Senior Supplier and Senior User and the Ministry of Health and NZ Treasury representatives, will have responsibility to make decisions affecting progress. The Executive will ensure that the programme gives value for money, ensures a cost-conscious approach to the programme and mix of projects, and balances the demands of the programme with expectations of the Ministry of Health and NZ Treasury, and the Board.
Senior Users	The Programme Senior User represents the interest of Waikato DHB Mental Health and Addictions service
Senior Suppliers	The Senior Supplier (internal) represents the interests of the Strategic Building Programme of work. The Senior Supplier (external) represents the interests of Ministry of Health, Treasury and other external consultants.
Programme Advisory Group	The Programme Advisory Group representatives are the Waikato DHB senior user and clinical directors, operations and project managers, who are responsible to develop and deliver project product; ensuring a co-design approach to the project The Programme Steering Group will approve the project plan and authorise any major deviation from agreed stage plan
Programme Business Case Team	The programme business case programme team prime responsibility is to ensure that the programme and projects produces the required products to the required standard of quality and within the specified constraints of time and cost. The project director is also responsible for the programme producing a result that is capable of achieving the benefits defined in the Detailed Business Case.
Programme & Project Team	The programme team prime responsibility is to ensure that the Creating Our Futures programme and projects produces the required products to the required standard of quality and within the specified constraints of time and cost.

9. Outline plan and approach

The key milestones for the programme business case are outlined below:

Proposed key milestones	Estimated timing
Discovery and Indicative	Jan 2017 – Apr 2018
Programme Business Case	May 2017 – Mar 2018
Indicative Business Case (Facilities Redevelopment Project)	Jan 2018 – May 2018
Single Stage Business Case (Transformational Pathway Project)	Apr 2018 – Sept 2018
Transformation System Changes	Jan 2018 – Jan 2020
Detailed Business Case (Facilities Redevelopment Project)	May 2018 – Sept 2018
Stage 1 Facilities Implementation	May 2018 – Dec 2021
Continuous Improvement	Jan 2017 – Dec 2020
Stage 2 Facilities Implementation	Jan 2021 – Dec 2022
PIR and Continuous Improvement	Jan 2021 – ongoing

9.1. Estimate of programme duration

The estimated duration of the programme months from 2016 to 2023.

9.2. Approach

The programme is to be delivered three stages (tranches) over a five year period to enable MH&AS to meet the delivery objectives while ensuring minimal disruption to BAU. MH&AS is taking a steady, incremental approach where all significant products and initiatives will fully tested before going live with appropriate assurance (including independent quality assurance where appropriate) in place.

a) Discovery and Indicative

b) Design, Planning and Delivery Transformation System Changes; and, Stage 1 MH Acute Inpatient Facilities Design, Planning and Delivery;

c) Continuous improvement and Stage 2 Facilities Planning and Delivery

Between October 2016 and December 2017 the programme focused on understanding the *problem* and discovery of solutions that can be delivered through a series of workshops.

- Care Coordination
- Culture and Values
- Leadership
- Profession Practice
- Productivity

Significant progress has been made on the discovery phase, where implementation plans have been developed for 30, 60, and 90 DAY management and monitoring. Note alongside this work effort, input into cultural responsive has been ongoing and continues to be weaved through all project deliverables.

The second tranche focuses on solutions that can be delivered in 2018 / 2020 and includes:

- refocusing of service delivery to provide integration and collective impact across the social and health sector
- mental health and addictions quality improvement initiatives
- initiating the acute Mental Health facilities solution
- implementing the Professional Practice workforce strategy, cultural responsiveness and best practice informed care
- implementing the required changes to achieve care coordination

Delivery of the third tranche starts in 2021. It builds on enhancing the first tranche ensuring sustainability and quality improvement cycles; and, includes Puawai; and, Multiple and Variable needs facilities solution delivery.

9.3. Configuration management

All documents will be maintained within the MH&AS folder structure:

- All approved documents will be scanned and maintained within the Strategic Projects Office and Creating Our Futures programme server sites.
- Hardcopy/s of the approved documents will be maintained by the Creating Our Futures programme office.
- Version control will be applied to all key work package documentation as per Waikato DHB document version control.

9.4. Interfaces

9.4.1. Interfaces for the completed product/s

Close alignment is required across the agreed duration of the programme with:

- All projects within the Waikato DHB programme of work to ensure phasing and scheduling of business case development is acceptable and appropriate.
- Close alliance with Property and Infrastructure.
- Regular contact with Mental Health and Addictions clinical services, work groups and managers to ensure planning is appropriate, timely and suited to clinical requirements as relevant.
- Close alliance with Media and Communications to ensure timely and appropriate communication is maintained throughout the duration of the project.

9.4.2. Interfaces maintained during the work

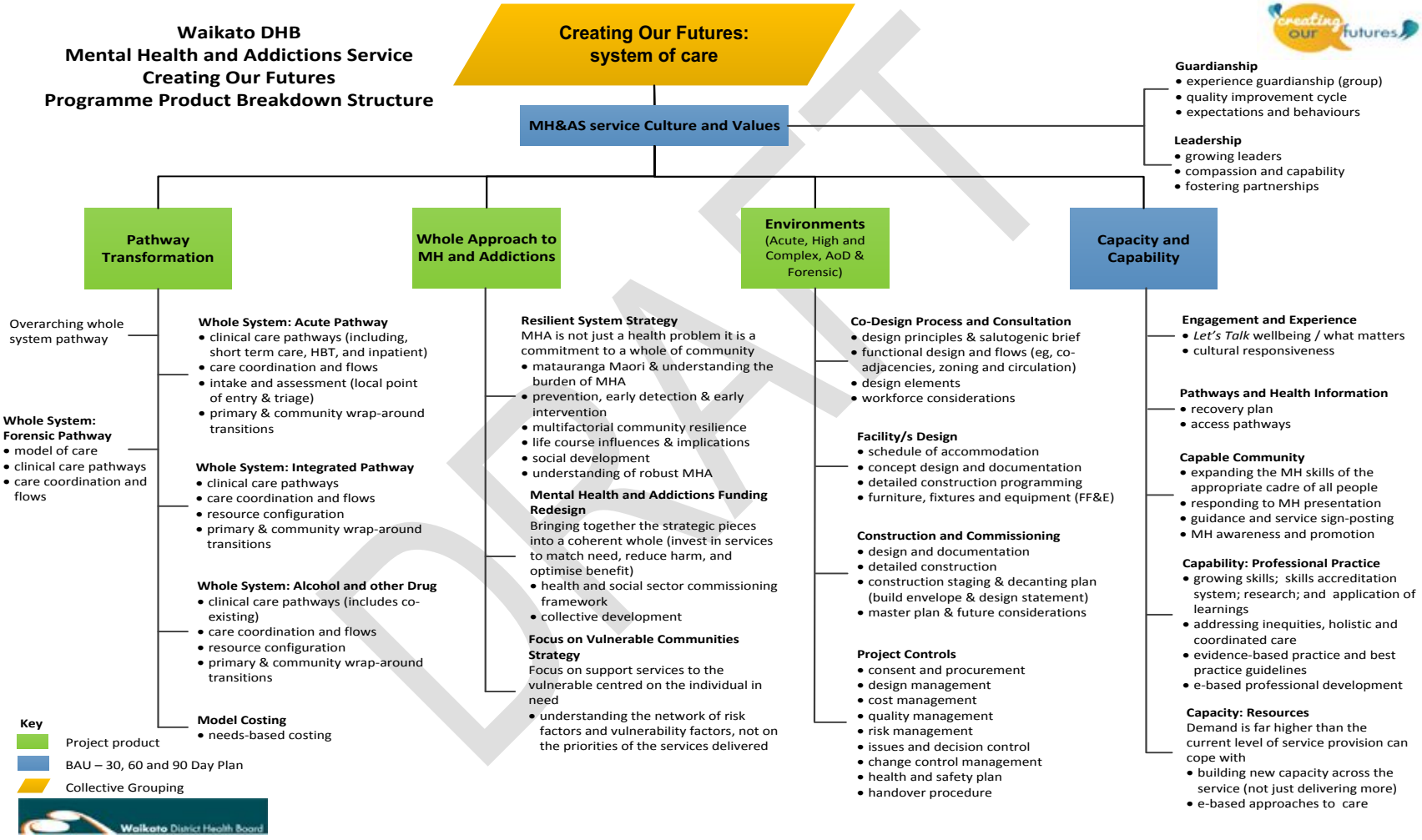
Close alignment is required across the agreed duration of the project with:

- Required input from the business, Waikato DHB MH&AS service, Planning and Funding, Property and Infrastructure. These teams will have to work closely together to achieve the required outcomes.
- Appropriate resources are required to be available from within Waikato DHB MH&AS service to support the business case development and confirm that requirements have been met.
- Waikato DHB Change Team
- Property and Infrastructure management of the procurement process, including EOI, RFP, functional design, concept planning processes.
- Outsourced resources that will support the ILM.
- Outsourced resources that will support the peer review of the documentation prior to submission to NZ Treasury and Ministry of Health.

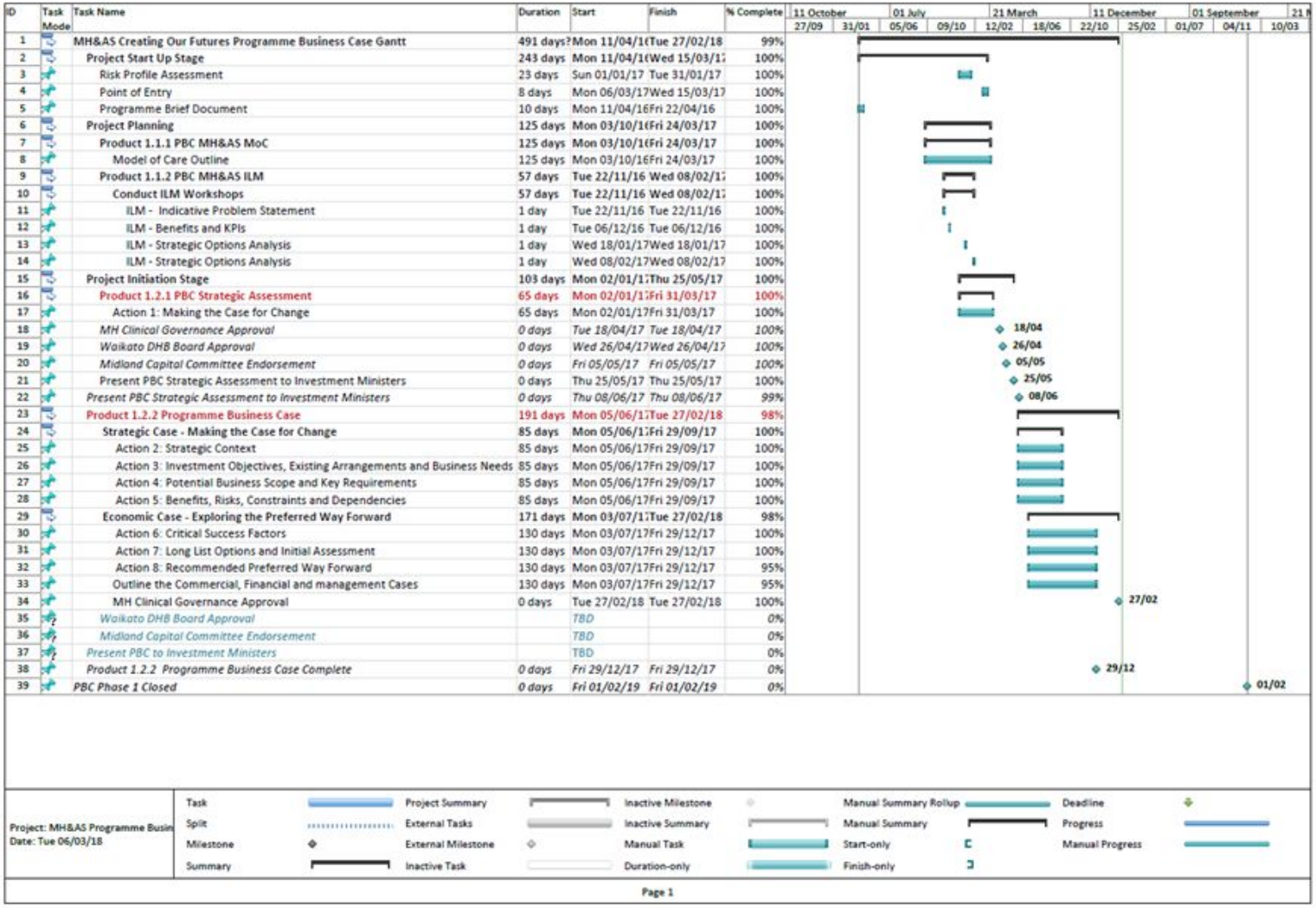
10. Associated documents or products

Document or product	Location	Reference information
Investment Logic Map (ILM)	ILM-MH&AS v0.7 VE.pptx	Investment Logic Mapping (ILM) is a technique to ensure that robust discussion and thinking is done up-front, resulting in a sound problem definition, before solutions are identified and before any investment decision is made. It is a technique to ensure the 'story' about any proposed investment makes sense (the 'logic' part of ILM) and to test and confirm that the rationale for a proposed investment is evidence-based and sufficiently compelling to convince decision makers to commit to invest in further investigation and planning.
Model of Care	COF_MoC_v2.pdf	A *Model of Care* broadly defines the way services are delivered. It outlines best practice care and services for a service user and their whānau as they progress through the journey of care.
Strategic Assessment	20170525 BBC Waikato DHB MH&AS	The Strategic Assessment outlines the initial justification for the need to invest in change and is used to support a recommendation to proceed to further business case development. It is the first step in the business case framework. The Strategic Assessment is intended to provide decision makers with a high degree of confidence that the investment they are considering aligns with strategic intentions and responds to a true business need - the Think phase of the investment management lifecycle.
Programme Business Case (draft)	bbc-prgbus- Creating Our Futures v0.02.dc	The Programme Business Case provides decision makers with an early indication of the preferred way forward for high value and/or high risk investment proposals and provides the senior responsible officer with early certainty. The Programme Business Case typically follows from the Strategic Assessment, which justified the need to change.
Engagement and Communication		A programme objective is to create transparency at the outset and to engage key stakeholders in the development of the programme.

10.1. Products Chart



10.2. Programme Business Case Gantt Chart



ID	Task Mode	Task Name	Duration	Start	Finish	% Complete
1		MH&AS Creating Our Futures Programme Business Case Gantt	491 days?	Mon 11/04/16	Tue 27/02/18	99%
2		Project Start Up Stage	243 days	Mon 11/04/16	Wed 15/03/17	100%
3		Risk Profile Assessment	23 days	Sun 01/01/17	Tue 31/01/17	100%
4		Point of Entry	8 days	Mon 06/03/17	Wed 15/03/17	100%
5		Programme Brief Document	10 days	Mon 11/04/16	Fri 22/04/16	100%
6		Project Planning	125 days	Mon 03/10/16	Fri 24/03/17	100%
7		Product 1.1.1 PBC MH&AS MoC	125 days	Mon 03/10/16	Fri 24/03/17	100%
8		Model of Care Outline	125 days	Mon 03/10/16	Fri 24/03/17	100%
9		Product 1.1.2 PBC MH&AS ILM	57 days	Tue 22/11/16	Wed 08/02/17	100%
10		Conduct ILM Workshops	57 days	Tue 22/11/16	Wed 08/02/17	100%
11		ILM - Indicative Problem Statement	1 day	Tue 22/11/16	Tue 22/11/16	100%
12		ILM - Benefits and KPIs	1 day	Tue 06/12/16	Tue 06/12/16	100%
13		ILM - Strategic Options Analysis	1 day	Wed 18/01/17	Wed 18/01/17	100%
14		ILM - Strategic Options Analysis	1 day	Wed 08/02/17	Wed 08/02/17	100%
15		Project Initiation Stage	103 days	Mon 02/01/17	Thu 25/05/17	100%
16		Product 1.2.1 PBC Strategic Assessment	65 days	Mon 02/01/17	Fri 31/03/17	100%
17		Action 1: Making the Case for Change	65 days	Mon 02/01/17	Fri 31/03/17	100%
18		*MH Clinical Governance Approval*	*0 days*	*Tue 18/04/17*	*Tue 18/04/17*	*100%*
19		*Waikato DHB Board Approval*	*0 days*	*Wed 26/04/17*	*Wed 26/04/17*	*100%*
20		*Midland Capital Committee Endorsement*	*0 days*	*Fri 05/05/17*	*Fri 05/05/17*	*100%*
21		Present PBC Strategic Assessment to Investment Ministers	0 days	Thu 25/05/17	Thu 25/05/17	100%
22		*Present PBC Strategic Assessment to Investment Ministers*	*0 days*	*Thu 08/06/17*	*Thu 08/06/17*	*99%*
23		Product 1.2.2 Programme Business Case	191 days	Mon 05/06/17	Tue 27/02/18	98%
24		Strategic Case - Making the Case for Change	85 days	Mon 05/06/17	Fri 29/09/17	100%
25		Action 2: Strategic Context	85 days	Mon 05/06/17	Fri 29/09/17	100%
26		Action 3: Investment Objectives, Existing Arrangements and Business Needs	85 days	Mon 05/06/17	Fri 29/09/17	100%
27		Action 4: Potential Business Scope and Key Requirements	85 days	Mon 05/06/17	Fri 29/09/17	100%
28		Action 5: Benefits, Risks, Constraints and Dependencies	85 days	Mon 05/06/17	Fri 29/09/17	100%
29		Economic Case - Exploring the Preferred Way Forward	171 days	Mon 03/07/17	Tue 27/02/18	98%
30		Action 6: Critical Success Factors	130 days	Mon 03/07/17	Fri 29/12/17	100%
31		Action 7: Long List Options and Initial Assessment	130 days	Mon 03/07/17	Fri 29/12/17	100%
32		Action 8: Recommended Preferred Way Forward	130 days	Mon 03/07/17	Fri 29/12/17	95%
33		Outline the Commercial, Financial and management Cases	130 days	Mon 03/07/17	Fri 29/12/17	95%
34		MH Clinical Governance Approval	0 days	Tue 27/02/18	Tue 27/02/18	100%
35		*Waikato DHB Board Approval*		*TBD*		*0%*
36		*Midland Capital Committee Endorsement*		*TBD*		*0%*
37		*Present PBC to Investment Ministers*		TBD		0%
38		*Product 1.2.2 Programme Business Case Complete*	*0 days*	*Fri 29/12/17*	*Fri 29/12/17*	*0%*
39		*PBC Phase 1 Closed*	*0 days*	*Fri 01/02/19*	*Fri 01/02/19*	*0%*

Annex Five: Communication and Engagement Strategy

Waikato District Health Board

Mental Health and Addictions Service:

Creating Our Futures Programme

Stakeholder Communication & Engagement Strategy

Purpose The purpose of this document is to provide an overview of the Stakeholder and Community Engagement Strategy

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Author	G O'Brien
Last Updated	14 03 2018
Document Name	MH&AS Creating Our Futures Programme Communications & Engagement Strategy
Version	0.09 (Final)

Revision History

Date	Author	Summary of Changes	Version
06/09/2017	G O'Brien	Edits	v.04
15/09/2017	G O'Brien	Updated with advisory group and other feedback	v.04
17/01/18	G O'Brien	Review to include Engagement	v.05
08/03/18	G O'Brien	Redacted version	v.06
12/03/18	G O'Brien	Feedback from K. Jenkin and J Ashman	v.07
12/03/18	G O'Brien	Project Director Edits	v.08
14/03/18	G O'Brien	Final	v.09

Distribution

Name	Title	Issue Date	Version
Dr Virginia Endres	Project Director	15 03 18	v.09

Approvals

Approver	Signature	Issue Date	Version
Vicki Aitken Executive Director (Interim) Mental Health & Addiction Services		V15 03 18	v.09

Table of Contents

1. Background

Over the past 20 years (since deinstitutionalisation), Waikato DHB has evolved its model of care to enable most of mental health services to be delivered in the community, in line with national and regional mental health strategies. Several of the aforementioned reviews found evidence of improved service delivery over time. However, with the growing number of people accessing services for mental health and addiction issues, the MH&AS service is under pressure and there is increasing potential for unmet need. Often services are available to people only once their condition deteriorates, and the dominant treatment option (medication and therapy) do not address the broader social factors that help people be well and support recovery.

Action is required to relieve pressure on existing mental health and addictions service. The '*Let's Talk' what matters* is an engagement with our community is currently underway. The rich information gathered through our engagement process will be used to inform the way mental health and addictions is deliver in the future, as more of the same will not deliver the wellbeing and recovery-oriented system that is required.

1.1. Iwi Māori Council

To ensure our *Let's Talk* process enables engagement with Māori, the programme received advice from Waikato DHB Iwi Māori Council in 2017. The council recommended five priority localities:

- North Waikato
- Hauraki
- Raukawa
- Maniapoto
- Ruapehu

The council also raised the importance of a shared collaborative approach between the COF programme; Strategy and Funding Te Pae Tawhiti project; Te Puna Oranga; and, Māori service providers in these localities: as a means of ensuring the voices of Māori are captured.

1.2. Engagement Purpose

The focus of the *Let's Talk* engagement process is to offers the opportunity for our Waikato community to have a voice in guiding the change direction. The goals include:

- engage our community by fostering opportunities that reduce stigma and share concerns for the common good
- harness the voices of our community to improve processes and services
- improve our ability to share information and collective impact

Engagement will run from December 2017 through to June 2018.

2. Approach

The Creating Our Futures programme is embracing a human centred co-design approach. Community hui/forums will be provided both face-to-face and alternative options for people unable to attend these hui, through electronic links to discuss and identify local issues and provide input to shape solutions for service improvement.

2.1. Communications Action Plan

An action plan is developed to guide these aspects of the projects. This plan will specify the communication actions designed to reach maximum impact with our communities.

The MH&AS service will work with people in all communities to ensure the most appropriate methods for communication are used and follow the lead of the local service providers to ensure our messages reach Māori, the people we serve, their whānau and the wider community. The action plan is one of the key enabling strategies to achieve successful communications and community engagement.

2.2. Work Package

The work package identifies the tasks and actions to be undertaken, the management of risks and issues, show the monitoring and evaluation framework and identify specific responsibilities of the programme team and the MH&AS service. Work packages are the smallest unit of work that a project can be broken down to and they are used to develop the work breakdown structure.

2.3. Engagement Steering Group

An engagement steering group has been established to oversee the development; implementation and monitoring of the engagement phase and provide coordination between the parallel MH&A service improvement projects.

Membership will include representation from:

- Media and Communications
- Te Puna Oranga Māori Health Services
- Waikato DHB Strategy & Funding
- The Creating our Futures programme team
- Service provider representatives will be co-opted to support planning and decision-making for their community hui

Terms of Reference of the Engagement Steering Group have been developed and demonstrate their specific role and responsibilities as guardians of the engagement process.

2.1. Service Provider Guidelines

The MH&AS service will engage with local service providers as partners in the planning and execution of local engagement hui. This partnership is necessary to gain valuable input to the respective community approaches for engaging with Māori and wider stakeholder networks. The partnership will also agree on the method for local engagement, venue, catering follow up hui and other joint decisions to ensure a successful outcome.

3. Outcomes

Embracing a human centred co-design approach means believing that all problems are solvable. The outcome will be to maintain a belief that if we stay grounded in what we have learned from people, we will arrive at solutions that meet our community needs and aspirations.

4. Levels of Interaction and Communication

As part of the project a communication and consultation plan will be developed to facilitate a robust process that will engage and deliver key messages to people internally and externally and to the wider general public within our Waikato community. The communication and consultation plan detail will be developed before initiation of each tranche.

The goal of communication is to create transparency at the outset regarding:
- the specific deliverables
- expectations about what can and cannot be achieved or influenced
- the constraints or boundaries within which Waikato DHB is operating
- the level of commitment that is being asked from employees and key stakeholders.

The specific underpinning communication principles include: **consistent messages, raising awareness and promoting engagement**. Specifically:
- Provide the platform to share information with internal and external stakeholders and our Waikato community, to create an atmosphere that promotes the free exchange of ideas and welcomes feedback
- Connect with stakeholders in a way that enables them to express any concerns, make suggestions, and raise queries
- Deliver communication in a timely (early point possible) and consistent manner that is in a form that allows different audiences to understand and connect with the subject, its significance and its likely outcomes
- Use a range of communication media, modes and channels to maximise audience engagement.
- Demonstrate an ongoing commitment and remain accountable to keep delivering regular updates and outcomes on decisions to all stakeholders
- Evaluate the engagement and consultation processes on an ongoing basis so lessons can be learned along the way - what did, and did not work well - to inform future consultation

- To meet agency and government requirements.

Ongoing involvement, communication and engagement will be required with all three categories with intensity of interaction being higher with those involved in the co-design groups. Methods include regular meetings and updates, participation in engagement actions, quarterly updates, and Waikato DHB website.

Actions	Method	Frequency
Keep informed and monitor awareness • Associated Government Departments, ACC Dept. of Corrections MSD etc., • Waikato Community	Newsletters, programme updates, Waikato DHB website www.waikatodhb.health.nz/letstalkmentalhealth	Quarterly, as required
Keep satisfied and engaged • Ministry of Health • Waikato DHB staff and associated services • Health Sector Groups – local, regional, national • Community Partners and significant other organisations • Suppliers	Programme Updates, Face to face contact, Direct contact with Project Director, Waikato DHB website www.waikatodhb.health.nz/letstalkmentalhealth	Minimum quarterly, or as required
Engage Closely & Human Centred Co-design • Waikato community; • Waikato DHB staff directly affected; • Non-Government Organisations; • Community Resources	Face to face Email updates Waikato DHB website www.waikatodhb.health.nz/letstalkmentalhealth	Routinely as required.

As part of the project a communication and consultation plan will be developed to facilitate a robust process that will engage and deliver key messages to people internally and externally and to the wider general public within our Waikato community. The communication and consultation plan detail will be developed before initiation of each tranche.

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- Use a range of communication media, modes and channels to maximise audience engagement.
- Demonstrate an ongoing commitment and remain accountable to keep delivering regular updates and outcomes on decisions to all stakeholders
- Evaluate the engagement and consultation processes on an ongoing basis so lessons can be learned along the way - what did, and did not work well - to inform future consultation
- To meet agency and government requirements.

5. Monitoring

Ongoing stakeholder engagement will be monitored and measured in the following ways:

a. evidence of a stakeholder analysis of communities directly / indirectly affected by the project (ongoing engagement is evident in the record of engagement)
b. evidence that consultation occurred early and throughout to facilitate meaningful co-design
c. evidence that consultation was based on adequate and relevant information (inclusive and culturally appropriate
d. evidence that consultation feedback has been considered and incorporate

An ongoing engagement schedule and record of activities will be maintained.

6. Follow-up Processes

Information gathered will be presented to the Creating our Futures Advisory Group, programme governance and approval processed as appropriate. In addition, the output of stakeholder involvement will to be communicated.

Internal & External

- Briefings to relevant groups
- Final Programme Indicative Business Case to be circulated to key clinical / professional / managerial leaders across the health and social system.
- Key programme points to be posted on the intranet.
- A synopsis and/or full final Creating Our Futures Indicative Business Case to be distributed to key stakeholders (including, Waikato DHB, Midlands DHBs, Ministry of Health and NZ Treasury

Community

- Briefings to relevant groups
- A synopsis and/or full final Creating Our Futures Indicative Business Case to key advocacy and other groups;

- Key points of Creating Our Futures programme on website;
- Post timeframes for ongoing programme development;

7. Communication Risks and Issues

Risks / Issues		
Issue description	**Action**	**Priority**
Staff/service reluctance to invest time	With existing workloads in many service areas already stretched, ensuring our staff invest time to this project is vital. • emphasis on highlighting the significant longer-term benefits of the programme will be stressed • support for releasing time for projects and engagement will be provided	**High**
Media	Possibility of misunderstanding the problems and proposed consequences and changes, and inaccurate information being portrayed and disseminated by media. Establishment of an Engagement Steering Group to advise and monitor programme/project media releases. The project and programme will partner with Waikato DHB communications to manage key messages.	High
Lack of innovative thinking	Our aim is to develop an innovative service delivery model that brings about change. We will provide a number of different workshop sessions and will draw on the 'creative thinking' exercises to support participants' thinking.	Med
Engagement	We plan to engage wide and deep in communities. Engaging with Māori will be a priority and we will work with local Māori service providers to maximise engagement opportunities with them and through their networks. Online surveys will be available to support engagement for people unable to attend community hui/meetings. Real Time Feedback data highlighting service user and family/whānau service experience feedback will be used alongside engagement, focus groups and survey information to identify opportunities for improvements. The communication plan will identify the KPIs to monitor engagement.	Med
Expectations	It is important expectations are not raised unrealistically and that the type of engagement is relevant for the respective stakeholder. Ongoing monitoring of evaluation and feedback on processes will be used to identify and manage any risk.	Med
Slippage in project time	The activities in the communication and engagement plans are dependent on the product deliverables – any slippage in time -/+ may impact on the delivery of communication and engagement priorities. We will develop the communication and engagement schedules in planned phases.	Low
Service Co-design	The service has experience in service co-design which was used for the refurbishment of the HRBC Forensic Inpatient Service and Making it Happen Work Stream Development Reports and Implementation plans. Engagement timeframes may be underestimated, and management of expectations is required. Site visits to local and national facilities will be undertaken to understand the design and co-design process lessons learned.	Low
Confusion	We have a number of initiatives underway to develop models of care (each with a different purpose); and a number of work streams aligned to the Creating Our Futures Programme. We will ensure people are clear with the focus of this project and how it	Low

Risks / Issues		
Issue description	**Action**	**Priority**
	aligns with other initiatives. • Strategy and Funding – Te Pae Tawhiti - models of care • MH&AS – BBC project and model of care • BOP – building relocation project • MH&AS Creating Our Futures programme and work streams • HRBC improvement evaluation	

8. Associated documents or products

Document or product	Location	Reference information
Model of Care	COF_MoC_v2.pdf	A *Model of Care* broadly defines the way services are delivered. It outlines best practice care and services for a service user and their whānau as they progress through the journey of care.
Programme Brief	MH Programme Brief v0.02.doc	To define the programme, to form the basis of its management and assessment of overall success. The Programme Brief gives direction and scope of the mix of projects.
Engagement Work Package	2018 03 14 Joint Engagement Work Pa	To define the approaches and tasks to achieve the objectives of engagement with Waikato DHB communities
Communications Action Plan	2018 03 14 Communications Actic	To define approach to providing stakeholders with information, who should be given specific information, when that information should be delivered and what communication channels will be used to deliver the information.
Data Management Protocol	2018 03 14 Data Management Protoco	To define the approach to the management and security of data/information collected from the engagement process
Engagement Steering Group Terms of Reference	2018 03 14 Engagement Steering	This document describes the Terms of Reference for the Te Pae Tawhiti and Creating our Futures Joint Improvement Projects Engagement Steering Group
Provider Guidelines Document	2018 03 14 Provider Guidelines.docx	The purpose of this document is to provide an overview of the guidelines for provider input to engagement hui.

9. Project communication plan

Interested parties	Information required	Information provider	Frequency of communication	Method of communication	Outputs
Waikato DHB Board	Update of project and business case activities and status Escalation of project issues	Project Executive	Monthly, or as required	Written	Highlight report and exception reporting Programme Board executive minutes
Project Executive Group - Project Executive - Project Senior Supplier - Project Senior User	Update of project and business case activities and status Update of project deliverables and milestones Management and escalation of project risks and issues	Project Manager – Business Case Writer	Monthly, or as required	Written, email	Highlight report and exception reporting
Creating Our Futures Programme Board MH Clinical Governance Forum	Update of project and business case activities and status Management and escalation of project risks and issues Awareness and understanding of the project products	Project Manager – Business Case Writer	Monthly, or as required	Written	Highlight report and exception reporting
Project Steering Group and Project Team	Update of project and business case activities and status Update of project plan Update on operational and implementation changes in supply models	Project Manager Business Case Writer / Facilities	Fortnightly	Face-to-Face, Written, and email	GANTT Meeting Minutes Products
Staff	Project updates	Project Steering Group members	As required	Written, face-to-face	Memorandum, newsletter, email, presentation

Annex Six: Programme Business Case 1 Pager

Programme Business Case

NZ Treasury 24 February 2014

Strategic Case:

Need to Invest

Over recent years demand for mental health and addictions services has increased in terms of numbers, acuity and complexity of need. The need to transform the way the service does things is necessary to ensure safe, effective and efficient service delivery without compromising outcomes for service users and their whanau, and staff now and into the future.

Strategic Context

The Waikato DHB MH&AS service has responsibility for ensuring service access to the top three percent of the population who are most severely affected by mental illness.

- Adult MH&A services.
- Specialty services and Integrated Care Coordination services.
- MH Services for Older People.
- Regional Forensic services.

The need to transform the way the service does things is necessary to ensure a sustainable health and social system that is characterised by more convenience, better outcomes, higher quality, better value, and greater performance that could ever be achieved under the current system.

Objective 1	***To transform service delivery in order to improve safety, effectiveness and efficiency***
Existing arrangements	Growing numbers of Waikato people are accessing health services for mental health and addictions issues, MH&AS is under pressure. Often services are reactive and available to people only once their condition deteriorates, and the dominant treatment option (medication and therapy) do not address the broader social factors that help people be well and support their recovery.
Business Needs	Broaden the focus of service delivery from mental illness and addiction to mental well-being and recovery. Improve the quality of mental health and addiction services, supported by evidence based practice and information about changing levels of need. Improve access [*front gate*] to early intervention before the impacts of mental health and addictions reach a more severe stage.
Objective 2	***To create safe and therapeutic environments that support holistic care at all times.***
Existing arrangements	HRBC footprint is out-dated and is out-dated and is based on institutional design, significant deficiencies; include lack of space and privacy, natural lighting, congestion, ventilation. Institutional layout is inflexible and unable to support interventions and future demand.
Business Needs	Contemporary fit-for-purpose inpatient facilities, with the necessary therapeutic space to manage and deliver holistic care. Spaces that are modular and flexible in order to meeting changing demand, needs and values now into the future. Health Professionals have the necessary space to manage clinical risk, safety and de-escalation, and appropriate co-location, freeing up time to enable staff to focus on care.
Objective 3	***To build sustainable capacity and capability of services to meet future demand***
Existing arrangements	Increasing demand and zero growth in resources (eg, people and funding) which threatens access to services for mental health and addictions issues. Services are under pressure and there is a potential for many needs are being unmet.
Business Needs	Implement a workforce strategy that enables the service and the broader sector to deliver better, more accessible services. Achieve change through collaborative leadership, supported by transparent outcome information.

Economic Case:

Programme Option Identification and Assessment

Dimension of Choice:	Potential Programme Choices by Dimension						
	Status Quo						
Scope: *what levels of service and coverage are possible?*	*Waikato DHB MH&AS*	Acute Mental Health	Addiction services	MH Services for Older People	Multiple and Variable needs	Regional prison muster	
Service Solution: *How can services be delivered?*	*Key Worker / IPC (partial) Model*	Inter-sectorial Fully Integrated Care Model	Multi-Community Providers (MCP)	Primary & Acute Care Systems (PACs)	Wrap Around Reach	Urgent & Emergency Care	Acute Care Collaboration
Service Delivery: *Who can help us?*	*Waikato DHB MH&AS & Regional Forensic*	Out-sourced (PHOs, NGOs and providers)	Out-source - NZ Corrections	Midlands DHB joint ventures	Auckland DHB joint venture		
Implementation: *When can services be delivered?*	*n/a*	Big Bang service transformation and capital infrastructure implementation	Agile service delivery model transformation and phased capital infrastructure implementation	Agile service delivery model transformation and deferred capital infrastructure			
Funding: *How can it be funded?*	*n/a*	Waikato DHB free cash flow	Waikato DHB capital growth funded	Crown funded debt			

The Preferred Programme:
Insert a description of the preferred programme. List the project mix that will achieve the investment objectives and service requirements, yet lie within the boundaries of the scope parameters and critical success factors identified for the preferred programme

Financial Case:

Indicative Programme costs

Tranche	Total tranche costs over period
1	
2	
3	
Total estimated	**$100 - $200m**

Affordability and Funding:
Affordability remains a significant issue for Waikato DHB given the current funding outlook. However, the alternative of no investment in these services would have an ongoing significant negative impact on access to services, clinical risk and service user safety and outcomes, as well as on the broader Waikato community health system and population health. Given the nature of MH&AS and issues with current facilities, the driver for the investment is clinical need rather than financial return.

Commercial Case:

The Potential Strategy:
By transforming the way in which services are organised, and how they integrate with primary care, the service can realise the benefits of improved service user flow, improved ability to deliver more effective evidenced based care, improved service user and staff safety will result in increased efficiency of service delivery. At this early stage conventional procurement has been identified as a possible procurement option for the capital infrastructure change (Waikato DHB manages the design and construction of the new facility/s and delivers clinical and non-clinical and facilities management services in-house).

Management Case: Delivery by Tranche

Tranche One:
Discovery and Indicative

Tranche Two:
Transformation system changes and Stage 1 Facilities

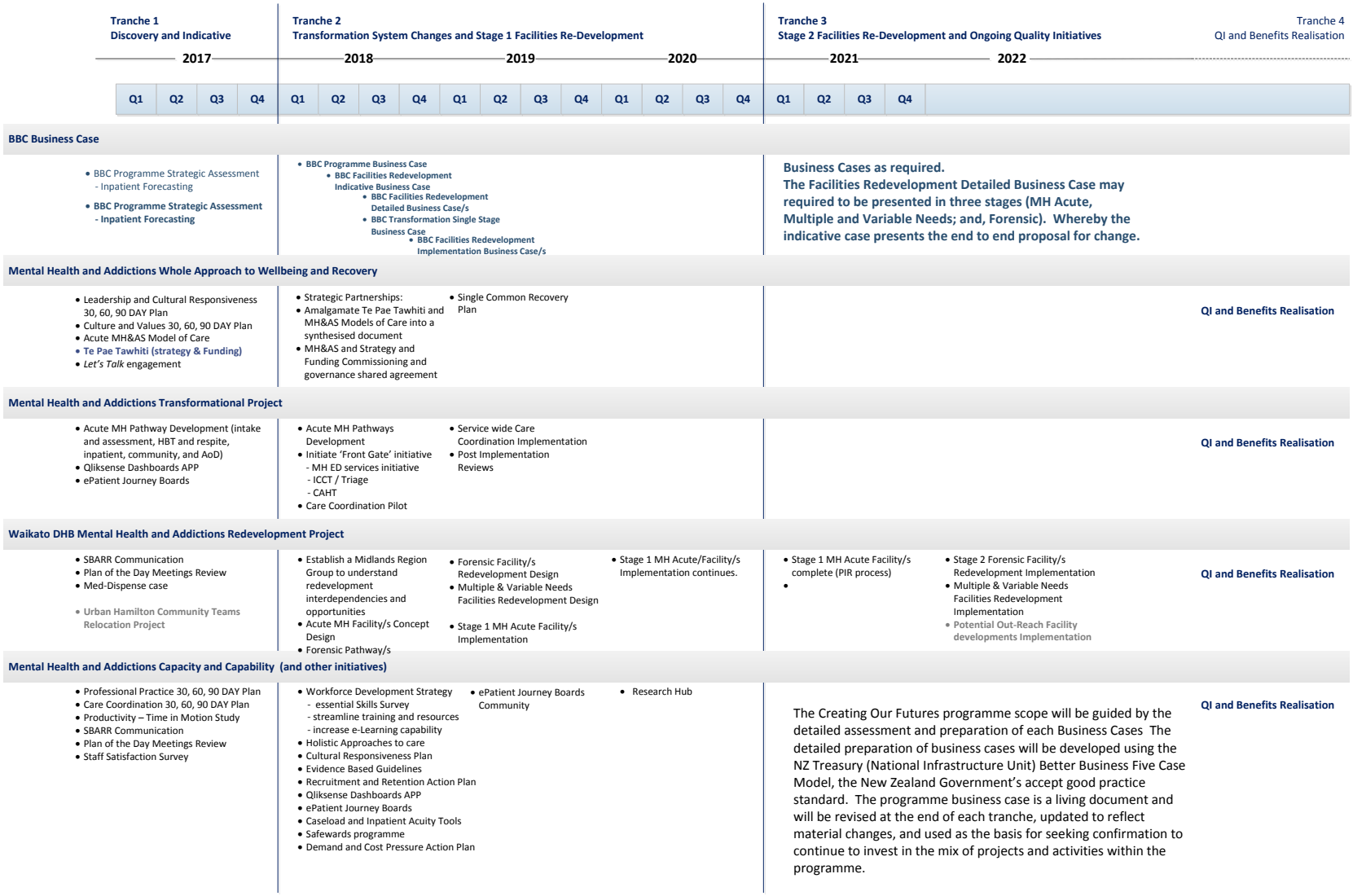
Tranche Three:
Stage 2 Facilities and ongoing Quality Improvements

Tranche Four:
Benefits realisation and ongoing Quality Improvements

Achievability:
Under the overall governance structure for the CoF programme, MH&AS service will manage the completion of the mix of business cases and the implementation of the new Model of Care using the project methodology PRINCE2. A Programme Board has been established to provide programme governance and control over the mix of projects. Project wok teams will comprise of key stakeholders to achieve a co-design approach and buy-in, accurate information, and ownership of programme outcomes facilitated by the project managers. Every effort will be made to provide optimal engagement and communication with stakeholders both locally and nationally. An engagement strategy 'Lets Talk what matters' has been developed that outlines how both stakeholders and the community will remain involved.

Annex Six: Programme Tranches (as at 12/03/2018)

Creating Our Futures - Delivery Plan



MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 11.3.2

CREATING OUR FUTURES PROGRAMME BUSINESS CASE – ADDITIONAL PROGRAMME RESOURCING

Purpose	For approval.

In 2016 the Mental Health and Addictions Service (MH&AS) commenced the process of preparing the acute inpatient facility business case. This is the first time the organisation has used the NZ Treasury Better Business Case process (the NZ Treasury accepted practice standard).

Seed funding of $159K was approved by BRRG in April 2016 and since that time $201K has been expensed principally on business case development.

During the Investment Logic Map (ILM) discussions with key stakeholders (representing the wider community), clear feedback was given on the scope and breadth of work required.

This process identified the compelling need to extend the scope of the investment to cover the whole of service user journey across the continuum of care. While the focus was initially on the building replacement project, this has subsequently changed to reflect a programme approach to include service reconfiguration, improved outcomes to be achieved for service users and communities, and to ensure sustainable and desirable mental health and addiction services into outer years. This change has been encouraged and endorsed by both NZ Treasury and Ministry of Health representatives who have participated in the discussions and subsequently have reviewed the drafts and programme development options thus far.

MH&AS *Creating Our Futures* is a significant health system transformation programme (developed through analysis and advice received around best practice principles) that is guided by the detailed assessment and preparation of the Programme Business Case. The programme investment objectives are:

a) To transform service delivery in order to improve safety, effectiveness and efficiency and deliver better outcomes for service users and communities.
b) To create safe and therapeutic environments that support holistic care at all times and in places best suited to individuals and community needs.
c) To build sustainable capacity and capability of service to meet future demand, values and need.

Appendix 1 presents the *Creating Our Futures* product breakdown chart (as at the Programme Indicative Business Case stage). The product chart indicates the scope and complexity of the investment solutions needed to address the current constraints in respect of the mental health service's ability to deliver safe, effective, efficient and best practice care. It is apparent that implementation of the programme and capital infrastructure will require additional resourcing to ensure successful delivery that is consistent with the programme investment objectives.

Appendix Two is tabled as a request for provisioning of required funding to support the programme resourcing and office set up costs for project delivery over a 12 month period (dates to be determined).

Appendix Three represents specific project resource required to establish the programme projects and work across the development work through the programme term.

- **Pathway Transformation Project** – Project resource is required to support changes to practice and end-to-end workflow across the continuum of care; and trust in transformative change. Priority deliverables include, for example, care coordination, 'front gate' approach to addressing immediate needs alongside primary care and NGO's, (place of assessment), ED Crisis Response. The anticipated duration this work will be between 18 months – 2 ½ years.
  - 1.0FTE Project Manager, 18 months community / >18 months inpatient
  - 0.75FTE Change Agent (internal secondment) >18 months
  - 0.25FTE Analyst, 5 pathways @ 12 weeks per pathway

- **Whole approach to Mental Health and Addictions across the sector** – This deliverable is requires a strategic and collective impact approach to how the service works with others: partnerships; values and culture; and peer and community resiliency. The anticipated duration is 18 months.
  - 1.0FTE Programme Manager

- **Environments Project** – Commencing on Cabinet Investment Committee endorsement to proceed to the Detailed Business Case (early-mid 2018) project resource will be required to support the capital infrastructure development and intensive co-design process. The total anticipated duration of the project is 3 – 5 years dependent on the preferred solution.
  - 1.0 FTE Project Manager, 5 years dependent on option
  - 0.25FTE Change Agents (internal secondment)
  - 0.25FTE Analyst
  - 0.2 FTE Finance Advisor (Note – this role will be resourced from within current DHB resource and experience and will work across all components of the programme. The role shows against the Environment Project being the largest of the planned spends.)

- **Capacity and Capability** – This deliverable is currently underway, with an anticipated duration of 18 months at this stage. Project resource will be required to support the business as usual requirements for future focus of workforce development inclusive of professional practice development, recruitment and retention, and, leadership capability.
  - 1.0FTE Workforce Development

At this stage, the estimated additional programme resourcing cost for the next 12 month period to deliver the mix of projects is approximately $1.513M (see appendix 3 for cost breakdown).

Appendix Four shows a role profile for a change agent position to be included into the wider projects for the term of the programme.

The alternative of no investment in project resource will mean the project is at risk from the point of initiation and both the investment objectives, and desired service and clinical outcomes will be at risk of not being delivered in whole or part.

The investment required is about the sustainable and best practice delivery of mental health services and requires acceptance of the programme business case along with support through the Capital Investment Committee to Ministerial approval of the investment.

With that in mind, we ask the Board approve the programme resources such that the cash flow planning can be developed for programme delivery.

Recommendation
THAT
The Board:

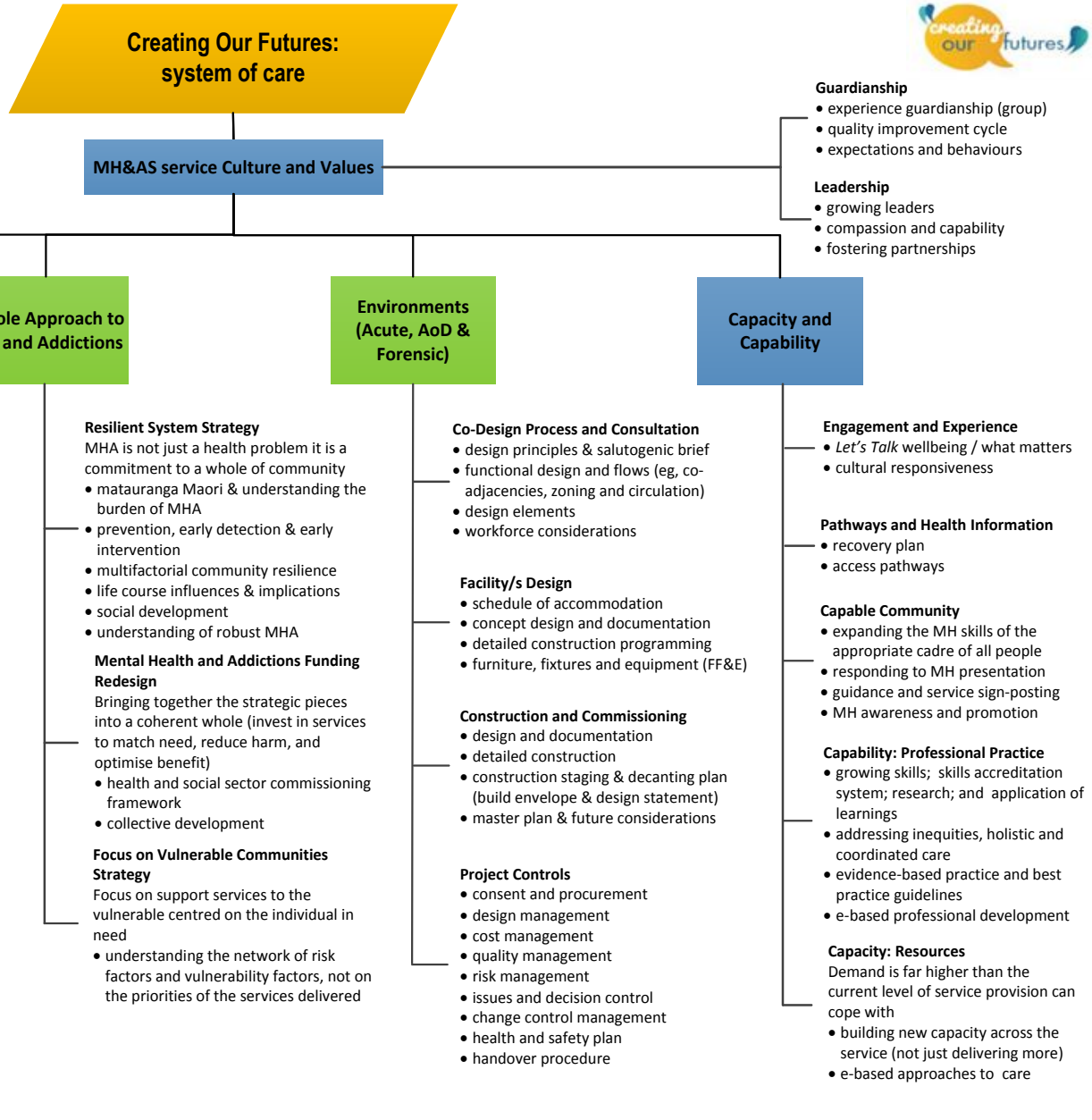
1) Receives the Mental Health and Addictions Service *Creating Our Futures* additional resourcing paper.
2) Approves the drawdown of capital for resourcing the Mental Health and Addictions Service *Creating Our Futures* programme over the next 12 months.

IAN WOLSTENCROFT
EXECUTIVE DIRECTOR, STRATEGIC PROJECTS

VICKI AITKEN
INTERIM EXECUTIVE DIRECTOR, MENTAL HEALTH AND ADDICTIONS SERVICE

Appendix 1

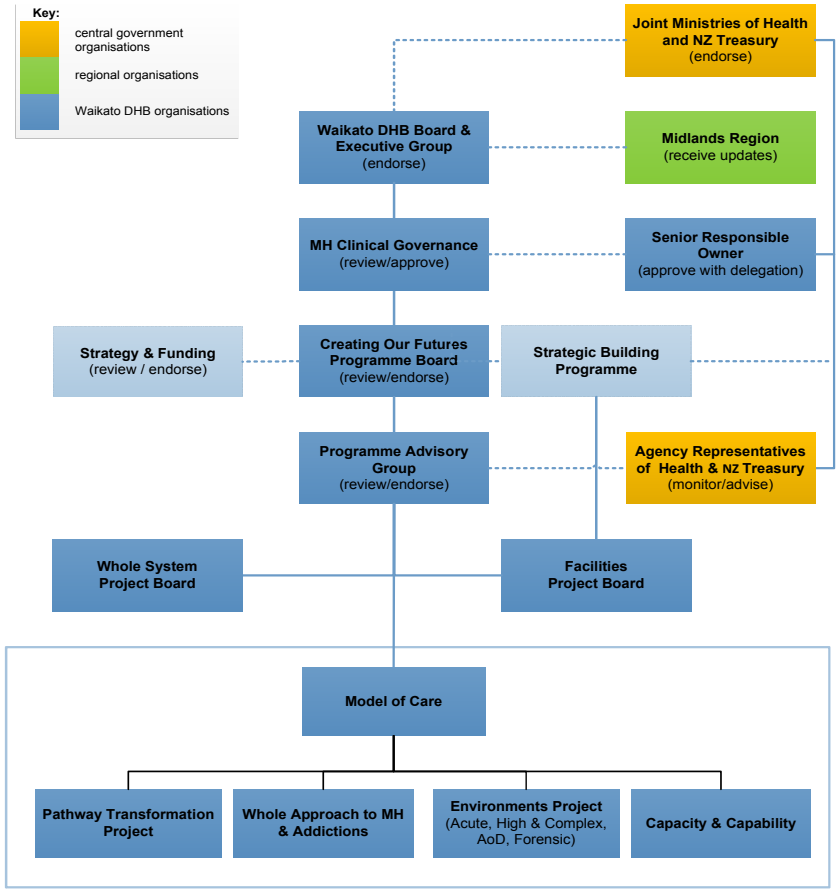
Waikato DHB
Mental Health and Addictions Service
Creating Our Futures
Programme Product Breakdown Structure



Appendix 2 Programme structure

The following programme chart depicts the proposed structure for the governance of the programme, defining the levels of responsibility and approval, communication channels and roles and responsibilities of each party and management tier.

Programme governance organisation chart



Appendix 3

Creating our Futures Programme

Indicative Resource Costs for all Four Projects

Project Name	Total	Project Manager	Business Change Mgr	Analysts	Business Case Writer	External Engagement Costs	Design Consultants to Prel Design	Office Set-up Equipment	Laptops	Cell-phone Costs	SPO Office Costs	Contingency
Pathway Transformation	$ 238,777	$ 110,000	$ 79,500	$ 18,750				$ 1,500	$ 3,000	$ 4,320		$ 21,707
Whole Approach to Mental Health	$ 124,234	$ 110,000						$ 500	$ 1,000	$ 1,440		$ 11,294
Capacity & Capability - Workforce	$ 124,234	$ 110,000						$ 500	$ 1,000	$ 1,440		$ 11,294
Environments	$ 796,250	(ii)	$ 26,500	$ 18,750			$ 645,000				$ 36,000	$ 70,000
Support:												
Business Case Writer	$ 100,000				$ 100,000							
Outside Engagement with Stakeholders	$ 100,000					$ 100,000						
Financial	$ 30,000			$ 30,000								
TOTALS	**$ 1,513,495**	**$ 330,000**	**$ 106,000**	**$ 67,500**	**$ 100,000**	**$ 100,000**	**$ 645,000**	**$ 2,500**	**$ 5,000**	**$ 7,200**	**$ 36,000**	**$ 114,295**
		3.00 FTE	**1.00 FTE**	**(iv)**	**1.00 FTE**	**(iii)**	**(i)**					

(i) may not all be expensed in the 1st twelve months

Architect to Preliminary Designs	incl. d'mnts	$ 300,000
Building Services to Preliminary Designs	incl. d'mnts	$ 130,000
Construction Project Management	6 mths/2 days	$ 80,000
Quantity Surveyors		$ 35,000
Civils	incl. geotech	$ 80,000
Structural		$ 20,000
Total		**$ 645,000**

(ii)
The Project Manager for the Environment's Project is seconded from the Change Team Office and is experienced in Prince 2 methodology

iii)
includes site visits

(iv)

Service Analyst across both Pathway and Environmental	0.5 FTE
Financial Analyst working across all projects	0.2 FTE

Appendix 4 – Change Agent Role Profile

Project Planning and Management

- Deliver change initiatives effectively using the organisation's project and change management frameworks and tools
- Ensure effective project governance is established at the outset of a project. Ensure project documentation is robust and completed at every phase (initiation, delivery and close are the minimum)
- Ensure project scope is clearly defined and project objectives are clear
- Ensure project roles and responsibilities are established, assigned and people understood
- Ensure project milestones, deliverables and timelines are clearly identified and met
- Ensure project budget remains within agreed tolerances
- Manage and maintain appropriate project documentation throughout the course of the project, in accordance with document naming conventions and file structure
- Identify, establish and deliver agreed project reporting
- Effectively manage stakeholder /customer relationships and expectations
- Identify, manage and as appropriate escalate risks and issues
- Correct and/or manage any project plan deviation in accordance with Waikato DHB project management principles
- Prepare project closure documentation (including lessons learned)
- Ensure effective transition from project to business as usual

Change Management and Business Analysis

- Ensure change impact assessments are undertaken relevant to size and scope of the change
- Develop change plans for all projects of high or medium risk
- Ensure change sponsors/leaders are in place and effectively prepared
- Assist the business' change leaders to apply the ADKAR framework and associated change tools
- Support business/service managers to prepare affected business areas for transition to new ways of working
- Undertake stakeholder analysis
- Prepare communication plans and messages
- Develop current state and future state process maps
- Facilitate workshops and meetings
- Collect and analyse data and provide information to support effective decision making
- Ensure appropriate training is prepared to support business change

Team Building

- Positively and actively participate as a member of the Change Team and support peers
- Drive reflective practice
- Champion ongoing improvement initiatives to implement best practice
- Model and uphold the DHB values

Relationship Management

- Develop and maintain relationships that enable the Change Team to effectively deliver value to portfolios, programmes and projects across all levels of stakeholders at the DHB
- Engender trust and confidence with the business in the team's ability to consistently deliver high quality and value add contributions
- Effectively communicate why it is so important change is lead and championed by assigned business staff ie not by the change team
- Maintain open and transparent communication across the wider Change Team

Papers for Information

MEMORANDUM TO THE BOARD
28 MARCH 2018

AGENDA ITEM 12.1

2018 INFLUENZA SEASON

Purpose	For information.

Higher risk of morbidity and mortality in the 2018 influenza season
In the Northern Hemisphere this year, influenza A(H3N2) has been the predominant strain. It is possible that this strain will also predominate in New Zealand this winter. A(H3N2) has historically been associated with higher morbidity and mortality especially for those aged over 65 years.

Immunisation is the most effective tool available to reduce the impact of influenza. Both Influvac Tetra and Fluarix Tetra vaccines contain a new A strain (A/Singapore/INFIMH-16-0019/2016 (H3N2)-like) which is expected to be a better match for the A(H3N2) strain than the previous vaccine.

This year, however, there is a slight delay in 2018 funded influenza vaccines being available – early and mid-April being the dates we have been given (Attachment A).

The indications coming from the United States is that the forthcoming season could be very challenging given the predictions around high influenza rates and the high level of existing demand on both primary and secondary care services.

> *"U.S. health officials last month predicted that the current "intense" season could continue for weeks. The number of flu-related doctor visits has already reached a 20-year high and nearly 100 flu-related paediatric deaths have been reported."*

The 2018 flu kit book contains important information on who should receive funded influenza vaccine and programme goals some of this has been summarised below (Attachment B).

Waikato DHB's Approach to the 2018 Influenza season

- Each year a stakeholder group within the DHB develops a plan on how to best address this within the forthcoming season including both the programme for staff and communications to the general public (Attachment C).
- The Waikato DHB Demand Management Advisory Group (DMAG) includes primary and secondary care, St John and Community Pharmacy.
- DMAG has set up a working group which, which includes Population Health and linkages to the DHB stakeholder group, to ensure that we have a whole of system approach to influenza vaccination including maximising any opportunities to increase immunisation coverage.

- The majority of community influenza Vaccination takes place within general practices.Over recent years there have been a number of initiatives including some Saturday clinics to try and make the service more available both to people unable to attend due to work commitment or difficulty with travel.
- We also have 38 community pharmacies providing funded influenza vaccination to > 65 year olds and pregnant women (Attachment D).

Summary of Eligibility for free vaccination

Vaccines are publicly funded free of charge for:

- Pregnant women (any trimester).
- People aged 65 years or older.
- People aged under 65 years with a medical condition that increases their risk of developing complications from influenza, and the condition is specified in the Influenza Immunisation Programme eligibility criteria (see note A below).
- Children aged 4 years or under who have been hospitalised for respiratory illness or who have a history of significant respiratory illness.

Note A: Anyone aged 6 months to under 65 years with a medical condition that increases their risk of acquiring influenza or developing complications from influenza:

- Cardiovascular disease (ischaemic heart disease, congestive heart disease, rheumatic heart disease, congenital heart disease, cerebrovascular disease).
- Chronic respiratory disease (asthma if on regular preventive therapy; other chronic respiratory disease with impaired lung function).
- Diabetes.
- Chronic renal disease.
- Cancer (patient currently has cancer), excluding basal and squamous skin cancer if not invasive.
- Other conditions (such as autoimmune disease, immune suppression, immune deficiency, human immunodeficiency virus (HIV), transplant recipients, neuromuscular and central nervous system diseases, cochlear implant, error of metabolism at risk of major metabolic decompensation, pre- or post-splenectomy, Down syndrome, haemoglobinopathies and children on long term aspirin).

Questions have recently been raised in relation to whether DHBs are able to fund influenza vaccines outside of the eligibility criteria detailed above and the response has been that this cannot occur. We are aware however that there have been proposals raised in relation to extending the criteria to include preschool children recognising the role children have in transmission of influenza. It is clear that even if there was agreement to progress this it would not be available for the 2018 season. Pharmac have advised that they are awaiting clinical advice on widening the scope of influenza vaccination in the future.

In addition to funded vaccine through Health a significant number of employers are also funding vaccination for their employees recognising the beneficial impacts on their employees health. In addition there are individuals who whilst not being eligible for public funded vaccination may choose to pay to be vaccinated. There is relatively little information available on the number of privately funded vaccines delivered within our community.

Recommendation
THAT
The Board receives the report.

DAMIAN TOMIC
CLINICAL DIRECTOR, PRIMARY AND INTEGRATED CARE

28 February 2018

Slight delay in 2018 funded influenza vaccines – early and mid-April

Vaccine supply
This year's funded influenza vaccines contain two different vaccine strains from the 2017 vaccine. This change has resulted in an unavoidable delay in the vaccines' release:

- Influvac Tetra vaccine will be available from early April (for adults and children aged 3 years and over)
- Fluarix Tetra vaccine will be available from mid-April (for children aged 6-35 months).

The updated strains are:
- A/Singapore/INFIMH/16-0019/2016 (H3N2)-like virus
- B/Phuket/3073/2013-like virus.

We recognise the slightly delayed arrival of the vaccine may have an impact on your immunisation service programmes. Some occupational health services may have purchased unfunded vaccines, and these may arrive earlier than the funded vaccines. Please do not schedule clinics until you have received your vaccine orders.

Vaccine ordering
Practices should pre-order your influenza vaccine, as these orders will be delivered first. Pre- ordering of vaccines can begin now. Providing you have sufficient fridge capacity especially with your zoster vaccine stocks, ordering influenza vaccine in multiples of 100 enables faster distribution. The Influvac Tetra vaccine comes in boxes of 10 doses and Fluarix Tetra comes in single dose packs.

Influenza vaccine ordering is handled by Healthcare Logistics (HCL). You can order in two ways:
- Online at www.hcl.co.nz (preferred option, registration required) or
- Fax: 0508 408 358

Enquiries can be made by calling 0508 425 358. The order form is also available on www.influenza.org.nz in the Resources section.

Influenza resources
The 2018 Influenza Kit is available online and will be sent to providers by mid-March. Please see the NISG website: www.influenza.org.nz, or call the Immunisation Advisory Centre helpline 0800 IMMUNE (0800 466 863), for more information. If you have any queries please contact us by the following email address immunisation@moh.govt.nz.

Higher risk of morbidity and mortality
In the Northern Hemisphere this year, influenza A(H3N2) has been the predominant strain. It is possible that this strain will also predominate in New Zealand this winter. A(H3N2) has historically been associated with higher morbidity and mortality especially for those aged over 65 years.

Immunisation is the most effective tool available to reduce the impact of influenza. Both Influvac Tetra and Fluarix Tetra vaccines contain a new A strain (A/Singapore/INFIMH-16-0019/2016 (H3N2)-like) which is expected to be a better match for the A(H3N2) strain than the previous vaccine.

Zoster vaccine can be co-administered with the influenza vaccine to those aged 65 to 80 years.

The Immunisation Team

Influenza.
Don't get it.
Don't give it.

Everything you need to know about

FLU

2018

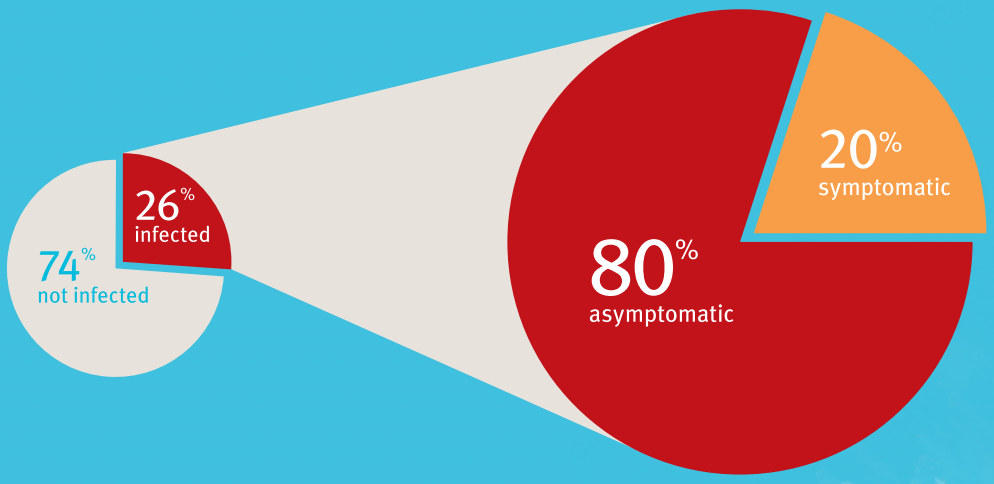
The Immunisation Advisory Centre

MINISTRY OF HEALTH
MANATŪ HAUORA

4 out of 5 people infected show no symptoms of influenza

The Southern Hemisphere Influenza and Vaccine Effectiveness, Research and Surveillance (SHIVERS) Serosurvey, in 2015, provided information about the immunity that people in the community have against influenza.

The results showed that 26% of people were infected with influenza and **4 out of 5 of these people (80%) were asymptomatic carriers.**[1] These carriers could have spread the virus among their family, co-workers, classmates and patients without ever realising it.



And once spread, influenza has a serious effect on our community

Other SHIVERS data showed that when applied to the New Zealand population:

- 31,850 sought help from their GP
- 2,209 were hospitalised

Help prevent the potentially devastating effects of influenza in your community

Recommend annual influenza vaccination to your patients

Please make sure you get vaccinated every year

The SHIVERS Serosurvey

The purpose of this study was to contribute to knowledge about influenza infection in the community and identify if participants:

- developed immunity to influenza by the end of the winter and
- had influenza during the winter

Study Overview: The study took place between February and November 2015 and involved about 1,500 adults and children randomly selected from general practices in Auckland.

After a short health survey, a blood sample was taken before the influenza season, and from May to September, weekly contact was used to check for cold or influenza symptoms. For those meeting the influenza-like illness case definition, and who hadn't visited a GP, a nose or throat swab was taken to test for viruses or bacteria that cause influenza, colds or sore throats. At the end of winter, a longer questionnaire was completed and a second blood sample was collected. Detection of influenza RNA or antibody against haemagglutinin was used to estimate influenza infection rates.

Contents

Key reference material

Clinical information

Influenza and special groups

The list of references is available in a separate document in the *Resources* section on the www.influenza.org.nz website.

Introduction with important information for 2018

This resource is for use by healthcare professionals supporting and/or providing influenza vaccinations in a variety of settings.

Influenza Immunisation Programme goals

- Vaccinate 75% of the population aged 65 years or older against influenza annually
- Improve influenza immunisation coverage for people aged under 65 years with certain medical conditions, and pregnant women
- Improve influenza immunisation uptake for healthcare workers
- 80% of District Health Board-based healthcare workers are vaccinated against influenza annually
- Distribute more than 1.2 million influenza vaccine doses annually, i.e. protect more than 25% of the community

Eligibility for funded influenza vaccination

Funded influenza vaccinations are available for those who meet PHARMAC's eligibility criteria:

- Pregnant women (any trimester),
- People aged 65 years or older,
- People aged under 65 years with certain medical conditions,
- Children aged 4 years or under who have been hospitalised for respiratory illness or have a history of significant respiratory illness and
- People aged under 18 years living in the:
  - Seddon/Ward and rural Eastern Marlborough region (within the Nelson Marlborough District Health Board), or
  - Kaikoura and Hurunui areas (within the Canterbury District Health Board) or
  - who have been displaced from their homes in Edgecumbe and the surrounding region

The best protection against influenza is provided if people are vaccinated before winter. However, eligible people will continue to have access to funded influenza vaccinations until 31 December each year.

Key messages

Your regular use and support of the following messages will play an essential role in increasing influenza vaccination and lowering infection rates.

- **Immunisation is the best protection against influenza. Get a 'flu shot' each year, before winter.**
- **Even a mild case of influenza can disrupt your everyday activities with family, friends, community and work.**
- **Many people don't know they have influenza as they do not feel unwell. But they can still pass it on and make other people very sick.**
- **Get immunised to stop the spread of influenza around your community.**
- **Influenza immunisation is recommended and FREE for people who are most likely to get very sick, be hospitalised or even die if they catch influenza:**
  - pregnant women,
  - people aged 65 years old or older,
  - people aged under 65 years with diabetes, most heart or lung conditions and some other illnesses and
  - children aged 4 years or under who have had a stay in hospital for asthma or other breathing problems

Two funded quadrivalent influenza vaccines for 2018

1. **INFLUVAC® TETRA**
   For adults and children aged 3 years or older. This vaccine is expected to be available in early-April 2018.
2. **FLUARIX® TETRA**
   For children aged under 3 years, i.e. 6–35 months. This vaccine is expected to be available in mid-April 2018.

New influenza vaccination precaution

Influenza vaccination may be contraindicated or need to be delayed for people receiving some new cancer treatments. The immune-stimulant actions of atezolizumab (Tecentriq®), ipilimumab (Yervoy®), nivolumab (Opdivo®) and pembrolizumab (Keytruda®) on the immune system increase a person's risk of developing autoimmune conditions.

It is not known whether receipt of an influenza vaccine whilst receiving these treatments or for up to six months after treatment increases a theoretical risk of triggering the occurrence of these side effects. Please contact the person's oncologist or 0800 IMMUNE (0800 466 863) for current advice about influenza vaccination for these people BEFORE administering the vaccine.

INFLUVAC® TETRA and FLUARIX® TETRA can be given to people with egg allergy or anaphylaxis

INFLUVAC® TETRA and FLUARIX® TETRA can be safely administered to people with a history of egg allergy or egg anaphylaxis at general practices, pharmacies or at the workplace.[2] Studies have shown that influenza vaccines containing less than one microgram of ovalbumin do not trigger anaphylaxis in sensitive individuals.[2] The residual ovalbumin in one dose of INFLUVAC® TETRA or FLUARIX® TETRA is significantly below this limit.[3,4]

Ordering influenza vaccine

Online ordering is available at www.hcl.co.nz. The online order process is less susceptible to error, has an audit trail and is faster. The fax order form is available on page 8.

Ordering printed influenza resources

Online ordering only, available at www.influenza.org.nz/resources.

Pharmacist vaccinators

Some community pharmacies provide purchased influenza vaccination to adults and children aged 13 years or older. Some community pharmacies also provide funded influenza vaccination to:

- pregnant women, and
- people aged 65 years or older

Recording influenza vaccination on the National Immunisation Register (NIR)

All influenza vaccinations given in general practice should be recorded on the NIR. This provides invaluable information for planning the programme to protect our population. For more information please refer to page 9.

Pharmacist vaccinators use the NIR web application called *ImmuniseNow* to record all vaccinations on the NIR. Pharmacist vaccinators are also required to inform the person's general practitioner (GP) when they have administered an influenza vaccine. It is planned for this process to be fully automated in the future.

Influenza coverage reports by District Health Board, Primary Health Organisation, ethnicity and deprivation are available for providers, including general practice, with access to the Business Objects NIR Datamart.

Go to influenza.org.nz for additional associated content

- Related diseases (pneumococcal, meningococcal and pertussis)
- Flu Kit references
- Claiming funded vaccine
- Use of antivirals for influenza treatment and/or prevention
- Data sheet for INFLUVAC® TETRA
- Data sheet for FLUARIX® TETRA

The Ministry of Health and The Immunisation Advisory Centre appreciate all your hard work, and thank you for your role in ensuring New Zealanders are protected from influenza.

Influenza disease

Influenza is caused by different strains of influenza viruses. Symptoms may vary with age, immune status and health of the individual, and include fever, sore throat, muscle aches, headache, cough and severe fatigue. The fever and body aches can last 3–5 days and the cough and fatigue may last for two or more weeks.[5]

During seasonal increases, most influenza diagnoses are based on symptoms. The definitive diagnosis of influenza can only be made in the laboratory, usually from PCR testing of secretions from a nasopharyngeal swab. Samples should be collected within the first four days of illness.[6]

Not everyone with influenza has symptoms or feels unwell. However, asymptomatic individuals can still transmit the virus to others.[5,8,9]

Influenza can be difficult to diagnose based on clinical symptoms alone because influenza symptoms can be similar to those caused by other infectious agents including *Neisseria meningitidis, respiratory syncytial virus (RSV), rhinovirus and parainfluenza viruses.[5]**

* For more information go to www.influenza.org.nz/meningococcal-disease

The Southern Hemisphere Influenza and Vaccine Effectiveness Research and Surveillance (SHIVERS) study, based in Auckland, identified around one in four people were infected with influenza during the 2015 influenza season. Data showed that four out of five children and adults (80%) with influenza did not have symptoms.[1]

In an earlier study following the 2009 New Zealand influenza season, almost one quarter of adults who reported that they had not had influenza in 2009 had serological evidence of prior infection (21% [95% confidence interval 13–30%]). Conversely, almost one quarter of adults who reported having had influenza during 2009 had no serological evidence of prior infection (23% [95% confidence interval 12–35%]).[10]

The SHIVERS hospital-based surveillance for severe acute respiratory infections in Auckland during 2017 identified that adults aged 80 years or older had the highest severe acute influenza respiratory infection hospitalisation rates of all age groups, 283 cases per 100,000 people compared with 97/100,000 for adults aged 65–79 years, 17/100,000 for midlife adults and 145/100,000 for infants aged under 1 year.[11]

Pacific peoples (83/100,000) had higher hospitalisation rates for severe acute influenza respiratory infection than Māori (45/100,000), and both groups had higher hospitalisation rates than Asian, European and other ethnicities.[11]

Transmission

The influenza virus is transmitted among people by direct contact, touching contaminated objects or by the inhalation of aerosols containing the virus. Therefore, thorough handwashing is an important preventative method. Symptomatic and asymptomatic influenza cases can transmit the virus and infect others at home, in the community, at work and in healthcare institutions. Healthy adults with influenza are infectious for up to five days, and children for up to two weeks.[5]

Handwashing is an important and effective way of reducing the spread of influenza.

Should healthcare workers be vaccinated?

Yes. The World Health Organization strongly recommends healthcare workers as a priority group for influenza vaccination, not only for their own protection and ability to maintain services but also to reduce the spread of influenza to their vulnerable patients including pregnant women.[12]

Healthcare workers can transmit influenza without knowing they are infected. Influenza does not always cause symptoms or make a person feel unwell.[5,8,9] Data from the Southern Hemisphere Influenza and Vaccine Effectiveness Research and Surveillance (SHIVERS) study, based in Auckland, suggest that four out of five children and adults (80%) with influenza did not have symptoms.[1] In an earlier study following the 2009 influenza season in New Zealand, almost one quarter of the adults who reported that they had not had influenza in 2009 had serological evidence of prior infection (21% [95% confidence interval 13–30%]).[10]

Healthcare workers have a duty of care to protect vulnerable patients from the serious health threat of influenza illness. Studies demonstrate that annual influenza vaccination for healthcare workers is likely to reduce illness among the patients they care for.[13-15] Relying on patients being vaccinated is not enough as vulnerable people may have a poor immune response to their vaccination or may not have been vaccinated this year.

Influenza vaccination coverage rates for District Health Board-based (DHB-based) healthcare workers has remained steady at 65–66% over the past few years.[16] For 2018, the Ministry of Health has introduced the goal of 80% of DHB-based healthcare workers are vaccinated against influenza annually. The 2017 Workforce Influenza Immunisation Coverage Rates by District Health Boards report is available on the Ministry of Health website www.health.govt.nz/our-work/preventative-health-wellness/immunisation/influenza.

Recommend annual influenza vaccination to your patients

When should people be vaccinated?

It is possible to come in contact with influenza viruses all year round. However, the likelihood of influenza viruses circulating in the community significantly increases during winter.

For most people, the best time to be vaccinated against influenza is before the start of the winter season. It can take up to two weeks for the vaccine to provide the best influenza protection. However, influenza vaccinations can be given when influenza virus activity has been identified as protective antibody levels have been observed to develop rapidly from four days after vaccination.[17,18]

The funded INFLUVAC® TETRA vaccine for eligible adults and children aged 3 years or older is expected to be available from early-April until 31 December 2018.

The funded FLUARIX® TETRA vaccine for eligible children aged under 3 years, i.e. aged 6–35 months, is expected to be available from mid-April until 31 December 2018.

Why is influenza vaccination needed every year?

Annual influenza vaccination is required for two important reasons:

- Protection from the previous vaccination lessens over time
- The circulating influenza viruses can change and the strains in the vaccine usually change each year in response to the changing virus pattern

For 2018, of the four influenza strains included in the funded vaccines, **two are new (in bold).[19]**

- A/Michigan/45/2015 (H1N1) pdm09-like virus
- **A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus**
- **B/Phuket/3073/2013-like virus**
- B/Brisbane/60/2008-like virus

Key reference material

New Zealand immunisation strategy

Who should be vaccinated?

Influenza continues to be a major threat to public health worldwide because of its ability to spread rapidly through populations. Influenza vaccination can be offered to individuals aged 6 months or older.

Influenza vaccination is funded for certain groups of people who are considered to be at greater risk of complications from influenza. Additional preventative strategies are important to reduce their risk of exposure to influenza. The vaccination is also recommended, although not funded, for those who are in close contact with individuals who are more vulnerable or at high risk of complications and who may also be less able to mount a strong immune response to vaccination. Front-line healthcare workers are usually funded by their employer.

Eligibility for funded influenza vaccine

All children aged under 18 years who meet the influenza vaccination eligibility criteria can receive funded influenza vaccination regardless of their immigration and citizenship status, and providers can claim the immunisation benefit for administering the vaccine.[20]

Adults aged 18 years or older who meet the influenza vaccination eligibility criteria must also be eligible to receive publicly funded health and disability services in New Zealand to receive funded influenza vaccination.[20] Refer to the *Health and Disability Services Eligibility Direction 2011* for eligibility criteria (available at www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/eligibility-direction).

Women aged 18 years or older who are pregnant and not eligible to receive publicly funded health and disability services in New Zealand are recommended to receive influenza vaccination but are not eligible to receive funded vaccination, even if they are receiving funded primary maternity services under the *Section 88 Primary Maternity Services Notice 2007*[21] (available at www.health.govt.nz/publication/section-88-primary-maternity-services-notice-2007).

Funded vaccines for 2018

INFLUVAC® TETRA

INFLUVAC® TETRA is funded if administered to eligible adults and children aged 3 years or older by 31 December 2018. This vaccine is expected to be available from early-April 2018.

FLUARIX® TETRA

FLUARIX® TETRA is funded if administered to eligible children aged under 3 years, i.e. 6–35 months, by 31 December 2018. This vaccine is expected to be available from mid-April 2018.

Note: Both INFLUVAC® TETRA and FLUARIX® TETRA are prescription medicines. For full prescribing information please refer to the data sheets at www.medsafe.govt.nz or www.influenza.org.nz.

Eligibility criteria for FREE influenza vaccination for 2018:

- **Pregnant women (any trimester)**
- **People aged 65 years or older**
- **People aged under 65 years with any of the medical conditions listed on the opposite page**
- **Children aged 4 years or under who have been hospitalised for respiratory illness or have a history of significant respiratory illness**
- **People under 18 years of age living in the:**
  - **Seddon/Ward and rural Eastern Marlborough region (within the Nelson Marlborough District Health Board), or**
  - **Kaikoura and Hurunui areas (within the Canterbury District Health Board) or**
  - **who have been displaced from their homes in Edgecumbe and the surrounding region**
- **The following conditions are excluded from funding:**
  - **Asthma not requiring regular preventative therapy,**
  - **Hypertension and/or dyslipidaemia without evidence of end-organ disease**

For vaccination eligibility and clinical queries contact:

The Immunisation Advisory Centre (IMAC)

The University of Auckland

Phone: 0800 IMMUNE (0800 466 863)

Email: 0800immune@auckland.ac.nz

Also refer to the New Zealand *Pharmaceutical Schedule* on the PHARMAC website (www.pharmac.govt.nz/tools-resources/pharmaceutical-schedule).

Influenza vaccination before winter offers the best protection

Eligible medical conditions for funded influenza vaccination

Funded influenza vaccine is available each year for people who meet the following criteria set by PHARMAC:*

- people 65 years of age or older; or
- people under 65 years of age who:
  - have any of the following cardiovascular diseases:
    - ischaemic heart disease, or
    - congestive heart failure, or
    - rheumatic heart disease, or
    - congenital heart disease, or
    - cerebrovascular disease; or
- have either of the following chronic respiratory diseases:
  - asthma, if on a regular preventative therapy, or
  - other chronic respiratory disease with impaired lung function;[a] or
- have diabetes; or
- have chronic renal disease; or
- have any cancer, please refer to the vaccine precaution below[#], excluding basal and squamous skin cancers if not invasive; or
- have any of the following other conditions:
  - autoimmune disease,[b] or
  - immune suppression or immune deficiency, or
  - HIV, or
  - transplant recipient, or
  - neuromuscular or CNS disease/disorder,[c] or
  - haemoglobinopathy,[d] or
  - children on long term aspirin, or
  - a cochlear implant, or
  - error of metabolism at risk of major metabolic decompensation, or
  - pre- or post-splenectomy, or
  - Down syndrome, or
  - pregnant women (any trimester); or
  - children aged 4 years or under who have been hospitalised for respiratory illness or have a history of significant respiratory illness;
- people under 18 years of age living in the:
  - Seddon/Ward and rural Eastern Marlborough region (within the Nelson Marlborough District Health Board), or
  - Kaikoura and Hurunui areas (within the Canterbury District Health Board) or
  - who have been displaced from their homes in Edgecumbe and the surrounding region

Unless meeting the criteria set out above, the following conditions are excluded from funding:

- asthma not requiring regular preventative therapy,
- hypertension and/or dyslipidaemia without evidence of end-organ disease

*Eligibility criteria as at March 2018.[22]

#New influenza vaccination precaution

Influenza vaccination may be contraindicated or need to be delayed for people receiving some new cancer treatments. Please read the information under *Contraindications and precautions to receiving influenza vaccine* on page 16 for people receiving atezolizumab (Tecentriq®), ipilimumab (Yervoy®), nivolumab (Opdivo®) and pembrolizumab (Keytruda®) and contact the person's oncologist or 0800 IMMUNE (0800 466 863) for current advice about influenza vaccination for these people BEFORE administering the vaccine.

For vaccination eligibility queries call 0800 IMMUNE (0800 466 863)

a. Chronic respiratory diseases include: chronic bronchitis, chronic obstructive pulmonary disease, cystic fibrosis, emphysema.

b. Autoimmune diseases may include: coeliac disease, Crohn's disease, Grave's disease, Hashimoto's thyroiditis, lupus, rheumatoid arthritis. Immune suppression or immune deficiency includes disease modifying anti-rheumatic drugs (DMARDS) or targeted biologic therapies.

c. Neuromuscular and CNS diseases/disorders include: cerebral palsy, congenital myopathy, epilepsy, hydrocephaly, motor neurone disease, multiple sclerosis, muscular dystrophy, myasthenia gravis, Parkinson's disease.

d. Haemoglobinopathies include: sickle cell anaemia, thalassemia.

Key reference material

Vaccine ordering, delivery and storage

Influenza vaccine ordering is handled by Healthcare Logistics (HCL). You can order in two ways: ONLINE: www.hcl.co.nz (preferred option, registration required) or TOLL-FREE fax: 0508 408 358

Enquiries can be made by calling: 0508 425 358. The order form is also available on www.influenza.org.nz in the *Resources* section.

Cost of the influenza vaccines

The vaccine costs $9.00 (excl. GST) per dose. For people eligible for funded influenza vaccine (refer to page 6), the vaccine is free (i.e. no vaccine cost and no administration service cost to the person). General practices can claim for the cost of the vaccine and the immunisation benefit for administration of a funded influenza vaccine to an eligible individual via the usual Sector Services process.

Note: Claims can only be made when the vaccine is given during the funded Influenza Immunisation Programme, usually March to 31 December.

How much is the immunisation benefit?

$20.51 (excl. GST)

Delivery charges?

There are no delivery charges.

Minimum order requirements?

The total influenza vaccine order must meet minimum quantities as follows:

MARCH	Min 60 doses	JUNE	Min 30 doses
APRIL	Min 60 doses	JULY	Min 20 doses
MAY	Min 60 doses	AUG-DEC	Min 10 doses

Notes for providers:

- Please base FLUARIX® TETRA stock on your known population of children aged under 3 years, i.e. aged 6–35 months, who are eligible for funded influenza vaccination
- Please consider your refrigerator capacity and the addition of Zostavax® to the National Immunisation Schedule on 1 April 2018

Influenza vaccine chilly bins

Influenza vaccine chilly bins cannot be recycled. To reduce wastage when ordering, please consider your expected usage. A small bin holds 60 doses, a medium chilly bin holds up to 120 doses, a large bin holds up to 180 doses, and the extra-large bin holds up to 500 doses.

Vaccine availability at the start of the season

Orders will be dispatched as soon as the vaccine is released by the Ministry of Health. **Please do not organise clinics before your vaccine stock has arrived.**

INFLUVAC® TETRA, for adults and children aged 3 years or older, is expected to be available in early-April 2018.

FLUARIX® TETRA, for children aged under 3 years, i.e. aged 6–35 months, is expected to be available in mid-April 2018.

Influenza vaccine stock damaged in transit

Influenza vaccine damaged in transit may be returned to Healthcare Logistics for destruction. Please contact Healthcare Logistics on 0508 425 358 before returning.

Refund for unused/expired funded influenza vaccine

One refund will be available for a total of 10 doses of unused INFLUVAC® TETRA and/or one dose of unused FLUARIX® TETRA from any one account. To be eligible for a refund, the unused stock must be returned prior to 31 January 2019. Please ensure you continue to have influenza vaccine stock available until 31 December for those who are eligible for influenza vaccination. Contact Healthcare Logistics on 0508 425 358 to request a Return Authorisation.

The shelf life of funded influenza vaccines

All influenza vaccines are marked with an expiry date that should be checked before vaccine administration.

Cold chain

The vaccines must be stored between +2°C and +8°C at all times. They must not be frozen.

Temperature-monitored chilly bins must be used if vaccines are temporarily stored outside the vaccine refrigerator or being transported. Refer to the *National Standards for Vaccine Storage and Transportation for Immunisation Providers 2017* (available at www.health.govt.nz/coldchain).

If vaccines have been stored outside the required temperature range, quarantine the vaccines and contact your Immunisation/Cold Chain Coordinator.

Temperature logging devices

A temperature logging device and instructions may be included with your order.

2018 funded influenza vaccine order form

(Failing to complete in full may delay the processing of your order)

TO: Healthcare Logistics
ONLINE: www.hcl.co.nz (preferred option, registration required) or
TOLL-FREE FAX: 0508 408 358

Date: _____ Healthcare Logistics Customer Number: _____

Surgery name: _____

Contact name: _____

Delivery address: _____

Contact phone: _____

Email address for invoice: _____

(Email address for invoicing only needs to be provided once)

Customer purchase order number (if applicable): _____

I would like to order:

☐ **INFLUVAC® TETRA DOSES** [1144113], funded influenza vaccine (only available in multiples of 10).

☐ **FLUARIX® TETRA DOSES** [1144112], funded influenza vaccine (only available in single dose packs)
Note: FLUARIX® TETRA will not be available until mid-April 2018

You will be supplied the doses that you commit to in your online or faxed order (please remember we cannot split boxes).

Notes for providers:

- Please base FLUARIX® TETRA stock on your known population of children aged under 3 years, i.e. aged 6–35 months, who are eligible for funded influenza vaccination.
- Please consider your refrigerator capacity and the addition of Zostavax® to the National Immunisation Schedule on 1 April 2018.

Influenza chilly bins cannot be recycled. To reduce wastage when ordering, please consider your expected usage. A small bin holds 60 doses, a medium chilly bin holds up to 120 doses, a large bin holds up to 180 doses, and the extra-large bin holds up to 500 doses.

Note: Due to demand, please allow up to 48 hours before dispatch. Please do not book your clinics before your stock has arrived.

Total influenza vaccine order must meet minimum quantities as follows:

MARCH	APRIL	MAY	JUNE	JULY	AUG-DEC
Min 60 doses	Min 60 doses	Min 60 doses	Min 30 doses	Min 20 doses	Min 10 doses

NOTE: Some orders may have a temperature logging device included with the shipment. Do not be concerned if your shipment does not contain a temperature logging device.

Refund for unused/expired funded influenza vaccine

One refund will be available for a total of 10 doses of unused INFLUVAC® TETRA and/or one dose of unused FLUARIX® TETRA from any one account. To be eligible for a refund, the unused stock must be returned prior to 31 January 2019. Please ensure you continue to have influenza vaccine stock available until 31 December for those who are eligible for influenza vaccination. Contact Healthcare Logistics on 0508 425 358 to request a Return Authorisation.

This form is also available on www.influenza.org.nz in the *Resources* section.

Key reference material

Recording influenza vaccinations on the National Immunisation Register

The National Immunisation Register (NIR) is a national database, held by the Ministry of Health (the Ministry). The NIR records National Immunisation Schedule vaccinations given to children and some Schedule vaccines given to adults, such as influenza vaccinations. The Ministry and District Health Boards use the NIR to help monitor vaccination coverage, including vaccination of pregnant women, assess protection against diseases such as influenza, and plan future population health programmes.

The following points are useful for informing your patients about the NIR

- The NIR provides an accurate record of a person's vaccination history, to help with their ongoing heath care even if they change doctors, and to help the Ministry measure vaccination coverage across the whole population
- The NIR records a person's NHI number, name, gender, address, date of birth and vaccination information
- Only authorised professionals will see, use or change the information
- Information that does not identify individuals may be used for research or planning

The NIR leaflet (HE2423) informs adults about the NIR. Leaflet pads can be ordered from www.healthed.govt.nz.

Influenza coverage reports by District Health Board (DHB), Primary Health Organisation (PHO), ethnicity and deprivation are available for providers, including general practice, with access to the Business Objects NIR Datamart.

Recording adult influenza vaccination, including pregnant women, on the NIR in:

General Practice

The NIR and Practice Management Systems (PMS) record all influenza vaccinations given in general practice for all age groups and for pregnant women. To record an adult's influenza vaccination information on the NIR select the opt-on button on your PMS.

To help avoid errors in recording influenza on the NIR:

- Ensure you have the most up-to-date PMS software version
- Send a list of all the vaccinators and general practitioners (GPs) who will deliver the influenza vaccine in your practice to your local DHB NIR administrator before the beginning of the influenza season to ensure they are entered into the system
- Vaccinators should validate the vacinee's address in all address fields before they are messaged to the NIR
- The provider should be noted as the "GP" and the nurse or "GP" who administers the vaccine as the "vaccinator"
- For adults wanting to opt off the recording of their influenza vaccination on the NIR please leave the opt-on/off fields blank. The vaccination information will only be recorded on your PMS and will not be sent to the NIR

Note: the NIR programme does not schedule influenza vaccinations and identify overdue influenza vaccinations in the *Overdue Tasks* report as it does for the childhood vaccinations.

Pharmacy

Pharmacist vaccinators use the NIR web application called *ImmuniseNow* to record all vaccinations on the NIR. Pharmacist vaccinators are also required to inform the person's general practitioner (GP) when they have administered an influenza vaccine. It is planned for this process to be fully automated in the future.

Other influenza vaccination settings

The Ministry is working towards expanding access to *ImmuniseNow* in the future for other influenza vaccination settings such as DHB clinics or workplaces.

Occupational health providers are also expected to notify an individual's general practice when they have administered an influenza vaccine so their records can be updated.

For questions about:

- The NIR, please contact your DHB NIR administrator or contact the Ministry of Health Support team 0800 505 125 and select option 3
- *ImmuniseNow,* contact the Ministry of Health Support Team (details above)
- Your general practice or pharmacy PMS, please contact your vendor directly

Key reference material

Influenza vaccination consent form

Patient/Guardian

Surname: _____ First name: _____

Phone: _____ Date of birth: _____ Gender: M F NHI: _____

Ethnicity: ◯ NZ European ◯ Māori ◯ Samoan ◯ Cook Island Māori ◯ Tongan ◯ Niuean ◯ Chinese ◯ Indian ◯ Other (such as Dutch, Japanese, Tokelauan) Please state: _____

Name of guardian (if applicable): _____

Address: _____

Your doctor's name / surgery address: _____

This form confirms that you have given your consent to have an influenza vaccination.
If any of the following apply to you then please advise your healthcare professional:

◯ I am currently unwell with a high fever ◯ I have had a previous severe response to an influenza vaccination

◯ I have a history of a bleeding disorder ◯ I have received treatment for cancer during the last 12 months

Possible responses to influenza vaccination:

Influenza vaccination is usually well tolerated. Possible responses include pain, redness and/or swelling at the injection site for a day or two; a mild fever, muscle aches or headache within the first two days. Rarely, an allergic response can occur.

You should remain under observation to watch for an allergic response for 20 minutes after your vaccination.

The influenza vaccine does not protect against other respiratory viruses such as the common cold. For more information on the influenza vaccine please refer to the consumer medicine information sheet located at **www.medsafe.govt.nz.**

The Ministry of Health keeps a record of influenza vaccinations on the National Immunisation Register so that authorised health professionals can find out what vaccinations have been given. It helps to monitor the population's protection against influenza. If you do not want your vaccination recorded on the National Immunisation Register please advise your doctor, nurse or healthcare professional.

I have read or have had explained to me information about influenza vaccination, and I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccination. I understand getting the vaccination is my choice. I agree to get the vaccination and that it is recommended that I wait here for 20 minutes after my vaccination.

I consent to this information being given to my healthcare provider to update applicable records.

Signed: _____ Date: _____

Signed/Guardian (if applicable): _____

Relationship to the child/patient: _____

Vaccination record (clinical use only)

Vaccine: _____ Administered: Left / right arm

Vaccine batch number: _____ Expiry date: _____

Vaccinator: _____

The influenza vaccine is a prescription medicine. Talk to your healthcare professional about the benefits and possible risks.

Key reference material 10

Useful contact information

All the information and contacts you may need are here:

Vaccination eligibility, clinical queries and general information

The Immunisation Advisory Centre (IMAC)
The University of Auckland

Phone: 0800 IMMUNE (0800 466 863)
Email: 0800immune@auckland.ac.nz

The New Zealand *Pharmaceutical Schedule* is available from PHARMAC at www.pharmac.govt.nz.

Ordering printed influenza resources

Online ordering only, available at www.influenza.org.nz/resources.

Ordering vaccine

Healthcare Logistics (HCL)
You can order in two ways:

ONLINE: www.hcl.co.nz
(preferred option, registration required)
TOLL-FREE fax: 0508 408 358

The order form is available on page 8 and is also available from www.influenza.org.nz in the *Resources* section.

Enquiries

Phone: 0508 425 358

Cold chain

Your Immunisation/Cold Chain Coordinator.

Ministry of Health

The *National Standards for Vaccine Storage and Transportation for Immunisation Providers 2017* are available from www.health.govt.nz/coldchain.

Claiming funded vaccine

Sector Services Help Desk

Phone: 0800 458 448 and select option 5

The manual claim form is available from www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/immunisation-subsidy.

NHI number

Sector Services

Phone: 0800 855 151

Reporting adverse events following immunisation

Centre for Adverse Reactions Monitoring (CARM)

Phone: (03) 479 7247
Email: carmnz@otago.ac.nz
Website: nzphvc.otago.ac.nz

(online reporting, use your practice number as login)

National Influenza Immunisation Programme promotion

Phone: (09) 373 7599 ext. 82075
Email: influenza@auckland.ac.nz
Website: www.influenza.org.nz

Your Immunisation Coordinator may be able to assist with more information.

National Immunisation Register

Ministry of Health Support team

Phone: 0800 505 125 and select option 3

Your District Health Board NIR administrator may be able to assist with more information.

ImmuniseNow

Ministry of Health Support team

Phone: 0800 505 125 and select option 3

NIR leaflet for adults (HE2423)

Available from HealthEd at www.healthed.govt.nz.

Vaccine data sheets

Available from www.influenza.org.nz, or Medsafe at www.medsafe.govt.nz

Summary table for 2018 funded influenza vaccines

Vaccine brand:	INFLUVAC® TETRA	FLUARIX® TETRA
Manufacturer:	• Mylan • Phone: 0800 737 271	• GlaxoSmithKline NZ Ltd • Phone: 0800 808 500
Funding status:	• Fully funded for eligible adults and children aged 3 years or older	• Fully funded for eligible children aged under 3 years, i.e. aged 6–35 months (not available until mid-April 2018)
Dosage:	See table below	See table below

INFLUVAC® TETRA

Age	Dose	Number of doses
6–35 months	NOT FOR USE IN THIS AGE GROUP	
3–8 years	0.5 mL	1 or 2*
≥ 9 years	0.5 mL	1

*Two doses separated by at least four weeks if an influenza vaccine is being used for the first time.

FLUARIX® TETRA

Age	Dose	Number of doses
6–35 months	0.5 mL#	1 or 2*
3–8 years ≥ 9 years	NOT FOR USE IN THESE AGE GROUPS	

#A full 0.5mL dose is administered for this age group
*Two doses separated by at least four weeks if an influenza vaccine is being used for the first time.

	INFLUVAC® TETRA and FLUARIX® TETRA
Influenza strains for 2018:	• A/Michigan/45/2015 (H1N1) pdm09-like virus • A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus • B/Phuket/3073/2013-like virus • B/Brisbane/60/2008-like virus
Route of administration:	• Intramuscular
Precaution:	• Influenza vaccination may be contraindicated or need to be delayed for people receiving the following cancer treatments, atezolizumab (Tecentriq®), ipilimumab (Yervoy®), nivolumab (Opdivo®) and pembrolizumab (Keytruda®), refer to page 16 for more information
Components of special note:	• Gentamicin • Less than 1 microgram ovalbumin
Latex:	• INFLUVAC® TETRA cannot be considered latex-free • FLUARIX® TETRA is latex-free
Presentation:	• Pre-filled syringe: 0.5 mL
Storage:	• Vaccines must be stored, protected from light, at +2°C to +8°C. DO NOT FREEZE • Temperature-monitored chilly bins must be used if vaccines are temporarily stored outside the vaccine refrigerator or being transported • Quarantine vaccines stored outside the required temperature range and contact your Immunisation/Cold Chain Coordinator
Order from:	• Healthcare Logistics (HCL) • Phone: 0508 425 358 • Fax: 0508 408 358 • www.hcl.co.nz

INFLUVAC® TETRA and FLUARIX® TETRA are a prescription only medicines.
Please refer to the Medsafe data sheets for further details.
www.medsafe.govt.nz and **www.influenza.org.nz**

The Immunisation Advisory Centre
www.influenza.org.nz
0800 IMMUNE
(0800 466 863)
www.immune.org.nz

Questions and answers about the 2018 funded influenza vaccines

What are the funded influenza vaccines for 2018?

- INFLUVAC® TETRA (Mylan) is the funded influenza vaccine for adults and children aged 3 years or older.
- FLUARIX® TETRA (GSK) is the funded influenza vaccine for children aged under 3 years, i.e. aged 6–35 months.

Both are quadrivalent vaccines. For more information, please refer to the Medsafe data sheets (www.medsafe.govt.nz or www.influenza.org.nz) and vaccines summary table on page 12 of this resource.

What are the influenza vaccine strains for 2018?

The funded quadrivalent influenza vaccines in 2018 offer protection against the following influenza strains:[19]

- A/Michigan/45/2015 (H1N1) pdm09-like virus
- A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus
- B/Phuket/3073/2013-like virus
- B/Brisbane/60/2008-like virus

The A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus in this year's vaccine is broadly matched to the strain being referred to in the media as *'Australian flu'*. This strain circulated in the southern hemisphere during winter 2017 and severely affected the northern hemisphere during their 2017–2018 winter.

Is there a minimum interval between an influenza vaccination at the end of 2017 and this year's vaccination?

No minimum interval is required between an influenza vaccination in 2017 and one in 2018. The 2018 influenza vaccination can be given as soon as the vaccine is available.

Why is an influenza vaccination recommended every year?

Yearly vaccination is recommended for two reasons: first, because protection from the previous vaccination lessens over time; and second, because the circulating influenza viruses can change and the strains in the vaccine usually change each year in response to the changing virus pattern.

Can INFLUVAC® TETRA or FLUARIX® TETRA be administered to people receiving anticoagulant medication?

Yes. Influenza vaccines can be administered to people on anticoagulants, including aspirin, dabigatran (Pradaxa®), enexoparin (Clexane®), heparin, and warfarin.[23] After vaccination, apply firm pressure over the injection site without rubbing for 10 minutes to reduce the risk of bruising.

Can INFLUVAC® TETRA or FLUARIX® TETRA be administered simultaneously with other vaccines?

Yes. Influenza vaccine can be administered with other vaccines, such as Tdap, the zoster (shingles) vaccine, pneumococcal vaccines or the childhood National Immunisation Schedule vaccines. However, the vaccines must be given at different injection sites.

In one study, children aged 6–23 months are two to three times more likely to develop a fever of 38°–39°C during the first 24 hours after receiving influenza and PCV13 (PREVENAR 13®) vaccines at the same visit compared with children who received the vaccines on separate days.[24]

Around one in 10 adults have an increased risk of experiencing fatigue, headache and/or body aches and pains during the 14 days after receiving influenza and PCV13 vaccines at the same visit.[25]

Around two in 10 adults have an increased risk of redness or pain at the site of one or both injection sites when receiving influenza and 23PPV (PNEUMOVAX®23) vaccines concurrently.[26-28]

Separating administration of these vaccines by two days can be offered, but is not essential.

Can INFLUVAC® TETRA and FLUARIX® TETRA be given to people with egg allergy or anaphylaxis?

Yes. These vaccines can be safely administered to people with a history of egg allergy or egg anaphylaxis at general practices, pharmacies or at the workplace.[2] Studies have shown that influenza vaccines containing less than one microgram of ovalbumin do not trigger anaphylaxis in sensitive individuals.[2] The residual ovalbumin in one dose of INFLUVAC® TETRA or FLUARIX® TETRA is significantly below this limit.[3,4]

Can INFLUVAC® TETRA and FLUARIX® TETRA be given to people with a sulfonamide (sulfur) allergy?

Yes. Sulfonamide (sulfur) antibiotics, such as co-trimoxazole, sulfasalazine, and sulfite preservatives used in food are different to medicines containing the words sulfate or sulphate, e.g. gentamicin sulphate.[29]

How are INFLUVAC® TETRA and FLUARIX® TETRA produced?

INFLUVAC® TETRA and FLUARIX® TETRA are subunit vaccines that contain only viral surface antigens (haemagglutinin proteins). Influenza virus is grown in embryonated hens' eggs from disease-free flocks and inactivated. The haemagglutinin protein for each strain is harvested and purified for use in the vaccine.[3,30]

Do INFLUVAC® TETRA and FLUARIX® TETRA contain gentamicin?

Yes. Both vaccines contain traces of gentamicin due to the use of this substance during production.[3,30] INFLUVAC® TETRA and FLUARIX® TETRA should be used with caution in people with a hypersensitivity to gentamicin.

Are INFLUVAC® TETRA and FLUARIX® TETRA latex free?

INFLUVAC® TETRA syringes do not contain any latex components. However, the manufacturer (Mylan) is unable to confirm that the product did not come in contact with any latex materials during the manufacturing and packaging process.

FLUARIX® TETRA prefilled syringes with a separate needle do not have any components made using natural rubber latex.[30]

If no latex-free influenza vaccine is available, please call 0800 IMMUNE (0800 466 863) before vaccinating a person who is highly sensitive to latex with a history of severe hypersensitivity response.

Do INFLUVAC® TETRA and FLUARIX® TETRA contain blood products?

No. Blood products are not used in the manufacturing processes for these vaccines.[3,30]

Do INFLUVAC® TETRA and FLUARIX® TETRA contain thiomersal?

No. Both these vaccines are preservative free. They do not contain thiomersal.[3,30]

Can you get influenza from INFLUVAC® TETRA and FLUARIX® TETRA?

No. These vaccines have been made from influenza viruses that have been concentrated, inactivated, and then broken apart. Neither INFLUVAC® TETRA nor FLUARIX® TETRA can cause influenza as the vaccines do not contain any live viruses.[3,30]

Sometimes influenza vaccination is accused of causing the disease. There are two possible reasons for this. First, when vaccinated, the body responds to vaccination by producing an immune response. This can include systemic symptoms such as fever, headache or fatigue, which may mistakenly be assumed to be early signs of influenza but are the body responding to the vaccination. Second, other respiratory viruses and bacteria circulate during the winter months and influenza vaccination does not protect against these.

Most of these other viruses cause milder infections. However, some viruses and bacteria may produce influenza-like symptoms and/or quite severe illness which can lead to the suggestion that influenza vaccination is ineffective. These illnesses should not be confused with influenza.

How effective are the vaccines against influenza strains not included in the formulation?

Effectiveness can be reduced by a difference between circulating virus strains and vaccine strains. The influenza virus keeps changing and new vaccines are formulated for each northern and southern hemisphere season. There may be some cross protection against a virus type that is not in the vaccine[31,32] but the amount of protection cannot be guaranteed or easily quantified.

Pharmacist vaccinators

Many community pharmacies offer purchased influenza vaccination for individuals aged 13 years or older. Some community pharmacies also provide funded influenza vaccination for:

- **pregnant women, and**
- **people aged 65 years or over**

Safety of inactivated influenza vaccines

Common responses to vaccination

Influenza vaccine is generally well tolerated.

Common responses associated with inactivated influenza vaccines in adults and children include pain, redness and/or swelling at the site of injection. Local responses are almost always mild. Systemic events such as headache, muscle aches and fatigue may occur in adults.[33-39] Fever, irritability and loss of appetite are more likely to occur in children.[33-35,40-45] These are generally mild and usually resolve after a day or so. Systemic events may appear influenza-like. However, the influenza vaccines currently used in New Zealand do not contain live viruses and cannot cause the disease.[33-35]

Serious events associated with influenza vaccination

The most significant serious adverse event associated with influenza vaccination is anaphylaxis, a serious allergic response that usually comes on within minutes of receiving the vaccine. This occurs around once in a million influenza vaccine doses.[46]

With the possible exceptions of Guillain-Barré syndrome (refer below) and that side effects related to some new immune-stimulant cancer treatments could be triggered (refer to page 16), other serious adverse events are no more likely to occur in individuals who are vaccinated compared with those who are unvaccinated.[33-35]

Guillain-Barré syndrome and influenza vaccination

Guillain-Barré syndrome (GBS) has an annual incidence of around 1–4 cases per 100,000 people worldwide.[47]

During a swine influenza vaccination campaign in the United States in the 1970s, an increase in GBS was observed in vaccine recipients (around one case per 100,000 vaccinations) and the vaccination campaign was halted and surveillance of GBS expanded.[48]

Epidemiological studies since then have suggested either no increased risk or a possible slight increase in risk of around one case per million adult influenza vaccinations. A recent meta-analysis of these studies identified a small increase in the risk of GBS following influenza vaccination.[49] However, studies have also identified that the risk of GBS following an episode of influenza-like illness is significantly higher than the risk following influenza vaccination, especially in older adults.[50,51] This highlights the importance of balancing the potential risks of disease with the potential risks and benefits of influenza vaccination to make an informed decision.[52]

Febrile events following influenza vaccination

Fever is a common adverse event in children after vaccination.[41-45] Convulsions associated with fever can occur in susceptible children. Around 3–8 children in 100 aged under 7 years will experience a febrile convulsion, most likely when aged between 16 and 30 months.[53]

In one study, children aged 6–23 months were two to three times more likely to develop a fever of 38°–39°C during the first 24 hours after receiving influenza and PCV13 (PREVENAR 13®) vaccines at the same visit compared with children who received the vaccines on separate days.[24]

Parents/guardians whose children are recommended to receive both influenza vaccine and PCV13 should be advised of the possible increase in risk of fever following concurrent administration of these vaccines. Separating administration of these vaccines by two days can be offered, but is not essential.

For the PREVENAR 13® data sheet please refer to the Medsafe website www.medsafe.govt.nz.

Reporting adverse events following influenza vaccination

Healthcare professionals/vaccinators are professionally and ethically responsible for reporting any serious or unexpected adverse events after the administration of all medicines, including the influenza vaccine, regardless of whether or not they consider the event to have been caused by the vaccination.

Information should include:

- vacinee's details
- the vaccine administered
- vaccine batch number
- date of onset of symptoms
- type and duration of adverse event
- treatment required
- outcome if known but do not delay reporting while waiting outcome information

Some providers are able to report events through their practice management system. Reports can be completed online (nzphvc.otago.ac.nz), or the form can be downloaded and printed using the above link, completed and mailed to:

Freepost 112002
The Medical Assessor
Centre for Adverse Reactions Monitoring
University of Otago Medical School
PO Box 913, Dunedin 9054
or faxed to: (03) 479 7150

Contraindications and precautions to receiving influenza vaccine

Who should not receive the vaccine?

Influenza vaccination is contraindicated for individuals who have had documented anaphylaxis to any ingredient in the vaccine except egg,[2] or a previous dose of inactivated influenza vaccine. These individuals should not receive the vaccine.

Influenza vaccination may be contraindicated or need to be delayed for people receiving some new cancer treatments

The immune-stimulant actions of atezolizumab (Tecentriq®), ipilimumab (Yervoy®), nivolumab (Opdivo®) and pembrolizumab (Keytruda®) on the immune system increase a person's risk of developing autoimmune conditions. It is not known whether receipt of an influenza vaccine whilst receiving these treatments or for up to six months after treatment increases a theoretical risk of triggering the occurrence of these side effects.

Please contact the person's oncologist or 0800 IMMUNE (0800 466 863) for current advice about influenza vaccination for these people BEFORE administering the vaccine.

Effectiveness of inactivated influenza vaccines

The efficacy (prevention of illness among vaccinated individuals in controlled trials) and effectiveness (prevention of illness in vaccinated populations) of influenza vaccines is dependent on several factors. The age, immune status and health of the recipient are important as well as the match between circulating viral strains and the vaccine. Research comparing vaccinated with unvaccinated participants show outcome measures that include laboratory-confirmed infection with influenza virus provide the most robust evidence of vaccine efficacy.

Trivalent influenza vaccines contain two influenza A strains (a H1N1 and a H3N2 strain) and one influenza B strain (from either the Yamagata or Victoria line). Quadrivalent influenza vaccines contain two influenza A strains (a H1N1 and a H3N2) and two influenza B strains (one from each line). Receipt of a quadrivalent influenza vaccine broadens the immune response, which may provide additional protection if influenza B viruses from both lines are circulating or the predominant circulating influenza B virus is not from the line included in the trivalent vaccine.[54]

Inactivated influenza vaccine effectiveness against influenza in recent meta-analyses and systematic reviews ranges from 59% (95% confidence interval 51–67%)[32] to 73% (95% confidence interval 54–84%)[31] in healthy adults for years when circulating and vaccine strains are well matched. Vaccine effectiveness may not be as high in the elderly and those with high-risk conditions. A re-analysis of the Cochrane Review, *Vaccines for preventing influenza in the elderly,*[55] applying a biological perspective to the same information found that influenza vaccination of the elderly is often protective.[56]

The following table summarises selected current estimates of both vaccine efficacy and vaccine effectiveness against a range of clinical outcomes.

Population	Type of outcome	Level of protection (95% confidence intervals)
Infants aged under 6 months whose mothers received an influenza vaccination during pregnancy	Efficacy against laboratory-confirmed influenza	41–49%[57-59]
Healthy children aged under 2 years	Effectiveness against laboratory-confirmed influenza	Insufficient data [32,60] 66% (9–88%)[61]
Healthy children aged 6–35 months	Effectiveness against laboratory-confirmed influenza	66% (29–84%)[61]
Healthy children aged under 16 years	Effectiveness against influenza requiring hospitalisation	56% (12–78%)[62]
Healthy adults (aged 18–64 years)	Effectiveness against influenza-like illness requiring a general practitioner (GP) visit or hospitalisation in NZ	30–60%[63]
	Effectiveness against laboratory-confirmed influenza	59% (51–67%)[32]
Pregnant women	Effectiveness against acute respiratory illness requiring: an emergency department visit, or hospitalisation	81% (31–95%)[64] 65% (3–87%)[64]
	Effectiveness against laboratory-confirmed influenza	50% (15–71%)[59]
Adults aged 65 years or older (Cochrane Review 2010)[55]	Effectiveness in preventing influenza, influenza-like illness, hospitalisations, complications and mortality	Inconclusive due to poor quality of studies[55]
Adults aged 65 years or older (Re-analysis of Cochrane Review 2010 information)[56]	Effectiveness against non-fatal and fatal complications	28% (26–30%)[56]
	Effectiveness against influenza-like illness	39% (35–43%)[56]
	Effectiveness against laboratory-confirmed influenza	49% (33–62%)[56]

Influenza vaccines are effective in children; however less evidence is available for children aged under 2 years.[32,60] In healthy adults, influenza vaccines are effective in reducing cases of influenza particularly when the vaccine and circulating virus strains are well matched.[32,63] Evidence suggests the effectiveness of influenza vaccination in the community-dwelling elderly is modest. There is some evidence that in long-term care facilities, influenza vaccination is effective against complications.[55]

Pooled New Zealand data from the Southern Hemisphere Influenza and Vaccine Effectiveness Research and Surveillance (SHIVERS) study have shown that influenza vaccine effectiveness over 2012–2015 was around 46% (95% confidence interval 35–55%) preventing influenza-like illness presentations to general practice and 52% (41–62%) preventing influenza-related hospitalisations.[63,65-67] For 2017, the seasonal level of influenza was too low to allow robust estimates of influenza vaccine effectiveness at preventing influenza-like illness presentations to general practice and influenza-related hospitalisations.[68]

How long after vaccination does it take for antibodies to be produced?

It can take up to two weeks for the vaccine to provide the best influenza protection. However, influenza vaccinations can be given when influenza virus activity has been identified as protective antibody levels have been observed to develop rapidly from four days after vaccination.[17,18]

Influenza and older people

As we age our immune system becomes less efficient at preventing infectious diseases and associated complications.[69] Older people (aged 65 years or older) with influenza are more likely to require hospitalisation and significantly more likely to die than adults with influenza who are aged under 65 years. The presence of chronic conditions such as diabetes or heart, kidney, neurological or respiratory diseases adds to their risk of influenza-related complications.[69,70]

Although older people may have a reduced immune response to influenza vaccine compared with younger adults, they may still benefit from influenza vaccination.[56,71,72]

Influenza vaccination has been shown to reduce symptom severity in older adults who get influenza despite having been vaccinated.[73]

Influenza vaccination is recommended (although not funded) for those who are in close contact with older people and individuals at high risk of influenza infections to reduce the spread of disease to those who are more vulnerable and also may be less likely to mount a strong immune response to the vaccine.

Influenza and pregnancy

Influenza affects different population groups disproportionately with pregnant women, the very young, the very old and people with certain health conditions at highest risk of serious complications.

Two important groups at high risk of disease and serious complications have been recognised since the 1918 influenza pandemic,[74] they are pregnant women and their babies (up to 6 months of age).[75-83]

Influenza vaccination of pregnant women during any stage of pregnancy has been found to be highly effective in preventing influenza and its complications in the woman and her baby, during pregnancy and for up to six months after birth by the passive protection passed on to the baby in utero, through the placenta.[57,58,64,83-88]

The World Health Organization recommends influenza vaccination of pregnant women at any stage of pregnancy, and that they are given the highest priority.[12] Influenza vaccination has been recommended and funded in New Zealand for pregnant women since 2010.

Inactivated influenza vaccine is used in New Zealand. There are no concerns about the safety of influenza vaccination during any trimester of pregnancy.[83,89-101]

The funded influenza vaccine is usually available from March until 31 December.

Pregnancy

It is well established that some of the physiological changes that occur during pregnancy leave pregnant women and their growing baby at greater risk of serious influenza complications.[77,107-109]

Influenza infection during pregnancy can have catastrophic consequences for both mother and baby including premature birth, stillbirth, small for gestational age and perinatal death.[76-79,82]

Physiological changes during pregnancy that can lead to complications from influenza include the following:

- **Immune system:** While humoral (antibody mediated) immunity appears to be enhanced, the cellular arm of the immune system is temporarily suppressed. This is to prevent harmful immune responses being directed at the growing baby, which is genetically foreign to the mother. These changes can leave a pregnant woman more vulnerable to some intracellular pathogens including viral infections[77,107-109]
- **Physical changes:** Changes in the pelvic region, abdominal and thoracic cavities place pressure on surrounding organs. Lung capacity is decreased and oxygen consumption increased. Blood volume, heart rate and the amount of blood pumped per contraction (stroke volume) are increased[107]

Risk for the woman

Data from the Southern Hemisphere Influenza and Vaccine Effectiveness Research and Surveillance (SHIVERS) hospital-based surveillance for severe acute respiratory infections in Auckland during 2012–2014 identified that pregnant women with influenza were five times more likely to be hospitalised than non-pregnant women.[1] A normally healthy woman who is pregnant has a similar risk for complications from influenza as non-pregnant women who have co-morbidities. This risk increases with gestation. When pre-existing medical conditions are superimposed on pregnancy the risks become even higher.[75,83]

Evidence suggests that pregnant women are even more vulnerable during pandemics.[78,82]

Risk for the growing baby

Direct vertical transmission of the influenza virus to the growing baby is thought to be extremely rare. The adverse effects observed on the baby in mothers who have influenza are likely to be indirect, i.e. as a result of the mother's response to the virus. Maternal influenza infection can be associated with congenital abnormalities caused by fever.[76] Overall there is an increase of general pregnancy complications in women who have influenza.[77-79,82,83]

Historical studies proposed a possible link between maternal influenza infection during pregnancy and an increased risk of cancer in infants and children, such as leukaemia, brain tumours or neuroblastomas. The increased risk of cancer in a child born to a mother who had influenza during pregnancy was extremely low as these are rare cancers.[110]

Risk for young babies

Babies aged under 6 months have a higher risk of being hospitalised with influenza than other age groups.[80,81,83,111] Influenza-related complications can include fever-related convulsions, vomiting and diarrhoea, pneumonia and occasionally brain inflammation.

In Auckland during 2017, infants aged under 1 year had the second highest rate of hospitalisation with a severe acute influenza respiratory infection compared with other age groups, 145 cases per 100,000 people compared with 283/100,000 for adults aged 80 years or older, 97/100,000 for adults aged 65–79 years and 17/100,000 for midlife adults.[11]

Influenza vaccination during pregnancy

Within New Zealand, influenza vaccination coverage of pregnant women has been very modest. Research has identified that the most significant barriers to vaccination during pregnancy are –

- A lack of information about:
  - influenza disease and potential complications, and
  - the "two for one" benefit of maternal influenza vaccination
- No recommendation from the woman's Lead Maternity Carer or other healthcare professionals involved in her care
- Structural barriers to accessing services through general practice[102]

There is considerable research to show that patients value the recommendation of their health professional.[103-105] Studies also show the importance of an explanation covering the risks associated with influenza disease, the effectiveness of vaccination for the woman and her baby, and the excellent safety record of influenza vaccination during pregnancy during the decision-making process.[103-106]

In 2018, some community pharmacies will provide funded influenza vaccination to pregnant women.

Influenza vaccination of pregnant women is recorded on the NIR to help monitor vaccination coverage and assess influenza protection. Refer to the section *Recording influenza vaccinations on the National Immunisation Register* on page 9.

Discuss influenza vaccination with pregnant women and their whānau

1. Explain

a. The risk of influenza for the pregnant woman, her growing baby and her vulnerable newborn

b. The effectiveness of the vaccine in reducing the influenza risk for the woman and her baby, both during pregnancy and after birth

c. The excellent safety record of influenza vaccination during pregnancy; and the potential complications from catching influenza, which pose a greater threat to the woman and her baby

2. Make a clear recommendation for the woman to receive an influenza vaccination during pregnancy

Effectiveness and safety of inactivated influenza vaccines during pregnancy

How effective is the inactivated influenza vaccine when given during pregnancy?

The immune response to influenza vaccination in pregnant women is similar to that of non-pregnant women.[112,113] The efficacy (prevention of illness among vaccinated individuals in controlled trials) and effectiveness (prevention of illness in vaccinated populations) of influenza vaccines is dependent on several factors. The age and immune status of the recipient are important as well as the match between circulating viral strains and the vaccine.

Influenza vaccination during pregnancy provides "two for one" protection, reducing the maternal risk of influenza disease and associated complications and the risk for their baby during the first six months after birth.[57-59,64,83-88,114]

A review of acute respiratory illness (ARI) and influenza vaccination during pregnancy over the 2012 and 2013 Australian influenza seasons identified that women who received an influenza vaccination during their pregnancy were 81% less likely to attend an emergency department with an ARI, and 65% less likely to be hospitalised than pregnant women who were not vaccinated.[64]

An increase in circulating maternal influenza antibodies after vaccination supports maximum transplacental antibody transfer to the growing baby and protection against influenza after birth.[113] Babies born during an influenza season in 2002–2005 in the U.S. were followed until they were aged 6 months. Those born to mothers who received an influenza vaccination during pregnancy were 41% less likely to have laboratory-confirmed influenza and 39% less likely to be admitted to hospital with an influenza-like illness than babies whose mother didn't have an influenza vaccination.[57]

How safe is receiving the influenza vaccine during pregnancy?

Inactivated influenza vaccines have been recommended for and used in pregnant women since the 1960s, along with ongoing safety monitoring and research.[89] Influenza vaccination during pregnancy has an excellent safety record for the woman herself, the growing baby and newborn.[89,90,92]

Studies comparing hundreds of thousands of vaccinated women with unvaccinated women have identified a lower incidence of stillbirth for vaccinated women[94-96,101] and no difference in the incidence of preterm births, or occurrence of congenital malformations.[91,93,95,97-101] No relationship between maternal influenza vaccination and spontaneous abortion has been identified.[96,97,99,115-117]

Questions and answers for pregnant women

Is INFLUVAC® TETRA the funded influenza vaccine for pregnant women?

Yes. One dose of the inactivated quadrivalent influenza vaccine is recommended each influenza season/year that a woman is pregnant. A woman who is pregnant across two influenza seasons would receive two influenza vaccinations during her pregnancy.

Is there a minimum interval between receiving an influenza vaccination at the end of 2017 and receiving one in 2018?

No. The 2018 influenza vaccination can be given as soon as the vaccine is available. No minimum time is required between an influenza vaccination in 2017 and one in 2018.

Why is an influenza vaccination recommended every year?

Yearly vaccination is recommended for two reasons: first, because protection from the previous vaccination lessens over time; and second, because the circulating influenza viruses can change and the strains in the vaccine usually change each year in response to the changing virus pattern.

Women who are pregnant across two influenza seasons are recommended to have an influenza vaccination in both of the seasons. In addition to the reasons explained above, a pregnant woman's risk from influenza also increases with increasing gestation.

When is the best time to be vaccinated?

Influenza vaccination can be given at any time during pregnancy. It is preferable to vaccinate as soon as the vaccine is available (usually from March), well before the start of winter. The funded vaccine is available through to 31 December.

Can influenza and whooping cough booster vaccinations be given at the same visit?

If the woman is between 28–38 weeks of pregnancy (in their third trimester) the influenza vaccine and whooping cough booster vaccine (Tdap) can be administered at the same visit. Both vaccines are funded for pregnant women.

Can women with a history of miscarriage receive an influenza vaccination?

Yes. Influenza vaccination does not increase the risk of miscarriage. However, catching influenza can increase the risk.

Can a post-partum woman receive an influenza vaccination? Will it protect her baby if she is breastfeeding?

It is safe for a breastfeeding woman to have the influenza vaccination. Breastfeeding may offer some initial influenza protection to her baby. However, babies will have more protection if their mother is vaccinated during pregnancy.

Is the influenza vaccine a live vaccine?

No. The influenza vaccine used in New Zealand does not contain any live viruses; the influenza viruses are completely inactivated and cannot cause influenza.

Are there any preservatives in the influenza vaccine, e.g. thiomersal?

No. The vaccine used in New Zealand is preservative free.

Should pregnant women who work with children receive an influenza vaccination?

Yes. Influenza infection rates are generally highest in children, and they are a major source of the spread of influenza. The influenza virus may be found in respiratory secretions (breathing, coughing and sneezing) for two weeks or longer in children. The risk of exposure to the influenza virus is higher and, for pregnant women, so is their risk of influenza disease and serious complications.

It is also important for all people working with children, and especially young babies, to be vaccinated against influenza to reduce the risk of passing influenza onto them.

Vaccination and breastfeeding

The influenza vaccine can be given to a breastfeeding woman. Protecting the mother can help prevent her becoming infected and transmitting influenza to her baby. Breastfeeding may offer some protection against influenza.

Influenza and children

Influenza infection rates are generally highest in children.[68,81,118] Healthy children are also the major cause of the spread of influenza viruses in the community.[81,118] Vaccination of healthy children has the potential to substantially reduce influenza-like illness and related costs in both the children themselves and their families.[119]

Influenza vaccination recommendations vary between countries. The United States recommends annual vaccination for all persons from 6 months of age.[120]

The United Kingdom influenza vaccination programme includes annual vaccination for all children aged 2–8 years with a live attenuated nasal spray influenza vaccine with the strategy to offer both individual protection and herd immunity.[121] This type of influenza vaccine is expected to be more effective in children but is not currently available in New Zealand.

New Zealand's current strategy

The current New Zealand strategy for children is to offer free influenza vaccination to those with certain medical conditions most likely to lead to serious influenza-related complications.[122]

Children aged 6 months to under 9 years who are receiving the influenza vaccine for the first time should receive two doses four weeks apart.[123] Children who have received a previous influenza vaccination need only a single dose.

Age	Funded vaccine brand	Dose	Number of doses
6–35 months	FLUARIX® TETRA	0.5 mL#	1 or 2*
3–8 years	INFLUVAC® TETRA	0.5 mL	1 or 2*
≥ 9 years			1

#A full 0.5 mL dose is administered for children aged 6–35 months

*Two doses separated by at least four weeks if an influenza vaccine is being used for the first time.

Why does a child aged under 9 years need two doses if being vaccinated for the first time?

Children under 9 years of age who are receiving influenza vaccine for the first time have a better immune response after two priming doses of vaccine. This may be because they are more likely to be immunologically naive to influenza.[123]

Children who have received one influenza vaccine any time in the past only need a single dose in the current season.

Why does a child aged 6–35 months receive a full 0.5 mL dose of FLUARIX® TETRA?

The historical recommendations to use a half-dose of influenza vaccine in this age group related to older whole-cell influenza vaccines that caused strong vaccine responses such as fever.

Current influenza vaccines are subunit vaccines that contain only viral surface antigens (haemagglutinin proteins). They are generally well tolerated by children in this age group. However, their ability to induce a robust immune response and protection from influenza is variable.

Receipt of a full 0.5 mL dose of inactivated influenza vaccine has the potential to improve protection against influenza.[45] Studies of children receiving a full 0.5 mL dose of quadrivalent inactivated influenza vaccine show that the vaccine is well tolerated, with vaccine responses comparable to those following either a full dose or a half dose inactivated trivalent influenza vaccine.[43-45]

Use of paracetamol following vaccination

The routine prophylactic use of paracetamol or any other antipyretic to control fever either prior to or following vaccine administration is not recommended. Evidence shows that the immune response to some antigens can be reduced.[124] However, there is no evidence that this causes individuals to be less protected from disease.

The current recommendations are as follows:

- Do not use routine prophylactic antipyretics pre- or post-vaccination in the absence of pain or significant discomfort
- Infants who are uncomfortable with fever should first be managed with appropriate removal of clothing and other cooling measures such as cool drinks or tepid sponging
- Only use analgesics (paracetamol or ibuprofen) for relief of pain or significant discomfort post vaccination

NOTE: treatment advice may differ for other groups.

Anyone with concerns following vaccination should seek medical advice

Influenza and other special groups

Immune compromised

Individuals who are immune compromised are at high risk of severe influenza and complications. It is important to offer vaccination prior to the initiation of chemotherapy, radiation treatment or immune suppressant medication. When this is not possible, influenza vaccination is recommended and can be given while an individual is receiving treatment. Two doses of vaccine administered four weeks apart are recommended in all age groups undergoing chemotherapy.[125] Following cessation of chemotherapy, normal immune responses return after about 30 days. Specialist's advice should be sought when considering influenza vaccination of individuals following haematopoietic stem cell or solid organ transplantation.

Regardless of their age, in the first year of being immune compromised/immunosuppressed individuals are recommended to receive two doses of influenza vaccine administered four weeks apart. Then in subsequent years, only one dose required.[126]

As the response to influenza vaccination in those with a poorly functioning immune system is likely to be low, additional preventative strategies are important to reduce their exposure to influenza. The vaccination is also recommended, although not funded, for those who are in close contact with individuals who are more vulnerable or at high risk of complications. Front-line healthcare workers are usually funded by their employer.

International travel

Studies have indicated that influenza is the most commonly contracted vaccine preventable disease amongst international travellers.[127,128] Influenza outbreaks have been linked to travellers.[127-129] Certain types of travel where large numbers of people are likely to be in close proximity, such as cruise ship voyages[130,131] or events that include mass gatherings[132] are particularly high risk. For these reasons, all people travelling outside New Zealand should consider influenza vaccination pre-travel. This is especially important for those who are at higher risk of influenza complications, many of whom will be eligible for subsidised vaccination.

In tropical countries, influenza activity can occur throughout the year, so vaccination is worthwhile regardless of season. In temperate climates in the northern hemisphere activity is more common between the months of December and March. If a traveller has received the southern hemisphere vaccine in the preceding New Zealand autumn or winter and the same strains are circulating in the northern hemisphere, they should remain protected. If they haven't been vaccinated in the proceeding autumn or winter or it is getting close to 6–8 months since their last influenza vaccination, repeat vaccination is recommended prior to travel. However, depending on stock, influenza vaccine may not be available for purchase far beyond the funded time period. Anyone receiving an influenza vaccination outside the funded period will need to pay.

If the southern and northern hemisphere vaccine strains differ significantly*, it would be preferable to obtain the local vaccine on arrival. However, vaccination with the southern hemisphere vaccine may offer some protection and would be preferable to having no vaccine. The northern hemisphere vaccine is not available in New Zealand.

*A comparison chart of southern hemisphere and northern hemisphere influenza vaccine strains can be seen on the back cover of this booklet.

Are there any circumstances where people may consider re-vaccinating within a year, e.g. prior to travel?

Yes. When the available vaccine gives protection against influenza viruses circulating in the northern hemisphere, travellers – particularly those in 'high-risk' groups – who will be exposed to a northern hemisphere influenza season should consider vaccination or repeat vaccination prior to travel.[127] However, re-vaccination prior to travel is not funded.

Protective antibodies peak one week to one month after vaccination and then begin to wane.[17,18] By 6–8 months after vaccination, protective levels are lower and may not be sufficient to provide good protection.

Southern hemisphere vaccine vs Northern hemisphere vaccine

The 2017–2018 northern hemisphere vaccine is different to the 2018 southern hemisphere vaccine.[12,61]

Southern hemisphere influenza vaccine for 2018[19]

Quadrivalent vaccines

- A/Michigan/45/2015 (H1N1) pdm09-like virus
- A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus
- B/Phuket/3073/2013-like virus
- B/Brisbane/60/2008-like virus

Northern hemisphere influenza vaccine for 2017–2018[133]

Trivalent vaccines

- A/Michigan/45/2015 (H1N1) pdm09-like virus
- A/Hong Kong/4801/2014 (H3N2)-like virus
- B/Brisbane/60/2008-like virus

Quadrivalent vaccines will also include

- B/Phuket/3073/2013-like virus

Note: these strains are the same as for the Southern hemisphere influenza vaccine for 2017

References

The list of references is available in a separate document in the *Resources* section of the www.influenza.org.nz website

INFLUVAC® TETRA (inactivated influenza vaccine, surface antigen): Single-dose 0.5 mL pre-filled glass syringe with needle. **Indication:** For the prevention of influenza caused by influenza virus, types A and B in adults and children from 3 years of age in accordance with the recommendations in the National Immunisation Guideline. **Contraindications:** Anaphylaxis related to a previous dose. Hypersensitivity to eggs, chicken proteins, gentamycin, formaldehyde, cetrimonium bromide or polysorbate 80. Postpone if acute febrile illness. **Precautions:** Immunological response may be diminished if the patient is undergoing immunosuppressant treatment. **Interactions:** No interaction studies have been performed. **Adverse reactions:** Local reactions, fatigue, headache, irritability, appetite loss, fever. Anxiety-related reactions, including vasovagal reactions (syncope), hyperventilation or stress-related reactions. May be accompanied by several neurological signs such as transient visual disturbance, paraesthesia and tonic-clonic limb movements during recovery. **Dosage:** Adults and children from 3 years of age: 0.5 mL; Children 3–8 years not previously vaccinated – two doses at least four weeks apart. Children less than 3 years of age: the safety and efficacy of Influvac Tetra have not been established. **Administration:** IM or deep SC injection. **Presentation:** Single dose 0.5 mL pre-filled glass syringe with 16 mm needle, in packs of 10. Each 0.5 mL may contain no more than 100 ng ovalbumin. **Cold chain:** Store between +2°C and +8°C. Store in the original package in order to protect from light. **Sponsor:** Mylan NZ Ltd. Auckland.

FLUARIX® TETRA (inactivated influenza vaccine, split virion): Single-dose 0.5 mL pre-filled glass syringe with separate needles. **Indication:** For the prevention of influenza caused by influenza virus, types A and B in adults and children from 6 months of age. The use of Fluarix Tetra should be based on official recommendations. **Contraindications:** Hypersensitivity related to a previous dose of Fluarix Tetra or influenza vaccine or any component of the vaccine. **Precautions:** Postpone if acute febrile illness. Thrombocytopenia, bleeding disorder; previous Guillain-Barre syndrome; an adequate immune response may not be elicited in patients undergoing immunosuppressant treatment or in patients with immunodeficiency. **Interactions:** Fluarix Tetra can be concomitantly administered with pneumococcal vaccines. **Adverse reactions:** Local reactions, fatigue, headache, irritability, drowsiness, appetite loss, nausea, vomiting, diarrhoea and/or abdominal pain, fever, myalgia, arthralgia and syncope (fainting). **Dosage:** Adults and children aged 6 months or older: 0.5 mL; Children aged 6 months to under 9 years not previously vaccinated – two doses at least four weeks apart. Children less than 6 months of age: the safety and efficacy of Fluarix Tetra have not been established. **Administration:** IM injection. **Presentation:** Single dose 0.5 mL pre-filled glass syringe with separate needles, in pack sizes of 1. Each 0.5 mL may contain residual amounts of ovalbumin. Prefilled syringe with separate needles are not made with natural rubber latex. **Cold chain:** Store between +2°C and +8°C. Store in the original package in order to protect from light. **Sponsor:** GlaxoSmithKline NZ Ltd. Auckland.

The Immunisation Advisory Centre

MINISTRY OF HEALTH
MANATŪ HAUORA

Waikato District Health Board

2018 Influenza vaccination plan

The annual influenza programme is now a significant project and needs to be managed as such. This plan aims to prepare us better and make better use of our limited human resources through improved coordination and reduction of duplication of effort. This plan, and the execution thereof, will also facilitate and improve our communication with each other and our key stakeholders, including those we aim to vaccinate.

Stakeholders/Group Members

Anton Turner	Portfolio Manager, Community Pharmacy
Cilla Wyllie-Schmidt	Clinical Nurse Coordinator: Hospital Opportunistic Immunisation
Shona Duxfield	District Service Manager – Screening Services
Damian Tomic	Clinical Director, Primary and Integrated Care. Facilitating influenza vaccination in pharmacy and primary care
Felicity Dumble	Public Health Medicine Specialist / Medical Officer of Health responsible for Authorising vaccinators
Greg Peploe	Director People and Performance
Jan Goddard	Pharmacy Manager
Karen Stockman	Team Leader , National Immunisation Register
Karren Moss	H&S advisor who leads the staff influenza vaccination programme
Kathryn Jenkin	Communications and Media Manager who organises internal and external comms for influenza vaccination
Marinda van Staden	Pharmacist who manages Influenza vaccine programme
Bianca Montgomery	Pharmacy on Meade (PoM) – immunised eligible patients and visitors (and staff at end of campaign)
Tess Richardson	Senior Human Resource Consultant responsible for Staff influenza data capture and reporting
Vicki Parry	CNM – Infection Prevention and Control
Cath Knapton	CEO – Midland Community Pharmacy Group

Meeting 30/01/2018 – General discussion: Bad season in northern hemisphere.
Additional action: CWS to get feedback from the National Influenza Symposium in Wellington on 8th February for group.
Next Meeting: Tuesday 27 February 2018.

Goal	Actions	Who (service or group)	By when	Progress Notes (as at 30/01/2018)	Date completed
1. Efficient vaccine supply, distribution and stock control.	• Determine the staff vaccine to purchase, which must be Pharmac approved and preferably one the DHB will receive a rebate on • Rent three spare fridge(s) for vaccine storage (approx. 6000 staff and 150 patient units) • Order staff and patient vaccine • Update the "how to order staff vaccine guide" and "how to order patient vaccine guide" to group to incorporate into the info packs that vaccinators / patient services respectively get. • Stock can be obtained from Pharmacy by chart or requisition for services that do not hold stock. • The stock will be issued to the ward at $77.00 per pack of 10. Pharmacy staff will visit all the areas allocated daily (Monday to Friday) to ensure that the stock is maintained at maximum level set. • Add seasonal flu vaccine to the ward / outpatient area stock imprest for ordering • Patient vaccine to be prescribed on medication chart Confirm distribution list for wards/areas to know how many vaccines are required in each area. In 2017 the following areas ordered vaccine: E4, E5 A2, A4 CC1, 2, 3 Waikidz ED AMU Womens Health Clinics OPR2,3,4 ICU Tokoroa Thames The following areas will order from Pharmacy by requisition: HBC OPR1 • Label patient vaccine "for patient use" if supplied on imprest. It would be labelled with the patients name if supplied on a chart	Pharmacy	February	Pharmacy H&S and HOIS to review Volumes from 2017 and update.	

	• Health and Safety to ensure it has adequate chilly bins and temperature monitoring as per cold chain standards.				
2. Agree which vaccine should be ordered for staff	• Ensure optimal clinical efficacy and cost • Explain any difference in vaccine to staff as part of overall comms strategy	Pharmacy manager H&S manager	March	Mid March for vaccine delivery & March – June in fridges. Proposed start date for staff vaccination programme is 9th April.	
3. Develop and circulate a staff vaccinator training schedule prior to staff roster being produced for that period	• Update Moodle package with generic information • Update Moodle package once specific information about that year's vaccine is known • Advertise training options and f2f training dates eight weeks in advance • Agree criteria for which staff can undertake online training versus f2f training and communicate this to staff. • Update f2f training package	H&S manager CNC -HOIS	March	Dates are in L&D calendar. Plans to update training packages both F2F and Online to be complete by March.	

4. Communication plan in place	• Start early (January) to raise profile and highlight importance of vaccination to staff and community
	• Consider advertising in ED for eligible patients / visitors to go to PoM for vaccinating
	• Consider t-shirts or other promotional material and budget
	• Comms team to see input from key stakeholders on key messages for:
	  ○ Staff campaign
	  ○ Patient campaign
	  ○ Community (eligible patients)
	• Improve comms regarding "where to go" and times staff vaccinators are available (consider privacy for staff outside café may not be private enough)
	• Consider target graph or reporting on number of staff vaccinated per area being made available on Intranet to increase staff vaccination numbers.
		Comms staff, H&S, HOIS MCPG	February	Communications Plan_staff influ vacc_
				Communications Plan community flu vaccina
				SD to follow up with comms.
					Contacted Lydia 1/02/18 Kathryn on group but has been on leave.

5. Review of consent forms	• Staff – Pursue possibility of online pre-populated form directly from Customer Portal – unlikely for 2018 • Patient – review form • Staff – review form • Feedback to NIR regarding timely upload of data • Add tick box for pregnant women to staff consent form for accurate data collection.	HOIS H&S manager T/L, NIR	February	Make changes to forms to reflect MoH guidelines regarding pre vaccination checklist e.g egg allergy probably not required.	

6. Improved engagement of SMO and service managers to increase inpatient and outpatient influenza vaccination	• Involve CMA and DON in promoting influenza vaccine • Expand beyond CMO FD to speak to GMO • Promotion to Medical staff re: opportunistic imms • SD to speak with community group leader Joanne Deane re Targets and plan	MoOH HOIS/Comms SD	February February		Meeting set up 1/02/2018
7. Plan in place with PoM regarding picking up staff influenza vaccine after initial 4-6 week roll out.	• Liaise with Pharmacy on Meade regarding when it will be needed to provide a back-up service for staff vaccination towards the end of the campaign. • Need to manage resources to prevent influx for PoM.	H&S manager H&S/Comms/PoM	February		
8. Improve ease of access to Staff for vaccination	• Consider having a vaccinator readily available at start and end of day (used H&S in 2017) • Agree to other locations for vaccinators to improve privacy & access for staff and take pressure off PoM e.g. pop up tent in MCC • Promotion of appropriate locations	H&S manager Dir P&P Comms	Feb/March March		
9. Support community pharmacists to immunise against influenza	• DHB to promote access • DHB promotes access as part of its comms strategy • Ensure Primary care are included in the plan	MCPG/ S&F Comms DT	February/March		
10. In the event of an influenza season being announced….	• Comms on the type of mask, how to order and use etc. • Following up with unimmunised staff • Process for following up with staff who signed contracts and have not had the vaccine • Addressing concerns of staff / services regarding use of masks	Comms, IPC, MOoH	March		

	 Masks for visitors policy.msg  Flu vac staff announce_1sT Media  Flu-Sign (1).pdf • Vaccination masking policy to be revisited				

Current list of vaccinating pharmacies

- Countdown Pharmacy - Claudelands
- Unichem Pharmacy Morrinsville
- Life Pharmacy - Centre Place
- Pharmacy 547
- Fairfield Pharmacy
- Unichem Pharmacy - Tokoroa
- Life Pharmacy - Matamata
- Pollen Street Pharmacy
- Unichem Pharmacy - Flagstaff
- Unichem Pharmacy Rototuna
- Unichem Pharmacy - Te Rapa
- Unichem Pharmacy - Leamington
- Comins Care Pharmacy
- Unichem Pharmacy Marshalls
- Unichem Pharmacy Te Kuiti
- Unichem Pharmacy Cambridge
- Unichem Pharmacy - Putaruru
- Northcare Pukete Pharmacy
- Unichem Pharmacy - Glenview
- Unichem Pharmacy - Dinsdale
- Anglesea Pharmacy
- Te Awamutu Pharmacy
- Tui Pharmacy
- Westend Pharmacy
- Life Pharmacy - Chartwell
- Unichem Pharmacy - Davies Corner
- Unichem Pharmacy - Hamilton East
- Countdown Pharmacy - Cambridge
- Life Pharmacy Te Awa - The Base
- Hillcrest Healthcare Pharmacy
- West Hamilton Pharmacy
- Avalon Pharmacy
- Sanders Pharmacy
- Unichem Pharmacy - Beerescourt
- Unichem Pharmacy Grey St
- Unichem Pharmacy Heather Moore Thames
- Unichem Stephenson's Whitianga
- Mercury Bay Pharmacy

Presentations

No presentations this month.

Next Board Meeting: Tuesday 24 April 2018.