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

Next Meeting Date: 23 May 2018

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

Agenda

Board

Date: **24 April 2018**

Time: **1pm**

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

Meeting of the Waikato District Health Board

to be held on Tuesday 24 April 2018
commencing at 1pm 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 March 2018
- 3.2 Committees Minutes:
  - 3.2.1 Iwi Maori Council: 5 April 2018
  - 3.2.2 Maori Strategic Committee: 18 April 2018
  - 3.2.3 Hospitals Advisory Committee: 11 April 2018
  - 3.2.4 Community and Public Health Advisory Committee: 11 April 2018

4. **INTERIM CHIEF EXECUTIVE REPORT**

5. **QUALITY AND PATIENT SAFETY** (no report this month)

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

7. **HEALTH TARGETS**

8. **HEALTH AND SAFETY**

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

10. **DECISION REPORTS**
- 10.1 Ethnicity Based KPI Reporting
- 10.2 CBD Office Name
- 10.3 Smokefree Policy
- 10.4 Managing Board Approvals in National Oracle System

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 (no report this month)

12. PAPERS FOR INFORMATION

12.1 Summary of Return to Nursing Open Day

13. PRESENTATIONS

13.1 Progress Report from Waikato DHB's Consumer Council
Consumer Council Co-Chairs to present at 1.15pm
13.2 The Waikato Health System Plan
Tanya Maloney to present at 2.30pm

14. NEXT MEETING: 23 May 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) Waikato District Health Board for confirmation: Wednesday 11 April 2018 (Items taken with the public excluded)**
- **(iii) Audit and Corporate Risk Management Committee – to be adopted: Wednesday 28 February 2018 (All items)**
- **(iv) Community and Public Health Advisory Committee – to be adopted: Wednesday 11 April 2018 (Item 13)**
- **(v) Midland Regional Governance Group – to be received: Friday 6 April 2018**

Item 16: 2018/19 Capital Expenditure Budget – Public Excluded

Item 17: Status of the 2018/19 Operating Budget – 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-v): 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:	Capital expenditure budget 18/19 – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 17:	Operating budget 18/19 – 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 March 2018
To be confirmed: Items taken with the public excluded

15.2 Waikato District Health Board: 11 April 2018
To be confirmed: Items taken with the public excluded

15.3 Audit and Corporate Risk Management Committee: 28 February 2018
To be adopted: All items

15.4 Community and Public Health Advisory Committee: 11 April 2018
To be adopted: Item 13

15.5 Midland Regional Governance Group: 6 April 2018
To be received: All items

16. 2018/19 CAPITAL EXPENDITURE BUDGET – PUBLIC EXCLUDED

17. STATUS OF THE 2018/19 OPERATING BUDGET – 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 APRIL 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, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Bay of Plenty DHB	TBA	TBA	
Member, Capital Investment Committee	TBA	TBA	
Director, SallyW Ltd	TBA	TBA	

Crystal Beavis

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

Note 1: Interests listed in every agenda.

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

Ministry of Health and other Government entities)		
Director, Ngati Pahauwera Commercial Development Ltd	Pecuniary	None
Director, Ngati Pahauwera Development Custodian Ltd	Pecuniary	None
Director, Ngati Pahauwera Tiaki Custodian Limited	Pecuniary	None
Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)	Pecuniary	None

Dave Macpherson

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Councillor, Hamilton City Council	Pecuniary	Perceived	
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	
Partner is a minor contractor to Waikato DHB in the area of "Creating our Futures"	TBA	Potential	

Pippa Mahood

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

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

Sharon Mariu

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

Note 1: Interests listed in every agenda.

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

Conflicts related to items on the agenda.

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 28 March 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
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)
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 (Executive Director, Strategy and Funding)
Mr I Wolstencroft (Executive Director, Strategic Projects)

The Board made the following statement in relation to The Ombler Report and related issues:

"Leadership starts with the Board, the Chair and the Chief Executive. The following of policies and procedures must be demonstrated by the Board and Executive Group.

It was the responsibility of the previous Chief Executive to demonstrate exemplary leadership. That did not happen.

We want to thank all of the staff who have been involved with highlighting these issues to management and the Board.

1. ***Use of a Public Relations (PR) firm during the investigation into Dr Murray.***
   The previous Board Chair had the support of the Board to contract the PR Firm. We understand this was on the advice from the State Services Commission.

   However the use of the PR firm to write Mr Simcock's letter of resignation was not authorised by the Board. We acknowledge there was nothing to preclude this from happening and are making appropriate changes to our Delegations of Authority Policy today so this cannot happen in the future.

2. The Ombler Report

We have welcomed the finalisation of the Ombler Report. There are some specific issues that we want to comment on:

- ***State Services Commission advice not to allow Dr Murray to resign.***
  Neither the Remuneration Committee nor the Board was informed about this. We were aware that Mr Simcock was having conversations with the State Services Commission, however, this crucial aspect of the conversation was not shared.

- ***Monetary differences***
  Currently we have reclaimed $74,265.04 identified as personal expenditure.

  - *Mr Ombler identified $120,608.00 as unjustified expenditure.*

  - *We have written seeking further clarification and will revisit the repayment issue if needed.*

- ***Dr Murray being fired from Fraser Health***
  None of the Board members at the time were aware of this. As the report highlights there was a vital gap in reference checking. Future recruitment processes by this Board will ensure this never happens again.

Finally on behalf of the Board, I want to sincerely apologise to the people of Waikato and in fact the wider Midland region. The inappropriate behaviour by the previous Chief Executive has brought disrepute to this organisation. We now want to focus on supporting the high quality health services provided by our organisation and how we can enhance the care provided to our community".

The Board passed on their thanks to Ms Webb for her handling of this matter.

Mr D MacPherson proposed a resolution to recover the unauthorised spending by Mr Simcock for having the PR firm write his letter of resignation. In a show of hands two Board members voted in favour of this motion; the remainder of the Board members voted against the motion. The motion was lost.

ITEM 1: APOLOGIES FOR ABSENCE

There was an apology for absence from Ms S Mariu.

ITEM 2: INTERESTS

2.1 Register of Interests

Mr MacPherson requested that two items be removed from his list of interests:

- Deputy Chair, Western Community Centre Inc
- Partner, Chair of Ngaruawahia Community House, Inc

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: 28 February 2018

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 28 February 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 March 2018

Resolved
THAT
The Board noted the minutes of this meeting.

3.2.2 Maori Strategic Committee: 21 March 2018

Resolved
THAT
The Board noted the minutes of this meeting

3.3 Terms of Reference and Agendas of Committees

Mr N Hablous attended for this item.

There was a recommendation that an ‘s’ be added to the title of the Hospital Advisory Committee so that it is named “Hospitals Advisory Committee.

The Chair recommended to the Board that the membership of the Chief Executive Performance Review Committee consists of Ms T Hodges, Ms MA Gill, Ms S Webb and Mr M Gallagher. The Chair will be Mrs C Beavis.

The Governance Manual to be updated to reflect these changes.

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.

ITEM 4: INTERIM CHIEF EXECUTIVE REPORT

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

- Board Member Orientation – a gap had been noted in that individual 'one on ones' should be held between the Chair and each Board member to identify any training needs to ensure that each Board member is the very best that they can be.

- Drinking Water – good progress had been made on resolving five of the six corrective actions required before seeking re-accreditation of the drinking water assessment service. Waikato DHB had written to the Ministry of Health requesting closer involvement of senior officials. The Ministry of Heath are considering options and plan to meet with Waikato DHB in late April.

- Waikato Health System Plan – a Programme Director has started to lead a programme of work to bring the Plan together.

- Medical Council of NZ Review – Planning is underway for an accreditation visit for prevocational medical training on 17 and 18 April.

- Update on Legal Matters – an acknowledgement was made to the Legal Service for their efforts and contribution over the last few months. The reviews carried out by the State Services Commission and the Office of the Auditor General along with the numerous Official Information Act requests regarding the previous Chief Executive had created a significant

amount of work for the Legal team. The Chief Executive's office, Finance and IS teams had assisted with gathering the information. The Board wished to thank all of the staff involved.

Resolved
THAT
The Board received the report.

ITEM 5: QUALITY AND SAFETY REPORT

Ms M Neville attended for this agenda item.

An update on the structures in place to assure the Board of the quality of care being provided:

- A review of the Board of Clinical Governance
- Patient Safety Program Group to oversee the patient safety programmes and projects
- The Quality and Patient Safety team

Resolved
THAT
The Board received the report.

ITEM 6: FINANCIAL PERFORMANCE MONITORING

6.1 Finance Report

Ms M Chrystall and Mr A Ellis attended for this agenda item.

The report for the month of February 2018 was taken as read highlighting the following:

- Year to date showed an unfavourable variance of $2.7 million
- That result included $1.4 million one off favourable variance
- $11.2 million centrally held savings plan contained high risk initiatives phased into the budget to take effect over the balance of the year.
- A population based funding formula had been included
- A number of funding concerns i.e. revenue and cost growth would be escalated to the Ministry of Health.

Resolved
THAT
The financial statements of the Waikato DHB to 28 February 2018 were received.

ITEM 7: HEALTH TARGETS

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

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

- Immunisation rates for 8 month olds still problematic. New work streams were being considered. One being opportunistic immunising at every encounter with the health system including accident and emergency and out of hours services. Consideration was being given to an approach aimed at Māori who are over represented in the 'delayers' category.
- Raising Healthy Kids – Waikato DHB had been rated as first in the country.
- Faster Cancer Treatment had the second highest results in the country.
- Green stars had been achieved in three categories for quarter 2 – Faster Cancer Treatment; Better help for smokers to quit, Maternity; and Raising Healthy Kids. The Board recognised the huge amount of work that goes into achieving these excellent results. The Board wished to pass on their thanks to all those who helped to achieve the green stars.

Resolved
THAT
The Board received the report.

ITEM 8: HEALTH AND SAFETY

Mr G Peploe attended for this item.
The report was taken as read. It was noted that:

- Since the Board papers had been issued there had been a report of serious harm. A staff member received a fracture in the car park. The incident had been reported to WorkSafe.
- A promotional campaign for Employee Assistance Programme had been conducted. The result showed that 107 people had used the service. The usage rate equated to 1.60% of the workforce.
- Uncivil behaviour showed as a red flag. The Board asked to be kept informed of any new initiatives taken to combat this type of behaviour.

Resolved
THAT
The Board received the report.

ITEM 9: SERVICE PERFORMANCE MONITORING

9.1 Waikato Hospital Services

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

- Acute Coronary Syndrome Target – doing reasonably well with 77% of patients receiving an angiogram within the timeframe across the month of February.
- Qualitative Measures – Waikato DHB had confirmed with the Ministry of Health that it was likely to be non-compliant with ESPIs 2 and 5 for February.
- Regional and Community based services – faster cancer treatments – final result of 96.6% showed that Waikato DHB continues to delivery on this national target. Performance for October to December 2017 showed that Māori are achieving better

results than non-Māori for the 62 day health target for the Midland Cancer Network DHBs.
- Staffing and Capacity – annual leave accrued but not taken was still a major liability across medical and nursing staff groups. The Board asked for an update on nurses (including nursing graduates and enrolled nurses) whose practice certificates had lapsed.
- Clinical Services Planning – a trial using the ENT service had commenced.

Resolved
THAT
The Board received the report.

9.2 Mental Health and Addictions Service

Ms V Aitken attended for this item. It was noted:

- ED presentations - 111 had been recorded for February.
- Recovery Plans – a continued focus was occurring across the service. High turnover and constant vacancies were causal factors. More specific commentary on this topic was requested for the future.
- A stock take of residential accommodation was taking place.
- An update on HoNoS was requested for the next meeting.

Resolved
THAT
The Board received the report.

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)

ITEM 10: DECISION REPORTS

10.1 Delegations of Authority Policy Renewal

Mr D Wright tabled this item.

The report was taken as read noting the late insertion of new clause into the policy - "Delegations to the Chair". This new clause was not in the copy of the policy attached to the agenda. It would be added to policy before being published.

Resolved
THAT
The Board:
1) Noted the new clause "Delegations to the Chair" that would be added into the policy.
2) Approved the updated Delegations of Authority Policy subject to the inclusion of the clause relating to the Chair.

3) Approved that the Delegations of Authority be passed to the Minister of Health to gain his approval.

10.2 Waikato DHB Demographic Model for the 10 Year Health Systems Plan

Ms T Maloney, Dr P Atotoa-Carr and Mr R Webb attended for this item.

Planning would be undertaken in two phases. Phase one based on developing the initial model requirements. Phase two will explore the possibility of a health needs index in localities at an ethnicity level relative to each other and also develop a "health population" picture of the people in the Waikato.

Resolved
THAT
The Board noted the content of the report and endorsed the proposed methodology for creating a Waikato DHB population model.

10.3 Ethnicity Based KPI Reporting

Mr M ter Beek attended for this item.

Information was requested on renal and respiratory patients in hospital split by Māori and non-Māori and also feedback from Te Puna Oranga.

Resolved
THAT
The Board:
1) Received the report.
2) Noted the proposal for ethnicity based reporting of performance measures.
3) Provided feedback on the proposed measure and reporting format.

ITEM 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

Ms S Webb declared an interest for this agenda item. She is a member of the Capital Investment Committee.

Mr I Wolstencroft, Ms V Aitken and Dr V Endres attended for this item.

11.3.1 Programme Business Case – Strategic Assessment

The report was taken as read. It was noted that the business case followed the NZ Treasury Better Business Cases model and recognised as being an evolving document.

Resolved
THAT
The Board:
1) Received the *Creating Our Futures* Programme Business Case.
2) Endorsed the *Creating Our Futures* Programme Business Case.
3) Endorsed the *Creating Our Futures* Programme Business Case for submission to NZ Treasury, the Ministry of Health and Investment Ministers.

11.3.2 Additional Programme Resourcing

A paper was tabled seeking the approval of the Board to support the additional programme resources to enable cash flow planning and development of the programme delivery. The report was taken as read.

Resolved
THAT
The Board:
1) Received the Mental Health and Addictions Service *Creating Our Futures* additional resourcing paper.
2) Approved the draw down for capital for resourcing the Mental health and Addictions Services *Creating Our Futures* programme over the next 12 months.

ITEM 12: 2018 INFLUENZA SEASON

Dr D Tomic attended for this item. The report was taken as read.

Resolved
THAT
The Board received the report.

ITEM 13: NEXT MEETING

The next meeting to be held on Wednesday 24 April 2018 commencing at 1.00 pm at in the Board Room in the Hockin Building, Waikato hospital.

BOARD MINUTES OF 28 MARCH 2018

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

THAT:

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

Item 15: Minutes - Various
- **(i) Waikato District Health Board for confirmation: Wednesday 28 February 2018 (Items taken with the public excluded).**
- **(ii) Sustainability Advisory Committee: 28 February 2018: to be adopted (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 – Friday 2 March 2018: to be received (All items).**

Item 16: Risk Register – Public Excluded
Item 17: Interim Chief Executive 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	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	Avoid inhibiting staff advice about organisational risks	Section 9(2)(c)
Item 17: Interim Chief Executive's Report	Negotiations will be required	Section 9(2)(j)

Item 18:	**Options for moving forward with the HealthTap System**	**Negotiations will be required**	**Section 9(2)(j)**
Item 19:	**Current Status of Issues identified in relationship to previous Chief Executive's expenditure**	**Negotiations will be required**	**Section 9(2)(j)**
Item 20:	**Contemporary challenges in cardiology and the genesis of complaint**	**Protect the privacy of the complainant**	**Section 9(2)(a)**
Item 21:	**FY 2018/19 Capital Plan**	**Negotiations will be required**	**Section 9(2)(j)**
Item 22:	**Execution of provider agreements exceeding delegation**	**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 16	**Section 9(2)(ba) Avoid inhibiting staff advice about organisational risks**
Item 20	**Section 9(2)(a) of the Official Information Act 1982 – to Protect the Privacy of naural persons including that a deceased natural person**
Item 17, 18, 19, 21, 22	**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
	•		
	• Item 9.1 Update on nursing graduates and enrolled nurses whose practicing certificates have lapsed.	Sue Hayward	May Meeting
	• Item 9.2 – - Recovery Plans – more specific commentary was requested for the future. • An update on HoNoS was requested for the next meeting	Vicki Aitken	May Meeting
	• Item 10.2 – Waikato DHB demographic model for the 10 year health system plan - presentation to update the Board	Tanya Maloney	May Meeting
	• Item 10.3 – information on renal and respiratory in hospital split by Māori and non-Māori requested	Marc ter Beek	April Meeting
	• Item 23 – General Business An update be provided to the Board on what the impact would be on Waikato DHB health services if the prison services at Waikeria were expanded	Vicky Aitken	
	• Item 23 – General Business A discussion on the Community Health Forum membership and process for reporting to the Board	Mo Neville	

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Iwi Maori Council
Held on Thursday 5th April 2018
Commencing at 9.30am
In the Board Room, Hockin Building

Present:	Mr H Mikaere	Chair
	Ms T Moxon	Deputy Chair
	Mr G Tupuhi	Hauraki Māori Trust Board
	Ms M Balzer	Te Rūnanga o Kirikiriroa
	Ms K Hodge	Raukawa Charitable Trust
	Ms K McClintock	Waikato Tainui
	Ms T Ake	Tuwharetoa
	Mr T Bell	Maniapoto Māori Trust Board
	Ms S Hetet	Maniapoto Māori Trust Board
In Attendance	Ms L Elliott	Executive Director Māori Health
	Ms T Hodges	Waikato DHB Board
	Ms P Mahood	Waikato DHB Board
	Ms S Webb	Waikato DHB Board (Acting Chair)
	Ms S Greenwood	Minute taker

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Mr Harry Mikaere

ITEM 3: APOLOGIES

D. Wright, E. Topine, K. Gosman, H. Curtis, P. Taiaroa, B Bryan, T Thompson-Evans.

Moved: K Hodge
Seconded: G Tupuhi

ITEM 4: APPONTMENT OF NEW CHAIR

Te Pora Thompson-Evans has been nominated by Waikato-Tainui to be Chair of IMC. All members present in favour.

Moved: T. Moxon
Seconded: K. Hodges

ITEM 5: APPOINTMENT OF DEPUTY CHAIR

One nomination for Tureiti Moxon to remain.
All members present in favour.

Moved: K. Hodge
Seconded: G. Tupuhi

- H. Mikaere to facilitate the appointments and provide induction process.
- Chair of the IMC has the support of WDHB relationships, the MOU and all IMC members to ensure they succeed in their role.
- Tenure of new Chair was previously discussed at three years.
- A suggestion was to review the appointment annually to ensure purpose was met.

ITEM 6 JOINT MEETING BETWEEN BOARD AND IMC

- Next joint meeting being held on Thursday 3 May 2018.
- Korero around what should be discussed.
- Daniel Wu presenting to the Board.
- Discussing our service plan.
- How the two groups work together in the governance space.
- Outcome focused.
- S Webb would like to know what the IMC aspirations are.
- H. Mikaere suggested looking at operational/project level.

ITEM 7 MINUTES OF LAST MEETING

- G. Tupuhi noted that Maori Health Services weren't asked to engage with Nga Mangaru. Concerns that kaupapa Maori Services have been depicted in a negative way to the Board or anyone else that read the minutes.
- K. McClintock noted issues around the language used by DHB staff while engaging with Nga Mangaru and the feedback wording to the other services/departments.
- Discussion around process for submitting minutes in draft form. Question was asked whether draft minutes should be submitted prior to being viewed and signed off by IMC. It was noted in response that other committees send minutes in draft so the Board have core information as soon as possible.
- Noted that it is a valuable contribution and an asset to have a Maori at such a high level within the WDHB (namely Rees Tapsell).

Minutes Passed
Moved: G. Tupuhi
Seconded: H. Mikaere

ITEM 8 ACTION POINTS

In reference to action point 3, there is no mental health nurse currently in ED. There is a process in place between ED and the mental health unit.
It has been raised that a mental health nurse should be in place in ED.

ITEM 10 STRATEGIC AGENDA ITEMS

ITEM 10A – Proposed Programmes of Work – Janise Eketone

- This proposed programme of work is broken into two distinct areas of activity.
- These are detailed in pages 11 and 12 of the April agenda.

- Funding the plans will be the biggest challenge, not the plans themselves.

ITEM 10B - PLANNING FRAMEWORK PRESENTATION – Daniel Wu.

- The plan is about developing the strategy and its six priorities.
- Presentation on pages 14-24 of the April agenda.
- A Health System Plan will be taken to the Board in Nov 2018.
- This is the first time the WDHB has attempted a 10 year investment plan.

- K. Hodge noted that further reading of the plan would be required in order to understand whether this had any positive changes for the rural community.
- Also noted that it was commendable to have a collaborative approach but how would this be outlined for rural areas.
- T. Hodges noted that the LTIP should contribute to our vision however, is the models or approaches different to what we have previously done?
- S. Webb noted that: 1.) we'll need to make significant change around culture and models of care and something which articulates clearly and simply the benefits. 2.) We aren't just the WDHB; we are also part of Midland Regional.
- T. Moxon would like to see how well we can integrate Clinical; MSC; Maori Health Plan etc., etc. in terms of the whole organisation.
- D. Wu noted that we are good at saying what we have done but not so well at saying what we need to do.
- G. Tupuhi noted that IMC priority is to build capacity in Maori Service Providers and would like to see Maori voices present at the table when decisions or changes are made.
- P. Mahood wanted not only to see engagement but repeated discussion over time with stakeholders.
- How do we get Maori health initiatives floating to the top – it must be prioritised as per the WDHB strategy.

ITEM 11 MATTERS ARISING

- Noted by K. McClintock that Maori who present with self-harming are not being offered Maori services.
- Noted by members that we need to look at the process around how mental health patients are triaged in ED in order to effectively treat them. When mental health patients wait in ED for many hours it can be additionally challenging to the patients, other patients waiting and staff.
- It was noted that demand for ED is getting higher therefore a change or re-assessment needs to happen across the whole system.
- It was noted that K. McClintock is currently working on developing the ToR and attending advisory meetings in respect of a MoH contract being developed across Maori Mental Health Services.
- It was suggested that IMC have a voice within this MoH contract being developed.

ITEM 12 GOVERNANCE

ITEM 12A – MSC Minutes and verbal update.
Workforce development discussed.

ITEM 12B – Hospital Advisory Committee

Improvement in terms of data noted. However checks need to be placed on this if data doesn't show if equity is being addressed.

ITEM 14 GENERAL BUSINESS

- K. Hodge submitted that Raukawa Charitable Trust had recently had its contractually obligated audit then shortly afterwards the MoH arrived saying they had been commissioned by the WDHB to carry out another audit. What has happened to produce an audit on top of an audit?
- S. Webb had asked the Minister specifically (during his recent visit) what his intensions are regarding the WDHB? He responded that there would be no knee-jerk changes needed and they would be looking at the sector as a whole including PHO's etc.
- S. Webb also noted that a discussion needs to happen with Waikato people about what the needs of the Waikato are.
- M. Balzer submitted that a barrier to delivery of effective healthcare is the drive towards risk management and accountability rather than how you do things. Will this change with the LTIP?
- S. Webb responded that there are a myriad of ways we can do things differently from a strategic perspective.
- P. Mahood submitted that her observation is that the current Board is more innovative than previously which may mean the appetite for risk is higher. The Board intends to do things differently therefore risk will occur.
- M. Balzer submitted there are many barriers to preventative treatment and medicine, why aren't we being more innovative in this area? The risk being we go against the current medical model of care.
- S. Webb responded this is about changing the culture and courage to change current bureaucracy.
- G. Tupuhi submitted that appropriately resourced Maori Services is the difference between current status-quo and innovation/change.

ITEM 8 **Hui Closed:** Tureiti Moxon at 12.05pm

Next IMC Hui: 9.30am 3rd May 2018 (Joint IMC / Board Meeting)

	Action List	Completed	Who
1.	Summary of HSC agenda for commentary for IMC.		Te Pora
2.	Submit letter to Ministry from IMC on Maori Mental Health		Glen, Kahu, Harry
3.	IMC to write a letter in support of purchasing a new hyperbaric chamber by the WDHB for the prevention of the removal of limbs and death by diabetes.		IMC
4.	Loraine to arrange the meeting of Te Pora Thompson-Evans with Sally Webb (acting Chair of Board).		Loraine
5.	IMC Chair to review draft IMC minutes prior to going to Board		Loraine
5.	Do they monitor the wait times for mental health patients in E.D.		Loraine

6.	Is there any data broken down by ethnicity around numbers of diabetes patients losing limbs or dying?		Loraine
7.	Interests Register to be followed up and completed		Loraine / IMC

WAIKATO DISTRICT HEALTH BOARD

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

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

In Attendance:
Mr D Wright
Ms L Elliott
Mr N Hablous
Mr I Tamaki-Takarei
Ms J Eketone
Ms J Crittenden
Ms J Sewell
Mrs R Walker (Minutes)

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Mr Ikimoke Tamaki-Takarei

ITEM 2: APOLOGIES

Apologies were received from Dr G Howard for being unable to attend the workshop part of the agenda.

ITEM 3: MINUTES OF 21 MARCH 2018

Minutes moved and accepted with the following correction;

Item 5 Priority 1.1 Proposed Programme of Work, General Discussion

"A greater understanding was required as to why 42% of Māori (and 31% of non-Māori were not attending their ~~clinic~~ **outpatient** appointments."

ITEM 4: MATTERS ARISING FROM MINUTES OF 21 MARCH 2017

No matters arose.

ITEM 5: DEVELOPING THE 10 YEAR IWI MĀORI HEALTH STRATEGY – KI TE TAUMATA O PAE ORA

Presented by Ms J Eketone, members were provided with an overview of the Iwi Māori Health Strategy: ki te Taumata o Pae Ora which would replace the priority programme plan.

It was agreed that a separate piece of work was initially required but ultimately that work should feed into one Waikato DHB Strategy. The Committee Chair again emphasised that whilst one "plan" is ideal, the Committee needs to have confidence that the one "strategy" will ensure radical improvements in Māori Health will occur.

Resolved
THAT

The proposed programme be noted.

ITEM 6: WORKSHOP: A VISION FOR THE HEALTH OF IWI MĀORI

Consumer Council representatives and Executive Management joined Committee members to workshop how to define the vision of Iwi Māori Health within the Waikato DHB catchment area.

Additional attendees were:
Consumer Council
Ms P Ormsby
Ms N Ahu
Ms L Wese
Ms H Anderson
Ms K Paki

Waikato DHB Executive/Staff
Ms N Scott
Ms T Maloney
Mr D Wu

Following a brief whanaungatanga, attendees spent time in groups discussing the ideal/vision for each of the three areas; Oranga Tangata, Oranga Whanau, Oranga Māori.

The next steps would be:
1. Literature review
2. Iwi strategic plans
3. Previous consultation note review
4. Visioning workshops with additional stakeholder groups

ITEM 7: UPDATE PROGRESS REPORT

A progress update was provided on the standard agenda item to provide an update on the Ki te Taumata o Pae Ora (previously Priority Programme Plan) and the October 2017 workshop priority areas of;

- DNA
- Navigators

- Why Ora
- Tikanga Best Practice

Te Puna Oranga (TPO) were working with Mr Marc Ter Beek (Executive Director Operations and Performance) and his team on the area of DNAs (Did not attend appointments). Ms L Elliott would circulate an outpatient equity report to members. A further piece of work was required to "deep dive" to provide more detailed information which would need to be resourced by TPO.

Further analysis of the data collected, has identified that with regard to the question of people identifying their ethnicity, only 3% was uncoded. Action: **Ms L Elliott** to confirm with Mr ter Beek to confirm that the data around this question is being collected consistently.

The Chair reminded members of the importance that plans or strategies are develop from a client or consumer perspective rather than an organisation perspective.

ITEM 8: DATE OF NEXT MEETING

8.1 Date of Next Meeting

Wednesday 16 May 2018

ITEM 9: KARAKIA WHAKAMUTUNGA

Karakia by Mr I Tamaki-Takarei.

Chairperson: _____

Date: _____

Meeting closed at 11:50 am

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Hospitals Advisory Committee Meeting Held on Wednesday 11 April 2018 Commencing at 9:00am

Present:
Ms S Christie (Chair)
Ms C Beavis (Deputy Chair)
Mr M Gallagher
Mrs MA Gill
Mr D Macpherson
Ms S Webb
Dr K McClintock
Ms C Rankin

In Attendance:
Ms L Aydon, Executive Director, Public and Organisational Affairs
Mr N Hablous, Chief of Staff
Dr G Howard, Interim Chief Operating Officer, Waikato Hospital
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
Ms A Welsh, Human Resources Manager
Ms B Garbutt, Director Older Persons and Rehabilitation
Ms G Pomeroy, Co – Chair Consumer Council
Mr C Wade, Chair of Community and Public Health Advisory Committee

---

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

ITEM 1: APOLOGIES

Apologies received for Ms Rolleston.

ITEM 2: INTERESTS

2.1 Schedule of Interests
Mr Macpherson noted that two interests need to be removed and one added. He will communicate this with the PA to the CE.

2.2 Conflicts Related to Items on the Agenda
No conflicts of interest.

ITEM 3: MINUTES AND MATTERS ARISING

3.1 Performance Monitoring Committee Meeting: 11 October 2017

Resolved
THAT
The Performance Monitoring Committee meeting minutes on 11 October 2017 are confirmed as true and correct.

3.2 Bay of Plenty DHB – Hospital Advisory Committee: 7 February 2018
Minutes were noted.

3.3 Lakes DHB – Hospital Advisory Committee: 26 February 2018
Minutes were noted.

It was noted that the committee would like the finalised HAC meeting minutes to be sent to Lakes DHB and BOP DHB.

ITEM 4: QUALITY

4.1 Quality report
Ms M Neville presented this agenda item.

Areas highlighted:

- Governance responsibilities in regard to quality and patient safety to be discussed further.
- Reporting to be focused on improvements rather than only challenges and issues.

Resolved
THAT
The committee received the report.

ITEM 5: SERVICES CHALLENGES

5.1 Mental Health and Addictions
Mr R Tapsell presented this agenda item.

Areas highlighted:

- Working with the community and clinical support team to identify how to improve the mental health after hour services.
- Pressure on services is a nationwide issue, attracting a skilled workforce has many challenges.
- The Waikeria Prison expansion has not been finalised, however, concerns were raised on the extra pressure it could put on the mental health and addictions services.

It was noted by the committee:

- Propose that the Board consider putting through a submission on the mental health review.
- Service pressures will be presented in further detail to the Board.

5.2 Community and Clinical Support

Mr M Spittal presented this agenda item.

Radiology

A project manager has been appointed to assist with the sustainability of the radiology service. Staffing within radiology is underway with plans to advertise positions internationally.

5.3 Waikato Hospital Services

Dr G Howard presented this agenda item.

Areas highlighted:

- Clinical services plan underway with ENT.
- The Francis Group have been engaged to support the patient flow process from ED to the Medical and OPR wards.

Resolved
THAT
The Committee received the reports.

ITEM 6: CULTURE

6.1 Culture report

Anne Welsh and Marc ter Beek presented this agenda item.

Areas highlighted:

- Board and Executive workshop in July 2018 with the Cognitive Institute.
- Health roundtable staff survey will take place in 2018, which 11 other DHBs are participating in.
- Emphasised the importance of all staff including the governance groups living the values.

Resolved
THAT
The Committee received the report.

ITEM 7: NEXT MEETING SCHEDULED FOR 13 JUNE 2018

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Community and Public Health Advisory Committee held on 11 April 2018 commencing at 1.30pm

Present:
Mr C Wade (Chair)
Ms S Webb
Ms S Mariu
Mrs P Mahood
Ms C Beavis
Ms TP Thompson-Evans
Mr F Mhlanga
Mr J McIntosh
Mr R Vigor-Brown

In Attendance:
Ms T Maloney, Executive Director, Strategy & Funding
Mr W Skipage, Strategy and Funding
Mr R Webb, Strategy and Funding
Ms L Aydon, Executive Director, Public and Organisational Affairs
Mrs MA Gill, Waikato DHB Board member
Mr N Hablous, Chief of Staff
Mrs S Hayward, Director of Nursing and Midwifery
Dr D Tomic, Clinical Director Primary and Integrated Care
Ms G Pomeroy, Consumer Council
Ms W Entwistle, Quality and Patient Safety
Ms J-A Deane, Primary and Integrated Care
Ms S Christie, Waikato DHB Board member
Ms J Clarke, Clinical Midwife Director

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

ITEM 1: APOLOGIES

Apologies from Ms T Hodges (Deputy Chair), Mr D Slone, and Mr M Arundel were received.

Resolved
THAT
The apologies were received.

ITEM 2: LATE ITEMS

There were no late items raised at the meeting.

ITEM 3: INTERESTS

3.1 Register of Interests

There were no changes made to the Interests register.

3.2 Conflicts Relating to Items on the Agenda

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

ITEM 4: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved
THAT

1) The minutes of a meeting of the Waikato DHB Health Strategy Committee held on 11 October 2017 be confirmed as a true and correct record.
2) The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 19 February 2018 be noted.
3) The minutes of a meeting of the Bay of Plenty DHB combined Community & Public Health Advisory Committee/ Disability Advisory Service Committee held on 6 December 2017 be noted.

ITEM 5: TERMS OF REFERENCE

5.1 Community and Public Health Advisory Committee

No discussion took place.

5.2 Disability Support Advisory Committee

No discussion took place.

Resolved
THAT
The Committee noted the Terms of Reference for CPHAC and DSAC.

ITEM 6: DISABILITY SERVICES

Mr W Skipage attended for this item. A Terms of Reference is to be developed in consultation with IMC and other groups. The Disability Responsiveness Plan will contribute to the Waikato Health System Plan.

Resolved
THAT
1) The Committee notes the development of a Disability Responsiveness plan
2) The Committee notes the draft Terms of Reference will be brought to the June 2018 CPHAC

ITEM 7: WORKPLAN

7.1 2018 CPHAC Workplan

Mr W Skipage and Dr D Tomic attended for this item. A draft of the workplan for 2018 was presented. This plan attempted to cover issues for both CPHAC and DSAC.

Of note:
- The items that are listed in the draft 2018 workplan will need to align with the Waikato DHB strategic goals;
- The Project Energise item to be uplifted to the Childhood Obesity item to keep it at a strategic level.

Resolved
THAT
1) The Committee notes the areas of focus were agreed for 2018;
2) The addition to the 2018 workplan of Prevention Strategies;
3) The addition to the 2019 workplan of Migrant Communities.

ITEM 8: PAPERS FOR ACTION

8.1 Waikato DHB Demographic Model for the 10 Year Health System Plan

Mr R Webb attended for this item. The intention of the Demographic Model is to inform the 10 Year Health System Plan and its components. The model will also be used across the organisation wherever population metrics are required. The work will be carried out in two phases; phase one to develop the initial model requirements, and phase two to implement the requirements.

Resolved
THAT
1) The Committee notes the content of the report;
2) The Committee endorsed the proposed methodology for creating a Waikato DHB population model.

ITEM 9: PAPERS FOR INFORMATION

9.1 Midwifery

Ms J Clarke and Ms S Hayward attended for this agenda item. There is a local and national challenge to recruit and retain midwives, along with a shortage of LMC's nationally. There is not national body looking at this work, it is however endorsed to be reviewed.

An update every six months about progress, along with any changes were proposed from Ms S Hayward. The current model was noted as unsuccessful for Maori women. The result of the national workshop is to be reported back to this Committee.

Resolved
THAT
1) The Committee noted the presentation;
2) An update on progress and the national workshop in six months be reported to the Committee.

9.2 Waikato DHB Annual Planning Process 2018/19

Mr W Skipage attended for this item. There has been no advice received from the Ministry of Health for the 2018/19 planning process. A refresh of the 2017/18 plan has been included for draft 2018/19 plan. No target measure changes have been indicated. A further update is expected at the June meeting.

Resolved
THAT
The Committee noted the report.

9.3 Community Health Forum Report Round One 2018

Mr W Skipage attended for this item. A report from the latest round of Community Health Forums was presented.

Of note:
- A higher level of focus on social determinates is emerging at the forums;
- The rural health communities have a high level of engagement for opportunities in virtual health;
- The Consumer Council will be working together with the Community Health Forum to formulate a community engagement strategy. This will result in a Community Engagement Strategy paper being brought to the Committee in June.

Resolved
THAT
1) The Committee noted the report;
2) The Community Engagement Strategy report be presented at the June Committee meeting.

9.4 Community Pharmacy Services Agreement Consultation

Ms T Maloney spoke to this item. Currently Pharmacies hold a contract that is at a national level and has been in place since 2012; the agreement is renewed every year. Pharmacists have expressed concerns about the proposed contract which will be an evergreen contract. Feedback has gone to the Ministry of Health via online platforms and regional consultation meetings.

It is expected the new contracts will be in place by 1 July 2018, those that opt out of the new contracts will be able to have the old contract in place for one year, at which point it will then transfer to the new contract.

Resolved
THAT
The Committee noted the paper.

ITEM 10: GENERAL BUSINESS

There were no general business items raised.

ITEM 11: DATE OF NEXT MEETING

13 June 2018

Chief Executive Report

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

Culture and Cognitive Institute

The Board is keen to ensure that the culture of the Waikato DHB reflects the values that we hold for ourselves and our staff.

One of the foremost organisations currently working in this area is the Cognitive Institute. Based in Brisbane it specialises in delivering programmes for healthcare organisations around concepts such as safety and reliability, professional accountability, open disclosure and clinical leadership.

A representative of the Institute has met with the Executive and members were impressed with their approach.

The Institute is currently working with a number of District Health Boards in New Zealand including Bay of Plenty.

The Institute is in significant demand and only works with organisations that it considers are positioned to benefit from what it delivers. It regards commitment from the top as the main prerequisite to success.

Accordingly we have invited the Institute back to do a workshop with the Board and Executive in July as a precursor to determining whether we will retain their services (or more pertinently to allow them to determine whether they wish to work with us!).

That session is timed for 4pm to 6.30pm on Wednesday 4 July and an appointment will be sent out shortly.

Medical Council of New Zealand (MCNZ)

Last week we had a following up visit from MCNZ, you will recall that last year we had an accreditation visit and failed on 4 of the 22 standards. MCNZ reviewed our progress on the 4 standards and gave us positive feedback. Some elements remain a work in progress and this was acknowledged by MCNZ but they were pleased with the work that had been done to date. Although the final report will not be presented to Medical Council for a couple of months, the indication is that we will receive full accreditation, but I suspect they will want to follow up on work in progress.

Health and Safety Board Report

Looking at the format for the Board agenda I note that we have Health and Safety as a monthly item. I would appreciate your advice as to whether we should reduce this frequency. While it is an important subject little changes from month to month and it might be more practical to report three monthly.

Keezz Project

The Keezz project proper will wind up on 20 April 2018 and we are in the process of securing an appropriate transition to business as usual with operations support until that can be attained.

There are favourable indicators of recovery in elective surgical volumes alongside incremental increases in acute surgical discharges – refer attachment 1. In addition we are still confident that February and March will be "amber" for ESPI 2 and 5 once data corrections are completed.

Francis Group Update

The Francis Group have been working with the Emergency Department, Medicine and Geriatrics to create work streams addressing patient flows and areas of common interest, to align efforts to high risk patient groups across departmental boundaries. At present these are workstreams with a view to more permanent management orientation in the future. The three workstreams will start rapid tests of change as a means to identify and then implement different work practices. Refer attachment 2.

Chief Medical Officer

We will be interviewing three candidates for the fulltime Chief Medical Officer position in the second week in May. Despite the negative publicity the DHB has had over the last eight months, I was pleasantly surprised by the calibre of the applicants, a number of whom were from outside of the DHB.

Influenza Vaccination

We have commenced our staff vaccination programme and below are some of the key messages we are sending to staff. Our intention is to work with staff to ensure we achieve good vaccination coverage, but not do this in a punitive manner.

Below are some key messages we have sent to staff:

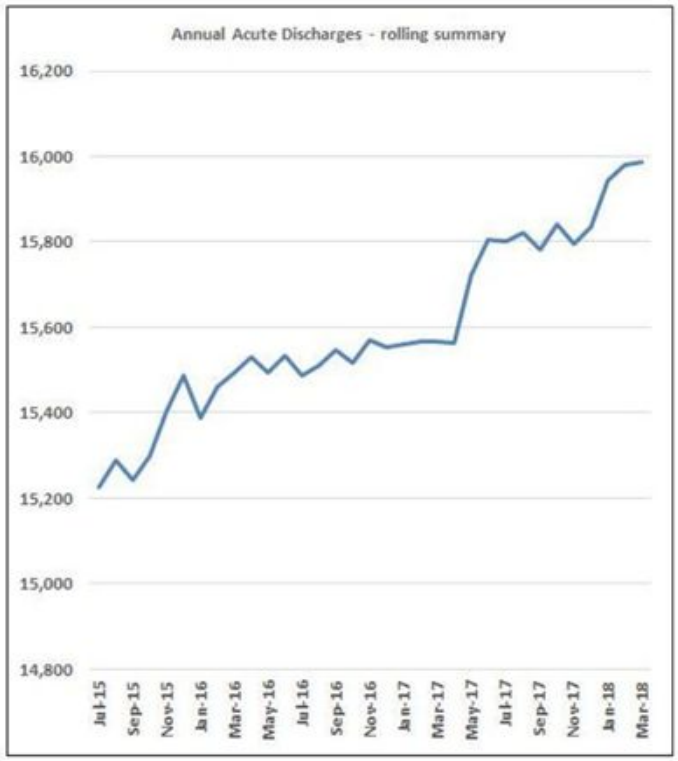
- Protect yourself, your colleagues and your patients – influenza kills.
- The Health and Safety team have more than 100 volunteer vaccinators located on wards, departments and some who will be wandering around our hospitals or based outside cafés around lunchtimes during the campaign.
- Influenza vaccination is free for Waikato District Health Board employees and contractors.
- It is our duty to protect our patients and visitors from infectious viruses like influenza. We expect you to take all available precautions to avoid putting others at risk from a debilitating and dangerous virus.
- Immunisation is the best protection available against influenza.
- Let's not catch influenza and let's not spread it.

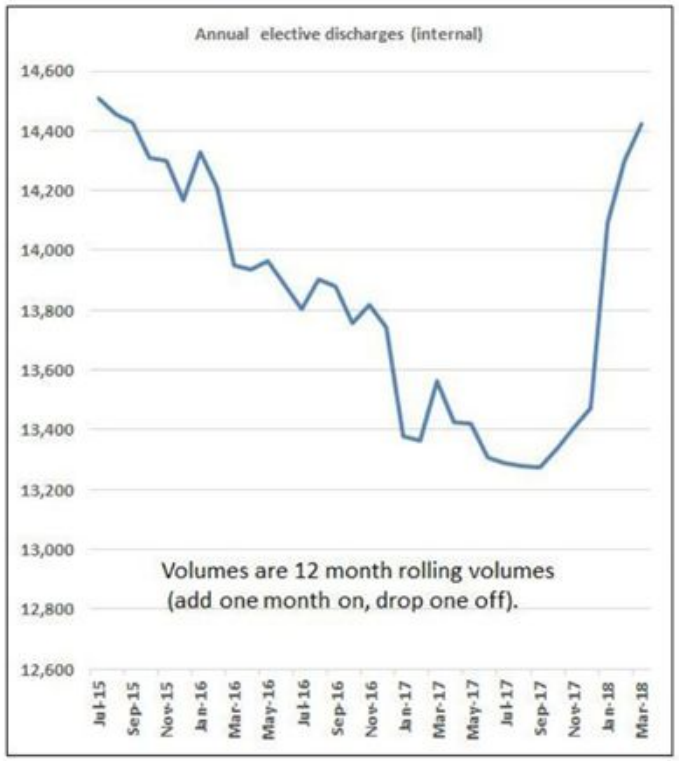
Recommendation
THAT
The Board receives this report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

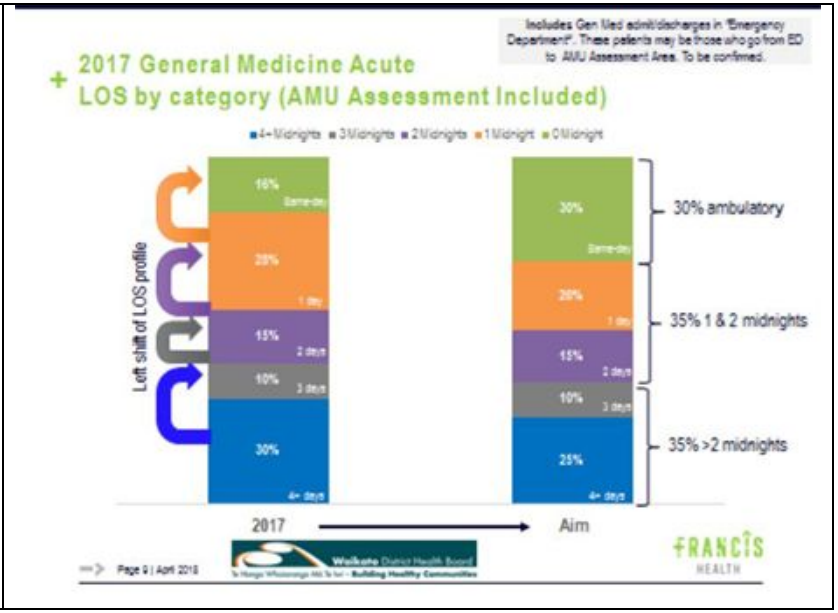
Keezz Project: Attachment 1

Surgical Discharges Waikato DHB





Francis Group: Attachment 2



Quality and Patient Safety

Finance Performance Monitoring

MEMORANDUM TO THE BOARD
24 APRIL 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 March 2018	Year to Date			Group Budget
	Group Actual $m	Group Budget $m	Variance $m	Jun-18 $m
Funder	25.5	26.7	(1.2) U	34.0
Governance	0.1	0.1	0.0 F	0.2
Provider	(39.8)	(30.3)	(9.5) U	(44.7)
Waikato Health Trust	(0.1)	0.2	(0.3) U	0.5
DHB Surplus/(Deficit)	**(14.3)**	**(3.3)**	**(11.0) U**	**(10.0)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

Episodes	March 2018 YTD				
Acute	Actual Mar 2018	Plan	Variance to Plan %	Actual Mar 2017	Variance to Prior year %
Surgical & CCTVS	13,211	13,353	-1.1%	13,027	1.4%
Medicine & Oncology	16,548	15,468	7.0%	15,334	7.9%
Child Health	4,051	3,735	8.5%	3,621	11.9%
Women's Health	6,629	7,010	-5.4%	6,771	-2.1%
TOTAL	40,439	39,566	2.2%	38,753	4.4%
Elective	Actual Mar 2018	Plan	Variance %	Actual Mar 2017	Variance to Prior year %
Surgical & CCTVS	11,309	11,547	-2.1%	10,285	10.0%
Medicine & Oncology	505	797	-36.6%	786	-35.8%
Child Health	521	558	-6.6%	532	-2.1%
Women's Health	876	771	13.6%	910	-3.7%
TOTAL	13,211	13,673	-3.4%	12,513	5.6%
Total Episodes - Acute plus Electives	**53,650**	**53,239**	0.8%	**51,266**	4.7%

CWDS	March 2018 YTD				
Acute	Actual Mar 2018	Plan	Variance to Plan %	Actual Mar 2017	Variance to Prior year %
Surgical & CCTVS	22,697	22,845	-0.6%	22,566	0.6%
Medicine & Oncology	15,668	14,742	6.3%	14,675	6.8%
Child Health	5,138	4,701	9.3%	4,493	14.4%
Women's Health	3,717	3,704	0.4%	3,483	6.7%
TOTAL	47,220	45,992	2.7%	45,217	4.4%
Elective	Actual Mar 2018	Plan	Variance %	Actual Mar 2017	Variance to Prior year %
Surgical & CCTVS	16,140	16,398	-1.6%	14,329	12.6%
Medicine & Oncology	390	465	-16.1%	493	-20.9%
Child Health	431	505	-14.7%	448	-3.8%
Women's Health	823	835	-1.4%	831	-1.0%
TOTAL	17,784	18,203	-2.3%	16,101	10.5%
Total CWDS - Acute plus Electives	**65,004**	**64,195**	1.3%	**61,318**	6.0%

March 2018 YTD	Actual	Prior year	Change
ED Attends	87,927	82,997	5.9%
Beddays	169,501	162,777	4.1%

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 March 2018 YTD we have an unfavourable variance to budget of $11.0m. This includes an unbudgeted accrual for estimated additional costs which could arise from nursing MECA negotiations, unfavourable leave movement and impact of centrally held savings plan. Furthermore, $8.4m 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.
The forecast position communicated to the Ministry is a deficit of $21.8m. The forecast does not include the impact of the outcome of the nursing MECA negotiations.

Provider:

The Provider is unfavourable to budget $9.5m - see detail for explanations. Variances include:

1. Revenue $11.1m 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 $7.1m - analysis below.
3. Outsourced Personnel costs unfavourable $11.4m, the dominant variances relate to medical locums ($5.2m partly offset by savings in medical personnel costs), nursing personnel ($1.8m) and Management and Administration $4.2m ($2.9m NOS costs recovered in other government revenue).
4. Outsourced Services favourable $4.0m.
5. Clinical supplies unfavourable to budget $6.7m.
6. Infrastructure & Non Clinical supplies are unfavourable to budget $14.1m.
7. Interest, depreciation and capital charge favourable to budget $0.6m.
8. Loss on disposal of fixed assets unbudgeted $0.1m.

Funder and Governance:

The results for the Funder is $1.2m unfavourable to budget. This mainly as a result of unfavourable internal provider payments (eliminates against Provider). This is partially offset by higher additional funding received across a number of areas. Governance is on budget.

Waikato Health Trust

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

RECOMMENDATION(S):

That this report for March 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 Revenue Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**$6.0 F**	
CFA Revenue		
● CFA revenue $0.8m favourable to budget which includes increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year). Current year funds are on-paid to providers (offset in NGO payments).	$0.8 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) $2.9m favourable (offset in Outsourced Personnel $3.1m).	$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 $0.8m unfavourable due to lower referrals from MSD for enrolment. This variance is partly offset by lower outsource, clinical supplies and infrastructure costs $0.5m.		
● Inter District Flow (IDF) income from other DHBs $0.5m favourable. High volume specialities compared to budget for the year to date include cardiothoracic surgery, haematology, neurosurgery and plastic and burns.		
● Inter District Flow (IDF) income relating to 2016/17 $1.8m favourable. This is as a result of the annual wash up of IDF activity across all DHBs. The final adjustment is not known until coding of all activity across all DHBs is completed. This variance is partly offset by an unfavourable variance on the IDF outflow wash up ($0.8m), which is included in NGO payments.		Favourable
Other Revenue		
Other revenue is on budget.	$0.0 F	Neutral

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($17.0) U**	
Personnel (employees and outsourced personnel total)	**($4.4) U**	
Employed personnel are favourable to budget mainly due to:	$7.0 F	Neutral
● Medical costs are favourable to budget by $7.0m. 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 $5.2m.		
● Nursing costs are unfavourable to budget by $3.2m. This variance, along with the unfavourable outsourced personnel cost for nursing of $1.8m, is due to higher patient numbers entering ED (5.9% above plan), and a higher level of mental health inpatient services and acuity. The variance also includes unfavourable annual leave movement for the year to date, higher than budget overtime and accrued costs for MECA rate changes yet to be confirmed.		
● Allied Health costs are favourable to budget by $1.0m. Variances continue to be mainly as a result of higher than expected vacancy levels. The net favourable variance of $0.8m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.5% of total allied health personnel budget to date.		
● Management, Administration and Support costs are favourable to budget by $2.2m. 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 ($1.1m).		
Outsourced personnel are unfavourable to budget mainly due to:		
● Medical personnel $5.2m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $7.0m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.	($11.4) U	Neutral
● Nursing personnel $1.8m unfavourable. As for employed nursing personnel this is due to higher patient numbers entering ED (5.9% above plan), and higher level of mental health inpatient services and acuity and higher than budgeted patient watches.		
● Allied health $0.2m unfavourable. The net favourable variance of $0.8m between employed and outsourced for allied health reflects the total level of vacancy across the provider. This net variance is 1.5% of total allied health personnel budget to date.		
● Management, Administration and Support costs are $4.2m unfavourable largely due to contractor costs of $3.1m for the implementation of the new NOS ERP solution (to date $2.9m of this cost is offset by additional other government revenue) and $1.1m 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	**$4.0 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced clinical service costs are $3.6m favourable as facility lists run through external providers did not reach full capacity. This is reflected in total elective episodes being 3.4% below plan, despite in house throughput being to plan. There continues to be a recovery plan in place to meet the elective services target. In addition, savings have been achieved relating to virtual health costs.	$4.0 F	Neutral
• Outsourced corporate service costs are $0.5m favourable to budget due mainly to a delay in commencing Information Systems outsourcing including a new national IS infrastructure.		
Clinical Supplies	**($6.7) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Instruments & equipment - favourable to budget by $1.0m. These particular supplies are not volume related, and instead the variance is due to timing of ordering.	$1.0 F	Neutral
• Implants & prosthesis - favourable to budget by $0.1m. The variance has reduced, but total costs continue to exclude high cost cardiothoracic devices for procedures that are no longer being delivered on behalf of other DHB's.	$0.1 F	Neutral
• Treatment disposables - unfavourable to budget by $4.1m (11.3% 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 (volumes 9% up on budget), and respiratory patients (case weights 9% up on plan).	($5.0) U	Unfavourable
• Pharmaceuticals - unfavourable to budget by $2.6m. Relates mainly to $1.8m 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 $0.4m in December due to a rebate adjustment for the increase in costs in 2017/18.	($2.4) 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.	($0.4) U	Unfavourable
Infrastructure and non-clinical supplies	**($14.0) U**	
• Infrastructure and non clinical supplies - $3.0m favourable variance includes savings 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.	($14.0) U	Neutral
• Savings plan - $17.0m unfavourable variance in infrastructure relates to centrally held savings plan not specifically allocated. We continue to monitor closely actual savings achieved across the organisation.		Unfavourable

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
NGO Payments	**$3.6 F**	
External Provider payments are favourable to budget mainly due to:		
• Payments to providers are $3.1m favourable. Payments to mental health providers are favourable to budget by $2.4m due to a delay in commencement of NGO contracts. Other variances arise due to costs not being incurred in line with CFA revenue received, MoH and accrual adjustments relating to prior year funding and costs arising from additional targeted revenue from MoH.	$3.6 F	Neutral
• IDF out payments for 2017/18 are $1.3m 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	**$0.6 F**	
Interest charge is close to budget.	$0.1 F	Favourable
Capital charge is on budget.	$0.0 F	Neutral
Depreciation is favourable to budget due mainly to the timing of capitalisation of IS projects.	$0.5 F	Favourable
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 Mar-17 $'000	Waikato DHB Cash flows for year to March 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				
1,005,903	Operating inflows	1,083,593	1,080,508	3,084	1,438,154
(978,068)	Operating outflows	(1,048,423)	(1,029,962)	(18,461)	(1,396,156)
27,835	**Net cash from operating activities**	**35,169**	**50,546**	**(15,377)**	**41,998**
	Cash flow from investing activities				
1,207	Interest income and proceeds on disposal of assets	1,174	876	297	1,170
(17,620)	Purchase of assets	(24,779)	(41,276)	16,497	(55,056)
(16,413)	**Net cash from investing activities**	**(23,605)**	**(40,400)**	**16,794**	**(53,886)**
	Cash flow from financing activities				
0	Equity repayment	(0)	0	(0)	(2,194)
(5,424)	Interest Paid	(592)	(600)	8	(810)
(150)	Net change in loans	(282)	4,962	(5,244)	12,700
(5,574)	**Net cash from financing activities**	**(875)**	**4,362**	**(5,237)**	**9,696**
5,848	**Net increase/**(decrease) in cash	**10,690**	**14,508**	**(3,820)**	**(2,192)**
856	Opening cash balance	9,577	9,577	(0)	9,577
6,704	**Closing cash balance**	**20,267**	**24,085**	**(3,820)**	**7,385**

Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Total Net cash flow from Operating Activities	**($15.2) U**	
Operating inflows	**$3.1 F**	
Operating inflow is favourable to budget mainly due to:	$3.1 F	
○ Unbudgeted IDF 2016/17 wash-up revenue received in December $1.8m.		Favourable
○ Inter District Flow (IDF) income from other DHBs $0.5m favourable. High volume specialities compared to budget for the year to date include cardiothoracic surgery, haematology, neurosurgery and plastic and burns.		Neutral
○ ACC income $0.4m favourable which includes increases in income as a result of a change to a new annual contract.		
○ CFA revenue $0.8m favourable to budget which includes increased funding from MoH for In Between Travel ($0.5m current year, $0.4m prior year).		
○ Return to Employment project income $0.8m unfavourable due to lower referrals from MSD for enrolment.		
○ 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	**($18.3) 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.	$10.7 F	Neutral
Operating cash outflows for non-payroll costs are unfavourable largely as a result of:	($31.4) U	
○ Unfavourable operating costs including outsourced personnel (offset in personnel cost), outsourced services, clinical supplies, infrastructure & non clinical supplies and provider payments (net - $24.5m).		Neutral
○ Higher prepayment balance due to timing of payments $2.7m.		
○ The actual timing of vendor payments against budget assumptions.		
○ GST cash movement is favourable due to timing variances on GST transacted.	$2.4 F	Neutral
Net cash flow from Investing Activities	**$16.8 F**	
○ Interest received is close to budget.	$0.3 F	Favourable
○ Capital spend is slower than planned YTD. This is as a result of deferred timing of spend.	$16.5 F	Neutral
Net cash flow from Financing Activities	**($5.2) U**	
○ Cash flow from financing activities is unfavourable due to the deferment of planned finance leases.	($5.2) 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 31-Mar-18	Mar-18 Actual	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	Mar-19 Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	4,154	4,116	4,564	4,228	6,764	4,708	4,366	5,855	4,594	4,468	6,650	3,252	4,480
Funder inflow (MoH, IDF, etc.)	132,741	133,919	125,369	130,048	131,880	131,880	136,560	131,880	131,880	136,750	131,880	131,880	136,750
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	3,184	2,297	2,757	2,412	2,642	2,757	2,412	2,642	2,642	2,297	2,415	2,185	2,415
Rents, ACC, & HealthPac (General Accou	3,182	2,518	2,765	2,654	2,736	2,820	2,645	2,760	2,818	2,658	2,676	2,562	2,673
	143,261	142,850	135,454	139,343	144,022	142,164	145,983	143,136	141,933	146,173	143,621	139,879	146,318
Cash was applied to:													
Personnel Costs (incl PAYE)	(44,280)	(44,726)	(49,875)	(49,569)	(46,921)	(60,539)	(47,016)	(53,003)	(49,877)	(57,143)	(48,168)	(50,372)	(47,076)
Other Operating Costs	(33,353)	(30,400)	(33,600)	(37,900)	(36,026)	(34,924)	(36,222)	(31,124)	(35,826)	(30,720)	(30,720)	(30,620)	(35,422)
Funder outflow	(48,051)	(45,599)	(46,617)	(45,700)	(46,808)	(50,807)	(46,148)	(47,037)	(46,808)	(45,818)	(46,478)	(46,047)	(49,986)
Interest and Finance Costs	(11)	(10)	(10)	(10)	(20)	(10)	(20)	(10)	(10)	(10)	(10)	(10)	(15)
Capital Charge	0	0	0	(18,483)	0	0	0	0	0	(18,483)	0	0	0
GST Payments	(7,615)	0	(15,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0	(13,710)	(9,000)	(7,210)
	(133,311)	(120,735)	(145,312)	(158,872)	(136,986)	(153,491)	(136,617)	(138,385)	(139,732)	(152,175)	(139,087)	(136,050)	(139,710)
OPERATING ACTIVITES	**9,950**	**22,114**	**(9,858)**	**(19,530)**	**7,036**	**(11,326)**	**9,366**	**4,751**	**2,202**	**(6,002)**	**4,534**	**3,829**	**6,608**
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	73	90	90	90	75	75	75	75	75	75	75	75	75
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
	73	90	90	90	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(1,876)	(4,000)	(4,000)	(3,500)	(3,500)	(4,000)	(4,000)	(5,000)	(3,500)	(5,500)	(3,500)	(5,000)	(4,000)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(1,876)	(4,000)	(4,000)	(3,500)	(3,500)	(4,000)	(4,000)	(5,000)	(3,500)	(5,500)	(3,500)	(5,000)	(4,000)
INVESTING ACTIVITIES	**(1,803)**	**(3,910)**	**(3,910)**	**(3,410)**	**(3,425)**	**(3,925)**	**(3,925)**	**(4,925)**	**(3,425)**	**(5,425)**	**(3,425)**	**(4,925)**	**(3,925)**
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	2,600	2,600	2,600	2,600	2,600	0	0	0	0
EECA loan received	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	0
Cash was applied to:													
Capital Repayment	0	0	0	(2,194)	0	0	0	0	0	0	0	0	0
Finance lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	0	(26)	0	0	(26)	0	0	(26)	0	0	(26)	0
Working capital facility repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	(26)	(2,194)	0	(26)	0	0	(26)	0	0	(26)	0
FINANCING ACTIVITIES	0	0	(26)	(2,194)	2,600	2,574	2,600	2,600	2,574	0	0	(26)	0
Opening cash balance	5,254	13,401	31,605	17,811	(7,323)	(1,112)	(13,789)	(5,748)	(3,321)	(1,970)	(13,398)	(12,289)	(13,411)
Overall increase/(decrease) in cash	8,147	18,204	(13,794)	(25,134)	6,211	(12,677)	8,041	2,426	1,351	(11,427)	1,109	(1,122)	2,683
CLOSING CASH BALANCE	13,401	31,605	17,811	(7,323)	(1,112)	(13,789)	(5,748)	(3,321)	(1,970)	(13,398)	(12,289)	(13,411)	(10,728)
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	13,401	31,605	17,811	(7,323)	(1,112)	(13,789)	(5,748)	(3,321)	(1,970)	(13,398)	(12,289)	(13,411)	(10,728)
Long-term Loans													
Finance Leases	0	0	0	0	(2,600)	(5,200)	(7,800)	(10,400)	(13,000)	(13,000)	(13,000)	(13,000)	(13,000)
EECA Loan	(195)	(195)	(169)	(169)	(169)	(143)	(143)	(143)	(117)	(117)	(117)	(91)	(91)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	13,206	31,410	17,642	(7,492)	(3,880)	(19,132)	(13,691)	(13,865)	(15,087)	(26,515)	(25,405)	(26,501)	(23,819)
Working capital facility	(70,937)	(70,937)	(70,937)	(70,937)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(70,937)	(70,937)	(70,937)	(70,937)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)

BALANCE SHEET

Opinion on Result:

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

Prior Year June 2017 $'000	Waikato DHB Group Financial Position	As at March 2018 Actual $'000	Budget $'000	Variance $'000	Budget Jun-18 $'000
88,517	Total current assets	94,039	84,663	9,376 F	65,434
(181,405)	Total current liabilities	(189,706)	(179,623)	(10,083) U	(160,570)
(92,888)	**Net working capital**	**(95,667)**	**(94,960)**	**(707) U**	**(95,136)**
736,618	Term assets	724,072	740,179	(16,107) U	739,628
(21,053)	Term liabilities	(20,174)	(25,838)	5,664 F	(34,411)
715,565	**Net term assets**	**703,898**	**714,341**	**(10,443) U**	**705,217**
622,677	**Net assets employed**	**608,231**	**619,381**	**(11,150) U**	**610,081**
622,677	**Total Equity**	**608,231**	**619,381**	**(11,150) U**	**610,081**

Prior Year June 2017 $'000	Waikato DHB Group Ratios	As at March 2018 Actual $'000	Budget $'000	Achieved
63,670	Borrowing facilities available at month end	70,627	65,344	✓
0.5	Current ratio	0.50	0.47	✓
75.5%	Equity to total assets	74.3%	75.1%	x
0.3%	Return on equity	-2.3%	-0.5%	x

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is unfavourable to budget mainly due to:		
Current Assets		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $3.8m due mainly to the unfavourable variance relating to operating activities($15.3m) and financing activities ($5.2m) offset by favourable variance from investing activities ($16.8m).	**$9.4 F**	Neutral
• Total accounts receivable and accrued debtors is higher than budgeted by $10.3m mainly due to the accrual of $7.9m capital charge funding not yet received from the MoH and $3.5m unbudgeted accrual for recovery of NOS costs.		
• Prepayments are higher than planned by $2.7 mainly due to timing of payment of e-Space prepaid license to use.		
• Other favourable variances across a number of areas $0.2m.		
Current Liabilities		
• Payroll liabilities are $4.6m unfavourable mainly due to accrual for the Nursing settlement, MECA increases and timing of pay runs (PAYE & leave) as compared with the phasing of the budget.	**($10.1) U**	Neutral
• Income in Advance $2m unfavourable to budget mainly due to unbudgeted quarterly pay equity settlement.		
• GST $2.4m unfavourable to budget mainly due to the timing of processing of vendor invoices and unbudgeted income received.		
• Other Current Liabilities are unfavourable to budget $1m 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 $16.5m and favourable YTD depreciation $0.5m. Please see attached for latest forecast of capital spend for the year for further detail.	**($16.1) U**	Unfavourable
Non Current Liabilities:		
Non Current Liabilities are favourable due to deferment of budgeted finance leases.	**$5.7 F**	Favourable
Equity:		
Driven mainly by variance in overall results.	**($11.2) U**	Unfavourable

CAPITAL EXPENDITURE AT 31 March 2018 ($000s)

Capital Plan					Cash Flow Forecast					Full Project Forecast		
Activity	Total Prior year Board Approvals	New Approvals FY17/18	Transfers During 17/18	Total Board Approved Capital Plans	Prior year expenditure for active Projects	Total Expenditure Forecast FY 17/18 (Actual + Planned)	Actual Expenditure YTD from 1 Jul-17 to 31 Mar 18	Approved and Planned Expenditure 01 Apr 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	1,897	1,103	0	3,000	0	839
Clinical Equipment Subtotal	12,668	20,354	3,672	36,694	2,559	13,561	8,902	4,659	20,296	36,416	277	4,709
Property & Infrastructure Subtotal	44,031	7,803	-646	51,188	18,264	11,008	8,289	2,719	20,268	49,540	1,623	2,586
IS Subtotal	20,082	7,729	109	27,920	8,310	6,932	5,348	1,583	10,298	25,540	2,380	1,497
Corporate Systems & Processes Subtotal	3,326	8,325	68	11,719	450	3,028	2,808	220	8,191	11,669	50	83
Regional Subtotal	4,425	798	0	5,223	270	2,837	640	2,197	824	3,931	1,292	30
MOH Subtotal	0	0	0	0	0	0	0	0	0	0	0	0
Trust Funded Subtotal	0	0	0	0	0	0	0	0	0	0	0	8
REPORT TOTALS	84,532	48,009	3,203	135,743	29,853	40,366	27,885	12,481	59,877	130,096	5,623	9,751

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

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
CT Machine Replacement Waikato x3	3,828	3,763	80	(16)
CT Machine Replacement Waikato x1	725	725	1	(1)
Ventilators (Critical Care)	400	-	400	-
Endoscopes	300	-	300	-
Replacement Theatre Lights OT 20-25	286	235	51	(0)
Glucose meters	275	-	275	-
Renal Dialysis (CCD) machines x4 Prismaflex	564	601	-	(38)
Other items - identfied per Clinical asset review	781	-	781	-
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	299	1,014	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	1,493	-	1,493	(0)
Vascular & Interventional Replacement	1,750	-	1,750	-
General X-Ray replacement Thames	700	-	700	-
Biochemistry main Analysers	300	-	300	-
Liquid Chromatography Mass Spectometry Analyser	600	482	118	0
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	20	805	(0)
Trauma Gantry (radiology)	350	-	350	-
L8 Menzies Surgical Assessment Unit (Acute)	1,561	3	1,567	(9)
Projects Removed to be Capitalised	4,880	4,500	19	361
Other Clinical Services Projects Budgeted <$250K	9,766	2,730	7,057	(21)
Clinical Equipment Subtotal	39,693	13,358	26,058	277
Property and Infrastructure				
Mental Health Facility - scoping	606	210	396	0
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Gallagher Build - Fitout	4,238	3,868	56	314
Gallagher Building - Med Store & CSES Clinic	406	402	4	(0)
Gallagher Building - Racking System	362	522	-	(160)
Gallagher Building - Converyor System	348	356	-	(8)
SCEP racking - hospital wide	400	-	400	-
Hamilton Consolidation of CBD facilities - 9th Floor	850	850	-	-
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	1,579	7,545	0
Hamilton CBD - Collingwood Street Development - First Floor	5,584	130	5,454	(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	2,360	228	1,096
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	16	304	0
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Waikato Hauora iHub	321	26	295	(0)
Waikato switchboard upgrades core buildings	675	9	665	1
Infrastructure Replacement Pool (17/18)	510	86	278	146
Infrastructure Replacement Pool (15/16)	600	725	20	(145)
Infrastructure Replacement Pool (16/17)	641	205	-	436
OCB Replacements	350	-	350	-
Waikato Distribution Boards	250	213	67	(30)
Lift car upgrades (Stage 1)	1,835	2,059	-	(224)
Electrical Systems Improvement	6,714	5,969	745	0

Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
Food & Nutrition Software	921	27	895	(1)
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	3,435	779	2,510	147
Property & Infrastructure Subtotal	**51,188**	**26,553**	**22,987**	**1,648**
Regional				
National Oracle Solution - Elevate	4,399	910	2,197	1,292
Other Regional Projects Budgeted <$250K	824	-	824	-
Regional Subtotal	**5,223**	**910**	**3,021**	**1,292**
MOH & Trust Funded				
National Patient Flow Phase 3 16/17	257	257	-	0
Telestroke Pilot	321	49	272	-
16/17 Trust Account	303	303	-	(0)
Other MOH & Trust Funded Projects Budgeted <$250K	(881)	(609)	(272)	0
MOH & Trust Subtotal	-	(0)	-	0
Information Systems				
Platform	2,688	734	1,955	(1)
Storage & Reporting	1,125	468	608	49
Network & Communications	3,680	1,714	1,728	238
IAAS	1,686	807	879	0
Devices	2,253	754	1,158	341
Licensing	1,125	194	931	-
Enterprise Service Business	937	291	647	(1)
Tools	3,134	1,513	1,654	(33)
Security	817	102	707	8
Clinical Systems	6,835	3,999	3,028	(192)
Other Projects	422	135	287	(0)
CORPORATE SYSTEMS & PROCESSES	11,719	3,258	8,411	50
Projects to be Capitalised	3,218	2,949	-	269
Adjustment to reflect capacity to deploy			(1,700)	1,700
IS Subtotal	39,639	16,917	20,292	2,430
Grand total	**135,743**	**57,738**	**72,358**	**5,647**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
March 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 accommodation. For this reason, costs reflected in this report may relate to prior months' travel.

Travel costs - Executive Group	Month			Year to Date			
Mar-18	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AYDON LYDIA HELEN MS	650.25	-	650.25	1,260.95	-	1,260.95	
AITKEN VICKI ANN	91.44	-	91.44	630.27	-	630.27	
CHRYSTALL MAUREEN MS	606.40	-	606.40	1,099.89	-	1,099.89	
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	233.91	-	233.91	3,526.78	3,144.68	6,671.46	Training related $3,145
LAWRENSON ROSS PROF	-	-	-	353.63	-	353.63	
MALONEY TANYA	-	611.08	611.08	280.12	4,157.48	4,437.60	Training related $4,157
MURRAY NIGEL MR	-	-	-	6,829.52	(499.90)	6,329.62	Detail below
NEVILLE MAUREEN MS	262.17	-	262.17	1,836.63	-	1,836.63	
PARADINE BRETT MR	-	-	-	312.26	-	312.26	
SPITTAL MARK MR	643.66	-	643.66	2,001.87	-	2,001.87	
TAPSELL REES	332.48	-	332.48	332.48	-	332.48	
TER BEEK MARC MR	-	-	-	607.67	-	607.67	
TOMIC DAMIAN MR	111.28	-	111.28	3,050.62	-	3,050.62	
WATSON TOM MR	-	-	-	1,292.58	-	1,292.58	
WILSON JULIE MS	756.34	-	756.34	4,068.38	-	4,068.38	
WOLSTENCROFT IAN	-	-	-	146.96	-	146.96	
WRIGHT DEREK MR	1,616.94	-	1,616.94	4,548.86	63.48	4,612.34	Detail below
Grand Total	**5,304.87**	**611.08**	**5,915.95**	**33,179.76**	**6,865.74**	**40,045.50**	

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
June 2017	350.63	Use of domestic taxi chits	Taxi chits	Domestic
	6,329.62			

Acting CE Travel Expenditure Neville Hablous

Travel charges for the year to		March 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		March 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	Mental Health and Addictions Services NGO Commissioning workshop	Mileage and parking expenses	Auckland
February 2018	199.13	Midlands DHBs regional meetings	Accommodation	Auckland
February 2018	624.54	National DHB CE meeting	Airfares	Wellington
February 2018	551.99	Health Select Committee, Ministry of Health executives, Health and Disability Commissioner	Airfares and taxi	Wellington
March 2018	130.43	Midland United Regional Intergration Alliance Leadership Team, Midland Regional meetings	Accommodation	Tauranga
March 2018	345.68	Oranga Mahi Goernance Board meeting, National Chair and DHB meetings	Accomodation, Taxi fares - air fare costs still to be processed	Wellington
	4,612.34			

Health Targets

MEMORANDUM TO THE BOARD
24 APRIL 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 three results where available. 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	2017/18 Q3 results (prov)	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 ✗	**Not available**	-	84% Mar-18 YTD
Improved access to elective surgery		**100%**	108% 7th ★	106% 10th ●	110% 3rd ★	114% 2nd ★	**100%**	111% 5th ★	104% 8th ●	**Not available**	-	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% 1st ★	√	98% Mar-18
Better Help for Smokers to quit	Primary Care	**90%**	87% 12th ●	86% 13th ●	87% 12th ●	88% 15th ✗	**90%**	88% 14th ●	89% 12th ●	**Not available**	-	89% 17/18 Q2 result
	Maternity	**90%**	93% 12th ●	96%	98% 4th ★	95% 8th ●	**90%**	94% 8th ●	97% 4th ★	**Not available**	-	97% 17/18 Q2 result
Increased immunisation (8 months)		**95%**	92.3% 13th ●	92% 15th ✗	90% 16th ✗	89% 15th ✗	**95%**	88% 15th ✗	90% 15th ✗	**89% 14th ✗**	X	89% Mar 18 3 mth rolling
Raising Healthy Kids[1]		**95%**	47% 11th ●	79% 6th ★	84% 9th ●	81% 14th ●	**95%**	76% 19th ✗	100% 1st ★	100% 1st ★	√	100% 6 mths Feb 17

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

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2018

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

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

Shorter Stays in Emergency Departments (EDs) health target

DHB name: Waikato
Quarter: 3 - 2018

Quarterly Results – by DHB total population

	Numerator: The number of ED presentations with a length of stay of less than six hours	Denominator: Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	24834	28940	85.8%
Waikato	16556	20055	82.6%
Taumarunui	1423	1462	97.3%
Thames	3833	4327	88.6%
Tokoroa	3022	3096	97.6%

Quarterly results – by ethnicity

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

	Māori Ethnicity			Pacific Ethnicity		
	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours	The number of ED presentations with a length of stay of less than six hours	Total number of ED presentations	Percentage of patients admitted, discharged or transferred from ED in less than six hours
DHB total:	6918	7851	88.1%	641	862	74.4%
Waikato	4552	5388	84.5%	474	671	70.6%
Taumarunui	570	587	97.1%	19	22	86.4%
Thames	612	667	91.8%	33	48	68.8%
Tokoroa	1184	1209	97.9%	115	121	95.0%

Waikato Hospital

Waikato Hospital's ED continues to experience significant monthly year on year increases in presentations. March 2018 experienced a 9.0% increase on March last year. Of note whilst presentations have increased for March, admission to hospital numbers have remained the same (average 73 per day) as the previous year, which shows that senior decision making at the front door is having some effect.

As in the previous report to the Board, 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. This is reflected in the performance figures with non-admitted (ED only work) consistently delivering >90%, whilst the admitted performance remains <70%.

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. Medicine has been able to achieve empty beds almost every morning to enable flow, unfortunately Surgical, CCTV, and Orthopaedics ward volumes have been very high in March and this has led to delays in bed placement with overflow into Medicine areas. Engagement with the Francis Group will see Rapid Change Test Cycles (RCTCs) being undertaken over the next few months to further improve admitted patient flow through AMU and to medical wards.
- OPR5's opening enabled a new improved frail elderly pathway of care and sorely needed additional bed capacity. Again work streams undertaken with the Francis Group are further developing the pathways both within hospital and looking at the wider community functions to prevent hospital admissions.

- Electronic SBARR handover has been implemented for medical wards with introduction to the wider hospital planned over the next quarter.
- GP enrolments continue to be actively promoted in the ED, through designated resource, in an attempt to reduce repeat presentations.
- Review of ED staffing model underway with consideration of moving to Nurse practitioner cover 24/7 within 12 months, dependent on funding.
- COPD project is agreed (SLM initiative), recruitment of staff is underway and a model of care will be in place for the winter months. This is a pilot project involving both primary and secondary care to proactively manage patients with acute COPD with the specific aim of reducing ED presentations and the number of emergency admissions with this condition.
- Recruitment of MOSS positions to ensure regular senior medical cover overnight during busier nights of the week that traditionally have had less staff rostered on.
- Business case approved for the opening of a 26 bedded Acute Surgical Unit (ASU) on Level 8, Menzies in order to fast track acute surgical admissions.

Thames, Tokoroa and Taumarunui Hospitals
An eight week pilot of a CNS-led model of care in the emergency department commenced in April. The local general practices are now fully recruited. It is expected that the significant flow of primary care patients coming to the ED because they could not access timely GP appointments will alter as the community becomes aware that primary care access has improved.

A formal tender process to seek Expressions of Interest to establish a primary care presence within Thames Hospital has closed. The DHB is now evaluating the responses and is aiming to lease part of the facility so that a primary care clinic can be established adjacent to the ED later this year.

The work to implement the Single Point of Entry (SPoE) 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 has been put on hold while the Ministry of Health's national tender is underway.

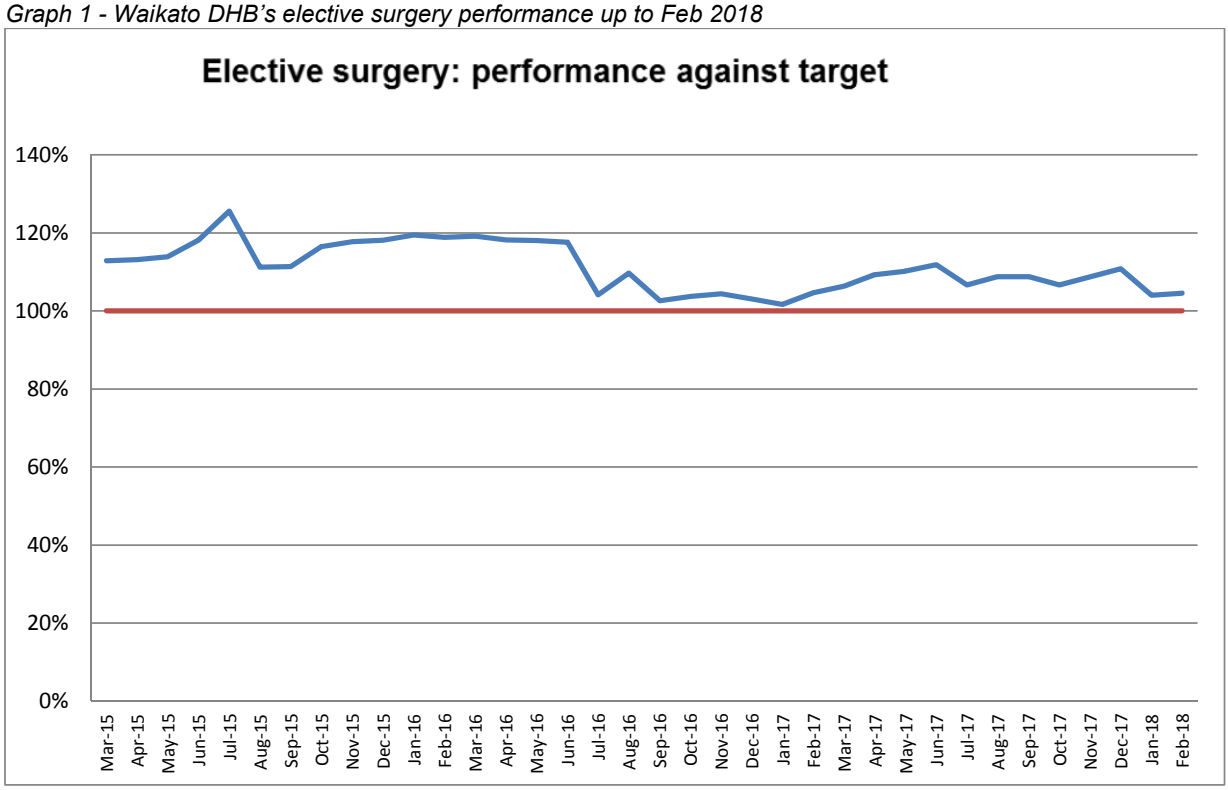
Target: Elective Surgery

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 March 2018

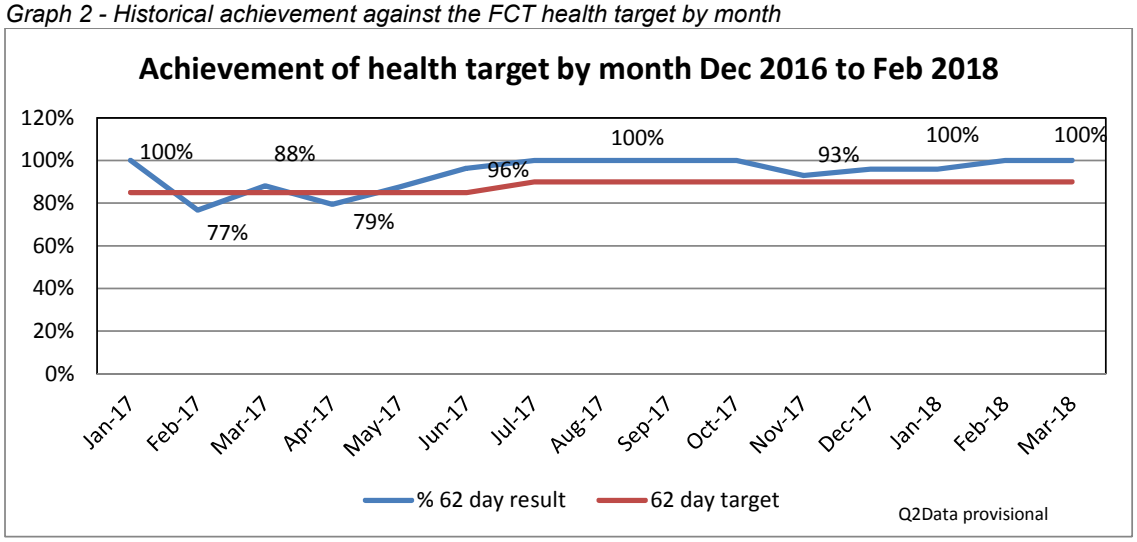
FCT 62 DAY HEALTH TARGET								
DHB Current Target	DHB Q4 Result 15/16	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	**DHB Q3 Result**
90%	72.6% 14th ranking	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 3rd equal ranking	96.6% 2nd ranking	99.0% Unavailable
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 Q3 Result**
25%	14%	17%	19%	19%	22%	14%	14%	**14%**

Waikato has continued to deliver sustained achievement against the 90% FCT health target. At the time of writing this report, we had not received the MoH report so we are not able to compare our results with national results for this quarter.

This Quarter is the third quarter for achievement against the new health target of 90%. Our provisional result of 99% shows that Waikato continues to perform strongly 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.
- 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.
- Urology service has now completely and successfully transitioned to using DHB patient management system and embedded FCT business rules into urology business as usual.

Table 6

Local FCT Database	**Jan-18**	**Feb-18**	**Mar-18**	**Total**
Number of records submitted	26	19	23	68
Number of records within 62 days	25	19	23	67
% 62 day Target Met (90%)	96%	100%	100%	99%
% Volume Target Met (15%)	16%	12%	14%	14%

Target: Increased immunisations for 8 months

Table 7 – 8 month Milestone Immunisation Results by Quarter

Quarter	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
Result	**90%**	**89%**	**88%**	**90%**	**89%**
Maori	**89%**	**86%**	**82%**	**86%**	**83%**
Ranking	**16**	**15**	**15**	**15**	**Unavailable**

Data for this target is reported on a three month rolling basis. Graph 3 shows our most recent result of 89% for the three month period from 1 January 2018 to 30 March 2018.

We have not achieved the target this quarter as has been the case since the inception of this target despite the significant investment we have made in this area.

We reported at the previous board meeting that we were consulting on a draft Immunisation Action Plan (IAP). We have now completed the draft which is expected to be approved by the Waikato Child and Youth Health Network "the network" on 17 April 2018. We will give a verbal update to the Board on the outcome of their decision at the meeting.

The focus in the new IAP is to enhance current activity such as opportunistic immunisations and reducing decline rates whilst consulting further on the proposed new areas outlined below.

Proposed new work streams

- Review / redesign of immunisation services and related services to ensure current providers are better able to achieve the 95% targets.
- Consideration of financial incentives for families/whanau that complete their immunisations on time.
- Rapidly progress the inter sectorial engagement which started in late 2017, with the Ministry of Children Oranga Tamariki, to improve immunisation coverage for the children who receive services from the five Family Start providers in Waikato.

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

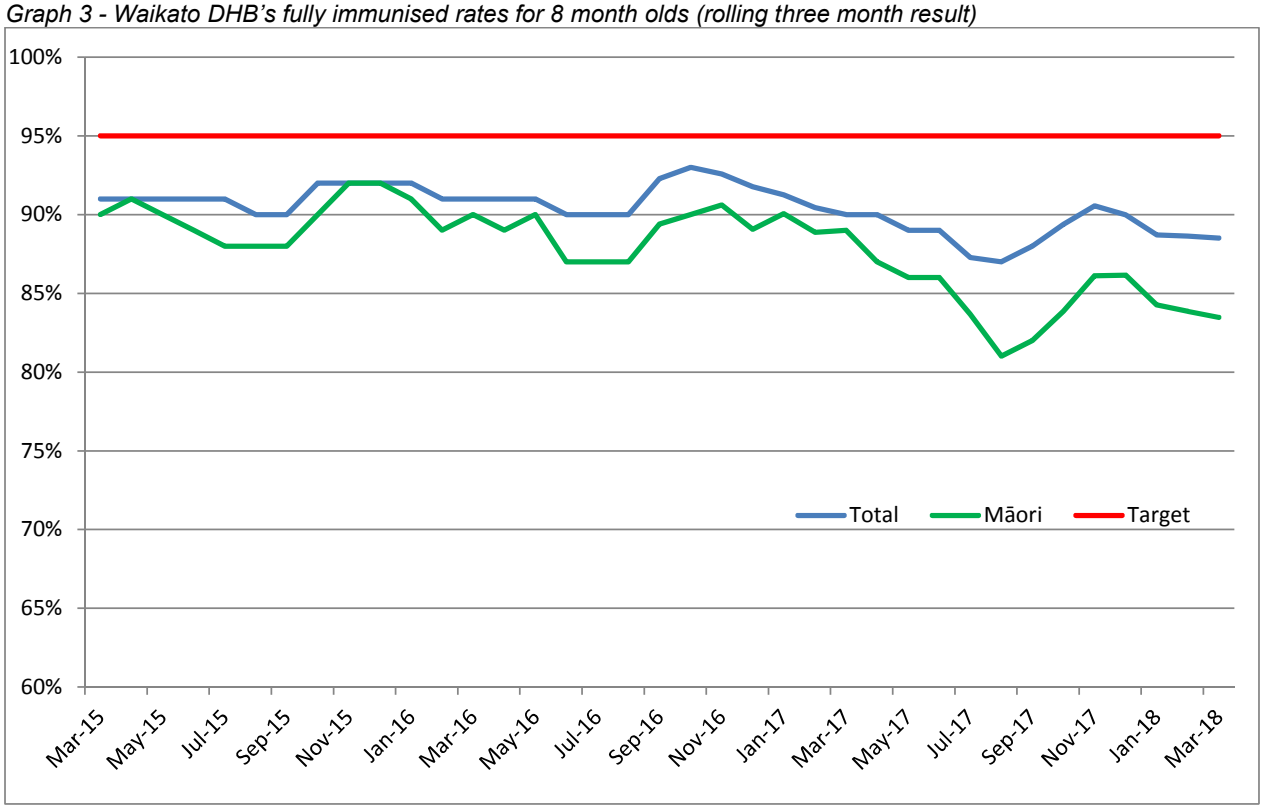


Table 8 (below) shows a breakdown of eight month immunisation by ethnicity including the number of additional children needing to be immunised to meet our 95% target across all ethnicities. Based on these results, 90 additional children needed to be immunised to meet the 95% target.

Table 8 - Waikato DHB 8 month old immunisations ethnicity breakdown from Jan 2018 to Mar 2018

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	575	527	92%	20
Māori	520	434	83%	60
Pacific	52	49	94%	1
Asian	153	148	97%	0
Other	75	59	79%	13
Total across ethnicities				94
Total	1,375	1,217	89%	90

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 Jan 2018 to Mar 2018

PHO	Total population			Maori population		
	No eligible population	No fully immunised population	Percent immunised	No eligible population	No fully immunised population	Percent immunised
Hauraki PHO	495	448	91%	209	180	86%
Midlands Health Network – Waikato	760	686	90%	250	214	86%
National Hauora Coalition	26	24	92%	14	12	86%
Enrolled with a PHO outside of Waikato	29	27	93%	14	13	93%
Unenrolled Waikato population	65	32	49%	33	15	45%
DHB Total	1,375	1,217	89%	520	434	83%

Target: Better help for smokers to quit - primary care

No new data this month.

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

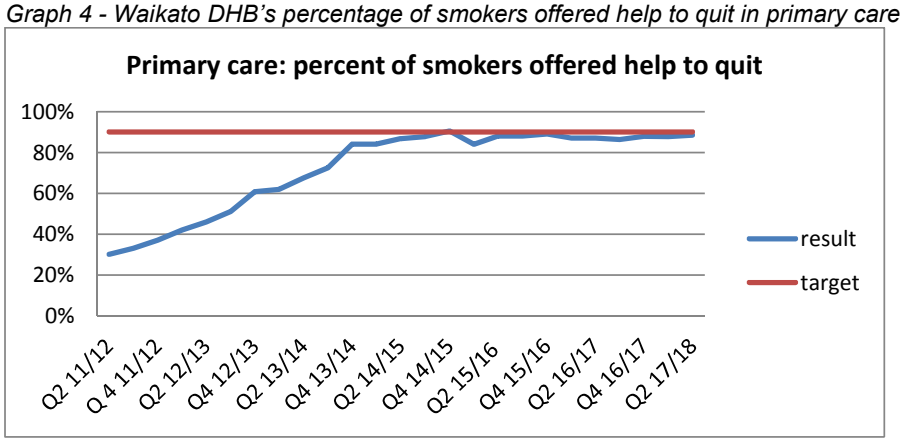


Table 11 shows a breakdown of primary care smoking results by PHOs up to 2017/18 quarter two.

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

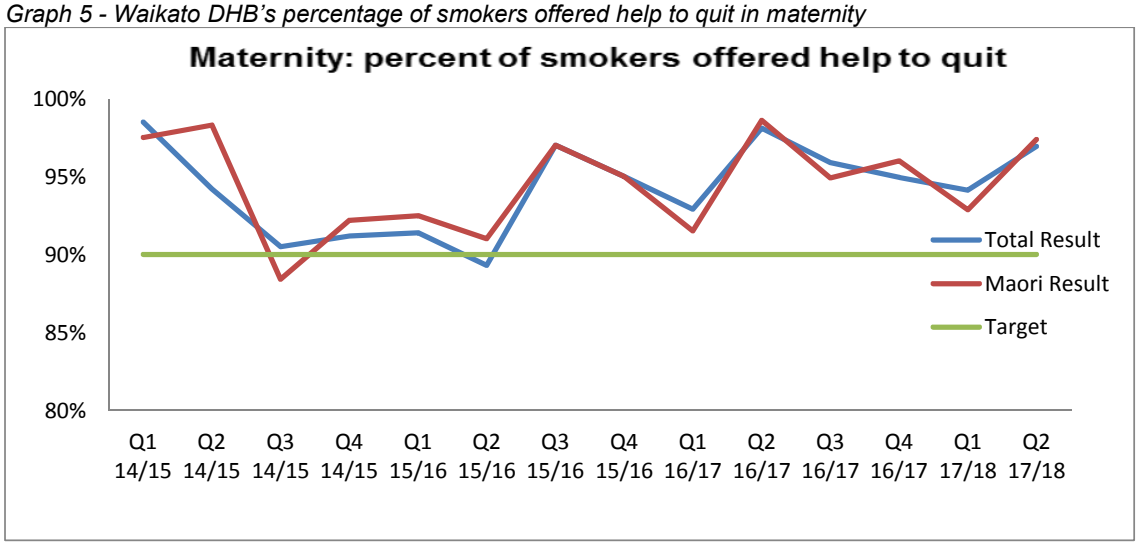


Table 13 shows our quarter three results provided by the Ministry for our total and Maori population.

Table 13 – 2017/18 Q2 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).*

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

Target: Raising healthy kids

Waikato DHB has continued to meet this target which means 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention. The Clinical Unit Leader Child Health, our dietetic service, and The Waikato Child and Youth Health Network have general oversight of this target.

Engagement with our three PHOs is effective and needed as the B4SC is provided by all general practice in our district. Once a child has been identified as “obese” by the practice nurse who does the B4SC their general practitioner will exclude any medical reasons for this significant health problem or refer the child to secondary services if required.

If there are no medical contradictions identified, the child and family /whanau can be referred to Sport Waikato, which has the Ministry contract to deliver intensive six weeks programmes for each child based on their identified needs. The service will be available throughout Waikato. The agreement with Sport Waikato is an extension of the Ministry’s other agreements with this provider such as Green Prescription, Active Families and Under-fives Energize.

It is expected that approximately 75 children will access the Sport Waikato Service this financial year and around 200 annually from 1 July 2018.

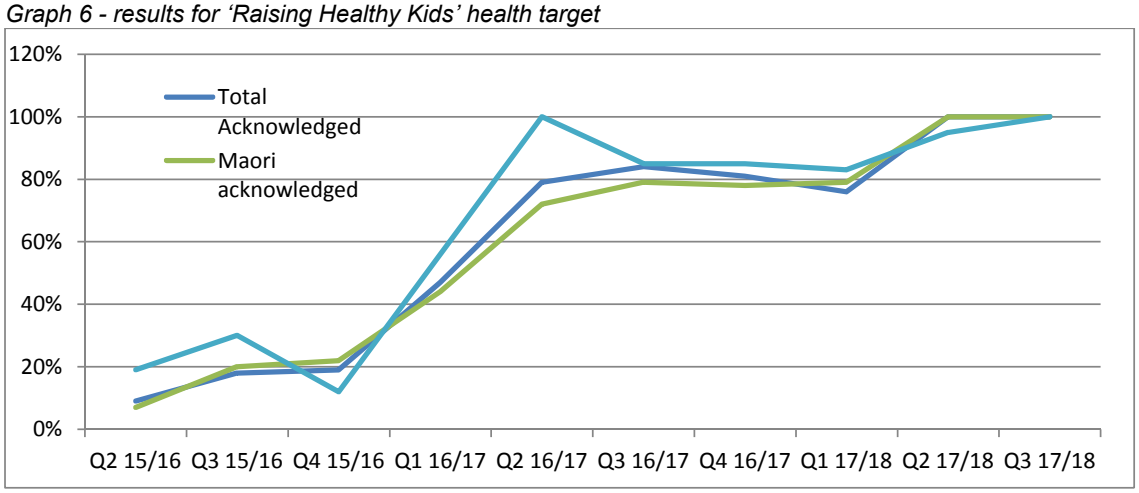
This programme is being rolled out now and a communication plan is in development for an April launch to encourage uptake of the intervention programme.

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

		Waikato						National
		2016/17 Q1	**2016/17 Q3**	**2016/17 Q4**	**2017/18 Q1**	**2017/18 Q2**	**2017/18 Q3**	**2017/18 Q2**
		Six mths Aug 16	**Six mths Feb 17**	**Six mths May17**	**Six mths Aug 17**	**Six mths Nov 17**	**Six mths Feb 18**	**Six mths Nov 17**
Total	Referral Sent	50%	86% (133)	83% (102)	77% (93)	100% (144)	100% (138)	99% (1,515)
	Referral Sent and Acknowledged	**47%**	**84% (127)**	**81% (98)**	**76% (91)**	**100% (144)**	**100% (138)**	**98% (1,492)**
Maori	Referral Sent	49%	82% (65)	80% (43)	79% (36)	100% (69)	100% (70)	98% (493)
	Referral Sent and Acknowledged	**44%**	**79% (61)**	**78% (41)**	**79% (36)**	**100% (69)**	**100% (70)**	**97% (484)**
Pacific	Referral Sent	56%	90% (9)	88% (10)	87% (13)	95% (12)	100% (12)	99% (411)
	Referral Sent and Acknowledged	**56%**	**85% (8)**	**75% (8)**	**83% (12)**	**95% (12)**	**100% (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 Feb 2018

Recommendation
THAT
The Board receives this report.

TANYA MALONEY
EXECUTIVE DIRECTOR
STRATEGY AND FUNDING

DAMIAN TOMIC
CLINICAL DIRECTOR PRIMARY CARE & INTEGRATION

MARK SPITTAL
EXECUTIVE DIRECTOR
COMMUNITY AND CLINICAL SUPPORT

GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER

Health and Safety

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 8

HEALTH AND SAFETY SERVICE UPDATE

Purpose	For information.

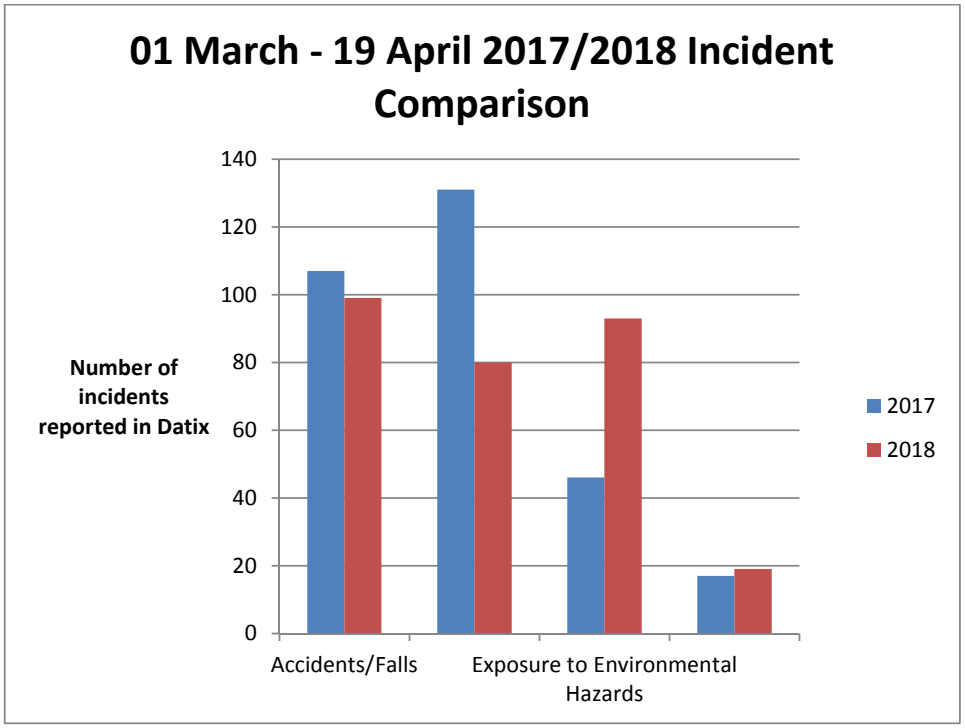
There are four branches to Principles of Due Diligence in Health and Safety Governance:

- Policy and Planning
- Monitor
- Delivery
- Review.

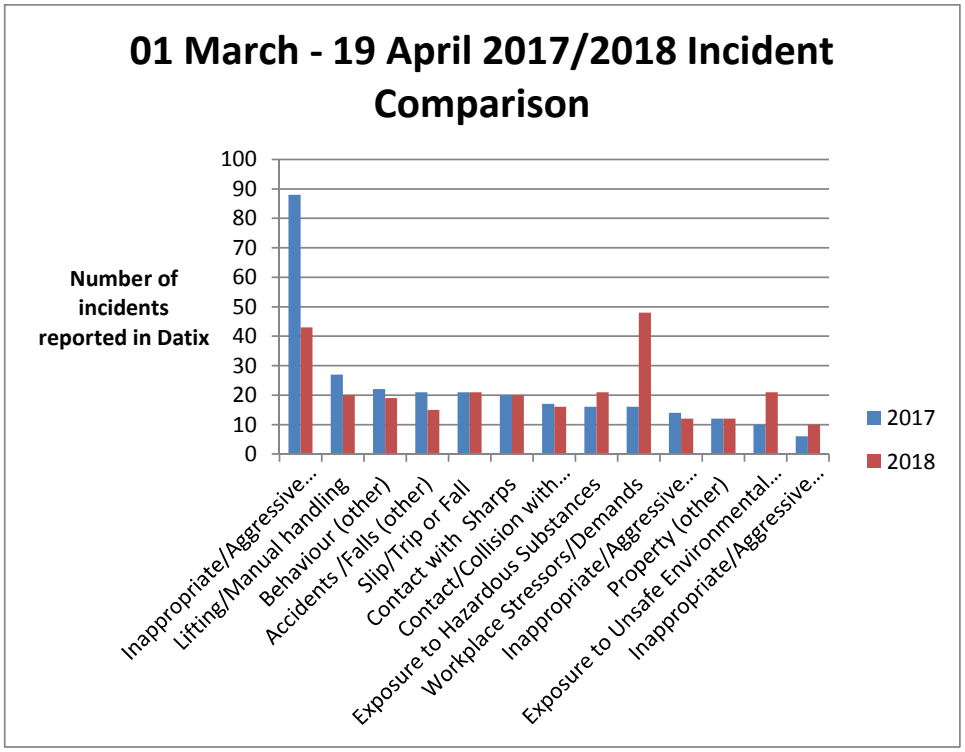
Incidents Reported to WorkSafe NZ year to date

	Year to date
Total Incidents reported	**1**

Employee collapsed in carpark displaced fracture to right leg.



First tier incident reporting data pulled from Datix



Second tier incident reporting data (top 13) pulled from Datix.

Employee Assistance Programme Comparison by sample District Health Boards

We have requested a review of the data from EAP, which has resulted in a more robust report, though our employees are still under utilising the service in comparison to DHBs who contract the same provider

Number of Clients Waikato DHB

Programme usage is based on an approximate employee headcount of 6700 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
379	4	31	352	5.25%	8.20%

Programme Usage – A sample of other District Health Boards

Sample A

Number of Clients

Programme usage is based on an approximate employee headcount of 9649 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
335	12	39	308	3.19%	8.20%

Sample B

Number of Clients

Programme usage is based on an approximate employee headcount of 1127 employee.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
14	0	1	13	1.15%	8.20%

Sample C

Number of Clients

Programme usage is based on an approximate employee headcount of 963 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
59	3	3	59	6.13%	8.20%

Sample D

Number of Clients

Programme usage is based on an approximate employee headcount of 620 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
39	0	2	37	5.97%	8.20%

Sample E

Number of Clients

Programme usage is based on an approximate employee headcount of 2,730 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
243	6	7	242	8.86%	8.20%

Sample F

Number of Clients

Programme usage is based on an approximate employee headcount of 1462 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
121	2	11	112	8.20%	8.20%

Sample G

Number of Clients

Programme usage is based on an approximate employee headcount of 2,354 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
145	3	7	141	5.99%	8.20%

Sample H

Number of Clients

Programme usage is based on an approximate employee headcount of 2709 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
166	2	9	159	5.87%	8.20%

Sample I

Number of Clients

Programme usage is based on an approximate employee headcount of 5,824 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
335	3	28	310	5.32%	8.20%

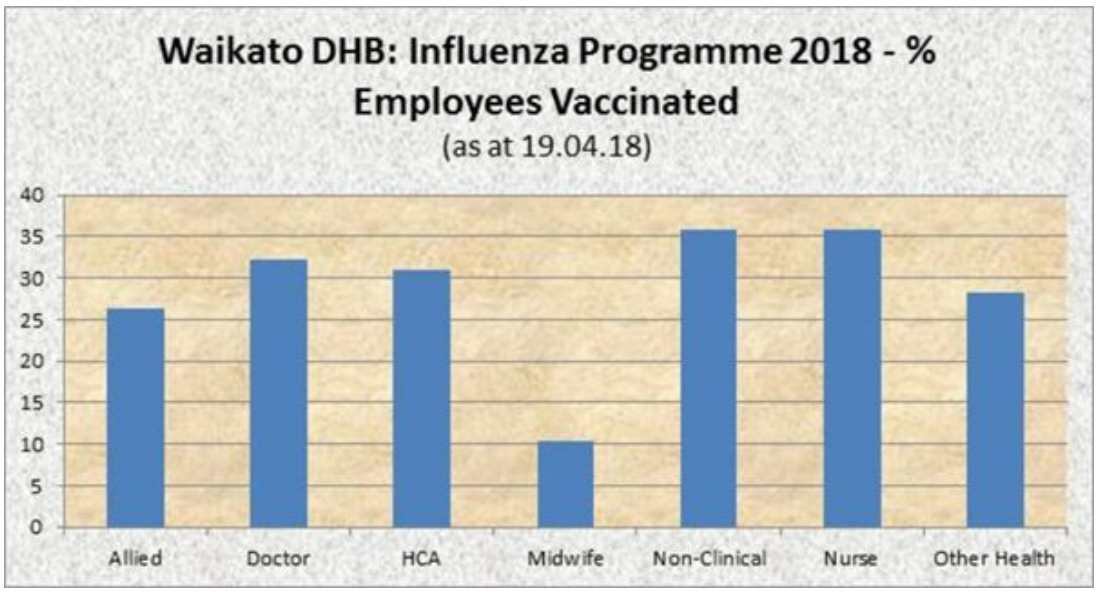
Sample J

Number of Clients

Programme usage is based on an approximate employee headcount of 3326 employees.

Employees	Family Members	Did Not Attend	Total	Usage Rate	National Usage Rate
247	3	22	228	6.86%	8.20%

Average usage across 10 other District Health Boards = 5.75% vs Waikato District Health Board = 5.25%



32.83% total staff Influenza vaccinated as at 19.04.18. Programme started on 9 April 2018.

Recommendation
THAT
The Board receives the report.

GREGORY PEPLOE
DIRECTOR PEOPLE AND PERFORMANCE

Service Performance Monitoring

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 9.1

COMMUNITY AND CLINICAL SUPPORT PERFORMANCE DASHBOARD

Purpose	For information.

The high level key performance dashboard for Community and Clinical Support for March 2018 is attached for the Board's information.

Recommendation
THAT
The Board receives the report.

MARK SPITTAL
EXECUTIVE DIRECTOR COMMUNITY AND CLINICAL SUPPORT

Key Performance Dashboard

Community & Clinical Support

March 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	92.2	95.0	(2.8)	93.1	95.0	(1.9)		
Number of long wait patients on outpatient waiting lists	# > 4 mths	0	0	0					
Number of long wait patients on inpatient waiting lists	# > 4 mths	0	0	0					
CTs reported within 6 weeks of referral	%	74.3	90.0	(15.7)	82.1	90.0	(7.9)		1
MRIs reported within 6 weeks of referral	%	72.1	85.0	(12.9)	77.1	85.0	(7.9)		2

General Throughput Indicators

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Emergency Department - Number relative to Target growth of 4% p.a.	Numbers	Rolling 12 month measure			35,557	35,190	(367)		
Elective and Arranged Day Surgery Percentage	%	Rolling 12 month measure			0.0	0.0	0.0		
Elective and Arranged Day of Surgery Admissions	%	Rolling 12 month measure			95.3	99.6	(4.4)		
Laboratory – Histology specimens reported within 7 days of receipt	% for Feb YTD	47.0	80.0	(33.0)	43.4	80.0	(36.6)		3
Pharmacy - Chart turnaround times, % within 2.5 hours	%	86.9	80.0	6.9	88.8	80.0	8.8		
Pharmacy on Meade script turnaround time in minutes	minutes	10.3	10.0	(0.3)	10.3	10.0	(0.3)		
Outpatient DNA Rate	%	9.6	10.0	0.4	11.2	10.0	(1.2)		4
Output Delivery Against Plan - Volumes for FSA, F/Up and Nurse Consults	%	104.2	100.0	4.2	89.5	100.0	(10.5)		5
Output Delivery Against Plan - Inpatient Number of Episodes	%	101.8	100.0	1.8	98.6	100.0	(1.4)		
Output Delivery Against Plan - Inpatient CWD Volumes	%	89.8	100.0	(10.2)	91.6	100.0	(8.4)		6
District Nurse Contacts (DHB Purchased)	Numbers	10,189	-		88,747				
District Nurse Contacts (ACC Purchased)	Numbers	2,215	-		19,312				

Discharge Management

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Assigned EDD (SAFER)	%	88	100	(12)	85	100	(15)		7
Inpatient Length of Stay - Acute (excludes patients discharged from ED)	Days	Rolling 12 month measure			3.26	3.24	(0.02)		
Inpatient Length of Stay - As Arranged	Days	Rolling 12 month measure			2.19	1.10	(1.10)		8
Inpatient Length of Stay - Elective	Days	Rolling 12 month measure			0.32	0.32	(0.00)		

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	87.8	95.0	(7.2)	89.4	95.0	(5.6)		9

Quality Indicators - Patient Safety

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Breast screening Total volumes - Waikato DHB	Numbers	2,019	2,073	(54)	16,712	16,127	585		
Breast screening Maori volumes - Waikato DHB	Numbers	273	361	(88)	2,917	2,665	252		
Hospital Acquired MRSA (Department)	Numbers	0	0	0	0	0	0		

Quality Indicators - Patient Experiences

Indicator	Unit of Measure	Month Actual	Month Target	Month Variance	YTD Actual	YTD Target	YTD Variance	Last 12 Mths Trend	Note
Complaints	Numbers (All)	5	2	3	20	15	5		
Compliments	Numbers	0	0	0	0	0	0		
All Falls	Numbers	1	1	(0)	9	5	(5)		10
Patient Feedback	*Not yet collected - in Development*								

Finance and Human Resource Measures

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Actual Expenditure vs Budget ($000s)	$000s	16,959	15,106	(1,853)	138,144	133,885	(4,259)		
Actual FTEs vs Budget	FTEs	1,026.7	1,041.3	14.6	1,011.5	1,031.1	19.6		
Sick Leave	% of paid hours	3.7	3.1	(0.6)	3.1	2.9	(0.2)		11
Overtime $'s	$000s	207	143	(64)	1,719	1,264	(455)		12
Annual Leave Taken	% of Budget	Rolling 12 month measure			86.0	100.0	(14.0)		13

Operational Management Indicators (for Service use only)

Indicator	Unit of Measure	Actual	Target	Variance	Actual	Target	Variance	Last 12 Mths Trend	Note
Indicator	Unit of Measure	Actual	Target		Actua	Target			
Unacknowledged Results > 10 days	Numbers	Current month result is shown as YTD			6,258	0	(6,258)		

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	

Community & Clinical Service: KPI Commentary

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

Note	Indicator	Commentary
1	CTs reported within 6 weeks of referral	Waikato was below the national average but third best amongst the tertiary DHBs for timely access to CT (74% in 6 weeks). The decline in performance reflects staffing issues. Performance is expected to deteriorate over the next few months.
2	MRIs reported within 6 weeks of referral	Waikato's outsourced MRI service was the best performing of any tertiary DHB and well above the national average (72% compared to 54% for the country).
3	Laboratory – Histology specimens reported within 7 days of receipt	Recent pathologist leave has affected turn-around times. One histologist role is currently vacant but recruitment continues. Performance benchmarking with other DHB services is underway.
4	Outpatient DNA rate	No concerns of note other than in Radiology where a specific IT upgrade to enable txt reminders and confirmations is due to go live in late April.
5	Output delivery against plan – FSA/ Nurse consults etc	Several specialty services have not delivered the contracted level of patient events in the visiting clinics in the four rural hospitals so far this year. Active engagement to remedy that situation is underway as evidenced by recent over delivery.
6	Output delivery against plan – inpatient cwd	YTD almost all inpatient events have occurred but only 91.4% of cwd have been earned. The funder is delighted. This is an artefact of the new WEIS method for calculating CWD that was introduced nationally on 1 July. Essentially the change means less revenue will be earned for treating the same number and type of patients as previously. These artefacts of changes in the calculation method bring periodic joy to the funder.
7	Assigned EDD – Safer	This is a new measure. The SAFER project launched in mid-August and improvements in the use of EDD re already evident.
8	Inpatient Length of Stay - As Arranged	The number of arranged admissions at Thames is so inconsequential that this KPI has no meaning.
9	Better help for smokers to quit	Improving trend. High variability due to small number variance.
10	Falls with harm	No concerns about the trend that are of note.
11	Sick leave	No concerns of note.
12	Overtime $'s	Current levels reflect staff shortages in Radiology in particular. The solution is to employ the number of staff required to staff the productive schedule. This common-sense approach is being advocated for as part of the planning for the 2018/19 year.
13	Annual leave taken	Exemplary performance relative to most industries.

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 9.2

STRATEGY AND FUNDING KPI DASHBOARD

Purpose	For information.

The Strategy & Funding KPI dashboard is attached as Appendix A. The dashboard indicates whether items have been updated since the previous report. All items with negative variances have a commentary provided, excluding those items already reported on within the health target report.

Recommendation
THAT
The report be received.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY & FUNDING

Strategy and Funding KPI Dashboard Commentary

Note	Indicator	Commentary
1	Proportion of older people waiting greater than 20 days for initial assessment or reassessment	Data has been updated and shows the most recent quarter. This indicator continues to improve and the service is managing the issues previously identified.
3	2 year old immunisations	The latest 2 year old coverage result is 91% (target 95%). The 4% point gap represents 60 children not immunised on time. For children aged 2 years, the highest coverage this quarter was for Asian children (98%) and lowest for Other (non Maori, Pacific, or Asian) (82%). Our latest results also show Maori as 3% lower than 'Total Population' at 2 years. In line with the approach taken in under 8 month immunisations an initial focus will be on addressing enrolment status of any children not enrolled and identifying reasons for declines.
4	Ambulatory sensitive hospitalisations	The data shows pleasing improvements in the rates for the Pacific Islander group in both 0-4 and 45-64 age brackets. However, ASH rates have deteriorated for Maori and Other ethnicities in both age groups. For Maori and Other ethnicities, in the 45-64 age group, the increase is driven by admissions for angina/chest pain, COPD, cellulitis and pneumonia. In the 0-4 age group, it is driven by conditions such as upper and ENT respiratory infections, gastroenteritis/dehydration, dental conditions and asthma.

Appendix A **Strategy and Funding KPI RESULTS**

March	2018

Health Targets

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

Finance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Month Actual	Target	Variance		YTD Actual	Target	Variance		Trend
IDF inflow estimate	$		Feb-YTD	n	10,558	11,273	-715	✗	92,875	79,429	13,446	✓	
IDF outflow estimate	$		Feb-YTD	n	4,803	4,967	-164	✓	40,146	35,376	4,771	✗	

Other Performance Measures

Indicator	Unit	⇵	Data period	Updated from prior report	Recent period Actual	Target	Variance		Previous Period Actual	Target	Variance		Trend
AOD waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Dec 17	Yes	84%	80%	4%	✓	85%	80%	5%	✓	
MH waiting times - % new clients seen within 3 wks of referral (12 mth period)	%	↑	12 months to Dec 17	Yes	80%	80%	0%	✓	80%	80%	0%	✓	
AOD waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Dec 17	Yes	96%	95%	1%	✓	97%	95%	2%	✓	
MH waiting times - % new clients seen within 8 wks of referral (12 mth period)	%	↑	12 months to Dec 17	Yes	92%	95%	-3%	!	92%	95%	-3%	!	
Proportion of Health of Older people initial needs assessments Waiting greater than 20 days	%	↓	Oct -Dec 17	no	6%	0%	-6%	✗	6%	0%	-6%	✗	
Proportion of health of older people need re-assessments Waiting greater than 20 days	%	↓	Oct -Dec 17	no	5%	0%	-5%	✗	6%	0%	-6%	✗	
Proportion of older person funding in community based services	%	↑	Dec YTD	no	27%	25%	2%	✓	27%	25%	2%	✓	
Pharmacy Items claimed	Items		Feb-18	Yes	480,546	N/A			509,408	N/A			
Laboratory turnaround tmes	%	↑	Dec-17	no	100%	97%	3%	✓	100%	97%	3%	✓	
Breast Screening (total eligible population)	%	↑	Dec-17	no	69%	70%	-1%	!	68%	70%	-2%	!	
Cervical screening (total eligible population)	%	↑	Sep-17	no	76%	80%	-4%	!	76%	75%	1%	✓	
Cervical screening (High Need)	%	↑	Sep-17	no	68%	80%	-12%	✗	68%	75%	-7%	✗	
2 year old immunisations (total population)	%	↑	Rolling 3 months	Yes	91%	95%	-4%	!	91%	95%	-4%	!	
2 year old immunisations (Maori)	%	↑	Rolling 3 months	Yes	89%	95%	-6%	✗	88%	95%	-7%	✗	
Green Prescriptions	%	↑	Jan - Mar 18	Yes	1,485	1,675	-190	✗	1,389	1,675	-286	✗	

Ambulatory Sensitive Admissions - Rates per 100,000 Population

Indicator	Unit	⇵	Data period	Updated from prior report	YT Dec 2017				YT Sep 2017			
Ambulatory sensitive admissions 0-4	rate	↓	YT Dec 2017	n	8284	7344	-940	✗	7908	7327	-581	✗
Ambulatory sensitive admissions 0-4 (Maori)	rate	↓	YT Dec 2017	n	9415	7958	-1457	✗	8841	8223	-618	✗
Ambulatory sensitive admissions 45-64	rate	↓	YT Dec 2017	n	4492	4137	-355	✗	4522	4020	-502	✗
Ambulatory sensitive admissions 45-64 (Maori)	rate	↓	YT Dec 2017	n	9314	7777	-1537	✗	9230	7494	-1736	✗

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

Decision Reports

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 10.1

ETHNICITY BASED KPI REPORTING

Purpose	For information and consideration.

A request for regular ethnicity-based (Māori) reporting was made in the February Board meeting. An initial shortlist of key measures and two additional measures was agreed in the March Board meeting, to be reported quarterly to both the Board and Iwi Māori Council. Following the March Board meeting, members of Te Puna Oranga (TPO) and the Operational Performance and Support teams met and agreed a plan to enable further access to data and existing reporting tools for the analysts in TPO.

This first report includes the results for agreed KPI measures and includes a 'deep-dive' analysis into the ED performance metric. Not all KPI measures could be reported on meaningfully in the time available and these will be added to future reports.

March quarter report – key findings

A few insights can be drawn from the partial March report results (Appendix I):

- Māori are more likely to be discharged from ED within 6 hours.
- The outpatient DNA rate for Māori is significantly higher than for non-Māori.
- Māori are more likely to be offered advice to stop smoking.
- Māori have more admissions to the Renal service.
- Other measures included in the March report do not show a statistical difference between Māori and non-Māori.

ED performance – Deep Dive analysis

The key findings from the ED performance Deep Dive (Appendix II) are that Māori are more likely to present to emergency departments in our DHB than non-Māori, Māori receive on average a higher triage score (lower acuity issues), Māori are seen quicker by ED physicians, Māori are less likely to be admitted to an inpatient ward and Māori are more likely to leave ED within 6 hours.

Next steps

Over the next period, remaining measures will be added to this report progressively.

Recommendation
THAT
The Board:

1) Receives the report.
2) Selects ‘outpatient DNA rate’ for a deep dive analysis in the June quarterly report.

MARC TER BEEK
EXECUTIVE DIRECTOR OPERATIONS AND PERFORMANCE

NEIL HALL
DIRECTOR BUSINESS INTELLIGENCE AND PRODUCTION PLANNING

Appendix I: Ethnicity-based KPI report - March 2018

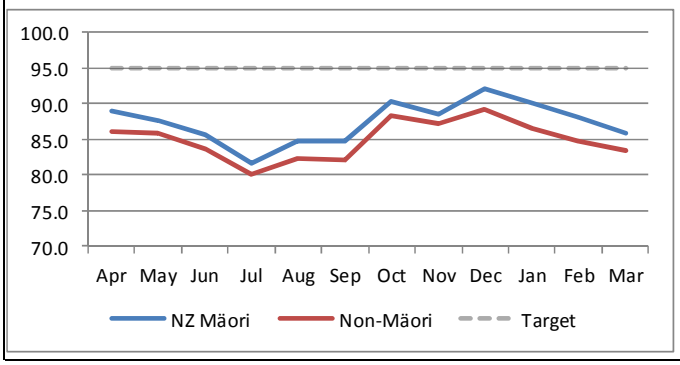
Below summarises the results for the first 13 of the proposed 24 performance indicators. Further work is underway to finalise the results for the remaining measures. Upon further discussion with Te Puna Oranga members, it has been agreed to include measures that demonstrate:

1) Service usage (i.e. number of ED presentations), relative to population
2) Service access (i.e. wait-times, ED six hour performance).

Measure Title	Included	Type
Emergency Department < 6 Hours	Yes	Access
Faster Cancer Treatment - Referral received to first treatment <= 62 days	Yes	Access
Faster Cancer Treatment - DTT to first treatment <= 31 days	Yes	Access
Number of long wait patients on outpatient waiting lists	To be refined	Access
Number of long wait patients on OPRS outpatient waiting lists	To be refined	Access
Number of long wait patients on inpatient waiting lists	To be refined	Access
Waiting Time for acute theatre < 24 hrs	Yes	Access
Waiting Time for acute theatre < 48 hrs	Yes	Access
Mental health seclusion hours	To be refined	Usage
Mental health recovery plans	To be refined	Usage
Mental health HoNos matched pairs	To be refined	Usage
Mental health inpatient bed occupancy	To be refined	Usage
Outpatient DNA Rate	Yes	Access
Number of long stay patients (>20 days length of stay)	Yes	Usage
Number of long stay patient bed days (>20 days los)	Yes	Usage
Mental health average length of stay	To be added	Usage
Average length of stay (Specialty excl AoD)	To be added	Usage
Mental health post discharge follow up - % seen in 7 days	Yes	Access
Mental health follow up - numbers seen in 7 days	To be added	Usage
Mental health community contract positions filled	To be refined	Usage
Mental health 28 day readmission rate	Yes	Usage
Better help for smokers to quit	Yes	Access
New: Admissions to respiratory service	Yes	Usage
New: Admissions to renal service	Yes	Usage

Measure details

Emergency Department < 6 Hours

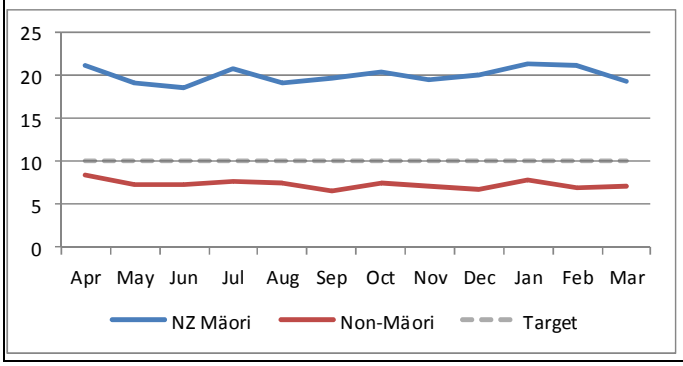


	Maori	Non-Maori
Mar-18	85.9	83.4
Target	95.0	95.0
Variance	-9.1	-11.6
Number	2717	7084
YTD	87.3	85.0
Target	95.0	95.0
Variance	-7.7	-10.0
Number	32791	82218

Statistical Difference

Māori are more likely to be discharged from ED within 6 hours. Appendix II contains further details about presentations in the last year.

Outpatient DNA Rate

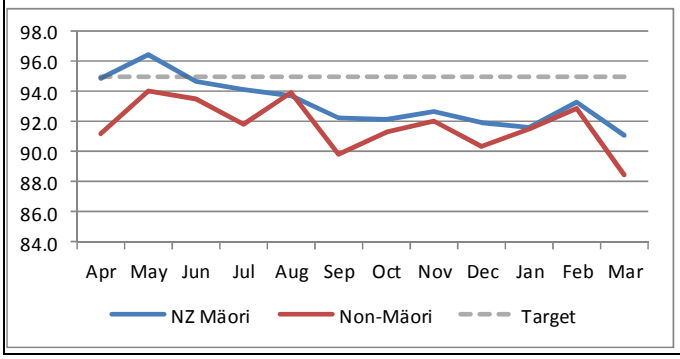


	Maori	Non-Maori
Mar-18	19.4	7.1
Target	10.0	10.0
Variance	9.4	-2.9
Number	3435	13417
YTD	20.0	7.3
Target	10.0	10.0
Variance	10.0	-2.7
Number	38060	150211

Strong Statistical Difference

Outpatient DNA rate for Māori is significantly higher than for non-Māori, at almost three times the rate.

Better help for smokers to quit

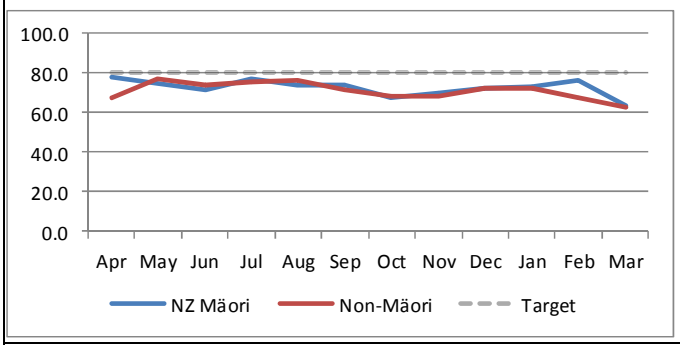


	Maori	Non-Maori
Mar-18	91.1	88.4
Target	95.0	95.0
Variance	-3.9	-6.6
Number	314	406
YTD	93.4	91.9
Target	95.0	95.0
Variance	-1.6	-3.1
Number	5822	7138

Statistical Difference

Māori are more likely to be provided with advice to quit smoking.

Waiting Time for acute theatre < 24 hrs

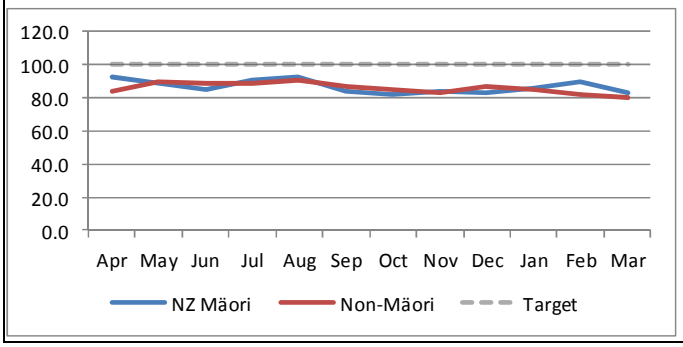


	Maori	Non-Maori
Mar-18	63.4	63.1
Target	80.0	80.0
Variance	-16.6	-16.9
Number	213	569
YTD	72.5	71.1
Target	80.0	80.0
Variance	-7.5	-8.9
Number	2488	6497

No Statistical Difference

There is no difference in proportion of patients waiting less than 24 hours for acute theatre.

Waiting Time for acute theatre < 48 hrs

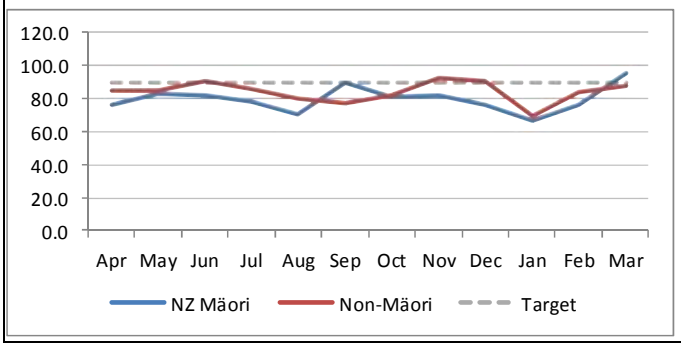


	Maori	Non-Maori
Mar-18	82.6	79.8
Target	100.0	100.0
Variance	-17.4	-20.2
Number	213	569
YTD	86.7	85.7
Target	100.0	100.0
Variance	-13.3	-14.3
Number	2488	6497

No Statistical Difference

There is no difference in proportion of patients waiting less than 48 hours for acute theatre.

Mental health post discharge follow up - % seen in 7 days

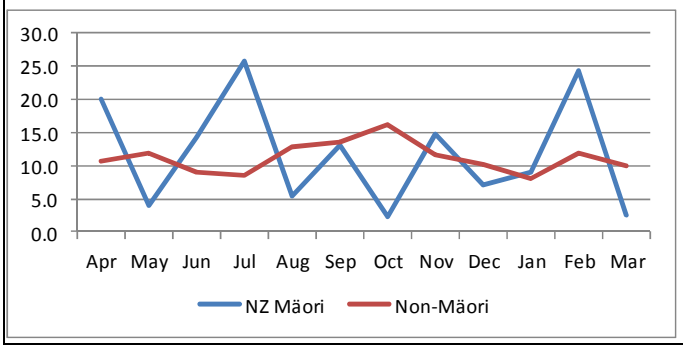


	Maori	Non-Maori
Mar-18	95.8	87.8
Target	90.0	90.0
Variance	5.8	-2.2
Number	24	49
YTD	80.0	84.1
Target	90.0	90.0
Variance	-10.0	-5.9
Number	315	534

No Statistical Difference

There is no difference in proportion of patient follow ups seen in 7 days.

Mental health 28 day readmission rate

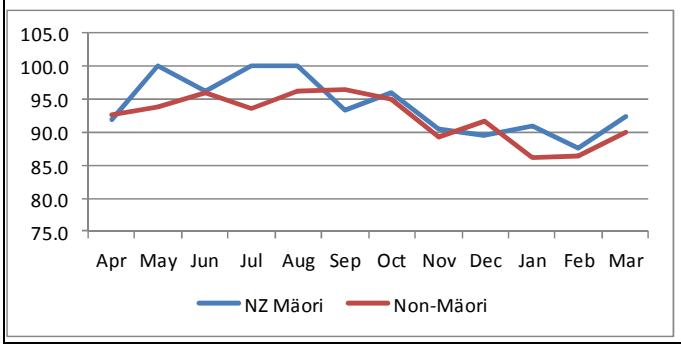


	Maori	Non-Maori
Mar-18	2.4	9.9
Number	1	7
YTD	11.0	11.2
Number	56	96

No Statistical Difference

There is no difference in 28 day readmission rate between Māori and non-Māori.

Faster Cancer Treatment - DTT to first treatment <= 31 days

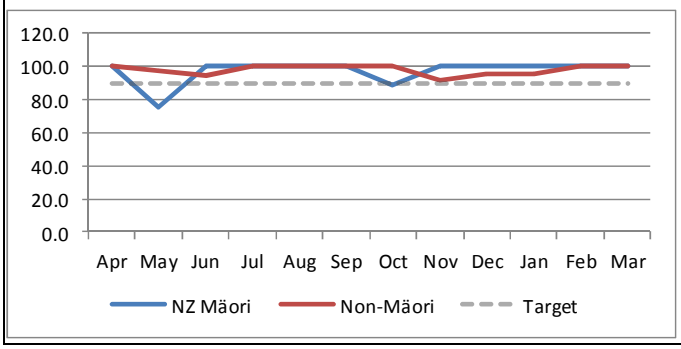


	Maori	Non-Maori
Mar-18	92.3	90.0
Number	13	80
YTD	94.5	92.3
Number	255	1209

No Statistical Difference

There is no difference in proportion of patients waiting less 31 days from decision to treat.

Faster Cancer Treatment - Referral received to first treatment <= 62 days

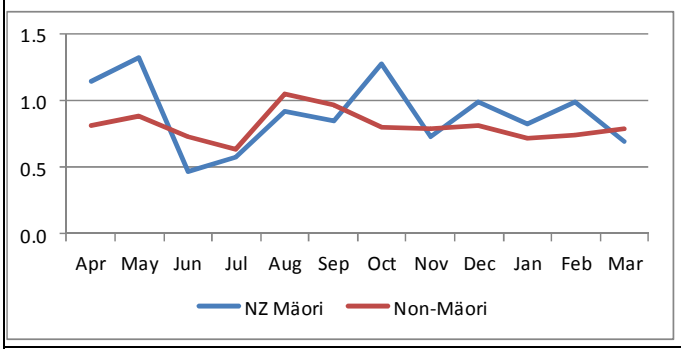


	Maori	Non-Maori
Mar-18	100.0	100.0
Target	90.0	90.0
Variance	10.0	10.0
Number	5	20
YTD	97.1	97.8
Target	90.0	90.0
Variance	7.1	7.8
Number	68	271

No Statistical Difference

There is no difference in proportion of patients waiting less than 62 days from referral.

Number of long stay patients (>20 days length of stay) per 100 discharges

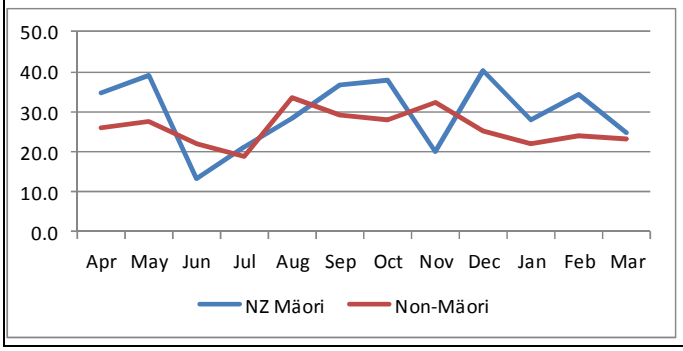


	Maori	Non-Maori
Mar-18	0.7	0.8
Number	14	49
YTD	0.9	0.8
Number	204	577

No Statistical Difference

There is no difference in proportion of admitted patients with a length of stay >20 days.

Number of long stay patient bed days (>20 days los) per 100 discharges

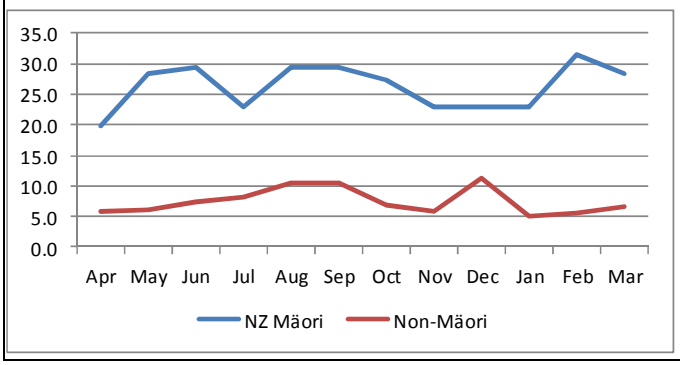


	Maori	Non-Maori
Mar-18	24.7	23.0
Number	494	1434
YTD	29.5	25.9
Number	6744	18390

No Statistical Difference

There is no difference in average LOS for patients with a length of stay >20 days.

Renal Admissions per 100,000 Population

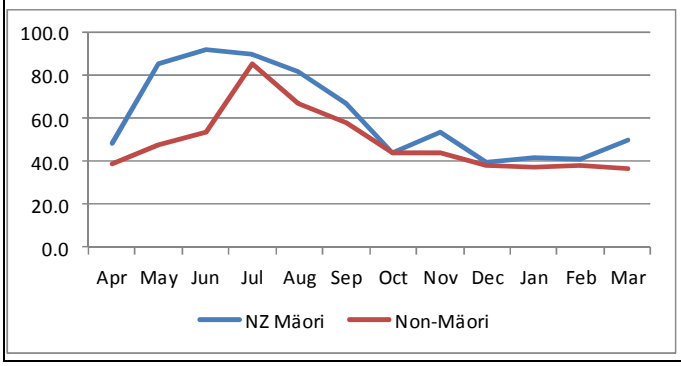


	Maori	Non-Maori
Mar-18	28.2	6.5
Number	27	21
YTD	314.8	89.6
Number	301	289

Strong Statistical Difference

Renal admission rate in Māori population are much higher than in non-Māori population.

Respiratory Admissions per 100,000 Population



	Maori	Non-Maori
Mar-18	50.2	36.3
Number	48	117
YTD	734.2	588.6
Number	702	1899

No Statistical Difference

Respiratory admission rate for Māori population is not statistically different from non-Māori.

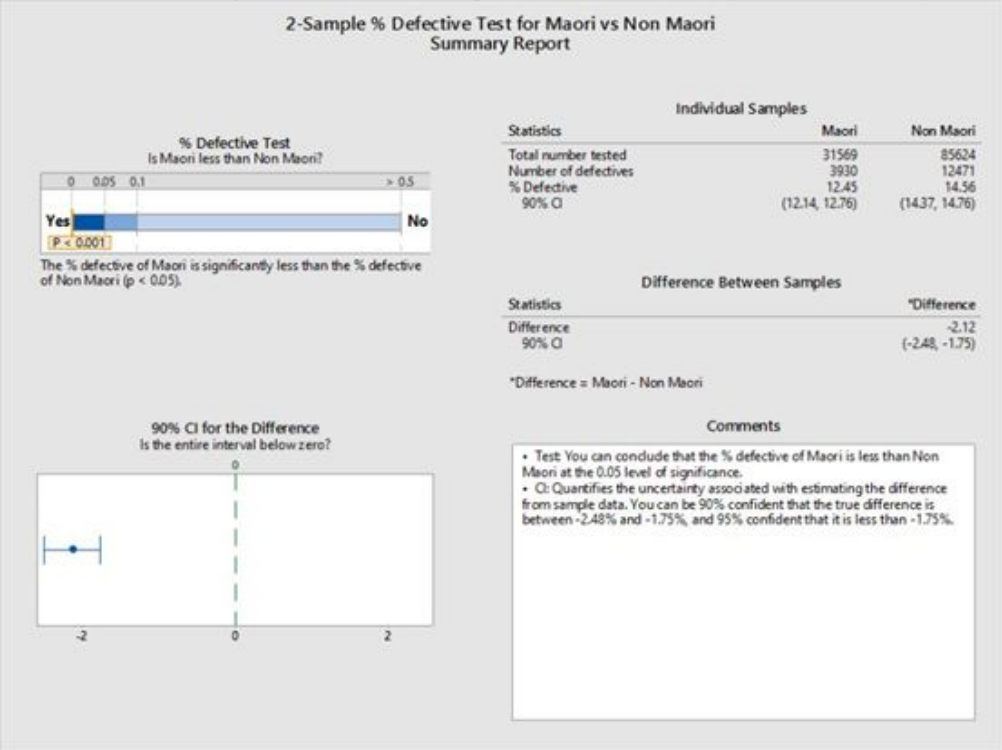
Appendix II: Deep-Dive analysis ED performance

22.9% of Waikato DHB population identifies with the Māori ethnicity (source: Health.govt.nz).

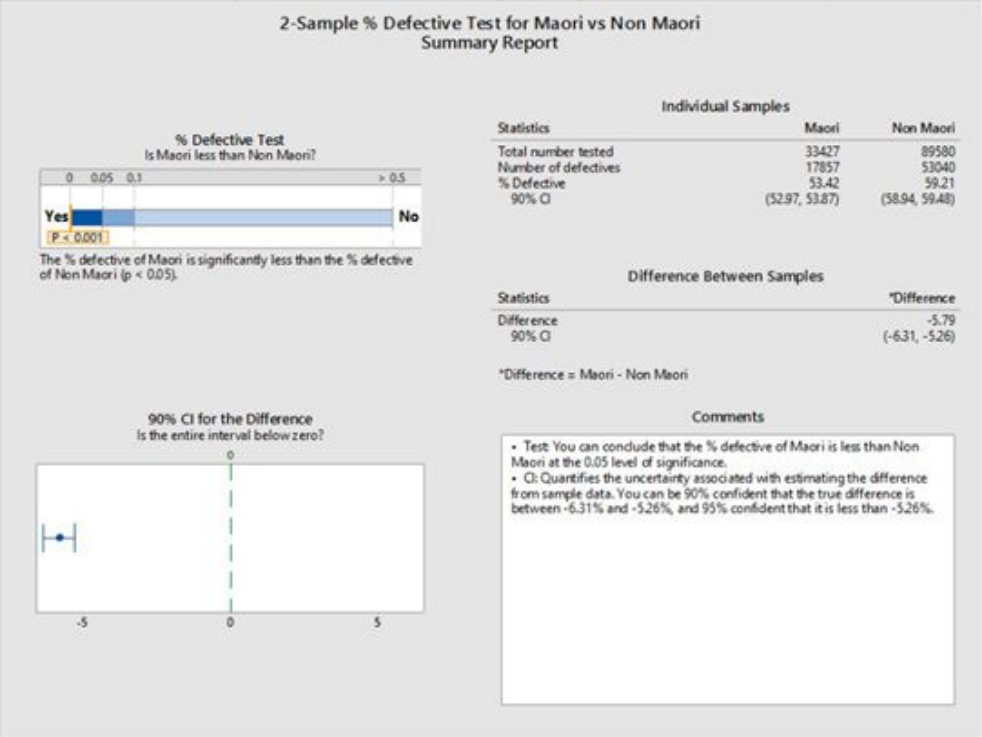
Presentation data source: Acute Flow Dashboard; 1 year of ED presentations to Waikato DHB hospitals (365 days to 17 March 2018; N=123,007).

Presentations:
Overall NZ Māori represent 27% of the ED presentations in Waikato DHB. The proportion of the ED presentations by Māori is significantly higher than the proportion of Māori in the Waikato DHB population, hence Māori are more likely to present to ED.

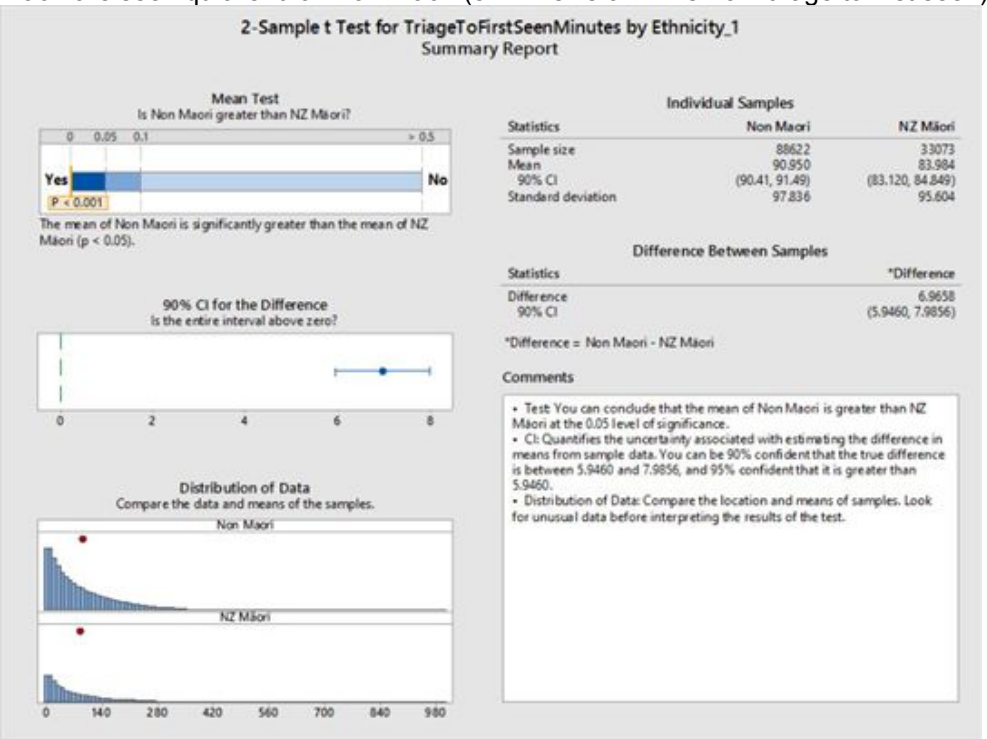
6 hr performance:
Māori are more likely to be treated through ED within 6 hours (87.5% vs 85.4%).



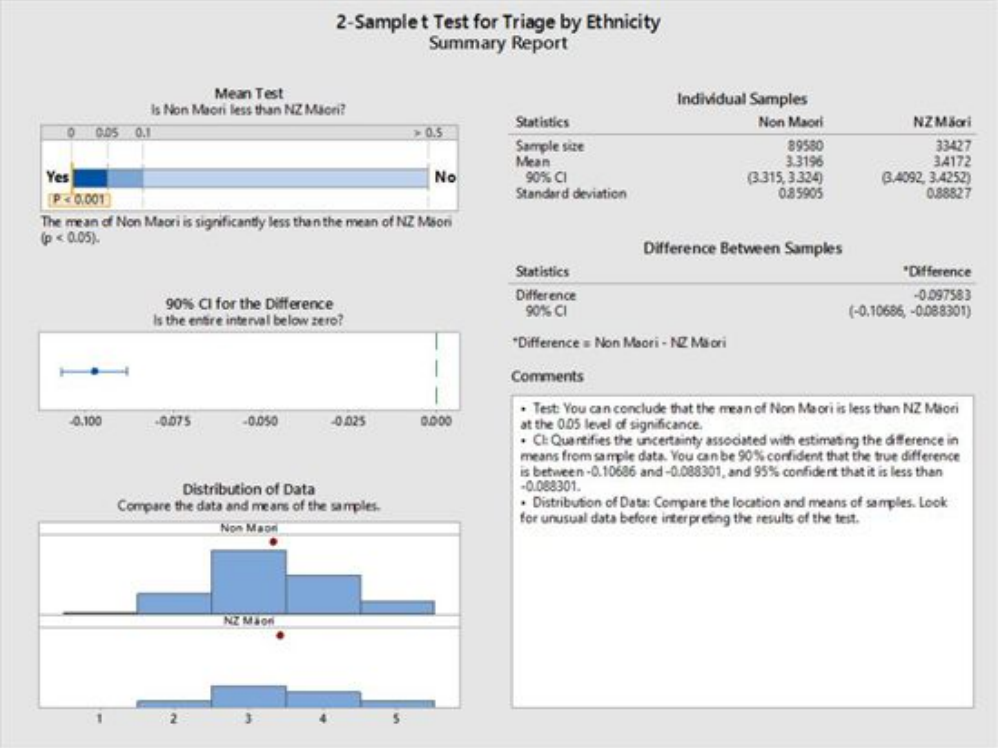
Triage times:
Māori are more likely to be seen within target triage time (47% vs 41%).



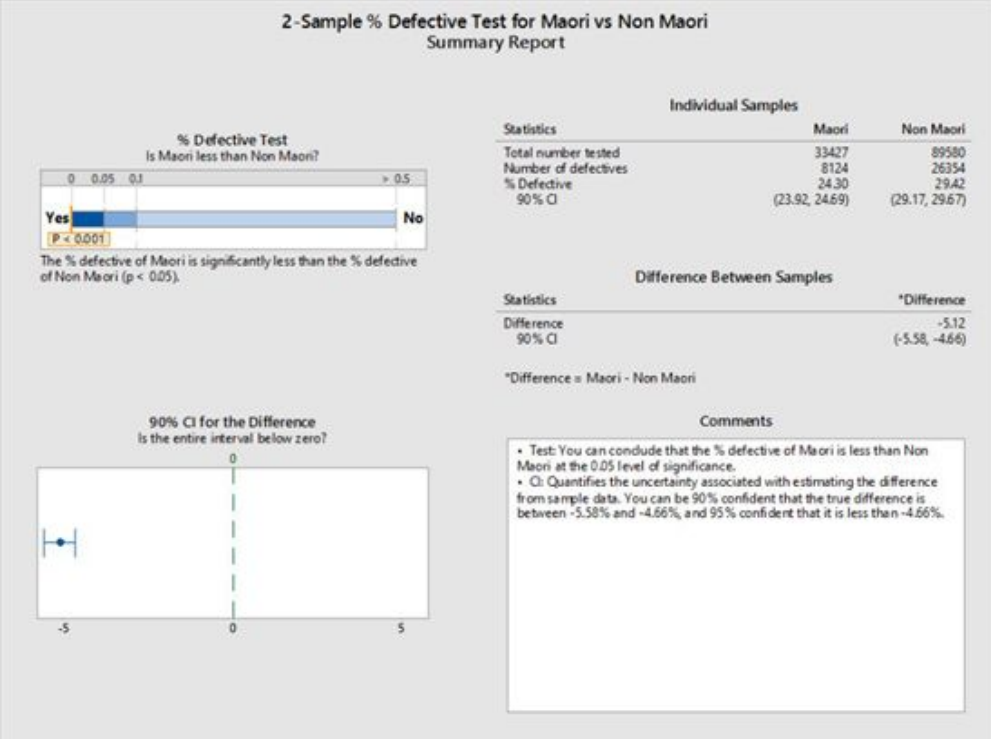
Māori are seen quicker than non-Māori (84 mins vs 91 mins from triage to first seen).



Mean triage score:
Non Māori have higher average triage score (3.4 vs 3.3), meaning Māori present with slightly lower acuity levels.



Admission conversion rate:
Māori are less likely to be admitted (24% vs 29%) from their ED presentation.



MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 10.2

CBD OFFICE NAMING

Purpose	For decision

Introduction

The DHB is leasing the former Farmer's Building in Hamilton CBD for a number of services and the Board has instructed staff to seek feedback on the naming of the building from tangata whenua and put a recommendation to the Board.

Background

The former Farmer's Building in the heart of the CBD is currently being fitted out for the DHB ahead of services starting to move into the building at the end of 2018. Around 800 staff will be moving into the refurbished space on the corner of Alexandra Street and Collingwood Street.

The offices will house Population Health, some Mental Health services, Diabetes services, Disability Support Link, REACH, Healthshare and most IS functions.

There will be patient/client consulting rooms and three street frontages.

Consultation

The DHB's Naming Rights Policy (attached Appendix 1) states that approval of names should be obtained from iwi by way of consultation with the Kaunihera Kaumatua.

At a meeting of the Kaunihera Kaumatua in December 2017, they advised that if they were asked formally to name the building they would choose the name and it would be a gift and therefore the Board could not change this.

For example Te Arikinui Te Atairangikaahu gifted the name Waiora Waikato for the Waikato Hospital campus in 1989.

The group's feedback around the history of the site is that the land has great significance to the Ngati Wairere hapu and the Tainui waka. The hills are well known for where the people watched the constellation of the stars and where Te Ao katoa, of Ngati Koura is said to have performed one of the last ancient rituals during his visit to Kirikiriroa with King Tawhiao in July 1881, when he removed the tapu from the hill.

The Kaumatua wanted to see the name of the building aligned to the Waikato Hospital site and the Waiora name that was gifted. They previously sanctioned the use of Waikids, following the same pathway.

At a second meeting of the Kaunihera Kaumatua in April 2018, they advised that myself and the Executive Director of Te Puna Oranga visit Tame Pokaia, the Kaumatua for Wintec and the Hamilton City Council, for his advice.

Tame advised that the name Waiora has significant mana, and our use of this word is particularly important as it was a gift from Te Arikinui Te Atairangikaahu.

He said just as Wintec was the gateway for the college's satellite offices around the region, so the Waiora Campus at Waikato Hospital is the gateway for the DHB. His view was that it was therefore fitting that we used the Waiora name on the CBD building and it would be bringing the mana of Te Arikinui Te Atairangikaahu to the centre of Kirikiriroa (Hamilton).

Naming rights requests

We have had one request from the Toti Trust to name the building after Dame Hilda Ross. (Letter attached in Appendix 2).

I am not recommending that this name is used as I believe it would be confusing for the public. Although Hilda Ross House on the Waikato Hospital campus has been demolished, people still assoiate the name with the campus. A request was also being considered by Hamilton City Council to name an area around a statue to Dame Hilda in the CBD, Hilda Ross Plaza, plus there is the Hilda Ross Retirement Village in Hamilton East.

Therefore the public could be confused about the location of the DHB building if it was called after Dame Hilda.

Considerations

Staff and public are still calling the new office 'The Farmer's Building' but obviously we cannot continue to name the building that as it is used by another commercial entity.

The Naming Rights Policy states that buildings will usually be named after their function if this is evident and long term. However we may choose to recognise people or sponsors by naming facilities in their honour.

The DHB sometimes names buildings after their location. For instance the current population health office is known as 'London Street' and the new community services and warehouse building is called 'Gallagher Drive.'

I don't believe the names of the streets around the building are appropriate to be used on this building as they relate to military or colonial historical figures, which have no relevance to the health board as it is today. The building also has three street frontages.

Staff often default to a short easy to remember name for offices, regardless of any more formal name, like the office space in KPMG tower. Or they will shorten a longer name e.g. ERB for the Elizabeth Rothwell Building. While public will often refer to buildings by the service e.g. 'Women's' or 'maternity'.

So a short, simple to remember name for staff and public would be helpful.

Recommendation

Taking into account the Kaumatua's preference to have a link to the Waikato Hospital site, the advice around the mana of the word Waiora, and the desire of staff for a short, memorable name, I am recommending that we incorporate the name Waiora into the name of the new building, and call it either Waiora CBD; Waiora Central; or Waiora Downtown. The project steering board prefer Waiora Central.

Recommendation
THAT
The DHB's CBD building is named Waiora Central

LYDIA AYDON
EXECUTIVE DIRECTOR PUBLIC & ORGANISATIONAL AFFAIRS

Appendix one

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

POLICY

Naming Rights of Waikato District Health Board Owned Facilities

Policy Responsibilities and Authorisation

Department Responsible for Policy	Media and Communications
Position Responsible for Policy	Executive Director Public Affairs
Document Owner Name	Lydia Aydon
Sponsor Title	Chief Executive
Sponsor Name	Nigel Murray
Target Audience	All staff
Committee Approved	Policy Committee
Date Approved	19 May 2016
Committee Endorsed	Waikato DHB Board
Date Endorsed	27 July 2016
Disclaimer: This document has been developed by Waikato District Health Board specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Waikato District Health Board assumes no responsibility whatsoever.	

Policy Review History

Version	Updated by	Date Updated	Summary of Changes
05	Lydia Aydon	May 2016	• Clarification of process for review and approval of naming request • Transfer to new template

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

POLICY

Naming Rights of Waikato District Health Board Owned Facilities

Contents

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

POLICY

Naming Rights of Waikato District Health Board Owned Facilities

1. Introduction

1.1 Purpose

Waikato District Health Board (DHB) facilities will usually be known by their function where this is evident and long term e.g. Acute Services Building, Thames Clinical Centre, Regional Renal Centre, Hague Road Carpark Building, Waikato Hospital.

However Waikato DHB may choose to recognise people or sponsors who supported the Waikato DHB, either through distinguished effort or substantial financial endowment, by naming facilities in their honour.

1.2 Scope

It is the responsibility of all Waikato DHB staff, managers and board members to comply with this policy.

2. Definitions

Facility / Facilities	Facility/Facilities in this context includes all buildings, portions of buildings, departments, wards, rooms, laboratories and roads owned by the Waikato DHB. It does not include leased buildings unless the leasor grants permission for Waikato DHB to name the leased building.

3. Policy Statements

The Waikato DHB Naming Rights of Waikato DHB Owned Facilities policy is that:

- Prior consent from an individual, or where appropriate their family, will be obtained before an individual's name is recommended to the board for consideration.
- The name used will normally be the family name or, in the case of a corporate entity, the shortest possible name.
- A name will be used only once unless the board determines otherwise.
- Where the name of a corporate entity is used the period of naming will be limited to the life of the corporate entity, or to the period originally specified by Waikato DHB whichever occurs sooner.
- In the event of demolition or destruction of a facility, its name or any parts of it will be the subject of fresh recommendations. No facility scheduled for demolition will be named.
- The board may cancel a name for whatever reason it deems appropriate provided that there is no resulting breach of contract.

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

POLICY

Naming Rights of Waikato District Health Board Owned Facilities

4. Roles and Responsibilities

4.1 Records of building names

Property and Infrastructure will:

- develop and maintain a list of all facilities on Waikato DHB owned sites capable of bearing naming rights in terms of this policy
- maintain records of approved dedication and building names and the basis for granting naming rights.

4.2 Submission of naming request

A formal letter of request must be submitted by a direct report to the Waikato DHB chief executive and the executive director of public affairs, with a statement about the nature of the request. If staff themselves have suggestions, they should put them through their manager.

The letter needs to discuss:

- the importance of the name to the Waikato DHB
- the nature of the person's distinguished service, sponsorship, and/or nature of the corporate identity
- the nature of any proposed contractual relationship
- plans for any plaque, funding and maintenance
- other conditions, concerns, or impacts of the naming.

A résumé or discussion of the person(s)/corporate entity being honoured needs to be included.

Letter(s) of reference or recommendation should also be included. Petitions may also be submitted to show those in favour of the naming.

The chief executive will be given early advice on recommended nominees.

The executive director of public affairs will submit a naming recommendation to the Waikato DHB executive group who will, if it is appropriate, approve a recommendation to the board. The submission must have written approval of the person/ corporate entity after whom the naming is to take place. If the person is deceased, the approval of the immediate family/or the estate representatives will normally be expected to have been obtained. If there is no immediate family or estate representative and the person is deceased the naming process can proceed.

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

POLICY

Naming Rights of Waikato District Health Board Owned Facilities

4.3 Review and approval of naming

Any submission on a naming request requires executive group approval before going to the Board.

The executive director of public affairs will undertake a review of all naming requests which do not require a functional name, and will then forward this to the Waikato DHB executive group for approval. When a naming request is approved by the executive group, the chief executive of Waikato DHB will submit the request to the board.

Final approval to grant naming rights, which do not require a functional name, rests with the board who will record in the relevant board meeting minutes each naming right granted over a facility.

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

POLICY

Naming Rights of Waikato District Health Board Owned Facilities

5. Standards for naming

5.1 Naming opportunities

A facility will always be known by its function where this is evident. However, a facility may also be given a chosen name reflecting the fact that functions may change over time.

In cases where functions change within a facility:

- if the building has been named for the function the functional name will be deleted when the function changes
- if the building has been named after a person/corporate entity, that name will remain regardless of function.

An entire facility may be given a chosen name. Parts of buildings that may be named are wards, rooms, laboratories and other distinctive areas. This may require the installation of commemorative plaques.

As a general rule, a building holds more importance or represents greater Waikato DHB recognition than the naming of a portion of a building, such as a ward or a single room.

Naming of new buildings should occur prior to construction.

5.2 Buildings may be named for the following purposes

Honouring individuals:

- Naming honours people with a record of distinguished service to health and disability services within the region served by Waikato DHB.
- The Waikato DHB may consider honouring people who gave such distinguished service to health and disability services within the area served by Waikato DHB that their names should be recognised by a later generation.
- Naming a building in honour of a person who has given extraordinary distinguished service to health and disability services within the region served by Waikato DHB will not normally be considered until after that person's substantive formal relationship with the Waikato DHB ends.

Sponsorship and donations:

- The Waikato DHB may name a building or part of a building in recognition of sponsorship or a donation. Generally, naming rights in recognition of sponsorship would be granted where there is a minimum commitment of five years. (See Waikato DHB Sponsorship Policy).
- A plaque may be placed on a building, ward, or room to acknowledge a sponsor. The design, wording and location of the plaque require the approval of the executive director of public affairs.
- All named buildings are the property of the Waikato DHB. Naming rights carry no power of direction from the person/family/entity after whom the building is named to the Waikato DHB on any matter whatsoever (e.g. use of or the appearance of the building).

5.3 Involvement of Māori and cultural groups in naming:

- Waikato DHB shall invite the Kaunihera Kaumātua and Te Puna Oranga (Maori Health Services) to participate in the naming process of names/ingoa of facilities/buildings when the recommendation is for a name other than a functional one e.g Acute Services Building, Regional Renal Centre.
- Approval of names/ingoa of Waikato DHB facilities/buildings, other than functional ones, should be obtained from iwi by way of consultation with the Kaunihera Kaumātua.
- Where and when appropriate, Waikato DHB will invite other cultures to participate in the naming process.
- Waikato DHB will ensure that names which have been approved by the Kaunihera Kaumātua or other cultures will not be changed without their involvement in the process.

6. Audit

6.1 Indicators

- Waikato DHB facilities are named appropriately with correct approval.
- There is evidence that consultation by the executive director of public affairs has occurred regarding the naming of any new building

7. Associated Documents

- Waikato DHB Design and Construction policy (1781)
- Waikato DHB Sponsorship policy (0122)
- Principles for naming buildings/facilities, master copy held by executive director of public affairs

Appendix two

toti

Tō Tī - Your Spirit
Tō Tā - Your Creativity
Tō Toi - Your Art

www.toti.co.nz

Waikato District Health Board
Hamilton
Attention Chief Executive Dr Nigel Murray nigel.murray@waikatodhb.health.nz

28 March 2017

Dear Dr Murray

Re Dame Hilda Ross renaming proposal:

Your chairman Bob Simock has recommended we write to you with our request:

> That Waikato District Health Board name your new facilities in Hamilton's central city – in the former Farmers building in Alexandra Street – 'The Dame Hilda Ross Health Centre', or an equivalent that records her name.

There is a strong link between Dame Hilda and health, as well as this particular precinct of the city.

She is considered one of New Zealand's most prominent 20th century women, acknowledged until recently with her name upon your former Nurses Home. Her name was also lost from the city's central library in the 1990s with the move to Garden Place, and now the Founders Theatre memorial fountain has a question mark on its future.

Dame Hilda has a long record, previously well recognised, but unfortunately fading. She gave more than half a century of effective public service, clearly recognised by Waikato health authorities in the past. much of which resonates with important public health issues today.

In brief, she was a widely recognised and admired public leader, elected to the Waikato Hospital Board during the Second World War, just as Hamilton reached city status, and went on to win election as the first woman city councillor, Deputy Mayor, then Member of Parliament, to become a Cabinet Minister in the first National Government of 1949, a staunch community advocate until her death in 1959.

She was a hands-on social activist, with many milestones in her contributions across many fields. She co-founded children's health camps (1926) and remained committed to improving the health and wellbeing of children throughout her career.

Our trust has City Council approval to erect a statue commemorating Dame Hilda on the corner of Ward Street and Worley Place in the CBD, and we are working through an associated street renaming proposal. We have mana whenua support, along with many other groups. Your involvement with such a significant presence coming to the CBD would add great value.

We would be delighted to provide you and your people with further information, and do hope you consider this request with favour. We are available to meet with you and your staff.

Thank you.

Margaret Evans (TOTI Trust)

4 Findlay Street, Hamilton East 3216.

Phone 8584467

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 10.3

SMOKEFREE POLICY

Purpose	For approval.

The DHB will be launching a range of activities to reinvigorate its commitment to being a SmokeFree workplace on world SmokeFree Day, 31 May 2018. One aspect of a much broader campaign is the updating of the SmokeFree policy.

The DHB's updated SmokeFree policy is attached as Appendix One. This policy update was previously tabled at the Board meeting in October 2017. At that meeting further information on vaping was requested.

A wide range of literature on vaping has been reviewed by the District Pharmacy service (over 100 articles). This is summarised in Appendix Two.

Overall the evidence did not present any compelling reason to introduce support for vaping into the DHB's policy. There are both benefits and harms from vaping. The major benefit is that it is less toxic than cigarette smoking unless used in conjunction with cigarette smoking (such as during a short break) in which case it may be more harmful. The major harm is that the evidence strongly suggests that it is a gateway drug and that it can have a normalising influence. The exact nature of e-liquid products is currently unknown and un-regulated in New Zealand although future legislation may seek to regulate them. Most devices contain a metal shaft which could potentially be used to inflict physical harm on others.

On balance the use of counselling and NRT as a front line therapy for staff, patients and visitors remains the recommended intervention.

Recommendation
THAT
The Board adopts the Smokefree / Tobacco free – Auahi Kore / Tupeka Kore policy.

MARK SPITTAL
EXECUTIVE DIRECTOR COMMUNITY AND CLINICAL SUPPORT

Waikato District Health Board

POLICY

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

Policy Responsibilities and Authorisation

Department Responsible for Policy	Community and Clinical Support
Document Facilitator Name	Kate Dallas
Document Facilitator Title	Waikato DHB Smokefree Coordinator
Document Owner Name	Mark Spittal
Document Owner Title	Executive Director Community and Clinical Support
Target Audience	All DHB staff and services
Committee Approved	Policies and Guidelines Committee
Date Approved	10 August 2017
Committee Endorsed	Executive Group
Date Endorsed	
Committee Endorsed	Waikato DHB Board
Date Endorsed	

Waikato District Health Board

POLICY

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

Policy Review History

Version	Updated by	Date Updated	Summary of Changes
06	Kate Dallas		This is an updated policy based on the Hawkes Bay DHB (HB DHB) smokefree policy. HB DHB developed this policy after they commissioned a research report into all New Zealand DHB smokefree policies. The report made recommendations for a best practice policy which will support the Smokefree New Zealand 2025 goal.
			Expectation the Waikato DHB senior management shall demonstrate leadership and support the roles and responsibility of staff in relation to tobacco products or electronic cigarettes
			Expectation that staff will be smokefree while at work and systems will be developed to achieve this.
			All staff who smoke will have access to support to manage tobacco dependency

Waikato District Health Board

POLICY

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

Contents

Waikato District Health Board

POLICY

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

1. Introduction

1.1 Purpose

To improve, promote and protect present and future health and wellbeing of the Waikato District Health Board (DHB) population from the harms of tobacco consumption and exposure to second-hand smoke through demonstrating commitment and responsibilities in supporting a smokefree / tobacco free lifestyle for all.

To be a leader in health promotion in the community through advocating good health by focusing on achieving equity in reducing tobacco prevalence as smoking rates are a major contributor to inequalities in health status and outcomes in Waikato.

This policy builds on from the government's commitment to a Smokefree New Zealand/Aotearoa 2025 where smoking rates are lower than 5% and smoking will no longer be the norm.

As stated by the Ministry of Health Smokefree 2025 will be achieved by:

- Protecting children from exposure to tobacco marketing and promotion
- Reducing the supply of, and demand for tobacco
- Providing the best possible support for quitting

This Purpose aligns with the Waikato DHB Position Statement 2017, the Public Health Tobacco Strategic Plan 2017/18 and the Waikato DHB Tobacco Control Plan 2017-2020 where priority groups and issues have been identified.

1.2 Scope

This policy applies to all Waikato DHB staff and services including

- Mental Health and Addiction services Inpatient, Forensic and Community Services,
- All general Inpatient and Maternity;
- Health Delivery Services e.g. Outpatient, Community settings
- All service users, visitors, volunteers, contractors, access agreement holders and others working on or accessing Waikato DHB premises
- All contracted service providers.

2. Definitions

Smokefree	The term 'smokefree' in this policy applies to all forms of tobacco or herbal smoking products and electronic cigarettes.
A.B.C.	Clinical interventions for people who smoke; A ascertain smoke status of every patient, B brief advice to be smokefree and C cessation treatment NRT for all smokers and referral if accepted.
DHB premises	This includes all buildings; grounds owned or occupied by the DHB and all DHB vehicles.

EAP	Employee Assistance Program; free counselling services with councillors trained nicotine addiction and motivational therapy.
E cigarette	Electronic cigarettes – or e-cigarettes – are electrical devices that mimic real cigarettes by producing a vapour by heating a solution (e-liquid), which the user inhales or vapes. E-liquid is available with or without nicotine, and usually contains propylene glycol and flavouring agents. People who choose to use e-cigarettes (to vape), should aim to stop smoking completely to reduce the harm from smoking. Ideally, people would eventually stop vaping as well.
NRT	Products containing nicotine designed to replace the nicotine from cigarette smoke used when smoking is not permitted
Tupeka Kore	The Waikato District Health Boards Māori Health Service (Te Puna Oranga) tobacco free programme targeting whānau, communities, iwi, hapū and marae encouraging tobacco free lifestyles. See Appendix A – Tupeka Kore for more information

3. Policy Statements

The Waikato DHB smokefree policy is that:

- There will be no smoking or electronic cigarette use by staff, patients/clients, family/whanau, visitors and contractors on any campus.
- This includes all buildings, vehicles and grounds owned or occupied by the DHB.
- Staff will not smoke while on paid Waikato DHB business either onsite or in the community.

4. Background

The Waikato DHB recognises the evidence of harm caused by tobacco:

- Tobacco use is the single largest preventable cause of illness and early death. There are approximately 5,000 deaths each year linked to smoking or second-hand smoke exposure. Smoking is a major risk factor for heart attacks, strokes, chronic obstructive pulmonary disease (including emphysema and chronic bronchitis) and cancer (particularly lung, larynx, mouth and pancreatic). Second-hand smoke is the inhalation of smoke by people other than the intended 'active' smoker and causes many of the same diseases as direct smoking, e.g. cardiovascular, lung cancer and respiratory diseases and causes the death of approximately 300 New Zealand people per year
- Tobacco dependence is a chronic relapsing addictive condition
- Tobacco use is a major determinant of inequality in health in the Waikato region with 17% of adults currently smoking. In adults and youth alike, smoking rates are higher for Māori and Pacific peoples. In the 2013 Census data, 35% of Māori, 24% of Pacific, and 13% of Other adults smoked
- South Waikato, Ruapehu, Waitomo, Hauraki, Otorohanga and Waikato have significantly higher rates than the overall Waikato DHB. The highest prevalence rates

are among females in South Waikato (26%), Ruapehu (25%) and Waitomo (26%). However, in the overall Waikato DHB females have lower rates than males.

- Pregnancy, neonatal, new-born and infant health is negatively affected by exposure to first and second hand tobacco smoke and smoking in pregnancy can be associated with low birth weight, miscarriage or stillbirth. In infants there is a higher risk of Sudden Unexpected Death in Infancy (SUDI) and in children, asthma, respiratory infections and glue ear
- Maternal smoking is more common in the Waikato DHB (17.1%) than in overall NZ (12%). In the Waikato a larger proportion of Māori women smoke during pregnancy in comparison with women of other ethnicities (36.8% Māori vs. European 8.1%, Pacific 6.6%, Indian and Asian 0.29%). The prevalence has only reduced slightly between 2011-2015.The highest rates of maternal smoking are in the Ruapehu, Hauraki and South Waikato areas. However the highest numbers of women smoking during pregnancy are in Hamilton.
- In recognition of the harmful effects of tobacco use, priority groups have been targeted in the Tobacco Control Plan 2017-2020 to address the above issues. The priority groups include Māori who smoke, particularly women across all age groups, pregnant women, people with mental health and addiction issues, certain geographic areas with high deprivation.

5. Processes

5.1 Roles and Responsibilities

Waikato DHB senior management shall support the roles and responsibility of staff in relation to tobacco products or electronic cigarettes which will include:

- Increasing the number of smokefree people in Waikato community through smokefree clinical practice, health promotion and health protection activities. To support these initiatives, all Waikato DHB events will be smokefree (whether or not held on DHB grounds including events sponsored, partnered or funded by the Waikato DHB)
- Demonstrate leadership through role modelling of positive smokefree behaviours and attitudes that can be displayed to each other and to the general public. This also means privately owned vehicles whilst on Waikato DHB grounds will be smokefree
- Being mindful of ‘our boundary neighbours’ and the community that tobacco use is a health risk and is not acceptable in or near a healthcare setting. Therefore groups named in the ‘Scope’ section of this policy shall not use tobacco products or e-cigarettes on any of the Waikato DHB boundary lines
- Waikato DHB, in operating public facilities, will take steps to ensure members of the public especially service users, are not subtly encouraged to initiate smoking, or have cessation attempts undermined, by the presence of visible tobacco products or e-cigarettes or smoking related media. This will mean displaying Smokefree signs in appropriate public areas within all hospitals and all other DHB occupied buildings and ground.

- New employees will be screened for tobacco use during the recruitment process, informed of the Waikato DHB Smokefree Policy and provided with information about support available to staff to be smokefree at work. Screening is for the purposes of monitoring tobacco dependence in prospective staff and to ensure that the expectations of this policy are understood before employment. To support this initiative, recruitment policies shall acknowledge this policy on all communication.
- Waikato staff, contractors or volunteers are prohibited from smoking in uniform or attire worn during work (mufti clothing worn to work), or when wearing any item that might associate them with Waikato DHB, e.g. identification badge. Staff, contractors or volunteers who are not smokefree during unpaid break times are expected to change out of their uniform/mufti worn during work hours and wash their hands after tobacco use to minimise exposure of third hand smoke or signs of tobacco use
- No DHB employee will be required to escort patients off DHB grounds for the sole purpose of smoking
- Integration with local and national initiatives to support a smokefree New Zealand/Aotearoa:
  - Te Puna Oranga Tupeka Kore strategy.
  - The government supported vision of a Smokefree Aotearoa by 2025.

Breaches to this policy:

- Visitors - Waikato DHB employees are encouraged to bring this policy to the attention of people who smoke or use their electronic cigarette within the hospital or hospital grounds.
- Waikato DHB employees, security, contractors or volunteers – employees are encouraged to bring the breach to the attention of the staff member's manager or Team Leader
- Should there be significant breaches of this policy, for example continuing to visibly and obviously bring tobacco products onto Waikato DHB sites or continuing to be observed smoking in uniform or attire worn during work etc., then disciplinary action could be taken.
- Managers/Team Leaders have the obligation of ensuring employees are aware of the Smokefree Policy roles and responsibilities at annual performance reviews. In addition those staff that are not smokefree at work will have a Smokefree Health Management Plan in place to be smokefree at work within three months. These staff are offered help to access stop smoking support including Employee Assistance Programme (EAP) and free NRT products to manage their tobacco dependency whilst at work. It is the responsibility of the manager or team leader to ensure that any breaches of this policy by Waikato DHB staff are not repeated.

5.2 Smokefree Clinical Practice

In recognition of the chronic relapsing condition of tobacco use and harm of tobacco exposure it is expected that when accessing Waikato DHB services:

- 100% of all adult clients / patients will be screened for tobacco use
- 100% of adult clients / patients who are not smokefree will receive advice to be smokefree and strongly encouraged to utilise stop smoking support (a combination of behavioural support and stop-smoking medicine works best) and offer to help them access it.
- All inpatients that are assessed as nicotine dependent will be assisted in the management of their nicotine dependency through the provision of nicotine replacement therapy on admission and have daily monitoring of nicotine withdrawal.
- 100% of all babies / children of Waikato DHB services will be assessed for smoke exposure
- 100% of whanau / family of babies or children that are smoke exposed will receive interventions that assist families to be smokefree

5.3 Smokefree Education

All Waikato DHB staff shall receive on-going evidence based smokefree education appropriate to their role i.e.

- New staff are informed of Waikato DHB Smokefree policy at orientation
- All health professionals regulated under the Health Practitioners Competence Assurance Act 2003, Medical Students, Nursing and Midwifery Students (3rd year and above) and Allied staff shall complete the Ministry of Health “Helping People to Stop Smoking” e-learning on Ko Awatea and then annually or sooner if the e-learning tool is reviewed.
- All health professionals regulated under the Health Practitioners Competence Assurance Act 2003, Medical and Nursing Students and allied staff in particular those staff working in Mental Health and Addiction services will complete the two modules “Smokefree in Mental Health and Addictions services” on Ko Awatea
- Smokefree education is available each month and on request from the Smokefree Coordinator to ensure 100% of nursing and midwifery; medical and allied health staff receive updated and current smoking cessation and nicotine addiction clinical education

5.4 Smokefree / Tobacco Free Staff

- Waikato DHB staff will be able to access smokefree motivational support through EAP and through the Smokefree Coordinator or Health and Safety team, which includes:
  - free provision of monthly Nicotine Replacement Therapy products for the purpose of management of nicotine dependence short term or for long term abstinence using the Quit card system
  - emergency supply of nicotine products at their place of work
  - provision of free smokefree counselling

5.5 Stop Smoking Support

- There will be accessible, appropriate, and sufficient range and volume of community based Stop Smoking Services for the Waikato DHB community. To enable this, Waikato DHB will support the Primary Health Organisation (PHO) contracted to deliver evidenced based, best practice Stop Smoking Services to community, including all PHOs, workplaces and other non-government organisations with the overall aim to achieve Smokefree Aotearoa 2025.
- The Waikato DHB smokefree coordinator will support local and national Stop Smoking Services.
- Waikato DHB will support Smokefree health promotion, regulation and tobacco free initiatives across the district.
- Waikato DHB will work closely with District and Regional Councils to increase the number of smokefree areas; such as sport grounds, cafes, public parks, businesses.
- Waikato DHB will work with District and Regional Councils to reduce the number of tobacco outlets near secondary schools and work towards regulation/ registration of same.

5.6 Smokefree Communications

Waikato DHB will ensure that smokefree strategies are supported with communications, which will include (but not limited to) the following activities:

- adequate smokefree and tobacco free signage on all premises
- smokefree messages on appointment letters and cards
- related guidelines, procedures and standing orders are updated regularly
- stop smoking support resources are readily available
- smokefree policy will be referred to in all job adverts and Position Descriptions
- smokefree messages are integrated into other health messages, media releases and high level communications
- The week leading up to World Smoke free day, May 31st each year the Waikato DHB will further promote the smokefree message in community settings by promoting smoking cessation and outlining support available

- The Waikato DHB Smokefree Champions will be supported with current information and education to support clinical practice of ABC; brief advice, treatment to prevent nicotine withdrawal symptoms, offer of referral, promote smokefree lifestyle messages and where to access support to become smokefree, i.e. EAP, local Stop Smoking Services or Quit line
- All staff are encouraged to inform patients/clients and visitors of the Waikato DHB Smokefree Policy, including encouraging people not to bring tobacco products or electronic cigarettes onto the hospital grounds

5.7 Smokefree Waikato DHB Contracts and Employment Agreements

All Waikato DHB clinical contracts, recruitment policies and employment agreements shall include smokefree clauses which include statements relating to:

- This Smokefree Policy
- Clear smokefree leadership from all management and team leaders.
- ABC smokefree clinical practice delivered to all service users
- Smokefree role modelling by staff
- Smokefree education current and available on request
- 100% smokefree environments with no staff exposed to second hand smoke

With the associated indicators applying:

- Smokefree policy
- ABC smokefree tobacco screening and intervention of all service users

6. Smokefree Monitoring and Reporting

Waikato DHB will ensure that smokefree initiatives be monitored and reported (ensuring an ethnicity analysis is incorporated). These include (but are not limited to) the following indicators:

- ABC clinical practice
- Waikato DHB tobacco prevalence
- Waikato DHB Smokefree contract clause
- Waikato DHB Smokefree education
- Community Stop Smoking Services
- Health Promotion activities

6.1 Measurement Criteria

1. Smokefree clinical practice – 100% of clients / patients will be screened for tobacco use and those that are not smokefree will receive the appropriate intervention.
2. Waikato DHB Clinical contracts have described clauses and associated indicators in place.
3. Increase in Waikato DHB staff being smokefree.
4. Drop in prevalence of population smoking in next Census 2017/18

7. Legislative Requirements

7.1 Legislation

Meet legal obligations

a) Under the Smokefree Environments Act 1990 (and its amendments in 2003) and The Health and Safety at Work Act 2015.

b) To protect the health and safety of employees and visitors to its workplaces (includes patients/clients and visitors) from the effects of identified hazards which includes second hand smoke.

c) Actively supporting staff, contractors and volunteers to be smokefree through the Smokefree Coordinator, Health and Safety, Quitline or local Stop Smoking Services

8. Associated Documents

8.1 Associated Waikato DHB Documents

- The New Zealand Guidelines for Helping People Stop Smoking 2014
- Waikato DHB Smoking Cessation Intervention and Pharmacotherapy procedure (Ref. 4951)
- Waikato DHB Nicotine Replacement Therapy standing order (Ref. 2580)
- Waikato DHB Nicotine Replacement Therapy in in Outpatient Areas guideline (Ref. 1619)
- Prescribing in Smoking Cessation (T1486HWF)
- Waikato DHB Health and Safety policy (Ref. 0044)
- Waikato DHB Hazard Management policy Ref. (0051)
- Waikato DHB Code of Conduct policy (Ref. 5674)
- Waikato DHB Performance Management and Discipline policy (Ref. 5250)
- Waikato DHB Professional Image and Uniform Clothing guideline (Ref. 2723)
- Waikato DHB Vehicle Usage and Safe Driving policy (Ref. 0112)
- Waikato DHB Inter-hospital patient transfers: competencies and standards protocol (Ref. 2742)
- Position Statement: Waikato DHB's Tobacco Control 2017
- Smoke-free Workplaces: A guide to the Smoke-free Environments Act 1990
- New Zealand Health Strategy 2000
- Midlands DHB Smokefree Vision Statement 2009

8.2 References and Further Information

- Government Response to the; Report of the Māori Affairs Committee on its *Inquiry into the Tobacco Industry in Aotearoa and the Consequences of Tobacco Use for Māori* (Final Response) Presented to the House of Representatives in accordance with Standing Order 248, 2011
- New Zealand, Ministry of Health: Maori Smoking and Tobacco Use, 2011
- New Zealand, Ministry of Health: Health Targets: Better Help for Smokers to Quit 2015
- New Zealand, Ministry of Health: New Zealand Guidelines for Helping People to Stop Smoking, 2014
- New Zealand, Ministry of Health: Smoking Cessation Competencies for New Zealand, 2007
- New Zealand, Ministry of Health: Implementing the ABC Approach for Smoking Cessation: Framework and Work Programme, 2009

- New Zealand, Ministry of Health: 2012/13: New Zealand Health Survey – Tobacco use in New Zealand, 2014
- New Zealand, Ministry of Health: New Zealand Health Strategy Future Direction 2016
- New Zealand, Prepared by the Ministry of Health: Inquiry into the Tobacco Industry in Aotearoa and the Consequences of Tobacco Use for Maori. Presented to the House of Representatives, Maori Affairs Committee, 2010
- Smoke-free Environments Amendment Act 2003. Retrieved from http://www.legislation.govt.nz/act/public/2003/0127/latest/DLM234940.html?search=qs_act_Smoke-free%20Environments%20Amendment%20Act%202003_resel_25_h&p=1
- U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioural Basis for Smoking-Attributable Disease: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.
- U.S. Department of Health and Human Services. Clinical Practice Guideline: Treating Tobacco Use and Dependence: Public Health Service, 2008.

Waikato District Health Board

POLICY

Smokefree / Tobacco free – Auahi Kore / Tupeka Kore

Appendix A Tupeka Kore

TUPEKA KORE
"Tobacco free whanau - a tobacco free world"

Tupeka Kore is the Waikato District Health Boards Māori Health Service (Te Puna Oranga) tobacco free programme targeting whānau, communities, iwi, hapū and marae encouraging tobacco free lifestyles. Tupeka Kore has been endorsed by the Waikato District Health Board Kaumātua Kaunihera and Iwi Māori Council to make a leadership contribution on the war against tobacco use amongst Māori.

One of the most powerful approaches to promoting Tupeka Kore is the process of making Tupeka Kore waahi / spaces. The process is to place a kawenata (covenant) through the use of karakia or prayer on an area / space or service to become Tobacco Free. Once the kawenata has been placed, No tobacco products are allowed within that designated area / space or service.

The concept of making area / spaces or services Tupeka Kore is another tool we can use to promote a smoke free environment. It is about:

1. Supporting the 2025 Smokefree Aotearoa / New Zealand vision
2. Role modelling healthy lifestyle choices
3. Supports auahi kore / smokefree initiatives
4. Aligns with the Waikato DHB Smokefree policy
5. Aligns to the national intent around quit support and smoking cessation
6. Upholds tikanga Māori as a valid and legitimate process in supporting health gain for Māori and non-Māori
7. Encourages service and community leadership
8. Workforce development

It should be noted that the creation of Tupeka Kore waahi is not limited to areas / spaces or services in the Waikato DHB but can also be extended to:

1. Early childhood centres and schools
2. Māori health provider services
3. Community health services
4. Other organisations / services who wish to role model a positive initiative

Tupeka Kore waahi becomes the responsibility of the area / space or service to promote that the covenant that has been placed is upheld and respected. General information about Tupeka Kore will be provided to visitors via signage, meeting material etc. It is not expected that staff will directly confront visitors about their smoking status or whether they are carrying tobacco products.

Should you require any further information please contact Executive Director Māori Health.

Appendix Two: Evidence for and against use of e-cigarettes and vaping

Pharmacy Services
April 2018

Summary

Both the NZ Ministry of Health (October 2017) and Royal College of Physicians (April 16) have stated that the risk of use of e-cigarettes and vaping is much less than the risk (or harm) of smoking in a person that is already smoking. There is benefit in existing smokers switching to the use of e-cigarettes or vaping, particularly for the purpose of attempting cessation of smoking, noting that not all e-cigarettes and vaping liquids contain nicotine, but a range of flavourants can be included.

Given the unknown nature of e-liquid products available in NZ however, the Government is currently legislating to regulate e-cigarettes and e-liquid as consumer products under the Smoke-free Environments Act 1990 (SFEA). http://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/e-cigarettes. The proposals are to:

- prohibit their sale, and supply in a public place, to those under the age of 18 years
- restrict the use of vending machines to R18 settings
- prohibit promotion and advertising, except for:
  - point-of-sale display of products in all retail settings
  - in-store (including window) display, promotion on the outside of stores, and offers of discounts, free samples and loyalty awards, and co-packaging in R18 settings
- prohibit vaping in legislated smokefree areas
- regulate product safety (eg, ingredients, manufacturing, labelling, packaging etc.).

It is well recognised that the use of e-cigarettes and vaping are not without risk and the general world-wide consensus is that the use of e-cigarettes and vaping should not be encouraged and in no way supported by physicians or healthcare workers. Nicotine replacement therapy still remains the number one therapy to be recommended for smoking cessation.

Although the long term effects of e-cigarette/ vaping use is still relatively unknown, the current main areas for concern are due to the risk of heavy metals and flavourants, used in the devices and e-liquids, being inhaled and the risk of the devices exploding whilst being used. Recent evidence also shows an emerging issue around the use of e-cigarettes/ vaping “normalising” the act smoking in children and teenagers, which results in an eventual increased uptake of cigarette smoking.

E-cigarettes are also increasingly being used to support the inhalation of illicit substances such as cannabis plants, oils and waxes.

E-cigarettes are also used in combination with smoking, resulting in recent evidence that points towards an increased risk of a having a myocardial infarction – that is, the combined or dual use of e-cigarettes with cigarettes is substantially more dangerous than smoking alone.

Evidence obtained from published literature:

- Position statement from MOH October 2017:

  https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/e-cigarettes

- Royal College of Physicians UK – Report April 2016
  Key recommendations

  - Provision of the nicotine that smokers are addicted to without the harmful components of tobacco smoke can prevent most of the harm from smoking.
  - Nicotine replacement therapy (NRT) is most effective in helping people to stop smoking when used together with health professional input and support, but much less so when used on its own.
  - E-cigarettes appear to be effective when used by smokers as an aid to quitting smoking.
  - E-cigarettes are not currently made to medicines standards and are probably more hazardous than NRT.
  - However, the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco.
  - Technological developments and improved production standards could reduce the long-term hazard of e-cigarettes.

- https://www.gov.uk/government/publications/e-cigarettes-and-heated-tobacco-products-evidence-review

One assessment of the published data on emissions from cigarettes and e-cigarettes calculated the lifetime cancer risks. It concluded that the cancer potencies of e-cigarettes were largely under 0.5% of the risk of smoking.

Comparative risks of cardiovascular disease and lung disease have not been quantified but are likely to be also substantially below the risks of smoking. Among e-cigarette users, 2 studies of biomarker data for acrolein, a potent respiratory irritant, found levels consistent with non-smoking levels.

There have been some studies with adolescents suggesting respiratory symptoms among e-cigarette experimenters. However, small scale or uncontrolled switching studies from smoking to vaping have demonstrated some respiratory improvements.

E-cigarettes can release aldehydes if e-liquids are overheated, but the overheating generates an aversive taste.

To date, there is no clear evidence that specific flavourings pose health risks but there are suggestions that inhalation of some could be a source of preventable risks.

To date, the levels of metals identified in e-cigarette aerosol do not give rise to any significant safety concerns, but metal emissions, however small, are unnecessary.

Biomarkers of exposure assessed to date are consistent with significant reductions in harmful constituents and for a few biomarkers assessed in this chapter, similar levels to smokers abstaining from smoking or non-smokers were observed.

One study showed no reductions across a range of biomarkers for dual users (either for nicotine replacement therapy or e-cigarette dual users).

To date, there have been no identified health risks of passive vaping to bystanders.

Reporting of some academic studies has been misleading.

- http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1470-23-february-2018/7489

- http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1472-23-march-2018/7534

- Government legislating to regulate e-cigarettes and e-liquid as consumer products under the Smoke-free Environments Act 1990 (SFEA). Details are available on the Ministry of Health's website http://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/e-cigarettes 6/4/18.

- Wise J. Doctors should state clearly that vaping is much lower risk than smoking, says report, BMJ 2018; 360 doi: https://doi.org/10.1136/bmj.k575

- National Academies of Sciences, Engineering, and Medicine. 2018. Public health consequences of e-cigarettes. Washington, DC: The National Academies Press. doi:https://doi.org/10.17226/24952

  - Based on the findings of this report, e-cigarettes cannot be simply categorized as either beneficial or harmful to health. The net public health outcome depends on the balance between adverse outcomes (increased youth initiation of combustible tobacco cigarettes, low or even decreased cessation rates in adults, and a high-risk profile) and positive outcomes (very low youth initiation, high cessation rates in adults, and a low-risk profile).

  - In some circumstances, adverse effects of e-cigarettes clearly warrant concern, such as the use of e-cigarettes among non-smoking adolescents and young adults, devices that are prone to explosion, and the presence of constituents in e-cigarette liquids that are of major health concern (e.g., diacetyl and some other flavorings).

  - In other circumstances, namely regular combustible tobacco cigarette smokers who use e-cigarettes to successfully quit smoking, e-cigarettes may represent an opportunity to reduce smoking-related illness. For these reasons, e-cigarette

regulation that merely considers whether to be restrictive or permissive to the marketing, manufacture, and sales of all e-cigarettes for all populations is unlikely to maximize benefits and minimize the risks.

- The use of e-cigarettes and other e-cigarette devices to vape cannabis plants, oils, and waxes is another emergent issue. Use of aerosolized cannabis and cannabis product may become an increasingly common precursor to or outcome of e-cigarette use.

- Given how rapidly the e-cigarette product marketplace and user population are changing, there will undoubtedly be many new issues that are currently unknown and will require careful surveillance and scientific scrutiny.

CONSTITUENTS

E-cigarettes contain liquids (referred to as e-liquids) that are aerosolized upon operation of the device. E-liquids typically contain nicotine (although some users prefer zero-nicotine solutions), flavorings, and humectants. Nicotine is a well-understood compound with known central and peripheral nervous system effects. It causes dependence and addiction, and exposure to nicotine from e-cigarettes likely elevates the cardiovascular disease risk in people with pre-existing cardiovascular disease(s), but the cardiovascular risk in people without cardiovascular disease(s) is uncertain. Based on studies of long-term users of NRT or smokeless tobacco, nicotine exposure from e-cigarette use will likely pose minimal cancer risk to users. Most flavorings in e-liquids are designated as generally-recognized-as-safe (also known as GRAS) by FDA, but those designations are for oral consumption in food and do not apply to flavorings used in e-cigarettes; most of these were never studied for toxicity via the inhalation route. The primary humectants are propylene glycol and vegetable glycerin, compounds also in widespread use for other purposes and about which significant scientific literature exists.

In reviewing the literature about the constituents in and exposures from e-cigarettes, the committee made nine conclusions:

*Conclusion 3-1. There is **conclusive evidence** that e-cigarette use increases airborne concentrations of particulate matter and nicotine in indoor environments compared with background levels.*

*Conclusion 3-2. There is **limited evidence** that e-cigarette use increases levels of nicotine and other e-cigarette constituents on a variety of indoor surfaces compared with background levels.*

*Conclusion 4-1. There is **conclusive evidence** that exposure to nicotine from e-cigarettes is highly variable and depends on product characteristics (including device and e-liquid characteristics) and how the device is operated.*

*Conclusion 4-2. There is **substantial evidence** that nicotine intake from e-cigarette devices among experienced adult e-cigarette users can be comparable to that from combustible tobacco cigarettes.*

*Conclusion 5-1. There is **conclusive evidence** that in addition to nicotine, most e-cigarette products contain and emit numerous potentially toxic substances.*

*Conclusion 5-2. There is **conclusive evidence** that, other than nicotine, the number, quantity, and characteristics of potentially toxic substances emitted from e-cigarettes is highly variable and depends on product characteristics (including device and e-liquid characteristics) and how the device is operated.*

*Conclusion 5-3. There is **substantial evidence** that except for nicotine, under typical conditions of use, exposure to potentially toxic substances from e-cigarettes is significantly lower compared with combustible tobacco cigarettes.*

*Conclusion 5-4. There is **substantial evidence** that e-cigarette aerosol contains metals. The origin of the metals could be the metallic coil used to heat the e-liquid, other parts of the e-cigarette device, or e-liquids. Product characteristics and use-patterns may contribute to differences in the actual metals and metal concentrations measured in e-cigarette aerosol.*

- Stephens WE. Comparing the cancer potencies of emissions from vapourised nicotine products including e-cigarettes with those of tobacco smoke. Tobacco Control 2018;27:10-17.
  The aerosols form a spectrum of cancer potencies spanning five orders of magnitude from uncontaminated air to tobacco smoke. E-cigarette emissions span most of this range with the preponderance of products having potencies<1% of tobacco smoke and falling within two orders of magnitude of a medicinal nicotine inhaler; however, a small minority have much higher potencies. These high-risk results tend to be associated with high levels of carbonyls generated when excessive power is delivered to the atomiser coil.

- https://www.sciencenewsforstudents.org/article/e-cigarettes-dont-need-nicotine-be-toxic

- Adolescent Exposure to Toxic Volatile Organic Chemicals From E-Cigarettes Mark L. Rubinstein, MD, a Kevin Delucchi, PhD, b, c Neal L. Benowitz, MD, d Danielle E. Ramo, PhDb,
  http://pediatrics.aappublications.org/content/pediatrics/early/2018/03/01/peds.2017-3557.full.pdf

  Although e-cigarette vapor may be less hazardous than tobacco smoke, our findings can be used to challenge the idea that e-cigarette vapor is safe, because many of the volatile organic compounds we identified are carcinogenic. Messaging to teenagers should include warnings about the potential risk from toxic exposure to carcinogenic compounds generated by these products.

- https://www.sciencenewsforstudents.org/article/concerns-explode-over-new-health-risks-vaping

- https://www.ncbi.nlm.nih.gov/pubmed/29298367
  E-cigarettes may be safer than tobacco products, but repeated prolonged exposure to their aerosols has its own considerable potential risk. The long-term health consequences of their use remain to be established. Physicians should vigorously discourage the use of e-cigarettes and tobacco products, with special emphasis on abstinence for younger people and during pregnancy or lactation

- https://www.ncbi.nlm.nih.gov/pubmed/27101543
  Electronic cigarettes: a systematic review of available studies on health risk assessment. There are limited HRA studies and the ones that were available provided inconsistent scientific evidences on the health risk characterization arising from the usage of e-cigarettes

- https://www.ncbi.nlm.nih.gov/pubmed/27343559
  Electronic cigarette aerosols and copper nanoparticles induce mitochondrial stress and promote DNA fragmentation in lung fibroblasts. These findings reveal both mitochondrial, genotoxic, and inflammatory stresses are features of direct cell exposure to E-cig aerosols which are ensued by inflammatory duress, raising a concern on deleterious effect of vaping.

- https://www.ncbi.nlm.nih.gov/pubmed/28837903
  The association of e-cigarette use with exposure to nickel and chromium: A preliminary study of non-invasive biomarkers Positive associations of Ni and Cr

aerosol concentrations with corresponding Ni and Cr biomarker levels indicate e-cigarette emissions increase metal internal dose. Increased e-cigarette use and consumption were also associated with higher Ni biomarker levels. Metal level standards are needed to prevent involuntary metal exposure among e-cigarette users.

- https://www.ncbi.nlm.nih.gov/pubmed/27810679
  E-cigarettes as a source of toxic and potentially carcinogenic metals. All of the tested metals (cadmium, chromium, lead, manganese and nickel) were found in the e-liquids analysed. Across all analysed brands, mean (SD) concentrations ranged from 4.89 (0.893) to 1970 (1540) µg/L for lead, 53.9 (6.95) to 2110 (5220) µg/L for chromium and 58.7 (22.4) to 22,600 (24,400) µg/L for nickel. Manganese concentrations ranged from 28.7 (9.79) to 6910.2 (12,200) µg/L. We found marked variability in nickel and chromium concentration within and between brands, which may come from heating elements.

- https://www.ncbi.nlm.nih.gov/pubmed/25838785
  E-cigarettes: Are we renormalizing public smoking? Reversing five decades of tobacco control and revitalizing nicotine dependency in children and youth in Canada.
  E-devices generate substantial amounts of fine particulate matter, toxins and heavy metals at levels that can exceed those observed for conventional cigarettes. Children and youth are particularly susceptible to these atomized products. Action must be taken before these devices become a more established public health hazard. Policies to de-normalise tobacco smoking in society and historic reductions in tobacco consumption may be undermined by this new 'gateway' product to nicotine dependency.

- http://www.racgp.org.au/your-practice/guidelines/smoking-cessation/behavioural-and-advice-based-support-for-smoking-cessation/unproven-approaches-to-smoking-cessation

  Concerns about e-cigarettes include a lack of evidence for short-term efficacy and short-and long-term safety, particularly in patients with current chronic disease. Rather than cessation, concurrent use with smoking may continue. There are also concerns that e-cigarettes may potentially act as a gateway to smoking.163 However it is reasonable to conclude that if used as a substitute rather than an addition, e-cigarettes are much less harmful than continuing to smoke.

- Article: American Lung Association Popcorn Lung: A Dangerous Risk of Flavored E-Cigarettes

  http://www.lung.org/about-us/blog/2016/07/popcorn-lung-risk-ecigs.html

➢ Over a decade ago, workers in a microwave popcorn factory were sickened by breathing in diacetyl—the buttery-flavored chemical in foods like popcorn, caramel and dairy products.

➢ While this flavoring may be tasty, it was linked to deaths and hundreds of cases of bronchiolitis obliterans, a serious and irreversible lung disease. As a result, the major popcorn manufacturers removed diacetyl from their products, but some people are still being exposed to diacetyl - not through food flavourings as a worksite hazard, but through e-cigarette vapor.

- When inhaled, diacetyl causes bronchiolitis obliterans - more commonly referred to as "popcorn lung" - a scarring of the tiny air sacs in the lungs resulting in the thickening and narrowing of the airways. While the name "popcorn lung" may not sound like a threat, it's a serious lung disease that causes coughing, wheezing and shortness of breath, similar to the symptoms of chronic obstructive pulmonary disease (COPD).

- Even though we know that diacetyl causes popcorn lung, this chemical is found in many e-cigarette flavors. It is added to "e-juice" liquid by some e-cigarette companies to complement flavorings such as vanilla, maple, coconut and more. So while diacetyl was swiftly removed from popcorn products since it could cause this devastating disease among factory workers, e-cigarette users are now directly inhaling this harmful chemical into their lungs.

- In fact, researchers at Harvard found that 39 of 51 e-cigarette brands contained diacetyl.

    - The study also found two similarly harmful chemicals—2,3 pentanedione and acetoin—present in 23 and 46 of the 51 flavors it tested.

    - And roughly 92 percent of the e-cigarettes had one of the three chemicals present.

- http://hsrc.himmelfarb.gwu.edu/gw_research_days/2017/SMHS/85/

  A cross sectional study reveals an association between electronic cigarette use and myocardial infarction.

  Our findings indicate that Electronic cigarette use, when adjusted for other risk factors, is associated with a 42 % increased odds of myocardial infarction. This increase in odds is consistent regardless of traditional cigarette smoking history. More studies are needed to further assess this risk.

  Using the National Health Interview Survey (NIHS), a large national survey done in the US, Nardos Temesgen and colleagues at George Washington University, found that the odds of a heart attack increased by 42% among people who used e-cigarettes.

- https://tobacco.ucsf.edu/first-evidence-e-cig-use-increases-heart-attacks-independent-effect-smoking-cigarettes

  Using the National Health Interview Survey (NIHS), a large national survey done in the US, Nardos Temesgen and colleagues at George Washington University, found that the odds of a heart attack increased by 42% among people who used e-cigarettes.

  This increase in risk was on top of the increases in risk due to any smoking that the e-cigarette users were doing. This is a particularly important finding because most e-cigarette users are dual users who keep on smoking at the same time that they use e-cigarettes. What this means is that dual use of e-cigarettes with cigarettes is substantially more dangerous than smoking alone.

- Pediatrics May 2016: Paediatric Exposure to E-Cigarettes, Nicotine, and Tobacco Products in the United States
  http://pediatrics.aappublications.org/content/early/2016/05/05/peds.2016-0041

  RESULTS: From January 2012 through April 2015, the National Poison Data System received 29 141 calls for nicotine and tobacco product exposures among children younger than 6 years, averaging 729 child exposures per month.

- Cigarettes accounted for 60.1% of exposures, followed by
- other tobacco products (16.4%) and
- e-cigarettes (14.2%).
- The monthly number of exposures associated with e-cigarettes increased by 1492.9% during the study period.
- Children <2 years old accounted for 44.1% of e-cigarette exposures, 91.6% of cigarette exposures, and 75.4% of other tobacco exposures.
- Children exposed to e-cigarettes
  - had 5.2 times higher odds of a health care facility admission and
  - 2.6 times higher odds of having a severe outcome than children exposed to cigarettes.
- One death occurred in association with a nicotine liquid exposure.

- Electronic Cigarettes and Conventional Cigarette Use Among US Adolescents A Cross-sectional Study – 2014 Lauren M. Dutra, ScD[1]; Stanton A. Glantz, PhD[1]

- Author Affiliations Article Information [1]Center for Tobacco Research and Education, University of California, San Francisco JAMA Pediatr. 2014;168(7):610-617. doi:10.1001/jamapediatrics.2013.5488

- http://tobaccocontrol.bmj.com/content/early/2017/01/04/tobaccocontrol-2016-053291?papetoc=

  E-cigarette use as a predictor of cigarette smoking: results from a 1-year follow-up of a national sample of 12th grade students.
  Richard Miech, Megan E Patrick, Patrick M O'Malley, Lloyd D Johnston

- Results contribute to the growing body of evidence supporting vaping as a one-way bridge to cigarette smoking among youth. Vaping as a risk factor for future smoking is a strong, scientifically-based rationale for restricting youth access to e-cigarettes.
- The most interesting new finding in the study, however, is the evidence on how and why e-cigarette use increases the risk of cigarette smoking:
- This paper contributes to the growing body of evidence that e-cigarette use is an independent risk factor for future smoking,both among youth who are non-smokers and also among youth with past smoking experience. Results support a desensitization process, whereby youth who vape lower their perceived risk of cigarette smoking.

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 10.4

MANAGING BOARD APPROVALS IN NATIONAL ORACLE SYSTEM

Purpose	For consideration and approval.

Background

We are in process of implementing the National Oracle System (NOS) in the HealthBis DHBs. This includes setting up the Delegated Financial Authority (DFA) hierarchy. The DFA policy was approved at last month's board meeting and this paper deals with one aspect of how we exercise DFA in our financial system

Information

In our policy the Board has delegated financial authority and, from a practical perspective, this is exercised by approval of a paper presented to the Board with decisions being minuted. Electronically this is managed by an approval hierarchy in Oracle with each position in the hierarchy having the DFA set out in the policy. As the Board is made up of a number of members we need to designate a person to transact the Board approval in Oracle. Our options are:

1) Interim Chief Executive – Derek Wright.
2) Acting Board Chair – Sally Webb.
3) Chief of Staff (or equivalent role) – Neville Hablous.

From a control perspective the Interim Chief Executive has the highest DFA in the DHB. If the Interim Chief Executive is responsible for exercising DFA transactions approved by the Board they would need to be double approved by the Interim Chief Executive. This creates the perception of a risk of approving without Board approval and is therefore not recommended.

This is mitigated by either the Acting Board Chair or Chief of Staff having this function. Either of these demonstrates division of duties between Board and management so addresses the risk identified above. This does not cut out the Interim Chief Executive as approvals flow up the hierarchy until they reach a level that has sufficient DFA and this triggers approval in the system.

From a practical perspective:

- approvals are infrequent;
- but often urgent;
- reliable access to systems and technical assistance is easily available to staff on site; and

- attaching the Board minute would be good practice.

Therefore delegating to a staff member with access to Board papers and minutes is pragmatic.

We recommend that the Chief of Staff (or equivalent role) be approved to exercise Board delegations in the National Oracle System.

Recommendation
THAT
The Board:

1) Receive this report.
2) Approves the Chief of Staff (or equivalent role) to exercise Board delegations in the National Oracle System.

MAUREEN CHRYSTALL
EXECUTIVE DIRECTOR CORPORATE SERVICES

Significant Programmes/Projects

Virtual Health: no report this month.

Medical School: no report this month.

Creating Our Futures: no report this month.

Papers for Information

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 12.1

SUMMARY OF RETURN TO NURSING OPEN DAY

Purpose	For information.

Attached for the Board's information is a summary of an open day held as part of a recruitment strategy aimed at increasing nursing numbers.

Recommendation
THAT
The Board receives the report.

SUE HAYWARD
CHIEF NURSING AND MIDWIFERY OFFICER

Situation

An open day for nurses who no longer had an annual practicing certificate (APC) yet remained on the Nursing Council of New Zealand (NCNZ) Register was held on Friday 13 April. The Nursing & Midwifery education fund would support those appropriate nurses interested in returning to complete a Return to Nursing programme thereby gaining an APC.

Background

This "open day" was held as part of a recruitment strategy aimed at increasing nursing numbers. The increase is aligned to extra beds opening, ability to respond to variations in workload (an increase not planned) and covering gaps in rostering at ward level associated with any delays between a resignation and employment of a replacement nurse.

Assessment

15 nurses in total attended on the day, of whom:

- 12 had formerly held a NZ APC and were interested in the Return to Nursing programme, and then working in Waikato DHB.
- 2 were international nurses who were interested in working at Waikato DHB but would require a different pathway to gain an APC.
- 1 nurse had worked at Waikato DHB previously, did have an APC and was invited to apply for existing positions.

All have received follow up phone calls and emails. Further contacts have been received by the Nurse Manager leading this out, and a high number of hits have been registered via Facebook and Twitter before and after the event.

At this point the actual number who will be engaged in the Return to Nurse programme and then employed is not known as it is early in the process.

Recommendation

We continue to follow up those nurses who have made contact and encourage them to apply for and then attend the Return to Nursing programme run by WINTEC.

Depending on the success rate will consider holding another "open day".

Presentations

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 13.1

PROGRESS REPORT FROM WAIKATO DHB'S CONSUMER COUNCIL

Purpose	For information.

A paper giving an update on the progress of the Consumer Council is attached for the Board's information.

Recommendation
THAT
The Board receives the report.

GERRI POMEROY
INTERIM CO-CHAIR, CONSUMER COUNCIL

LOUISE WERE
INTERIM CO-CHAIR, CONSUMER COUNCIL

Report from Waikato DHB's Consumer Council to the Waikato DHB Board
April 2018

Overview
The purpose of this report is to provide:

- An overview of the Consumer Council and their progress to date
- Insight into their ways of working and how our contribution supports success as a DHB
- Identify strategies going forward to maximise the contribution of Consumer Council

Introduction
The Consumer Council was established in January 2018 to promote and oversee consumer involvement in the planning and delivery of Waikato DHB services, and provide advice to the Waikato DHB's senior management and the Board. It works in partnership with the DHB to provide a consumer perspective to help shape health services and make sure they meet the needs of Waikato communities.
The Consumer Council has 15 members (including two co-chairs) with a range of skills, ages, experience, qualities and networks. Importantly, all members have personal or family experience in accessing health services. They bring their own experiences to the Consumer Council and are not representatives of any specific organisation or community.

The Consumer Council meets monthly and summaries of the meeting are posted on the DHB website approximately two weeks after the meeting.

Members
The 15 members come from across the Waikato region. Brief biographies of members can be found on the Waikato DHB website via the link below:
https://www.waikatodhb.health.nz/about-us/consumer-council/members/

Meetings
The Consumer Council held its first hui in March, and has now met twice. Hui are held on the first Thursday of each month (excluding January) from 4-6 p.m. The Co-Chairs meet monthly with the Board Chair and Interim CE to discuss progress to date and opportunities or challenges that have been identified.

Progress and Focus to date
Work over the past two months has focused on the following:

The strategic priorities of the DHB and how individual member's experience and interest areas link to these.
Introducing members to projects/ work / activities outside Waikato DHB that may influence health outcomes for consumers in the priority areas e.g. co-production & co-design initiatives such as Enabling Good Lives and similar initiatives in Mental Health
Identification of key areas of work in Waikato DHB where the Consumer Council should have influence, e.g. Long Term Health Systems Plan, Public Health Annual Plan. Met with Danny Wu, Programme Manager for 10 Years Health Systems Plan to discuss ongoing engagement with this work.
Establishment of 3 'sub groups' - one for each of the Strategic Priority areas: • Radical improvement in Māori health outcomes by eliminating health inequities for Māori; • Eliminating health inequities for people in rural communities,

• Removing barriers for people experiencing disabilities. These sub groups meet and work outside of the Consumer Council meeting. Identification of key focus areas for each priority and associated work plan is underway, which will help inform engagement moving forward.
Need to ensure that we have a robust process that brings communities' experience into the Consumer Council work plan and the Waikato DHB's planning and decision making process.
Setting up a Disability Core group, made up of people with experience of living with a disability (either themselves or via a loved one) across the spectrum of disability. The purpose of this group will be to provide guidance to the Consumer Council and Waikato DHB on a range of disability matters, as well as making connections with members of the disability community across the Waikato.
Positioning of the Consumer Council for optimal impact and success, and identification of key committees on which the Consumer Council will need to have a presence and/or connect to.
Success measures - what success will look like for the Consumer Council and formulation of appropriate measures, these will be based on the priorities identified at the April meeting and tested with the Disability Core group, and others.
Establishment of links and participation with a range of community groups/forums: • Creating our Futures, one Consumer Council member is part of the Creating our Futures Advisory Group. • Regional Rural Transport Group. • Community Health Forums • National Collective of Consumer Councils • Community Pharmacy Consultation Work will continue to identify further groups and mechanisms to stay engaged to support collaboration and bring consumer expertise and experience into service design and decision making.
Improving accessible parking for people with disabilities in the Hague Road Car Park. Organised for consumers to work with Property & Infrastructure on improvements to mobility parking spaces for people with disabilities, to ensure access and safety of access to hospital facilities.
A communication strategy that sits alongside the workplan development process engaging with community to identify and implement short, medium and long term priorities

Ways of Working

The Consumer Council works in an inclusive, culturally respectful way and is focussed on ensuring that consumer experience informs Waikato DHB planning and decision making.

The voice of consumer experience is critical and especially relevant to disabled people as currently there is little regional evidence to inform decision making and ensure removal of barriers to achieve equitable health outcomes for this group. The Consumer Council is working to ensure it provides robust advice using a Disability Core group process supported by information gathered from the Quality and Patient Safety Complaints process in the interim until more robust data and information can be collected.

While it is recognised that there are data sources to inform service design and implementation for Māori and rural communities, the Consumer Council seeks to create and take advantage of opportunities to elevate consumer experience as a credible source of evidence that it utilised to inform decision making early.

Co-design processes, such as the Consumer Council, are particularly suited to ensure that the less well heard voice, can influence and inform decision making. It is hoped that as the Council builds credibility and trust within Waikato DHB, it's leadership and advice will significantly influence decisions made within, and outside the organisation.

Some Measures of Success

Ultimately Consumer Council success will contribute to:

- Waikato DHB services and facilities, and those they fund will provide a culturally relevant approach to care for Maori, Pasifika, other ethnicities and people with disabilities
- People will feel safe to reach out for health support and know they will be heard, understood and supported to receive the care and services they require, to manage their own health in their community
- People who have high health support needs will work in partnership with health professionals to be empowered to manage their own health in their community
- Services will display cultural humility, Waikato DHB staff and those services they fund, will recognise that they are expected to listen to, and respect, all people accessing services and respond appropriately.
- Waikato DHB management processes recognise gaps in health support and work to rectify these by working collaboratively with consumers across agencies and organisations

Going Forward

The Consumer Council is committed to the shared vision of healthy people, excellent care.
Through partnership and co-design processes, Waikato DHB can enhance its responsiveness to the communities it serves. The Consumer Council can play a vital role in bringing consumer experience, leadership and expertise more deeply into co-design and decision making processes.
Co-design approaches ensure that consumers are engaged at the 'problem-defining' stage as well as at 'solution-finding' stages, in fact throughout service design and improvement processes.

To do this, it is hoped that Consumer Council can:

- Establish a working relationship with the Board that is mutually beneficial, and enables early and on-going engagement, including active participation on or with DHB committees
- Actively support co-design processes by ensuring that there is clarity about what co-design means in each context, that it is implemented authentically, and consumers are kept at the heart of all design processes

Louise Were and Gerri Pomeroy
Interim Co-Chairs
Waikato DHB Consumer Council

MEMORANDUM TO THE BOARD
24 APRIL 2018

AGENDA ITEM 13.2

THE WAIKATO HEALTH SYSTEM PLAN

Purpose	For information.

A presentation on the Waikato Health System Plan is attached for the Board's information.

Recommendation
THAT
The presentation be received.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY & FUNDING

The Waikato Health System Plan

Delivering the Waikato District Health Board Strategy;
Healthy people. Excellent care

24 April 2018

Waikato District Health Board

Healthy people. Excellent care

- Vision and mission reflect:
  - ✓ People empowered to live healthy lives and to stay well and;
  - ✓ Quality, safe, efficient, and effective services delivered around the needs of people.
- 6 strategic imperatives
- Under each imperative are our priorities

Our Priorities

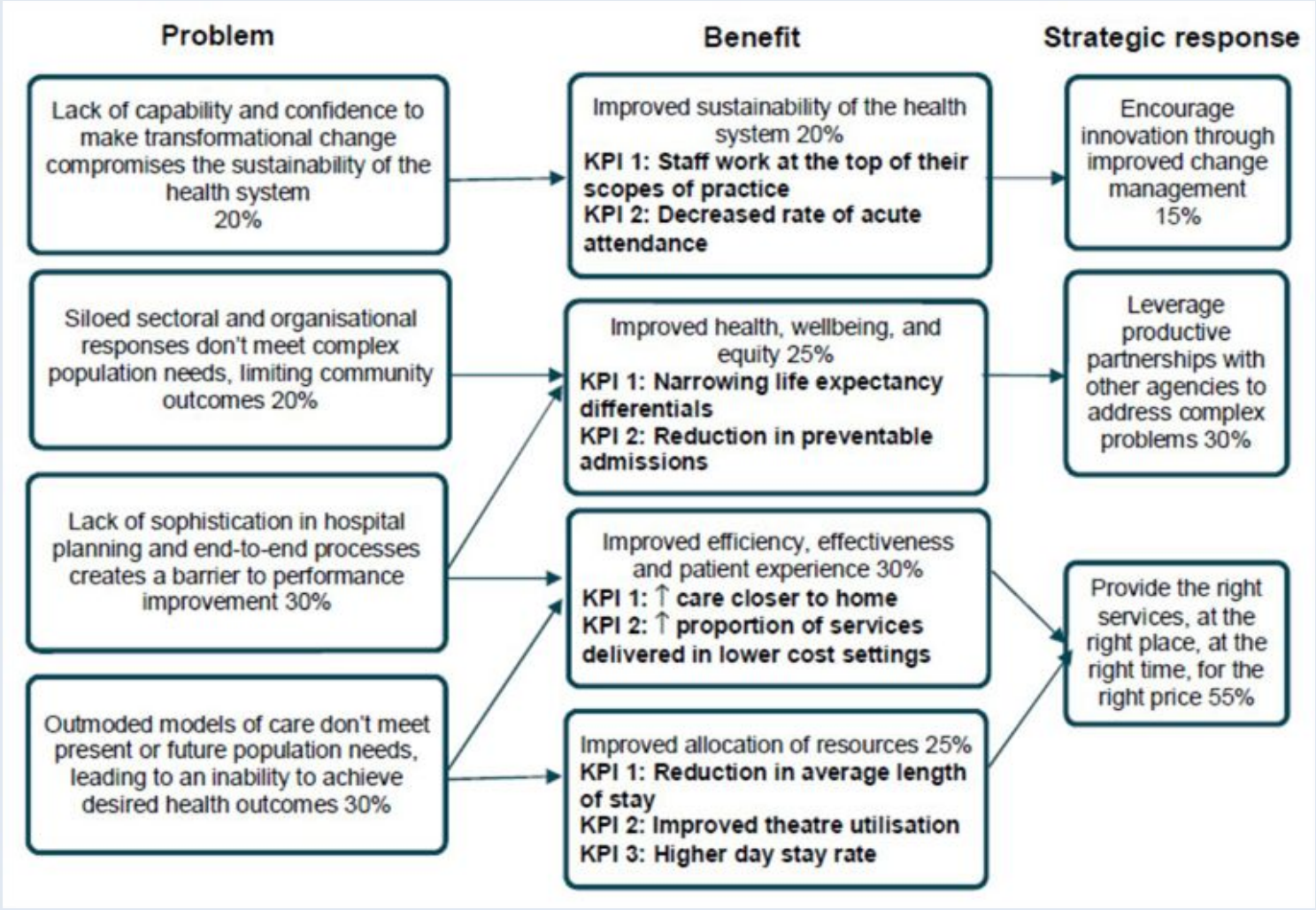
- Priorities guide our actions
- Overlay everything we do
- No strategic objectives specified yet
- Current lack of clarity on strategic investments and roadmap

Why do we need a Health System Plan?

- Stubborn key health status indicators;
  - smoking, obesity, life expectancy for Maori vs non-Maori, disproportionate rates of mental health for Maori, and deaths amendable to intervention.
- Ongoing investment in DHB services operational capacity.
- Current models unsustainable over the next 10 years
- Different scenarios modelled – cannot continue to do more of the same.
- Transformational approach, whole of system performance improvement only positive option but….

- Many benefits are long term
- Needs actions that will radically change the system and eliminate health inequities
- Whole of system improvement therefore requires long term commitment, structured and planned to allow for changes in models of care, workforce capability/capacity, attitudes, behaviours, finances, and infrastructure developments
- Whole of system approach requires multiple stakeholders to be aligned and committed to actions
  - collective and shared responsibilities
  - collaborative actions

The Why, What and How



What will the Health System Plan do?

- HSP outlines specific actions for the sector in the implementation of our strategy
- HSP is a living document and will continue to be iterated for changing needs and circumstances – rolling 10 year view
- 6 strategic imperatives and their priorities remain unchanged
- System and service integration as a core function
- Long Term Investment Plan follows HSP - describes prioritised investments.
- Replaces Priority Programme Plan process
- Projects/initiatives already underway continue – may be reviewed (scope, resourcing)

HSP Approach

- Multiple strategic planning processes aligned e.g.
  - Maori Health
  - Clinical Service Plans
  - Care in the Community
  - Mental Health and Addictions
  - Virtual health
- Innovations for services, localities, population groups, and disease types
- Strategic and operational. Both required
- Community engagement

HSP Approach (continued)

- Care in the Community includes wananga in 7 localities, focus groups in 3 localities, and in-depth interviews with individuals
- End to end care and prevention processes
- Supported by organisational changes, workforce needs, enablers, clinical equipment, infrastructure
- Transformational
- Prioritised initiatives form basis for specific projects, LTIP, and financial models
- Regional engagement with Midland DHBs
- Engagement with metro Auckland DHBs for the clinical services plans

HSP Approach (continued)

- Ongoing sector engagement
- Draft HSP – September
- Draft Action Plan – October
- HSP to Board – November

Next Steps:

- Maori Strategic Committee 18 April
- Combined Board & IMC workshop 3 May

Next Board Meeting: 23 May 2018.