Board Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	26 September 2018	**Time:**	1pm

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

Next Meeting Date:	24 October 2018	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680

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Board Agenda

Item

1. Apologies

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

3. MINUTES AND BOARD MATTERS
   - 3.1 Board Minutes: 22 August 2018
   - 3.2 Committees Minutes:
     - 3.2.1 Maori Strategic Committee: 19 September 2018

4. INTERIM CHIEF EXECUTIVE REPORT

5. QUALITY AND PATIENT SAFETY
   No report this month

6. FINANCIAL PERFORMANCE MONITORING
   - 6.1 Finance Report
   - 6.2 Waikato DHB Deficit 2017/18

7. HEALTH TARGETS

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

9. SERVICE PERFORMANCE MONITORING
   - 9.1 People and Performance
   - 9.2 Facilities and Business (refer item 18 in public excluded)
   - 9.3 IS
   - 9.4 Chief Data Officer Directorate (report due in October)
   - 9.5 Interim Chief Operating Officer (report due in November)
   - 9.6 Mental Health and Additions Service (report due in November)
   - 9.7 Strategy and Funding (report due January)

10. PROFESSIONAL ADVISORY REPORTS
    - 10.1 Chief Nursing & Midwifery Officer (report due in October)
    - 10.2 Chief Medical Officer (report due in January)

11. DECISION REPORTS
    - 11.1 Equity Focussed Reporting (report due in November)
    - 11.2 Integrated Community Pharmacy Agreements

12. SIGNIFICANT PROGRAMMES/PROJECTS
    - 12.1 Medical School (no report this month)
    - 12.2 Creating our Futures (no report this month)

Board Agenda

13. **PAPERS FOR INFORMATION**

No papers

14. **PRESENTATIONS**

14.1 Advancing Telehealth for Waikato DHB

Dr R Large to attend at 1.30pm

14.2 eSPACE Programme

Ms M Chrystall to attend at 3pm

15. **BOARD MEMBER ITEMS**

15.1 Car Parking Pay Stations (refer item 18 in public excluded)

15.2 Living Wage (report due in October)

NEXT MEETING: 24 October 2018

Board Agenda

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

THAT:

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

Item 16: Minutes – Various
- (i) Waikato District Health Board for confirmation: Wednesday 22 August 2018 (Items taken with the public excluded)
- (ii) Audit and Corporate Risk Management Committee to be adopted: Wednesday 22 August 2018 (All items)

Item 17: Funding: Equity Requirements and Leasing Options – Public Excluded
Item 18: Service Performance Monitoring – Facilities and Business – Public Excluded
Item 19: Property and Infrastructure Indicative Capital Plan and Project Reprioritisation – Public Excluded
Item 20: Waikato DHB 2017-18 Annual Report (Draft) – Public Excluded
Item 21: People and Performance Report – Public Excluded

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

(3) Pursuant to Clause 33 (1) of Schedule 3 of the NZ Public Health & Disability Act 2000 the general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED		REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER	SECTION OF THE ACT
Item 16 (i-ii):	Minutes – Public Excluded	Items to be adopted/confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 17:	Funding: Equity and Leasing – Public Excluded	Negotiation with Ministry of Health will be required	Section 9(2)(j)
Item 18:	Facilities and Business report – Public Excluded	Negotiation with suppliers will be required	Section 9(2)(j)
Item 19:	Property and Infrastructure Indicative Capital Plan and Project Reprioritisation – Public Excluded	Negotiation with suppliers will be required	Section 9(2)(j)
Item 20:	Draft Annual Report – Public Excluded	Negotiation with Ministry of Health will be required	Section 9(2)(j)

Board Agenda

Item 21:	Employee relations – Public Excluded	Negotiation will be required	Section 9(2)(j)

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

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

Board Agenda

16. MINUTES – PUBLIC EXCLUDED

16.1 Waikato District Health Board: 22 August 2018
To be confirmed: Items taken with the public excluded

16.2 Audit and Corporate Risk Management Committee: 22 August 2018
To be adopted: All items

17. FUNDING: EQUITY REQUIREMENTS AND LEASING OPTIONS – PUBLIC EXCLUDED (Paper to be distributed on Monday 24 September)

18. SERVICE PERFORMANCE MONITORING – FACILITIES AND BUSINESS – PUBLIC EXCLUDED

19. PROPERTY AND INFRASTRUCTURE INDICATIVE CAPITAL PLAN AND PROJECT REPRIORITISATION – PUBLIC EXCLUDED

20. WAIKATO DHB 2017-18 ANNUAL REPORT (DRAFT) – PUBLIC EXCLUDED

21. PEOPLE AND PERFORMANCE REPORT – PUBLIC EXCLUDED

RE-ADMITTANCE OF THE PUBLIC

THAT:

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

Apologies.

Interests

SCHEDULE OF INTERESTS AS UPDATED BY BOARD MEMBERS TO SEPTEMEBER 2018

Sally Webb

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

Crystal Beavis

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

Sally Christie

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Chair, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Thames Coromandel District Council	TBA	TBA	
Partner, employee of Workwise	Pecuniary	Potential	

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

Martin Gallagher

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

Mary Anne Gill

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Sustainability Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Life Unlimited Charitable Trust	Pecuniary	Perceived	
Member, Public Health Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Disability Support Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Health Strategic Committee, Bay of Plenty DHB	Pecuniary	Potential	

Tania Hodges

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

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

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

Dave Macpherson

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Maori Strategic Committee, Waikato DHB	Non-Pecuniary	None	
Councillor, Hamilton City Council	Pecuniary	Perceived	
Deputy Chair, Waikato Regional Passenger Transport Committee	Non-Pecuniary	Potential	
Member, Waikato Regional Transport Committee	Non-pecuniary	Potential	
Member, Future Proof Joint Council Committee	Non-pecuniary	None	
Partner is an occasional contractor to Waikato DHB in “Creating our Futures”	TBA	Potential	

Pippa Mahood

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

Sharon Mariu

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

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

Interest	Nature of Interest	Type of Conflict	Mitigating Actions
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Director/Shareholder, Register Specialists Ltd	Pecuniary	Perceived	
Director/Shareholder, Asher Business Services Ltd	Pecuniary	Perceived	
Director, Hautu-Rangipo Whenua Ltd	Pecuniary	Perceived	
Owner, Chartered Accountant in Public Practice	Pecuniary	Perceived	
Daughter is an employee of Puna Chambers Law Firm, Hamilton	Non-Pecuniary	Potential	
Daughter is an employee of Deloitte, Hamilton	Non-Pecuniary	Potential	

Clyde Wade

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

Professor Margaret Wilson

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2

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

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

Te Pora Thompson-Evans

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

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 22 August 2018 at 1.00pm in the Board Room, Hockin Building at Waikato Hospital

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

In Attendance:
Ms T Thompson-Evans (Chair, Iwi Maori Council)
Mr D Wright (Interim Chief Executive)

Professor Margaret Wilson was welcomed to the meeting. Professor Wilson has been appointed as the Deputy Chair.

Noting that this was Mr Wolstencroft's last Board meeting, the Board thanked Mr Wolstencroft for the services he has provided to the Waikato DHB over the last 14 years.

ITEM 1: APOLOGIES FOR ABSENCE

There were no apologies for absence.

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

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

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 25 July 2018

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 25 July 2018 taken with the public present was confirmed as a true and accurate.

3.2 Committee Meeting Minutes

3.2.1 Iwi Maori Council: 2 August 2018
3.2.2 Maori Strategic Committee: 15 August 2018
3.2.3 Hospitals Advisory Committee: 8 August 2018
3.2.4 Community and Public Health Advisory Committee: 8 August 2018

Resolved
THAT
The Board noted the minutes of these meetings.

ITEM 4: INTERIM CHIEF EXECUTIVE REPORT

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

- A short summary of the DHB's Board meetings will be made available to the Community Health Forums (CHFs).

- A suggestion that a clash of dates is avoided between CHF and Board meetings.

- Mental Health Bed Capacity – an option to transfer eight forensic longer term rehabilitation patients was being negotiated with another provider. This would free up eight beds in the Henry Rongomau Bennett Centre.

- Emergency Department and Acute Medicine – the Emergency Department is still not meeting the 6 hour target and remained under significant pressure due to the heightened prevalence of influenza during the last few weeks. The new Acute Surgical Assessment Unit had now opened.

- Acute Surgery – the DHB had continued to meet 24 hour and 48 hour targets for 80% and 100% of waiting patients being operated on. Compliance with ESPI 2 and 5 had been achieved.

- Discussion with Counties Manukau DHB – the Chair and Interim Chief Executive had met with the Chief Executive and Chair of Counties Manukau DHB to develop a closer working relationship between the two DHBs particularly around health services for the "Northern Corridor". It was suggested that the two DHB boards and executive teams meet to discuss future collaborations. It would be beneficial for IWI representatives to be part of any discussions.

DRAFT

- Executive Recruitment - two new appointments had been made:
  - Gil Sewell as Executive Director, Human Resources and Organisational Development; and
  - Claire Tahu as Chief Advisor, Allied Health, Scientific and Technical.
- DHB 2018/19 Budget – the Ministry of Health and two DHB Chief Executives had been invited to attend a workshop on 30 August to undertake a peer review of the Waikato DHB's 2018/19 budget.
- Alcohol and gambling licences – it was suggested that Public Health takes a more active role in attending hearings for alcohol and gambling licences.

Resolved
THAT
The Board:
1. Received the report.
2. Agreed that Messrs D Slone and J McIntosh are formally advised that their appointment to the Community and Public Health Advisory Committee will continue until early 2020.
3. Mr F Mhlanga is formally appointed to the Hospitals Advisory Committee until early 2020 subject to (re)submission of advice as to conflicts of interest to be reviewed by the Board Chair and Chair of the Hospitals Advisory Committee.
4. Adopted the reviewed terms of reference for the Māori Strategic Committee.

ITEM 5: QUALITY AND SAFETY REPORT

5.1 Quality and Safety Report

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

- It was important to ensure that there were sufficient stocks of Information leaflets available for patients managing conditions at home.
- A suggestion was made to reintroduce patient medication cards.

Resolved
THAT
The Board received the report.

ITEM 6: FINANCIAL PERFORMANCE MONITORING

There was no financial reporting for the month of July 2018. Andrew McCurdie gave a brief verbal update. It was noted:

- The NOS financial system went live successfully on 2 July 2018 – as expected some issue shave been encountered, but no show stoppers
- We have a budgeted deficit for July 2018 of $1.9m. The actual result was a surplus of $900k. However, there were timing differences that accounted for the majority of the favourable variance and we expect some flow of costs into August as a result of the NOS implementation.
- Thus, we have not adjusted our forecast for the year of a $56m deficit.

DRAFT

Resolved
THAT
The Board received the verbal update.

ITEM 7: HEALTH TARGETS

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

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

- Shorter stays in Emergency Department - the target had not been achieved. The newly opened Ward M18 should assist achieve better outcomes.
- Work continued to be done by the Francis Group to improve outcomes.
- Tokoroa Hospital's Emergency Department provide primary care types of services.
- Board members acknowledged the workload that staff in the Emergency Departments is currently experiencing and passed on their thanks.

Resolved
THAT
The Board received the report.

ITEM 8: HEALTH AND SAFETY

The next Health and Safety Services Update is due in October 2018.

ITEM 9: SERVICE PERFORMANCE MONITORING

9.1 Strategy and Funding

Ms T Maloney and Dr D Tomic attended for this item. The report was taken as read. It was noted:

The Interim Director for Strategy and Funding had released a consultation document that proposed a new approach to commissioning and a restructure of the Strategy and Funding team.

Child health and primary care continued to work with providers, managing commissioning and performance and reviewing the way in which those services are delivered.

A review of outreach immunisation services was planned to ascertain effectiveness and value of investment which is around $750k per annum. It was suggested that Maraes could be considered as an outreach location.

A workshop was planned with Oranga Tamariki to discuss working together.

Resolved
THAT
The Board received the report.

DRAFT

9.2 People and Performance (report due in September)
9.3 Facilities and Business (report due in September)
9.4 IS (report due in September)
9.5 Chief Data Officer Directorate (report due in October)
9.6 Interim Chief Operating Officer (report due in November)
9.7 Mental Health and Addictions Service (report due in November)

ITEM 10: DECISION REPORTS

10.1 Equity Focussed Reporting (report due in October)

10.2 Reappointment of the New Zealand Health Partnerships Independent Directors

Ms S Webb tabled this item. Board members authorised Ms Webb to attend the September AGM to vote for the reappointment, or otherwise, of NZ Health Partnerships' independent directors.

Resolved
THAT
The Board:
1) Received the report.
2) Provided feedback on the reappointment of NZ Health Partnerships' independent directors for appointing directors moving forward.

ITEM 11: SIGNIFICANT PROGRAMMES/PROJECTS

11.1 Medical School (no report this month)

11.2 Creating our Futures – Mental Health and Addictions Service Facilities and Service Redevelopment Preferred Way Forward

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

Waikato DHB is in the process of developing a series of business case documents using the NZ Treasury Better Business Case model. The DHB is in the discovery phase with a long list of options being considered.

The Board members requested more time to consider the options. It was agreed that the next Hospital Advisory Committee meeting would be a workshop dedicated to discussing the options available. This would enable the decision to be made at the October 2018 Board meeting.

It was suggested that the Ministry of Health be invited to this meeting. Also to have more information available about the proposed developments at Waikeria Prison and gazetting of a new hospital.

DRAFT

Resolved
THAT
The Board:
Approved that further discussion to consider the options would be held at the Hospital Advisory Committee meeting on the 10 October 2018.

ITEM 12: PAPERS FOR INFORMATION

There were no papers for information this month.

ITEM 13: PRESENTATIONS

There were no presentations this month.

ITEM 14: BOARD MEMBER ITEMS

1) Car Parking Ticketing Machine Problems – (report due in September).
2) Living Wage – (report due in October).

NEXT MEETING

The next meeting is to be held on Wednesday 26 September 2018 commencing at 1.00 pm at in the Board Room in the Hockin Building, Waikato hospital.

DRAFT

BOARD MINUTES OF 22 AUGUST 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 25 July 2018 (Items taken with the public excluded)

(ii) Midland Regional Governance Group: Friday 3 August 2018: (All items)

Item 16: Replacement of Linear Accelerator – Public Excluded

Item 17: CBD Accommodation Project – Scope Change Proposal – Public Excluded

(2) 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 OFFICIAL INFORMATION ACT
Item 15: (i-ii): Minutes	Items to be adopted/ confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 16: Replacement of Linear Accelerator – public excluded	Negotiations will be required	Section 9(2)(j)
Item 17: Change of scope proposal for CBD accommodation – public excluded	Negotiations will be required	Section 9(2)(j)

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

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

DRAFT

ACTION LIST

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

Agenda Item	Action Agreed	Name of Executive Director Responsible for Action	Month action to be reported to the Board
3.2.2	A report on performance in accommodating patients and families following the demolition of Hilda Ross House	Andrew McCurdie	

DRAFT

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Māori Strategic Committee held on Wednesday 19 September 2018 commencing at 10:00am in the Board Room, Hockin Building

Present: Ms T Hodges (Chair)
Ms T Moxon
Ms S Christie
Mr D Macpherson

In Attendance: Ms L Elliott
Mr N Hablous
Mr H Curtis
Ms N Te Ahu
Ms P Ormsby
Ms J Sewell
Ms S Greenwood (Minutes)

DRAFT

ITEM 1: KARAKIA/MIHI

Karakia and mihi by Mr H Curtis.

ITEM 2: APOLOGIES

Apologies were received from Mr G Tupuhi, Ms M Balzer, Dr C Wade, Ms T Thompson-Evans, Mr D Wright.

ITEM 3: MINUTES OF MSC MEETING HELD ON 22 AUG 2018

Minutes accepted as true and correct.

Moved: Mr D Macpherson
Seconded: Ms S Christie

ITEM 4: MATTERS ARISING

4.1 MSC TERMS OF REFERENCE

- Final terms of reference presented for noting.

ITEM 5: MĀORI DNA UPDATE

It was noted that:

- DNA report of survey findings were presented – see attached
    - Paediatrics had the highest response rate
    - Waitemata (presented at the last MSC meeting) findings also found that many people were unable to be contacted due to incorrect phone numbers.
    - Majority issues were systemic – hadn't received a notice or an appointment.
    - Some DNA related to transport, childcare etc but this was the minority.
- It was clear from the survey conversations that there is confusion overall of patient who have a multitude of health issues. Patients currently have two opportunities for non-attendance (two letters) and then are removed from the outpatient appointment register. This does not work for Māori; the process must be changed immediately.
- Outpatient appointments are all clinically focused and not orientated to the needs of whānau.
- Tolerance of high DNA rates appears to have been normalised in some services. Organisational commitment and accountability needs to be driven from the top both clinically and at executive director level.
    - This was also indicated by Waitemata.
- DNA is a symptom of not doing our services well. This is about excellence in service that we have a responsibility to delivery to all our population and not accepting mediocrity.
- Committee is keen to see what action will be taken to address the DNA's in particular for Māori at the next meeting.

It was MOVED that:

1. A coherent organisation-wide approach to addressing DNA rates is implemented.
2. That this approach is monitored monthly by the Maori Strategic Committee until the inequity has been eliminated.

Moved: Ms T Hodges
Seconded: Ms S Christie

ITEM 6: UPDATE HSP/CCP – DANNY WU: 10.30AM

Presentation delivered by Ms T Maloney and Mr D Wu.

- See attached presentation.
- Presentation also attended by Ms I ter Beek.

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ITEM 7: UPDATE COF AND LET'S TALK

- The Executive Director Maori Health presented a verbal update as tabled in the agenda.

ITEM 8: MSC UPDATE

- The Executive Director Maori Health presented a verbal update as tabled in the agenda.

ITEM 9: GENERAL BUSINESS

- Treaty claim WAI-1315 and WAI-2575: The Crown has submitted their evidence and will be responded to by the claimants.
  - After Labour Day, interested parties speak then the Crown.
  - Held at Turangawaewae Marae, invitations have gone out.
- Remind Board and IMC to follow up on the issue of systemic racism as workshopped in the last joint IMC/Board meeting in Rangiriri.

ITEM 10: DATE OF NEXT MEETING

Wednesday 17 October 2018, Board Room, Level 1, Hockin Building

ITEM 11: KARAKIA WHAKAMUTUNGA

Karakia whakamutanga by Mr H Curtis.

Chairperson: ___________________________________

Date: ___________________________________

Meeting closed at: 11.50am

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ACTION POINTS

	Action List	Completed	Who
1.	**Agenda Item 5** Organisational approach and recommendation to Board.		Ms T Hodges
2.	To present what action will be taken to address the DNA's in particular for Māori at the next MSC meeting.		Ms L Elliott Mr D Wright
3.	**General Business** Systemic racism workshop follow-up.		Ms T Thompson Evans Ms S Webb

DRAFT

MEMORANDUM TO THE MĀORI STRATEGIC COMMITTEE
19 SEPTEMBER 2018

AGENDA ITEM 5

MĀORI DNA UPDATE

Purpose	For noting

In line with the discussions previously within the Māori Strategic Committee the top three specialties with the highest Māori DNA rates were identified.

1. Specialist Paed Oth Surg
2. Plastic Surgery Non Burns
3. Diabetology

A sample of 50 people from each of the specialities (n=150) who had been recorded as not attending a scheduled in the month of July and August were collated. Phone interviews were carried out and an attempt to contact all 150 people.

The data from the phone interviews has been collate and a summary is presented below.

Overall total responses

Number of patients surveyed (n)	150
Participants	73
Response rate	49%

Individual responses by clinic

	Specialist Paed Oth Surg	Plastic Surgery Non Burns	Diabetology
n	50	50	50
Participants	31	21	21
Response rate	62%	42%	42%

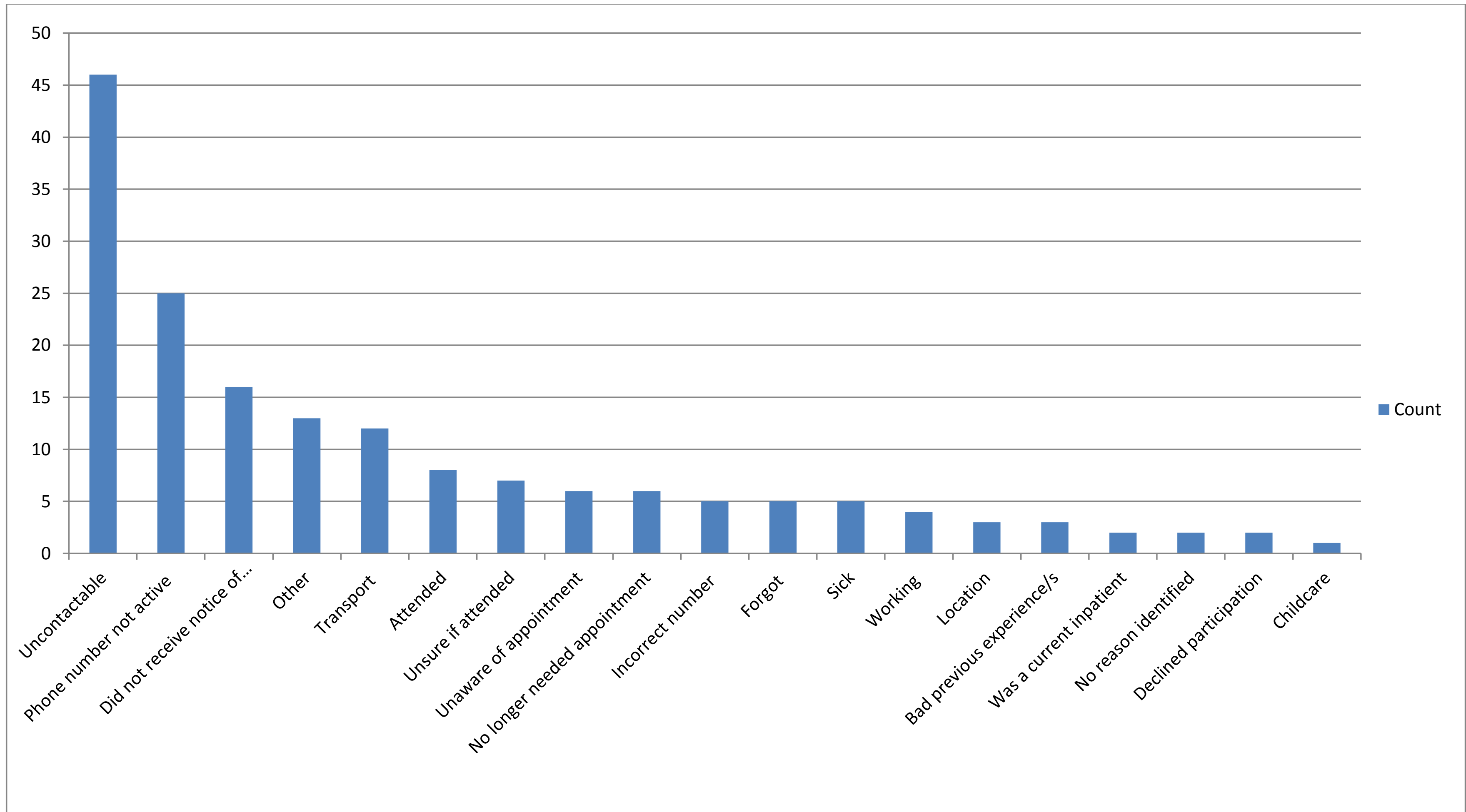


Figure 1: Individual counts for reasons provided regarding why someone had not attended their scheduled appointment.

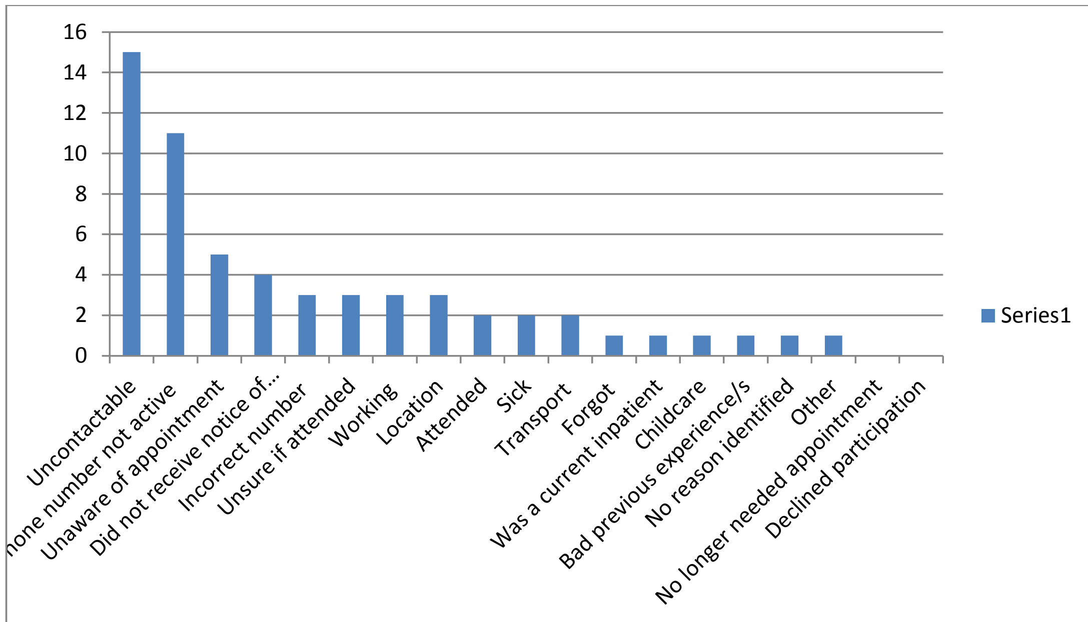


Figure 2: Diabeteology - Individual counts for reasons provided regarding why someone had not attended their scheduled appointment.

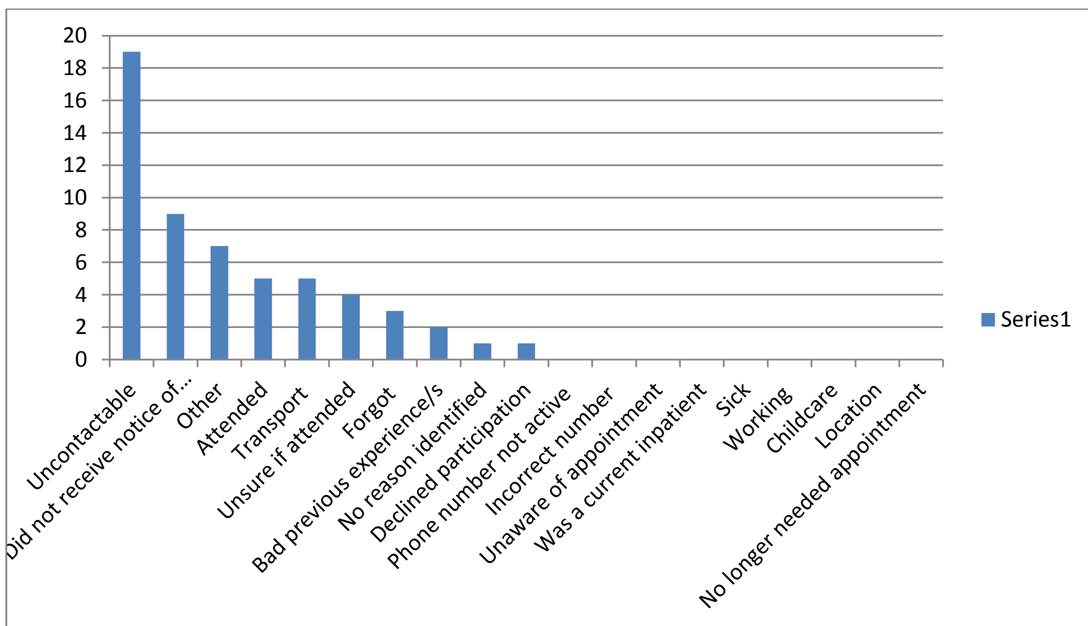


Figure 3: Paediatrics - Individual counts for reasons provided regarding why someone had not attended their scheduled appointment.

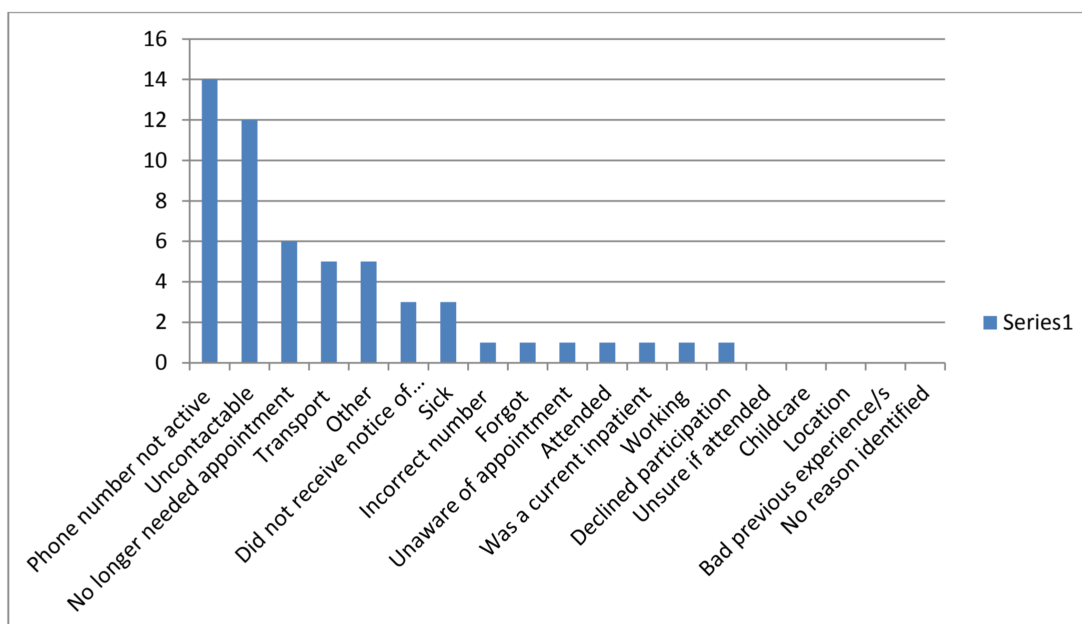


Figure 4: Plastics- Individual counts for reasons provided regarding why someone had not attended their scheduled appointment.

Reasons for non-attendance

Reasons provided reasons why they had not attended their scheduled appointment. Patients also provided feedback in some cases as to what would support their circumstance more effectively.

Uncontactable	The number connected but there was no answer of the call or return of messages in the defined survey period.
Phone number not active	Phone number did not connect or the call went straight to answer machine each call during the defined survey period.
Incorrect number	Number provided was answered and was not the correct number for the person.
Forgot	
Did not receive notice of appointment/letter	Patient specifically mentioned they had not received a letter or notice of appointment.
Unaware of any missed appointment	Patient sure they had not missed any appointments

	(usually frequent services users)
Unsure if attended	Patient was unsure if they had attended or not (usually in these instances, patient had many appointments and/or were being provided multiple services)
Attended	Patient sure they had attended scheduled appointment.
Was a current inpatient	
Sick	
Working	
Transport	
Childcare	
Location	Lived in a location and situation that made it difficult to attend appointment.
Previous bad experience	
No reason identified	Throughout the survey the patient did not give any reason that they did not attend their scheduled appointment
No longer needed appt	Patient self-identified that they no longer needed/wanted an appointment so did not attend.
Declined to participate	
Other	Received notice too late. Clinic error. Did not want to attend.

Comments from individuals surveyed
Preferred method of contact will be by email.
Missed first appointment, but attended the following meeting on Tuesday 28th August at 2:30pm

Previous mail was sent to address however but was never received by the whānau. Has confirmed that any mail sent to current address on hospital file should now be received.
Wasn't sure if DNA as have been to a few appointments since June. Was really happy with service, seen immediately and nothing to note on improvements needed to the service
Finding parking is a huge barrier. Phone call the family if appointments were changed or cancelled by the hospital for the inconvenience. Preferred method of contact – email (Why ask for email addresses on Hospital forms if they don't get used).
Location Te Awamutu. Preferred method of contact – email. Reminder text of appointment. Whānau live rurally so require early notifiction of appointment.
Spoke with grandmother who couldn't speak for long. Have missed a few appointments however Ururangi has been going to appointments and happy with service.
Not sure what we're calling her (grandmother) for.
Missed her appointment because she has a learner's license and could not drive from Rotorua. She (mum) is happy that an appointment was rescheduled and she attended that yesterday.
Mix up, appointment letter fell off fridge and missed appointment.
Too late notice but rescheduled
Forgot not concerned to go. A confirmation text the week before and the day before.
Reasons for not attending- transport, cost of transport, whānau take, bad previous experience/s. Not legal guardian therefore not much knowledge or background of illness. Appointment was pushed back because legal guardian was late and stuck in traffic. Improvements suggested, shorter wait time, better communication, pointless coming in rather say it all over the phone to save time going in.
Better communication – be able to email out the appointments. Also email all specialist so they aware of everything - better access for adults.
On different occasions the appointment letter comes too early or too late or not at all. No support. Going overtime
No contact number
Did not attend as date mix up from the clinics side. Terrible experience with nurse and doctor as they were unprofessional taking care of child as illness was around private parts. Has seen gp and better experience with them. Have another appointment with Waikato hospital soon. To prove better service – kid friendly, speak at kids age. Be more professional. Be more communicative
Less waiting time required
Moved to Auckland

Forgot about it as it wasn't top priority for the mother. Has been getting follow up letters to re-schedule. Mother is not too sure if she wants to re schedule. Mother is not too sure why she needs to or doesn't.
Missed appointment not sure what happened but have a new appointment
Experience – didn't like the appointment experience at all beforehand hence why not going to this one. From doctors and nurses giving her the wrong information from medication dosage to where to be seen. She commented that every step of the way was all miscommunicated. Mistreated. Argument with Waikato hospital. May have re booked due to this one being missed but didn't want to and trusted her doctor instead. Hasn't had one letter since the scheduled appointment.
Tried to rebook several times but no response.
Answer the phone when trying to patients try to call.
Patient was unaware she had missed appointment.
Patient discussed that it would be helpful to have an appointment time that was more convenient for the patient and also to have an additional appointment confirmation letter.
Patient fed back that she has many services that she is attached to. When she gets text reminders the reminder does not include where the appointment venue is. This would be helpful so she knows where to go, especially if the letter does not arrive in time.
Lives in Whitianga so the appt time needs to factor in the travel distance and childcare considerations.
He suffered a stroke a few years ago and can't speak, however, this phone number is his place of work and they asked it be removed after multiple calls from Waikato DHB
Patient was unsure or not whether they had missed an appointment. Lives in Te Awamutu. Father works in Auckland so is unable to get transport to the hospital.
Patient attended appointment and said it went well. Commented that Paeroa doctors were good.
Attended. Spoke to wife who was with her husband at appointment and found the process positive and straight forward.
Sick so was unable to attend appointment. Would like to reschedule
Had a follow up appt last week perhaps, unsure which department. Saturday appt was no trouble, food outlets and hot drinks are appreciated, and everything was "fabulous."
Wife is primary caregiver for husband. It would be ideal if a wheelchair were organised in advance of her husband's appts. Currently, she has to drop her husband at a point (he is disabled), then she has to quickly find a car park, then go looking for a wheelchair to mobilise her husband, then come back to her husband and get him to all of his appts on time. Unclear whether appointment was for wife who is listed as the patient.
Working. Continues to keep rescheduling for mornings but cannot get one.

Husband has phone
Not an engaging or customer/patient-oriented service. Mobility is an issue. Mail arrived after the appt date. He suggested a phone call reminder and he is keen on kaitiaki services or a liaison.
Post, wasn't delivering as was too hard to get to mailbox. This has since been sorted and patient has been attending other clinics (cardiology, oncology). Has had positive experiences.
Contact number is for mother. From mothers perspective patient refuses to go to his appointments. Mother has tried everything to get him to attend. Previous bad experience (his father died of diabetes and also had cancer so has negative experiences with the hospital) has resulted in complete lack of engagement – despite being severely unwell.
Patient could not recall details of missed appt, however, is happy with times and has no issues with transport or support in appts
Patient has moved
Patient called to ask what was happening with his follow up as he recieved no notice. He suggested secondary contact and call the doctor to let their patients know. Preferred email contact as active with email. - It's a long wait and a long drive for him. He has to leave home at 6am to get here by 10am find parking, wait around, and then still make his way home. He said it's about a 12 hour day before he gets home again. He complained that he gets hurt driving a long distance which means he has to leave earlier so he can allocate time
Had no transport in general to get to his appointment and doesn't want further appointments
She acknowledged her non-attendance, mentioned that she missed her apt because of the extent of her illness kept her from attending. She was given plenty of notice and reminder of the apt but she was in and out of the hospital due to her illness therefore she could not attend.
Patient identified that waiting time was horrendous. Wasn't worth the stress with her other children
Spoke to mother. Her daughter (patient) has new number and address
Talked to parent. Son no longer needed appointment.
Spoke to father, he wasnt too sure if the appointment was for him or his 2 year old son. His son got burnt a while ago, and hes had a stuffed up knee as well. So he will follow up regarding appt.
Deceased
Patient messaged in response to text and declined to participate.
Patient received letter but no longer needed appt so did not attend.
Patient has moved to Christchurch

Had a whanau issue and no longer needs appt
Patient is constantly at the hospital and is admitted at the moment and would like to get further support from Kaitiaki.
Mum rang to rebook as the date she was given, wasn't suitable for the whanau. However they did attended the latest scheduled appointment.
Spoke to daughter and wife of patient, he was unable to attend due to transport and would like some support.
Car was broken down.
Got the letter, couldn't attend because of her job commitments. She phoned, and got straight to the answer machine. No one to date has been in contact with her. She also mentioned that she received a discharge letter saying she no longer needed to attend any future appointments which made her feel like she was a tick box. *suggestion – answer the phone/respond to left messages
Toni said she attended her appointment and also mentioned that "they" (the hospital) said she doesn't need any further appointments.
She said she needs an appointment URGENTLY as her skin was growing over her stitching.
Contact number is for mother. Patient is now living with father
Mother answered call and provided patient cell phone number. Cell was uncontactable.

Health System Plan & Care in the Community Plan

Update to Maori Strategic Committee
19 Sept 2018

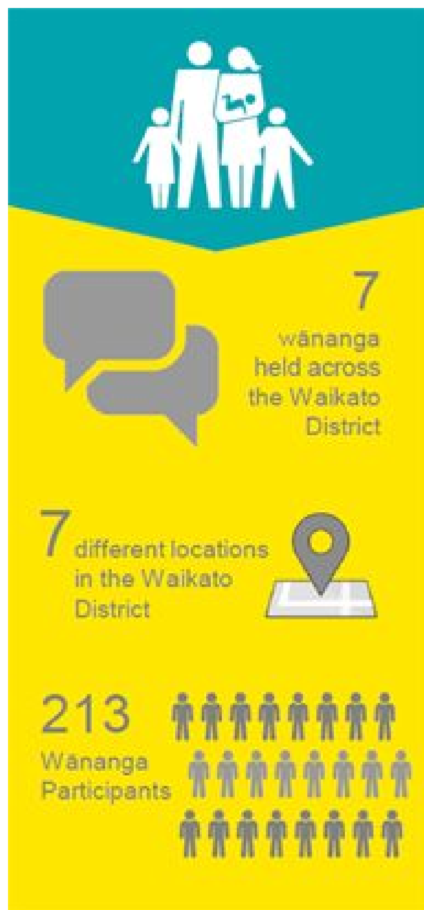
Waikato District Health Board

Engagement Process

- 7 wananga in the localities – EY Tahi led
- 6 focus groups with people from Hamilton, North Waikato and Taumarunui areas
- 9 in depth interviews with individuals from Hamilton, North Waikato and Taumarunui areas
- 7 provider engagement hui in localities
- Separate reports for each

Waikato District Health Board

Wananga Findings Report



- An additional rangatahi wānanga is being planned

Waikato District Health Board

What did we ask whānau?

The four key questions that the wānanga asked Māori health consumers were:

1. What would 'good whānau health' and 'a good health system' look like?
2. What stops the health system from being good for you and your whānau?
3. What are the priority issues / challenges?
4. How could health care services be improved to better serve your needs?

Waikato District Health Board

What would good look like?

Choice
Kotahitanga
Pono
Community
Targeted
Exercise
Training
Whakawhanaungatanga
Hope
Empowerment
Care
Proximity
Sustainable
Opportunity
Confidentiality
Ukaipo
Relationships
Safety
Private
Manaaki
Necessities
Holistic
Integrity
Healthy
Based
Food
Intergenerational
Coordinated
Whanau
Confidence
Aroha
Identity
Collective
Belonging
Reassurance
Korero
Active
Rongoa
Nurturing
Employment
Karakia
Marae
Approachable
Happiness
Laughter
Education
Respect
Nutrition
Adaptable
Tikanga
Patience
Comfortable
Tika
Awhina
Co-designed
Availability
Accountability
Assistance
Trust
Fitness
Simple
Aspirational
Kai
Ahi ka
Accessible
Quality
Independent
Navigation
Connected
Tailored
Environment
Reliable
Te Reo
Preventative
Free
Staff
Transport
Support
Timely
Whakapapa
Equity
Forgiveness
Wairuatanga
Mokopuna
Motivated
Understand
Maori
Housing
Technology
Warmth
Titiro
Affordability
Specialists
Funding
Whakarongo
Travel

Waikato District Health Board

Local wānanga themes

Community	Themes
Taumarunui	Improved transport options, acknowledgement and respect for tikanga and healthy housing
Thames	Improved guidance and information delivered by a local Māori workforce who show respect to health customers
Te Kuiti	Greater access to services, improved discharge and recognition of whanaungatanga

Waikato District Health Board

Local wānanga themes

Community	Themes
Matamata	Respect for Papatūānuku and tikanga Māori through kotahitanga
Hamilton	Support Māori to take health into their own hands, encourage and support healthy kai and deliver affordable health services
Huntly	Improved customer experience, lower costs and acknowledge and utilise rongoā Māori
Tokoroa	Locally based services, greater coordination and access to safe, affordable housing

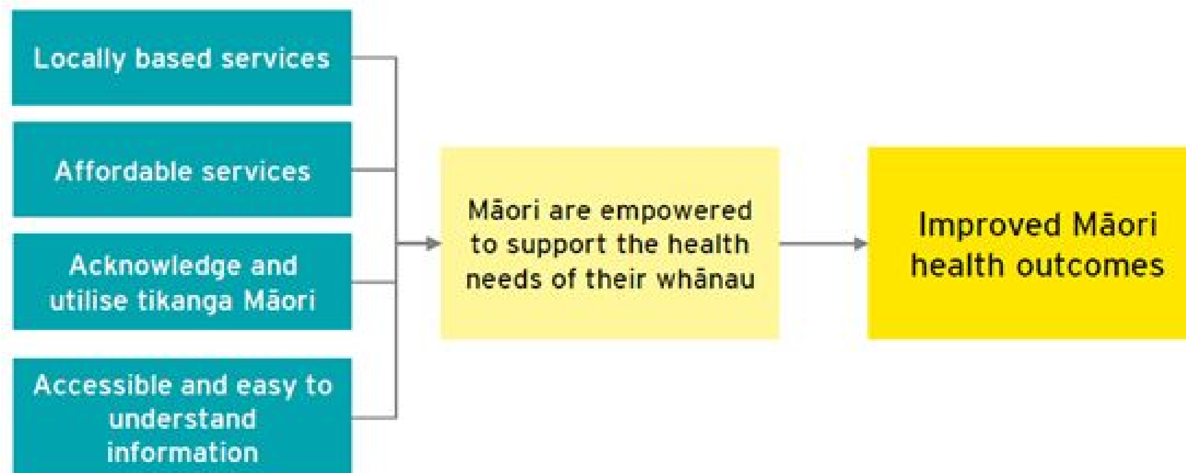
Collective wānanga themes

- Provide locally based services so whānau health is more accessible
- Good health is inaccessible because it is expensive (money and time); health services should be more affordable so whānau can prioritise their health
- The health system and staff need to acknowledge tikanga Māori: manaakitanga, whanaungatanga, kotahitanga, aroha and provide access to rongoā
- Accessing credible information is difficult: Māori need to know what help is available and want information that is easy to understand

Waikato District Health Board

Collective wānanga themes summary

The health system needs to be configured to support and empower Māori to achieve and maintain good health



Waikato District Health Board

Process from here

- Draft strategic options – collaborative process with Te Puna Oranga and others
- Locality hui to test options (mid-October)
  - Facilitated workshop
  - Consumer, providers, professionals
  - Invite people who have participated in earlier process
  - Open invitation
  - 7 localities
- Update IMC and Board
- Draft Care in the Community Plan
  - Roadmap
- Formal consultation in early 2019

Waikato District Health Board

Chief Executive Report

MEMORANDUM TO THE BOARD
26 SEPTEMBER 2018

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

Monitoring of Capital Projects

The Board at its last meeting briefly discussed (and sought advice on) the basis on which it might more effectively monitor capital projects.

Various options were proposed in the discussion at the time including using the Audit Committee, using a (re)established Capital Committee, and using the Board.

Our view is that in the first instance the first two options should not be pursued. Reasons for this are that:

- The Audit Committee was established to be the Audit and **Corporate** Risk Management Committee and to be more about audit than monitoring (although the two can overlap) and while it is not fatal to extend its brief for specific purposes it does seem sensible to maintain some consistent logic around its parameters just to avoid confusing ourselves if nothing else; and
- While the (re)establishment of a stand-alone Capital Committee might be sensible in the event of a capital project of the magnitude of the construction of the Meade Clinical Centre, we do not presently have a project of that size pending.

We do however have on our Board agenda a heading called **Significant Programmes/Projects** which was intended to be the place at which projects of significance to the Board would be reported. It seems appropriate to make that the point at which monitoring of significant capital projects occurs. In fact, it was envisaged at the time that we reviewed the committee structure that the Board would from time to time identify projects to be included under that heading.

Recommendation
THAT

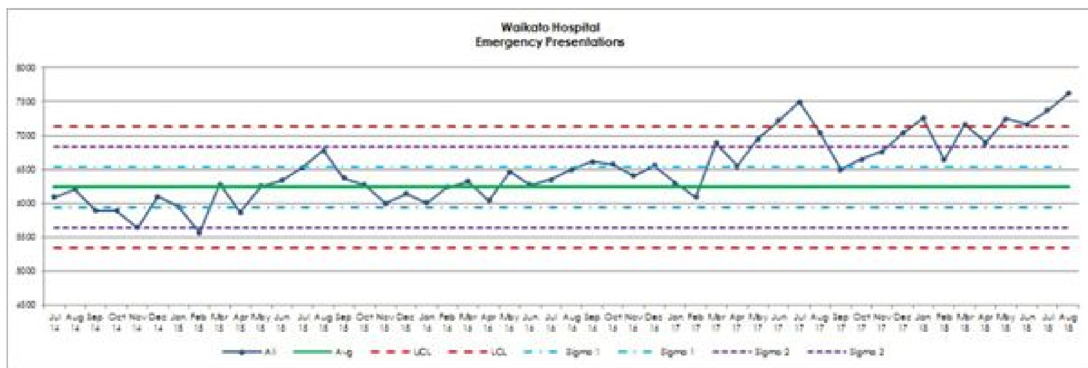
1) eSPACE, National Oracle System and the CBD Accommodation Project are included within scope of Item 12 of the Board agenda with reports to be submitted on a quarterly basis in respect of the first two items and every second month in respect of the last item.
2) The general approach is that if a capital item is required to be approved by the Board under the Delegation Policy, it will be reported upon under item 12 at a frequency to be determined on a case-by-case basis unless the Board resolves to the contrary (noting that some capital items may require Board approval but are very limited in project terms).

Waikato Hospital – Busy Month

First time in hospital history we have admitted over 8000 patient (episodes).

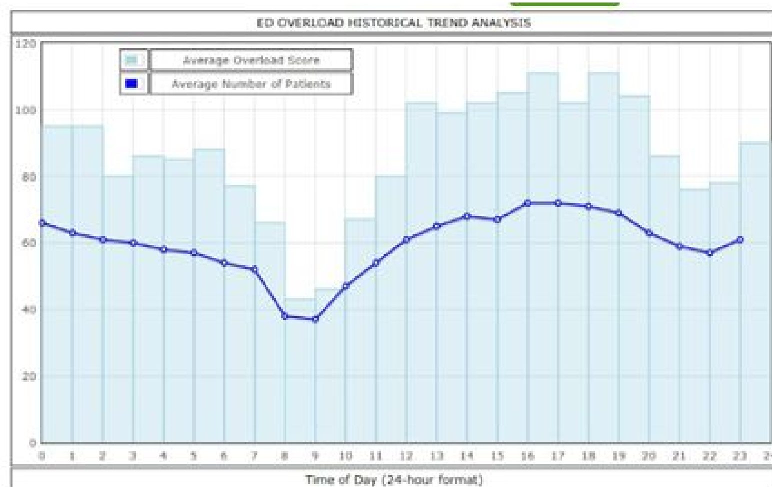
Emergency Department and Acute Medicine

Emergency presentations 8% greater than last August with the last four months now above the long run upper confidence limit.

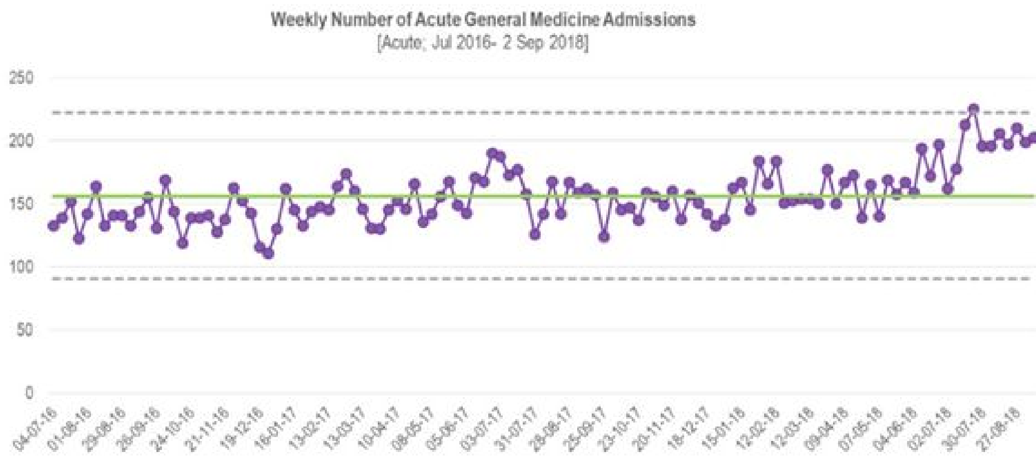


Accordingly the 6 hour Emergency Department overall compliance has fallen below 80% at times.

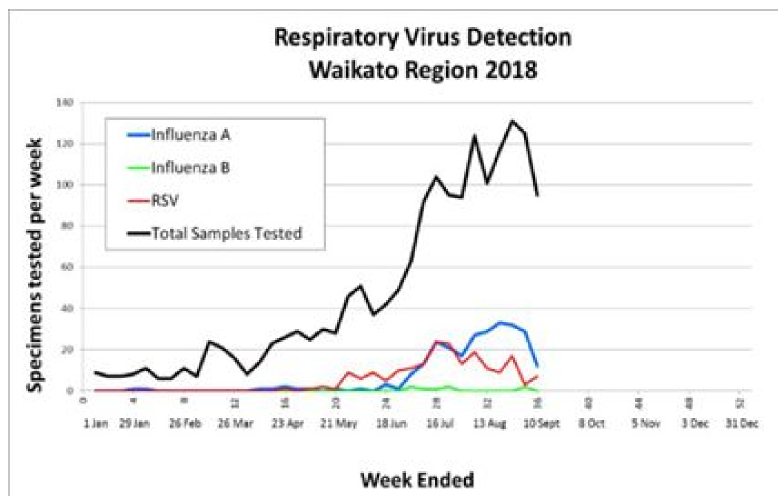
Emergency Department overload scores compared to last year for the same month are not worse, and may be better overall, despite the increased volumes, however this issue remains a significant challenge.



General medicine admissions is the most affected with a new normal of over 200 admissions a week for a sustained period.



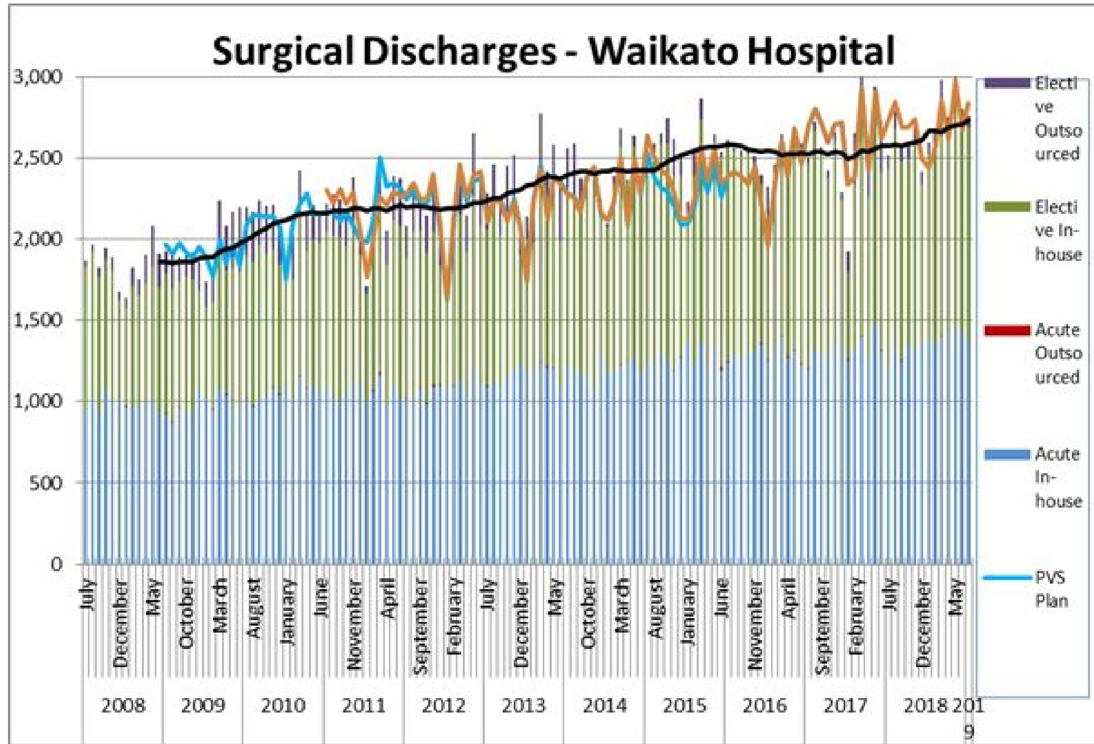
The comparison with the same period last year is notable. Clearly this year the peak is more sustained and mirrors the influenza presence across the Waikato.



The numbers of patients presenting with Influenza A is now declining but not yet absent.

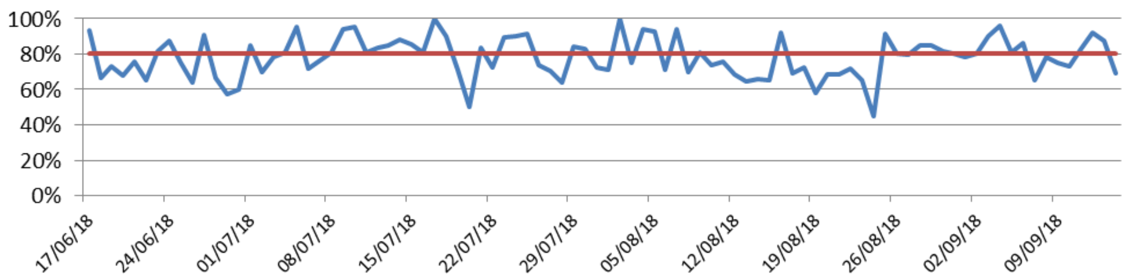
Surgery

Surgical volumes continue to increase.



Acute and Emergency Surgery

Overall our ability to meet our own standards of access to acute surgery are being met with reasonable regularity.



Elective Surgery

Still ESPI 2 and 5 compliant. Now six months in a row

MoH Elective Services Online

Summary of Patient Flow Indicator (ESPI) results for each DHB

DHB Name: Waikato

	2017			2017			2017			2017			2017			2018		
	Aug			Sep			Oct			Nov			Dec			Jan		
	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.
1. DHB services that appropriately acknowledge and process patient referrals within required timeframe.	16 of 26	61.5%	10	17 of 27	63.0%	10	15 of 27	55.6%	12	20 of 27	74.1%	7	11 of 27	40.7%	16	18 of 27	66.7%	9
2. Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	33	0.4%	-33	134	1.5%	-134	35	0.4%	-35	46	0.3%	-46	178	1.7%	-178	342	3.3%	-342
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	71	0.4%	-71	35	0.2%	-35	47	0.3%	-47	68	0.4%	-68	75	0.4%	-75	69	0.4%	-69
5. Patients given a commitment to treatment but not treated within the required timeframe.	37	0.8%	-37	43	0.9%	-43	59	1.3%	-59	43	1.0%	-43	72	1.8%	-72	82	1.9%	-82
6. Patients in active review who have not received a clinical assessment within the last six months.	3	4.0%	-3	9	20.9%	-9	8	14.5%	-8	0	0.0%	0	0	0.0%	0	0	0.0%	0
8. The proportion of patients who were prioritised using approved nationally recognised processes or tools.	1770	95.7%	80	1587	95.5%	75	1386	96.3%	54	1484	94.8%	81	1030	93.2%	75	1150	95.2%	58

	2018			2018			2018			2018			2018			2018		
	Feb			Mar			Apr			May			Jun			Jul		
	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.
1. DHB services that appropriately acknowledge and process patient referrals within required timeframe.	24 of 27	88.9%	3	13 of 27	48.1%	14	20 of 27	74.1%	7	6 of 27	22.2%	21	22 of 27	81.5%	5	19 of 27	70.4%	8
2. Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	23	0.2%	-23	29	0.3%	-29	17	0.2%	-17	23	0.3%	-23	22	0.2%	-22	28	0.3%	-28
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	53	0.3%	-53	47	0.2%	-47	46	0.2%	-46	33	0.2%	-33	39	0.2%	-39	36	0.2%	-36
5. Patients given a commitment to treatment but not treated within the required timeframe.	36	0.9%	-36	15	0.3%	-15	18	0.4%	-18	9	0.2%	-9	8	0.2%	-8	26	0.5%	-26
6. Patients in active review who have not received a clinical assessment within the last six months.	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0
8. The proportion of patients who were prioritised using approved nationally recognised processes or tools.	1416	93.6%	97	1679	93.7%	113	1220	93.1%	91	1820	95.0%	96	1547	93.2%	113	1140	[illegible]	516

Data Warehouse Refresh Date: 31/Aug/2018

Report Run Date: 03/Sep/2018

On-line Voting

The Board has previously discussed whether or not it should support on-line voting, recognising that there is no process under the legislation for District Health Boards to compel or veto a particular approach used by territorial authorities in conducting an election.

The general view at the Board discussion was that when it comes to new technologies it is perhaps best not to be first. Cost was also a consideration but it was not possible at the time to quantify what the additional cost of on-line voting might be.

Since then the Hamilton City Council has agreed to participate in an on-line voting trial. A request has also been received from Board members asking that the Board's support or otherwise of on-line voting be re-considered.

I am happy to prompt a further discussion on the subject through this commentary. Arguably this is a matter on which the Board is entitled to have a clear view even if it could also be regarded as a purely operational matter.

A number of random points to assist with discussion are as follows:

1) The regulatory framework to apply to on-line voting is not yet known and will not be known until January at the earliest. That framework will partly determine cost.
2) It is envisaged by the interested parties that an RFP will be conducted to identify who might conduct the election on an on-line basis. That in turn means:
    a. The incremental cost of on-line voting cannot be known until the RFP is complete; and
    b. There are potentially some significant practical hurdles to be overcome relating to the way in which the successful responder to any RFP is able to "bolt-on" their offering to the services provided by existing suppliers of election services who will continue to act for large parts of the country.

Given this relative dearth of information it may be that an "in principle" discussion is all that is possible at this time.

PHO Services Agreements Update

The following provides an update on the contract status of our PHO agreements following information to the Board in July 2018 about historical delays in securing signed agreements with PHOs. The PHO agreements are "ever green" but are renewed annually with most of the terms being negotiated nationally through the Primary Services Agreement Amendment Protocol (PSAAP) process. However, the flexible funding plans (FFP) are negotiated and agreed locally at the respective Alliance Leadership Teams.

Midlands' Health Network (MHN)

The 2017/18 agreement has been generated following extensive negotiation with MHN and our regional colleagues and was sent to MHN for signing on 6 September 2018. As for previous years, the 2017/18 agreement includes FFP for Lakes, Tairawhiti, Taranaki and Waikato DHBs. We are yet to receive the signed contract from MHN.

We are still in the process of negotiating the FFP allocation for the 2018/19 PHO agreement as are the other DHBs that are party to the agreement. We hope to reach agreement on the FFP in order to finalise the 2018/19 agreement by the end of this month.

Hauraki PHO

The Hauraki PHO's 2018/19 FFP was approved and finalised at the Hauraki PHO Alliance Leadership Team meeting on 6 September 2018. We are confident that the 2018/19 PHO agreement will be generated and signed by both parties by 30 September 2018.

Official Information Act statistics

The attached letter from the Director General of Health is for the Board's information.

Waikato DHB has completed more requests than any other DHB (with 172 requests, the next DHB on the list is Counties Manukau DHB with 144 request). We got 98.3% requests sorted within the legislated timeframe (three requests went AWOL) with nil Ombudsman decisions going against Waikato DHB.s decisions.

Beattie Varley Report – Lessons for District Health Board

Attached is a report by Beattie Varley Ltd that looked into management and governance decisions by Counties Manukau DHB. This report was released publicly by the Director General Health, Dr Ashley Bloomfield. Dr Bloomfield's letter is also attached.

This matter will be reported on more fully in October.

2019 Board and Committee Meetings Schedule

Attached please find a draft schedule for next year's Board and Committee meetings, which is submitted for Board member's consideration and input. An extra column has been added to the schedule for training and as placeholders for additional meetings that the Board may need during the year.

Recommendation
THAT
The Board receives this report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

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13 September 2018

DHB Chairs and Chief Executives
By email

Release of six-monthly Official Information Act 1982 statistics

As you will be aware, the State Services Commission publishes the public sector's compliance with the Official Information Act 1982 (the OIA) on a six-monthly basis. The latest release occurred on 5 September 2018.

The latest release shows that most district health boards (DHBs) are making good progress. However, there is also variable performance across the sector, and some DHBs are not meeting their obligations under the law.

The State Services Commissioner, Peter Hughes, has written to me to reinforce his expectation that the health system is collectively meeting its responsibilities around openness and transparency. Compliance with the OIA is a key part of ensuring the public has trust and confidence in our public health system. While I understand the pressure you are under to deliver on a number of fronts, we need to lift our collective performance in this area. The Ministry of Health is keen to support you to do this.

I have asked the Ministry's OIA management team to make themselves available to support DHBs as required. If you would like to discuss this, your key contact is the Acting Executive Director of my office, Monique Burrows. Monique can be contacted at Monique_Burrows@moh.govt.nz.

Thank you for your attention to this important matter. Please let me know if there is any other support that the Ministry can provide to you.

Yours sincerely

Dr Ashley Bloomfield
Director-General of Health

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5 September 2018

All DHB CEs and Chairs

RELEASE OF THE BEATTIE VARLEY REPORT – LESSONS FOR DISTRICT HEALTH BOARDS

Today I have publicly released the attached report by Beattie Varley Ltd that looked into a number of management and governance decisions by the Counties Manukau DHB (CMDHB) prior to 2017. I have carefully reviewed the report and consider it raises important matters for all District Health Board (DHB) Chairs and Chief Executives to attend to.

Openness and transparency in decision making are fundamental to our maintaining a strong and highly valued public health system. Public organisations like DHBs need to have the trust and confidence of New Zealanders and that means being beyond reproach. I know how committed DHB Board members and staff are to serving the public of New Zealand and it is in all our interests to ensure that this commitment is not undermined.

In 2017 Beattie Varley was commissioned by the Ministry of Health (the Ministry) to look at a number of historical governance and financial decisions by CMDHB. This followed concerns raised with the Ministry by the Board and senior management at CMDHB. Beattie Varley's review included consideration of:

- the approval process, involvement of the Board and the Ministry in capital decisions, and capital raising by sale and leaseback, of medical equipment for the $9.9 million building extension project to the Ko Awatea building at Middlemore Hospital;
- financial reporting for the APAC conference run by CMDHB; and
- remuneration and benefit decisions relating to some senior staff.

Beattie Varley looked at the relevant documentation and undertook a series of interviews with CMDHB staff to determine whether the appropriate processes were followed in a range of transactions. Importantly, from a controls and procedures perspective, Beattie Varley did not draw any conclusions of wrongdoing, or find there were matters that warranted further investigation by the appropriate authorities.

The review did, however, raise for me questions about the way we conduct ourselves in the health sector. The report points to a lack of openness and transparency in some capital expenditure decisions related to Ko Awatea and in the financial reporting associated with the APAC conference. It is these actions, and what could be perceived to be the deliberate construction of financial arrangements to avoid external scrutiny, that trouble me most. This behaviour does not meet the ethical standard that the public would expect of us and I do not consider it acceptable.

The review supports the concerns raised by the CMDHB Board in 2017 and its public comment on these matters earlier this year. Given there has been a change of personnel at CMDHB at both the executive and governance levels I do not intend to impose 'sanctions', e.g. a reduction in delegations around capital expenditure. Instead, I have referred the report to CMDHB to review

its findings, consider what if any further action it may need to take to resolve any remaining issues and ensure it has controls in place to avoid a repeat. This includes seeking further advice as appropriate.

CMDHB acknowledges the tenor of the report and has provided me with an assurance that it is implementing appropriate changes to policies and practices to ensure that taxpayers' funds are being expended consistent with the purposes for which they are provided, and that the management approach is now consistent with expectations in the State Services Code of Conduct.

The report identifies some issues that I would like all DHB Chairs and CEs to pay particular attention to. The review examined the threshold at which capital expenditure approval is required, and the need to engage the Ministry as it related to a specific building project. The rules and requirements for DHBs in relation to such projects are well laid out and I expect your teams to be clear about these. I expect Boards to ensure there is openness and transparency at all times in your consideration of significant amounts of public monies.

It is my expectation that all DHBs will pay close attention not just to what decisions are made regarding taxpayers funding of health services but also how these decisions are made. Any actions that give rise to the perception that DHBs are not acting responsibly in the expenditure of taxpayers' money are not acceptable as they undermine public trust and confidence.

I need to be able to assure Ministers that public funds are being expended appropriately and will take action where needed to ensure this is the case. I want you to err on the side of caution in informing the Ministry to ensure there is no question about appropriate disclosure.

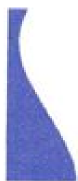
In addition, it is timely to remind you of the expectation across the wider public sector that sensitive expenditure, such as travel and expenses, is handled carefully and reported transparently. As the employer of the Chief Executive, it is particularly important that DHB Boards ensure that New Zealanders' expectations of their senior public servants are met. I will also pay close attention to these matters.

Finally, regarding remuneration and conditions for tier two DHB employees, many DHBs already have Board remuneration committees that can review matters regarding senior management remuneration, terms and conditions. Such committees support the Chief Executive in making these important decisions and also provide a level of assurance to the Board. I expect you to consider whether your arrangements are fit for purpose in light of this report and make any necessary changes to ensure your processes are robust.

I know you will agree that trust and confidence in public health services, and in particular the governance and management of DHBs, is critical and needs to be maintained if we are to deliver the services that New Zealanders need. I need your support to address any perceptions that arise that DHBs are not accountable. The Ministry will be able to assist you or your teams where you need support to understand or adopt appropriate responses to the matters suggested in the report and this letter.

Yours sincerely

Dr Ashley Bloomfield
Director-General of Health



Beattie Varley Limited

Financial Investigation - Forensic Accounting - Support for Litigators

23 July 2018

Michael Hundleby
Director Critical Projects
Ministry of Health
PO Box 5013
Wellington 6140

Dear Michael

Counties Manukau District Health Board – Forensic Review of Certain Matters

1. You have asked for a *snapshot* of where we are at in respect of the various matters we were asked to enquire into. This report summarizes the current position.

2. Since beginning our review we have received and considered many documents provided by the Counties Manukau District Health Board ("CMDHB"). We have interviewed various people within the organization. Unfortunately, the people that might have the most information have left the DHB. Current CMDHB staff members have been very helpful.

3. As agreed with you, we restricted interviews to people currently employed at CMDHB. There was one exception, Mr Bartrum, the former General Manager Human Resources. We have not spoken with former employees or former board members.

4. We turn to the matters that we are looking into.

Remuneration and benefits paid to Ron Pearson – former CFO/Deputy CEO

5. In June 2017 Regional Internal Audit ("RIA") conducted an audit of the remuneration, benefits and allowances paid to Ron Pearson, the former CFO. We understand that RIA identified areas where the reimbursement and benefits paid to the CFO were either unauthorized, unjustified or excessive. We have not focused on whether payments were excessive but have focused on whether payments were authorized.

6. We have not spoken with Mr Pearson or to his direct supervisor, the then CEO, Geraint Martin. Nor have we interviewed the then Chair of the Audit Risk and Finance Committee (a sub-committee of the Board) Wendy Lai or Dr Lee Mathias, the CMDHB Chair. From time to time, Mr Martin's EA had an involvement in remuneration documentation and communications (no doubt acting on Mr Martin's instructions) and we have not spoken to her.

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7. We have had access to an interview of Mr Pearson which was conducted by the RIA executive, Mr Manzano.

8. Based on the interviews that we have conducted, it seems that Mr Martin approved all the salary increases in respect of Mr Pearson and the cashing up by Mr Pearson of some of his leave benefits. Mr Martin was the CEO. He employed Mr Pearson. It would be unusual if a CEO were not authorized to approve an increase in the salary of a staff member. We have not identified any restrictions on Mr Martin by the Board that would limit his ability to approve salary changes.

9. For his part, Mr Pearson would be entitled to assume that any decision by the CEO in relation to his remuneration and benefits fell within the authority delegated to the CEO by the Board. Even if certain CMDHB policies were breached (and we will consider that shortly) it would be difficult to hold Mr Pearson accountable for any such breach.

10. With respect to the increases to Mr Pearson's salary from time to time, the concern of RIA appeared to be that a *"two-steps-up"* authorisation policy was not followed. This was a documented policy requiring any approval for a salary increase be authorized by a manager at least two levels up from the relevant employee. Some of the people that we have spoken with have interpreted the policy as requiring the approval of the employee's immediate supervisor <u>and</u> of the supervisor one-step up from him/her. We are not convinced that is an accurate interpretation as it appears to us that only one authority is needed, albeit that person being a manager two levels above the employee in question. In practical terms, we accept that an immediate manager is likely to be aware of and supportive of any proposed increase that they pass up the chain.

11. RIA was of the view that salary increases for members of the Executive Leadership Team ("ELT"), including Mr Pearson, required the approval of Mr Martin (as immediate supervisor) <u>and</u> the Board Chair (<u>or</u> the Chair of the Audit Committee <u>or</u> any board member with the appropriate delegation).

12. We have not been provided with any document or board directive that required the CEO to obtain the sign-off of a board member in respect of any salary decisions. As we said earlier, Mr Martin was the CEO. He employed the staff, including Mr Pearson. We do not know what interaction in respect of staff remuneration (if any) he had with the Board (i.e. the Chair and/or a delegated board member) or the Chair of the ARFC. Mr Martin may have kept the Chair informed on salaries paid to the ELT but there is nothing we have identified thus far, that made a board member's sign off a prerequisite.

13. We have spoken with Sam Bartrum, who was the General Manager, Human Resources from 2008 until 2012. Mr Bartrum gave some helpful insights into Mr Martin and Mr Pearson's interaction in respect of Mr Pearson's remuneration but most importantly was of the view that the '*two-steps-up*' policy did <u>not</u> apply to members of the ELT. He said that Mr Martin could approve salary increases for the ELT on his own, that Mr Martin did approve such salary increases, and that he (i.e. Mr Bartrum) was content to implement them.

14. In commenting on the two-steps policy, Mr Bartrum said that the CEO was the highest-level manager in the organization and so could, and did, sign alone. He said the policy did not contemplate the need for a board member to sign for any of Mr Martin's direct reports.

15. The policy itself refers to the approval of *"a manager at least two levels up"*. There is no mention of a board member needing to authorize in specific circumstances. Mr Bartrum's view (i.e. that the CEO was the ultimate signing authority for employee remuneration) is reasonable and we think, available to him. In the absence of a specific contrary interpretation, we think it is also available to Mr Martin.

16. The current acting CFO, Margaret White, said that the *"two-steps-up"* policy should have applied to ELT salary increases but did not think that it was generally applied in that way. She did not suggest that Mr Pearson's increases were authorized differently than any other member of the ELT. Mr Bartrum advised that ELT salary approvals were all treated in the same way.

17. Ms White pointed out that the relevant *Change Request* form only had a space for one signature. Not much turns on that but it does perhaps explain why the payroll people at Health Alliance were content to process salary increases with just the CEO's signature on it. Certainly, to our knowledge, no one at Health Alliance pushed back on a CEO-signed form because, in the case of an ELT increase, they were expecting to see a board member's signature.

18. It was drawn to our attention that in one instance in 2008, Mr Pearson appeared to have signed off on his own salary increase. Our preliminary view is that he did not. We think there is evidence that Mr Martin approved a number of salary increases before absenting himself (as CEO) for a time and that Mr Pearson signed the (offending) form as an administrative step while he was acting CEO, so that it could be sent to those implementing the salary changes. We have not spoken to Mr Martin or his EA, but we expect that those enquiries would confirm that Mr Martin approved, and was aware of, the salary increases signed off by Mr Pearson.

19. For the absence of doubt going forward, it might be beneficial for the policy in relation to salary variations to specify whether ultimate signing authority rests with the CEO or if some board participation is also required.

20. Mr Bartrum advised us that from time to time, Mr Pearson would seek to cash up some of his annual leave and other (study) leave and that in every instance it was approved by Mr Martin. He said that Mr Pearson would approach Mr Martin to cash up leave and that Mr Martin would then instruct Mr Bartrum either verbally, through his EA, or by email, to do it.

21. Mr Bartrum says he was aware that on some occasions the cashing-up would conflict with the relevant CMDHB policy (which restricted the amount of leave that could be cashed up) and that there was a risk that Mr Pearson might still be entitled (under the relevant legislation) to physically take leave that he had cashed-up but that he actioned the instructions anyway because they came from the CEO. Mr Bartrum believed the CEO could vary administrative policy if he thought it was appropriate. Mr Bartrum said that Mr Martin was aware of the relevant CMDHB policy and the risks under relevant employment law.

22. Mr Bartrum said that he would advise Mr Martin as to how much leave Mr Pearson had available to cash up including on at least one occasion that Mr Pearson was able to cash-up leave that he had not yet formally earned, and which resulted in Mr Pearson's leave balance going (temporarily) into a negative position. Mr Martin was content to proceed with Mr Pearson's request to cash the leave.

23. There is an email dated February 2010 that was used by Mr Pearson as proof (for Human Resources) that Mr Martin had approved relevant cashed-up leave. The narrative on the email does support Mr Pearson's assertion but the subject heading on the email is not specific to the cashing of leave.

24. Mr Pearson's position is simply that from time to time he asked for leave to be cashed up and that his requests were agreed to by the CEO. It is likely (and reasonable) that he would say that Mr Martin and Mr Bartrum are the custodians of any policy relating to his cashing of leave.

25. At one particular point in time Mr Pearson assumed the work responsibilities of a departing staff member. An electronic signature in Mr Martin's name was affixed to an approval for Mr Pearson to receive an extra allowance, in compensation for the extra responsibilities. On the face of things, it appears that the signature was properly affixed and certainly Mr Bartrum says he is comfortable with the transaction (and the use of an electronic signature), which he knew about at the time. We understand Mr Martin's EA was the custodian of the electronic signature and there is no reason to suggest that it was put on the approval form without Mr Martin's knowledge of the allowance.

26. There is another instance of Mr Pearson cashing up some educational leave in February 2011. We have not spoken with Mr Martin about this matter but there is email traffic between Mr Pearson and Mr Bartrum in which Mr Pearson advised that Mr Martin was aware of the request and that it be referred to Mr Bartrum. Mr Bartrum replied that he had yet to hear from Mr Martin on the cashing up but that he had no issues with it. The Change Request form submitted to Health Alliance contained the electronic signature of Mr Martin.

27. At this point, we have yet to complete enquiries into the receipt by Mr Pearson of an allowance relating to the use of a motor vehicle. We understand that an allowance was given to Mr Pearson to offset payments that he would need to make if he were to use a CMDHB car.

Remuneration paid to Jonathan Gray

28. We were asked to review certain issues concerning the remuneration of the Director of Ko Awatea, Jonathan Gray and in particular the funding of his position (as a professor) at Auckland and Victoria Universities. We have not spoken with Professor Gray.

29. Professor Gray commenced employment at CMDHB in November 2010. We understand that Mr Martin introduced Professor Gray to CMDHB and that Professor Gray went through an employment process that included a panel interview before being appointed Professor of Health, Improvement and Innovation at CMDHB. He

reported to Mr Martin. We have requested more information from CMDHB regarding the recruitment process for Professor Gray but CMDHB is having difficulty locating any relevant material.

30. Professor Gray's initial contract set out an initial gross salary but stipulated that he was employed in a 0.75 FTE position (i.e. working 60 hours in every 80-hour fortnight) so would be paid 0.75 of his contracted salary.

31. It seems that the FTE deduction from 1.0 FTE to 0.75 FTE reflected the expectation that Professor Gray would work at Auckland University (as a Professor) for up to 20 of the 80 hours per fortnight and that the University would remunerate Professor Gray on the basis of a 0.2 FTE. Gloria Johnson, the current CEO of CMDHB, says that is her assumption as well.

32. There are two questions in respect of Professor Gray's remuneration:

    a. The first is why Professor Gray's FTE was changed from the 0.75 FTE factor to one of 1.05 FTE. This occurred on 1 July 2011 and remained the FTE through to his departure from CMDHB. It meant that CMDHB was paying Professor Gray 105% of his contracted salary at the time.

    b. The second question relates to the funding of Professor Gray's (university) FTE once he left his Auckland University position and took up a similar posting at Victoria University. Victoria University paid Professor Gray (the 0.2 FTE remuneration) but was then reimbursed by CMDHB. In reimbursing the University, CMDHB was expending 1.25 FTE (i.e. 1.05 FTE + 0.2 FTE) in respect of Professor Gray.

33. On 1 July 2011, Professor Gray's FTE was adjusted from 0.75 to 1.05, meaning from that date he received 105% of his contracted salary amount. On various occasions (including on 1 July 2011) Professor Gray's salary was increased and the 1.05 FTE factor then applied to the increased amount. We note that Mr Martin approved the increases without any two-step authority process, i.e. the same practice as for Mr Pearson's increases.

34. At present we have been unable to locate any written authority or documented reasons for the change in FTE factor. There is nothing on Professor Gray's personnel file in respect of the FTE increase. We do know, from documents obtained, that the change occurred and was implemented by the payroll personnel.

35. Mr Bartrum has little if any specific recollection of the change but suspects he was involved in its implementation. There is email evidence that Mr Bartrum's EA interacted with Health Alliance in processing the change in calculation of Professor Gray's remuneration. Mr Bartrum suggested to us that the FTE factor increase might have been to reflect a different *"job-sizing"* by which he means an increase in job responsibilities. Apparently, this was something that occurred at CMDHB from time to time, as it does in a range of organizations.

36. Professor Gray certainly knew of the change because he sent an email (one in reply) to Mr Bartrum's EA asking whether she had received the email exchange between Mr Martin and Mr Bartrum that confirmed CMDHB picking up *"my extra time and*

salary". In the same email, Professor Gray referred to Mr Martin having agreed *"verbally"*. Mr Bartrum's EA replied that she did not have the email trail but the EA to Mr Martin (who was copied on the email) replied that she would *"discuss with Geraint next week".*

37. Given the involvement of his EA, it appears likely that Mr Martin was aware of the increase in the FTE factor.

38. If the increase to FTE was a job sizing adjustment or the recognition (say) of a greater role or responsibility than was envisaged when the original 0.75 FTE factor was set, then that increase would not impact on the matter of his 0.2 FTE remuneration that was to come from the University. To put this another way, it would be wrong to simply assume that the increase in FTE was to compensate for a situation whereby Professor Gray was ending his work at the University.

39. When he commenced at CMDHB, or shortly thereafter, Professor Gray was appointed to the position of Professor at the University of Auckland. The position was established at 0.2 FTE. Presumably his 0.75 FTE from CMDHB and his 0.20 FTE from Auckland University comprised his (nearly full time) employment arrangement (of 0.95 FTE).

40. There is some reference in documents to *The Stevenson Trust* (on behalf of Auckland University) meeting the cost of the remuneration to Professor Gray. That trust is apparently involved in providing funding for the University and to CMDHB (for unrelated matters). We have yet to establish exactly how the Auckland University was funding Professor Gray and who bore the ultimate cost.

41. After approximately two years at the University, on 4 October 2012, Professor Gray resigned from Auckland and accepted a position of Professor at Victoria University, for a term of three years.

42. We have located a letter, dated three years later, i.e. 12 October 2015, from Mr Martin to the Dean of the Victoria University Business School which included the following statement:

> *"As you are aware, we are able to continue to support the 0.2 FTE appointment of Professor Jonathan Gray to VUW for a further period of three years. Our original proposal in 2012 when that arrangement was established was to provide further funding to support Professor Gray's work. This has taken some time to arrange but we are pleased to let you know that we are working with the Middlemore Foundation to support new positions within the HSRC…. $150 p/a for three years will be available to support these positions and this funding will also support travel between Wellington and Auckland for the researchers to regularly meet."*

43. Mr Martin followed that up with a letter of 6 November 2015 which said:

> *"I am therefore writing to confirm that Counties Manukau District Health Board will cover the directly related salary costs of the 0.2 FTE three year employment arrangement between Professor Gray and Victoria University of Wellington. The maximum amount payable by CMDHB towards these costs will be a total of*

> s 9(2)(a) *over the three-year period. Payment will be made by CMDHB quarterly in arrears, within 30 working days of receiving an appropriate invoice from VUW."*

44. It seems clear that CMDHB was to fund the cost of Professor Gray's position at Victoria University and that the CEO, Mr Martin, was aware of it. We have obtained the invoices issued by Victoria University to CMDHB and have confirmed that, from the beginning of the arrangement, Victoria University paid Professor Gray (the 0.2 FTE remuneration), then rendered invoices for that expenditure to CMDHB, and that CMDHB then paid them. Mr Pearson signed off on the payments.

45. At present, CMDHB has been unable to locate anything in its records that explains the arrangements concerning Professor Gray, Auckland University and Victoria University including why CMDHB was prepared to meet the cost of (at least) the Victoria University Professor's position.

46. There is some email correspondence from Professor Gray to the finance manager of Ko Awatea (copied to Mr Martin and Mr Pearson) explaining that the salary recovery for his academic appointment was being charged to Ko Awatea (Professor Gray was the director of Ko Awatea) and that if funds were recovered (from either the Stevenson Trust or from Auckland University) he would like that recovery credited to Ko Awatea. He wrote the following email to Mr Martin:

> *"Geraint, can I please ask for your help with a letter that formally agrees the underwrite of my day a week at Victoria – as it does feel precarious, and dependent on your good will that we carry the risk. I am conscious that other CEO's may not be so imaginative… If the above is not possible, I would like to discuss alternatives including becoming full time at Counties, to guarantee my full time working."*

47. It seems clear from this correspondence that Mr Martin was aware CMDHB was underwriting the 0.2 FTE cost of Professor Gray's remuneration (and it follows had approved it) but that the arrangement (at least in Professor Gray's view) was not formalized in a manner that Professor Gray thought might withstand a change in CEO.

48. Further, it seems clear from the correspondence that Professor Gray was not full time at CMDHB, suggesting that the FTE increase to 1.05 FTE (discussed earlier) was not because he had given up his University post.

49. We also refer to a paper written by Professor Gray in April 2015 entitled *"Clarification on the status of work relating to the Stevenson funding of Professor Jonathan Gray"*. Our reading of the paper suggests it is possible that the Stevenson Trust was funding the arrangement with the University of Auckland but that once Professor Gray resigned and went to Victoria, that CMDHB covered his entire salary (including the 0.2 FTE). The paper suggests that the Victoria arrangement was pursued so that Professor Gray could retain a position as Professor. Professor Gray wrote:

> "*Counties still paid my salary, but a small part was routed via Victoria University and then to me so that they could offer me a professorial title….*

"UoA last paid me late in 2012. I then worked on half salary for some weeks. When I announced this, I was humbled that CMDHB offered to pick up all my salary and continue my employment full time".

50. The last two sentences do not appear to reflect the payroll records of CMDHB which show that Professor Gray was paid for 84 hours per fortnight from 1 July 2011, i.e. not on half salary. We have not pursued this.

51. We understand that it is not unusual for an employer to bear some or all of the cost of an academic position if it is believed that the position brings value to the employer and/or its employee and in the situation where third party funding cannot be secured. It appears that third party funding was obtained for the Auckland University position but that third party funding could not be secured for Victoria so was borne by CMDHB.

52. We are unaware of whether the arrangements relating to Professor Gray's University remuneration were brought to the Board or needed to be. Nothing has been provided which suggests the circumstances surrounding Professor Gray could not be handled within the authority of Mr Martin.

53. The documentation concerning the 1.05 FTE increase and the reimbursement of the 0.2 FTE has not been located. Obviously, it is preferable to establish a full and transparent record of such information at the time that these decisions are made.

54. We understand that Professor Gray is now resident in the United Kingdom.

Accounting for the APAC Conference

55. We were asked to consider the appropriateness of the financial reporting for APAC conferences run by CMDHB, and to comment on any omission of conference costs from the reported conference results.

56. In May 2017 the ELT endorsed the tabling of a paper at the Audit Risk and Finance Committee meeting and which concerned APAC conferences from 2012-2017. The paper explained the history of the APAC conferences and included a financial summary of performance against budget for the 2014-2016 years. It also presented the budget for the yet-to-be-held 2017 conference.

57. The Chair of the Audit Committee asked RIA to conduct an audit to validate the 2016 reported profit (of AUD $55,216). RIA completed its audit and concluded that the reporting of a surplus was inappropriate, as the forum had run at a deficit. RIA provided its estimate of the deficit but said that its estimate of a deficit was likely to increase if further work and enquiries were made.

58. RIA was of the view that Ko Awatea management authorized certain adjustments to show a favourable result. In reaching this view it referred to a November 2016 email involving Ko Awatea senior financial and conference staff in which the Ko Awatea Commercial Lead instructed that certain specified costs were to be excluded from the accounting for the 2016 forum because *"we need to show a favorable result for this year's APAC".*

59. We have not undertaken our own reconstruction of the financial results of the 2016 APAC forum, or for the 2014–2015 conferences. However, the current CFO recently led a team that reviewed and recalculated the results. Her team relied on adjustments initially identified by the RIA and came up with the following results: For the 2014 conference, the reported surplus of $91,087 deteriorated by $397,167 to become a $306,080 deficit; For the 2015 conference, the reported surplus of $131,218 deteriorated by $321,099 to become a $189,881 deficit; For the 2016 conference, the reported surplus of NZ $60,017 deteriorated by $535,936 to become a $475,918 deficit.

60. Our enquiries have in the main focused on how the APAC figures were compiled back in 2014-2016. It appears that APAC costs and revenues were captured in the wider CMDHB accounting system but were not necessarily separated in (say) an APAC sub-ledger within that wider system. Instead, the figures needed to assess performance were manually extracted by the Ko Awatea Finance Manager and then incorporated into a spreadsheet.

61. The revenues earned did not reflect the participation-fees paid by attendees. Rather a formula was applied to arrive at a Revenue number – essentially taking the number of attendees and multiply this by a nominated participation fee. The potential problem with that approach was that none of the CMDHB attendees paid to attend and so the figure for Revenue would not reflect cash in the door.

62. The inclusion of costs on the spreadsheet (at least on their initial extraction from the wider ledger) relied on the judgment and accuracy of the person extracting the data, and on any instructions he/she had been given as to what costs to include and what to leave out.

63. We have spoken with the Ko Awatea finance manager who maintained the spreadsheet. She reported to the General Manager and provided financial updates, including to the Director, Professor Gray. Monthly meetings were held in respect of APAC matters. We have not interviewed the senior Ko Awatea executives that attended these meetings (and who were involved in relevant APAC emails).

64. The finance manager said it was clear to her from her discussions and meetings with the Director and General Manager that APAC's objective was to at least break-even, and preferably, to show surpluses. She said the focus of monthly APAC meetings was how to deliver those surpluses. In saying this, she was not referring to any discussions on the manipulation of results, but rather on how the participants could make the conferences successful.

65. As the costs of an annual conference were incurred, the finance manager would advise the General Manager as to how they were tracking against agreed budgets. She said she regularly advised the General Manager that actual costs exceeded budgeted costs and that a deficit could or would be incurred. She said that sometimes there would be discussions (involving her, the General Manager, and the Commercial Lead) about transferring APAC costs to other Ko Awatea cost centres. She said it was those two people who would instruct her what costs would be transferred. We take this to mean which costs would not be included in the APAC spreadsheet as part of the performance calculations.

66. We have not established the reason why certain costs would be excluded from the spreadsheet and instead left in other Ko Awatea cost centres. It was either done because these costs were more appropriate to other Ko Awatea cost centres or done to manipulate results.

67. We have been advised that APAC results were provided to the ELT and the Board. We interviewed a member of the ELT (NB we have not spoken with the entire ELT). He said that both Ko Awatea and APAC were *"very close to Mr Martin's heart"*. He said:

> *"there was pressure to paint a good picture about those. If anyone questioned their performance [Mr Martin] would say "get back on the bus". For example, my doubts as to the accuracy of the APAC financial reporting in 2016 was at a meeting. [Another ELT member] raised the issue (supported by me) that the report must contain some false accounting in respect of the number of staff attending and the income and expenses. Geraint was not happy with this being raised at ELT. He came to my office about six times after that meeting to complain about me having raised those concerns. He did the same with [the other ELT member]".*

68. We have not spoken with the General Manager or Commercial Lead who instructed the Finance Manager to exclude certain costs from the spreadsheet/reporting. They are both involved in relevant email traffic. An interview of them would likely establish why they decided to exclude costs and if there was a reason, other than manipulation, for doing so.

69. Clearly there is a significant difference between the figures presented back in 2014 to 2016 and those re-calculated by Margaret White's team. We suspect both sets of figures will contain value judgments as to inclusion or exclusion. As we have noted, we have not completed our own reconstruction.

70. It does seem that the results of APAC conferences were compiled through a manual selection of data and of course it is possible that the drive to report successful outcomes may have influenced how costs were selected for inclusion or omission. We cannot say if such an influence led to an inappropriate accounting for costs, but it is a possibility. An accounting system that removed the need for a manual extraction of APAC results would have been more reliable (because it would remove the potential for error and judgment) and a more-complete record of how the numbers were constructed would provide a more reliable basis for APAC performance to be assessed.

71. The finance manager says costs were omitted. The relevant emails show some being excluded. The rationale for their exclusion is the key issue, in light of the reconstruction by RIA/Ms White's team showing results significantly and consistently different from those presented to the Board.

Ko Awatea II – Expansion Project

72. We were asked to review certain approvals and processes employed at CMDHB in respect of the Ko Awatea II Expansion project and consider whether the required authorisations were obtained for each step. We were also to review whether the extent of funding required was disclosed in an appropriate manner.

73. We were asked to consider the sale and leaseback agreement with MCL Capital (that was the funding method settled on for the project) and ascertain if the arrangement complied with CMDHB policy and whether the costs were properly accounted for and disclosed.

74. We have looked at documentation relating to the expansion project including papers submitted to the CMDHB board. However, we have not spoken with many of the people involved with the approvals process or the preparation of the information that went to the Board.

75. We have spoken with Braedon Makgill who was appointed Acting Commercial Lead at Ko Awatea in early 2016 while the permanent Commercial Lead was on maternity leave. On her return Mr Makgill remained as project manager/commercial lead reporting to the Commercial Lead. Later he reported to the project steering group and advises that 95% of his interactions were with the CFO, Ron Pearson. Mr Makgill still works at CMDHB.

76. In late 2015 papers relating to the Expansion project (along with estimates of cost) were prepared and submitted to the Audit Risk and Finance Committee and then, later, to the full board.

77. Mr Martin and Mr Pearson prepared a paper for presentation at the ARFC meeting on 11 November 2015. Their paper included; advice on the options that were available in respect of the build, a feasibility plan, and a total-cost summary.

78. Included with this paper was one dated 3 November 2015 and prepared by Mr Mackellar of Jasmax (Architects and Design Consultants). The Jasmax paper provided various build options and costs and, importantly, included references to various items (named "exclusions") each of which was included in the cost summaries, but given a zero cost value. Exclusions included items such as *'Services Infrastructure', 'Escalation', and furniture, fittings and equipment ("FFE").* The Jasmax paper also stated that the total capital budget could not exceed $10,000,000.

79. The Jasmax paper offered two pricing options (one costing $15.94m and one costing $7.620m) and included a total-cost summary (prepared by Quantity Surveyor RLB) that estimated a total cost of the wider project at $18.51m. The RLB summary provided a breakdown of various costs for each option and identified twelve "exclusions" – this time for items such as those mentioned above but also for *piling, vending machines, printers/copiers, computers and artwork*.

80. In our view, anyone reading the material that was presented to ARFC could see that the wider Expansion project would cost far more than $10 million and that a phased approach was being considered to bring the current phase under that amount. A reader would also see that some costs, for tangible or intangible assets/expenditure, included on the costing summaries had been labeled "exclusions" and been given a nil dollar value.

81. Mr Martin and Mr Pearson's recommendation was clear that *"the various options are still under active consideration to ensure the final proposal is within the capital funding cap to be approved by the board".*

82. The minutes of the ARFC November meeting record that the papers would be referred (with an ARFC endorsement) to the 2 December 2015 CMDHB Board meeting. Acknowledgement was made that the final proposal would be within the $10m capital funding cap able to be approved by the Board.

83. The CMDHB Board met on 2 December 2015. The papers provided to the ARFC meeting were tabled. We have still to determine when the board pack was distributed to board members but we are advised that usually happened in the week before the Board's meeting.

84. The business case presented to the Board sought approval for $9.9m of project expenditure, which incorporated the $7.62m option (above) and some specified project enhancements, on the basis that the enhancements could be designed to fit within a $10m financial cap.

85. The CMDHB Board resolved to *"approve the intent to support the expansion of Ko Awatea"* subject to remaining within the $10m delegated authority limit of the Board. The wording of the resolution is a little confusing *("approve the intent")* but the board wanted whatever it was approving to remain within a defined dollar (i.e. $10m) limit.

86. The Board also noted the recommendations and endorsement of the ARFC committee and approved that *"the CEO and CFO to negotiate the funding source for this approval, noting that since the ARFC meeting two options had been confirmed as options to fund this proposal ...".* We will return to this aspect later.

87. In February 2016 Mr Makgill was instructed to prepare a further paper on the Expansion project and it was presented, under the name of Jonathan Gray, at the February Board meeting. This paper recorded that additional work had been undertaken since the December Board meeting and summarised the intended way forward. It also provided a revised costing of $9.895m.

88. Mr Martin and Mr Pearson presented that paper to the Board and the minutes record Mr Pearson's advice that the paper had been *"peer reviewed and discussed with a wide range of people before confirming the plans, and what was previously put to the Board. This has been future proofed to enable the ability to extend, etc."*.

89. The Board resolved to receive the paper, noted the redrafted use of building space, the new teaching & learning space, and the updated capital cost of $9.895m. Mr Makgill said that after the Board meeting, Professor Gray told him *"we were good to go, we've got the approval to proceed."*

90. On the assumption that the various items included within the project papers and forming part of the $9.895m (even if costed at a zero dollar value) captured the proposed work, there does not seem to be any deception of the Board. The Board certainly had knowledge that the wider project was going to cost significantly more than $10m and that a phased approach was being submitted for approval. The Board was also on notice that there were items that were part of the project (called "Exclusions") that were being presented at a nil value in the cost totals.

91. If those Exclusions should have been included at a dollar amount (i.e. at other than zero) there is nothing that records such advice being given. Nor is there any evidence that Board members sought any clarification about Exclusions or asked why they could legitimately have a nil dollar value in the proposal up for approval. There may be a valid reason why those preparing and submitting the papers have included Exclusions at a nil value but that is yet to be determined. In any event it must have been clear to the Board that the inclusion of Exclusions had not changed the overall cost attributed by those who were submitting the proposal.

92. Mr Makgill thinks that certain costs were excluded when they ought not to have been. He says that certain items were needed to make the buildings functional and that these should have been included in the costings. Further, he says that he queried Mr Pearson as to why Fixtures, Fittings and Equipment ("FFE") were included (within "exclusions") at a nil cost. According to Mr Makgill, Mr Pearson advised,

> *"Construction costs were all that we were after at the time so don't worry about including them. Leave it out of this cost schedule and we will worry about it later."*

93. Mr Makgill said that Mr Pearson decided which project costs should be included and which would be excluded. He said there were discussions at keeping the cost at $9.895m, i.e. the figure that had been approved by the board. He said that he did not know about the $10m [cap limit] at that time. He said that items were excluded from the RLB schedule in order to not go over the $9.9m but that it was still intended that these things were built.

94. Mr Makgill considers that five significant items were omitted. They are (1) Services infrastructure Upgrade (2) Escalation (3) FFE (4) Piling and (5) Finance Fees and GST. He says he does not know why they were left out of the costings but advised that RLB and Mr Mackellar of Jasmax might be able to assist. We have not spoken with Jasmax or RLB.

95. If Mr Makgill is correct in what he says, then there may be an issue with the papers put before the board. Of course, Mr Makgill may have misunderstood and misinterpreted what he was told and, as we have said, we have not spoken with Mr Pearson or the people from Jasmax and RLB.

96. A Capital Expenditure Request for $9.985m dated 29 July 2016 was signed by Mr Makgill and passed to the General Manager – Projects for Ko Awatea on 11 August 2016. Two weeks later Professor Gray signed, followed by Mr Pearson and Mr Martin. On 7 September 2016 the Board Chair, Dr Lee Mathias signed. After Dr Mathias had signed, a steering group was established to manage the procurement processes, including the identification and appointment of a main contractor.

97. The CMDHB Board was informed at its November 2016 meeting that the project had progressed well, with Leighs Construction (working alongside Jasmax) engaged as the contractor to deliver the design and a guaranteed maximum price, which was currently in the process of being worked through. Site works were to commence in December 2016.

98. Mr Makgill signed an agreement (a letter of acceptance) with the main contractor in March 2017. He says he did so on the instructions of Mr Pearson. At interview with RIA, Mr Pearson denied that he so instructed Mr Makgill.

99. The construction contract itself remained unsigned (it required Mr Martin's signature) on 24 April 2017 when Gloria Johnson became the CEO. However, by then, construction had commenced, and some payments had already been made to Leighs Construction. s 9(2)(h) the Board noted (in June 2017) that there was an obligation to sign the contract, notwithstanding some discomfort and concern around the processes employed.

100. s 9(2)(h)

101. We have spoken with Margaret White. In her opinion the proper process for the consideration and approval of the Expansion Project business case was not followed. She says the correct process required the completion of a BBC Lite Template Document and consideration by the Executive Leadership Team. Ms White also contends that the funding for the project was not properly processed or considered. She refers to Section 3.2.3 of the CMDHB Manual under *"Decision Making Structures"* says *"All decisions and advice to the board must be endorsed by ELT prior to submission."*

102. We note that the CEO, Mr Martin, the CFO, Mr Pearson and the director of Ko Awatea, Professor Gray, were on the ELT and would have played a major part, and had a major influence, on any consideration of this CAPEX proposal by the wider executive team. The matter was not brought to a formal ELT meeting.

103. The December 2015 Board Minutes record that the Board considered two options for funding the project. One option was to use existing CAPEX budgets (at $5m per year over a two-year build) and another option was the sale and leaseback of operating assets. The paper presented to the Board meeting (by Mr Martin and Mr Pearson) noted that the first option would depend on the priority given to competing capital requests and that the second option had been negotiated and prepared in draft. It required further discussions and negotiations to ensure it (i.e. that option) was viable.

104. The Board approved the CEO and CFO negotiating the funding source for the project (which it called *"this approval")* while noting the two options available to complete the funding.

105. Mr Pearson advised RIA that he considered this minute was the board's approval to go ahead with both the project and the sale and leaseback agreement. He said, "*The Board Chair had said, "Make it Happen"".* He also said that while the board minutes were not completely clear, the Board had authorised the arrangement.

106. We have not spoken to Dr Mathias or Ms Lai or other members of the Board to see if they agree with Mr Pearson that the project had been approved (subject to it being under $10m) and that the required funding was being left to the CEO and CFO to organize. In our view the minute of the Board could be read as approving the concluding of an agreement for the sale and leaseback option – at the very least *"negotiating"* is a simile for *"settling"* – but that remains to be determined.

107. It is also possible that in presenting two options for funding, with the first being subject to other competing capital requests, and the second having been negotiated in draft, that the Board was in substance being asked to adopt the second option over the first. In approving the CEO and CFO to negotiate the second option, the Board might have conveyed that it had settled on the sale and leaseback. That certainly appears to be Mr Pearson's position.

108. The CMDHB policy No. 21 in respect of Capital Expenditure requires (at Note 5) "*Capex proposals over $10 million ($0.5million for I.T. projects), whether funded internally or externally, must go the National Capital Committee*". It is clear that the CEO and CFO tabled papers to the Board that set out costs (for the wider project) of in excess of $10m and made it clear of the phased approach. Any failure to refer to the Capital Investment Committee sits with the Board, which had the information before it.

109. The same CMDHB policy No. 21 stipulates that there is a $200,000 limit on the CEO approving the leasing of assets. It is Mr Pearson's position (and likely to be Mr Martin's) that the Board had approved the leasing option. That would make it difficult to successfully assert that policy 21 had been breached by the CEO/CFO.

110. Further, CMDHB policy No. 20 "Finance – General" says that approval for the sale or disposal of an asset over $100,000 must be by the ARFC. We note the same observation as in the paragraph above. That is, that if the CEO/CFO thought the full board had approved the sale and leasing option they could not be said to be acting outside their authority.

111. We also made some preliminary enquiries into the Ministry of Health's Capital Investment Committee ("CIC") rules around capital investment. We have not spoken to anyone from the CIC or put the proposal as tabled to the CMDHB Board to a CIC member for comment.

112. The CIC rules say that the criteria for the CIC's involvement include investment in projects where one or more of the following applies:

    a. Capital expenditure of $10m
    b. Capital expenditure of $10m calculated as the capitalised value of future revenues if financed from these revenues (such as a finance lease)
    c. Etc.

113. It seems likely that breaking a larger capital project into sub-$10m phases would not be an acceptable reason for failing to submit a significant project to CIC for approval. There may be a grey area depending on what capital development might be genuinely contemplated at a given point in time and whether an intended project could be later developed and added on to in the future but we doubt that the Ministry intended that its approval of significant expenditure could be defeated by breaking a large project up into sub $10m phases.

114. It is unclear to us whether all the expenditure needed to make a project functional should be included as part of the total cost and is therefore a factor in whether CIC approval is needed. CMDHB included certain items as “Exclusions” and at a nil value in its costings. It seems a stretch to count expenditure at zero, particularly if that was done to bring a project under an arbitrary dollar amount.

115. We also suspect that CIC would consider the financing costs of a project to be an integral part of the amount to be approved. If a project that is estimated at less than $10m requires third party funding then there is a cost to that money. It is difficult to see why such costs would not be a part of the overall consideration.

116. If the CIC believes that any or all of the above points required the project to be submitted to it, then there may have been a failure at CMDHB to follow the proper process. Such a conclusion would be subject to CMDHB’s understanding of when a CIC approval was required.

117. It may be appropriate for the CIC to ensure that its rules / policies are easily understood and not exposed to an easy misinterpretation.

118. There is nothing in the CMDHB Board minutes we have seen that identifies any discussion on whether the project ought to have been referred to the Ministry for approval given the proposition before the Board was one that sat within a wider project which would cost more than $10m.

119. There is nothing in the Board minutes we have seen that identifies any discussion on why a number of items clearly part of the project (i.e. the Exclusions) were costed at zero dollars and the impact, if any, this might have on ultimate expenditure or the need for Ministry approval.

120. There is nothing in the Board minutes that identifies any discussion on whether a financing option that involved a third-party funder would escalate the actual cost of the project to an amount over $10m and whether that fact required a referral to the Ministry.

121. These issues appear to us to be matters that Board members should want to turn their minds to, when being asked to approve such a significant capital expenditure.

Localities

122. We were asked to consider the management reporting and accounting for the Localities Programme for accuracy and appropriateness.

123. The Localities Strategy is an approach to assist people with managing their health from four locally based "clusters" situated across Counties Manukau. It has been in place since 2012 and was implemented with the purpose of minimising the number of hospital admissions.

124. In April 2017 two reports that assessed the benefits and impact of the strategy were prepared for ARFC:

a. The Localities Verification Analysis report prepared by Benedict Hefford (Director Primary Health & Community Services and Localities project owner) at the request of the new Board Chair.

b. The CMH Localities Strategy Impact Assessment report prepared by Dr Luis Villa (research and evaluation manager in Ko Awatea) requested by Mr Martin. Dr Villa's role is the evaluation of services and programmes provided in the health area.

125. The Villa report was at odds with the Hefford report in respect of the success of the strategy. Each report relied on differently-sourced data in support of conclusions. Dr Villa undertook a comparison of data from the three Auckland based DHBs while Mr Hefford did not.

126. Dr Villa demonstrated that the three Auckland DHBs showed the same trends in hospital readmissions between 2011 and 2016, suggesting the reduction across all three DHBs was due to other factors and not a benefit attributable to Localities. His view was that if Localities was working, then CMDHB should be outperforming the other DHBs.

127. Mr Hefford said that Dr Villa's evaluation was comparing *"apples and oranges"* He said that comparing the three Auckland DHBs (each which had different programmes and strategies in place to meet similar goals) was misconstrued and the proper comparison ought to be between CMDHB and DHBs with similar population attributes, such as Northland or Gisborne.

128. Dr Villa's opinion was that the Hefford report did not make sense and appeared to be misleading by suggesting that the Localities Strategy was successful, simply because of the methodologies used. Dr Villa has explained to us that his approach was one of evaluation, which was about proving the success of a service or programme and showing why.

129. Dr Villa stated:

> "*we did not find evidence of change in high level system indicators in CMH after the implementation of the Localities Strategy in 2012. We are by no means concluding that the LS did not bring any change or gains at Locality or program level - only that those gains, if they exist, have not yet impacted the high-level system measures. There are studies that indicated there are small positive outcomes with specific groups of patients that are not detected by high level indicators, but attribution remains a challenge*".

130. In his report, Mr Hefford stated:

> "*Whilst it is difficult to identify attribution of benefits and the counter-factual, there are indications that the model of care is having an impact on patient outcomes and producing savings in avoided hospital admissions*". He also stated, in conceding the difficultly in assessing available data, that "*Ultimately however, we simply do not know what the counter-factual is to our approach – it is possible that the data trends presented in this report would have materialised without intervention, but it seems unlikely*".

131. Mr Hefford and Dr Villa have met about the differences in their reports but neither accepts that their report is incorrect.

132. We note that Mr Hefford's report (at pg. 54 of the 19 April 2017 ARFC Agenda) included a statement that *"In terms of financial savings, in the past year the model of care has delivered significant benefits of around $3m".* It then goes on to show two tables, one entitled Hospital Savings (in which a $2.383m amount is disclosed) and one entitled Aged residential care savings (in which a $606k savings amount is disclosed).

133. There are two issues with the statement and tables. The Hospital Savings table is actually a comparison of actual vs targeted savings, and the $2.383m is the variance between the two amounts. It therefore represents an improvement against a target. Secondly, the table contains incorrect data. When the source data was provided to Mr Hefford, it erroneously showed savings as against target. It should have shown a cost overrun as against target.

134. Mr Hefford explained that he relied on the information provided, but in any event, the incorrect data for this aspect of his report would not have changed his conclusions. He said

> "*We had been tracking these savings in a different format than the one used in the report (graphs rather than a table) and as we were all used to being ahead of target in this area no one involved in preparing the ARF report picked up on the mistake where the columns were transposed. However I would not have changed my recommendations or conclusions in the report had I picked up on the mistake. Overall, acute hospital useage was increasing at a lower rate than demographic growth post localities based initiatives being implemented, so the main jist of that part of the report was still accurate. The report was clear that attribution and counter-factuals are very difficult to pin down and the data is not linear and indeed sometimes contradictory depending on how population demographics are adjusted for*".

135. The two reports became the focus of a RIA investigation, for which a draft report has been prepared but not finalised. The RIA draft was released in September 2017.

136. Mr Manzano's view was that:

> *"It is not possible using the current evaluation methodology to determine whether the Localities Strategy is successful and providing value for money. It may be possible to evaluate the outcomes using an appropriate*

*framework…..The report presented to the ARFC [*i.e. Hefford's] *is misleading as it indicates the Localities Strategy is successful when it is not possible to prove with the method used to evaluate the project"*.

137. RIA thought that the differences in conclusions between Mr Hefford and Dr Villa meant it was not possible to determine whether Localities was successful or not.

138. Mr Hefford and Dr Villa continue to maintain opposing views. Both admit that the data can be read in other ways to give an opposing result. We cannot conclude if any window dressing of results has occurred. Expert testing and a review of data, peer reviewed by medical/infometrics people, might be an appropriate way of assessing the Localities strategy, if that were required.

SWIFT (System Wide Integration for Transformation)

139. We were asked to consider whether the management reporting and accounting journals for SWIFT were appropriate. We have undertaken some initial enquiries regarding the reporting and accounting for SWIFT.

140. SWIFT is a widespread "care system", focusing on people and their care, with a technology component. CMDHB collaborated with other organizations such as The New Zealand Health Innovation Hub and the National Health IT Board to initiate SWIFT.

141. At the outset, two potential IT contractors were identified to partner with CMDHB, with a contract eventually agreed with IBM. The evaluation of the contractors involved an executive committee comprising people from wider government (including MBIE) and senior CMDHB personnel including Dr Mathias.

142. There were various phases involved. The Director Strategic ICT Transformation was brought in by the former CEO and CFO to manage the SWIFT programme. She advises that the phases were separately budgeted and funded (business cases were put before the ELT, Audit Risk and Finance and the full Board for approval) and included the creation of the initial strategic relationship agreement with IBM, a Joint Validation Period, Detailed Design Phase and ultimately the creation of Healthy Together 20/20.

143. She informed us that she went before the Board monthly (often with the Commercial Development Manager) to report progress against milestones, advise of any issues and risks, and report the tracking of the financials for the project. She considers that the board and the ARFC were properly briefed. She disagreed with any suggestion that reporting to the Board on SWIFT included only "good news". She felt no pressure to report positively but rather to report honestly. She said that four elected members of the Board provided feedback to her that she had reported honestly and factually which is what they were wanting.

144. An example of her reporting is in the ARFC meeting of 17 April 2017. The briefing paper provided a background and explanation of the project. It included summarised financial information of the current and projected costs and benefits of the project.

145. IBM was a significant participant in SWIFT. $8.5m of the $12.3m expended from 2013 to 2016 on SWIFT was paid to IBM. We have been advised by senior management that there was disagreement between some current Board members and between ELT members as to the value provided by IBM. The disagreements may have led to the current board being concerned as to the value of the SWIFT project.

146. The CFO has reviewed the accounting and advised us that she believes that there may have been some problems with the accounting for aspects of SWIFT but cannot at this stage confirm that any inappropriate entries were made. She said that some journals were posted on Mr Pearson's instructions for which no explanation or trail is now available. She assumes that the entries may have been made following phone calls or verbal instructions to the accounting team (i.e. why no trail exists) but cannot confirm if the entries were appropriate or not. The historical nature of the project (dating back to 2013/2014), makes a detailed tracing of all expenditure difficult.

147. Mr Pollock from Health Alliance has been interviewed and confirmed that he posted journals involving the accounting for SWIFT, and that direction he received regarding SWIFT accounting came from the Finance Group's Peter Tod or Steve Murray. Mr Murray has been interviewed and has no issues with any instruction he received from Mr Pearson for SWIFT accounting. Mr Tod was not available for interview.

148. Margaret White has undertaken a review of the costs recorded for SWIFT. As at June 2017, there was a sum of approximately $5.5M recorded as Work in Progress (i.e. as an intangible asset) primarily representing IBM costs incurred during the project. Her review, undertaken with the assistance of the Director ICT Transformation, determined that it was inappropriate to continue to record the asset in the accounts, and recommended it be written off.

149. We have not conducted enquiries into whether the updates provided to the Board on a monthly basis adequately presented how the project was travelling in terms of its suitability as a widespread care system.

150. We trust this update is of assistance to you and we await your further instructions.

Yours faithfully

Beattie Varley Limited

2019 Waikato District Health Board, Committees, Iwi Maori Council and joint Board/IMC Meeting Schedule

Board 4th Wed Monthly 1pm **Board & CEO Sessions at 12noon**	**Training Sessions/** **Placeholder for additional meetings for the Board**	**Audit & Risk** 3 Monthly 4th Wed 10am	**Board and Iwi Maori Council** Bi Annual All Day	**Iwi Maori Council** 1st Thurs Monthly 9.30am	**Maori Strategic Committee** 3rd Wed Monthly 10am	**Hospitals Advisory Committee** 2nd Wed Monthly 8.30am	**Community & Public Health Advisory Committee** 2nd Wed Monthly 12.30pm	**Waikato Health Trust** Bi Annual 4.00pm
23 Jan								
27 Feb		27 Feb		7 Feb	20 Feb	13 Feb	13 Feb	
	20 Feb Cognitive Institute Training (4pm – 6:30pm)							
27 Mar	13 Mar			7 Mar	20 Mar			
24 Apr				4 Apr	17 Apr	10 Apr	10 Apr	10 Apr
22 May	8 May	22 May	29 May	2 May	15 May			
26 Jun				6 Jun	19 Jun	12 Jun	12 Jun	
24 Jul	10 Jul			4 Jul	17 Jul			
28 Aug		28 Aug		1 Aug	21 Aug	14 Aug	14 Aug	

Board 4th Wed Monthly 1pm **Board & CEO Sessions at 12noon**	**Training Sessions/ Placeholder for additional meetings for the Board**	**Audit & Risk** 3 Monthly 4th Wed 10am	**Board and Iwi Maori Council** Bi Annual All Day	**Iwi Maori Council** 1st Thurs Monthly 9.30am	**Maori Strategic Committee** 3rd Wed Monthly 10am	**Hospitals Advisory Committee** 2nd Wed Monthly 8.30am	**Community & Public Health Advisory Committee** 2nd Wed Monthly 12.30pm	**Waikato Health Trust** Bi Annual 4.00pm
25 Sep	11 Sep			5 Sep	18 Sept			
23 Oct			30 Oct	3 Oct	16 Oct	9 Oct	9 Oct	9 Oct
27 Nov	13 Nov	27 Nov		7 Nov	20 Nov			
11 Dec – Powhiri and first meeting of new Board	10 Dec Board Orientation Day							

Quality and Patient Safety

No Quality and Patient Safety report this month.

Finance Performance Monitoring

MEMORANDUM TO THE BOARD
26 SETEMBER 2018

AGENDA ITEM 6.1

FINANCE REPORT

Purpose	For information.

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

Recommendations
THAT
The Board receives this report.

ANDREW MCCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Waikato DHB Group	Year to Date			Group Budget
Result for August 2018	**Group Actual $m**	**Group Budget $m**	**Variance $m**	**Jun-19 $m**
Revenue - CFA	211.7	211.9	(0.2) U	1,269.2
Revenue - other	37.8	38.6	(0.8) U	229.7
Operating Expenses	(246.4)	(245.0)	(1.4) U	(1,468.2)
IDCC	(13.4)	(14.0)	0.6 F	(86.8)
DHB Surplus/(Deficit)	**(10.3)**	**(8.5)**	**(1.8) U**	**(56.1)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

Waikato DHB Group	Year to Date			Group Budget
Result for August 2018	**Group Actual $m**	**Group Budget $m**	**Variance $m**	**Jun-19 $m**
Funder	2.4	(4.3)	6.7 F	24.9
Governance	(0.3)	(0.2)	(0.1) U	(1.5)
Provider	(12.4)	(4.0)	(8.4) U	(79.5)
Waikato Health Trust	0.0	0.0	0.0 F	(0.0)
DHB Surplus/(Deficit)	**(10.3)**	**(8.5)**	**(1.8) U**	**(56.1)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

Episodes

Acute

August 2018	2019 Actuals	2019 Plan	Variance to Plan %	2018 Actuals	Variance to Prior Year %
Surgical & CCTVS	3,347	3,037	10.19%	3,005	11.38%
Internal Medicine	3,638	3,723	-2.29%	3,500	3.94%
Regional Services	830	821	1.11%	794	4.53%
Child Health	1,640	1,611	1.80%	1,519	7.97%
Womens Health	1,524	1,523	0.06%	1,467	3.89%
TOTAL	**10,979**	**10,715**	**2.46%**	**10,285**	**6.75%**

Elective

August 2018	2019 Actuals	2019 Plan	Variance to Plan %	2018 Actuals	Variance to Prior Year %
Surgical & CCTVS	2,939	2,820	4.22%	2,565	14.58%
Internal Medicine	98	168	-41.68%	110	-10.91%
Regional Services	12	9	35.75%	7	71.43%
Child Health	123	134	-8.42%	122	0.82%
Womens Health	269	214	25.79%	190	41.58%
TOTAL	**3,441**	**3,345**	**2.87%**	**2,994**	**14.93%**
Total Episodes Acute + Elective	**14,420**	**14,060**	**2.56%**	**13,279**	**8.59%**

Case Weighted Discharges

Acute

August 2018	2019 Actuals	2019 Plan	Variance to Plan %	2018 Actuals	Variance to Prior Year %
Surgical & CCTVS	5,355	5,068	5.65%	4,854	10.31%
Internal Medicine	3,077	3,256	-5.50%	3,058	0.62%
Regional Services	883	1,004	-11.99%	975	-9.41%
Child Health	1,408	1,462	-3.68%	1,338	5.24%
Womens Health	855	847	0.89%	832	2.74%
TOTAL	**11,578**	**11,637**	**-0.51%**	**11,057**	**4.71%**

Elective

August 2018	2019 Actuals	2019 Plan	Variance to Plan %	2018 Actuals	Variance to Prior Year %
Surgical & CCTVS	3,478	4,019	-13.46%	3,922	-11.31%
Internal Medicine	64	120	-46.88%	72	-11.91%
Regional Services	18	17	5.48%	11	56.82%
Child Health	98	111	-11.72%	95	2.95%
Womens Health	210	208	1.12%	184	14.46%
TOTAL	**3,868**	**4,475**	**-13.57%**	**4,284**	**-9.72%**
Total CWDs Acute + Elective	**15,446**	**16,112**	**-4.13%**	**15,341**	**0.68%**

August 2018	2019 Actuals	2018 Actuals	Variance to Prior Year %
ED Attends	20,138	20,310	-0.85%
Beddays	42,198	42,558	-0.85%

MONTHLY COMMENTS

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

Delivery Plan Performance

Please note that episodes are up on plan and prior year. However, CWDs are reflecting a decline. A contributing factor related to this is the higher than usual % of CWD accruals at the beginning of each year, which usually reflects an under coding. We continue to work with Operational Performance & Support to improve the accuracy of these CWD accruals.

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

Financial Performance YTD Comment:

For August 2018 we have an unfavourable year to date variance to budget of $1.8m. This includes unfavourable variances arising from the timing of funding related to NZMO MECA and nursing acuity assumed to be receivable ($1.1m) and nursing personnel (employed and outsourced) costs unfavourable $2.2m largely as a result of the new MECA rates being higher than budget ($0.5m), unfavourable annual leave movement ($0.4m), higher than budgeted overtime driven by the new acuity levels for staffing being in place earlier than budgeted. Furthermore clinical supplies unfavourable $2.3m which is impacted by the transition to NOS. We are working through transition to NOS including greater transactional clarity which could impact accrual calculations to date, including for clinical supplies. The savings plan to date is $2.5m unfavourable. We are awaiting washups from prior year which may provide a small favourable offset.

As we are still in the first quarter of the year, and have transitioned to a new financial system (NOS), our best estimate at this stage for forecast remains unchanged from budget.

We recognise the capital expenditure spend as per the Capital Expenditure report (YTD spend of $5,465k) doesn't agree with the Treasury Purchase of Assets amount of $6,330k. This is due to NOS issues that are being worked through. We also recognise that this reflects a very slow start to the capital plan. This is due to a number of factors, including the impact of an "annual" capital plan (which we are very actively moving to a pro-actively managed rolling capital plan) and a shortage of resources, especially IS resources, which is being worked through. We have added in a new Asset Performance Indicator (API) to reflect the age of clinical assets compared to the suppliers expected life expectancy. An update of APIs will be provided to the Board as at 30 September 2018.

Provider:

The Provider is unfavourable to budget $8.4m - see detail for explanations. Variances include:

1. Revenue is unfavourable $7.2m due mainly to unfavourable internal revenue ($6.5m - eliminates against Funder) and timing variances relating to side arm contracts ($0.8m), partly offset by the recovery of NOS costs ($0.5m).
2. Employed personnel cost is favourable to budget $2.4m mainly due to favourable variances relating to Medical, Allied and Management, Administration and Support costs (offset in outsourced services), offset by an unfavourable Nursing variance. Further analysis below.
3. Outsourced personnel cost is unfavourable to budget $3.3m - partly offset in employed personnel cost and NOS costs recovered in other government revenue.
4. Outsourced services is favourable to budget $1.7m - analysis below.
5. Clinical Supplies is unfavourable to budget $2.2m due to the mix of activity. We are also working through the potential impact of the transition to NOS on these costs.
6. Infrastructure and non clinical supplies is unfavourable to budget $0.5m - analysis below.
7. IDCC is favourable to budget $0.7m. This relates mainly to a favourable depreciation variance as a result of the timing of capitalisation of assets.

Funder and Governance:
The results for the Funder is $6.7m favourable to budget. This mainly as a result of favourable internal provider payments ($6.5m) (eliminates against Provider) and a favourable provider payment variance ($0.6m). This is offset by unfavourable timing variances relating to CFA and side arm revenue receivable ($0.4m). Governance is close to budget.
Waikato Health Trust
The result for the Waikato Health Trust is on budget.

RECOMMENDATION(S):

That this report for the period ended August 2018 be received.

ANDREW McCURDIE
CHIEF FINANCIAL OFFICER

WAIKATO DISTRICT HEALTH BOARD
YEAR TO DATE FINANCIAL COMMENTARY

Opinion on Group Result:		
The Waikato DHB YTD Revenue Variance resulted from:	**Variance $m**	**Impact on forecast**
Revenue	**($1.0) U**	
CFA Revenue		
CFA revenue is unfavourable to budget mainly due to:		
• Timing variances across several revenue lines.	($0.2) U	Neutral
Crown Side-Arm Revenue		
• Crown side-arm contracts $0.7m unfavourable to budget which includes Ministry of Health funding yet to be received for acuity and salary costs related to the NZNO MECA (1.1m), with other offsets.	($0.7) U	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is on budget in total, but is made up of offsetting variances which include:		
• Reimbursement of haemophilia costs $0.2m favourable in line with actual costs incurred (clinical supplies).	$0.0 F	Neutral
• Reimbursement of costs associated with the implementation of National Oracle Solution (NOS) $0.5m favourable (offset in Outsourced Personnel $0.9m).		
• ACC Income $0.2m unfavourable which includes the annual contract for non acute rehabilitation being less than budget assumption for the year.		
• Trauma service $0.3m unfavourable due to a timing difference for funding received against an annual ACC contract.		
Other Revenue		
Other revenue is close to budget	($0.1) U	Neutral

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($0.8) U**	
Personnel (employees and outsourced personnel total)	**($1.1) U**	
Employed personnel are favourable to budget mainly due to:		
• Medical personnel are favourable to budget by $2.4m. This includes a higher than expected vacancy level, including delayed implementation of improvement initiatives. This favourable variance is partly offset by outsourced personnel unfavourable variance of $0.8m.	$2.4 F	Neutral
• Nursing personnel are unfavourable to budget by $1.5m. This variance, along with the unfavourable outsourced personnel cost for nursing of $0.7m, includes higher final settlement of the NZNO MECA compared to budget, of $0.5m, unfavourable annual leave movement for the year to date $0.4m, and higher than budget overtime. The variance includes the impact of new acuity levels for staffing in place earlier than budgeted, and a higher level of mental health inpatient services.		Unfavourable
• Allied Health personnel are favourable to budget by $0.2m. The net favourable variance between employed and outsourced is $0.1m favourable and is as a result of higher than expected vacancy levels.		Neutral
• Management, Administration and Support personnel are favourable to budget by $1.2m. Variances are spread across the DHB including clinical support, and are mainly as a result of higher than expected vacancy levels. Part offset in outsourced personnel ($0.4m).		
Outsourced personnel are unfavourable to budget mainly due to:		
• Medical costs are $0.8m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $2.4m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.	($3.5) U	Neutral
• Nursing costs are $0.7m unfavourable. As for nursing personnel this is due to the impact of new acuity levels for staffing in place earlier than budgeted, and a higher level of mental health inpatient services.		Unfavourable
• Allied Health costs are $0.1m unfavourable to budget. The net favourable variance between employed and outsourced is $0.1m favourable and is as a result of higher than expected vacancy levels.		Neutral
• Management, Administration and Support costs are $1.8m unfavourable largely due to contractor costs of $0.9m for the implementation of the new NOS ERP solution ($0.5m of this cost is offset by additional other government revenue), and contractor costs of $0.5m for the patient flow project. The balance of $0.4m covers management, administration and support vacancies (offset in favourable employed personnel variance of $1.2m).		

The Waikato DHB YTD Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$1.9 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced Clinical Services are $0.6m favourable to budget. This mainly relates to timing of outsourced elective services as facility lists run through external providers did not reach full capacity.	$1.9 F	Neutral
• Outsourced corporate service costs are $0.6m favourable to budget which includes delays in the implementation of Crown initiated information system changes such as IaaS.		
• Spend against allocated strategic funding is $0.7m favourable to date. This is expected to be a timing difference and includes initiatives related to health system transformation and to health equity.		
Clinical Supplies	**($2.3) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Treatment disposables - unfavourable to budget by $1.2m. This variance, along with the unfavourable instruments and equipment variance ($0.7m) is due to mix of activity (includes total episodes up on budget despite CWDs being below budget), and timing of transfer of products from inventory. We are working through transition to NOS including greater transactional clarity which could impact accrual calculations to date. High cost areas include haemophilia costs over budget by $0.2m (offset by other Government revenue).	($2.3) U	Unfavourable
• Diagnostic and Other Supplies - close to budget at $0.2m favourable.		
• Instruments and Equipment - unfavourable to budget by $0.7m. As for treatment disposals, this variance is due to mix of activity (includes total episodes up on budget despite CWDs being below budget), and timing of transfer of products from inventory.		
• Implants and prosthesis - close to budget at $0.1m favourable.		
• Pharmaceuticals - unfavourable to budget by $0.6m. This includes timing of savings expected as a result of PHARMAC taking over further hospital drug procurement.		
Infrastructure and non-clinical supplies	**($0.5) U**	
• Favourable variances include a delayed start to building maintenance plan ($0.6m), budgeted surgical services project costs actually included in prior year ($0.6m), delayed commencement of information services projects ($0.2m), utilities costs under budget for winter months ($0.2m), and savings related to CBD delays ($0.1m)	$2.0 F	Favourable
• Savings allocation - $2.5m unfavourable variance in infrastructure relates to centrally held savings plan not specifically allocated.	($2.5) U	Unfavourable
NGO Payments	**$0.6 F**	
External Provider payments are favourable to budget mainly due to:		
• Accrual adjustment relating to prior year favourable to date by $0.4m, and relates to Aged Residential Care (ARC)	$0.6 F	Favourable
Interest, depreciation and capital charge	**$0.6 F**	
Interest charge is on budget.	$0.0 F	Neutral
Capital charge is close to budget.	($0.1) U	Neutral
Depreciation is favourable to budget due mainly to:		
• Slower than planned capital spend and the timing of capitalisation of assets.	$0.7 F	Neutral

TREASURY

Opinion on Group Result:

Cash flows are favourable to budget as detailed below.

YTD Actuals Aug-17 $'000	Waikato DHB Cash flows for year to August 2018	Year to Date Actual $'000	Year to Date Budget $'000	Year to Date Variance $'000	Budget Jun-19 $'000
	Cash flow from operating activities				
222,878	Operating inflows	242,735	249,700	(6,965)	1,497,069
(205,356)	Operating outflows	(237,976)	(250,709)	12,733	(1,488,012)
17,522	**Net cash from operating activities**	**4,759**	**(1,009)**	**5,768**	**9,057**
	Cash flow from investing activities				
255	Interest income and proceeds on disposal of assets	195	196	(1)	1,187
(2,606)	Purchase of assets	(6,330)	(20,741)	14,411	(117,089)
(2,351)	**Net cash from investing activities**	**(6,135)**	**(20,545)**	**14,410**	**(115,902)**
	Cash flow from financing activities				
0	Equity repayment	(263)	0	(263)	(2,194)
(1,455)	Interest Paid	(142)	(138)	(4)	(826)
77	Net change in borrowings	(63)	7,829	(7,892)	115,782
(1,378)	**Net cash from financing activities**	**(468)**	**7,691**	**(8,159)**	**112,762**
13,793	**Net increase/**(decrease) in cash	**(1,845)**	**(13,863)**	**12,019**	**5,917**
856	Opening cash balance	(2,973)	(2,973)	0	(2,973)
14,649	**Closing cash balance**	**(4,818)**	**(16,836)**	**12,019**	**2,944**

Cash flow variances resulted from:	**Variance $m**	**Impact on forecast**
Total Net cash flow from Operating Activities	**$5.8 F**	
Operating inflows	**($7.0) U**	
• The unfavourable inflow variance is predominantly due to cash receipts budgeted but not received. There is a corresponding increase in Accounts Receivable and Accrued Debtors $9.5m. This relates to many items including ACC contract for Trauma and non-acute rehabilitation services, expected MoH funding for Nursing salary settlement, public health revenue contracts and Older Persons & Child Development contracts with MoH.	($7.0) U	Neutral
Operating outflows	**$12.8 F**	
Operating cash outflows for payroll costs are unfavourable mainly due to:		
• Personnel costs are unfavourable against budget mainly due to NZNO MECA lump sum settlement payment made in August.	($4.6) U	Unfavourable
Operating cash outflows for non-payroll costs are favourable mainly due to:		
• Favourable operating costs are largely due to an early payment of June Creditors of $17.8m on 26th June to assist with the NOS transition. This payment was budgeted to be made in July (20th month) resulting in a favourable variance.	$17.5 F	Favourable
• GST cash movement is favourable due to timing variances on GST transacted.	($0.1) U	Neutral

Cash flow variances resulted from:	Variance $m	Impact on forecast
Net cash flow from Investing Activities	**$14.4 F**	
• Interest charge is on budget.	$0.0 F	Neutral
• Purchase of assets is slower than planned for the year. This is as a result of deferred timing of spend.	$14.4 F	
Net cash flow from Financing Activities	**($8.2) U**	
• Cash flow from financing activities is unfavourable due to the deferment of planned finance leases.	($8.2) 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-Aug-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	1,968	4,366	5,855	4,594	4,468	6,650	3,252	4,480	6,422	4,708	4,252	6,966	4,680
Funder inflow (MoH, IDF, etc)	135,119	136,306	131,626	131,626	136,496	131,626	131,626	136,496	131,626	131,626	136,496	132,225	132,225
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	1,824	2,507	2,747	2,747	2,387	2,520	2,280	2,520	2,280	2,760	2,280	2,440	2,581
Rents, ACC, & HealthPac (General Accou	2,753	2,649	2,764	2,757	2,662	2,680	2,566	2,743	2,551	2,895	2,553	2,875	3,087
	141,664	145,828	142,992	141,724	146,013	143,476	139,724	146,239	142,879	141,989	145,581	144,506	142,573
Cash was applied to:													
Personnel Costs (incl PAYE)	(61,360)	(48,415)	(53,799)	(49,897)	(56,639)	(47,788)	(50,022)	(46,726)	(46,168)	(54,771)	(45,654)	(56,668)	(49,746)
Other Operating Costs	(38,942)	(42,722)	(38,624)	(37,826)	(37,218)	(32,620)	(35,520)	(39,122)	(37,820)	(38,524)	(33,520)	(23,580)	(29,926)
Funder outflow	(53,690)	(47,896)	(48,905)	(48,576)	(47,556)	(48,329)	(47,792)	(51,848)	(47,626)	(49,009)	(47,556)	(49,510)	(52,888)
Interest and Finance Costs	(13)	(22)	(22)	(22)	(20)	(20)	(20)	(20)	(17)	(12)	(17)	(22)	(22)
Capital Charge	0	0	0	0	(18,483)	0	0	0	0	0	(18,711)	0	0
GST Payments	(7,701)	(7,210)	(7,210)	(7,210)	0	(13,710)	(9,000)	(7,210)	0	(14,420)	(7,210)	(7,210)	(7,210)
	(161,706)	(146,265)	(148,560)	(143,531)	(159,916)	(142,467)	(142,354)	(144,926)	(131,631)	(156,736)	(152,668)	(136,990)	(139,792)
OPERATING ACTIVITES	(20,042)	(437)	(5,568)	(1,807)	(13,903)	1,009	(2,630)	1,313	11,248	(14,747)	(7,087)	7,516	2,781
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	81	75	75	75	75	75	75	75	75	75	75	75	75
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
	81	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(1,786)	(5,000)	(5,000)	(9,000)	(9,000)	(3,500)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(1,786)	(5,000)	(5,000)	(9,000)	(9,000)	(3,500)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)	(9,000)
INVESTING ACTIVITIES	(1,705)	(4,925)	(4,925)	(8,925)	(8,925)	(3,425)	(8,925)	(8,925)	(8,925)	(8,925)	(8,925)	(8,925)	(8,925)
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	20,000	10,000	20,000	0	10,000	0	0	20,000	20,000	0	0
Finance Lease received	0	0	0	3,000	3,000	3,000	3,000	3,000	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	20,000	13,000	23,000	3,000	13,000	3,000	0	20,000	20,000	0	0
Cash was applied to:													
Capital Repayment	0	0	0	0	0	0	0	0	0	0	(2,194)	0	0
Finance lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	(26)	0	0	(26)	0	0	(26)	0	0	(15)	0	0	(15)
Working capital facility repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
FINANCING ACTIVITIES	**(26)**	**0**	**20,000**	**12,974**	**23,000**	**3,000**	**12,974**	**3,000**	**0**	**19,985**	**17,806**	**0**	**(15)**
Opening cash balance	9,043	(12,731)	(18,092)	(8,585)	(6,342)	(6,169)	(5,584)	(4,164)	(8,775)	(6,451)	(10,137)	(8,342)	(9,750)
Overall increase/(decrease) in cash	(21,774)	(5,361)	9,507	2,243	172	585	1,420	(4,610)	2,324	(3,686)	1,794	(1,408)	(6,159)
CLOSING CASH BALANCE	(12,731)	(18,092)	(8,585)	(6,342)	(6,170)	(5,584)	(4,164)	(8,774)	(6,451)	(10,137)	(8,343)	(9,750)	(15,909)
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	(12,731)	(18,092)	(8,585)	(6,342)	(6,169)	(5,584)	(4,164)	(8,775)	(6,451)	(10,137)	(8,342)	(9,750)	(15,909)
Long-term Loans													
Finance Leases	0	0	0	(3,000)	(6,000)	(9,000)	(12,000)	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)	(15,000)
EECA Loan	(143)	(143)	(143)	(117)	(117)	(117)	(91)	(91)	(91)	(76)	(76)	(76)	(61)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(12,874)	(18,235)	(8,728)	(9,459)	(12,286)	(14,701)	(16,255)	(23,866)	(21,542)	(25,213)	(23,418)	(24,826)	(30,970)
Working capital facility	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)	(72,356)

BALANCE SHEET

Opinion on Result:

There are no material concerns on the balance sheet.

Prior Year June 2018 $'000	Waikato DHB Group Financial Position	As at August 2018 Actual $'000	Budget $'000	Variance $'000	Budget Jun-19 $'000
79,945	Total current assets	96,244	86,061	10,183 F	76,022
(197,999)	Total current liabilities	(223,984)	(216,447)	(7,537) U	(206,215)
(118,053)	**Net working capital**	**(127,740)**	**(130,386)**	**2,646 F**	**(130,193)**
722,564	Term assets	721,468	733,138	(11,670) U	787,359
(22,150)	Term liabilities	(21,642)	(22,470)	828 F	(30,732)
700,414	**Net term assets**	**699,826**	**710,668**	**(10,842) U**	**756,627**
582,361	**Net assets employed**	**572,086**	**580,282**	**(8,196) U**	**626,434**
582,361	**Total Equity**	**572,086**	**580,282**	**(8,196) U**	**626,434**

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 higher than budget by $12m which reflects the product of all cash transactions. This is represented as a $1.3m favourable variance in Current Assets and $10.7m favourable variance in Current Liabilities. • Total accounts receivable and accrued debtors is higher than budgeted by $9.5m mainly due to an unbudgeted accrual of NOS recoveries $4.2m and unsigned revenue contracts $2.6m. The remaining variance is as a result off the timing of cash received compared with budget assumptions. • Prepayments are lower than budgeted by $0.2. • Other unfavourable variances across a number of areas $0.4m.	**$10.2 F**	Neutral
Current Liabilities		
• Cash held with New Zealand Health Partnership Limited is higher than budget by $12m. This is represented as a $1.3m favourable variance in Current Assets and $10.7m favourable variance in Current Liabilities. This is due mainly to the favourable variance relating to operating activities($5.8m) and investing activities ($14.4m) offset by an ufavourable financing variance from activities ($8.2m). • Payroll liabilities are $0.1m unfavourable mainly due to a unfavourable variance for SMO CME entitlements of $7m (will decrease during the year). This is mainly offset by a favourable variance of $6m for PAYE and Salaries accrual due to timing of fortnightly payruns varying each month against the end of month set budget amount. • Income in Advance $1.3m unfavourable to budget mainly due to the unbudgeted Health Workforce NZ contract. • GST $0.1m favourable to budget mainly due to timing variances on GST transacted.	**($7.5) U**	Neutral

Balance Sheet variance's resulted from:	**Variance $m**	**Impact on forecast**
Current Liabilities (continued		Neutral
• Accrued Creditors $5.8m unfavourable mainly due to unbudgeted accrual of NOS costs, and higher operational expenses which is evident in the results for the month and the timing of payments.		
• Accounts Payable is $12m unfavourable mainly due a low budgeted creditors at the start of the year. This abnormally low Accounts Payable Balance at the start of the year was used calculate the budgeted Accounts payable balance for the remainder of the year.		
• Other Current Liabilities are favourable to budget $0.9m mainly due to the Finance Lease being pushed out to later this year.		
Net Term Assets:		
Net Fixed Assets are under budget mainly due to slower than planned capital spend $12.5m, offset by favourable YTD depreciation $0.7m. Please see attached for latest forecast of capital spend for the year for further detail.	($11.8) U	Neutral
Investment in HealthShare has increased by $0.1m due to the share of profits for the 2017/18 year.	$0.1 F	Favourable
Non Current Liabilities:		
Non Current Liabilities are favourable due to deferment of budgeted finance leases.	**$0.8 F**	Neutral
Equity:		
Unfavourable variance driven mainly by budgeted MoH deficit support not received $6.6m and the unfavourable result variance of $1.8m.	**($8.2) U**	Neutral

CAPITAL EXPENDITURE AT 31 August 2018 ($000s)

Capital Plan					Cash Flow Forecast					Full Project Forecast		
Activity	**Total Prior year Board Approvals**	**New Approvals FY18/19**	**Transfers During 18/19**	**Total Board Approved Capital Plans**	**Prior year expenditure for active Projects**	**Total Expenditure Forecast FY 18/19 (Actual + Planned)**	**Actual Expenditure YTD from 1 Jul-18 to 31 Aug 18**	**Approved and Planned Expenditure 01 Sep 18 - 30 Jun 19**	**Approved and Planned Spend Subsequent Years**	**Total Planned Expenditure (Actual + Forecast to Project completion)**	**Total Planned Expenditure Versus Total Board Approved**	**Total Commitments**
Under $50K Subtotal	0	3,974	0	3,974	0	3,974	718	3,256	0	3,974	0	
Clinical Equipment Subtotal	16,972	41,719	0	58,690	11,406	47,294	2,283	45,011	0	58,701	-11	
Property & Infrastructure Subtotal	32,081	13,417	0	45,498	13,525	25,835	1,010	24,825	6,507	45,867	-369	
IS Subtotal	18,123	14,706	0	32,829	13,345	19,257	1,380	17,877	0	32,602	227	
Corporate Systems & Processes Subtotal	10,042	320	0	10,362	3,788	6,545	40	6,505	0	10,333	28	
Regional Subtotal	8,216	1,264	0	9,480	1,043	7,678	33	7,645	0	8,721	759	
MOH Subtotal	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	
REPORT TOTALS	**85,434**	**75,400**	**0**	**160,833**	**43,107**	**110,584**	**5,465**	**105,119**	**6,507**	**160,198**	**634**	

The transition to NOS has resulted in delays in capital reports becoming available. As a result the above data does not reconcile to the accounting records. This is being actively addressed.

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

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
Under $50K Subtotal	3,974	718	3,256	-
Dialysis Machine - Model 5008S -17	527	-	527	-
Dialysis, Hemofiltration Unit	364	-	364	-
Computer Information Sys. - Oncology (Eclipse & Aria) -1	250	-	250	-
Linarc Accelerator	5,000	-	5,000	-
Blood Culture Analyzer	250	-	250	-
Radg. Unit, (Xray General Ed Room 1)	350	-	350	-
Easy Diagnost (Mcc Room 5)	350	-	350	-
Radg. Unit, Mobile Xray Machine -Mobile	300	-	300	-
Radg. Unit, Trauma Diagnost (Ed Resus)	700	-	700	-
Dual Head Gamma Camera - Hawkeye Infinia	730	-	730	-
Intellivue	364	-	364	-
Mp30 Intellivue	322	-	322	-
Monitor, Cardiac Multi-Parameter	282	-	282	-
Mammotest Breast Biopsy System	680	-	680	-
Monitor, Multi-Parameter	1,053	-	1,053	-
Datex As/3 Monitor 0E3867	320	-	320	-
Pump, Roller, Perfusion System	290	-	290	-
Scanners, Ultrasonic, Cardiac (Ie33)	250	-	250	-
Heart Lung Machine, Stockeret S111	303	-	303	-
Heart Lung Machine	315	-	315	-
Respiratory Function Equipment	299	-	299	-
Electophysiology Equipment	285	-	285	-
Maclab Muse & Haemodynamic System	690	-	690	-
Apex Pro Telemetry System (Including Installation	573	-	573	-
Toshiba Digital Image Processing (Cath Lab 2)	1,143	-	1,143	-
Toshiba Digital Image Processing (Cath Lab)	1,204	-	1,204	-
ICU Monitoring System	1,122	-	1,122	-
Monitoring System Upgrade - Network Project	625	-	625	-
S/5 Aespire 7900 Anaesthetic Machibe E11246	612	-	612	-
Physiologic Monitor Module, Multiparameter	456	-	456	-
Incubators, Infant	294	-	294	-
Incubator/Radiant Warming Unit, Infant, Mobile	330	-	330	-
Monitor, Bedside, Fetal	468	-	468	-
CT Machine Replacement Waikato x3	3,828	3,846	-	(18)
CT Machine Replacement Waikato x1	725	725	-	(0)
Ventilators (Critical Care)	400	-	400	-
Endoscopes	300	85	215	0
Replacement Theatre Lights OT 20-25	286	235	51	(0)
Renal Dialysis (CCD) machines x4 Prismaflex	564	601	-	(37)
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	1,029	284	(0)
Mobile Dental Unit Replacements - level 2	600	117	483	(0)
Bed Replacement Programme	400	-	260	140
Digital Mobile X-Ray Project	1,246	1,205	41	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	-
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	529	71	0
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	20	805	(0)
L8 Menzies Surgical Assessment Unit (Acute)	1,561	1,342	219	(0)
Other Clinical Items <$250K	8,844	1,575	7,370	(101)
Unplanned Clinical Items - Bucket	6,155	-	6,155	0
New Clinical Items - required due Activity Growth	3,688	-	3,688	-
Projects Removed to be Capitalised	893	887	-	6
Other Clinical items - Reserve funding	4,999		4,999	(0)
Savings required	(5,981)		(5,981)	
Clinical Equipment Subtotal	**62,664**	**14,408**	**48,267**	**(11)**

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
Mental Health Facility - Scoping -part 2	2,973	41	2,932	0
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Gallagher Building - Med Store & CSES Clinic	406	402	-	4
Gallagher Building - Racking System	362	522	-	(160)
Gallagher Building - Converyor System	348	356	-	(8)
Waiora Level 1 - ED Acute Observation Unit	650	-	650	-
Waiora Level 1 - Development of MCC L1 Shell space (for other decants from Waiora L1 : attend	750	-	750	-
Waiora Level 1 - Seismic Works *** part of $2m in Capital Plan	500	-	500	-
Waiora Level 4 - Workspace open plan / decant from Waiora L3 (Includes item removed from be	650	-	650	-
Waiora Level 4 - Sleep space expansion	300	-	300	-
Waiora Level 2, 3 & 4 - Decant space development in ERB3 for Waiora L2, L3 & L4	600	-	600	-
Waiora L3 - Laboratory / Histology / Molecular Biology co location	250	-	250	-
Waiora L1, Menzies L8, OPR5 Kitchen Impact : Kitchen & Food Delivery - Refurbishment & extra	1,500	-	1,500	-
Hamilton Consolidation of CBD facilities - 9th Floor	850	850	-	-
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	2,362	6,763	(0)
Hamilton CBD - Collingwood Street Development - First Floor	5,584	447	5,337	(200)
Tokoroa / Te Kuiti / Taumarunui Pregnancy Support Facilities (Fitout of leased premises)	300	-	300	-
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	175	375	0
Hague road carpark - Seismic and Beam support	2,032	-	2,032	-
Urology to L8 Menzies	320	22	298	(0)
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Waikato Hauora iHub	321	276	45	0
Ward Block A & Environs	250	-	250	-
Waikato switchboard upgrades core buildings	866	76	790	0
Infrastructure Replacement Pool (17/18)	510	483	-	27
Infrastructure Replacement Pool (15/16)	600	731	-	(131)
Infrastructure Replacement Pool (16/17)	641	205	436	-
Infrastructure Replacement Pool (18/19)	600	-	600	-
Project Management Resource to deliver BAU Critical Infrastructure projects (2 FTE Equivalent)	250	-	250	-
Cooling Tower Dosing System Upgrades (2-plus)	300	-	300	-
Lomas Chillers	390	240	150	0
Fire Protection Upgrade to meet compliance requirements	425	-	425	-
Thames - PHO enabling works	500	-	500	-
Seismic Assessments & Remediation (all campus's not itemised elsewhere)	500	-	500	-
Waikato Distribution Boards	250	213	37	-
Electrical Systems Improvement	6,714	5,969	745	-
Carpark safety improvement (Nets / Cages)	550	-	550	-
Other P&I Projects Budgeted <$250K	4,456	1,075	3,468	(87)
Projects removed to be capitalise	276	92	-	184
Less: Proceeds on sale of property (206 Collingwood St)	(1,500)	-	(1,500)	-
Savings required	-	-	-	-
Property & Infrastructure Subtotal	**45,498**	**14,535**	**31,332**	**(369)**

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
Information Systems				
ISSP - Clinical and corporate Platform SQL Server consolidation	365	257	108	(0)
IMPACT Patient Flow Tool	1,534	813	721	0
SQL Server 2016 upgrades / Citrix XenApp vS VDI	500	-	500	-
ISSP - Data Warehouse Upgrade (Data Warehouse Phase 1)	387	327	60	0
ISSP- Clinical Photography and Image Management	397	156	241	(0)
ISSP - Communication Room Remediation Lifecyle	368	31	337	0
ISSP - Paging System Replacement	290	296	-	(6)
ISSP - Network Remediation Work Package 2015/2016	399	340	59	0
ISSP - WiFi Rollout	487	454	33	0
ISSP - Network Remediation Lifecycle Work Plan 16/17	282	258	24	0
LAN / WLAN - IMPLEMENT: Install WAPs (extend Wi-Fi coverage)	997	48	949	(0)
LAN / WLAN - UPGRADE: Wireless LAN Controllers (Address core capacity constraints)	263	34	229	(0)
LAN / WLAN - UPGRADE: Distribution Switches	750	-	750	-
LAN / WLAN - UPGRADE: Access Switches	1,519	-	1,519	-
NIPS - IaaS Implementation	1,557	1,153	404	0
Disaster Recovery Solution	1,800	-	1,800	-
DeskTop WorkPlan 16/17	288	174	114	(0)
End User Devices (<$2k) - now capitalised	1,740	830	910	0
Rollout of devices at point of care (Investment in circa 500 tablets)	491	2	489	(0)
ISSP - Mobile office Productivity & Management	392	183	209	(0)
Tablet rollout (Year 2 of 4 year plan)	500	-	500	-
ISSP - MS Licensing True-Up	476	129	347	-
ISSP - Other Licensing True-Up	349	83	266	-
ISSP - MS Licensing True-Up -2	400	-	400	-
ISSP - Other Licensing True-Up 2	266	-	266	-
ISSP - Enterprise Business Intelligence Tool	305	260	45	(0)
Business Intelligence Data & Reporting	453	50	403	0
Enterprise Service Bus (ESB) Phase II	263	-	263	-
Enterprise Messaging/Communication Solution	350	-	350	-
ISSP - SharePoint Work Pan 16-17	401	219	182	0
ISSP - Rapid Logon	359	34	325	0
ISSP - Toolsets (IS Toolsets 15/16)	507	506	-	1
ISSP - Netscaler Infrastructure	301	340	-	(39)
Sharepoint 15/16	350	285	65	(0)
Win 10 Upgrade	500	53	447	0
Mobility & Mobile Apps	371	-	371	0
Patient IS capabilities - Observations Platform	361	23	338	0
ISL merge ANZ version with European version	500	-	500	-
EBI Tool implementation phase 2 (Qlik Sense Licences)	450	-	450	-
Archiving Tool Implementation	378	-	378	-
Office 2016 upgrade	300	-	300	-
Windows 2008r2 to 2016 Server upgrades	800	-	800	-
Security Defence in depth	500	70	430	-
Clinical Workflow Integration Work Plan	384	388	-	(4)
Clinical Workstation Core Component Workplan	513	578	-	(65)
Database Replacements	301	68	233	0
iPM upgrade to V10 - after 16/17	484	563	-	(79)
Cat1-5 In-House Developed Applications Work Plan	330	369	-	(39)
Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	259	245	14	(0)
Oral Health system	852	923	-	(71)
eCWB Infrastructure	254	238	16	-
HealthViews access to Primary Encounters (GP to Workstations)	306	304	2	-
eOrders	290	237	53	(0)
Anaesthesia Information System - Implementation	600	-	600	-
Observations Platform (eVitals) - implementation	700	-	700	-
Nutrition & Food Management	932	40	892	0
Other IS Projects Budgeted <$250K	8,040	2,789	5,555	(304)
Projects to be Capitalised	1,408	574	-	834
Savings required	(7,070)		(7,070)	-
IS Subtotal	32,829	14,725	17,877	227

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
Corporate				
HRIS Lifecycle Upgrade 15_16	529	51	478	-
Costpro Upgrade	313	242	71	0
HRIS remediation	4,218	-	4,218	-
SmarthHealth devices	320	-	320	-
incl Mobile printing for IOS	600	389	211	(0)
Clinical Device Platform	491	13	478	(0)
SCEP racking - hospital wide	400	-	400	-
PeopleSoft Global Remediation	478	478	-	(0)
MECA and Rule Management	289	289	-	0
PLA and Leave Rule Updates	361	361	-	0
Payroll Process Improvements	480	631	-	(151)
National Patient Flow Phase 3 16/17 & 17/18 & 18/19	385	277	107	1
Other Corporate Projects Budgeted <$250K	1,498	1,096	222	180
Corporate Subtotal	10,362	3,828	6,505	29
MOH & Trust Funded				
HSL - eSpace Programme	6,014	-	6,014	-
National Oracle Solution - Elevate	3,929	1,076	2,094	759
PACS review	392	-	392	-
Telestroke Pilot	321	7	314	-
Other MOH & Trust Funded Projects Budgeted <$250K	872	-	872	-
Savings required	(1,727)		(1,727)	-
(Funded by MOH)	(321)	(7)	(314)	-
MOH & Trust Subtotal	9,480	1,076	7,645	759
Total Projects	**160,833**	**48,571**	**111,626**	**636**

The transition to NOS has resulted in delays in capital reports becoming available. As a result the above data does not reconcile to the accounting records. This is being actively addressed.

WAIKATO DISTRICT HEALTH BOARD

EXECUTIVE TRAVEL

August 2018

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

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

Travel costs - Executive Group	Month			Year to Date			
August 2018	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AITKEN VICKI	-	-	-	111.30	-	111.30	
AYDON LYDIA	-	-	-	-	-	-	
CARDWELL CHRIS	-	-	-	-	-	-	
CHRYSTALL MAUREEN	31.00	-	31.00	1,019.59	-	1,019.59	
ELLIOTT LORAINE	-	-	-	-	-	-	
HABLOUS NEVILLE	-	-	-	-	-	-	
HAYWARD SUE	390.00	701.20	1,091.20	583.26	701.20	1,284.46	
HOPGOOD GARY	-	-	-	-	-	-	
HOWARD GRANT	927.18	-	927.18	927.18	-	927.18	
MALONEY TANIA	480.98	-	480.98	1,175.67	-	1,175.67	
NEVILLE MO	239.99	-	239.99	424.47	-	424.47	
SEWELL GILL	-	-	-	-	-	-	
TAHU SUE	-	-	-	-	-	-	
TAPSELL REES	17.39	-	17.39	17.39	-	17.39	
TER BEEK MARC	-	-	-	-	-	-	
TOMIC DAMIAN MR	414.20	-	414.20	1,108.89	-	1,108.89	
WRIGHT DEREK	85.30	-	85.30	151.32	-	151.32	
Grand Total	**2,586.04**	**701.20**	**3,287.24**	**5,519.07**	**701.20**	**6,220.27**	

Interim CE Travel Expenditure Derek Wright

Travel costs for the period to 31 August 2018				
Date(s)	Cost ($) (exc GST)	Purpose	Nature	Location
21 February 2018	40.91	Late charge prior year Taxi Fare Health Commissioner	Taxi	Wellington
8 June 2018	45.12	Meet & Welcome new MoH Director General	Taxi	Wellington
18-19 June 2018	40.54	MoH - WDHB annual plan and Budget meeting, meeting Dept. Corrections	Taxi	Wellington
9 August 2018	24.75	National DHB CE meeting	Taxi, airfare not yet charged	Wellington
	151.32			

Discussion on Waikato DHB's 2017/18 deficit - $37.4m.

Health Targets

MEMORANDUM TO THE BOARD
26 SEPTEMBER 2018

AGENDA ITEM 7

HEALTH TARGETS REPORT

Purpose	For information.

Most Recent Results
The most recent official results on the (former) Health Targets were presented last month (Quarter 4) as the Quarter 1 results are not available until October 2018. The only new data available on the health targets is the monthly ED target result and the three-month rolling immunisation (8 months) result as shown in Table 1.

Table 1- Health targets performance summary

HEALTH TARGETS		16/17 Target	2016/17 Q1 results	2016/17 Q2 results	2016/17 Q3 results	2016/17 Q4 results	17/18 Target	2017/18 Q1 results	2017/18 Q2 results	2017/18 Q3 results	2017/18 Q4 result	Target achieved	Most recent result
Shorter stays in emergency departments		**95%**	89.3% 19th ✗	87.6% 20th ✗	88.4% 20th ✗	86% 20th ✗	**95%**	82% 20th ✗	89% 20th ✗	86% 19th ✗	84% 19th ✗	X	83% Jul-18 YTD*
Improved access to elective surgery		**100%**	108% 7th ★	106% 10th ●	110% 3rd ★	114% 2nd ★	**100%**	111% 5th ★	104% 8th ●	105% 6th ★	105% 7th ★	√	105% Q4 17/18 result*
Faster Cancer Treatment (FCT)	Achievement	**85%**	81.4% 5th ★	85.9% 4th ★	86.1% 5th ★	86% 2nd ★	**85%**	98% 1st ★	98% 2nd ★	97% 3rd ★	96% 3rd ★	√	92% June - 18 Provisional
Better Help for Smokers to quit	Primary Care	**90%**	87% 12th ●	86% 13th ●	87% 12th ●	88% 15th ✗	**90%**	88% 14th ●	89% 12th ●	88% 14th ●	87% 16th ✗	X	87% 17/18 Q4 result
	Maternity	**90%**	93% 12th ●	96% 4th ★	98% 4th ★	95% 8th ●	**90%**	94% 8th ●	97% 4th ★	99% 3rd ★	87% 14th ●	X	87% 17/18 Q4 result
Increased immunisation (8 months)		**95%**	92.3% 13th ●	92% 15th ✗	90% 16th ✗	89% 15th ✗	**95%**	88% 15th ✗	90% 15th ✗	89% 14th ✗	88% 14th ✗	X	89% Aug 18 3 mth rolling
Raising Healthy Kids		**95%**	47% 11th ●	79% 6th ★	84% 9th ●	81% 14th ●	**95%**	76% 19th ✗	100% 1st ★	100% 1st ★	100% 1st ★	√	100% 6 mths Jul 18

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

*Changes in IPM and patient flow process has resulted in coding changes that need to be addressed, thus Aug result unavailable until rectified

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2017/18

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

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

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

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

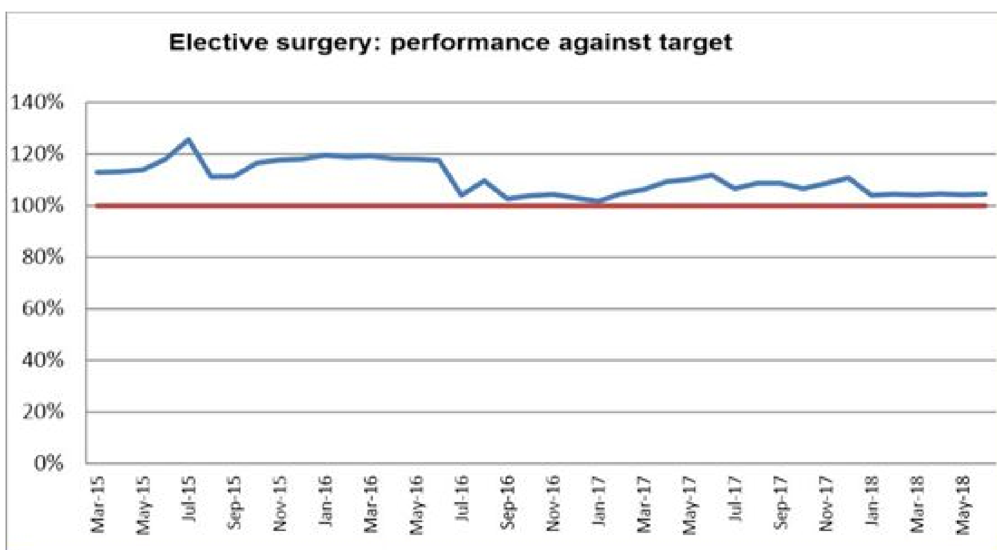
Target: Elective Surgery

Table 4 – Elective Surgery Results by Quarter

Quarter	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Result	102.6%	103.1%	106.3%	111.8%	111%	104%	105%	105%
Ranking	7	10	3	2	5	8	6	7

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

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



Target: Faster Cancer Treatment (FCT)

Summary of achievement against the FCT health target from July 2015 to August 2018.

FCT 62 DAY HEALTH TARGET									
DHB Current Target	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	DHB Q3 Result 17/18	DHB Q4 Result 17/18	DHB Q1 Provisional Result 18/19
90%	81.4% 5th ranking	86.1% 5th ranking	85.9% 5th ranking	86.4% 2nd ranking	96.6% 3rd equal ranking	96.6% 3rd equal ranking	99.0% 3rd Ranking	95.5% 3rd ranking	92%
FCT VOLUME TARGET									
DHB Current Target	DHB Q1 Result 16/17	DHB Q2 Result 16/17	DHB Q3 Result 16/17	DHB Q4 Result 16/17	DHB Q1 Result 17/18	DHB Q2 Result 17/18	DHB Q3 Result 17/18	DHB Q4 Result 17/18	DHB Q1 18/19
25%	17%	19%	19%	22%	14%	14%	14%	18%	18%

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

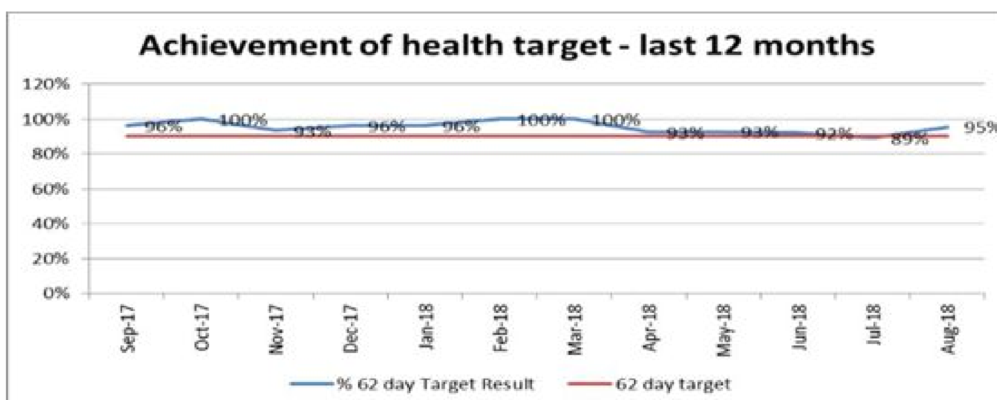


Table 5

Local FCT Database	Jul-18	Aug-18	Total
Number of records submitted	28	22	50
Number of records within 62 days	25	21	46
% 62 day Target Met (90%)	89%	95%	92%
% Volume Target Met (15%)	17%	14%	13%

Target: Increase in 8 month olds fully immunised

Table 6 – Eight month Milestone Immunisation Results by Quarter

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

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

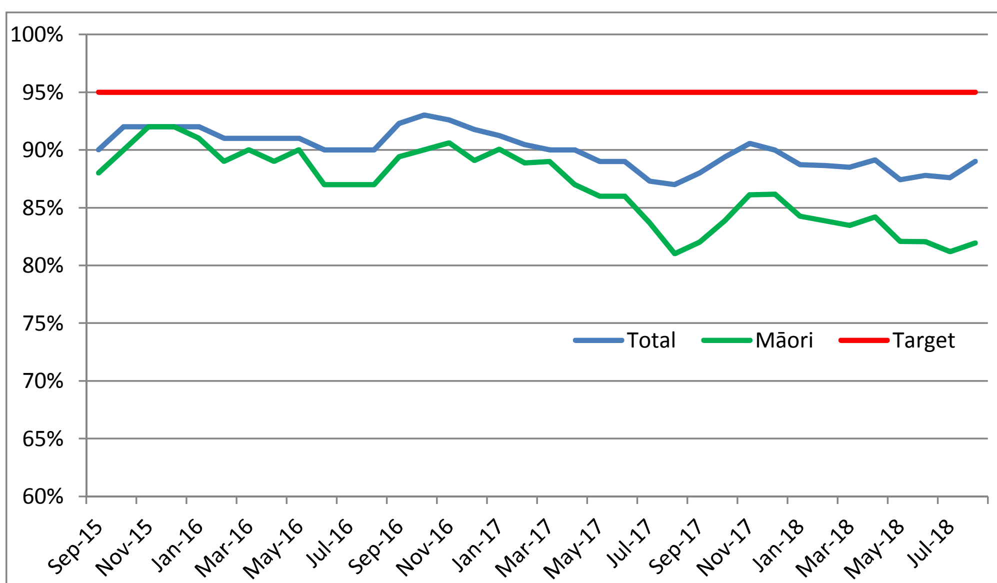


Table 7 - Waikato DHB 8 month old immunisations ethnicity breakdown from Jun 2018 to Aug 2018

Ethnicity	Number eligible	Fully immunised	Result	Increase needed to meet target (95%)
NZ European	565	530	94%	7
Māori	537	440	82%	71
Pacific	52	44	85%	6
Asian	173	165	95%	0
Other	90	82	91%	4
Total across ethnicities				88
Total	1,417	1,261	89%	86

Target: Better help for smokers to quit - primary care

Table 8 – Quarterly Results

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

Ethnicity splits only provided from Q3 17/18

Target: Better help for smokers to quit - maternity

Table 9 – Quarterly Results

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

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

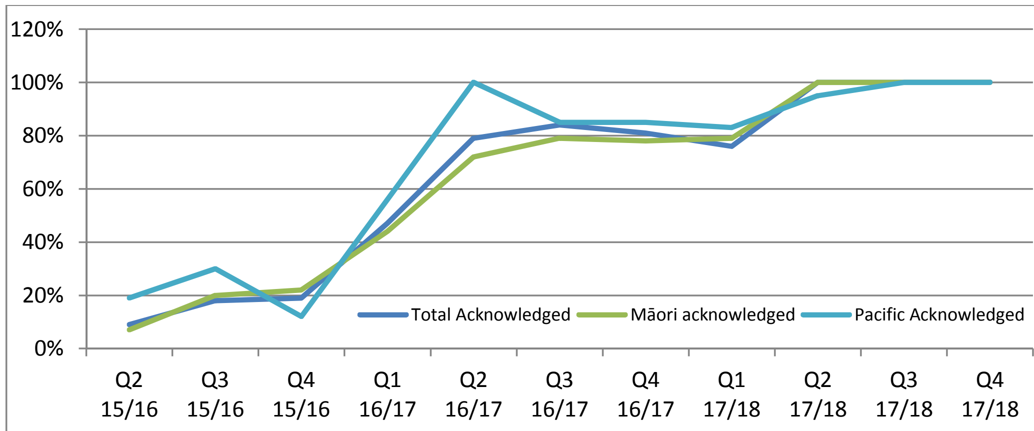
Target: Raising healthy kids

Table 10 – 2017/18 Q4 Raising Healthy Kids Results (target 95%)

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

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

Graph 4 - Results for 'Raising Healthy Kids' health target
Data for a 6 month rolling period up to May 2018



Recommendation
THAT
The Board receives this report.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

DR GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER

Health and Safety

Health and Safety Service report due in October.

Service Performance Monitoring

MEMORANDUM TO THE BOARD
26 SEPTEMBER 2018

AGENDA ITEM 9.1

PEOPLE AND PERFORMANCE REPORT

Purpose	For information.

HEALTH ROUND TABLE STAFF SURVEY 2018

Background

The Midland Chief Executives have agreed to a common staff survey, which will enable comparisons of results across the five Midland DHBs.

Why are we doing this?

It is three years since our 2015 internal staff survey. During the past three years work around our values and priorities has progressed, equally there have been many high profile issues for the District Health Board.

The question for us is whether three years on are we changing for the better. Are we walking the talk?

We:

- want to build on the success of staff involvement in creating our values
- know if our culture, "the way we do things around here" has improved since implementing Staff Safety Culture Working Group initiatives, such as Living the values, Work Place Support Person, Staff Safety resources
- need the data to show:
    (i) how we are doing with changing and shaping our culture to be positive
    (ii) identify areas we need to improve on.

In addition, our Board has been requesting an external survey.

A new Staff Safety Culture Working Group (SSCWG) work plan is required, as the first workstream plan scoped work for two years, commenced September 2016; with a milestone of 30 June 2018. The survey will help frame that plan.

The survey timing aligns with the commencement of the Executive Director Human Resources and Organisational Development.

The survey comes in the middle of two other big events; Mental Health Awareness week which occurs the week before the survey and then Patient Safety week.

How will we do this?

Health Round Table (HRT) is the external organisation, who has been engaged by HealthShare to also complete the survey.

HRT has designed the survey which we have had input, they will analyse the results and produce DHB and comparative reports.

Timeline

The five Midland DHBs are partaking in the survey at approximately the same time, in October and November 2018. Waikato DHB dates endorsed by our Interim Chief Executive are below.

Weeks	Existing focus	Comment
1 October – 4/9 November	Communications	Before, during, after the survey
8 – 14 October	Mental Health Awareness week	Good lead in.
15- 21 October	Survey week one	Three weeks allows extra time
22 October – 28 October	Survey week two	22nd Labour Day
29 October – 4 November	Survey week three	Three weeks allows extra time. Patient safety week
4 November – 9 November	Patient Safety week	Complementary
End of December	HRT report	Waikato DHB report available
Start of 2019	Comparative report	Comparative report against Midland DHBs available

Survey Questions

We have added five of our own questions, and these along with four questions within the standard 25 questions in the survey, will provide Waikato DHB with:

a) longitudinal data to compare against the 2015 staff survey results
b) comparisons of the standard questions and professional groups against the other Midland DHBs.

The survey should take approximately 10 minutes to complete.

See Appendix 1.

Approach

A subgroup has been formed to project manage the communication and survey monitoring requirements. Executives need to encourage staff to fill out the survey and *Walk the Talk*. The Staff Safety Working Group is key in supporting this survey. Managers are key in passing the message and encouraging their staff to complete the survey.

RECRUITMENT INDICATORS

Outlined below are recruitment indicators to 31 August 2018.

RMOs have been removed from the information provided because they are predominantly hired over an annual recruitment cycle – November to November.

Recruitment in progress

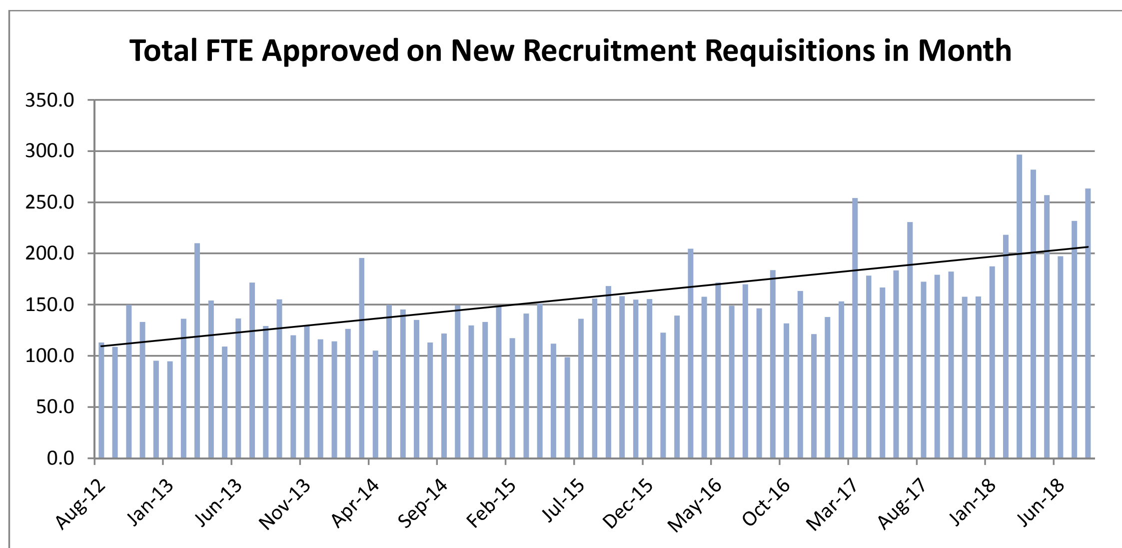
These figures show the percentage of total workforce that is currently in some part of the recruitment process, from approval to recruit to commencement. They give an indication over time as to whether the number of vacancies is increasing or decreasing.

Recruitment in Progress	Aug 2017	May 2018	Jun 2018	Jul 2018	Aug 2018
Total FTE open to recruit as percentage of total contracted FTE within organisation (at month end)	10.95%	13.90%	14.24%	14.44%	14.63%

Note that new positions will affect numbers so total FTE open to recruit should not be confused with staff turnover.

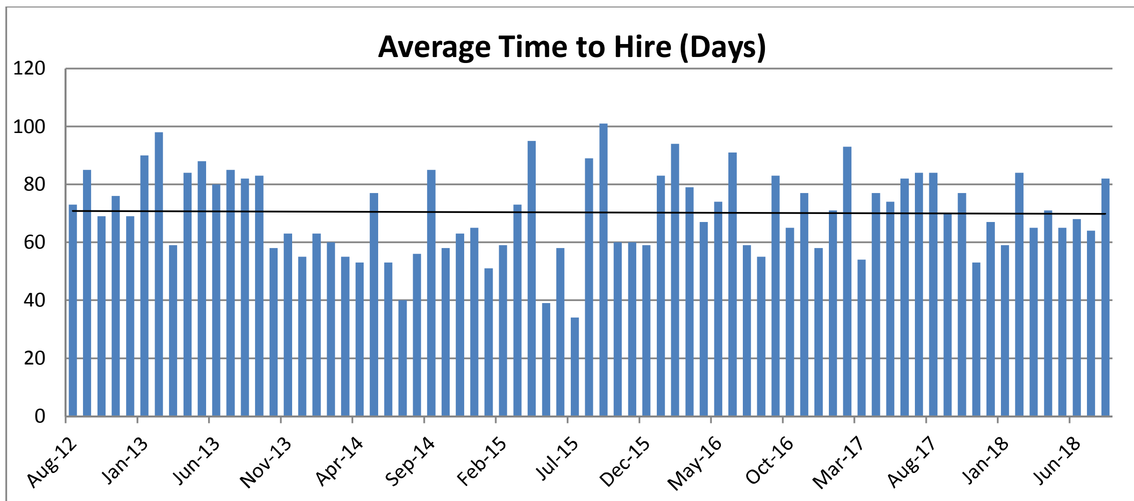
August 2018 saw 286 offers extended, compared with 212 in August 2017 (this includes new hires, as well as those moving internally, or having their fixed terms extended).

Recruitment activity remains high across all staff groups. The graph below shows the steady increase of FTE being approved to recruit to from around 100FTE per month in 2013 up to 200FTE per month in 2018, peaking at nearly 300FTE in March and April 2018.



Time to hire

The graph below shows that average time from recruitment requisition approved until offer accepted has remained fairly stable over time.



Recommendation
THAT
The Board receives this report.

GREGORY PEPLOE
DIRECTOR PEOPLE AND PERFORMANCE

APPENDIX 1

Health Roundtable (HRT) Staff Survey: Waikato DHB five questions

No	Waikato DHB question	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
1	How often do you get the following support from your team leader/manager - helpful information or advice?	2015 Staff Safety survey Q 1 (a)				
2	How often do you get the following support from your team leader/manager - sympathetic understanding and concern?	2015 Staff Safety survey Q 1 (b)				
3	How often do you get the following support from your team leader/manager - clear and helpful feedback?	2015 Staff Safety survey Q 1 (c)				
4	How often do you get the following support from your team leader/manager - practical assistance?	2015 Staff Safety survey Q 1 (d)				
5	I believe I have had a positive influence on the culture pf my workplace, since I joined the organisation	2015 Staff Safety survey Q 5 – reframed stem to the two question: "I believe I can have a ---", and "I am willing to have a ---"				

Our 2015 survey was worded differently, but mirrors the HRT five point scale

Waikato DHB 2015	Never	Not often	Sometimes	Often	Very often
HRT	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree

Health Roundtable Survey: Organisational Climate Questions

Please rate your views about the following statements.

No	HRT question	Strongly disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Strongly agree
1	All team members accept the team's performance priorities					
2	Senior and junior members of our team work well together					
3	Team leader (line manager) is clear about what he or she expects of me.					
4	Staff performance problems are identified	2015 Staff Safety survey Q 3 (a)				
5	Staff performance problems are corrected in a timely manner	2015 Staff Safety survey Q 3 (b). The word corrected is used; in 2015 the word resolved was used.				
6	My Team Leader (Line Manager) encourages team work and cooperation between departments					
7	My Team Leader (Line Manager) provides useful feedback on my performance at work.					
8	My Team Leader (Line Manager) encourages the adoption of new ideas to improve the way we work.					
9	I feel accepted as a valued member of my team					
10	I feel appreciated for the contribution that I make	2015 Staff Safety survey Q 4, noting does not expand to sources (manager, patients/ clients/ customers, peers, others)				
11	I am happy with my career development options within this DHB					
12	I am supported to develop the skills I need in my career					

13	I have opportunities to contribute to important decisions that affect my work.					
14	I am receiving the right level of supervision for my working requirements					
15	I intend to continue working at this DHB for at least the next 12 months					
16	I have a trusted friend / colleague at my place of work					
17	I have the equipment and supplies I need to do my job properly					
18	In the last 12 months I have witnessed bullying behaviour in my workplace					
19	In the last 12 months I have been subjected to bullying behaviour in my workplace	Replaces 2015 Staff Safety survey Q 2, "I have not felt bullied by other team members in the last 12 months?"				
20	I feel safe working within this DHB					
21	I recommend this DHB as a place to work.					
22	Overall I am satisfied with my job					
23	Patients are treated with respect and dignity					
24	I feel comfortable reporting any concerns about patient safety					
25	I would feel safe being treated as a patient here					

The one thing, MORE THAN ANYTHING ELSE, that needs to change to make this organisation better.

If you would like to provide further information / explanation on the above answers that you have given please feel free to do so in this space.

Facilities and Business report: refer item 18 in public excluded.

MEMORANDUM TO THE BOARD
26 SEPTEMBER 2018

AGENDA ITEM 9.3

IS PERFORMANCE MONITORING REPORT

Purpose	For information.

The IS Plan report is submitted for Board information.

Recommendation
THAT
The Board receives this report.

GEOFF KING
CHIEF INFORMATION OFFICER

IS Plan Report

Period Ending	31 August 2018
Prepared By	Geoff King

KPI's	Status	Metric Change	Comment
Overall	A		This report covers Information Services (IS) operational performance for the three months ending 31 August 2018 and financial reporting as at M02 2018. After two months of the 2018/19 financial year the Information Services is favourable to budget. The volume and targeting of Cyber security attacks continues to present increased risk and the team is maintaining focus on developing improved security approaches and controls to ensure the appropriate level of protection is maintained. Recognising that human behaviour is the biggest risk the team are looking to implement staff phishing awareness assessments, in the form of fake phishing emails, to assess maturity of awareness and behaviour. With the accelerated delivery plan for 2018/19, which results in the implementation of required enhancements and the 3+ year journey to catch-up on deferred maintenance, the volume and complexity of IS workload will grow to a level that requires increased active management to ensure a balance is maintained between risk, delivery and cost.

Key Results Area - DevOps Transformation (DevOps is an improvement approach that IS has been implementing.)

The DevOps transformation has been a major undertaking for IS and the implementation phase was, by its nature, the disruptive phase of the transformation.

From reviewing some the baseline statistics it is clear that we have already realised some massive improvements:

- Service Requests: When we started we had 960 outstanding Service Requests of which 75% were breaching Service Level Agreement (SLA). This is now halved to 402 outstanding (meeting SLA) and only 120 in breach of SLA. This has been achieved at a time when volumes of Service Requests have increased by 31% over the 2 year period.
- Incidents: When we started we had 295 unresolved incidents in breach of SLA. At the end of July we only had 88. This has been achieved at a time when, due to deferred maintenance, increased reliance and other factors, volumes of Incidents have increased by 44% over the two year period.
- Time to resolve: The average time it took to close calls (Incidents and Service Requests) has reduced from 27.3 days in 2016, to 5.9 days now. This has been achieved at a time when contact volumes have increased by 45% over the two year period. To put this into context in May 11,000 contacts were received (in 2016 the average was 7,000 per month).
- Availability and Service Stability: We consistently meet our Availability (Top 4 Cat 1), Service Stability (number of P1 and P2 incidents), and Service Resolution (speed to resolve P1, P2, and P3) targets.
- Risk Score: Our Risk score was reduced from 85% to 74%, which whilst not at where it needs to be (70% or Medium Risk), is a huge improvement.
- Customer Satisfaction: The overall customer satisfaction survey score has increased dramatically from below 50% to now being over 90%, which is a reflection of the previously mentioned improved statistics and changing customer engagement.

- Audit: The 2018 Information and Communications Technology (ICT) Controls and Assurance Audit concluded that governance over ICT at Waikato DHB is well embedded across the IS team, and that the delivery of value to the business and the mitigation of ICT risks, appear to be effectively governed.
- Ministry: In the Health Information Security Framework (HISF) maturity review the DHB scored 4, the top score which only two DHBs achieved. Ministry of Health (MoH) feedback on our Assurance Plans for ICT Operations was that it was very comprehensive, has excellent coverage, and they intend to hold it up as an exemplar of the standard to be achieved.

We have not finished the journey and it is fair to say that there has been some (expected) 'bruising' resulting from the change.

Key Result Area – Financials M02 (31 August 2018)	Status	Metric Change	Comment
Annual Operating Budget - Before IDCC and Extraordinary	G	29,506 k	
YTD Budget Actual		4,891 k 4,389 k	
Variance		**502 k**	M02 result is $502 k fav
Including IDCC Variance		**451 K**	M02 result is $451 k fav

Key Result Area – Capital Budget M02 (over 50k)	Status	Metric Change	Comment
Capital Budget (over 50k)	G		As at 31 August 2018
Board Approved (carry forwards) Board Approved (2018/19 Capex) Transfers Savings Plan target **Board Approved (TOTAL)**		$18,123 $14,706 $0 -$7,070 **$32,829**	As noted within the project delivery KPI 100% of projects have been delivered within budget. In accordance with the IS Project Delivery Framework and the DHB's Delegations of Authority policy all variations to project budgets are formally approved.
DHB funding of Regional Initiatives		**$9,480**	Due to challenges resulting from the National Oracle Solution (NOS), the project variance figures are currently not 100% accurate. As a result no Major Variance figures are included in this report. The NOS and local teams are working through reconciling the post migration issues.
Status of DHB IS Investment IS Projects yet to commence Deferment to meet Savings Plan target IS Projects Open or Completed **TOTAL**		 $13,025 $7,070 $12,734 **$32,829**	Major Variances: • NIL (see above).
Forecast Spend for approved projects **Underspend / (Overspend)**		$See note $See note	Deferred Maintenance / Technical Debt: • Currently estimated to be $28m. • This is forecast to reduce to $15m by 30 June 2019.

Key Result Area – Labour Recoveries M02	**Status**	**Metric Change**	**Comment**
YTD Budget Actual **Variance**	G	775 k 917 k **142 k**	Favourable.
Key Result Area - IS Service Delivery	**Status**	**Metric Change**	**Comment**
- Yearly review of Service Level Agreements with Waikato District Health Board Executive Management and Clinical Information Governance Board	A	**No**	Review has been delayed slightly.
- Service level Agreement reporting on a quarterly cycle	G	**Yes**	Report developed and published monthly.
- 75% of Information Services customers satisfied or very satisfied.	G	**75%** (satisfied/ Very Satisfied)	Of those customers responding to the October 2017 survey 75% indicated they were satisfied. The next survey will be scheduled for October/November 2018.
- 75% of Information Services users satisfied or very satisfied.	G	**91%** (satisfied/ Very Satisfied)	The Service Desk satisfaction survey tests one in five service desk calls logged and indicates service delivery satisfaction remains well above target.
- No more than **2 Priority 1** issues occurring per month. This means we have no more than 2 site wide or critical system issues in a calendar month.	G	**0** Occurrences Average per month	0 x P1 Incidents experienced over the three month period since last report. With increasing deferred maintenance (technical debt) and the resulting move from preventative maintenance to reactive resolution of incidents, organisational tolerance to increased disruption resulting from incidents is under review.
- No more than **4 Priority 2** issues occurring per month. This means we have no more than 4 single system or single department issues in a calendar month.	G	**2.3** Occurrences Average per month	7 x P2 Incidents experienced over the three month period since last report. With increasing deferred maintenance (technical debt) and the resulting move from preventative maintenance to reactive resolution of incidents, organisational tolerance to increased disruption resulting from incidents is under review.
- **All** category 1 & 2 services with an agreed Service Level Agreement and business owner Identified.	G		
– **100%** Service Level Agreement	G	**100%**	All systems now covered by SLA (KPIs are formally agreed with the Executive Group). SLA under review and targets expected to change.
– **100%** Business Owner	G	**100%**	All (cat 1 and 2) systems in IS systems register have business owner identified. The Business Owners Charter procedure has expired and a new version is currently progressing through the approval process.

– **100%** Business Owner Charter	A	**90%**	Team are progressively reviewing and updating Business Owner Charters with the respective corporate and clinical solution owners.
– **100%** Criticality assessments	A	**90%**	The Initial Criticality and Risk Assessment (ICRA) is completed for all new and significant change deliveries. With the increasing transition to automation and digitalisation of clinical processes and clinical documentation the DHBs reliance on specific applications is increasing and as a result the ICRA reviews are identifying the need to increase the Cat rating of specific systems.
– **100%** Systems with risk scorecard	A	**90%**	Implementation of annual risk reviews for all Cat 1 and 2 solutions scheduled for this financial year.
– **100%** Risks with mitigations agreed	A	**90%**	Monthly IS Risk review forum is established and risks have mitigation and assurance activities identified.
- Small projects – (Non Standard Service Requests).	A		Non Standard Work Requests (NSWR) delivery continues to be an area of challenge. Resource is allocated in accordance with the agreed budget, however this continues to be insufficient to meet demand.
Resource allocation	G	**133,255**	Target for the two months was for $136k per month of resource assigned to the delivery of NSWRs. For the first two months of the financial year the resource delivering NSWR was slightly behind target ($3k) due to a higher allocation to delivery of projects (project target was exceeded).
Number Delivered or Closed Target is 35 per month / 420 per year	A	**27**	80 NSWRs were completed over reporting period (30 delivered and 50 closed).
Older than 6 months	G	**14%**	Target is <20% of the total number outstanding.
Older than 9 months	A	**11%**	Target is <10% of the total number outstanding.
Older than 12 months	R	**36%**	Target is 0.
Number Open	A	**203**	The number of NSWRs delivered and exceeding KPIs remains a concern and the ISLT have initiatives underway to reaccelerate delivery whilst receiving on average an additional 32 new requests each month.

Key Result Area - IS People	**Status**	**Metric Change**	**Comment**
- Skills maps for all staff incorporated into annual performance management that maps to Waikato District Health Board Information Services needs	G	**Yes**	
- **90%** of staff with appropriate professional qualifications	A	**No**	Training plans agreed on annual basis as part of the annual performance review process, aligned to available budget.
- Staff retention rate greater than **90%** per annum	A	**86.1%**	Attrition rate over the past 12 months is at 13.9% and as at August IS have 16 positions vacant, which at 11% of the workforce presents impairment to operational support and delivery. In the two months a further three staff have transitioned to HealthShare, which whilst positive for the Midland region, creates notable operational and delivery challenges for the DHB. Finding suitable replacements is

			challenged by; market conditions (skill shortages, market remuneration, and increased recruitment activity), the DHB brand, and DHB salary bands targeting recruitment below 80% of market. Recruitment of staff into critical roles is increasingly challenging, leading to delays. IS continues to work with HR on strategies to manage remuneration challenges, as reported to the May Audit Committee.
- Staff satisfaction **(75% satisfied or very satisfied)**	R	**57%**	The latest survey has indicated a significant decrease in staff satisfaction from 70% to 57%. The report has highlighted a number of drivers for this (remuneration, on call/callout requirements, 'bruising' from DevOps transition, churn/stability, workload, culture, etc). A plan to address this is under development.

Key Result Area - IS Process	**Status**	**Metric Change**	**Comment**
- Alignment of Waikato IS processes and frameworks	G	**Yes**	The integrated IS Project Delivery Governance Framework is embedded across the IS PMO, with supporting materials and training.
- Project Assurance regime in place to ensure all projects are compliant with process	G	**Yes**	Formal processes in place.
- Security Audit Performed	G	**Yes**	The ICT Controls Audit was completed over the reporting period which assessed the efficacy of controls at Governance, Management and Operational levels. The report recognised that governance over ICT at Waikato DHB is well embedded across the IS team, and that the delivery of value to the business and the mitigation of ICT risks, appear to be effectively governed. The annual operational assurance was submitted to the GCIO in June and improved process maturity and follow up is strengthening this control point. The annual 'network penetration' test was completed in August 2018.
- Critical Issues recorded	G	**Yes**	Quarterly ISLT internal update and reporting of outstanding audit items has been moved to monthly to better cover audit and risk management accountabilities. With the appointment of the Chief Data Officer the membership and role of IS Security Governance Group is being reviewed.
- Service Delivery assurance regime in place to ensure Service level Agreement attainment	G	**Yes**	Service Delivery follow up audit completed and identified recommendations under ISLT review.
- Information Technology Infrastructure Library (ITIL) Review Undertaken	A	**No**	Work is underway.
- Processes at agreed level	A	**No**	Work is underway.
- Control Objectives for Information and Related Technology (COBIT) Review Undertaken	A	**No**	Work is underway.
- Processes at agreed level	A	**No**	Work is underway.
- The Open Group Architecture Framework (TOGAF) framework review undertaken	A	**No**	Work is underway.

yearly:			
- Processes at agreed level	A	No	Work is underway.

Key Result Area - IS product	Status	Metric Change	Comment
- Execution of plan to move to current or current-1 release of software products with reporting on project timelines	R	Yes	IS continues to progress software lifecycle plans constrained to available funding. A deferred maintenance "debt" of $28m is estimated. Lifecycle refresh plans and inherent risks are agreed by the Lifecycle Prioritisation Executive Group. The deferred maintenance technical debt is recorded and tracked as an enterprise risk within Datix.
- Execution of plan to maintain hardware at appropriate levels of currency	R	Yes	IS continues to progress hardware lifecycle plans to address capacity, support and performance challenges, to the extent possible within the bounds of the constrained funding. Constrained funding has resulted in an increase in deferred maintenance (technical debt) and as a result risk.
- On-going decrease of number of projects not aligned with roadmaps (and associated cost)	G	Yes	The Executive Group has accepted the overall 2018/19 IS Roadmap, inclusive of deferred maintenance (technical debt).

Key Result Area - IS Strategy	Status	Metric Change	Comment
- **100%** of Information Services projects prioritised via the business group (BRRG).	G	**100%**	All projects prioritised and approved by BRRG.
- Awareness of the regional portfolio in local Waikato District Health Board decision making	G	Yes	The DHB is the major contributor to the funding of projects delivering regional portfolio solutions. Of particular note is the Midlands Clinical Portal Foundation Project.
- Business resource review group goals delivered to Waikato DHB	A		BRRG and Enterprise Portfolio Office is under review as a result of changing obligations from Treasury (ICR, P3M3) and Ministry of Health.
– **25% On Time**	G	**67%**	**12 Months ending 31 August 2018** **8/12** projects were delivered on time. Projects that failed to meet time targets included: • PACs Upgrade 2015 (IS1504-002) due to technical complexity and vendor delivery. • NCAMP 2016 (IS1604-021) in order to reduce duplicate testing. • Netscaler Infrastructure (IS1610-008) due to resourcing and scope changes. • Paging System Upgrade (IS1702-004) due to technical complexities around testing resulting from aging legacy technology.
– **100%** On Budget	G	**100%**	**12/12** projects were delivered on budget.

– **100%** With Deliverables achieved	G	**100%**	**12/12** projects achieved deliverables.
– **100%** With PIR's completed	G	**100%**	No PIRs identified as outstanding.

Delivery Status

The Information Services team currently has 82 projects at various stages of delivery. The RAG (Red/Amber/Green) status of these projects is summarised within the following table.

		Overall RAG Status			
Phase	**Total**	**Red**	**Amber**	**Green**	**On Hold**
Scoping (Propose)	10		2	4	4
Delivery (Initiate/Plan/Develop)	65	3	40	12	10
Close	6		2	4	
PIR	1			1	
	82	**3**	**44**	**21**	**14**

Green = Project being delivered in accordance with agreed tolerances (Time, Cost, Scope, Risk, Resource & Benefit Realisation).
Amber = One or more of the delivery tolerances are at risk or not being meet, however Project Team / Project Executive has a plan to address.
Red = Delivery tolerances not being meet and assistance required to resolve.

3 projects are currently reporting a status of red (see before mentioned NOS challenges).

14 Projects are currently on hold:

Internal eReferrals	On Hold	Linked to Internal Referrals (On hold subject to eSpace repr
Anaesthesia Information System Discovery	On Hold	Pending Site Visits
IOS Mobile Printing	On Hold	Pending Design Review
Histology Digital Imaging	On Hold	Stakeholders have requested this be deferred
Mobile Application Management (Android KNOX)	On Hold	Approved June 18. Project Initiation Documents out for revie
Mobile Application Management	On Hold	Approved June 18. Project Initiation Documents out for revie
Point of Care Devices	On Hold	Approved June 18. Project Initiation Documents out for revie
ISL Reporting Tool	On Hold	On hold subject to a PIR and decision on next steps
IPM Data quality and Rules Engine	On Hold	Approved June 18. New PM to be allocated once available, 2018
CWS Tree structure and search (CDV)	On Hold	On hold subject to confirmation by MCP that we will proceed (linked to Metadata)
Clinical Workstation Metadata Scoping	On Hold	On hold subject to confirmation by MCP that we will proceed (linked to CDV Tree)
Maternity Information System Programme	On Hold	Deferred by Ministry
eData Workflow Scoping	On Hold	No funding for implementation
eData Workflow Implementation	On Hold	No funding for implementation

Potential/actual changes to key dates

Potential/actual changes to costs/benefits

Top Issues

Issue	Impact
IS Structure – Ongoing impacts of IS reorganisations and associated structure and process changes.	**High** – Impact to staff morale, retention and potential impacts to delivery and throughput.
Work program – IS ability to meet user expectations now heighted with forecasted effort related to the planned accelerated work program, IaaS delivery, windows 10 upgrade, regional service provision and eSPACE programme.	**High** – Impact to business and potential for increased failures.
Resourcing – Staff turnover and market pressures including competition from other health sector agencies is continuing to increase resource risks.	**High** – Loss of key staff will impact delivery of IS services both operational and project.
Capacity – The implementation of the IaaS solution is progressing to plan however whilst alleviating capacity constraints increases the financial risk footprint if current data storage growth rates continue as the demand for digital solutions increases.	**High** – Impact to business and potential for increased failures.
Security – Increased cyber security threat risk due to current level of delivery focus, system access and global phising and malware activity.	**High** – Impact to business if service delivery impacted by malware/virus attack.

Legend		Status
	R	Area of focus not on target with risk to service delivery. Area requires remediation plan to be in place and executing.
	A	An area of focus close to target or has improvement to target and has low risk to service delivery. Area requires direct management oversight and engagement.
	G	Area of focus on target with no risk to service delivery.

IS Performance Monitoring Committee Report

August 2018

M02 Financials

Annual Operating Budget		
-Before IDCC & Extraordinary	**29,506**	**k**
YTD Budget	**4,891**	**k**
Actual	**4,389**	
Variance (M02 is $502 K Fav)	**502**	**k**
Including IDCC		
Variance (M02 is $451 K Fav)	**451**	**k**

Capital Budget

Capital Budget		
>50k		
Board Approved c/f	**18,123**	**k**
Board App 17/18 Capex	**14,706**	**k**
Transfers	**0**	
Savings Plan Target	**-7070**	
Board Approved Total	**32,829**	**k**
DHB fund of Regional	**9,480**	**k**
IS Proj yet to commence	**13,025**	**k**
Defer to meet savings Plan	**7,070**	**k**
IS Proj open/completed	**12,734**	**k**
Total	**32,829**	**k**
Frcst Spend approved Proj	**} See Notes**	
Underspend/overspend	**} See Notes**	

Labour Recoveries

YTD Budget	775	**k**
Actual	917	**k**
Variance	**142**	**k**

IS Service Delivery

	Status	*Metric Chg*
Yearly review of SLA's	A	No
Qtrly SLA Reporting	G	Yes
75% services cust satisfied	G	75%
75% services users satisfied	G	91%
No more than 2 P1's / Mth	G	0
No more than 4 P2's / Mth	G	2.3
All CAT1&2 services with SLA ID	G	
100% SLA	G	100%
100% Business Owner	G	100%
100% Business Owner Charter	A	90%
100% Criticality Assessments	A	90%
100% Systems with risk score	A	90%
100% Risks with mitigations agreed	A	90%
Small Projects (NSWR)	A	
Resource allocation	A	133,255
Del/Closed (Target 35/Mth, 420/Yr)	A	27
Older than 6 Mths	G	14%
Older than 9 Mths	A	11%
Older than 12 Mths	R	36%
Number open	A	203

IS People

	Status	*Metric Chg*
Skills Maps for all staff	G	Yes
90% Staff with appropriate qual	A	No
Staff retention > 90% pa	A	86%
Staff satisfaction (75% satisfied)	R	57%

IS Process

Alignment IS process / frameworks	G	Yes
Project Assurance/proj compliance	G	Yes
Security Audit performed	G	Yes
Critical issues recorded	G	Yes
Serv delivery assurance vs SLA's	G	Yes
IT Infrastructure Lib review (ITIL)	A	No
Process at agreed level	A	No
COBIT review done	A	No
Process at agreed level	A	No
TOGAF reviewed yearly	A	No
Process at agreed level	A	No

IS Product

	Status	*Metric Chg*
Move of current to current -1	R	Yes
Maint hardware at correct levels	R	Yes
Decrease non-aligned projects	G	Yes

IS Strategy

100% IS projects prioritised by BRRG	G	100%
Awareness of Regional in Board Decisions	G	Yes
BRRG Goals delivered to Waikato DHB	A	
25% on time	G	67%
100% on budget	G	100%
100% with deliverables achieved	G	100%
100% with PIR completed	A	100%

Overall RAG Status

Phase	Total		Red	Amber	Green	On Hold
Scoping (Propose	10			2	4	4
Delivery (Initiate/Plan/Develop)	65		3	40	12	10
Close	6			2	4	
PIR	1				1	
	82		**3**	**44**	**21**	**14**

Professional Advisory Reports

Chief Nursing & Midwifery Officer: report due in October.

Chief Medical Officer: report due in January.

Decision Reports

Equity Focussed Reporting: report due in November.

MEMORANDUM TO THE BOARD
26 SEPTEMBER 2018

AGENDA ITEM 11.2

INTEGRATED COMMUNITY PHARMACY AGREEMENTS

Purpose	For approval.

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

The new national Integrated Community Pharmacy Agreement was agreed on 16 July 2018 and the new Agreement is due to come into effect on 1 October 2018. There are 77 pharmacy agreements that are due to be signed this month. As the new agreement is an evergreen agreement the term exceeds the delegations of the Chief Executive who has delegated authority to sign agreements with a maximum term of five years.

Given the large number of contracts requiring a DHB signatory, it is recommended that the Board delegate authority to sign evergreen agreements to the relevant management level based on the estimated per annum value of the agreement. For clarity this would be to the Executive Director Strategy & Funding for evergreen agreements with an estimated value of up to $5m per annum and the Strategy & Funding Manager for agreements with an estimated value of up to $1m per annum.

Recommendation
THAT
The Board adopt the above delegations and the Delegations policy be amended accordingly.

TANYA MALONEY
INTERIM EXECUTIVE DIRECTOR STRATEGY AND FUNDING

Significant Programmes/Projects

Medical School: no report this month.

Creating our Futures: no report this month.

Papers for Information

No Information papers.

Presentations

MEMORANDUM TO THE BOARD
26 SEPTEMBER 2018

AGENDA ITEM 14.1

ADVANCING TELEHEALTH FOR WAIKATO DHB

Purpose	For approval.

Introduction

Eight years ago a keen team of clinicians came together and formed a Telehealth interest group. This was a group of passionate individuals who firmly believed that there had to be a better way to provide health care, particularly to our rural population. With a huge amount of assistance from Andrew McCurdie (Chief Financial Officer) and our network service team we worked together to develop a business case to enable us to deliver our dream of supporting our rural hospitals by Telehealth. From that interest group grew a user's group and now this has grown to incorporate our Midland colleagues into the Midland Telehealth Advisory Group with a formal Midland Telehealth Strategy and work-plan.

Through the hard work of these individuals the Waikato DHB now provides a Telehealth service that provides regional and rural outpatient clinics to about 100 patients a month ranging from general surgery through to haematology. Our DHB has been considered pioneers for many of these clinics in New Zealand. As well as outpatient clinics we provide support to Thames Hospital via mobile telehealth cart for virtual rehabilitation ward rounds and acute stroke assessment. Thames and Waikato hospitals even have a Telehealth robot each to support our OPIVA clinic and allow interaction between clinicians at both sites. From this experience we have recently set up a trial with Tairawhiti DHB with a telehealth robot on loan from the Ministry of Health. In addition, we have trialed stethoscopes hooked into our Telehealth cart, as well as a number of different style cameras which can be used for looking at wounds and lesions or into ears, noses and throats. As an example two weeks ago we had our first formal oncology clinic with Dr Matthew Seel. Dr Seel saw 14 patients in Thames whilst he was physically present in Waikato. That one clinic saved our patients 2504 kilometers of driving amounting to a cost saving of about $1900, and that's just the direct financial savings, never mind the extra time the patients would have had to take off work or the cost to their family.

Currently about 20 services provide clinics by Telehealth. This averages about one clinic a month. However there is no regular monitoring or reporting of this provision and no clear way for services to grow clinics. With one part-time Telehealth Coordinator it is difficult to actively support the start-up of new clinics and we have no formal means to supply a service into a patients domicile, aged care facility, marae or General Practice. We could be so much more than this. The HealthTap work gave us clear insights into what could be achievable, and we now have threee services providing Telehealth visits into patient's homes as part of the interim solution. We now have a number of services literally champing at the bit to be able to

deliver services closer to home, and this includes the mental health service, paediatrics, diabetes, district nursing, and the trauma service. None of these services are able to get up and running however whilst we have no clear plan for our interim SmartHealth service. We are at a crossroads now and need to make a decision to either fully support the interim solution and move the solution into a supported growing model or allow the services to falter along as they are.

We know our population is aging, we know there is huge inequity and we also know that 60% of the population we serve live in a rural area. How will we best serve them into the future? At this exact moment in time we have probably the best opportunity that we have ever had to make a real difference in the lives of our patients through digital technology, this includes but is not limited to Telehealth.

The following has been put together for the purpose of informing you of the current potential options for the Telehealth programme.

Definitions

Telehealth is defined as: “The provision of healthcare by information/communication technology where the receiver of care is separated by distance from the provider.” The earliest form of Telehealth provision in New Zealand is that of radiological imaging (store and forward) with interpretation at a distant site (eg the existing Everlight service). Waikato DHB currently conducts a number of patient consultations via Telehealth using videoconferencing technology on a site by site basis (those that occur between Waikato Hospital and rural hospitals and other DHBs) and has done so for the past 7 years. Following the cessation of the HealthTap trial in early 2018 an interim solution was put in place to enable those outpatient services that had the highest Video-conferencing usage of the application to continue to provide a Telehealth service. These services were Public Health (Observation Therapy), Speech Language Therapy (SLT) and the renal service. This interim solution is currently being reviewed, however initial feedback suggests that it has been successfully received by patients and Clinicians, with 30% of the SLT outpatient consultations now performed using this solution. This paper sets out to briefly outline potential opportunities to extend the delivery of Telehealth to patients served by the Waikato DHB.

Opportunities

In order to further enable patients to receive the care they need closer to home there are four main opportunities for growth of Telehealth delivery accompanied by examples below:

1. Tele-acute care

    a. Support the development of tools to assist patients in information gathering and decision making as to where to go when. (Health navigator, kiosk technology, Healthline for example).

    b. Telehealth services within acute care facilities outside of Waikato Hospital (Rural hospitals, Anglesea, other GP sites providing acute care) to enable Specialist support to those facilities. Of note there are Telehealth facilities in the resuscitation rooms of all of the rural hospitals but these are currently used in a very ad hoc manner.

2. Tele-ambulatory care

    a. Encourage further development of Telehealth clinics between sites (rural and Midland DHBs) for outpatient visits. Currently there are around 100 formal outpatient visits by Telehealth a month, 20-30 of these are to Tairawhiti DHB, the rest are predominantly to the Waikato DHB rural hospitals.

    b. Support patients to have telehealth clinics wherever they may be (General Practice, Marae, home, work, travelling) these may be supported by health workers beside the patient.

    c. Support our Primary Care partners through integrating our Telehealth with both the cloud based solution used across primary care (Zoom) and that embedded within the dominant primary care PMS solutions.

    d. Observation therapy and diagnosis that may require video or imaging only such as that carried out by the public health team or the dermatology service may be performed by store and forward of images or video.

3. Tele-inpatient care

    a. Enable consultations to occur at the bedside between specialist teams at other centres.

    b. Enable patients to have video-conferences with their loved ones and enable ward rounds to be inclusive of whanau who may be offsite.

4. Tele-workplace support

    a. Continue to promote the ability of staff to videoconference for meetings, consider supporting staff to work from home and book videoconference meeting rooms.

    b. Support staff at different sites to attend meetings by videoconference

    c. Provision of specialised education to GPs, NGOs, rest homes etc.

Basic Requirements

The basic requirements for supplying a Telehealth solution can be put simply as:

1. Video conferencing technology (including technology diagnostic capabilities and statistical data gathering).

2. Booking tools.

3. Learning and support tools.

4. Reporting tools.

5. Integration of Telehealth into patient care pathways.

6. Staff and patient support to use the tools and assistance when things go wrong.

7. Clear consent processes for patients.

Current state

The technology to provide and book off-site and between site consultations by Telehealth is available within the interim solution and the requirements are documented. Learning tools have been developed for the interim solution. A reporting tool has not been formally developed but should be relatively easy to develop for those consultations that are being formally booked on iPM. Staff support and encouragement is still wanting and at the moment only the current services are supported by the interim solution (this project ends in November). One thing that is very clear is that most staff require a "silver-spoon" approach with hand holding for the first few consultations, this is quite resource intensive initially.

Options

From here we have four possible choices for the DHB to consider:

1. Continue to allow ad hoc development of Telehealth supported by the small Telehealth team of the Clinical Director and Telehealth Coordinator with the back-up of the network and e-learning team. This is status quo and reliant on the goodwill of staff to continue to support outside their usual remit. The risk is that some patients will benefit more than others and inequity will develop with the additional risk that the investment in the interim solution (and the HealthTap work) will potentially be lost and there will be very slow development of Telehealth.

2. Endorse the interim solution and move forward with other specialties as they come forward to request support for their patients. Set up a formal project in order to support the development of Telehealth for the DHB with a clear way of obtaining tools for consultations and support for growth of service. The risk is that this will provide slow growth of Telehealth services and will not achieve a change in paradigm at pace.

3. Actively promote the interim solution as the final solution, re-brand SmartHealth, market and provide full team support for change of practice within services within a fully-fledged project. Risk is mostly over-investment and potential to disrupt practice.

4. Go to RFP for a new solution. Major risk is as above and time lost in going to RFP.

All of these options should be approached in conjunction with primary health organisations to develop an all of community approach to the delivery of Telehealth services.

Of the options considered above the least favourable would be option 1, investment is still required for this option but it would likely be significantly less than other options. Options 2 and 3 give the best opportunity for progress but both require investment in the current interim solution and a dedicated resource to proceed.

The best path forward is to develop a formal business case and project plan in the first instance which should be informed by the current interim solution, the Ernst & Young HealthTap report, the Health System Plan and Care in the Community Plan and with clinician engagement. There is a need for speed in this instance as the interim solution has approval to the end of November and there is a need to have a clear path forward from that date.

Reference to EY report: (https://www.nzdoctor.co.nz/sites/default/files/2018-05/EY%20Waikato%20DHB%20Assessment%20of%20HealthTap%20Report.pdf).

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

Rurality and inability to access services are two of the biggest impediments to equity and Telehealth is an important tool in addressing these challenges.

Recommendation
THAT
The Board:

1) Notes the options presented in the report.
2) Notes that the development of a business case and project plan for the advancement of Telehealth at Waikato DHB is being pursued internally as an agreed consequence of the ending of the HealthTap contract, and will come to the Board in due course.
3) Notes that while it was previously agreed that future development of virtual care would be informed by the Health System Plan and Care in the Community Plan, we now envisage work occurring in the development of Telehealth in parallel to avoid delay.

DR RUTH LARGE
CLINICAL DIRECTOR INFORMATION SERVICES AND VIRTUAL HEALTHCARE

MEMORANDUM TO THE BOARD
26 SEPTEMBER 2018

AGENDA ITEM 14.2

PRESENTATION ON THE ESPACE PROGRAMME

Purpose	For information.

The eSPACE Programme has been approved by the five Midland DHBs and is for the implementation of the Midland Clinical Portal (MCP) that will replace the existing five clinical workstations. MCP is the primary tool used by DHB clinicians and implementation will include enhanced functionality and integration to primary care. This will improve DHB and NGO clinicians' access to patient information.

The presentation covers:

1) The status of the eSPACE programme.
2) Demonstrate what has been delivered and what is in the pipeline.
3) Outline what and when the next phase will be delivered.
4) Outline some of the benefits that have been delivered.
5) Summarise the key risks.

This presentation will be given by:

1) David Page (Programme Director).
2) Shelley Baker (Programme Manager).
3) Alex Slater (Technology Director).

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

The Midland Clinical Portal will provide a single point of access to standards based patient information from all five Midland DHBs. This will support:

1) Better reporting for the region.
2) Feedback loops to improve the quality of the data.
3) Clinical risk reduction for highly mobile populations which tends to be a characteristic of Maori.

Recommendation
THAT
The Board receives the presentation.

MAUREEN CHRYSTALL
EXECUTIVE DIRECTOR CORPORATE SERVICES

eSPACE

Supporting Patients and Clinicians Electronically

Waikato DHB Board Meeting
26 September, 2018

We are a clinically-led transformation programme across all five Midland District Health Boards that is supported and enabled by technology.

eSPACE

How are we governed?

There are several levels governance within the eSPACE Programme, each with specific levels of accountability and decision making rights.

Bay of Plenty DHB
Chair: Sally Webb

Hauora Tairāwhiti
Chair: David Scott

Lakes DHB
Chair: Deryck Shaw

Taranaki DHB
Chair: Pauline Lockett

Waikato DHB
Chair: Sally Webb

MIDLAND eSPACE CHIEF EXECUTIVE GOVERNANCE GROUP

Bay of Plenty DHB
CE: Helen Mason

Hauora Tairāwhiti
CE: Jim Green

Lakes DHB
CE: Ron Dunham

Taranaki DHB
CE: Rosemary Clements *(Chair)*

Waikato DHB
CE: Derek Wright

eSPACE SRO
Maureen Chrystall

eSPACE Programme Director
David Page

Programme Manager
Shelley Baker

Technology Director
Alex Slater

Financial Director
Derek Shorter

Programme Operations Lead
Dianne Johnson

Benefits Lead
Mandy Lacy

Change & Learning Manager
Cathy Taylor

Communications Lead
Kiriwai Mangan

eSPACE Programme Board
Chair: Maureen Chrystall

Clinical Authority
Chair: Dr Ian Martin

Design Authority
Chair: Alex Wheatley

Operational Authority
Chair: Lynsey Bartlett

One Patient One Record

Midland Clinical Portal

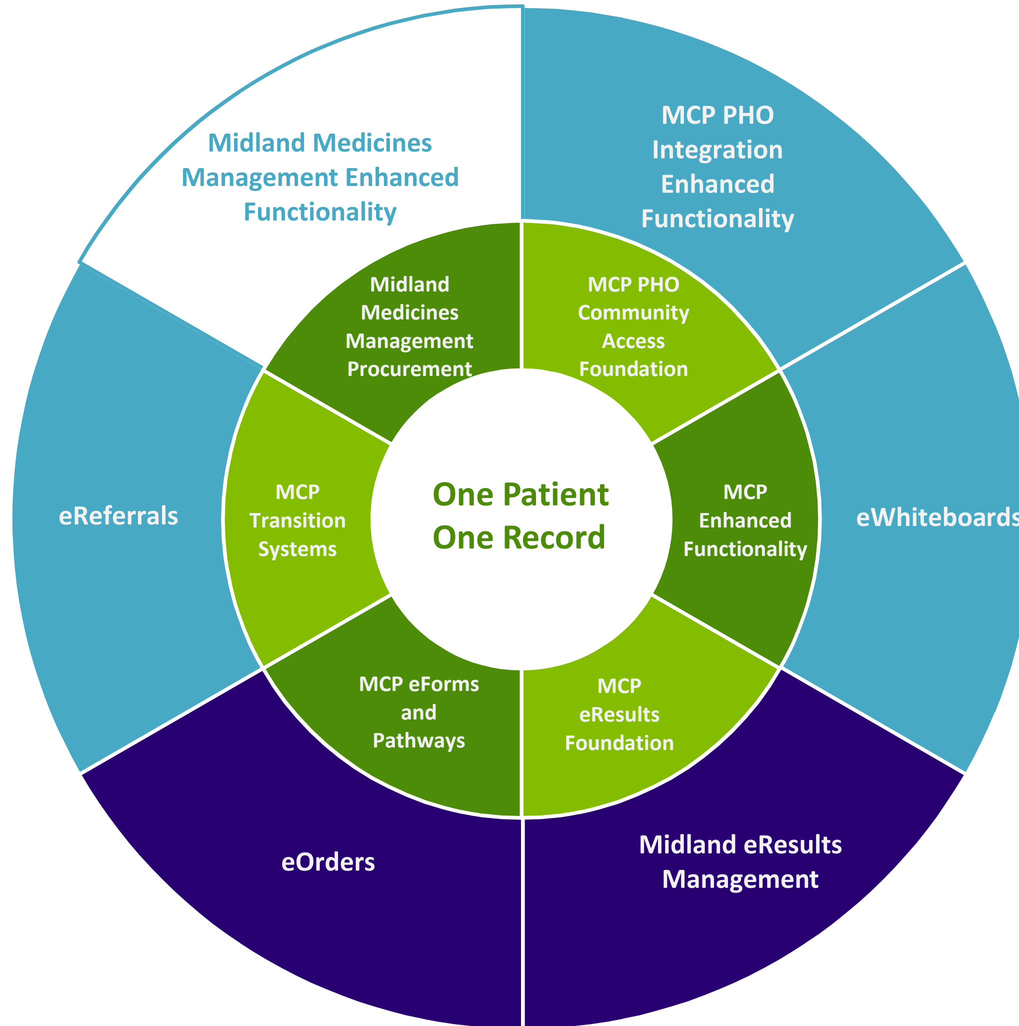
Realising our shared vision of one patient, one record

*Video here

eSPACE

Midland Clinical Portal

Delivery in three phases



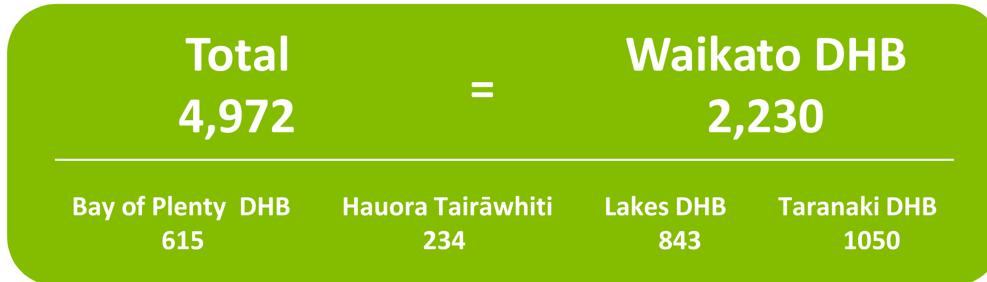
Phase One
Read only

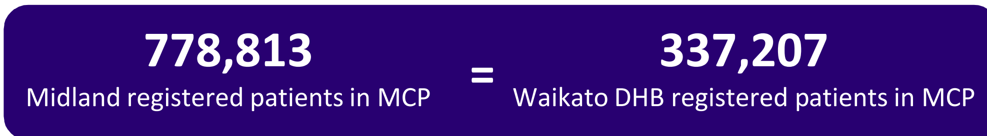
Phase Two
Create - read/write

Phase Three
'Smarts' - decision support

Our numbers so far

Midland Clinical Portal dashboard





Most popular

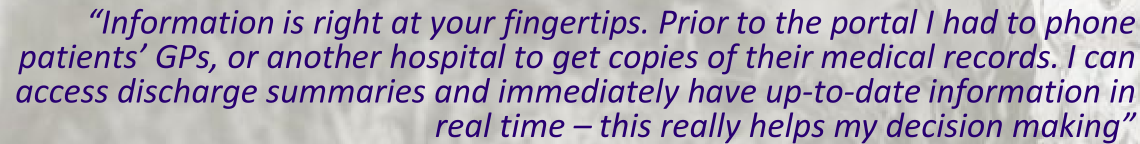
Documents Accessed

Discharge summaries
Clinical letters
Interventions/Procedures
Referrals
Assessments
Progress Reports

Top

User Activities

Problem List
Search Performed
Open Document
Patient Details
Encounter Summaries

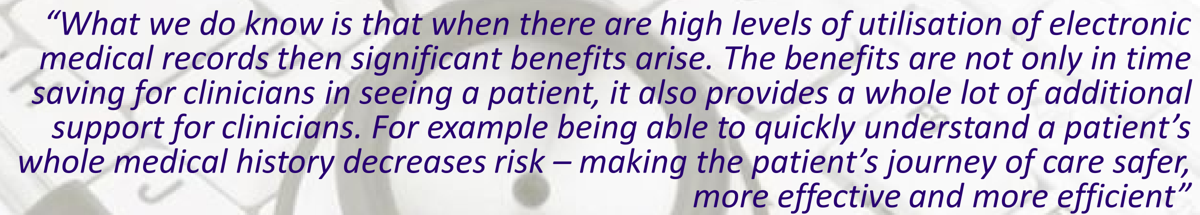


Dr Hannah Lawn
Emergency Department, Hāwera Hospital

Benefits

- Saving time
- Supporting clinical decision-making
- Improving quality of care
- Improving clinical outcomes
- Reduced testing and improving accuracy
- Standardising care across the region

eSPACE



Dr Andrew Darby
Psychiatrist, Waikato DHB

Demonstration

- Midland Clinical Portal
- NZePS
- Results

eSPACE

eSPACE

Supporting Patients and Clinicians Electronically

Board Member Items

Car Parking Pay Stations (refer item 18 in public excluded).

Living Wage (report due in October).

Next Board Meeting: 24 October 2018.