Board Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	23 January 2019	**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 Dr C Wade
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:	27 February 2019	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680
	www.waikatodhb.health.nz	

Our Vision: **Healthy People. Excellent Care**

Our Values:

People at heart – **Te iwi Ngakaunui**
Give and earn respect – **Whakamana**
Listen to me talk to me – **Whakarongo**

Fair play – **Mauri Pai**
Growing the good – **Whakapakari**
Stronger together – **Kotahitanga**

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: 28 November 2018
   - 3.2 Committees Minutes:
     - 3.2.1 Iwi Maori Council: 4 December 2018
     - 3.2.2 Hospitals Advisory Committee: 12 December 2018
     - 3.2.3 Community and Public Health Advisory Committee: 12 December 2018

4. INTERIM CHIEF EXECUTIVE REPORT

5. QUALITY AND PATIENT SAFETY
   No report this month

6. FINANCIAL PERFORMANCE MONITORING
   - 6.1 Finance Report

7. HEALTH TARGETS

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

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

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

11. DECISION REPORTS
    - 11.1 Equity Focussed Reporting (quarterly report, due March)

12. SIGNIFICANT PROGRAMMES/PROJECTS
    - 12.1 Creating our Futures (report due in February)
    - 12.2 CBD Accommodation Project
    - 12.3 Regional eSPACE Programme
    - 12.4 National Oracle System (quarterly report, due February)

Board Agenda

13. PAPERS FOR INFORMATION

13.1 Waikato DHB Suicide Prevention and Postvention Annual Report 2017-18

14. PRESENTATIONS

No presentations

15. BOARD MEMBER ITEMS

15.1 The Living Wage Update (report due in February)

NEXT MEETING: 27 February 2019

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 28 November 2018 (Items taken with the public excluded)
- (ii) Audit and Corporate Risk Management Committee to be adopted: Wednesday 28 November 2018 (All items)

Item 17: Exit of Practices from Hauraki Primary Health Organisation – Public Excluded
Item 18: Review of Care of Thames Patients – Public Excluded
Item 19: Consultation on the Health Finance Procurement and Information Management System (FPIM) Business Case – 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:	Exit of Practices from Hauraki PHO – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 18:	Review of Thames patients – Public Excluded	Negotiation will be required	Section 9(2)(j)
Item 19:	Consultation on the FPIM business case – 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.

Board Agenda

(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: 28 November 2018
To be confirmed: Items taken with the public excluded

16.2 Audit & Corporate Risk Management Committee: 28 November 2018
To be adopted: All items

17. EXIT OF PRACTICES FROM HAURAKI PRIMARY HEALTH ORGANISATION – PUBLIC EXCLUDED

18. REVIEW OF CARE FOR THAMES PATIENTS – PUBLIC EXCLUDED

19. CONSULTATION ON THE HEALTH FINANCE PROCUREMENT AND INFORMATION MANAGEMENT SYSTEM BUSINESS CASE (FPIM) – 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 JANUARY 2019

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	

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

Clyde Wade

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

Professor Margaret Wilson

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

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

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

Te Pora Thompson-Evans

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

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

Conflicts related to items on the agenda.

Minutes and Board Matters

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Board Meeting held on Wednesday 28 November 2018 at 1.00pm in the Board Room, Hockin Building at Waikato Hospital

Present: Ms S Webb (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

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

ITEM 1: APOLOGIES FOR ABSENCE

Apologies for absence were received from Professor M Wilson (Deputy Chair) and Dr C Wade. Ms P Mahood for lateness (arrived at 1:15 pm)

ITEM 2: INTERESTS

2.1 Register of Interests

No changes to the Register of Interests were noted.

2.2 Interest Related to Items on the Agenda

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

ITEM 3: MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato District Health Board Minutes: 24 October 2018

Resolved
THAT
The part of the minutes of a meeting of the Waikato District Health Board held on 24 October 2018 taken with the public present was confirmed as a true and accurate record subject to an amendment under 11.1 Building Research for Waikato DHB it be recorded that 700 Māori had participated in the research not the number previously stated.

Resolved
THAT
The Board accepted the minutes of the last meeting.

3.2 Committee Minutes:

3.2.1 Iwi Māori Council: 4 October 2018
3.2.2 Māori Strategic Committee: 17 October 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:

- Chief Operating Officer – following the interview process the panel did not appoint a suitable candidate. The Chief Operating Officer role will not be re-advertised until a Chief Executive is appointed.

- Business case for telehealth – feedback from a recent CHIF meeting was well received. The public in attendance expressed a willingness to become involved with new technology.

- A plan to create a decanting space will be presented at the January 2019 meeting.

- Outcome statement from meeting with Pinnacle – there had been an agreement to work together on the proposal for ALT and to advance the roll-out of the Health Care Home model. Concern was expressed that more focus could be placed on enhancing primary care services for the population served including Maori health equity rather than just concentrating on the Health Care Home model.

- Transport to and from Campus – a Meeting had been held with the Regional Council. Waikato Regional Council will come back the DHB with further information and numbers.

- Living Wage – The objective is to have everyone in employment on a living wage. Board Members requested that consideration be given to how this fits in terms of services available to people with the Community Health Card.

ITEM 5: QUALITY AND PATIENT SAFETY REPORT

5.1 A Patient Story

Ms M Neville attended for the Quality and Patient Safety Report that focussed on a patient story. The mother of a young man had complained to the DHB about their experiences at an ophthalmology clinic appointment. The lady had been invited to the Board meeting to share their story and experiences as

service users. She explained to the meeting that she had attended an out patients appointment with her son. They had a long wait at the out patient's clinic to see a doctor. She stated that when they asked the reception staff how long the wait would be until they saw the doctor a lack of empathy and maanaki was shown by the staff. No explanations or apologies were offered for the long wait at the clinic. This complaint had been investigated by the Quality and Patient Safety team.

The Chair commented that it is totally inappropriate for people to have to wait hours at an outpatient clinic to be seen. The Interim Chief Executive's view was that the DHB needs to look at co-designing clinics to make sure that this doesn't continue happening.

Resolved
THAT
The Board adopted the proposed approach and guideline to consumer stories as part of the overarching consumer engagement framework.

ITEM 6: FINANCIAL PERFORMANCE MONITORING

6.1 Finance Report

Mr A McCurdie attended for this item. The financial results summary for the month of October 2018 was presented to the Board. The report was taken as read. It was noted:

- A favourable variance year to date of $3.8m. However $2.8m related to the prior year.
- $3.4m were net costs
- $2.4m adverse to budgets
- Nursing costs were $1.5m unfavourable due to the impact of the new acuity based nurse staffing levels and the recruitment of nurses. Board members asked to be informed from a geographical perspective where the new nurses are coming from along with how many people are 'returning to nursing'.

Resolved
THAT
The Board received the Finance Report for October 2018.

ITEM 7: HEALTH TARGETS

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

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

- Some targets i.e. "Better help for smokers to quit maternity" had not been updated due to a data problem.
- Smoking cessation is an area where there is significant work to do. A question was asked what the consequences were for PHOs who are not

performing in this area; what levers does the DHB have to address poor performance.
- Shorter stays in ED – the number of people who have waited more than 6 hours in ED are still high despite different models of care had been tried over the winter period.

Resolved
THAT
The Board received the report.

ITEM 8: HEALTH AND SAFETY

Quarterly Report due in January 2019

ITEM 9: SERVICE PERFORMANCE MONITORING

9.1 Chief Data Officer Directorate (report due in January
9.2 Interim Chief Operating Officer (report due in January)
9.3 Mental Health and Addictions Service (report due in January)
9.4 Strategy and Funding (report due January)
9.5 People and Performance (report due January)
9.6 Facilities and Business (due in February)
9.7 IS Performance Monitoring (due in February)

ITEM 10: PROFESSIONAL ADVISORY REPORTS

10.1 Chief Medical Officer (report due in January)

10.2 Chief Nursing and Midwifery Officer (report due in April)

ITEM 11: DECISION REPORTS

11.1 Equity Focussed Reporting

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

- Raising Healthy Kids – Board members asked that the actual numbers be included in the next report.
- Board Members asked that performance takes on a community focus rather than a PHO focus. An assurance was given it is a community focus that does look a responsive models of care.

Resolved
THAT
The Board received the report.

11.2 Information Services Disaster Recovery Project

Mr G King attended for this item. A paper was presented to seek approval for the Information Services Disaster Recovery Project business case. It was noted:

- Forty core applications had been identified with continuity plans that are not sufficient.
- Six options were considered for the purpose of the business case.
- Option 5b was the DHB's preferred option. However it was recognised that the DHB may be directed to implement one of the AoG IaaS options.

Resolved
THAT
The Board
1) Noted the contents of this paper.
2) Noted the operational and capital investment required.
3) Noted that Option 5b is Waikato DHB preferred option. However it may be directed to implement one of the All of Government IaaS based options, with resulting OPEX cost uplift.
4) Approved the Information Services Disaster Recovery Project business case.

11.3 Naming of the Youth Room – Chiefs Chill Out Zone

Ms L Aydon attended for this item. The paper set out a proposal to name a youth space in Waikids at Waikato Hospital 'the Chiefs Chill Out Zone' recognising the long association with the Chiefs and the fundraising by the team.

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Resolved
THAT
The Board approved the naming of the youth room in Waikids, the 'Chiefs Chill Out Zone'.

ITEM 12: SIGNIFICANT PROGRAMMES/PROJECTS

12.1 Creating our Futures

12.1.1 Mental Health and Addictions System

Ms T Maloney and Ms V Aitken gave a presentation that focussed on mental health and addictions treatment and support services and acknowledged the protective factors (determinants of well-being) that enhance mental health and well-being and the role of the healthcare system has in influencing those factors.

It was noted that the draft Healthcare system map included in the presentation was still a draft.

Resolved
THAT
The Board provided their feedback on the draft Mental Health and Addictions draft system of care.

12.1.2 Waikato DHB Mental Health an Addictions Facilities and Service Redevelopment Project Indicative Business Case.

Ms V Aitken and Mr C Cardwell attended for this item. The Waikato DHB Mental Health and Addictions Facilities and Service Redevelopment Project Indicative Business Case document was attached for the Board's approval. It was noted:

- The proposed Option D – New Acute MH Building Waikato Hospital and sub-acute/Outreach Services was taken forward to Detailed Business Case.
- Additional understanding of the acute option was required to determine the size, location and site implications.
- The preferred way forward will take into account the specific needs for Māori using frameworks and models of care that includes a holistic approach to health and well-being.
- One Board member expressed that more focus should be put on services in the community where there is a gap. The Board member did not support the business case at this time.

Resolved
THAT
The Board

1) Approved the Indicative Business Case submission to NZ Treasury and the Ministry of Health for presenting to Investment Ministers. Provided that the cost remained within the agreed budgeted amount.
2) Endorsed to proceed with developing the Detailed Business Case (due for submission in June 2019)
3) Approved the continued funding of the programme related work.

Mr MacPherson voted against the resolution to approve the Indicative Business Case being forwarded to NZ Treasury and the Ministry of Health.

12.2 CBD Accommodation Project (bimonthly report, due January)
12.3 Regional eSPACE Programme (quarterly report, due January)
12.4 National Oracle System (no report this month)
12.5 Medical School (no report this month)

ITEM 13: PAPERS FOR INFORMATION

There were no papers for information this month.

ITEM 14: PRESENTATIONS

There were no presentations this month.

ITEM 15: BOARD MEMBER ITEMS

15.1 Living Wage – (report due in February).

NEXT MEETING

The next meeting is to be held on Wednesday 23 January 2019 commencing at 1.00 pm at in the Board Room in the Hockin Building, Waikato hospital.

BOARD MINUTES OF 28 NOVEMBER 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 16: MINUTES – VARIOUS:

(i) WAIKATO DISTRICT HEALTH BOARD MEETING FOR CONFIRMATION: WEDNESDAY 24 OCTOBER 2018 (ITEMS TAKEN WITH THE PUBLIC EXCLUDED)
(ii) AUDIT AND CORPORATE RISK MANAGEMENT COMMITTEE – VERBAL UPDATE TO BE RECEIVED: WEDNESDAY 28 NOVEMBER 2018 (ALL ITEMS)
(iii) MIDLAND REGIONAL GOVERNANCE GROUP – TO BE RECEIVED: FRIDAY 5 OCTOBER 2018
(iv) MIDLAND REGIONAL GOVERNANCE GROUP – TO BE RECEIVED: FRIDAY 2 NOVEMBER 2018

ITEM 17: ALL OF GOVERNMENT MICROSOFT NEGOTIATIONS – PUBLIC EXCLUDED

ITEM 18: PATIENT TRANSFER SERVICES – PUBLIC EXCLUDED

ITEM 19: WAIKATO DHB MENTAL HEALTH AND ADDICTIONS FACILITIES AND SERVICE REDEVELOPMENT PROJECT INDICATIVE BUSINESS CASE – PUBLIC EXCLUDED

ITEM 20: HUMAN RESOURCES INFORMATION SYSTEM RENEWAL – 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 16: (i-iv) Minutes	Items to be adopted/ confirmed/ received were taken with the public excluded	As shown on resolution to exclude the public in minutes
Item 17: All Of Government Microsoft Negotiations – public excluded	Negotiations will be required	Section 9(2)(j)
Item 18: Patient Transfer Services – Public Excluded	Negotiations will be required	Section 9(2)(j)

Item 19:	**Waikato DHB Mental Health and Addictions facilities and Service Redevelopment Project Indicative Business Case – Public Excluded**	**Negotiations will be required**	**Section 9(2)(j)**
Item 20:	**Human resource Information System Renewal – Public Excluded**	**Negotiations will be required**	**Section 9(2)(j)**

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

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

ACTION LIST

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

Agenda Item	**Action Agreed**	**Name of Executive Director Responsible for Action**	**Month action to be reported to the Board**
12.5	28 November 2018 Future discussion on clinical workforce development	Gil Sewell	TBA

Meeting Minutes

Meeting name:	Iwi Maori Council		
Location:	KPMG, Level 9, Kotahitanga Meeting Room		
Date:	04/12/2018	**Time:**	09.30am
Chairperson:	Ms T Thompson-Evans	**Minutes by:**	Ms S Greenwood
Attendees:	Ms T Moxon (Deputy Chair), Mr G Tupuhi, Ms T Ake, Dr K McClintock, Ms C Brears, Ms M Balzer		
Apologies:	Ms K Gosman, Ms S Turner		
Others in attendance	Ms J Eketone, Ms J Crittenden, Mr T Turner (Kaunihera Kaumātua), Ms T Hodges		

Item No.	Details	Attachments	Assigned to
1.	**KARAKIA** Mr T Turner		
2.	**MIHI** Mr T Turner		
	Public excluded until 11:10am		
3.	**MENTAL HEALTH AND ADDICTIONS** • Suicide data shows children at higher risk when living in organised care, fallen out of school and have been abused. • Tamariki are unsure of their own whakapapa – not knowing one or both sides of their family. Identity (whakapapa) is critical to recovery process and impact of mental health and wellbeing. • Hinemoa Elder made a recommendation to the Courts about how they should be engaging with Maori as there is no current framework that engages with families. • Youth suicide rates in Maori from 15-25, male are the highest and have been for the last 20 years. They may not have even come into contact with mental health services or support. • How do we strengthen whanau to address any MH issues? How do we address safety at home? • We should stop asking for permission and look at a starting point of “what can we do for ourselves?” • Board have agreed for a bid to go ahead for the building of a new building through the capital investment committee. If we miss this opportunity it would be a further 5 years before this bid could be made again. • Detailed business case is required by the end of 2019 including detailed design. • It is expected that we have an IMC voice on the Board for an indicative business case. • A Māori voice is required throughout this and every project from the very beginning. • This business case should also include where the money is coming from and how the additional beds will be funded. There is concern that this money will be		

Meeting Minutes

	pulled from Maori community provider funding. • IMC should consider that we can be involved in project building governance board and the clinical governance group. • Any additions need to be emailed to IMC Chair. • There was a recommendation to remove middle management from the project structure and to have project committee information going directly to IMC and Board. **MENTAL HEALTH EQUIRY** • Invites have gone out to DHBs to find representatives to join the Ministry Committee. Waikato-Tainui has nominated Dr K McClintock. • Given the DHBs are providers, a watchdog group should be independent of DHBs. • Could the DHB withdraw their nomination and endorse the Waikato-Tainui nomination? This approach is endorsed by IMC. • Terms of Reference wanted by IMC.		
4.	**PRESENTATION – BREAST SCREENING – Shona Duxfield** **Screening rates** • Gradual increase in rates of screening for wahine Māori. **Coverage rates** • Data presented for Waikato DHB, Lakes DHB, Bay of Plenty DHB wahine from 45-69 years of age. **How should we do it?** • Change of thinking from Ministry to whanau-focused. • Iwi and whānau specific strategies depending on community functions. • Wellness focus. • Community centric / development approach. • Inclusive approach of inter-generational whānau. • Locality specific. • Opportunistic screening benefits the DHB with higher rates but doesn't empower women to get follow up. • Trying to improve access. • Initiatives for wahine to engage and follow up and improve their experience. • Breast screening to work with TPO to put forward an approach that would be presented to IMC for approval. **IMC discussion** • We should be using social media to get screening messages across. • Presenting in light hearted ways to get serious messages out.	Pages 12-31, agenda item 10 04/12/2018	

Meeting Minutes

Actions

Details	Who
Hui in Feb 2019 to discuss strategic model for breast screening with a whānau approach to screening.	J Eketone

Meeting Ended: 13.30pm
Next Meeting: Thursday 7th February 2019

Hospitals Advisory Committee minutes: verbal report from the Committee Chair will be given.

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Community and Public Health Advisory Committee and Disability Support Committee held on 12 December 2018 commencing at 1.00pm

Present: Dr C Wade (Chair)
Ms T Hodges
Ms C Beavis
Mrs P Mahood
Mr J McIntosh
Mr D Slone
Ms J Small
Ms TP Thompson-Evans
Ms S Webb

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

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

ITEM 1: APOLOGIES

Apologies were received from Mr M Arundel, Ms S Mariu, and Mr R Vigor-Brown.

Resolved
THAT
The apologies were received.

ITEM 2: INTERESTS

2.1 Register of Interests
There were no changes made to the Interests register.

2.2 Conflicts Relating to Items on the Agenda
No conflicts of interest relating to items on the agenda were foreshadowed.

DRAFT

ITEM 3: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

3.1 Waikato DHB Community and Public Health Advisory Committee; 8 August 2018

The opportunity of a joint media smoking cessation campaign with Lakes DHB will be explored.

An outcome of the Strategy and Funding Team review was that the Public Health Unit would be subject to a separate review in 2019.

Resolved
THAT
The minutes of a meeting of the Waikato DHB Community and Public Health Advisory Committee held on 8 August 2018 be confirmed as a true and correct record.

3.2 Lakes DHB Community and Public Health Advisory Committee; 8 August 2018

Ms P Mahood highlighted agenda item 1.5 of the Lakes DHB minutes regarding the presentation on a very successful immunisation programme.

Resolved
THAT
The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 8 October 2018 were noted.

3.3 Lakes DHB Disability Support Advisory Committee; 5 November 2018

Resolved
THAT
The minutes of a meeting of the Lakes DHB Disability Support Advisory Services Committee held on 5 November 2018 were noted.

3.4 Bay of Plenty DHB Combined Community & Public Health Advisory Committee / Disability Advisory Services Committee Members; 3 October 2018

Ms MA Gill recommended the presentation "First 1000 Days – Unbroken Chain of Care"

Resolved
THAT
The minutes of a meeting of the Bay of Plenty Combined Community & Public Health Advisory Committee / Disability Advisory Services held on 3 October 2018 were noted.

DRAFT

ITEM 4: DISABILITY SERVICES

4.1 Disability Responsiveness Plan Update

The newly appointed Director of Māori Health and Equity (Ms Rachel Poaneki) would be leading the development of the Disability Responsiveness Plan.

Mr D Sloane and Ms J Small were part of the Reference Group. Members suggested the inclusion of conditions such as diabetes and Cystic Fibrosis be included in the Plan.

Resolved
THAT
The Committee noted the Draft Disability Responsiveness Plan will be brought to the April 2019.

ITEM 5: PAPERS FOR DECISION

5.1 Draft Committee Schedule

A draft committee schedule for 2019/20 was discussed by members with the following inclusions/ changes suggested;

- A deep dive into the effects of dental health. Information to be provided on thresholds for coverage under the public system for over 18 year olds, data on how poverty links with dental health, and consideration of research from areas such as Taumarunui.

- Diabetes to be included under the topic “Prevention and Management of Long Term Conditions. It was suggested Justina Wu provide a presentation. Members requested a whole of system approach be included as part of this topic which should cover how the DHB was working with PHOs

- Establish which DHB Board/Committee was appropriate to received feedback from other initiatives such as Waikato Plan, Te Pae Tawhiti and the other numerous plans and reviews underway.

- “Our approach to Community Engagement and Partnering with Māori” is scheduled for April to allow time to clarify framework across the organisation. Management suggested this topic could be brought to an earlier committee meeting for open discussion.

Resolved
THAT
The Committee accepted the draft schedule for 2019/20 with the inclusion of the above discussion points.

DRAFT

ITEM 6: PAPERS FOR INFORMATION

6.1 Immunisation Coverage Update and Actions to Improve Coverage

An update was provided on immunisation coverage and the challenges in addressing improvement. Management acknowledged that whilst some service configuration had been changed, a more holistic approach was required if radical improvement in the health of the most at risk was to be realised. This approach required the vulnerable population to be better identified; and then working alongside the at risk population in a whānau ora way. This should not only include opportunistic activities (like pharmacists being able to immunise) but required the DHB to develop a fundamentally different approach to Māori health. It was expected that the Care in the Community Plan would help identify how this can be addressed in a holistic way.

It was highlighted that a significant amount of babies which are not immunised were not enrolled in a PHO.

Te Puna Oranga had completed some work on Did Not Attend figures which identified that often it was because notification of the appointment had not been received. Consideration should be given to the fact that it may not just be an access issue but rather the way we are engaging with whānau

Further work may be required on identifying vulnerable families.

Resolved
THAT
The Committee received the report.

6.2 Waikato DHB Submission Draft 2018-2028 Waikato Regional Draft Transport Plan

Dr Richard Vipond attended for this agenda item.

The Waikato DHB September submission on the Waikato Regional Council's Draft Public Transport Plan was submitted for the Committee's information.

Of note:
- Mr M Gallagher highlighted his support to encourage Hamilton City Council to provide free transport for people with disabilities.
- The CEO and some board members had met with Waikato Regional Council staff to advance the case for better public transport for patients and staff.
- The geographical area covered by Waikato DHB and Waikato Regional Council differed.
- The inclusion of radical improvements for Māori Health would have strengthened the submission presented and should be included in future all future DHB submissions.

Resolved
THAT
The Committee noted the report.

6.3 Waikato DHB Submission on Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22

Mr Richard Wall attended for this agenda item.

The Waikato DHB August 2018 submission on the Strategy to Prevent and Minimise Gambling Harm was reported to the Committee for information.

Of note:

- The relocation of pokie machines was not part of the revised document as it would be considered separately.
- On-line gambling could benefit from further research.

Resolved
THAT
The Committee noted the report.

6.4 Waikato DHB submission on Healthy Homes

Dr Richard Vipond attended for this agenda item.

The Waikato DHB September submission on Healthy Homes was submitted for the Committee's information.

It was agreed that item 3.2.3.1 of the submission should be re-worded to note that unflued gas heaters are not acceptable heating devises.

Resolved
THAT
The Committee noted the f the report.

6.5 Waikato DHB Submission on the Reform of the Residential Tenancies Act 1986

Dr Richard Vipond attended the meeting for this agenda item.

The Waikato DHB September submission on the Reform of the Residential Tenancies Act 1986 was reported to the Committee for information.

Resolved
THAT
The Committee noted the content of the report.

DRAFT

ITEM 7: PRESENTATIONS

7.1 Review of Waikato DHB Position Statements on Tobacco Control, Alcohol Harm, and Psychoactive Substances

Presented by Dr Richard Hoskins, members were provided with an overview of the purpose of position statements and an updates to three Waikato DHB position statements.

Of note:
- Recognition that the DHB will not achieve the smoke free target on our own by 2025, but was getting closer.
- Vaping outlets can only be controlled if nicotine is being sold.
- Evidence is currently not available regarding the effects of vaping however grave concerns arising regarding moisture being inhaled into lungs.

Resolved
THAT
The Committee noted the presentation.

Mr M Gallagher left the meeting at 2:30pm.

7.2 Waikato Health System Plan (HSP) Update

Presented by Mr Danny Wu, HSP Programme Director, the Committee were provided with an update on the Health System Plan.

Of note:

- The Long Term Investment Plan is due in July but would be updated every two years.
- Due to the collaborative approach used for the HSP, the process has taken longer than normal.
- A draft plan would be brought to the CPHAC members prior to it being publically released.

Resolved
THAT
The Committee received the report.

7.3 Tamariki and Rangatahi Health and Wellbeing

Presented by Dr Damian Tomic, members were provided with an over view of current services and investment in child and youth services by the Waikato DHB.

Of note:
- Data capture only portrays where the population are living not necessarily how the population is made up so would not necessarily identify those with disabilities. It was acknowledged that it is hard to capture what it is that makes a person identify as having a disability especially if intellectual.

- The new public sector reform process currently underway is about joined up services. It was intended that the Health System Plan and Care in the Community Plan would provide this context. It was expected that a whole system approach would be completed for Child Health similar to what Te Pae Tawhiti approach was for Mental Health

Resolved
THAT
The Committee noted the report.

ITEM 8: GENERAL BUSINESS

There were no general business items raised.

ITEM 9: DATE OF NEXT MEETING

13 February 2019

Chairperson: ______________________________

Date: ______________________________

Meeting Closed: 3:40 pm

DRAFT

Chief Executive Report

MEMORANDUM TO THE BOARD
23 JANUARY 2019

AGENDA ITEM 4

INTERIM CHIEF EXECUTIVE'S REPORT

Purpose	For information.

RDA Strike Action

Last week we had a 48 hour strike by RMOs and a further 48 hour strike has been notified for 29 and 30 January. There is some indication that there may be to two further strikes in February.

The planning we put in place for last week's strike worked well, though some elective operations and some outpatient clinics were deferred.

We had a number of RMOs that were not RDA members or are members but chose not to strike, who came to work during the 48 period.

We respect the RMOs right to strike and are still hopeful that a resolution to the current dispute can be found.

MERAS (Midwives Union)

MERAS have called off their 2 hour rolling strikes to go back into negotiations and we are hopeful a resolution can be found.

Biomedical Technicians

Biomedical Technicians, who are member of APEX, had initiated industrial action, which resulted in the Technicians not undertaking their full duties; they refused to test equipment once it had been repaired.

This action has now been called off and the DHB are back in discussion with APEX and an offer has been made to settle this contract.

MECAs and SECAs

For the Board's information please find attached a list of all MECAs (multi-employer collective agreements) and SECAs (single employer collective agreements) that the Waikato DHB is party to along with their expiry dates.

Maori Equity

The four Northern District Health Boards (DHBs) and Waikato DHB met before Christmas to discuss how we could work together with Iwi to improve the health outcomes for Maori. This meeting followed a meeting our Board and members of Iwi Maori Council had with Pat

Sneddon (Chair of Auckland DHB) to discuss options for how we can radically improve health outcomes for Maori.

This discussion dovetails with our own Board discussions on radical improvement for Maori being our number one priority.

At the meeting it was proposed that the five DHBs worked together to share information but that in terms of practical solutions it would be better to work along Iwi boundaries, though there is clear agreement about the boundaries. This would mean Auckland, Waitemata and Northland DHBs would work closely together on solutions, and Counties Manukau and Waikato DHBs would collaborate. We would need to consider how we involve all our Iwi partners.

Executive Appointments

In the latter part of 2018 we advertised and interviewed for a Chief Operating Officer (COO) but did not make an appointment. Dr Grant Howard left the role on 7 January 2019. I have retained Ron Dunham as Acting COO for a period of six months through to the end of June 2019, following his resignation as Chief Executive of Lakes DHB. In the meantime we will commence a search for a permanent COO. It is planned that this search will coincide with the appointment of the permanent Chief Executive. The Chief Executive can then organise interviews and make the permanent COO appointment.

In December we recruited for an Executive Director Mental Health and Addictions and Vicki Aitken was appointed to that position on a permanent basis.

Our Board Chair was part of the panel for the recruitment of both positions and the Chief Executive of Waitemata DHB was on the panel for the COO.

In January we recruited for an Executive Director Strategy, Funding and Public Health and Tanya Maloney accepted this permanent position. Board member Sally Christie and Iwi Maori Council Chair Te Pora Thompson-Evans were on the recruitment panel for this position.

I know you will join me in congratulating Ms Aitken and Ms Maloney and also in welcoming Mr Dunham to the DHB.

“Speaking up for Safety” Programme

The “Speaking up for Safety” programme was launched last week with a request for our staff to nominate themselves or others to become accredited trainers to teach our 7300 staff including our contractors. The speaking up for safety programme is a critical aspect in our drive to achieving a safe and reliable culture here at Waikato DHB. We need a common language where individuals support each other and speak up whenever there is a concern for safety. We need 36 trainers and already we are seeing a high level of interest which is great.

This work precedes the workshop that we have scheduled for the Board, Executive Group and senior clinicians (doctors, nurses and allied health staff) for 20 February as part of the Promoting Professional Accountability programme. This is not a project but a clear decision to focus on developing the culture that we need to make sure our patients and staff are safe. It needs the full commitment of the Board and the Executive team.

On-line Voting

The Board has previously discussed on-line voting and the support of Waikato DHB for it. A briefing for the Board on the subject was to be held in 2019 from staff at Hamilton City Council involved in a national trial of on-line voting at the 2019 elections. However as the attached press release indicates, the trial has now been halted. It is assumed that the Board will not wish to take the matter further at this time.

Letter of Expectations 2019/12

The Health Minister's letter of expectations is attached for Board member's information. There are a significant number of areas the letter wishes DHBs to consider in their Annual Plan.

As a DHB who, like many other DHBs, has some financial pressures we will need to consider how we prioritise the expectations as set out in the letter.

DHB Performance 2018/19

The attached letter from the Health Minister on financial and system performance is attached for Board member's information.

Our ESPI compliance has significantly improved over the last 18 months, though this will be impacted by the current RMO strikes, as it was during the NZNO action.

Resource Review Project

As discussed with the Board, we have commenced a Resource Review project to better understand where we focus our spending and where there are opportunities to do this differently. We have engaged an external consultant who has extensive experience in health, both in Australia and New Zealand. She will lead a team which is made up of a number of our own DHB staff, SMOs, Nurses, Finance and supported by staff from the Change Team. They will review our current resource allocations and make recommendations to the Steering Group, which will include a senior manager from the Ministry of Health on short and long term options to better control our resource usage. As stated previously realistically to get the DHB back into a positive financial position is likely to be a three project.

Inaugural Allied Health Physical Health Team Awards and Celebration Day

This event was held on 18 December and was an opportunity to acknowledge and celebrate the contribution of Allied Health professionals to supporting the health and wellbeing of our community.

Award winners included:

- Values Award – Rachel Swain Manager Social Work and Psychology.
- Patient Experience – Sharon Bourke Booking Clerk Audiology/New Born Hearing Screeners.
- Service Development and Innovation Award – Sian Beattie & Ashleigh Wood – Physiotherapists.
- Clinical Educator Award – Shannon Tisbury, Physiotherapist.
- Teamwork Award – Hamilton Region Community Social Work Team.

Allied Health e-PDU (Professional Development Unit) – Goes Live

The Allied Health e-PDU was launched in December. The purpose of the e-PDU is to provide a single source of information for Allied Health staff, that aims to link them to opportunities to advance their professional practice. The newly developed Ko Awatea site includes a training calendar, links to courses, annual performance review and objective setting information, professional supervision information, and there is also a section for therapy assistants. As well as generic Allied Health information, there are sections where each specific discipline within allied health care review their own professional registration and training needs. The allied health team look forward to further expansion and continued development within the hub moving forward into this year.

Allied Health, Scientific and Technical

As you are aware late last year Claire Tahu was appointed as the Chief Advisor for Allied Health, Scientific and Technical, which is our second biggest workforce.

Claire will provide a quarterly update to the Board on activities in this area.

Parking and Transport

It was agreed in 2018 that a number of Board members would stay in contact with staff as we work through transport and parking issues. A productive meeting was held with the Waikato Regional Council towards the end of last year. A number of opportunities for joint action are being explored. We are intending to workshop some of those opportunities and others specific to Waikato DHB, with the Board in February to gain a steer on where to place our emphasis.

Health Targets Board Report

This month's Health Target report does not contain any commentary. Due to the departure of the Interim COO and the Acting COO being on sick leave, it was not possible to complete this report. This will be remediated for the February board meeting.

Recommendation
THAT
The Board receives this report.

DEREK WRIGHT
INTERIM CHIEF EXECUTIVE

#	Union	MECA / SECA	Term		Comment
			Commencement	Expiry	
1	**APEX**	Anaesthetic Technicians - SECA	1-Jul-14	31-Oct-16	Document expired. No further movement at this stage
2	APEX	Biomedical Tecnicians - SECA	4-Sep-17	4-Sep-18	Bargaining underway. Offer tabled 9 Jan 2019
3	APEX	Clinical Physiology - MECA	19-Dec-16	18-Dec-19	
4	APEX	Laboratory - MECA (Formerly NZMLWU)	7-Sep-16	6-Sep-19	
5	APEX	Medical Physicists - MECA	26-Nov-15	31-Aug-18	Bargaining initiated 3 July 2018. Progress unknown
6	APEX	Medical Radiation Technologists - MECA	8-Feb-16	3-Feb-19	Bargaining initiated 18 Dec 2018
7	APEX	Perfusionists - SECA	1-Jul-18	30-Jun-21	
8	APEX	Pharmacy - SECA	1-Jan-17	31-Dec-19	
9	APEX	Physiotherapists - SECA	28-Dec-15	28-Apr-18	Bargaining in process. Offer tabled 21 Nov 2018. Still ongoing
10	APEX	Psychologists - MECA	1-Jun-16	28-Feb-19	Bargaining initiated 31 Dec 2018
11	APEX	Radiation Therapists - MECA	8-Apr-16	7-Apr-19	
12	APEX	Sonographers - MECA	1-Dec-16	30-Nov-19	
13	**ASMS**	Senior Medical and Dental Officers - MECA	1-Jul-17	31-Mar-20	

14	**E Tu**		Kitchen, Orderlies, Food Service Attendants - MECA		25-Jun-18	14-Jun-21	
15	E Tu		Support Service Workers		1-Nov-17	31-Oct-19	
16	**MERAS**		Midwives - MECA		1-Mar-15	31-Jul-17	Waiting for further strike notice?
17	**NZNO**		Nursing and Midwifery - MECA		4-Jun-18	31-Jul-20	
18	**NZRDA**		Resident Doctors - MECA		13-Feb-17	28-Feb-18	Strikes currently in progress
19	**PSA**		Allied, Public Health & Technical - MECA		1-Nov-17	31-Oct-20	
20	PSA		Clerical, Administrative and Related Employes - MECA		1-Jul-16	28-Feb-19	Bargaining initiated 31 Dec 2018
21	PSA		Information Services		28-Oct-11	25-Dec-13	Bargaining initiated 5 June 2018. Bargaining scheduled for 31 Jan 2019
22	PSA		Medical Radiation Technologists - SECA		N/A	N/A	Bargaining initiated 5 June 2018. No visibility re progress of negotiations
23	PSA		Mental Health & Public Health Nursing - MECA		1-Oct-17	30-Sep-20	
24	**SToNZ**		Specialty Trainees of New Zealand		10-Dec-18	9-Dec-20	

25	**UNITE**		Attendants		1-Dec-15	30-Nov-18	Bargaining underway. Consultation document with MoH for consideration (in line with E Tu Kitchen, Orderlies, Food Service Attendants MECA terms.)

Councils halt online voting trial for local body elections

Wednesday, 12 December 2018, 4:21 pm
Press Release: Local Government NZ

The proposed trial of online voting in next year's local body elections will not proceed after the working party comprised of nine councils made the reluctant decision to halt the trial. Although the working party had recently selected a provider that satisfied all of the security and delivery requirements, the cost burden for the councils involved ultimately forced the decision.

While the proposed trial for 2019 has been halted, the working party will continue to work collaboratively with central government and the wider local government sector to deliver online voting for the 2022 local body elections. The working party remains focused on ensuring the legislative and regulatory changes required to enable online voting occur as soon as possible, and on securing the necessary funding to deliver an online solution.

Although online voting has been legal in New Zealand since 2001, current legislation requires the government to make regulations that set out the way an online voting system would work and the expected standards. The working party will continue to work with the Department of Internal Affairs to develop legislation and regulations that would allow online voting in future years.

The working party comprises Auckland Council, Gisborne District Council, Hamilton City Council, Marlborough District Council, Matamata-Piako District Council, Palmerston North City Council, Selwyn District Council, Hamilton City Council, Tauranga City Council and Wellington City Council, supported by independent experts and representatives from LGNZ (Local Government New Zealand) and SOLGM (New Zealand Society of Local Government Managers).

Working Party spokesperson Marguerite Delbet said: "The working party is hugely disappointed that the trial won't proceed at next year's local body elections. We will continue to work in partnership with central government and the wider local government network to ensure online voting is a reality for future elections. With rising postal costs, sections of our communities currently unable to vote privately and growing disengagement with elections generally, there is simply too much at stake to give up now."

The reliance of the local body elections on a postal system which is in long-term decline has forced the local government sector to look at how future elections might be delivered. The complex nature of local body elections means that booth voting is not a viable option and so efforts over the course of the last five years have focused on an online solution. Online voting has been successfully adopted in local and national elections overseas for a number of years.

The working party - with the support of the Department of Internal Affairs - has made significant progress in this area over the course of the last 18 months, proving that with the right regulatory framework and the financial support of the wider central and local government community, a reliable and secure online voting system can be successfully delivered within the local government context.

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Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

19 DEC 2018

Ms Sally Webb
Chair
Waikato District Health Board
sally@sallyw.co.nz

Dear Sally

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

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Fiscal responsibility
Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery
High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025
I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability
I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing

carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Hon Dr David Clark

MP for Dunedin North

Minister of Health | Associate Minister of Finance

17 DEC 2018

Ms Sally Webb
Chair
Waikato District Health Board
sally@sallyw.co.nz

Dear Sally

DHB Performance 2018/19

Following my meeting with all DHB Chairs on 13 December 2018, this letter reiterates the key expectations for DHB performance that I discussed with you. It should be read in conjunction with my Letter of Expectations to DHBs for 2019/20.

I want to reiterate the message I have conveyed in my meetings with you both individually and collectively over the past year about my sincere appreciation for all your hard work this year. I acknowledge the importance and complexity of the work that you do and I thank you for the public service that you provide.

As I have discussed with you individually and collectively as a group, this Government is strongly focussed on both the financial and non-financial performance of DHBs. In your role as Chair, along with the board, you are accountable for the performance of your DHB. It is also important that you hold management strongly to account for financial and non-financial performance.

Financial performance

As you are aware, my expectation for the total DHB sector financial position was that it was an improvement on 2017/18. We are now halfway through the financial year and, based on current evidence from DHB annual plans, this expectation is unlikely to be met. This is very disappointing as in 2018 the Government provided DHBs with the highest increase in funding in ten years. We recognise that improving the financial sustainability of the sector cannot be done all in one year but it is important that DHBs are doing all they can locally to manage in a financially prudent way. While I will be approving some DHBs' plans shortly, I would like all DHBs to continue to focus on opportunities for improving financial results. There are also several DHBs that have signalled they are likely to require equity support in 2018/19 to address working capital pressures. The available funding for equity support is limited, so I will need to be certain that those DHBs requesting this support have plans in place to reach a more sustainable financial position. I have therefore been considering additional measures and reporting for those DHBs that require equity support.

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System performance

There are some areas of DHB performance that I have particular concerns about and would like to see improvements across the sector. I am expecting all DHBs to place an increased focus on meeting waiting times for first specialist assessment, Planned Care (elective) treatment, and radiology services. There has been a deterioration in the number of people waiting beyond expected timeframes and I am looking for you to lead meaningful, sustainable improvement so that you consistently meet commitments to patients. This will require good planning by DHBs to manage capacity, workforce and investment, and strong engagement across clinical and operational teams.

I do want to acknowledge the significant improvement in the number of people waiting beyond clinically appropriate timeframes for an ophthalmology follow-up appointment nationally. While some DHBs have made limited progress, most have developed and successfully implemented a recovery plan. This has reduced the number of long-waiting patients and, in turn, reduced the risk of harm to patients. Maintaining progress is important and I ask that you continue to focus on sustained improvements. I was particularly pleased to hear of the close engagement between clinical and operational leaders from across the eye health system, which has enabled the development of new guidelines for the management of Age-Related Macular Degeneration and Glaucoma Referral, spanning various workforce groups and settings.

Conclusion

It is vital that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders. I will be monitoring the performance of all DHBs closely for the remainder of the financial year and will consider a range of governance options to strengthen and improve performance if necessary.

I again thank you for your leadership of your local DHB and strongly encourage you to drive both financial and non-financial performance improvement.

Yours sincerely

Hon Dr David Clark
Minister of Health

Quality and Patient Safety

Quality and Patient Safety: No report this month.

Finance Performance Monitoring

MEMORANDUM TO THE BOARD
23 JANUARY 2019

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 December 2018	Group Actual $m	Group Budget $m	Variance $m	Jun-19 $m
Revenue - CFA	644.3	636.6	7.7 F	1,269.2
Revenue - other	116.2	113.6	2.6 F	229.7
Operating Expenses	(746.0)	(730.8)	(15.2) U	(1,468.2)
IDCC	(38.9)	(42.2)	3.3 F	(86.8)
DHB Surplus/(Deficit)	**(24.4)**	**(22.8)**	**(1.6) U**	**(56.1)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

Waikato DHB Group	Year to Date			Group Budget
Result for December 2018	Group Actual $m	Group Budget $m	Variance $m	Jun-19 $m
Funder	16.4	8.5	7.9 F	24.9
Governance	(1.2)	(0.7)	(0.5) U	(1.5)
Provider	(39.4)	(30.5)	(8.9) U	(79.5)
Waikato Health Trust	(0.2)	(0.1)	(0.1) U	(0.0)
DHB Surplus/(Deficit)	**(24.4)**	**(22.8)**	**(1.6) U**	**(56.1)**
Note: $ F = favourable variance; ($) U = unfavourable variance				

VOLUMES

Episodes

Acute

December 2018	2019 Actuals	2019 Plan	*Variance to Plan %*	2018 Actuals	*Variance to Prior Year %*
Surgical & CCTVS	9,362	8,736	*7.16%*	8,769	*6.76%*
Internal Medicine	9,388	9,504	*-1.22%*	8,670	*8.28%*
Regional Services	2,311	2,314	*-0.13%*	2,271	*1.76%*
Child Health	3,059	2,731	*12.02%*	2,777	*10.15%*
Womens Health	4,638	4,509	*2.86%*	4,377	*5.96%*
TOTAL	**28,758**	**27,794**	***3.47%***	**26,864**	***7.05%***

Elective

December 2018	2019 Actuals	2019 Plan	*Variance to Plan %*	2018 Actuals	*Variance to Prior Year %*
Surgical & CCTVS	7,977	7,830	*1.88%*	7,411	*7.64%*
Internal Medicine	310	468	*-33.71%*	326	*-4.91%*
Regional Services	40	23	*74.33%*	19	*110.53%*
Child Health	318	374	*-14.93%*	346	*-8.09%*
Womens Health	768	596	*28.86%*	544	*41.18%*
TOTAL	**9,413**	**9,290**	***1.32%***	**8,646**	***8.87%***
Total Episodes Acute + Elective	**38,171**	**37,084**	***2.93%***	**35,510**	***7.49%***

Case Weighted Discharges

Acute

December 2018	2019 Actuals	2019 Plan	*Variance to Plan %*	2018 Actuals	*Variance to Prior Year %*
Surgical & CCTVS	15,704	15,354	*2.28%*	15,060	*4.27%*
Internal Medicine	8,261	8,519	*-3.02%*	7,973	*3.61%*
Regional Services	2,701	2,864	*-5.67%*	2,828	*-4.48%*
Child Health	3,722	3,442	*8.14%*	3,647	*2.08%*
Womens Health	2,626	2,568	*2.26%*	2,454	*7.00%*
TOTAL	**33,014**	**32,746**	***0.82%***	**31,962**	***3.29%***

Elective

December 2018	2019 Actuals	2019 Plan	*Variance to Plan %*	2018 Actuals	*Variance to Prior Year %*
Surgical & CCTVS	11,277	11,176	*0.90%*	11,097	*1.63%*
Internal Medicine	218	333	*-34.53%*	244	*-10.64%*
Regional Services	72	47	*53.85%*	28	*155.51%*
Child Health	341	309	*10.53%*	287	*18.98%*
Womens Health	674	580	*16.25%*	532	*26.70%*
TOTAL	**12,583**	**12,445**	***1.10%***	**12,188**	***3.24%***
Total CWDs Acute + Elective	**45,597**	**45,191**	***0.90%***	**44,150**	***3.28%***

Bed Days					
December 2018	**2019 Actuals**	**2019 Plan**	***Variance to Plan %***	**2018 Actuals**	***Variance to Prior Year %***
Waikato Inpatient Bed Days	102,846	101,568	*1.26%*	101,372	*1.45%*
Waikato Other Bed Days*	63,221	54,934	*15.09%*	54,934	*15.09%*
T-Hospital Bed Days*	15,948	15,930	*0.11%*	15,930	*0.11%*
TOTAL	**182,015**	**172,432**	***5.56%***	**172,236**	***5.68%***

December 2018	2019 Actuals	2018 Actuals	Variance to Prior Year %
ED Attends	60,486	58,512	*3.37%*

* - T-Hospital and Waikato other bed days plan numbers are not available and reflect prior year actual totals

MONTHLY COMMENTS

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

Delivery Plan Performance

Half way through the year, the December results continue the general trends observed so far.

Overall acute volumes are ahead of plan (3.5%), with slightly lower than planned average caseweight.

The impact of the new M18 surgical assessment and short stay ward is also pushing general Surgery acute volumes over plan as use of the assessment capability has moved volumes from ED to General Surgery acute admissions. These patients, assessed and not operated on, represent a lower complexity, hence lowering average CWD for general surgery.

December is a short month for electives, with the half year results showing volumes over plan by 1.3% and a very close to plan average caseweight.

Within the clusters, Internal Medicine is overall slightly lower than plan, with respiratory as noted previously, being significantly lower.

Two variations attributable to the planning process have been identified. We expect these to continue throughout the year.
These variations are:
1. An error in setting the volumes for a small number of ED Short Stay purchase units. These are most utilised by patients in Paediatrics and Surgical services, hence why these two are reporting ahead of plan.
2. Analysing the variation within Child Health, the Acute Paediatric Medicine figures show significant variance to plan, volumes are higher, and average caseweight is lower than anticipated – the resulting total caseweight is almost exactly at plan.

This has been attributed to a single outlier discharge (211 caseweights, next highest is 9) in the historical data which skewed the average caseweight ratio used in planning assumptions. This means the planned caseweight total is correct, while the planned volumes are lower than they should have been.

Volume analysis continues to be an area of desired improvement. The FY 19/20 volume planning process, which has already commenced, will plan day case and long stay patient volumes and caseweights separately for appropriate clinical services. This will provide an additional dimension with which to understand performance. Further enhancements to the planning and modelling are being identified and documented for FY 20/21. While current reporting makes all the detailed data on performance to plan available, it is somewhat cumbersome to analyse and the desired goal is to develop a Performance Reporting Qlik application to enable greater use and interpretation of this data.

Financial Performance Comment:

For December 2018 we have an unfavourable year to date variance to budget of $1.6m. This includes $5.3m favourable variances relating to prior year adjustments and washups.

Material variances for the month of December 2018 are:

Favourable - total $6.2m:
- $1.8m CCDM Revenue
- $2.9m DSS related to prior year adjustment
- $1.0m Depreciation favourable variance
- $0.5m NOS cost recovery catch-ups

Unfavourable - total $7.0m:
- $1.3m Savings Plan not realised
- $1.0m Actuarial revaluation (mid year)
- $1.5m Personnel Costs (largely nursing)
- $1.8m Clinical supplies (volume/mix)
- $0.8m Outsourcing (compliance cost)
- $0.6m Infrastructure (timing)

Other net favourable/unfavourable variances - $0.9m favourable result in a total $0.1m favourable variance for the month.

Material YTD variances as at December 2018:

Operating revenue is $10.3m favourable which includes the following variances:
- $1.7m favourable - additional funding related to NZNO MECA
- $1.8m favourable - reimbursement of NOS costs
- $1.9m favourable - prior year wash-ups
- other favourable variances include pay equity funding, IDF income and higher cafeteria sales, donations and research grants

Direct cost offsets against favourable variances amount to $5.9m.

Operating expenditure is $11.9m unfavourable which includes:
- $8.4m unfavourable - nursing personnel (employed and outsourced) costs. This includes higher NZNO and MHN MECA settlements ($2.2m), new acuity based staffing levels in place earlier than budgeted and a higher level of mental health inpatient services. There is a favourable offset in CFA revenue ($3.8m).
- $5.7m unfavourable - clinical supplies which includes mix of activity and timing of Pharmac savings. Final NOS impacts are expected to be corrected in January, including those related to processes for receipting of goods.
- $7.5m unfavourable centrally held savings plan.

Unfavourable variances offset by favourable variances arising from vacancies, delayed start to building maintenance plan, depreciation, over accrual of prior year costs and timing.

Our best estimate at this stage for forecast remains close to budget.

We recognise that the capital expenditure spend as per the Capital Expenditure report (YTD spend of $18,236k) doesn’t agree with the Treasury Purchase of Assets amount of $17,041k. Reconciliation of the difference is being worked through but is impacted by NOS issues.

Provider:

The Provider is unfavourable to budget $8.9m - see detail for explanations. Variances include:

1. Revenue is favourable $6.4m due mainly to favourable internal revenue ($5.9m - eliminates against Funder), reimbursement of NOS costs (offset in Outsourced personnel) and IDF income.
2. Employed personnel cost is favourable to budget $1.5m 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 $10.6m - partly offset in employed personnel cost and NOS costs recovered in other government revenue.
4. Outsourced services is favourable to budget $1.0m - analysis below.
5. Clinical Supplies is unfavourable to budget $5.7m due to the increase and mix of activity, and timing.
6. Infrastructure and non clinical supplies is unfavourable to budget $4.8m - analysis below.
7. IDCC is favourable to budget $3.3m. This relates mainly to a favourable depreciation variance as a result of lower capital spend.

Funder and Governance:
The result for the Funder is $7.9m favourable to budget. This is mainly as a result of additional CFA funding relating to pay equity, acuity funding, NZNO MECA settlement and prior year electives ($7.7m), favourable IDF revenue variance ($1.8m), favourable NGO payments $4.1m (mainly as a result of a prior year over accrual of DSS costs $3.3m) offset by unfavourable provider payment variance ($5.9m eliminated against Provider). Governance is close to budget.
Waikato Health Trust
The result for the Waikato Health Trust is close to budget.

RECOMMENDATION(S):

That this report for the period ended December 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	**$10.3 F**	
CFA Revenue		
CFA revenue is favourable to budget mainly due to:		
• CFA revenue $7.7m favourable includes $2.0m favourable variance for funding received from MoH for NZNO MECA settlement (offset by nursing personnel additional cost $1.7m). A further $2.1m has been received from MoH for acuity costs related to the NZNO MECA. There is an offset in side arm revenue as the funding was expected to be received directly by the provider. Other favourable variances include additional pay equity funding (offset in NGO payments), and a variance arising from prior year under accrual of elective revenue $0.6m.	$7.7 F	Neutral
Crown Side-Arm Revenue		
• Crown side-arm contracts $2.0m unfavourable to budget which includes MoH funding for nursing acuity costs received as a CFA variation ($2.1m, offset in CFA revenue), with other offsets.	($2.0) U	Neutral
Other Government and Crown Agencies Revenue		
Other Government and Crown revenue is favourable to budget mainly due to:		
• Reimbursement of costs associated with the implementation of National Oracle Solution (NOS) $1.8m favourable (offset in Outsourced Personnel $1.9m).	$3.9 F	Neutral
• Reimbursement of haemophilia costs $0.5m favourable in line with actual costs incurred (clinical supplies).		
• Income for an ACC contract is $0.4m unfavourable due to a variance in the optimistic budget estimate as against actual income earned.		
• Inter District Flow (IDF) income from other DHBs $0.5m favourable. Volumes by speciality and by DHB continue to fluctuate compared to budget.		
• Inter District Flow (IDF) income relating to 2017/18 $1.3m favourable. This is as a result of the annual wash up of IDF activity across all DHBs. The final adjustment is not known until coding of all activity across all DHBs is completed. This variance is partly offset by an unfavourable variance on the IDF outflow wash up ($0.7m), which is included in NGO payments.		Favourable
Other Revenue		
• Other revenue $0.7m favourable to budget which includes favourable variances to budget for cafeteria and food sales, donations, and research grants.	$0.7 F	Neutral

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
Operating expenditure including IDCC	**($11.9) U**	
Personnel (employees and outsourced personnel total)	**($9.5) U**	
Employed personnel are favourable to budget mainly due to:		
In December 2018 a mid year actuarial revaluation adjustment impacting across all payroll classes was processed relating to Long Service Leave and Retirement Gratuity liabilities resulting in $1.0m additional expense which is included in personnel variances below.		
• Medical personnel are favourable to budget by $5.6m. This includes a higher than expected vacancy level, including delayed implementation of investment requests. This favourable variance is partly offset by outsourced personnel unfavourable variance of $3.4m.	$1.2 F	Neutral
• Nursing personnel are unfavourable to budget by $6.1m. This variance, along with the unfavourable outsourced personnel cost for nursing of $2.3m, includes higher final settlement compared to budget of the NZNO MECA ($1.7m, offset by CFA revenue favourable $2.0m), and the MHN MECA ($0.5m, no offset). Other variances include costs of a transferred contract of $0.6m (offset in NGO providers) and the impact of new acuity based staffing levels in place earlier than budget. In most areas we are running at full matrix for additional beds and acuity levels. This additional cost includes unfavourable annual leave movement, outsource costs, and overtime. We also have a higher level of mental health inpatient services.		Unfavourable
• Allied Health personnel are favourable to budget by $0.1m. The net unfavourable variance between employed and outsourced is $0.1m. This includes higher final settlement of the ALT MECA compared to budget of $1.0m, partly offset by higher than expected vacancy levels.		Neutral
• Management, Administration and Support personnel are favourable to budget by $1.6m (offset in outsourced personnel ($1.7m). Variances are spread across the DHB including clinical support, and are mainly as a result of higher than expected vacancy levels. The variance also includes higher settlement costs for DOM and ATT MECAs compared to budget, of $0.3m (no offset).		
Outsourced personnel are unfavourable to budget mainly due to:		
• Medical costs are $3.4m unfavourable due to higher than planned use of locums to cover vacancies (offset by medical personnel underspend $5.6m). This is mainly across Waikato Hospital, Community Hospitals, and Mental Health and Addiction.	($10.7) U	Neutral
• Nursing costs are $2.3m unfavourable. As for nursing personnel this is due to the impact of new acuity based staffing levels in place earlier than budget, and a higher level of mental health inpatient services.		Unfavourable
• Allied Health costs are $0.2m unfavourable to budget. The net unfavourable variance between employed and outsourced is $0.1m. This includes higher final settlement of the ALT MECA compared to budget of $1.0m, partly offset by higher than expected vacancy levels.		Neutral
• Management, Administration and Support costs are $4.8m unfavourable largely due to contractor costs of $1.9m for the implementation of the new NOS ERP solution ($1.8 of this cost is offset by additional other government revenue), and contractor costs of $1.2m for the patient flow project. The balance of $1.7m covers management, administration and support vacancies (part offset in favourable employed personnel variance of $1.6m).		

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
Outsourced services	**$0.9 F**	
Outsourced services are favourable to budget mainly due to:		
• Outsourced Clinical Services are $1.5m unfavourable to budget. Outsource costs for meeting ESPI compliance, including the areas of cardiology and radiology are unfavourable, partially offset by a favourable variance relating to outsourced services to meet our elective initiatives.	$0.9 F	Neutral
• Outsourced corporate service costs are $0.3m favourable to budget which includes delays in the implementation of Crown initiated information system changes such as IaaS.		
• Spend against allocated strategic funding is $2.1m favourable to date. This includes initiatives related to health system transformation and health equity. This is partly a timing difference.		
Clinical Supplies	**($5.7) U**	
Clinical supplies are unfavourable to budget mainly due to:		
• Treatment Disposables, Instruments and Equipment - unfavourable to budget by $1.0m. This includes MoH coding changes of $1.1m (offset in pharmaceuticals). The adjusted variance is $2.1m unfavourable. The variance is due to mix of activity and total episodes up on budget 2.9%. This includes theatres at 106% of budget. High cost areas also include haemophilia costs over budget by $0.5m (offset by other Government revenue $0.5m).	($5.7) U	Unfavourable
• Diagnostic and Other Supplies - close to budget.		
• Implants and prosthesis - unfavourable to budget by $0.9m includes monthly fluctuations for volume and mix of procedures.		
• Pharmaceuticals - unfavourable to budget by $3.4m. This includes MoH coding changes of $1.1m (offset in treatment disposals). The adjusted variance is $2.3m, which includes a change in how savings are being received from Pharmac (offset in payments to NGO providers). Higher PCT and retail pharmacy costs are both in line with higher levels of activity.		Neutral
Infrastructure and non-clinical supplies	**($4.9) U**	
• Favourable variances include a delayed start to building maintenance plan ($1.2m), budgeted surgical services project costs actually included in prior year ($0.6m), delayed commencement of information services projects ($0.6m), and utilities costs under budget ($0.5m).	$2.6 F	Neutral
• Savings allocation - $7.5m unfavourable variance in infrastructure costs relates to centrally held savings plan not specifically allocated.	($7.5) U	Unfavourable
NGO Payments	**$4.1 F**	
External Provider payments are favourable to budget mainly due to:		
• Net favourable variances amounting to $5.7m arise due to costs not being incurred in line with CFA revenue received, MoH and accrual adjustments relating to prior year funding, a contract transfer (offset in nursing costs) and savings received from Pharmac that are budgeted under clinical supplies (pharmaceuticals). The most significant permanent difference to date is disability support costs over accrued in prior years by $3.3m. Favourable variances are partly offset by unfavourable variance to budget for pay equity (offset by CFA revenue).	$4.1 F	Favourable
• Inter District Flow (IDF) outflows to other DHBs $0.9m unfavourable. Volumes by speciality and by DHB continue to fluctuate compared to budget.		Neutral

The Waikato DHB YTD Expenditure Variance resulted from:	Variance $m	Impact on forecast
● IDF out payments for 2017/18 are $0.7m unfavourable. As for IDF in receipts, this relates to the annual wash up of IDF activity across all DHBs. This final adjustment is not known until coding of all activity across all DHBs is completed. Variance is offset by a favourable variance on the IDF inflow wash up ($1.3m), which is included in Other Government and Crown Agencies Revenue.		Unfavourable
Interest, depreciation and capital charge	**$3.3 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.	$3.4 F	Neutral
Extraordinary costs	**($0.1) U**	
Loss on disposal of fixed assets - not budgeted.	($0.1) U	Unfavourable

TREASURY

Opinion on Group Result:

Cash flows are unfavourable to budget as detailed below.

YTD Actuals Dec-17 $'000	Waikato DHB Cash flows for year to December 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				
681,241	Operating inflows	761,200	751,299	9,901	1,497,840
(650,444)	Operating outflows	(752,490)	(725,825)	(26,665)	(1,484,968)
30,797	**Net cash from operating activities**	**8,710**	**25,474**	**(16,764)**	**12,872**
	Cash flow from investing activities				
841	Interest income and proceeds on disposal of assets	611	624	(13)	1,187
(11,827)	Purchase of assets	(17,041)	(58,600)	41,559	(117,094)
(10,986)	**Net cash from investing activities**	**(16,430)**	**(57,976)**	**41,546**	**(115,907)**
	Cash flow from financing activities				
0	Equity repayment	0	0	0	(2,194)
(4,309)	Interest Paid	(462)	(414)	(48)	(826)
(101)	Net change in borrowings	(161)	29,231	(29,392)	116,821
(4,410)	**Net cash from financing activities**	**(623)**	**28,817**	**(29,440)**	**113,801**
15,401	**Net increase/**(decrease) in cash	**(8,343)**	**(3,685)**	**(4,658)**	**10,766**
856	Opening cash balance	(2,973)	(2,973)	0	(2,973)
16,257	**Closing cash balance**	**(11,316)**	**(6,658)**	**(4,658)**	**7,793**

Cash flow variances resulted from:	Variance $m	Impact on forecast
Total Net cash flow from Operating Activities	**($16.8) U**	
Operating inflows	**$9.9 F**	
• The favourable CFA inflow variance arises mainly as a result of unbudgeted MoH funding for the NZNO MECA settlement, additional pay equity and acuity funding ($4.1m) and prior year elective revenue wash-up $0.6m. Other Favourable variances relates mainly to unbudgeted NOS cost reimbursement $1.8m, Haemophilia cost reimbursement $0.5m, IDF's $0.5m favourable, IDF revenue wash-up for prior year $1.3m and increased cafeteria sales, donations and research grants $0.7m.	$9.9 F	Neutral
Operating outflows	**($26.7) U**	
Operating cash outflows for payroll costs are unfavourable mainly due to:		
• Personnel cost outflows are unfavourable against budget mainly due to the timing of pay runs as compared with the phasing of the budget. The payrun ($10.9m) due for payment in the first week of January was released on 31 December due to the Public Holiday on Wednesday 2 January. Further unfavourable variances include MECA settlement payments, the impact of new acuity based staffing levels for nursing and a higher level of mental health inpatient services. This offset by favourable variances arising as a result of higher than anticipated vacancy levels in Medical , Allied Health and Management, Administration and Support.	($10.5) U	Unfavourable

Cash flow variances resulted from:	Variance $m	Impact on forecast
Operating cash outflows for non-payroll costs are unfavourable mainly due to:		
• The unfavourable operating cash flow variance arises mainly from unfavourable operating expenditure against budget (excluding payroll and IDCC costs) $16.3m, higher prepayments than budgeted $2m, offset by the favourable impact of the timing of supplier payment runs.	($14.5) U	Neutral
• GST cash movement is favourable due to timing variances on GST transacted.	($1.7) U	Neutral
Net cash flow from Investing Activities	**$41.6 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.	$41.6 F	
Net cash flow from Financing Activities	**($29.4) U**	
• Cash flow from financing activities is unfavourable due to the deferment of planned finance leases and budgeted deficit support not received.	($29.4) U	Unfavourable

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-Dec-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
OPERATING ACTIVITIES													
Cash was provided from:													
MoH, DHB, Govt Revenue	5,450	3,780	3,052	6,039	4,252	4,708	6,811	4,796	4,680	7,123	4,680	4,564	7,239
Funder inflow (MoH, IDF, etc)	145,806	132,336	132,761	132,761	137,631	132,761	132,814	136,162	136,162	141,032	136,162	136,162	141,032
Donations and Bequests	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Income (excluding interest)	4,011	3,020	2,780	3,020	3,780	3,260	2,780	2,940	3,081	2,963	3,081	2,963	2,961
Rents, ACC, & HealthPac (General Accou	4,066	3,484	3,436	3,481	3,440	3,775	3,433	3,698	3,736	3,549	3,702	3,639	3,521
	159,333	142,620	142,029	145,301	149,103	144,504	145,838	147,596	147,659	154,667	147,625	147,328	154,753
Cash was applied to:													
Personnel Costs (incl PAYE)	(60,721)	(46,057)	(52,344)	(49,252)	(49,134)	(57,056)	(49,027)	(61,075)	(52,509)	(50,045)	(56,056)	(51,809)	(61,063)
Other Operating Costs	(38,627)	(30,620)	(30,520)	(34,122)	(32,820)	(33,974)	(33,420)	(30,250)	(32,096)	(29,848)	(33,820)	(35,192)	(32,822)
Funder outflow	(55,481)	(53,960)	(50,463)	(54,585)	(50,297)	(51,739)	(50,173)	(52,268)	(55,657)	(51,673)	(51,516)	(50,739)	(51,032)
Interest and Finance Costs	(14)	(21)	(21)	(21)	(21)	(21)	(23)	(23)	(28)	(28)	(38)	(38)	(38)
Capital Charge	(17,430)	0	0	0	0	0	(17,430)	0	0	0	0	0	(18,711)
GST Payments	0	(13,192)	(9,000)	(7,210)	0	(14,420)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	(7,210)	0
	(172,273)	(143,850)	(142,348)	(145,190)	(132,272)	(157,210)	(157,283)	(150,826)	(147,500)	(138,804)	(148,640)	(144,988)	(163,666)
OPERATING ACTIVITES	(12,940)	(1,230)	(319)	111	16,831	(12,706)	(11,445)	(3,230)	159	15,863	(1,015)	2,340	(8,913)
INVESTING ACTIVITIES													
Cash was provided from:													
Interest Income	80	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
	80	75	75	75	75	75	75	75	75	75	75	75	75
Cash was applied to:													
Purchase of Assets	(2,347)	(3,500)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(6,000)	(6,000)
Investment in NZHPL (FPSC)	0	0	0	0	0	0	0	0	0	0	0	0	0
	(2,347)	(3,500)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(7,000)	(6,000)	(6,000)
INVESTING ACTIVITIES	(2,267)	(3,425)	(6,925)	(6,925)	(6,925)	(6,925)	(6,925)	(6,925)	(6,925)	(6,925)	(6,925)	(5,925)	(5,925)
FINANCING ACTIVITIES													
Cash was provided from :													
Capital Injection	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance Lease received	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan received	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash was applied to:													
Capital Repayment	0	0	0	0	0	0	(2,194)	0	0	0	0	0	0
Finance lease repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA loan repaid	0	0	(26)	0	0	(15)	0	0	(15)	0	0	(15)	0
Working capital facility repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
FINANCING ACTIVITIES	**0**	**0**	**(26)**	**0**	**0**	**(15)**	**(2,194)**	**0**	**(15)**	**0**	**0**	**(15)**	**0**
Opening cash balance	(4,013)	(19,220)	(23,874)	(31,143)	(37,957)	(28,050)	(47,696)	(68,259)	(78,414)	(85,194)	(76,255)	(84,195)	(87,794)
Overall increase/(decrease) in cash	(15,207)	(4,654)	(7,269)	(6,814)	9,906	(19,645)	(20,563)	(10,154)	(6,781)	8,940	(7,940)	(3,599)	(14,838)
CLOSING CASH BALANCE	(19,220)	(23,874)	(31,143)	(37,957)	(28,051)	(47,695)	(68,259)	(78,413)	(85,195)	(76,254)	(84,195)	(87,794)	(102,632)
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	(19,220)	(23,874)	(31,143)	(37,957)	(28,050)	(47,696)	(68,259)	(78,414)	(85,194)	(76,255)	(84,195)	(80,584)	(95,422)
Long-term Loans													
Finance Leases	0	0	0	0	0	0	0	0	0	0	0	0	0
EECA Loan	(117)	(117)	(91)	(91)	(91)	(76)	(76)	(76)	(61)	(61)	(61)	(45)	(45)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(19,337)	(23,991)	(31,234)	(38,048)	(28,141)	(47,772)	(68,335)	(78,490)	(85,255)	(76,316)	(84,256)	(80,629)	(95,467)
Working capital facility	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)
	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(82,974)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)	(85,299)

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 December 2018 Actual $'000	As at December 2018 Budget $'000	As at December 2018 Variance $'000	Budget Jun-19 $'000
79,945	Total current assets	85,959	84,768	1,191 F	78,872
(197,999)	Total current liabilities	(224,010)	(232,537)	8,527 F	(208,093)
(118,054)	**Net working capital**	**(138,051)**	**(147,769)**	**9,718 F**	**(129,221)**
722,564	Term assets	718,290	756,441	(38,151) U	787,735
(22,150)	Term liabilities	(22,096)	(27,001)	4,905 F	(32,080)
700,414	**Net term assets**	**696,194**	**729,440**	**(33,246) U**	**755,655**
582,360	**Net assets employed**	**558,143**	**581,671**	**(23,528) U**	**626,434**
582,360	**Total Equity**	**558,143**	**581,671**	**(23,528) U**	**626,434**

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Net Working Capital:		
Net working capital is favourable to budget mainly due to:		
Current Assets		
• Total accounts receivable and accrued debtors is lower than budgeted by $0.4m mainly as a result off the timing of cash received compared with budget assumptions.	**$1.2 F**	Neutral
• Prepayments are higher than budgeted by $2m mainly due to eSPACE payment timing assumption variances actual against budget.		
• Other unfavourable variances across a number of areas $0.4m.		
Current Liabilities		
• Cash held with New Zealand Health Partnership Limited is lower than budget by $4.7m. This is represented as a $4.7m unfavourable variance in Current Liabilities. This is due mainly to the unfavourable variance relating to operating activities ($16.8m) and financing activities ($29.4m) offset by a favourable investing variance from activities ($41.5m).	**$8.5 F**	Neutral
• Payroll liabilities are $7.7m favourable mainly due to the over budgeting of payroll accruals as a result of the timing of pay runs. December 2018 required accrual of only 1 day for the WAI payrun so accrual was substantially lower. The accrual budget is evenly phased.		
• Income in Advance $0.8m favourable to budget mainly due to the timing of budget assumptions relating to funds received against actuals.		
• GST $1.7m favourable to budget mainly due to timing variances on GST transacted.		

Balance Sheet variance's resulted from:	Variance $m	Impact on forecast
Current Liabilities (continued		Neutral
● Accrued Creditors and Accounts Payable $0.6m favourable mainly due to timing of payments differing from budget assumptions.		
● Other Current Liabilities are favourable to budget $2.4m mainly due to Finance Leases being deferred.		
Net Term Assets:	**($38.2) U**	
Net Fixed Assets are under budget mainly due to slower than planned capital spend $41.6, offset by favourable YTD depreciation $3.4m. Please see attached for latest forecast of capital spend for the year for further detail.	($38.3) 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 mainly due to deferment of budgeted finance leases.	**$4.9 F**	Neutral
Equity:		
Unfavourable variance driven mainly by budgeted MoH deficit support not received $22.1m and the unfavourable result variance of $1.6m. The remaining favourable variance relates to Waikato Health Trust Partially Reserved Funds movements.	**($23.5) U**	Neutral

CAPITAL EXPENDITURE AT 31 December 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 Dec 18	Approved and Planned Expenditure 01 Jan 19 - 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	2,131	1,844	0	3,974	0	1,721
Clinical Equipment Subtotal	23,428	41,719	0	65,146	12,326	31,736	5,937	25,800	0	44,062	21,084	8,027
Property & Infrastructure Subtotal	30,814	13,417	0	44,231	12,084	13,498	3,075	10,423	10,130	35,713	8,518	6,084
IS Subtotal	25,428	14,706	100	40,234	13,345	10,331	5,569	4,762	8,338	32,014	8,220	1,806
Corporate Systems & Processes Subtotal	9,819	320	0	10,139	3,788	2,087	223	1,864	3,913	9,788	351	214
Regional Subtotal	9,943	1,264	0	11,207	1,043	7,678	1,301	6,377	0	8,721	2,486	30
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	(47)
REPORT TOTALS	**99,431**	**75,400**	**100**	**174,931**	**42,585**	**69,306**	**18,236**	**51,070**	**22,381**	**134,272**	**40,659**	**17,837**

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

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
CLINICAL EQUIPMENT				
Under $50K Subtotal	3,974	2,131	1,844	-
Dialysis Machine - Model 5008S -17	527	-	527	-
Dialysis, Hemofiltration Unit	364	-	364	-
Computer Information Sys. - Oncology (Ecilpse & Aria) -1	250	-	250	-
Linarc Accelerator	5,000	3	4,490	507
Blood Culture Analyzer	250	-	250	-
Radg. Xray General Ed Room 1, MCC 5, Resus 1 & 2	1,400	15	1,278	107
Radg. Unit, Mobile Xray Machine -Mobile	300	-	300	-
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	204	46	0
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	-
Replacement Theatre Lights OT 20-25	286	235	51	(0)
New MCC Theatre (Ceasar Theatre) - clinical equipment components	1,313	1,117	197	(1)
Mobile Dental Unit Replacements - level 2	600	117	483	(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	557	6	37
Rural Laboratories - biochemistry Analysers (x4)	720	-	720	-
Ultrasound (replacement)	825	20	805	(0)
L8 Menzies Surgical Assessment Unit (Acute)	1,561	1,717	34	(190)
Oncology Facility Development (Interim Facility_ Scoping	450	160	258	32
Other Clinical Items <$250K	7,626	702	6,931	(7)
Unplanned Clinical Items - Bucket / Growth	9,199	-	4,533	4,667
Projects Removed to be Capitalised	13,116	13,416	71	(372)
Other Clinical items - Net Funding & savings required	4,999	-	696	4,303
Timing adjustment based on capacity constraints			(12,000)	12,000
Clinical Equipment Subtotal	**69,120**	**20,393**	**27,644**	**21,084**
PROPERTY & INFRASTRUCTURE				
Mental Health Facility - Scoping -part 2	2,973	106	2,816	51
Multi level carpark 3 or 4 levels (related to Mental health / Med school)	250	-	250	-
Waiora Level 1 - ED Acute Observation Unit	650	-	650	-
Waiora Level 1 - Development of MCC L1 Shell space (for other decants from Waiora L1 : atten	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	-	0

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
Hamilton CBD - Collingwood Street Development - Ground Floor (Clinical)	9,124	3,075	6,049	0
Hamilton CBD - Collingwood Street Development - First Floor	5,584	552	5,032	0
Tokoroa / Te Kuiti / Taumarunui Pregnancy Support Facilities (Fitout of leased premises)	300	20	280	(0)
Regional Renal expansion on Campus (Is equipment on Clinical Plan??)	550	400	784	(634)
Hague road carpark - Seismic and Beam support	2,032	76	1,956	0
Urology to L8 Menzies	320	22	298	(0)
Tokoroa & Taumarunui Birthing Unit Upgrades (Stage 1 17/18)	300	-	300	-
Ward Block A & Environs	250	-	250	-
Waikato switchboard upgrades core buildings	866	469	397	0
Infrastructure Replacement Pool (17/18)	510	551	2	(43)
Infrastructure Replacement Pool (15/16)	600	745	-	(145)
Infrastructure Replacement Pool (16/17)	641	205	436	-
Infrastructure Replacement Pool (18/19)	600	55	545	(0)
Project Management Resource to deliver BAU Critical Infrastructure projects (2 FTE Equivalent)	250	-	250	-
Cooling Tower Dosing System Upgrades (2-plus)	300	86	214	(0)
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	1	549	0
Other P&I Projects Budgeted <$250K	4,626	1,430	3,379	(183)
Projects removed to be capitalise	276	95	3	178
Less: Proceeds on sale of property (206 Collingwood St)	(1,500)	-	(1,500)	-
Savings required	-	-	(293)	293
Timing adjustment based on capacity constraints			(9,000)	9,000
Property & Infrastructure Subtotal	**44,231**	**15,160**	**20,553**	**8,518**
Information Systems				
ISSP - Clinical and corporate Platform SQL Server consolidation	365	285	80	0
IMPACT Patient Flow Tool	1,769	1,908	206	(345)
SQL Server 2016 upgrades / Citrix XenApp vS VDI	500	55	445	(0)
ISSP - Data Warehouse Upgrade (Data Warehouse Phase 1)	387	332	55	(0)
ISSP- Clinical Photography and Image Management	397	202	195	(0)
ISSP - Communication Room Remediation Lifecyle	368	115	253	0
ISSP - Paging System Replacement	290	296	-	(6)
ISSP - Network Remediation Work Package 2015/2016	399	405	-	(6)
ISSP - WiFi Rollout	487	487	-	0
ISSP - Network Remediation Lifecycle Work Plan 16/17	282	278	4	(0)
LAN / WLAN - IMPLEMENT: Install WAPs (extend Wi-Fi coverage)	997	367	630	0
LAN / WLAN - UPGRADE: Wireless LAN Controllers (Address core capacity constraints)	263	248	15	0
LAN / WLAN - UPGRADE: Distribution Switches	750	-	750	-
LAN / WLAN - UPGRADE: Access Switches	1,519	-	1,519	-
NIPS - IaaS Implementation	1,557	1,361	196	(0)
Disaster Recovery Solution	1,800	-	1,800	-
DeskTop WorkPlan 16/17	288	191	97	(0)
End User Devices (<$2k) - now capitalised	1,740	987	753	0
Rollout of devices at point of care (Investment in circa 500 tablets)	491	2	489	(0)
ISSP - Mobile office Productivity & Management	392	210	182	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	296	9	(0)
Business Intelligence Data & Reporting	453	69	384	0
Enterprise Service Bus (ESB) Phase II	263	-	263	-
Enterprise Messaging/Communication Solution	350	-	350	-
ISSP - SharePoint Work Pan 16-17	401	464	34	(97)
ISSP - Rapid Logon	359	110	249	0
ISSP - Toolsets (IS Toolsets 15/16)	507	508	-	(1)
ISSP - Netscaler Infrastructure	301	340	-	(39)
Sharepoint 15/16	350	310	40	(0)
Win 10 Upgrade	364	135	229	0
Mobility & Mobile Apps	371	103	268	0

Project Activity	Total Budget	Total Spend to Date	Planned Future Spend	Under/ (over) Spend
Patient IS capabilities - Observations Platform	361	41	320	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	5	295	(0)
Windows 2008r2 to 2016 Server upgrades	800	-	800	-
Security Defence in depth	500	70	430	-
Clinical Workflow Integration Work Plan	358	399	-	(41)
Clinical Workstation Core Component Workplan	513	605	-	(92)
Database Replacements	301	134	167	(0)
iPM upgrade to V10 - after 16/17	484	575	-	(91)
Cat1-5 In-House Developed Applications Work Plan	330	381	-	(51)
Life cycle - cat 3 -5 Off shelf Apps Workplan(eg PaceArt)	259	247	12	(0)
Oral Health system	852	931	-	(79)
eCWB Infrastructure	254	238	16	-
HealthViews access to Primary Encounters (GP to Workstations)	306	304	2	-
eOrders	469	306	107	56
Anaesthesia Information System - Implementation	600	-	600	-
Observations Platform (eVitals) - implementation	700	-	700	-
Nutrition & Food Management	932	197	735	(0)
Other IS Projects Budgeted <$250K	7,841	3,582	5,180	(921)
Projects to be Capitalised	1,408	575	-	833
Savings required	-	-	-	-
Timing adjustment based on capacity constraints	-	-	(9,000)	9,000
IS Subtotal	40,234	18,914	13,100	8,220
Corporate				
HRIS Lifecycle Upgrade 15_16	529	51	478	-
Costpro Upgrade	313	247	66	0
HRIS Renewal Preparation	470	42	318	110
HRIS remediation	3,435	-	3,435	-
PeopleSoft IPS	313	250	20	43
SmarthHealth devices	320	-	320	-
incl Mobile printing for IOS	600	389	211	(0)
Clinical Device Platform	491	83	408	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	302	83	0
Other Corporate Projects Budgeted <$250K	1,275	888	208	179
Savings required	-		(170)	170
Corporate Subtotal	10,139	4,011	5,777	351
MOH & Trust Funded				
HSL - eSpace Programme	6,014	1,243	4,771	0
National Oracle Solution - Elevate	3,929	1,101	2,069	759
PACS review	392	-	392	-
Telestroke Pilot	321	7	314	-
16/17 Trust Account	-	-	-	-
Other MOH & Trust Funded Projects Budgeted <$250K	872	-	872	-
Savings required	-		(1,727)	1,727
(Funded by MOH)	(321)	(7)	(314)	-
MOH & Trust Subtotal	11,207	2,344	6,377	2,486
Total Projects	**174,931**	**60,821**	**73,451**	**40,659**

WAIKATO DISTRICT HEALTH BOARD
EXECUTIVE TRAVEL
December 2018

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

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			
December 2018	Domestic $	International $	TOTAL $	Domestic $	International $	TOTAL $	Comment
AITKEN VICKI	809.21	-	809.21	2,078.84	-	2,078.84	
AYDON LYDIA	-	-	-	35.00	-	35.00	
CARDWELL CHRIS	-	-	-	-	-	-	
CHRYSTALL MAUREEN	-	-	-	1,284.55	-	1,284.55	
ELLIOTT LORAINE	603.55	-	603.55	1,566.11	-	1,566.11	
HABLOUS NEVILLE	-	-	-	590.04	-	590.04	
HAYWARD SUE	-	-	-	1,050.75	1,559.78	2,610.53	Int Travel - Quality & Safety in Healthcare forum, Melbourne
HOPGOOD GARY	364.95	-	364.95	1,257.39	-	1,257.39	
HOWARD GRANT	-	-	-	927.18	-	927.18	
MALONEY TANIA	20.00	1,989.71	2,009.71	1,471.94	3,594.85	5,066.79	Int Travel - Learning Set - Melbourne
McCURDIE ANDREW	491.49	-	491.49	1,308.14	-	1,308.14	
NEVILLE MO	526.47	-	526.47	1,785.71	1,487.19	3,272.90	Int Travel - Health round table, Sydney
SEWELL GILL	589.51	-	589.51	955.35	-	955.35	
TAHU SUE	-	-	-	-	-	-	
TAPSELL REES	-	-	-	667.27	-	667.27	
TER BEEK MARC	463.45	-	463.45	3,025.23	-	3,025.23	
WRIGHT DEREK	1,851.75	-	1,851.75	4,519.00	-	4,519.00	
Grand Total	**5,720.38**	**1,989.71**	**7,710.09**	**22,522.50**	**6,641.82**	**29,164.32**	

Interim CE Travel Expenditure Derek Wright

Travel costs for the period to 31 December 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
June 2018	72.17	3 x meetings in Wellington with MoH in June 2018	Hamilton airport parking x3	Hamilton
18-19 June 2018	40.54	MoH - WDHB annual plan and Budget meeting, meeting Dept. Corrections	Taxi	Wellington
6 August 2018	77.13	Meeting CE and Chair of Counties Manukau DHB	Mileage and parking	Auckland
7 August 2018	70.00	Presented to APEX conference	Mileage	Auckland
9 August 2018	577.38	National DHB CE meeting	Parking, airfare , taxi	Wellington
24 September 2018	513.32	Allied Health Partnerships Meeting	Airfare, Taxi	Wellington
11 October 2018	497.60	National DHB CE meeting	Airfare, Taxi	Wellington
7-8 November 2018	829.19	National DHB CE meeting & NZPHL workshop	Airfare, Taxi, Accommodation	Wellington
30 November 2018	439.13	Koru Club	Membership	N/A
12-14 December 2018	910.50	National DHB meeting, Pharmac meeting, Mental health and SSC meetings	Airfare, Taxi, Accommodation	Wellington
6-7 December 2018	406.00	Midland Regional meeting	Accommodation	Tauranga
	4,519.00			

Health Targets

MEMORANDUM TO THE BOARD
23 JANUARY 2019

AGENDA ITEM 7

HEALTH TARGETS REPORT

Purpose	For information.

Most Recent Results
At the time of writing this report we had not received any Q2 results from the Ministry of Health. The "most recent result" (far right coloumn) shows data generated from within the DHB. Such data is not available for the smoking quit targets. Nor do we have updated information on 8 month immunisations.

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& 18/19 Target	2017/18 Q1 results	2017/18 Q2 results	2017/18 Q3 results	2017/18 Q4 results	2018/19 Q1 results	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 ✗	80% 20th ✗	X	81% Dec-18
Improved access to elective surgery		**100%**	108% 7th ★	106% 10th ●	110% 3rd ★	114% 2nd ★	**100%**	111% 5th ★	104% 8th ●	105% 6th ★	105% 7th ★	102% 7th ★	√	99% Dec-18
Faster Cancer Treatment (FCT)	Achievement	**85%**	81.4 % 5th ★	85.9 % 4th ★	86.1 % 5th ★	86% 2nd ★	**90%**	98% 1st ★	98% 2nd ★	97% 3rd ★	96% 3rd ★	93% 8th ●	√	95% Dec 18
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 ✗	85% 17th ✗	X	Not available
	Maternity	**90%**	93% 12th ●	96% 4th ★	98% 4th ★	95% 8th ●	**90%**	94% 8th ●	97% 4th ★	99% 3rd ★	87% 14th ●	89% 13th ●	X	Not available
Increased immunisation (8 months)		**95%**	92.3 % 13th ●	92% 15th ✗	90% 16th ✗	89% 15th ✗	**95%**	88% 15th ✗	90% 15th ✗	89% 14th ●	88% 14th ●	87% 16th ✗	X	Not available
Raising Healthy Kids		**95%**	47% 11th ●	79% 6th ★	84% 9th ●	81% 14th ●	**95%**	76% 19th ✗	100% 1st ★	100% 1st ★	100% 1st ★	100% 1st ★	√	100% 6 mths Nov 18

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

Target: Shorter stays in Emergency Departments (ED)

Table 2 - DHB quarter results 2018/19

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
82.1%	88.8%	85.8%	83.6%	80.4%

Table 3 - Emergency Department Q1 results by site and by clinical unit

	Total		
	Numerator: Number of Patient Presentations to ED with Length of Stay < 6 hours	Denominator: Total number of ED presentations	Percentage of Patient Events Admitted, Discharged or Transferred from ED within 6 hours
DHB Total:	*24,924*	*29,704*	*83.9%*
Waikato	*16,837*	*21,003*	*80.2%*
Taumarunui	*1,408*	*14.50*	*97.1%*
Thames	*3,686*	*4,154*	*88.7%*
Tokoroa	*2,993*	*3,097*	*96.6%*

		Maori			Pacific		
DHB	Individual ED Facilities	Numerator: Number of Patient Presentations to ED with Length of Stay < 6 hours	Denominator: Total number of ED presentations	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: Total number of ED presentations	Percentage of Patient Events Admitted, Discharged or Transferred from ED within 6 hours
Waikato DHB	*Combined DHB*	*7,750*	*9,037*	*85.8%*	*634*	*737*	*86.0%*
	Waikato	*5,167*	*6,314*	*81.8%*	*501*	*594*	*84.3%*
	Taumarunui	*627*	*646*	*97.1%*	*10*	*11*	*90.9%*
	Thames	*675*	*758*	*89.1%*	*43*	*49*	*87.8%*
	Tokoroa	*1,281*	*1,319*	*97.1%*	*80*	*83*	*96.4%*

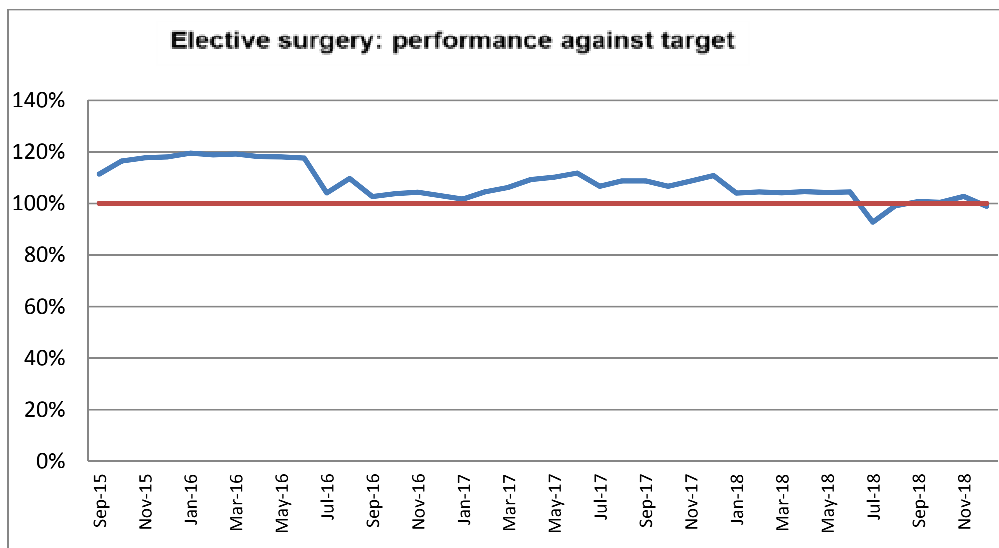
Target: Elective Surgery

Table 4 – Elective Surgery Results by Quarter

Quarter	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
Result	111%	104%	105%	105%	102%
Ranking	5	8	6	7	7

Graph 1 below provides the most recent result of 98.8%.

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



Target: Faster Cancer Treatment (FCT)

Table 5 - Summary of achievement against the FCT health target from July 2015 to December 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 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	94% TBC
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

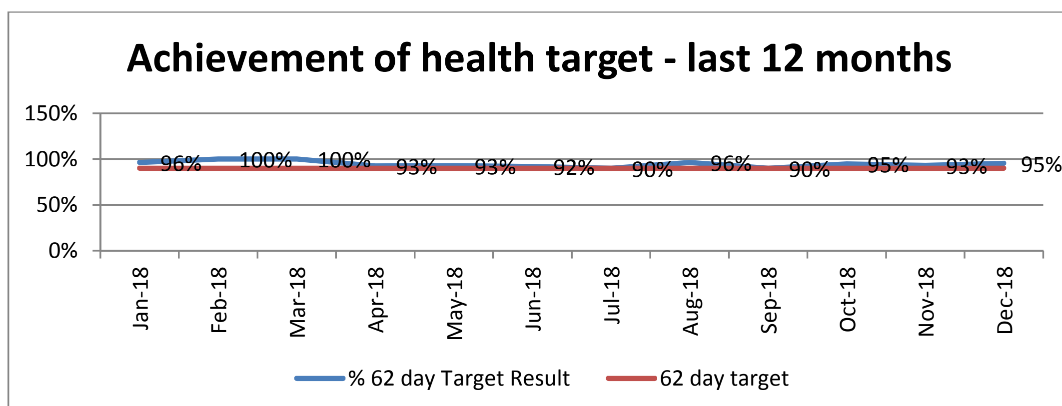


Table 6

Local FCT Database	**Oct-18**	**Nov-18**	**Dec-18**
Number reported on pathway	23	36	27
Number excluded (patient reasons/clinical considerations)	4	7	6
Number included for 62 day indicator	19	29	21
Number within 62 days	18	27	20
% 62 day Target Result	95%	93%	95%
% Volume Target Met (15%)	14%	22%	17%

Recommendation
THAT
The Board receives this report.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

MARC TER BEEK
ACTING CHIEF OPERATING OFFICER

Health and Safety

Health and Safety Service Report due in February.

Service Performance Monitoring

MEMORANDUM TO THE BOARD
23 JANUARY 2019

AGENDA ITEM 9.1

CHIEF DATA OFFICER DIRECTORATE

Purpose	For information.

Introduction
Since the Chief Data Officer directorate started, focus has shifted from operations management to strategic data and analytics leadership. With the aim 'to provide single source of truth data to decision makers enabling value based healthcare decisions', work towards the 2019 objectives has progressed in three areas: Data management, data analytics and technology.

Data management (governance)
The Chief Data Officer led a DHB-wide **Data Governance workshop** on 20 August to create a common vision to ‘treat information as an asset’, agree data governance priority areas and identify key activities for increasing data governance maturity in Waikato DHB. Self-assessment by workshop participants revealed that Waikato DHB currently has a basic maturity level for data governance. The group identified four priority areas for establishing stronger capabilities: Master Data Management, Data integration, Data Quality and Health Outcomes data.

Since the workshop, the **Information Security and Privacy Governance Group** (ISPGG) has been re-established as a quarterly item scheduled on the Executive Group agenda. The group is a requirement under the Operational Policy Framework (OPF) and Waikato DHB is obligated to comply with Ministry approved Heath Information Standards (HISO) and establish a governance group to safeguard our information privacy and security. The quarterly report will seek endorsement of relevant policies, provide findings from auditing and breach reporting and provide and update on improvements underway.

A new **Health Information privacy policy** for Waikato DHB is currently under review with key stakeholders in Legal and IS. The new policy also will identify business process and responsibilities for mandatory privacy training for all staff and audit reporting. These are cost-effective measures to provide a basic assurance for our DHB’s Privacy obligations. As highlighted in recent Privacy Impact Assessments for new projects there is a lot more that can be done, however resource from a system investment as well as ongoing operational resource is not available. As became clear at the recent DHB privacy hui in Wellington, all DHBs have minimal FTE invested in Privacy protection, in particular when compared to other organisations, notably ACC. As information systems are becoming more integrated, and contain more personal information, the privacy risks are increasing accordingly. A residual privacy risk assessment for Waikato DHB will be conducted and added onto our organisational risk register in Datix.

With regard to **Master Data Management**, our Clinical Coding team is investigating whether Waikato DHB can become a pilot site for implementation of SNOMED for ED presentations. With St Johns on board, a keen interest from the clinical unit and an example in Nelson Marlborough DHB, this can provide good benefits for clinical communication.

With regard to **Data Quality** – the work to improve the quality of the professional carer table has been completed. Information in this master data table caused significant issues for clinicians acknowledging test results, which has now subsequently improved measurably.

Furthermore, **National Patient Flow**, the new collection for elective patients through the health system, is progressing. Significant data quality issues are uncovered and addressed with each new service on-boarded. The Ministry of Health and Minister have clarified their respective expectations for the completion of this work in the latest OPF and Letter of Expectations, substantially by July 2019.

In conjunction with the Clinical Records Committee (CRC), work is being undertaken to review the increased use of **scanned clinical documents**. As a result of the DHB Paper-Lite movement, there is strong increase in demand from clinical services to scan clinical documentation. However it has become apparent that not all documents are fit for scanning purposes, causing concerns from clinicians and clinical coders using the scanned documents in the electronic clinical record in CWS (Clinical Work Station). The Clinical Coding and Clinical Records scanning departments will work with CRC to establish a clear guideline for outsourced providers to improve the quality of their scanned clinical documentation. Also, building on ongoing efforts to improve quality of clinical documentation and adherence to the Clinical Records Management policy by other people in the DHB, further education will be provided to junior doctors.

Data Analytics
The implementation of **QlikSense** based reporting in Mental Health has been successful, with clinicians and managers very engaged in the use of the new reporting functionality for their service. Key learnings from the project have been taken for future projects. One learning has been the importance of dedicated resource for application development, in order to speed up development and complete the work in a focused, collaborative manner with the users.

Like in Mental Health, the team have received many requests for ‘Qlik-like’ interactive analysis applications from other services. Following a recent presentation on the topic by an Anaesthetic Technician from Waitemata DHB, requests for these reports have been made by Labs, Theatre, Anaesthetists, Finance, Clinical audits team amongst others.
To meet the demand, a total of 18 analysts from teams across the DHB have been trained to become developers in QlikSense. However, it has proven challenging for these people to dedicate time to new report development, alongside their Business As Usual reporting responsibilities. The **lack of dedicated resource** has significantly slowed the development of new applications, and a business case to remedy this for a fixed period of time is being prepared.

As part of the Business Intelligence programme of work, the **consolidation of current reports** is underway with several hundred reports to be de-commissioned.

The design work for a DHB wide **Performance Measurement framework** has commenced and initial business requirements have been identified. The objective is to create a measure library with performance measures that are defined once, and used consistently by many people for many reports and analyses. Clinical services should be

able to select a balanced set of measures to use for performance improvement and accountability purposes. In simple terms, the aim is for services to only measure things that are a) *important* (from a customer point of view), b) are *cause of concern* and c) where there is *commitment and ability to improve* it. This will allow services to focus on a few key areas, where they are going to make a difference as a team, rather than long reports with measures which are used for monitoring only. A design proposal for the KPI framework will be developed for Board approval early 2019.

Lastly, forward planning to inform our **DHB delivery plan** (DAP) and budget for FY20 has commenced with the creation of an initial volume forecast. In line with the vision of the interim COO, volume plans will increasingly be compared against available input capacity required to delivery these, in order to understand plan feasibility and gaps, and required resource to meet the gaps and deliver the agreed volumes.

Technology
The launch of **Patient Flow Manager (PFM),** the new system to replace existing patient whiteboards on wards as well as providing clinical task management functionality, was successfully completed in October. This has been a significant undertaking involving 5 hospitals, Mental Health and 50 plus Waikato hospital wards. The project included the roll-out of over 90 monitors in all wards, strengthening of Wifi, and provisioning of over 540 handheld devices. The system was made available to over 3,000 staff including nurses, doctors including RMOs for non-urgent task management, Allied Health, Kaitiaki, OPAL for referrals, Nutrition for food orders and more. The feedback from users has been great and take up of the system has been excellent. A report with learnings from this successful implementation will be prepared for use in future large scale change projects.

The **QlikSense server** installation was completed with access now available to all new development users and Mental Health business users.

Future work in the enabling technology will focus on establishing the supporting database infrastructure for easy and timely access to analytical data. Currently some of our key data is only refreshed daily, which hampers the ability to use this data for operational decision making. The development of an Enterprise Operational Data Store and supporting data infrastructure will be investigated once recruitment of a **Data Architect** has been completed.

Finally, changes to the **internet security settings** have been proposed in order to relax the access to internet for DHB users. This is in response to feedback from users commenting that they are currently unable to access some internet content required for providing patient care.

Team overview report – period ending October 2018

Team: Operational Performance and Support (OP&S)

Initiatives and Highlights

Qlik (Analytical reporting tool)

- Qlik production servers fully installed.
- Mental Health pilot applications live and training partially completed.
- Developer training completed by 18 analysts in OP&S, IS reporting team, Strategy & Funding.
- Second pilot struggling for development time from analysts due to regular work tasks – no dedicated developers currently available.

Production Planning

- Picking up additional operational reporting and planning tasks – mainly bed modelling, roster planning.
- Delivered capacity plan analysis for most surgical services.
- Planning underway for development of 19/20 delivery plan volumes – CDO leading development approach with COO, CFO and Executive Director S&F to agree timeframes and roles and responsibilities.
- Will also be liaising with the CCDM (Care Capacity & Demand Management) analyst who will be starting soon on meeting the CCDM reporting requirements.

Other

- National Patient Flow (NPF) development continues with continued challenges in achieving high quality mapping of our data into NPF. Clinical Physiology and Audiology service implementations in validation phase and significant steps taken to match inpatient volumes with NBRS (National Booking Reporting System) collection.
- CostPro data load impacted by stability of source system database performance on two separate occasions leading to an inability to deliver daily reports for several sequential days. IS have implemented mitigations, and further opportunities to increase robustness have been identified.

Emerging issues and risks

- Ability to allocate time to develop new Qlik Apps is a significant constraint.

Next period focus areas

Production planning

- Defining the 19/20 planning process and starting execution with updated volume forecasts for service validation.

Qlik

- Finding way to develop more content – there is no shortage of users who see value in Qlik analytics – Mental Health, Labs, Theatre, Anaesthetists, Finance, Clinical audits to name a few.

Reporting

- Ethnicity KPI's to continue to be developed and to be included in organisational review of all KPIs.
- ED data reporting to be enhanced to support work initiated by Francis Group with Hot/Warm zones as well as greater visibility into AMU and ASU flow.

Team: Clinical Records

Initiatives and Highlights

- New people have been recruited and are now awaiting their start date.
- New shelving has been installed. This enables decant of files as repairs needed to be undertaken to the track of some other shelves. Culling of old shelves to free up space underway.
- Sent deceased records from 2011 to offsite storage and deceased records from 2016 have been sent to Wairoa basement to free up more space in the general Clinical Records office.

Emerging issues and risks

- Kofax software has been upgraded but experiences ongoing issues.
- Some of these are to do with the limited file size that the Midland Clinical Portal (MCP) will accept (there are no issues with the Clinical Workstation). We have sign off on the 'Authority to retain digital' on the basis that we scan in colour to reproduce the documents. At the moment one of the workarounds is to scan in black and white to get these documents across to MCP.

Next period focus areas

- Ensure 2 new appointees are trained.
- Continue culling and sending records to offsite storage or basement areas.
- Participate in review and resolution for issue with scanning of large clinical documentation files, mainly involving outsourced providers.
- Reconfigure the way records are stored to enable one sequence (may mean moving all files in the New Office area).
- Try to get resolution to the Kofax issues.

Team: Clinical Coding

Initiatives and Highlights

- Completed the internal audit of Clinical Documentation and Coding requested by Waikato DHB Audit and Corporate Risk Committee and implemented all but one of the recommendations assigned to the Coding Team.
- A follow up audit by a Senior Coder on Thames Medical Discharges (01/01/2018-30/06/2018) showed significant improvements from the one conducted above. This is attributed to the commitment from the Thames Clinicians to improve documentation for Coding and improvements in, and availability of Discharge Summaries at the time of coding. In addition education to new SHO's on the relationship between documentation and Coding has been successfully delivered via videoconferencing. Thames administrative staff has also worked hard to scan rehabilitation progress notes which in turn assists the Coding Department to meet the MOH KPIs for coded data and improve the Health Round Table data reports.
- To ensure that the quality improvements continue, random audits of coded Thames Discharges will be implemented on 1 December 2018 in line with other daily Coding audits of IDF, Mortality discharges and Specialty Clinician audits.
- Two senior Coders are enrolled on the La Trobe External and Internal Clinical Coding Auditing Course.

Emerging issues and risks
New:

- Installation of 3M edit engine in a timely manner to ensure Coding staff are trained in its use and any potential problems are rectified prior to the training for the major update in the ICD 10 AM 11th Edition upgrade which goes live 01 July 2019. Contingent on IS completing a Cloud based risk assessment.

Ongoing:

- Current location of Clinical Coding in Portacom D15 & D16 external to Clinical Records Department is ongoing risk for staff health and safety, transporting and accessing records especially after hours.
- The location is also inadequate for storage of and access of records for month end coding and for conducting audits with Clinicians.

Next period focus areas

- Implement the final recommendation from the Internal Audit liaising with the Director of Clinical Training to provide an example of both poor and exemplary discharge summaries that can be made available on the Resident Medical Officer Intranet page. These will act as a reference resource to encourage RMOs to use a set of agreed words which will enable the Coders to assign codes which will better capture the true complexity and comorbidity of patient episodes and meet the reporting requirements of MOH and HRT comparative data reports.
- Manager of Clinical Coding will attend a MOH led workshop (20 November 2018) on the implementation of SNOMED CT across NZ Health care settings to be able assist other key WDHB staff to develop a strategy for the introduction of the SNOMED CT codes particularly into the under 3 hours observed patients in the ED Department.

Recommendation
THAT
The report be received

MARCTER BEEK
CHIEF DATA OFFICER

MEMORANDUM TO THE BOARD
23 JANUARY 2019

AGENDA ITEM 9.2

MENTAL HEALTH AND ADDICTIONS SERVICES REPORT

Purpose	For information.

Service Overview

While the service has continued with the level of demand and pressure reported previously, staff continue to demonstrate resilience and a willingness to engage in planning for changes to the current mental health service delivery system, quality improvement activities and initiatives aimed at improving the wellbeing of both service users and their colleagues.

Mental Health in ED

Following the decision to develop a more responsive mental health service into the Waikato Hospital Emergency Department (MHED) Louise Quinn, Nurse Practitioner, was appointed and has been situated in ED since 20 August last year, initially working Monday-Friday, office hours.

Recruitment of two experienced mental health nurses has also progressed and they started on 29 October. A comprehensive orientation period followed and the nurses started their rostered shifts with Mental Health in ED on 10 December 2018. Within current funding we are able to provide two shifts (non-replaced) of Nurse Practitioner or Senior Medical Officer time up until 22:30 per week.

The team is located within the emergency department and works Monday-Friday 8.00am-23.30 hours. On weekends calls go through to the Crisis and Home Treatment (CAHT) team and overnight to the after-hours coordinator.

Their preferred referral method is in person and there is a dedicated duty phone that is with a clinician at all times to receive referrals. The team are still accepting and monitoring electronic referrals. The team are slowly building relationships in the department, and their presence appears to be having a positive impact on the 6 hour target.

Longer term it is envisaged that we will build capacity in the crisis service to ensure we can respond to crises earlier, either in ED or community settings.

Operationally, current referral pathways are being streamlined to direct service users to the Nurse Practitioner (NP) to triage and prioritise. The advantage of this system is that it enables the NP to have discussions directly with ED staff, allowing her to assess the patient sooner than the current system. The MHED team has been working closely with the Consult Liaison team who provide clinical support and back up when the workload requires or the NP is not in the ED. A draft MHED triage document is being developed using MOH guidelines and evidence based practice,

around risk factors and important information to be collected at a triage level. It is envisaged this will allow more consideration of risk at the triage point to accurately determine who needs safety partners, reducing the amount of ED resources used for the duration of the patient's stay in the department.

The NP attends the monthly ED complex case meeting and has noted that several of the top ten presenters had a mental health concern. A positive outcome is that following this, follow up was arranged for our complex clients who are under community services, and management plans have been developed with the people who know the service users best.

A further development is that the NP has been authorised to complete s.8 (medical certificate supporting an application for assessment) of the Mental Health (CAT) Act 1992 (the Act) papers. This means that when she is within ED, a doctor is not required to complete this portion of the paperwork. This is a new development under the Act, as currently in the Waikato we have no other nursing staff authorised to complete these applications

The NP is also reviewing iPM (inpatient Patient Management System) for people that may be able to be identified as requiring mental health input. This 'pull' model allows earlier intervention and assessment prior to a patient being medically cleared and before a referral has been completed, which has reduced duration in ED for some people.

Finalisation of the model of care requires consideration of two key factors:

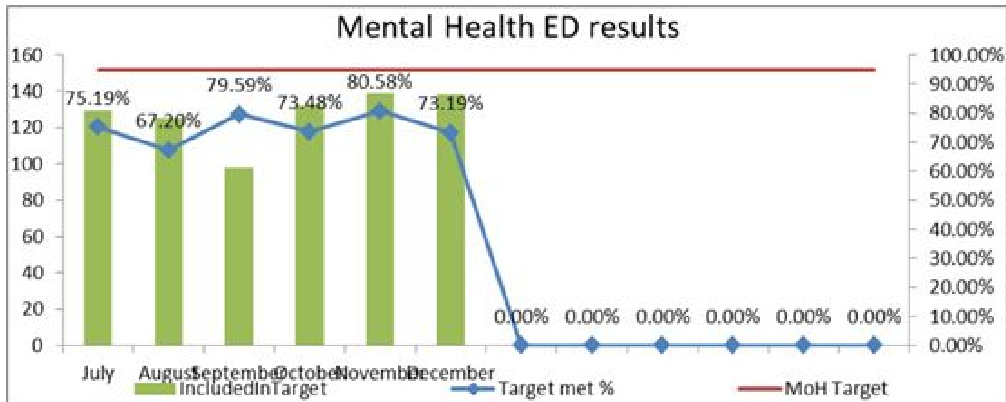
1. Ensuring the mental health presence in ED delivers an improved response by providing mental health interventions to those individuals with the greatest need.

2. Equally ensuring the presence of mental health specialists does not result in de-skilling of ED staff to respond to people in distress. There is a potential risk that the presence of specialist staff will drive diversion of individuals who may exhibit distress or unusual behaviour to mental health clinicians, when one of the key goals should be to upskill and equip ED clinicians. The services will need to work closely to monitor progress and ensure there are no unintended negative service impacts for patients and service users.

As the model develops the service will continue to examine the current evidence and best practice examples for out of hours mental health response, including any lessons learnt from those areas in Australia and New Zealand who currently provide a mental health response in ED.

ED Data

There were 174 mental health related ED presentations during December 2018. 138 of these were included in the MH 6 hour target resulting in a compliance rate of 73.19%. 123 of the 174 MH presentations occurred after hours (5pm to 8am) – 70.7%.



Seclusion Elimination

As a national approach to seclusion elimination, the HQSC has provided the impetus and co-design methodology for DHB's to undertake the task of eliminating seclusion by 2020. The Waikato MHAS has been heavily involved in this project and work here is being undertaken by a dedicated project team, comprising an experienced Clinical Nurse Specialist, Psychiatrist, Charge Nurse Manager, Recovery Advisor and the Team Leader – Kaitakawaenga. The group is closely linked to and supported by the HSQC Mental Health Improvement team and receives peer support and one to one mentoring as part of the project.

The project is currently running in line with HSQC's timeline and project plan and is about to embark on an audit programme to measure progress to date. A number of quick wins have been achieved recently including:

- Ward 36 has a dedicated Kaitakawaenga based on site during normal working hours.
- Use of the guideline Medications in Acute Psychiatry is being used, where clinically indicated as appropriate, as an active pre-emptor to avoid the use of seclusion.
- The Safe Practice Effective Communication (SPEC) training roll out continues. This is a nationally recognised and recently updated programme with a very strong focus on early de-escalation techniques.
- The implementation of the DASA (although not part of the seclusion project) should alert nurses to provide interventions in a timely manner to avoid aggression and the subsequent use of seclusion.

The following actions are also underway:

- Specific acute interventions and learning from seclusion debriefs is included in the recovery plans for all service users who have experienced seclusion in the past.
- A forensic service sub group has been formed. A forensic perspective in seclusion elimination is necessary as adult and forensics services face different challenges.
- The provision for staff to work with the SPEC instructors to further develop de-escalation skills (on ward sessions using scenarios and role play that build on the classroom based training and techniques demonstrated in the formal learning sessions).

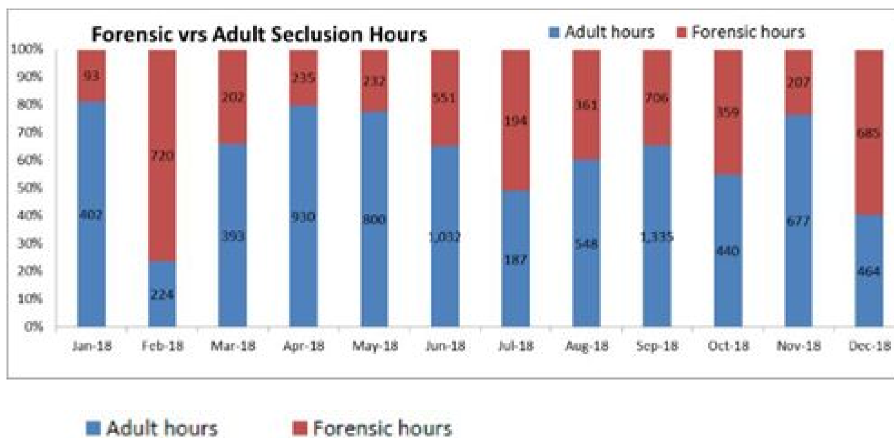
- Over the past month there have been a number of significant changes to our low stimulus area. The most prominent being the reduction from three seclusion rooms, down to two.
- We have created a number of flexible area's within the LSA (Low Stimulus Area) environment, where seclusion is now separated from the general area of LSA.
- We have also developed a further lounge/de-escalation area to support admissions of clients needing a more low-stimulus environment from the open wards.
- We are now in the process of formalising a 'new model of care' for this area, which will involve a rather significant culture change in the way that we currently deliver services.

You will note a number of the actions identified to address and reduce the use of seclusion are further detailed in this report as mitigations and areas for improvement impacting staff safety issues and particularly assaults.

As has been reported to the Board in the past, reducing seclusion and ensuring staff safety are both negatively impacted by the current environment and occupancy challenges faced by the service. The Board will be well aware of service the commitment to manage occupancy and improve staff safety.

There are still a number of challenging individuals with complex presentations in both the forensic and adult services, whose presentation cannot be managed safely in an acute mental health inpatient setting entirely without the use of seclusion at present. This is reflected in the data for September and October periods, with some very unwell individuals experiencing pro-longed periods of seclusion.

Seclusion Hours



It is also helpful to understand the use of HoNOS in relation to our work around seclusion elimination.

What is HoNOS?

Health of the Nation Outcome Scale (HoNOS) is a clinician rated tool developed by the United Kingdom's Royal College of Psychiatrists' Research Unit to measure the health and social functioning of people experiencing severe mental illness. This is an outcome tool mandated for use by specialist mental health services.

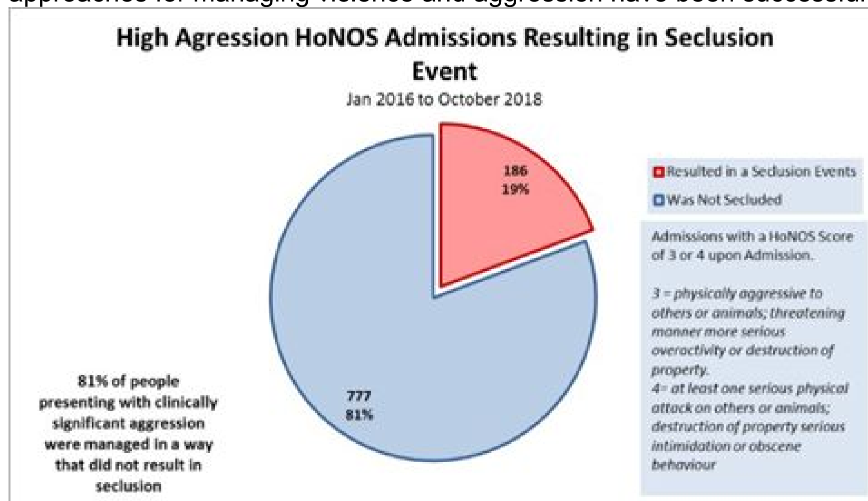
HoNOS measures symptom severity and social functioning across time. It has 12 items that measure behaviour, impairment, symptoms and social functioning. The items are rated on a scale of 0–4 and the results or changes in ratings are known as outcomes and may be attributed to services provided. The rating is made using a glossary that has detailed descriptors of level of severity and complexity.

HoNOS and seclusion elimination

It is heartening to note that 80.69% of individuals presenting with clinically significant aggression were managed in a way that *did not* result in seclusion.

From January 2016 to October 2018, PRIMHD HoNOS data together with seclusion data extrapolated from our data warehouse was collated and reviewed. A total of 603 service users HoNOS scores were rated at 3 for aggression and 360 service users score was rated at 4. Out of the total of 963 service users, 186 were secluded which means for the remaining 777 that were not, staff worked proactively and supportively to minimise distress and reduce the likelihood of a seclusion episode.

This means that there are significant numbers of individuals for whom other approaches for managing violence and aggression have been successful.



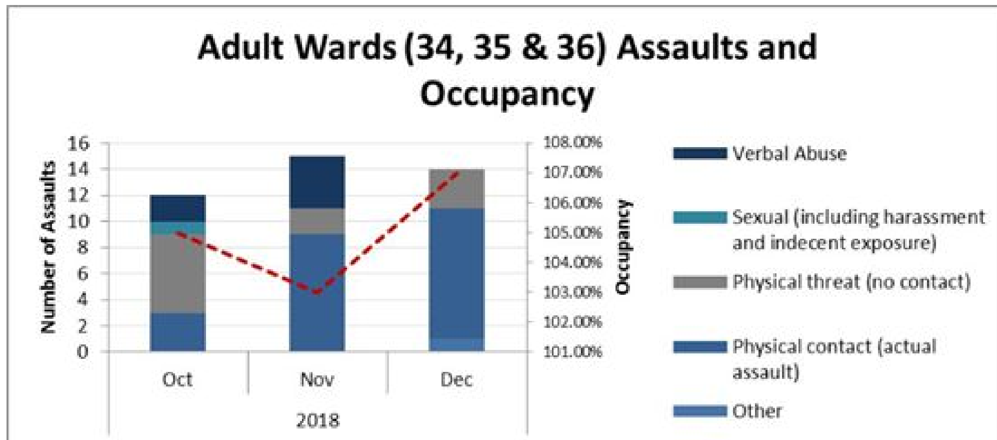
Note that the January 2016-October 2018 information timeframe is being kept consistent for the Board's information as it dovetails into the attached poster that is being printed and is displayed on the HRBC wards for staff information.

Staff Safety

Why are our staff being assaulted?

To understand the health and safety data it is useful to explore some of the context. This includes the demand on the adult inpatient unit. The following graph shows the percentage occupancy in the adult acute wards alongside the reported incidence of assaults. In general, phsyical assaults are associated with higher levels of occupancy.

Occupancy over this period has ranged from 89% (at its lowest) and 128% at its highest. Funded bed volume for the adult inpatient wards is 53 acute beds. Numbers have not remained below 53 for more than three days.



Of the 18 physical contacts (actual assaults) which occurred in this period, one was classified (Incident Management SAC rating as major. Upon review, it was confirmed this was not a staff related incident, however an incident of domestic violence noted and reported by a community staff member during a home visit. The remaining reported incidents were considered to be moderate or minor.

To ensure follow up, after further investigation, the major incident was reassessed as having a moderate or minimal SAC 4 score. Three SAC 3 (moderate) incidents were reclassified to SAC 4 (minor/minimal)

Injuries sustained over the time period included punches resulting in bruising and swelling; strains/muscle damage; scratches and abrasions; being spat at, and strains from being punched with force causing loss of balance. Five of the assaults were in the forensic unit, one was at a private address, one each occurred at the rural south and north services, and the remainder were within the adult service

What are we doing about this?

During 2018 as incidents began to spike, the inpatient leadership team met to develop actions to mitigate the assault trend. Whilst there are limited options to affect occupancy once individuals are unwell and require hospital treatment, a number of ideas are being progressed.

1. After liaising with a prevention manager from New Zealand police, a walk through has been undertaken to identify environmental changes which might reduce opportunities for violence.

2. We have met with Waikato DHB Media and Communications department to discuss a media messaging campaign to promote a zero tolerance of violence to staff and others. Initially this was considered to be a picture only campaign of our staff, similar to that in ED, but after receiving feedback it is planned to include positive words of encouragement and printed messages, incorporating the DHB values and including pictures of our staff.

3. We have met with nursing union organisers to work collaboratively around ensuring our staff have the highest level of training around de-escalation and restraint, so that we have a skilled and competent workforce across our higher risk areas.

4. Our post-vention approaches to staff assaults include:

- immediate diffusion with staff involved
- planned and facilitated debrief
- follow up from the charge nurse manager; and
- support from that manager or other identified staff member to facilitate individuals to make a complaint.

Our procedure is being amended to ensure there is a greater emphasis put on pastoral care.

5. The last two months, have seen Kaitakawaenga (cultural advisors) physically present in ward 36 (intensive care ward), welcoming and working with new admissions, with good effect.

6. Our Safe Practice, Effective Communication (SPEC) educators will be working directly with small groups of unregistered staff and those wanting practical refreshers to role play situations and options for responding. These will be rapid and frequent ward based sessions with practical exercises, to build confidence and remind staff of the skills they were taught in the four-day programme.

7. With environmental modifications being made to ward 36, there are increased separate spaces which can be used for de-escalation which will prevent staff and service users from being in a small confined space when agitation levels are high. As part of this small refurbishment, another seclusion room has been decommissioned and there are increased quiet lounge areas incorporating soothing artworks/pictures from around the Waikato.

8. All shared bedrooms have now been converted to single spaces, and whilst the space is limited, it has increased both privacy and safety for service users. This reduces the risk of patient to patient assaults.

9. As part of our quality improvement approach to minimising seclusion, we are working with community staff to ensure medication is offered proactvely prior to transfer to hospital. Being admitted to hospital can be extremely anxiety provoking and frightening. As well as offering better reception and admission processes which are supportive and culturally appropriate, it is important that medication administration is also proactive.

10. Nearly all of our inpatient staff are trained in the new national SPEC approach, which has a strong focus on de-escalation techniques, rather than restraint techniques (where injuries are more likely and increase traumatic experiences for service users).

11. The inpatient unit is currently operating an acuity and flow model. When this was introduced both acuity and demand was less. Now that there is significant demand, the model has created a pressure cooker of very unwell individuals mostly in wards 35 and 36. These wards both have secure gardens. Ward 34, has the largest internal space, but does not have a secure garden. Research shows that when patients are acutely mentally unwell and/or in a state of high anxiety or agitation, they respond best to calm and space. Plans are underway to securely fence the ward 34 outdoor space, which will mean that the unit can return to a sector (geographical) model and spread out those individuals with high acuity, ensuring they can receive the best care in an environment that suits their needs.

Workforce project

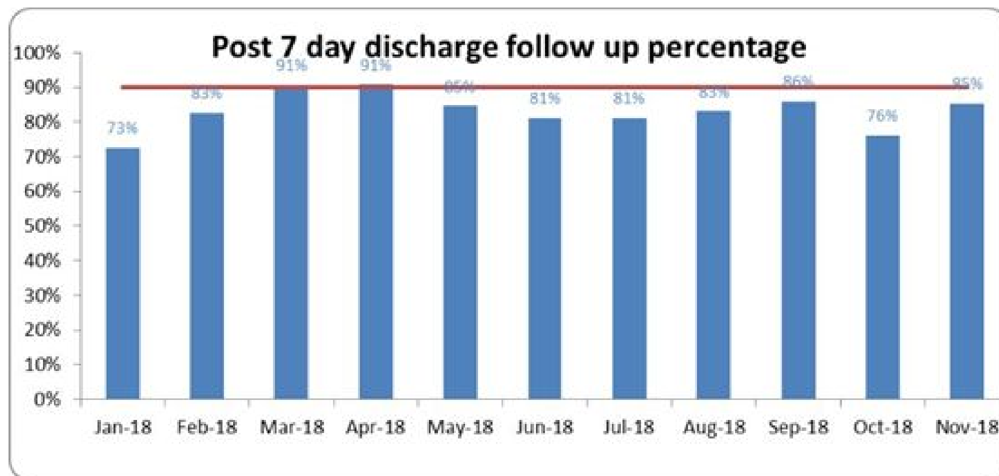
The workforce development consultant commenced on 29 October and has hit the ground running. Sima Clarke comes to us from Te Pou o te Whakaaronui and is well versed in maximising opportunities for workforce development. Sima's brief is to ensure we continue to formulate strong plans around workforce; from recruitment to retention, to guarantee our pipeline into the professions is maximised.

Sima is working closely with Anne Welsh (Learning & Development) to develop the talent management model. This will empower managers to ensure all leadership capacity is realised and that individuals both want to work, and also stay in the Waikato DHB Mental Health and Addictions Services (MHAS). A key part of the role will be ensuring there is a link between the goals and values MHAS have and those of the wider DHB. There is also a need to ensure that the work we do as part of the project will have synergies back to the wider DHB support services (HR, L &D, Communications, etc.). The service will be working to consolidate its mandatory training into one week next year, with an appropriate cultural welcome and service welcome. This will ensure our new staff feel connected to and understand the current and future needs and direction of the service.

Medical staff

All advance trainees who are eligible for SMO appointment, are being offered positions within the service and this is testament to a strong and supportive Psychiatry training programme. The adult inpatient unit at HRBC has been able to attract and retain excellent senior medical officers, which will ensure there continues to be accreditation of the training programme. The small number of locums in mental health are slowly being replaced with permanent employees as candidates become available.

Post 7 day discharge



This remains a priority for the service as a KPI, but more importantly, as a responsive service. Recognition of the need to respond more effectively to service users being discharged is of paramount interest and forms the greater part of our commitment to plans to increase KPI compliance. The reported percentage for November was 85%.

Enhancing communication between community and inpatient before and at the point of transition is key to making gains in this area. Service pressure is an inexcusable, but realistic contributing factor. The risk is that communication breakdowns occur at times of very high demand. Where this does occur, team and operations managers work together with a quality improvement lens to explore the factors.

Community staff ideally should be in a position to actively support the point of transition for service users and their families. From an optimal service journey experience, 7 days post discharge is too long to wait. Identification of a community clinician who can facilitate active follow up for a target population of people has been identified and this is being worked up at present. This will assist in continuing to improve compliance – however, and more importantly, will improve connectedness of services for those being discharged who are new to the service.

Current actions in place to monitor post discharge 7 day follow up include:

- Dedicated team leader in the community who checks information daily, and notifies respective team leaders and/or charge nurse managers when it seems that follow-up has not been completed or notes have not been finished.

- Team leaders/charge nurse managers will, as a matter of course, review and proactively act on the daily discharge information that comes through via discharge and compliance reporting.

Variables that have contributed to those not being followed up within the 7 day discharge timeframe include incorrect contact details, people who haven't been referred for community follow up (therefore shouldn't be included in the data), discharges not recorded in a timely manner, failed attempts to contact, dissatisfaction with the service or keyworker and lost opportunity on our part. The operations managers are working proactively with their teams to raise collective awareness of errors to boost compliance.

The business intelligence pilot Qlik Sense has now commenced in MHAS.

The post 7 day Qlik dashboard provides information on clients recently discharged in order to better manage immediate post discharge care. The dashboard provides up to date information on:

- discharges from the wards and associated contacts
- lists open referrals and the identified key worker for discharged clients
- percentage of individuals seen within 7 days vs not (over different time periods)
- individuals not yet seen with discharge date; and
- breakdown to service, team and individual staff member.

The purpose of this technology is to equip staff with the tools to understand their own work more effectively, be curious and improve performance. This is a move away from data and information being fed down to staff from managers and business support staff.

Recovery planning

Recovery planning is a fundamental component of community mental health care. It is an area that service users, whanau and staff identify as requiring improvement.

Recovery planning champions have been identified and are working on recovery planning as a quality improvement initiative.

This group have identified three key areas of focus:

1. Design and complete a best practice Recovery planning document.
2. Review a sample of current Recovery Plans to understand what is working well and what is not.
3. Understand service user requirements.

The working group facilitators collated recovery planning literature and distributed to the group and ensured they liaised with the Recovery Advisor to ensure input from service users.

A culture change around recovery planning is a current focus for the service. While recovery plans are a KPI, they should also more fundamentally, be an integral part of supporting recovery and a foundation of practice.

Staffing changes create both challenge and opportunity. There are a number of new staff coming into the teams, and their orientation process includes expectation setting around the integration of recovery planning into practice.

Monthly education sessions are being implemented at London Street, to facilitate key aspects of quality practice. The first of these is about recovery planning and will provide an opportunity for clinicians to discuss recovery plans, any challenges / questions they have about good plans and how to engage service users in them and to establish expectations for the New Year. ‘Champions’ will be identified in each team who can support clinicians in the development of meaningful recovery plans developed with individual service users. A working group is established to review and enhance the quality of recovery plans.

A clear and comprehensive guideline has been developed for clinicians and will be circulated for consultation to all MHAS staff in late January. Feedback will be considered during the following weeks and the final document will be issued and published by the end of February 2019.

Ensuring a consistent focus on recovery planning will be key to sustaining improvement.

Recovery in Hand

The Community Alcohol and Drug Service has been piloting an innovation in addictions relapse prevention. A smartphone app connects people with clinical teams, their recovery community, peers, and other resources 24 hours a day, 7 days a week. Developed in the United States, at the University of Wisconsin, ACHESS (Addiction Comprehensive Health Enhancement Support System) and the Waikato DHB Community Alcohol and Drugs service has been engaged in a one year trial, in a New Zealand setting.

A smartphone app, that supports people in their recovery, uses a number of features including:

- a “hot beacon” which provides accessibility to a counsellor with the National Telehealth Service 24/7

- GPS detection (optional) which can alert service users to potential high risk locations
- supportive resources
- goal setting, journaling, ability to personalise the app, and identify motivations
- medication and appointment reminds
- recovery tracking and progress.

Internationally ACHESS has been successful in reducing relapse rates, and a considerable reduction in heavy drinking days, which has resulted in an extension of abstinence rates. While it is relatively early days within a local context, a process evaluation has been undertaken and findings are encouraging. Positive feedback has been obtained from app users and staff who are engaged. With 66 active users currently, 65% of them utilise the app every couple of days. Those who sign up, largely remain active participants.

Clinician engagement has been variable, and it is noted that uptake has been higher in periods where a dedicated resource has been championing the product. Service demand and staff retention has impacted on the availability of a dedicated champion, so more recently, a partnership has been entered into with Progress to Health (NGO) and one of their peer support workers is providing assistance to work with service users to understand the app and provide sign up support.

Narrative feedback obtained through the process evaluation provides insights into service user experience of the app features and functionality:

> *"This app is helpful and it is great to talk to other people going through the same thing. You are able to support each other, no matter what comes up in life. Support and help is the key to become a better person in life".*

The Director, Community Mental Health and Addictions Services, presented this initiative at the fourth annual e-Mental Health Expert Forum, on 17 October, where our Interim Chief Executive was the recipient of the e-Health Innovation Leadership Award for innovation, implementation and forward thinking leadership.

Next steps included an extension of the initial pilot to ensure use of the application is part of treatment as usual, and further roll out across the two rural alcohol and drug services.

A new E-Mental Health initiative was launched on 16 October 2018. Waikato DHB is participating as a pilot site for WAKA. This is a new digital initiative to support people who live with schizophrenia, living in their communities with the vision to improve their recovery experience. While there are a number of E-mental health initiatives operating nationally, they are often in the early intervention and prevention space. WAKA is specifically designed to improve the wellbeing of those with long term serious mental illness. The intent is to co-create a scalable solution to improve the recovery experience for service-users with schizophrenia undergoing treatment with long-acting treatment. The goal is to improve health and social outcomes for service users:

- improve social connection
- increase confidence to self-management
- reduce early discontinuation of treatment.

The 'Waka' is a technological platform which has the following functions:

- WAKA coaches
- online community, moderated
- self-management and resources
- daily Tracking and progress
- messaging to coach
- access to crisis helplines
- personalised on boarding experience
- both web and app options
- share resources with whanau/family and other supporters.

There are five WAKA Modules:

1. Understanding my condition *(learning to manage your Schizophrenia)*
2. Treatment experience *(getting well and staying well)*
3. Emotional wellness and managing stress *(learning to manage emotions and stress)*
4. Healthy Living *(getting and staying physically healthy*)
5. The importance of good sleep *(getting a good night's rest),*

Joint provider governance meeting

At the beginning of the 2018 year, Waikato DHB MHAS leaders, called together a meeting to explore provider engagement and commitment to addressing compounding system pressures. Initial attendees included representation from Te Runanga o Kirikiriroa, LinkPeople, Hauora Waikato, Connect and Pathways. There is strong commitment across providers to explore opportunities to provide collective impact, agreeing focus and developing and consolidating membership. While formatively intended as a strategy to support greater system 'flow', and to assist in easing pressures in the inpatient facility, systemic contributing factors have been readily identified.

As a result of these initial governance discussions, an early and exciting development was the formation of a weekly operational occupancy and flow meeting of MHAS and NGO service provider staff. This developed during 2018 into an efficient and effective forum for discussing the residential needs of inpatient service users. The meeting is working well providing open communication, and information-sharing and identifying pathways and flow for service users from inpatient to residential services, and into independent living.

There have been some remarkable success stories as a result of this collective forum. These include streamlining the referral process and administration requirements of providers thereby enhancing consistency of information provided by our DHB workforce to providers when referrals are made, to creative solutions which have made the difference to the lives of individuals and the way in which they receive services.

The governance group held its last meeting for the 2018 year and consolidated its agreement to maintain momentum into 2019. It has agreed to widen its membership and seek specific input from the funder at a governance level as Strategy and Funding input is critical to progressing opportunities and addressing challenges. The governance group provides oversight of the weekly occupancy and flow meetings and provides a mechanism for escalation of issues arising from the weekly operational joint providers meeting.

This development is an example of services working together, to maximise positive outputs and putting the service user at the centre of their care.

Residential support options

Active transition beds have been identified and utilised during 2018 to support people from inpatient settings that require a structured transition beyond inpatient, to independence. Aimed at a transition period of around 12 weeks, these 'beds' offer a rehabilitation focus, which is tailored to individual need. Two service users 'graduated' in the latter part of 2018, with great feedback from providers about what this programme offers.
Regional Coordination service (RCS)

A longstanding and very valuable component of provider services relates to residential support beds, with around 233 supported accommodation beds across our region.

There has been a lack of visibility of these beds and any potential vacancies as a result of the way the system was previously set up. Recent developments now mean that this information is made electronically visible for every one of those beds, using Patient Flow Manager (PFM). We are able to readily see any vacancies, length of stay in residential support facilities, and where providers have people occupying beds that may require less support.

A review of our regional coordination service is currently in progress, to explore the model and fit for current and future states of service delivery. Findings of this review will be known early in 2019.

Project 7

This joint initiative, between Waikato DHB and LinkPeople to review and proactively address the needs of several current inpatients who cannot be discharged from HRBC as a result of homelessness, was established during 2018. These were people identified as not requiring residential support or active transition programmes but were more specifically, homeless.

Initial meetings were set up as a targeted initiative for this population that more latterly has become integrated into work that is in progress between the Inpatient Coordination Team and LinkPeople. We also identified a community clinician to work alongside the project, to ensure that the transition beyond inpatient can occur with flexibility to respond to anticipated community intensity of resource to support the service user beyond discharge, and with other providers engaged in working with them. Lack of housing stock in the region is a problem, consistent with the national picture. And while housing provides a roof over a head, the sustainability of that housing, and the transformation of a house to a home, requires multi-agency collaboration and responsiveness.

It is envisaged that Project 7 will continue as a targeted and focused initiative, with exploration of the synergies with the work in progress around joint provider governance and operational groups.

Community service pressures

Demand for services continues across both inpatient and community services.

Community mental health teams in particular struggle to keep up with the level of need. High inpatient occupancy is in part a reflection of the high demand and need in the community. In the current state community roles are increasingly becoming less attractive areas to work in and recruitment and retention strategies have featured throughout 2018 to attempt to mitigate workforce challenges.

Retention is an increasing concern with Adult community central sector teams in particular experiencing the highest turnover of staff. Anecdotal feedback from staff describe the challenges faced on a daily basis in responding to new referrals, having stretched capacity resulting in restricted ability to deliver proactive care and support.

Occupancy compounds this picture, as a higher threshold for admission is required and a higher degree of acuity and complexity being managed in community sector teams. While every effort is made to ensure that high quality, responsive and accessible services continue to be delivered, this can result in service users experiencing a frequent 'change' of keyworker or clinician, which is less than optimal in terms of best practice service delivery. Long term, this is not sustainable, nor acceptable.

A number of contingencies were put in place during 2018 to manage the current pressures:

- A rolling recruitment strategy has assisted in reducing the 'gap' when roles are vacated, with monthly interviews occurring to screen and employ suitable applicants into a buffer pool. While there is a high calibre of occupational therapy and social work applicants, frequently there are less nursing applicants in general.
- Non-core services have been required at times to share their staff resource, with adult community teams in an effort to support those teams to get by, and clinical leads of professions have been required to return to frontline clinical work at times.

In addition, a number of initiatives have been proposed as part of Creating our Futures which provide short term and longer term guidance for a change in the model of care and service delivery across the system of care.

These initiatives range from local points of access, marae based clinics alongside primary care and community providers, centres of wellbeing incorporating physical wellbeing in inpatient and community services and integrated health care hubs in areas of high need and inequity.

These are initiatives by our staff in collaboration with other services as part of the Creating our Futures Advisory group. There is a strong level of interest in a shared governance arrangement across Creating our Futures and Te Pae Tawhiti to ensure a joined up approach to how we both commission and deliver mental health and addiction services.

A focused process is underway to actively review and explore opportunities for service users to transfer to primary care from specialist services, using the Integrated Care Coordination Team (ICCT) and physical health pathways.

Dr Andrew Darby is working 0.6FTE with Pinnacle, and 0.4FTE with our ICCT team. Proactive screening of caseloads within central sector teams is in progress, with a number of service users identified as prospectively suitable for these pathways. We

are confident that this will result in successful transition for a number of them. Ensuring that these pathways are readily identified and utilised in the future will require a change in practice and some strategies to embed that.

There is energy for change and staff are identifying opportunities for improvement and are committed to making a difference in the lives of people that need our services.

Waikeria Prison Developments

On 13 June 2018, the Minister of Corrections announced that the Government as part of developments at Waikeria prison would build a first of its kind (in New Zealand) mental health facility by early 2022.

At the time of the announcement there was not a clear policy statement from either Health or Corrections Ministries regarding the function and detailed nature of the unit and which prisoners would be accessing it, or indeed the relationship with health and forensic psychiatric services.

It is reasonable to assume that this change in direction reflects a desire by Government to:

- Provide better environments for managing prisoners with mental health and/or behavioural challenges
- Increase access to appropriate services and rehabilitative interventions
- Improve community reintegration and reduce the changes of reoffending and reimprisonment.

Given the significance of this shift in direction and the significant interface and potential impact on mental health and addiction services, the Department of Corrections has sought input from MH&A'S into the governance of this development. The Executive Director and Director of Clinical Services are part of the newly formed Waikeria Mental Health Facility Project Board which is tasked with establishing a model of care and operating model for this development.

The first task of this group was to finalise a briefing paper for Ministers to provide a comprehensive overview of the required considerations from a legislative perspective, the options for how the facility should operate including who will be in the unit, the nature of their treatment needs, the workforce requirements and the impact on forensic and general mental health services in Waikato. This paper has been accepted by both Ministers and a meeting with both Ministers will be attended by representatives of the Project Board.

In essence this paper outlined the prevalence of mental disorder and substance use disorder for those currently in prisons. It also identified the current pressures experienced by prisons services in trying to manage a range of vulnerable and challenging prisoners with both disturbed behaviours and/or significant mental health need. In addition mental health and forensic services are experiencing unprecedented demand for beds, and in the case of Forensic services a waiting list for access to inpatient care and treatment. New Zealand's existing legislative framework explicitly precludes the delivery of compulsory treatment within a prison, and it is clear that with a 100 bed mental health unit in our area that there will need to be an increase in forensic and other mental health beds to ensure people have greater access to mental health care when in Prison.

It is against this backdrop that the following work programme is underway, overseen by the joint governance group:

- A joint partnership model where people can receive multidisciplinary support in a specialist mental health unit. Care provided by health professionals and security provided by corrections staff.
- A model of care agreed by all parties (Corrections, Ministry of Health and Waikato DHB) which describes who will be housed in this setting, where will they come from, what interventions will be provided and by whom, and what the relationship with the Midland Regional Forensic Psychiatry Service will need to be.
- Information to be used to inform the WDHB Business case and the increased capacity requirements.
- Staff from WDHB to have input into the key operational aspects of the development at the earliest stage.

Let's Talk Community Engagement Hui

The Te Pae Tawhiti and Creating Our Futures Let's Talk | Me Kõrero Tātou Engagement Hui met with 32 communities from December 2017 to July 2018 to seek their views and experiences on the provision of Mental Health and Addiction Services. A significant amount of feedback was received.

During October and November, this information has been reviewed and analysed guided by a specifically developed Kaupapa Māori methodology. The team of reviewers and analysts have included: Tangata whaiora and whānau, Te Puna Oranga, Strategy and Funding and Mental Health and Addiction Service representation. The Iwi Māori Council Chair has provided oversight.

This process has identified the following six themes out of the hui feedback. These are as follows:

Whānau | Strengthening Families
Hapori | Thriving Communities
Whakamomori | Prevent Suicide
Ngā Awenga Oranga | Influencing Wellbeing Environments
Ngā Mõrearea | Crisis Resolution
Mana Motuhake | Holistic Autonomy

These themes are now being developed into a final report that will include the recommended transformational actions required to address these themes. Alignment of these themes to the Care in Community and Health System Plan will be undertaken.

Mental Health Awareness Week

MHAS participate in Mental Health Awareness Week during October each year. Ordinarily the events are largely focussed on service users and communities, often with multi-agency events occurring across the region.

During 2018 and as an extension of the work that has come out of the MH&AS wellbeing group, this group collaborated with the Staff Safety and Culture Working group to look at focusing the week on staff wellbeing. The theme was 'Growing and Flourishing in your Work: He Mahi Whakatupu ake

A number of planned activities and messages occurred throughout the week aimed at supporting all staff to think about their own wellbeing. Some of the actions included:

- messages on the intranet and social media
- launch the week at the Hauora iHub with the Interim Chief Executive
- photo competition with selfies
- Lunch and learn sessions
- Resource packs for managers to use in their areas
- Introduction to mindfulness/chair yoga
- Nature and history walk around Waikato Hospital campus.

The key messages link in with the DHB's vision and values and the five actions or ways to wellbeing.

Recommendation
THAT
The Board receives the report.

VICKI AITKEN
EXECUTIVE DIRECTOR MENTAL HEALTH AND ADDICTIONS SERVICES

MEMORANDUM TO THE BOARD
23 JANUARY 2019

AGENDA ITEM 9.3

STRATEGY AND FUNDING UPDATE

Purpose	For information

This report provides an overview of key developments within Strategy and Funding over the last three months.

Strategy and Funding Unit Reorganisation

Over the last three months, there has been considerable focus on implementing the new structure for Strategy and Funding that was announced in September 2018. Almost all positions have been appointed to, although recruitment has intentionally slowed to assist in addressing DHB budget pressures. The new structure will enable a more engaging commissioning approach and the capability to drive health system change in line with the Health System and Care in the Community plans.

Mental Health System Development

A whole system mental health model was presented to the Board in November last year. Following the broad acceptance of this model, we have commenced the work to ascertain what services are needed in each of our localities. The locality planning will enable us to assess the gaps in current service provision and plan for new (or reconfigured) services. We expect to have a plan that details the above, including actions and investment requirements, by April 2019 in line with the completion of the first draft of the Health System Plan. We have already identified gaps in the quality and capacity of acute community care, such as acute respite care, particularly in our rural communities. We will provide an update to the Board at the February 2019 meeting.

Health System Plan (HSP) and Care in Community Plan (CCP)

Over the course of consultation for the CCP, six goals have been identified for Waikato health system development as follows:

1. Partner with Māori in planning delivery of health services
2. Empower whānau to achieve wellbeing
3. Support community aspirations and address determinants of health
4. Improve access to services
5. Enhance the capacity and capability of primary and community care
6. Strengthen intermediate care.

The goals have been supported by stakeholders involved in the engagement process including the Consumer Council and Waikato DHB Clinical Directors. Workshops to

develop actions for each of the goals were undertaken in November and December 2018.

The actions are being refined during January 2019 and the draft plans will be written over January/February. The draft actions will be discussed with Iwi Māori Council and the Board at the respective February meetings.

In parallel to development of the plans, workshops will be held over February to develop an implementation roadmap. The roadmap will provide detailed actions for the first three years with less detail for medium and long term actions.

Public consultation on the HSP, CCP and roadmap is scheduled for April 2019 and is expected to run for four weeks.

Long Term Investment Plan

The Long Term Investment Plan (LTIP) is a reasonably significant component of the *Investor Confidence Rating* (ICR) which is undertaken by Treasury to assess investment management capability and performance. The LTIP accounts for 10% of the assessment. Waikato DHB was assessed in May 2017 and is due to be reassessed mid-2019.

An Interim LTIP was submitted in 2017 with a number of options but without a clear direction of investment. The next iteration of our LTIP is due for submission to Treasury in July 2019 and will be developed as soon as the HSP is finalised. Whilst the HSP will provide a high level direction for services (and investment) a comprehensive LTIP requires further clarity on the strategic direction for secondary and tertiary clinical services (including regional services) in order to plan the investments required to support them. Thus, LTIP 2019 will provide estimates of the impact of changes in model of service delivery on the DHB's investment profile, but will not be able to provide details of an investment approach until strategic clinical services plans are completed. The LTIP is viewed as an iterative plan that is typically submitted every three years.

Annual Plan

The 2019/20 planning package was received on 20 December 2018 along with the Minister's Letter of Expectation. It is of note that an updated Statement of Intent is required this year.

The government planning priorities have been identified as;

- Strong fiscal management
- Strong and equitable public health and disability system
- Mental health and addiction care
- Child wellbeing
- Primary health care
- Public health and the environment.

The timeline for delivery of the Annual Plan is very tight and work has already commenced; a draft plan is due for submission on 5 April 2019 and the final draft is due on 21 June 2019. An early draft will be available for the Board to review in March 2019.

Tamariki Oranga Plan

Strategy and Funding is commencing the process to develop a Tamariki Oranga plan. The plan will align with advice and feedback from the Community and Public Health Advisory Committee (December 2018) about the need for a comprehensive approach to tamariki and whānau health and wellbeing. It will also align with government priorities for child wellbeing outlined in the letter of expectation from the Minister of Health, including but not limited to:

- Improving equity of outcomes
- Supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and mental wellbeing
- Contributing to the Ministry of Health review of the Well Child Tamariki Ora programme
- Supporting the reduction of family violence and sexual violence.

Our intention is to partner with Māori in the planning and delivery of the plan and to also work with other agencies and community organisations to address the social determinants of health and wellbeing. We expect our approach will actively support tamariki and their whānau to receive more holistic support in the future.

The draft Tamariki Oranga plan will be completed and submitted to the June CPHAC meeting for endorsement before being submitted to Board for approval.

Recommendation
THAT
The Board receives this report.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

DAMIAN TOMIC
CLINICAL DIRECTOR, STRATEGY, FUNDING AND PRIMARY CARE

Professional Advisory Reports

Chief Medical Officer: report due in February.

Chief Nursing & Midwifery Officer: report due in April.

Decision Reports

Equity Focussed Report due in March.

Significant Programmes/Projects

Creating our Futures - report due in February.

MEMORANDUM TO THE BOARD
23 JANUARY 2019

AGENDA ITEM 12.2

CBD ACCOMMODATION PROJECT UPDATE

Purpose	For information.

High Level Summary

Project Tolerance	Status	Commentary
Overall	On track	Re-scoped project is on track in relation to both high level programme and cost plan. Key contracts are in place. Detailed design and consent processes completed. Main contractor is established onsite with works underway.
Time	On track	Previously published move in date for first round of occupiers on track for August 2019, with phased moves due to operational requirements through to March 2020.
Cost	Plan in development	Current cost plan remains within the Board approved envelope of $14.7M. Current committed expenditure is $1.77M. A further $9.7M is now contracted with suppliers. Remaining costs of $3.23M relate predominantly to furniture, signage and equipment and are being specified, procured or are in negotiation.
Contracts and Documentation	On track	Major supplier contracts in place, including construction/fit-out contract with Foster Construction pursuant to procurement exemption.
Scope	On track	No material scope changes.
Risk	Plan in development	Tracking satisfactorily. Programme and cost risks will remain to be managed until commissioning.
Resource	On track	Project fully resourced.
Benefit	On track	Per revised business case.
Status key:		
Plan in development.		On track.

Commentary

- Since the revised Board approval in August 2018, a complete re-design in accordance with the revised scope concept plans has been completed, re-costed and new contract documentation finalised.
- Revised council consent documentation has been completed and approved.
- Enabling work on site and long lead procurement initiated.
- Revised occupancy plans have been finalised with staff consultation.
- Detailed occupier neighbourhood plans and seating layouts have been completed and these are attached at Appendix A.
- The main fit out construction contract has been executed.

Relocating Services

The following services are relocating from the Campus, Collingwood Street owned site (ICAMHS) and the KPMG Tower (Strategy & Funding):

- Payroll / HRIS
- Accounts Payable / Accounts Receivable
- Health Share / eSpace (as a DHB tenant)
- IS
- Public Health
- Strategy & Funding
- ICAMHS
- HOP/START/REACH

Perspectives of Public Areas

Imagery relating to the spatial environment for the public entry areas:

Space divestment

- It will be recalled that 2,505 sqm of ground floor space was removed from the revised fit-out scope for cost management and due to service relocation requirements. Now that detailed DHB fit out design has been completed within the constrained foot print, it is planned to formally market this space for sub-lease, commencing February 2019.

- In addition, Level 9 KPMG tower will also be available for sub lease in early 2020 once teams move into Waiora CBD podium levels.

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

Provision of fit-for-purpose and sustainable accommodation to enable clinical and support services is critical to delivering all aspects of our strategy, including radical improvements in Maori health by eliminating health inequities.

Recommendation
THAT
The Board notes this report.

CHRIS CARDWELL
EXECUTIVE DIRECTOR FACILITIES AND BUSINESS

Appendix A: Detailed occupier neighbourhood plans and seating layouts

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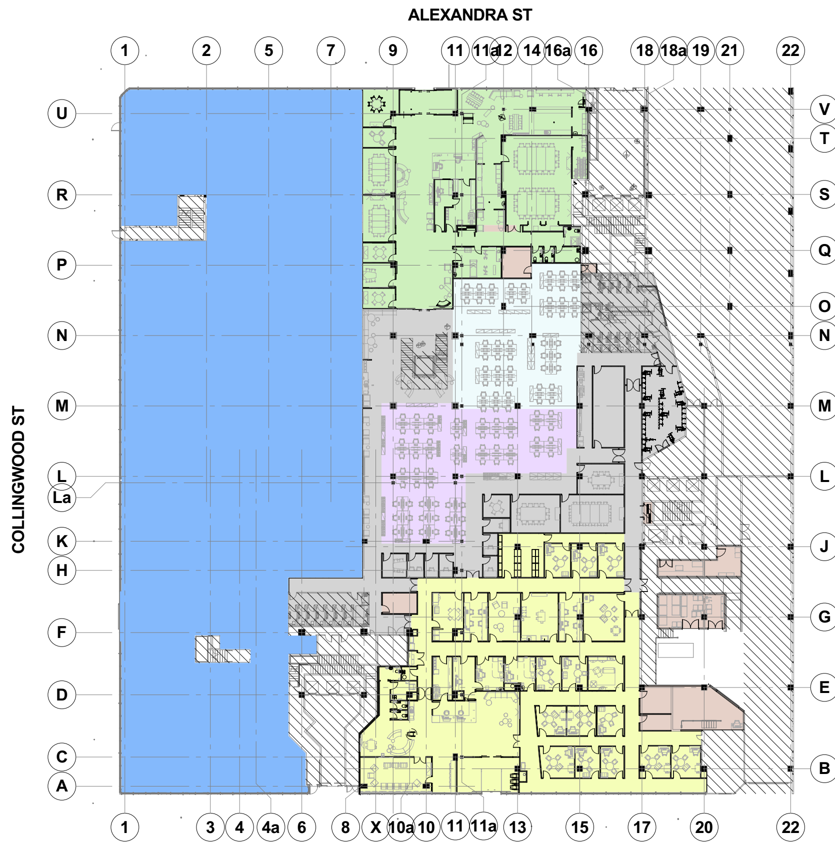

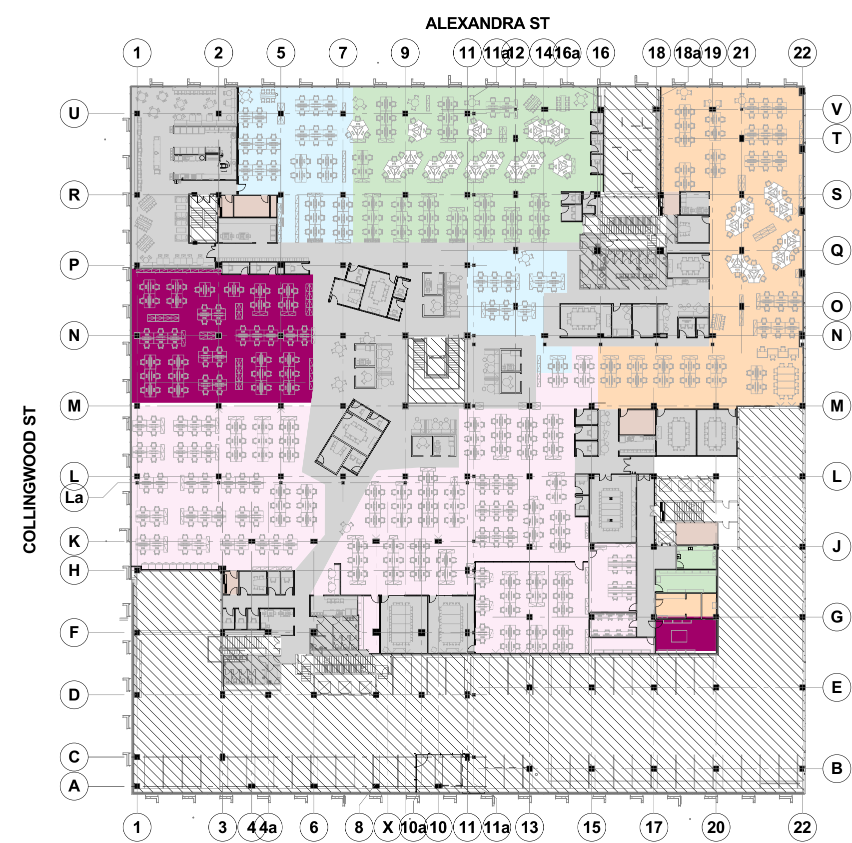

Vacant Space
2505 m2

Service Area
175 m2

Shared
866 m2

ICAMHS Clinical
1050m2

ICAMHS Workspace
308m2
60ppl

Client
699m2

Future Capacity
286m2
52ppl

Basebuild

Shared 1853m2

Future Capacity / Payroll & HRIS
66 ppl
405m2

Public Health, Strategy & Funding
100ppl
639m2

Health Share eSpace
72ppl
439m2

Information Services
250ppl
1388m2

DSS, DSL, HOP, REACH, START
100ppl
722m2

Services
67m2

Basebuild

Revisions

A	25% DEVELOPED DESIGN	31.08.18
B	80% DEVELOPED DESIGN	18.09.18
C	100% DEVELOPED DESIGN	20.09.18
D	BUILDING CONSENT	13.11.18
E	DETAILED DESIGN	12.12.18

Notes

No building work shall proceed until Building Consent has been granted for the work described.

ARCHITECTS
URBAN DESIGNERS
INTERIOR DESIGNERS
LANDSCAPE ARCHITECTS
AUCKLAND | TAURANGA
WELLINGTON | CHRISTCHURCH
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Client

Consultant Team

Project Number: 216041
Collingwood Street Building Interior Fitout Alexandra, Collingwood and Anglesea Streets

Sheet
NLA

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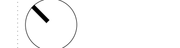

Milestone Issues / Revision & Date
FIRST ISSUED
RESOURCE CONSENT
BUILDING CONSENT
TENDER
FOR CONSTRUCTION

ARCHITECTURAL

Drawing Number: B9-011 Revision: E

DO NOT SCALE OFF THIS DRAWING
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DETAILED DESIGN

MEMORANDUM TO THE BOARD
23 JANUARY 2019

AGENDA ITEM 12.3

REGIONAL ESPACE PROGRAMME

Purpose	For information.

Introduction

The Board has sought regular updates on eSPACE. This update is technical in style but we are available to answer questions around detail especially in respect of the work being done under phase 2 which is primarily what is being implemented during 2019.

This report assumes that members have a broad understanding of eSPACE as a common Midland approach to sharing clinical information between district health boards and third parties, with increasing ability over time for clinicians to undertake tasks in a common way within that system.

Our assessment is that in broad terms the programme is proceeding appropriately in terms of delivery against time and budget.

Already delivered

The core Midland Clinical Portal has been operating for 10 months and as at 14 January 2019, the Midland Clinical Portal:

- contained 845,893 registered patients
  - 722,569 emergency events
  - 805,477 inpatient events
  - 3,156,838 outpatient events
- contained 3,712,279 documents
  - 651,507 from Taranaki DHB
  - 865,809 from Bay of Plenty DHB
  - 159,469 from Lakes DHB
  - 2,035,494 from Waikato DHB
  - 0 from Hauora Tairāwhiti
- 4,946,126 registered events
- active users for month of December 2018
  - 1,209 from Taranaki DHB
  - 906 from Bay of Plenty DHB
  - 974 from Lakes DHB
  - 2,685 from Waikato DHB.

Some performance issues (time to access the system) have been experienced, mostly for Bay of Plenty DHB users but these are being addressed and monitoring is in place to measure system performance.

Next delivery

Phase 1 The Midland Clinical Portal (MCP) is a read only system. Incremental improvements (e.g. visibility of community dispensed medicines, integration with St Johns Ambulance service) continue to be implemented.

Phase 2 includes read-write functionality. Within this phase there are a number of workstreams:

1. Technical enablers which include:
    a. Creating the necessary environments
    b. Messaging gateway (to enable system to talk to other systems)
    c. New patient administration system feeds
    d. Re-platform MCP (current platform is not scalable to extent required)
    e. Upgrade MCP (to keep system current)
    f. Implement identity and access management (to allow clinician's across the region to login seamlessly.

    These enablers will be delivered in April and May 2019 and are required to implement clinical functionality.

2. Regional functionality which includes:
    a. Transfer of care functionality (discharge summaries)
    b. Progress notes
    c. Pre-anaesthetic assessment form
    d. Role based access
    e. Worklists
    f. Improved patient searches
    g. Expand patient encounters (on timeline)
    h. X-ray viewing
    i. Care plan visual indicators
    j. Enquiries across a number of events
    k. System Administration
    l. Regional Results
    m. Electronic Data Interchange & Provider Index
    n. Streamlined Release Process (to enable small incremental updates)
    o. Enhanced Audit Capability
    p. Coding and Terminology
    q. Extracts to support reporting for clinicians.

    Regional functionality will be available for all five DHBs with implementation in Hauora Tairawhiti DHB and Bay of Plenty DHB from July 2019 to October 2019.

3. Specific functionality to enable Hauora Tairawhiti DHB to replace their local clinical workstation with the regional system. We plan to deliver by October 2019.

4. Specific functionality to enable Bay of Plenty DHB to replace their local clinical workstation with the regional system. Bay of Plenty DHB clinical workstation (CHiP) has a bigger footprint and significant data that will need to be migrated or archived so delivery will be done incrementally from July 2019 through into February/March 2020.

5. GAP analysis and delivery to the three other DHB is being done in parallel.

Phase 3 includes functionality that supports clinical decision making (i.e. the smarts) and workstreams to deliver these are running in parallel with Phase 2 and delivery will be sequenced in at logical points. Functionality includes:

1. Complete results management (electronic ordering, viewing and acknowledgement)
2. Workflow and forms –
   a. Clinical pathways
   b. Mental Health solution
   c. Replacement of paper based forms with electronic forms (supported by workflow)
3. Completion of integration to non-DHB providers
4. More integration to DHB systems.

Phase 4 covers Medicines Management and this includes electronic prescribing and recording medicine administration so that with electronic dispensing (which is already in place for the region) medicine reconciliation can be done. The benefit of this work stream is that medication errors will be significantly reduced. This phase was included in scope of the programme business case but without incremental cost so a full business case is being worked for this Phase.

Dependencies

When complete MCP will provide access to vast amounts of clinical data and will grow year on year so the infrastructure needs to ensure that data is safe, recoverable in event of a disaster and that system performance is acceptable to clinician's. There are a number of projects to ensure that the infrastructure meets these requirements. Critical dependencies include:

- Operational support model in place for first go-live
- Rhapsody upgrade completed (Rhapsody is an integration engine)
- Server builds and creation of necessary environments
- Right size MCP database
- Network enhancements complete
- Business continuity plans in place (for each DHB)
- Disaster Recovery in place
- Current MCP upgrade completed

Risks and Issues

eSPACE is a complex programme and there are a many risks and issues. These are being actively managed and are escalated when appropriate.

Key risks include:

1. Delivery of dependencies and technical enablers on time (as they are required to roll out further phases)
2. Affordability – DHBs are short of cash and this is an expensive programme
3. Re-litigation – costs time and money.

Finances
Spend to date is:

Description	**$m (Dec-18)**
Budget (approved in Programme Business Case)	$74.9
Less: Actual capital expenditure	$17.7
Less: Actual operational expenditure	7.5
Less: Commitments	$1.5
Budget remaining	**$48.2**
Forecast to complete (excludes full scope for Medicines Management)	$74.9

Approvals
The five DHB boards in the region approved the programme business case and this was submitted to the Ministry. The Ministry have requested that individual business or project initiation documents be submitted for projects within the programme. The logic is that this gives more flexibility to adopt new technologies and respond to changes in clinician requirements over the life of eth programme.

We are working through this process with the Ministry. All the submissions are within the scope and cost of the programme business case so already approved by the DHB boards.

Recommendation
THAT
The Board receives this report.

MAUREEN CHRYSTALL
ESPACE SENIOR RESPONSIBLE OFFICER

National Oracle System: report due in February.

Papers for Information

MEMORANDUM TO THE BOARD
23 JANUARY 2019

AGENDA ITEM 13.1

WAIKATO DHB SUICIDE PREVENTION AND POSTVENTION ANNUAL REPORT 1 JULY 2017 TO 30 JUNE 2018

Purpose	For information.

This report documents the actions carried out during the reporting period and outlines progress against the Suicide Prevention and Postvention (SPP) Plan.

The Ministry of Health requested that the SPP plan 2014-2017 be extended for one year. However, given the strong community input gathered to develop the plan, this year was used to draft and finalise the new plan for the next three years. The new plan reflects the explicit premise that suicide is not solely a health issue.

In addition, the new plan's actions have been started, and the actions in the previous plan have been closed off.

Radical Improvement in Māori Health Outcomes by Eliminating Health Inequities for Māori
All suicide prevention work is prioritised and every action is required by the SPPAG to align to at least one of the priority groups. Māori are over-represented in the suicide statistics for young people and people up to the age of 40 years. As a consequence of this, and our commitment to reducing inequities, we focus our community-based suicide prevention work at events aimed at Māori. We also have developed relationships with Māori organisations.

Zero Suicide Aspiration
All actions are undertaken with an aspiration to reduce the suicide rate in the Waikato to zero.

Recommendation
THAT
The Board receives the report.

MO NEVILLE
CHAIR, SUICIDE PREVENTION AND POSTVENTION ADVISORY GROUP
DIRECTOR QUALITY AND PATIENT SAFETY

Waikato Suicide Prevention and Postvention Health Advisory Group

Report

1 July 2017 to 30 June 2018

28 October 2018

Executive summary

This is the second report of the Waikato Suicide Prevention and Postvention Health Advisory Group.

The Suicide Prevention and Postvention Plan (SPP) 2014-2017 has been a robust document and was extended by the Ministry of Health for one further year. The plan formed the basis for the suicide prevention and postvention work for 2017/18. During this reporting period, a new plan has been developed for 2018-2021 after consultation with a wide range of stakeholders including those subgroups of our population deemed most at-risk.

Prevention work has continued in accordance with the SPP plan with all but one of the objectives making good progress. We have encouraged and supported community-driven prevention work and it has been commendable that two communities have developed their own formalised and strategic suicide prevention action plans.

During this period, there were 59 people who died as a result of an intentional and self-inflicted death (some still classified provisionally), who had usually been resident within the Waikato DHB area[1]. The acute postvention response was initiated for all of these deaths and the postvention action group has continued to review and improve the response provided following a death. The grief support stream of the work has shown an increasing uptake of the grief counselling offered through a discrete fund.

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[1] Coronial Services of New Zealand (2018). Retrieved from https://coronialservices.justice.govt.nz/suicide/

Table of Contents

Executive summary 2
Table of Contents 3
1. Introduction 4
2. Suicide Prevention and Postvention Health Advisory Group (SPPHAG) 4
3. The SPP plan 5
4. Prevention 6
5. Postvention work 9
6. Grief support 10
7. Community-driven action 12
8. Subgroups 13
9. Communication and collaboration 14
10. National SPP coordinators network 16
11. Financials 17
12. Conclusion 18
Appendix A – Membership of the Suicide Prevention and Postvention Health Advisory Group 19
Appendix B Terms of Reference Waikato DHB Suicide Prevention and Postvention Health Advisory Group 20

1. Introduction

The Waikato DHB's Suicide Prevention and Postvention Plan (SPP plan) for 2014 to 2017 was approved by the Community and Public Health Advisory Committee (CPHAC) in 2015. One of the objectives of the plan was to establish a strategic advisory group and so the Suicide Prevention and Postvention Health Advisory Group (SPPHAG[2]) was established in late 2015. This report sets out the work achieved through the SPPHAG during the period 1 July 2017 to 30 June 2018.

2. Suicide Prevention and Postvention Health Advisory Group (SPPHAG)

The SPPHAG's members for the time period covered by this report are listed in Appendix A. The Terms of Reference of the SPPHAG are included as Appendix B (the Terms of Reference are currently being updated).

Nine SPPHAG meetings were held during the twelve-month period 1 July 2017 to 30 June 2018.

As part of the quality improvement and iterative process of the suicide prevention and postvention work, and as we move into the plan for 2018 to 2021, there will be a review and potential restructure of the health advisory group. It is anticipated that the advisory group will move to a more strategic advisory role and a working group be formed to drive the actions within the SPP plan.

2.a. Governance

The Governance Group for the SPPHAG is Intersect Waikato and there is cross representation between the groups with the Interim CEO, Derek Wright on both groups. The SPP coordinator updated Intersect on the SPP work in March 2018.

[2] In late 2018, the Waikato Suicide Prevention and Postvention Health Advisory Group (SPPHAG) was renamed to the Waikato Suicide Prevention and Postvention Advisory Group (SPPAG).

2.b. Aims of the SPPHAG

The primary aims of the SPPHAG are to:

- reduce suicide in the Waikato DHB area through a number of different approaches. These streams of work are conducted in conjunction with the various community-based agencies working in the area of suicide prevention.
- support those people who have been bereaved by suicide.

2.c. Zero suicide.

The Board agreed to the aspirational goal of zero suicide in June 2018. The zero suicide approach represents a commitment to:

- Patient safety and person-centred services
- The safety and support of clinical and community based staff, who do the demanding work of treating and supporting suicidal patients
- Our partners working with families, whānau and communities – that best practice and culturally appropriate practice will be used for people who are being treated and supported for mental illness.

The approach is based on the realisation that suicidal individuals often fall through the cracks between services. It requires a system-wide approach to improve outcomes and close gaps. There will be a section identified in the 2018-21 action plan to assist with this aspiration.

3. The SPP plan

2017/18 has been a transition year for the SPP plan. The first Waikato DHB Suicide Prevention and Postvention Plan expired at the end of June 2017 but shortly before the end the FY 2016/17, the Ministry of Health requested the then existing plan be extended for one year to June 2018.

3.a. 2018's actions in relation to the 2014-17 SPP plan

The SPP work has generally tracked well against the SPP plan. Many areas of the work have exceeded the planned actions but there is one area where the

documented progress was slower than that outlined in the plan. This is ensuring that the Waikato DHB suicide prevention and self-harm protocols within emergency and mental health and addiction services are appropriate to the needs of Māori and Pacific people and include appropriate follow up services and support services. It should be noted though that there has been extensive review and plans are underway which will address these.

The Ministry of Health's extension of one year has given us the opportunity to fully develop the new three year plan. The resulting plan is being well received as an innovative approach and has outwardly focussed actions. Another strength of the plan is that it reflects stronger strategic partnership and collaboration. The prevention and postvention work carried out under the plan in 2017/18 is presented as Sections 4 and 5.

4. Prevention

Building resilience and encouraging healthy lifestyles have been shown to be protective factors against mental unwellness and potential suicide. Consequently a number of wellness and suicide prevention actions have been carried out.

4.a. Sharing wellness messages

The DHB mental health and addictions service (MH&AS) and the SPP coordinator continue to work together to participate in community events where wellness messages can be shared with members of the public. These include information about the 1737 Need to Talk telephone counselling service which was introduced during the reporting period. Our sole criterion to bring a Let's Talk Wellbeing stand into a community, is that we are invited in. We have participated in the following events during the twelve month period:

- CANDO expo, Thames, August 2017
- Meade Centre, Waikato Hospital for 2017 Mental Health Awareness week
- HopeWalk, Whitianga November 2017
- Mangaru o Waikato Health day, 11 November 2017
- ATC Vision College, October and November 2017
- It is ME health day, Sport Waikato, Te Kuiti, December 2017

- Ride Against Teenage Suicide with Tribal Nations, Community House, Ngaruawahia, February 2018
- Pasifika Festival, February 2018
- University of Waikato O Week, February 2018
- Health and Information Day, Taumarunui, March 2018
- Shining Light on the Dark relay, Otorohanga, March 2018
- Health Expo, Otorohanga, March 2018
- University of Waikato, Wellness Week, March 2018
- Te Wharekura o Rakaumanga Health Day (Hauora Waikato attended), March 2018
- National Fieldays, Mystery Creek, June 2018

4.b System Level Measures

The Ministry of Health requested DHBs establish a range of System Level Measure (SLM) groups comprising secondary and primary health staff. Waikato DHB's Amenable Mortality SLM has selected suicide as one of the areas of preventable death that will have a measurable and reducing target.

Additionally, the Waikato DHB's Youth SLM group has set targets for reducing self harm in the age range 24 years and younger as follows:

- 90% of patients with recurrent self-harm admissions within three years are referred to an appropriate service.
- 100% of patients with recurrent self harm admission within three years are enrolled with a primary care provider.

The SPP coordinator is a member of both SLM groups.

4.c ACC-Waikato DHB suicide prevention pilot

In November 2016, Waikato DHB was awarded the suicide prevention pilot by Accident Compensation Corporation (ACC). The Injury Prevention arm of ACC aims to reduce repeat deliberate self-harm injuries and the first phase was the design of the pilot. Following a number of stakeholder workshops, the business case was finalised and ACC presented to their Investment Committee. Since then, there has

been discussion and assurance by ACC, the DHB and the Ministry of Health of their commitment to the project, but as of 30 June 2018, progress is pending.

However, the complementary strengthened psychiatric service based in the Waikato Hospital Emergency Department is progressing.

4.d. Primary care training

Dr Annette Beautrais presented to the SPPHAG about suicide prevention and how the evidence shows that primary care is such a vital touchpoint for prevention work. Because of this, the Rural Health Alliance of Aotearoa New Zealand (RHAANZ) in collaboration with the Ministry of Health and Dr Annette Beautrais and Dr Martin London developed the Safe Hands Safe Plans training for rural primary care.

The SPPHAG requested this rural primary care training for the Waikato DHB area. A total of 10 Safe Hands Safe Plans workshops were offered. In total, 270 staff attended the training. The workshops took place throughout the region:

- Thames
- Te Kuiti
- Cambridge
- Coromandel Town
- Hamilton – Integrated Safety Response team staff
- Huntly
- Tokoroa
- Hamilton
- Whangamata
- Matamata

Four of the workshops were funded by the Ministry of Health through RHAANZ and the other six workshops were funded by Waikato DHB.

The PHOs assisted in advertising these workshops through their practices.

4.e. Training

In addition to the commissioned workshops, a number of organisations have provided training. These include LeVa's Lifekeepers, Living Works trainings, Te Rau Matatini and TaylorMade. These have all been advertised through the Waikato DHB webpage on the calendar of training and events and through more targeted marketing.

5. Postvention work

5.a Deaths:

The Coronial Services of New Zealand (2018) recorded that 59 people died as a result of a self-inflicted and intentional cause of death (some still provisionally classified as suicide). This represents both an increase in the absolute number (50 people for 2016/17) and in the rate over the previous reporting period (14.43 per 100,000 usually resident (based on population estimates 2017 (Stats, NZ) for 2017/18 from 12.52 per 100,000 people in 2016/17). Sadly, this increase has been noted in other DHB areas too with an overall increase from 2016/17 to 2017/18 (12.64 to 13.67 per 100,000 usually resident population).

5.b Early notifications

The early notifications of a suspected suicide continue to be shared with a prescribed and small group of people whose organisations can assist in the postvention work.

If there is any concern about a potential or emerging cluster (more suspected suicides than could be expected usually within a timeframe and geographical location though the people may not have any social connection) or contagion (when there was social connection), the SPP coordinator liaises with Clinical Advisory Services Aotearoa (CASA). When one is identified there is a specific documented process followed.

Waikato DHB's postvention response is initiated following all notifications of a suspected suicide although the level of response will vary depending upon a number of factors.

The members of the Postvention Action Group are:

- NZ Police, Injury Prevention
- NZ Police, Coronial Officer
- Ministry of Education, Manager Traumatic Incident Team
- Waikato DHB/Oranga Tamariki Liaison staff member
- Senior administrator, Mental Health and Addictions Service
- Bereavement specialist, Victim Support Bereavement Team

- SPP coordinator

6. Grief support

Whilst grief support is a postvention activity, the SPPHAG has been explicit in its intent to ensure that families/whānau bereaved by suicide will be offered grief support rather than having to seek it for themselves. In order to improve this access to support, the actions outlined in sub-sections 6.a.-d. have been implemented.

6.a. Funded bereavement counselling

Strategy and Funding assigned a discrete fund for bereavement counselling in December 2016. All primary care practices, funeral directors and social agencies within the Waikato DHB area have been informed of the availability of the fund for counselling or psychological services. Referrals for counselling or psychological services have been received with increasing frequency as shown in Figure 1.

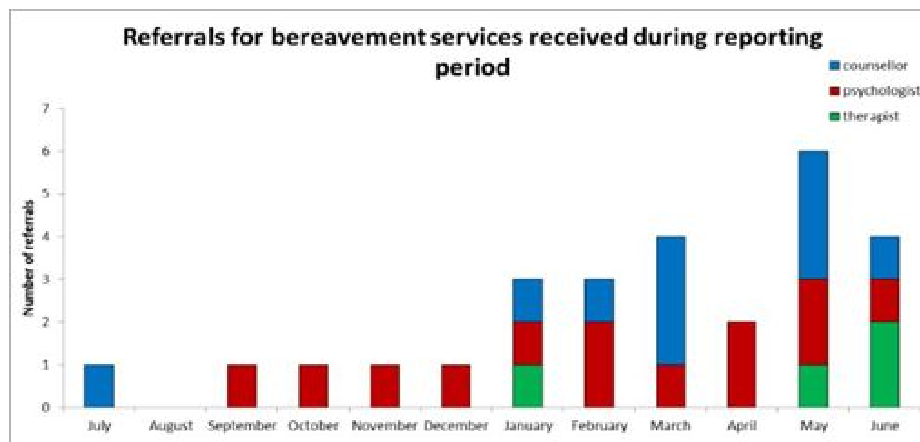


Figure 1. Referrals received for bereavement counselling.

There have been some implementation issues. The most prevalent issues associated with the bereavement fund are described in the table below

Issue	Mitigation measure
Some areas do not have providers and so it involves some travel by the bereaved family.	Case by case discussion to establish most practical process for bereaved person

The ethnicity of the counsellor may not be the same as the bereaved person	Discussion with referrer to find out if this is an issue and to find the best suited provider
Managing the expectations of the people being referred and referrers.	Re-worded pamphlet clarifying process and will be used as from Q1 2018/19 reporting year.

An evaluation of this service is planned for 2018/19.

6.b. WAVES bereavement programme

Following the WAVES facilitator training in 2016, two courses have been held during the reporting period. One took place in Hamilton and the other in Tokoroa. One of the difficulties associated with setting up the eight-week structured WAVES programme, is ensuring sufficient (the optimal number is 6-8 people) uptake before finalising the dates. Two Hamilton-based facilitators plan to invite Expressions of Interest to the course with the intention of holding another course in early 2019. Larger centres have got round this issue by having back-to-back courses.

6.c. Grief hui

In late 2016, Dr Bev Gatenby was commissioned to research what would be appropriate and sustainable to ensure that people bereaved by suicide in the Waikato DHB are supported through the grieving process. A number of the recommendations from the commissioned research have been implemented and two of the major actions have been undertaken during the reporting period.

One was that a kaupapa Māori conference discussing the topic of grief and how to support whānau after a suicide would be timely and appropriate. The organising rōpū comprised the following:

- Te Rau Matatini
- Rauawaawaa Kaumatua Trust
- Bereaved whanau
- Waikato DHB Population Health
- Waikato DHB Te Puna Oranga
- Waikato DHB SPP coordinator

Taupiripiri Trust, Northland, provided guidance as they had had a similar topic conference earlier.

The two-day conference was held in October 2017 at Turangawaewae Marae. There was a range of speakers – some specifically around suicide-related grief but

others presented on grief from a number of causes of death. All the speakers are based in New Zealand and come from a variety of backgrounds including academia, clinical and lived experience. There were 144 participants on the first day and 127 on the second day. The feedback was overwhelmingly positive and "has started the conversations about grief, now we need to continue them". The DHB funded specific expenditure for the conference. The conference was evaluated by Dr Jordan Waiti – it achieved its set outcomes:

- Opened the conversation to talk about loss and this appears to be a healing component. The hui created a space where it was safe to korero.
- Connected people to share their hopes. It also promoted whanau and community centred prevention and empowerment
- National and local rangatahi voices were heard and rangatahi-centred solutions were discussed
- Encouraged collaboration between the various agencies

6.d. Bereaved whānau network

Another recommendation from Dr Bev Gatenby was the development of a bereavement network. To progress this, a workshop for bereaved whānau was held in March 2018. The workshop looked at what services were helpful/not helpful and what could be done to lessen the distress when a person dies. Further work on the development of the network will begin in the next reporting year.

7. Community-driven action

7.a. Community plans

Kokiri Trust in Te Kuiti and Taumarunui held workshops in each town to develop Māori models of suicide prevention. The workshops were facilitated by Dr Keri Lawson-Te Aho and from the workshops and community events, a suicide prevention strategy has been developed for each town. Staff from Kokiri Trust presented to the SPPHAG on the development of their plans.

7.b. Contestable Fund – pilot

A contestable fund for conference attendance is due to be established in 2018. However, a pilot of the fund was run when three community members were partially funded to attend the Global Indigenous Suicide Prevention Symposium in Wellington on 26 and 27 February. One of the three participants presented to the SPPHAG on the key points from the symposium and what she and the others gained from their attendance.

The feedback was compelling about the benefits of being able to attend such conferences and bringing the information gained back to the community.

7.c. Community Project Fund – pilot

A community project fund is due to be set up later in the year. This fund will be available to support community projects (programmes or events) which can show:

- a clear link to at least one objective set out in the Plan 2018-21; and
- will support people who are identified as at risk (as specified in the Plan).

When Riders Against Teenage Suicide (RATS) requested funding for training, this was used as a pilot for the fund. Two members of RATS participated in a Safetalk training in Hamilton.

8. Subgroups

There are prevention subgroups of the SPPHAG which come together for a specific purpose and report back to the SPPHAG. However, there are two which have been formed permanently.

8.a. Suicide Review Group (SRG)

International and New Zealand literature provides strong evidence on risk factors and which subgroups of our population are most at risk. Waikato suicide data is also used to identify any local differences where stronger preventative work needs to be focussed.

In order to identify any local quality improvement initiatives, a local Suicide Review Group was developed for the Waikato DHB area. This group is a Waikato

DHB Protected Quality Assurance Activity rather than operating under the Health Quality Safety Commission as a mortality review group. The SRG comprises a multi-disciplinary and inter-agency review group. During the reporting period, a total of 26 reviews were completed and these resulted in a number of recommendations which have been shared with the Director, Quality & Patient Safety, SPPHAG members' departments, SLM Amenable and SLM Youth groups, various hospital departments including MH&AS and the organisations represented on the SRG. The SPPHAG continues to seek opportunities for the appropriate sharing of the recommendations.

8. b Consumer Group

A small (four members) Consumer Group has been established to help guide suicide prevention work. The group meets as required and will work on particular tasks. Some strict measures are in place to provide as much safety as possible:

- This is a closed group;
- a member of the MH&AS is present for all meetings
- supervision for members is available through an independent counsellor; and
- the meetings do not exceed 1.5 hours duration.

Members are paid for their attendance at the rates applicable to other DHB consumer groups.

During this year, the group has spent several meetings reviewing and offering suggestions on the various pages on the SPP section of the Waikato DHB website. The group has also identified places where information can be shared with members of the public when no internet access is available (this list of places has since been used for targeted prevention work).

9. Communication and collaboration

Good working relationships exist with a large number of government and non-government organisations working in suicide prevention, wellbeing,iwi organisations and social agencies. Each of these relationships is highly valued and the interaction with them, much appreciated.

9.a Presentations

There has been continued interest from organisations and hospital departments in learning more about the SPP work. Presentations during this reporting year include:

- Community Health Forums
- Te Rōpū Tautoko
- Child Health Network
- Youth System Level Measure Group
- Quality & Patient Safety
- Waikato Strategic Planners Group
- Pinnacle PHO
- Waikato Mental Health and Addictions Service
- South Waikato Service Improvement Group
- InterSectoral Governance Group

9.b Webpage

During this reporting period, the DHB website has been overhauled and the Suicide Prevention and Postvention pages have been aligned to a new format. This did result in some loss of applicability of the webpages and these are currently being reworked to make them more helpful to the public.

One of the recommendations by the Consumer Group was to install a moving help button on the webpages. This work was contracted to an external provider and the help icon now follows the read down the SPP webpages.

9.c. GP liaison newsletter

SPP has a section in the newsletter which is circulated to GP practices every two months.

9.d Communications

The SPP coordinator regularly attends the Community Health fora held in communities three times a year. The coordinator usually gives an update on recent work. It has also been an opportunity to update on how the SPP plan has been progressing as communities, through this channel and others, provided input to the plan. The other important aspect of attending the CHF is it allows the

coordinator to hear any SPP-related concerns directly from members of thesecommunities.

10. National SPP coordinators network

The network feels more cohesive in the past year and there is increasing cross-DHB boundary acute postvention interaction following a suspected suicide. There have been several pieces of collaborative work:

- The SPP network initiated and contributed to resources guiding parents before the 13 Reasons Why Series 2 television programme was released.
- SPP coordinators were also invited to join the subgroup assisting the external contractor reworking the Toolkit.
- a joint SPP coordinators' submission to the national MH&A Inquiry panel
- a number of SPP coordinators were asked to attend the MH inquiry when the panel was in their DHB area.

The network has met twice this year. The first meeting, arranged by the SPP coordinator for South Canterbury, was primarily an opportunity for a range of organisations to present to the coordinator network. The second, arranged by senior programme manager who holds the SPP portfolio at the Ministry of Health, focussed more on what SPP coordinators were doing in the areas of prevention and postvention in their respective DHBs. The programme manager is looking to create more consistency across the DHBs in terms of areas of work. She encourages DHBs to have a number of preventative streams of work as occurs in the Waikato but she acknowledges work plans need to allow for local differences too.

Both meetings were good learning opportunities as well as a chance of getting to know the other coordinators better.

The monthly teleconferences continue and are an excellent opportunity to share information and learn from each other.

11. Financials

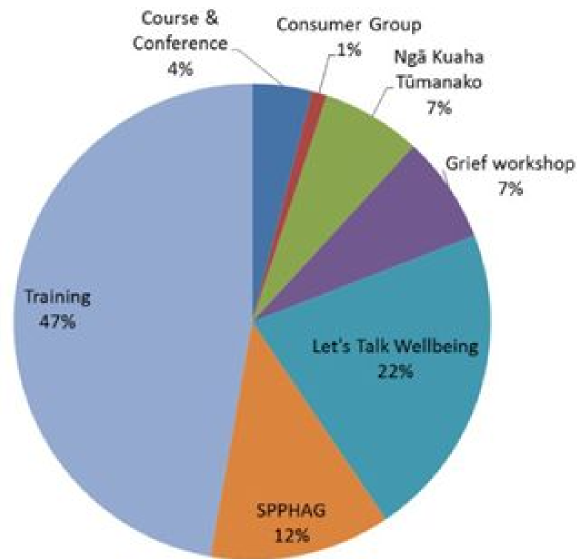
An annual discrete budget was assigned to the SPP work in 2016. For the current reporting year this has been divided into the project fund and the counselling fund.

11.a. Project Fund

Of the total budget, 61% is assigned to projects and 94% of the project fund was spent. Figure 2 shows the proportion of expenditure by main category and Table 1 below gives a brief overview of each category:

Course and Conference:	SPP network meetings, conference and training attendance for the coordinator
Consumer Group:	all Consumer Group costs
Ngā Kuaha Tūmanako:	Two day conference – partially funded by Waikato DHB
Grief workshop:	First bereaved whānau workshop
Let's Talk Wellbeing:	Purchase of resources Printing of resources Equipment for use at events
SPPHAG:	Intersectoral workshop Costs associated with bringing community group to present to health advisory group
Training:	Externally facilitated training workshops (see 4.d.)

Figure 2. *Project fund expenditure as a percentage of total budget*



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11.b. Counselling Fund

As displayed on Figure 1 (page 10), there has been an increasing demand for counselling or psychological services. During this reporting year, 26% of the assigned budget was used. It should be noted though that this increase in uptake has been sustained as we progress into the next reporting year and, if the current increased demand continues, the majority of the budget will have been spent by the end of June 2019.

12. Conclusion

The SPPHAG has made significant progress against the 2014-2017 SPP plan and its extension to June 2018. The progress has been achieved as a result of effective collaboration with a number of partners, strong guidance and interest by the members of the SPPHAG and this linked work has been further facilitated through an assigned budget.

Appendix A – Membership of the Suicide Prevention and Postvention Health Advisory Group

- Mo Neville (chair), Director, Quality & Patient Safety
- Julie Wilson (deputy chair), Executive Director, Strategy and Funding (Resigned March 2018)
- Lydia Aydon, Executive Director, Public Affairs
- Loraine Elliot, Executive Director of Māori Health
- Millie Berryman, Kaitakawaenga, Te Puna Oranga (Māori Health Service)
- Ian Martin, Clinical Director, Emergency Department
- John Bonning, Clinical Director, Emergency Department
- Jo-Anne Deanne, Director Integrated Care
- Vicki Aitken, Executive Director, Mental Health and Addictions Services
- Andrea Coxhead, Manager, Acute Services
- Wayne de Beer, Consultant psychiatrist, Consult Liaison
- Amanda Bradley, Mentally Well Lead , Pinnacle PHO
- Felicity Dumble, Medical Officer of Health, Public Health
- Jane Hudson, Project Manager, Strategy and Funding
- Kathryn Jenkin, Manager, Communications
- Derek Wright, Interim CEO, Waikato DHB
- Mark Spittal, Executive Director, Community and Clinical Support (Resigned June 2018)
- Rees Tapsell, Clinical Director of Clinical Services, Mental Health & Addiction Services
- Janine Thomas, Health psychologist, National Hauora Coalition
- Damian Tomic, Clinical Director, Primary and Integrated Care
- Lindsey Webber, Deputy CEO, Hauraki PHO
- Aroha Waipara-Panapa, CEO, Hauora Waikato
- Inoka DeSilva, Hauora Waikato
- Bev Elenor, PA Director Quality & Patient Safety (minute taker)
- Clare Simcock, coordinator Suicide Prevention and Postvention

Appendix B Terms of Reference Waikato DHB Suicide Prevention and Postvention Health Advisory Group

1 May 2018

TERMS OF REFERENCE
1. Name Waikato District Health Board Suicide Prevention and Postvention[3] Health Advisory Group (SPPHAG)
2. Purpose The group supports an aspirational zero suicide aim The main purpose of the Health Advisory Group is to provide health sector advice and oversight to the Suicide Prevention and Postvention (SPP) Co-ordinator on actions in the Waikato DHB Suicide Prevention/postvention Plan. The Advisory Group also provides direction regarding strategic actions in the Waikato DHB Suicide Prevention/postvention Plan
3. Objectives 3.1 Drives the achievement and evaluation of the Waikato suicide prevention and postvention plan 3.2 Assigns responsibilities for actions associated with suicide prevention and postvention activities 3.3 Provides information and guidance to the SPP Co-ordinator about clinical systems and processes within the DHB 3.4 Decides and evaluates actions to improve DHB staff knowledge, delivery and co-ordination of suicide prevention and postvention activities (training) 3.5 Provides advice to the SPP co-ordinator in working with consumers and communities to support bereavement, suicide prevention and postvention actions which will improve the experiences of family/whanau and communities where suicides have occurred. 3.6 Provides current best-evidence on suicide prevention and postvention activities from the scientific literature and ensures that evidence based suicide prevention and postvention activities are implemented 3.7 Champions interagency co-operation when addressing district-wide suicide prevention and postvention.

[3] A **postvention** is an intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). Family and friends of the suicide victim may be at increased risk of suicide themselves.

TERMS OF REFERENCE
3.8 Evaluates trends and information to identify where improvements in co-ordination of responses could be made to enable intervention. Clients may include those being treated/in care (Provider Arm, GP etc; those unknown to GPs or the provider arm/Mental Health & Addiction Services) 3.9 Facilitates the involvement of stakeholders such as kaupapa Māori organisations, NGOs and primary care to continually improve suicide prevention and postvention responses
4. Chairperson Chair Mo Neville Director of Quality and Patient Safety
5. Membership • Director of Quality and Patient Safety • Interim Executive Director or Project Manager Strategy and Funding • Director of Clinical Services Mental Health & Addiction Services • Interim Executive Director, Mental Health and Addictions Services • Executive Director of Maori Health • Clinical Director/Director of Primary and Integrated Care • Manager Emergency Department • Communications Executive/Manager • Executive Director Community and Clinical Support • Clinical Leader Public Health • Hauraki PHO • Mental Health Specialist • Clinical Director Adult Services/Consultant Psychiatrist Hauora Waikato • Consumer Council Representative • Midlands PHO • Suicide Prevention/Postvention Co-ordinator • National Hauora Coalition representative (minutes only) • Emergency Department Physician (minutes only) • Interim Chief Executive (minutes only)
5. Quorum Chair and five others
6.Key Performance Indicators **6.1 KPIs linked with 3 year plan** 2018-2021 Suicide Prevention/Postvention Plan is completed

TERMS OF REFERENCE
6.2 Meeting KPIs - 80% of meetings start and finish on time - Members who cannot attend send delegates - Minutes and agendas circulated one week prior to meetings
7. Frequency of meetings and length of tenure Meetings 6 weekly and tenure to be 2 years with annual approval
8. Location of minutes Minutes will be held within Quality and Patient Safety
9. Reporting Through the Chief Executive to the Governance Group (Intersect Waikato) - 6 monthly Ministry of Health – quarterly Community and Public Health Advisory Committee (CPHAC) – 6 monthly Waikato District Health Board - annually Iwi Māori Council – annually or as agreed
10. Resources The Health Advisory Group will be supported by the Director Quality and Patient Safety and her personal assistant, and the Suicide Prevention/postvention Co-ordinator
11. Collaborative partnerships The Suicide Prevention and Postvention Plan lists a number of partners with whom they will collaborate in order to carry out many of the actions. These include: • Waikato DHB Consumer Council • Waikato Child & Youth Mortality Group • Local suicide prevention and/or postvention groups • ACC • Emergency services • Māori health and workforce development organisations • Iwi groups • District Councils • Men's groups • National suicide prevention organisations • Social service agencies

TERMS OF REFERENCE
The SPPHAG will also use information gained through its sub-committees. Some of the sub-committees will be formed for a specific purpose but fixed sub-groups are: • Suicide Review Group • Consumer Group
12. Confidentiality Agendas, minutes and papers relating to the Health Advisory Group are published as 'in confidence' documents in an effort to comply with the Coroners Act 2006, sections 71, 72, and 73. The meaning 'in confidence' is that these documents are not to be held in publicly available locations and are not to be distributed or reported on without the authorisation of the Chair. Members of the Health Advisory Group will also operate within the bounds of the Privacy Act 1993

Presentations

No presentations.

Board Member Items

The Living Wage: report due in February.

Next Board Meeting: 27 February 2019.