# Counties Manukau District Health Board Board Meeting Agenda

Wednesday, 4 May 2016 at 1.30 – 4.30pm, Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>1.00 – 1.30pm</td>
<td><strong>Board Only Session</strong></td>
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<tr>
<td>1.30 – 1.35pm</td>
<td><strong>Governance</strong></td>
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<tr>
<td>1.35 – 1.45pm</td>
<td>2.1. Attendance &amp; Apologies</td>
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<tr>
<td>1.45 – 1.55pm</td>
<td>2.2. Conflicts of Interest/Specific Interests</td>
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<td>1.55 – 2.00pm</td>
<td>2.3. Confirmation of Public Minutes – 23 March 2016</td>
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<td>2.00 – 2.05pm</td>
<td>2.4. Action Items Register</td>
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<tr>
<td>2.05 – 2.10pm</td>
<td><strong>Strategy</strong></td>
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<tr>
<td>2.10 – 2.30pm</td>
<td>3.1. Chair’s Report (Verbal Update)</td>
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<td>2.30 – 3.00pm</td>
<td>3.2. Chief Executive’s Report</td>
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<td>3.00 – 3.05pm</td>
<td><strong>General Business</strong></td>
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<td>3.15 – 3.35pm</td>
<td>5. Resolution to Exclude the Public</td>
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<tr>
<td>3.35 – 4.05pm</td>
<td><strong>Confidential</strong></td>
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<td>6.2. Action Items Register</td>
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<td>6.3. Social Investment Board Update (Geraint Martin/Margie Apa)</td>
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<td>6.4. <strong>Healthy Together - Technology Business Cases: (Sarah Thirlwall)</strong></td>
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<td>6.4.1. Electronic Laboratory Business Case</td>
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<td>6.4.2. Electronic Radiology Business Case</td>
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<td>6.4.3. iPM Upgrade Business Case</td>
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<td>6.5. IS Projects Update (Leanne Elder)</td>
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<td>6.7. Second Draft Northern Region Health Plan (Tony Phemister)</td>
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<td>6.8. MRI Business Case (Phillip Balmer)</td>
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<td>6.9. Regional Clinical Pathways Business Case (Kathryn DeLuc)</td>
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<td>6.10. NHC Contract (Geraint Martin/Karli Menary)</td>
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Next Meeting: 15 June 2016
Room 101, Ko Awatea, Middlemore Hospital, Otahuhu
## Board Member Attendance Schedule 2016

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>10 Feb</th>
<th>23 Mar</th>
<th>4 May</th>
<th>15 June</th>
<th>27 July</th>
<th>7 Sept</th>
<th>19 Oct</th>
<th>30 Nov</th>
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<tr>
<td>Lee Mathias (Chair)</td>
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<td>Wendy Lai (Deputy Chair)</td>
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<td>Arthur Anae</td>
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<td>Colleen Brown</td>
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<tr>
<td>Sandra Alofivae</td>
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<td>Lyn Murphy</td>
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<tr>
<td>David Collings</td>
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<tr>
<td>Kathy Maxwell</td>
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<td>George Ngatai</td>
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<tr>
<td>Dianne Glenn</td>
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<tr>
<td>Reece Autagavaia</td>
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<td>✓</td>
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* Attended part meeting only

* Counts Manukau District Health Board Agenda 4 May 2016
<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| Dr Lee Mathias, Chair         | • Chair Health Promotion Agency  
• Chairman, Unitec  
• Deputy Chair, Auckland District Health Board  
• Director, Health Innovation Hub  
• Director, healthAlliance NZ Ltd  
• Director, New Zealand Health Partners Ltd  
• External Advisor, National Health Committee  
• Director, Pictor Limited  
• Director, John Seabrook Holdings Limited  
• MD, Lee Mathias Limited  
• Trustee, Lee Mathias Family Trust  
• Trustee, Awamoana Family Trust  
• Trustee, Mathias Martin Family Trust |
| Wendy Lai, Deputy Chair       | • Partner, Deloitte  
• Board Member Te Papa Tongarewa, the Museum of New Zealand  
• Chair, Ziera Shoes  
• Board Member, Avanti Finance |
| Arthur Anae                   | • Councillor, Auckland Council  
• Member, The John Walker ‘Find Your Field of Dreams’ |
| Colleen Brown                 | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Chair, IIMuch Trust  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group |
<table>
<thead>
<tr>
<th>Name</th>
<th>Memberships</th>
</tr>
</thead>
</table>
| Dr Lyn Murphy         | • Member, ACT NZ  
                          • Director, Bizness Synergy Training Ltd  
                          • Director, Synergex Holdings Ltd  
                          • Trustee, Synergex Trust  
                          • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
                          • Member, New Zealand Association of Clinical Research (NZACRes)  
                          • Member, Franklin Local Board  
                          • Senior Lecturer, AUT University School of Inter professional Health Studies |
| Sandra Alofivae       | • Member, Fonua Ola Board  
                          • Board Member, Pasifika Futures Ltd  
                          • Director, Housing New Zealand  
                          • Member, Ministerial Advisory Council for Pacific Island Affairs |
| David Collings        | • Chair, Howick Local Board of Auckland Council  
                          • Member, Auckland Council Southern Initiative |
| Kathy Maxwell         | • Director, Kathy the Chemist Ltd  
                          • Regional Pharmacy Advisory Group, Propharma (Pharmacy Retailing (NZ) Ltd)  
                          • Editorial Advisory Board, New Zealand Formulary  
                          • Member, Pharmaceutical Society of NZ  
                          • Trustee, Maxwell Family Trust  
                          • Member, Manukau Locality Leadership Group, CMDHB  
                          • Board Member, Pharmacy Guild of New Zealand |
| Dianne Glenn          | • Member, NZ Institute of Directors  
                          • Member, District Licensing Committee of Auckland Council  
                          • Life Member, Business and Professional Women Franklin  
                          • Member, UN Women Aotearoa/NZ  
                          • President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
                          • Life Member, Ambury Park Centre for Riding Therapy Inc.  
                          • Vice President, National Council of Women of New Zealand  
                          • Justice of the Peace  
                          • Member, Pacific Women’s Watch (NZ)  
                          • Member, Auckland Disabled Women’s Group |
| George Ngatai                | • Chair, Safer Aotearoa Family Violence Prevention Network  
|                            | • Director, Transitioning Out Aotearoa  
|                            | • Director, BDO Marketing  
|                            | • Board Member, Manurewa Marae  
|                            | • Conservation Volunteers New Zealand  
|                            | • Maori Gout Action Group  
|                            | • Nga Ngaru Rautahi o Aotearoa Board  
|                            | • Transitioning out Aotearoa provides services and back office support to Huakina Development Trust and also provide GP Services to their people  
|                            | • Chair, Restorative Practices NZ  

| Reece Autagavaia            | • Member, Pacific Lawyers’ Association  
|                            | • Member, Labour Party  
|                            | • Member, Auckland Council Pacific People’s Advisory Panel  
|                            | • Member, Tangata o le Moana Steering Group  
|                            | • Employed by Tamaki Legal  
|                            | • Board Member, Governance Board, Fatugatiti Aoga Amata Preschool  
|                            | • Trustee, Epiphany Pacific Trust  

# BOARD MEMBERS’ REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

## Specific disclosures (to be regarded as having a specific interest in the following transactions) as at May 2016

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Collings</td>
<td>Innovation Hub</td>
<td>Mr David Collings has a conflict of interest in regard to ATEED (being a member of the Local Community Board, which is part of the Auckland Council) and will be involved in the Innovation Hub.</td>
<td>5 October 2011</td>
<td>The Board notes that Mr Collings has a conflict of interest in regard to the Innovation Hub. He may participate in the deliberations of the Board in relation to this matter because he is able to assist the Board with relevant information, but is not permitted to participate in decision making.</td>
</tr>
<tr>
<td>David Collings</td>
<td>Potential Botany Land Development</td>
<td>Mr Collings declared a specific interest in relation to the Potential Botany Land Development, being a member of the Howick Local Board.</td>
<td>4 September 2013</td>
<td>That Mr Collings’ specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations or decisions.</td>
</tr>
<tr>
<td>Wendy Lai</td>
<td>HBL – Food &amp; Laundry &amp; FPSC Programme</td>
<td>Ms Lai declared a specific interest in regard to Deloitte providing support to HBL in the food and laundry and FPSC Programme. Deloitte has mainly been providing Oracle implementation resources to FPSC. Ms Lai is not directly involved with this work.</td>
<td>12 February 2014</td>
<td>That Ms Lai’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>George Ngatai</td>
<td>Community Services Pharmacy Funding Policy</td>
<td>Mr Ngatai declared a specific interest in terms of their GP Service being like to use a local Pharmacy.</td>
<td>13 August 2014</td>
<td>That Mr Ngatai’s specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Name</td>
<td>Item</td>
<td>Details</td>
<td>Date</td>
<td>Notes</td>
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</tr>
<tr>
<td>Wendy Lai</td>
<td>HBL Business Cases</td>
<td>Ms Lai declared a specific interest in regard to Deloitte’s involvement with HBL on this work.</td>
<td>13 August 2014</td>
<td>That Ms Lai’s specific interest be noted and that she may not participate in either the deliberations or determination of the Board in relation to this matter and is asked to leave the room.</td>
</tr>
<tr>
<td>Wendy Lai</td>
<td>Ko Awatea Panel Advisory Services</td>
<td>Ms Lai advised that Deloitte have been shortlisted to provide Panel Advisory Services to Ko Awatea. This work does not have any involvement with the APAC Business Case</td>
<td>5 November 2014</td>
<td>Noted. Ms Lai advised on the 3 December 2014 that Deloitte have now been selected to work with the Ko Awatea team to improve commercial awareness and increase income levels.</td>
</tr>
<tr>
<td>Lee Mathias</td>
<td>Otahuhu Boundary Change</td>
<td>The Chair noted her Specific Conflict of Interest, being Deputy Chair at ADHB.</td>
<td>25 March 2015</td>
<td>That Dr Mathias’ specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Lee Mathias</td>
<td>Northern Region Electronic Health Record (NEHR) Project &amp; Regional Information Strategy (RIS 10-20) Refresh</td>
<td>The Chair declared her specific interest as a Director of HealthAlliance.</td>
<td>25 March 2015</td>
<td>That Dr Mathias’ specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Wendy Lai</td>
<td>FPSC</td>
<td>Ms Lai advised that Deloitte is involved with FPSC, but confirmed that she personally does not have any involvement.</td>
<td>6 May 2015</td>
<td>That Ms Lai’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Wendy Lai</td>
<td>EPIC</td>
<td>Ms Lai noted that a Deloitte colleague worked with EPIC in the US. Mr Pearson and Mrs Zacest have met with him for his independent expertise on EPIC.</td>
<td>6 May 2015</td>
<td>That Ms Lai’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
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<tr>
<td>Name</td>
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<tr>
<td>Wendy Lai</td>
<td>Botany Land Discussions</td>
<td>Ms Lai advised that Deloitte has been appointed by the three parties involved in the Botany Land discussions (CMDHB, BUPA &amp; East Health). She is not personally involved in this work.</td>
<td>17 June 2015</td>
<td>That Ms Lai’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>David Collings</td>
<td>Fencing of Swimming Pools Legislation</td>
<td>Mr Collings advised that he is the Chair of the Howick Local Advisory Board Swimming Pool Fencing Exemption Committee.</td>
<td>9 September 2015</td>
<td>That Mr Collings’ specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Lyn Murphy</td>
<td>Fencing of Swimming Pools Legislation</td>
<td>Mrs Murphy advised that she is the Deputy Chair of the Swimming Pool Fencing Exemption Committee for Franklin Local Board.</td>
<td>9 September 2015</td>
<td>That Mrs Murphy’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Lyn Murphy</td>
<td>MIT Nursing Programme Report</td>
<td>Mrs Murphy is a Lecturer in the Faculty of Business &amp; Information Technology at MIT.</td>
<td>9 September 2015</td>
<td>That Mrs Murphy’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
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Minutes of Counties Manukau District Health Board
Held on Wednesday, 23 March 2016 at 1.30 – 4.30pm Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

Present: Dr Lee Mathias (Chair), Mrs Dianne Glenn, Apulu Reece Autagavaia, Dr Lyn Murphy, Mrs Sandra Alofivae, Mrs Kathy Maxwell, Mrs Colleen Brown, Ms Wendy Lai, Anae Arthur Anae

In attendance: Mr Geraint Martin (Chief Executive), Mr Ron Pearson (Deputy CEO), Mrs Lyn Butler (Board Secretary)

Apologies: Mr George Ngatai, Mr David Collings (lateness)

1. **Welcome**
   The Chair welcomed everyone to the meeting.

2. **Governance**
   2.1 **Attendance & Apologies**
      Noted.
   
   2.2 **Conflicts of Interest/Specific Interests**
      Noted.
   
   2.3 **Confirmation of Public Minutes – 10 February 2016**

      Resolution
      That the public Minutes of the Board Meeting held on **Wednesday, 10 February 2016**, were taken as read and confirmed as a true and correct record.
      Moved: Sandra Alofivae Seconded: Wendy Lai Carried: Unanimously

   2.4 **Action Items Register**
      Noted.

3. **Strategy**
   3.1 **Chair’s Report (verbal update (Lee Mathias)**
      The Chair provided an update to the Board on the new Ministry of Health executive structure, effective 1 March 2016.

      Dr Gloria Johnson gave a briefing on NEHR at the last RGG Meeting. Sign off for the Change Control Note will need to go to the Finance & Audit Committee, and to a Special Board Meeting, due to timing. Papers will be put in the Diligent Resource Centre.

      The CEOs agreed to underwrite another month, subject to executive advice to go to the end of an Indicative Business Plan and then decide whether to proceed or not.
Mr Pearson confirmed that he had discussed this with Mr Martin, who advised that this needs to proceed to the Indicative Business Case. Mr Martin supported the $200,000 transitional funding at RGG.

Ms Lai advised that this did not need to wait for the next Finance & Audit Committee Meeting and could be managed by circular resolution. The Chair confirmed that Northland DHB have signed this off.

A Special Board Meeting is to be set up.

Sir Ray Avery, Chair of NZHIH has resigned, and Dr Mathias has been appointed as Acting Chair. The Hub are in the middle of a review, and their executive team are preparing proposals on how to move forward. CMDHB would like to maintain the functions for their projects. A further update will be provided at the next meeting.

3.2 Chief Executive’s Report (Ron Pearson, Acting CEO)
The report was taken as read.

Mr Pearson advised that the March result was on target.

An interim financial position of $25M deficit has been filed. This is gradually reducing and is now at $13.5M. A surplus of $2.7M needs to be achieved. Initiatives will be prioritised through ELT, but there are significant challenges ahead.

Health targets continue to track closely, with some challenges around Maori and Pacific in some areas.

The Chair referred to the Investor Confidence Rating, which requires all public sector entities to have a rating. CMDHB are aiming for a ‘B’, but this is more likely to be a ‘C’. Mr Pearson said that there is a lot of work to do on this requirement.

Dr Margaret Aimer provided an update on the Healthy Equity Campaign, which has been designed to achieve equity in key health indicators. Discussions have taken place with ELT, Population Health team, Maori and Pacific leaders, etc. Work is also underway with MoH.

The first part is looking at Childhood Obesity and Diabetes, with the second part applying a health equity lens.

The method is based on a Model of Improvement. The team will target strengths of existing work, test it and then spread it.

Ms Margie Apa advised that there are a lot of ‘bright spots’, with the aim of highlighting the gaps and making things more accessible. Childhood obesity has been identified as a particular focus.

Mrs Maxwell said that this as a ‘top down’ initiative, noting that communities were not aware of this work and would not have heard of 20,000 Bed Days, and needs to work from the ‘bottom up’.

Mrs Apa advised that this work is translating into useful information, and is not aimed at the hospital. Dr Aimer added that this same method is being used in GP Practices, noting the need to be mindful of the language used.
The Chair said that obesity areas are getting crowded, and referred to work by the Ministry of Education on sugary drinks, and the work with Yendarra School and asked how this work would link with primary schools. Dr Aimer advised that the team would be meeting with MoH and Yendarra School in a couple of weeks, and would identify other schools in South Auckland that could also come on board.

Mrs Alofivae referred to the .....initial aim of returning 500,000 health life years..... and was not sure what this actually means. She also asked about this work and the implications of Dr Mat Lyndon going to Harvard for ten months. Dr Aimer said that Ko Awatea will keep the relationship with him, plus he is the Clinical Lead. This work will also be linked to the Handle the Jandal campaign.

The Chair asked Mr Pearson to arrange removal of the Pinky Bars from vending machines.

Resolution
That the Chief Executive’s Report be received.
Moved: Lee Mathias           Seconded: Dianne Glenn         Carried: Unanimously

4. General Business

5. Resolution to Exclude the Public

Resolution
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health & Disability Act 2000, that the public now be excluded from the meeting as detailed in the above paper.
Moved: Kathy Maxwell           Seconded: Sandra Alofivae        Carried: Unanimously

The meeting was re-opened to the public.

The meeting closed at 4.30pm. The next meeting of the Board will be Wednesday, 4 May 2016 at Ko Awatea, Middlemore Hospital.

The Minutes of the meeting of the Counties Manukau District Health Board of 23 March 2016 are approved.

Signed as a true and correct record on 4 May 2016.

Chair                      
Dr Lee Mathias (Chair)

Recommendation (moved          /seconded            )
Counties Manukau District Health Board  
Action Items Register (Public)

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
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<tr>
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<td>No current action items.</td>
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Counties Manukau District Health Board
Chief Executive’s Report

Recommendation

It is recommended that the Board receive the Chief Executive’s Report.

Prepared and submitted by: Geraint Martin, Chief Executive

1.0 Introduction

1.1 As routine, my report is set out in three sections:

- **Strategic** – with a special focus on planning for 2015/16.
- **Operational** – including the reports from the Director of Strategic Development, Director of Corporate & Business Services and Director of Ko Awatea.
- **Compliance** – included is an update on Health & Safety.

2.0 Strategic

2.1 Annual Plan 2016-17

The first draft CMDHB Annual Plan was submitted to National Health Board on 31 March 2016. Prior to submission, the Plan was refined following feedback from CM Health leadership across the system. Preliminary feedback on the plan is expected 2 May 2016 with finalised MoH guidance shortly after. A working second draft Annual Plan will be tabled at the 4 May 2016 Board meeting, ahead of submission to National Health Board on 30 May 2016.

2.2 Healthy Together 2020

2.2.1 Prior to the arrival of David Lenihan, Director of Healthy Together 2020 Delivery, we are ensuring we are ‘match fit’ for rapid deployment of the Transformation Programme. Currently we:

- Are reviewing how the operational management structure from ELT down is aligned, not only to deliver its function, but to be able to work across silos in an integrated way.

- Are identifying where our transformation and change capacity exists, and ensuring we lever greatest value from the investment.

- Are, through the Investor Confidence Rating, identifying where we need to become much more disciplined and focussed, especially in Programme and Project Management.

- Are identifying critical challenges in each of our target areas.
2.2.2 In the case of our operational management structure, two points are notable:

- Firstly, we will be realigning the services managed by the Director Primary & Integrated Care and Director Hospital Services, to better reflect our strategic direction.

In particular, Ambulatory & Outpatient Care will be better placed under Integrated Care to ensure optimum linkage with General Practice and Localities.

- Secondly, in the sphere of Patient Care & Professional Standards (e.g. Nursing, Midwifery, Allied Health, The Patient Experiences, Patient Centred Care, Patient Safety & Complaints Management), we have too many ‘moving parts’ which are not well configured for delivery of transformational change. Consequently, I have commissioned a review of our Patient Care and Professional Standards structure, to recommend the way forward for the end of May. This will be an external review and will be conducted by the same team who undertook the Review of Waitemata’s structure.

2.2.3 In the case of identifying current challenges in each of our target areas (Population Health, Primary and Integrated Care and Hospital Care), we are conducting a Deep Dive in each area. The first, Population Health, raises a number of challenges, in particular, in the balance between national and local priorities. The Deep Dive has been discussed at ELT, but the Board’s view is critical, and I would be grateful for the Board’s advice before we discuss these issues with the MoH in detail.

**Deep Dive – Healthy Together 2020 Transformation of Population Health**

ELT considered the population health transformation opportunities presented by Healthy Together 2020 Strategy. The highlights of those opportunities were population health approaches that:

- sharper targeting and segmentation of populations to enable co-design of initiatives that are more likely to work for specific communities;
- whole of system improvement to reduce inequalities in service performance, targeted using both quantitative data and qualitative information from engagement with providers and service users
- escalated efforts (as resources permit) to:
  - *Smokefree*: reduce number of people who smoke by prioritising local adaptation of policy and regulatory approaches and increased access to quitting aids (NRT and other medications) this work is mostly funded from MoH;
  - *Alcohol Harm*: reducing harm from alcohol by increasing brief interventions and community based initiatives, no MoH funding available for this work;
  - *Childhood Obesity*: focused effort on initiatives that shape environments and equip families and communities with approaches to reduce childhood obesity through Healthy Families NZ as the primary MoH funded and CMH’s broader work programme in child health
• greater mobilisation of communities and groups and joined up local social investment decision-making to get better value out of intersectoral working (nb Social Investment Board in separate proposal)
• challenge Ministry of Health on evidence based scale and scope of screening and developmental checking programmes to target resources for best investment.

Population Health activities: Scope for the purposes of Healthy Together 2020
While a wide range of actions across the health system and communities impact on population health gain and equity, there are specific activities that are usually deemed ‘at the population health end of the spectrum’. These comprise a range of health promotion and disease prevention work, including intersectoral initiatives. This range of activities can be grouped into four broad areas:

1. Social Determinants; e.g. housing, education, employment
2. Lifestyle Risk factors; e.g. smoking, harmful use of alcohol, poor nutrition and inadequate physical activity
3. Early Intervention/proactive care; e.g. screening, oral health preventive care, immunisation
4. Overarching System Drivers; e.g. health literacy (assuming that attention to equity and evaluation as system drivers are already acknowledged as fundamental planks for Healthy Together Transformation).

These activities collectively, and in some cases individually, span all three Strategic Objectives of the Healthy Together 2020 strategy – healthy services, healthy people/whaanau/families, healthy communities.

Population Health Key Areas of Focus for the Healthy Together Health Equity Goal
Everyone across the system needs to be able to see how their day-to-day work contributes to our Healthy Together goal, and be challenged and supported to work out what a health equity approach means in their service, their role and to implement change to accelerate gain towards our goal. We know that no single programme, initiative or service change will achieve the health gains our communities deserve. The Health Equity Campaign is a significant contributor to this and is currently being developed within Ko Awatea (led by Mataroria Lyndon).

However having reviewed the burden of ill-health across our communities, existing health system indicators, life course considerations and short to long term impacts, the Population Health Team has recommended (and had endorsed by various leadership groups including ELT and ALT) key areas for focus and identification of key health indicators to track in relation to our Healthy Together 2020 health equity goal:

• Smoking prevalence
• CVD/Diabetes management
• Hazardous use of alcohol
• Childhood obesity
• Health literate systems and people
• Workforce development (people capability and capacity).
The latter two areas are identified as key enablers to make progress on the first four areas.

**Population Health Key Areas of Focus: the scale of the issues in CM**
The quantum and scale of the population health issues for the Counties Manukau population dwarf the challenges faced by most DHBs, especially when set in the context of the proportion and quantum of our population who live in areas of high socioeconomic deprivation (36% at Census 2013; applied to the 2015 population, approximately 188,000 people).

<table>
<thead>
<tr>
<th>Population health key area of focus</th>
<th>Quantum of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number of people who smoke*</td>
<td>57,000</td>
</tr>
<tr>
<td>Number of people with diabetes and number with poor glucose control (2015)</td>
<td>37,400; 9,100</td>
</tr>
<tr>
<td>[Estimated number of people with ‘pre-diabetes’ 2013]</td>
<td>116,000</td>
</tr>
<tr>
<td>Estimated number of people drinking hazardless 2015#</td>
<td>53,500</td>
</tr>
<tr>
<td>Estimated number of obese children 2015 (aged 2-14 years)#</td>
<td>18,500</td>
</tr>
<tr>
<td>Number of obese 4 year old children at the B4School Check 2015</td>
<td>1,500</td>
</tr>
</tbody>
</table>

* applying prevalence at Census 2013, minus % for further decline from 2013 – 2015, applied to Est Res population for 2015
# applying results from the NZ Health Survey for CM Health to 2015 estimated resident population

Most of the infrastructure to support population health initiatives above are directly funded by the Ministry of Health outside our PBFF. These strategies have been reported previously to Board. The opportunities for **dis-investment** however requires significant discussion with Ministry with particular focus on the scale and scope of screening.

**Challenging conversations: Weighing up the potential benefits, harms and opportunity costs of screening activities.**

Screening activities, formalised or opportunistic, raise important questions about prioritisation of our scarce resource and opportunity costs, even in the face of nationally mandated screening programmes. For any screening activity it is imperative that the whole screening pathway (including further investigation and intervention where needed) is implementable and engaged in continuous quality assurance.

The evidence for screening programmes is continually being re-examined. Given the pressing needs across many of our service areas, and the complex nature of weighing up potential benefits and harms of screening programmes, we need to decide if / at what point we might want to engage in a strategic conversation with Ministry colleagues regarding investment in screening programmes. For example:

- might the potential benefits of work to achieve equitable coverage rates for cervical and breast cancer screening (under current programme scopes) be outweighed by the potential benefits of investing that resource in other activities, targeting inequities?
- what is our readiness and what are the equity implications when bowel cancer screening becomes a nationally mandated programme – if we do not have capacity to mitigate the impact on diagnostics for symptomatic patients, and significant concerns about the inequities in participation in
the pilot programme, would we signal we are not ready to proceed, or wish to proceed with a more restricted programme?

- the Well Child schedule includes many screening opportunities. There is a potential conversation about the timing and actual benefits to children of the B4School Check – could the considerable resource directed to this programme be better used at another time point (e.g. aged 3 years), as an opportunity to intervene earlier and to see progress before children begin school?

- Currently there is systematic family violence screening for women presenting in ED. Work with colleagues in Police and MSD for the Social Investment Board, and increasing our focus on reducing alcohol related harm, highlights the opportunity to increase our engagement in Family Violence screening and referral (see further below re local settings work).

The Board will be consulted in more detail on the risks and opportunities before we approach the Ministry of Health.

2.2.4 A major step forward in Population health was achieved with the creation of a Social Investment Board in South Auckland. A detailed report on this is included in the confidential part of the meeting.
3.0 **Operational**

3.1 **Streamlining performance reporting from 1 July 2016**

Our Healthy Together strategy and transformational change model provides the framework to streamline performance reporting to the Counties Manukau District Health Board, HAC, CPHAC and AR&F committees.

Put simply, the Board will focus on strategic performance and subcommittees on assigned accountabilities for operational performance oversight. I am working with my ELT to streamline their reports to me to enable a more cohesive picture of CM Health’s performance. Transformational change reporting will be the responsibility of the Director Healthy Together 2020, in collaboration with responsible ELT leads.

The diagram below summarises how I see this working in principle from the 2016/17 financial year.

3.2 **Performance for May 2016**

Our performance remains strong and we remain on course to achieve key targets for the third year running. We will also ensure delivery of improvements to diagnostic tests. This will be reported at the next HAC Meeting.
## Health Target Summary

<table>
<thead>
<tr>
<th>Target</th>
<th>Current Results</th>
<th>Status by 30 June 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Departments</strong></td>
<td>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</td>
<td>ACHIEVE</td>
</tr>
<tr>
<td>March result: 96%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Elective Surgery</strong></td>
<td>Elective surgery will increase by an average of 4,000 discharger per year</td>
<td>ACHIEVE</td>
</tr>
<tr>
<td>March result: 105% (internal result)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WIES: 97% (internal result) - Ministry agreed target of 95%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Faster Cancer Treatment</strong></td>
<td>85% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer</td>
<td>ON COURSE</td>
</tr>
<tr>
<td>March result: 70% (internal result)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvements being made require a two month/62 day lead-in time, as a result the retrospective reporting reflects work done up to 8 months ago given the 6 month reporting cycle.</td>
<td>ACTION: Weekly case reviews and tumour stream reporting; CanTrack system monitoring patient pathway for improved oversight (and intervention) expanded (now includes urology &amp; upper GI); research development to understand patient DNA to identify service improvement; continued analysis of breaches.</td>
<td></td>
</tr>
<tr>
<td><strong>Immunisation</strong></td>
<td>95% of eight month olds will have had their primary course of immunisation on time</td>
<td>ON COURSE</td>
</tr>
<tr>
<td>March result: 94%</td>
<td>ACTION: Monthly monitoring, prioritising Maaori referrals, Saturday clinic provision.</td>
<td></td>
</tr>
<tr>
<td><strong>Heart &amp; Diabetes Checks</strong></td>
<td>90% of eligible population have had their CVD risk assessed in the last five years</td>
<td>ACHIEVE</td>
</tr>
<tr>
<td>Q2/Dec result: 92%; Q3/March result expected to exceed target.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Tobacco</strong></td>
<td>90% of enrolled patients who smoke and were seen by a health practitioner in general practice and were offered brief advice and support to quit smoking</td>
<td>ON COURSE</td>
</tr>
<tr>
<td>March result: 89%</td>
<td>ACTION: Targeted support for lower performing PHOs.</td>
<td></td>
</tr>
<tr>
<td><strong>Secondary Tobacco</strong></td>
<td>95% of hospitalised patients who smoke and were seen by a health practitioner in a public hospital were offered brief advice and support to quit smoking</td>
<td>ACHIEVE</td>
</tr>
<tr>
<td>March result: 96%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>90% of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a LMC is offered advice and support to quit smoking</td>
<td>ACHIEVE</td>
</tr>
<tr>
<td>March result: &gt;95% (internal result)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ACHIEVE**: Already meeting target / will meet target by 30 June 2016  
**ON COURSE**: Includes actions to meet target; expected to meet target by 30 June 2016
3.3 **Financial Key Issues**

- Monthly results continues the very tight pattern of the past, but we remain marginally ahead of budget overall with no new material concerns arising or evident currently.

- Key operational issues are primarily hospital based. Despite a very mild entry towards winter, hospital attendances are at all-time highs for this time of the year with multiple “Dot” (i.e. well in excess of 100% bed capacity) days. Being well managed by the team but causing increasing stress as this continues. Elective WIES numbers remain behind budget despite being well over discharge budget levels, a presentation from Phillip Balmer was presented to the Audit, Risk and Finance Committee reflecting the agreed plan to correct this by year end. Note nearly 40% of the shortfall is generated by the national change in WIES calculation which has been accepted by MOH. The balance however will be recovered primarily through third party provisions contracts now being enacted.

- Forecast year end position reaffirmed at the budget level. While it has been stated previously many times, the operating position remains extremely tight requiring intense management on all fronts.

- Steady but positive progress towards breakeven has been made towards the Annual Plan / Budget 16/17. With this now being achieved but has requiring and received enormous organisation wide commitment. The next challenge is now identifying further savings to fund implementation of key additional priority initiatives. This amounts to approximately $5-10M, on top of the money required for other priority initiatives that have already been approved and occurring currently. ELT is currently finalising the overall position in time for submission to MoH, according to the national timetable.

- Current year capital budget being finalised. Still outstanding is regional discussion/resolution of hA IT capital funding both in terms of core infrastructure replacement/upgrade and new investment. The greater challenge is the consequent related higher depreciation and operating costs against continuing under investment and the consequences of such.

- Huge effort organisation wide is being put into the initial Treasury Investor Confidence Rating (ICR) requirement, given both its accepted process improvement but equally the critical impact the rating will have on the DHB’s future flexibility around freedom to operate both from a capital investment and operating perspective. Despite CMDHBs generally high Treasury and National reputation around this, the new requirements are a significant step up on existing health sector standards particularly around very much formalised, documented processes than currently exist. Very positive supportive and helpful meetings have been held recently with Treasury to assist us but are clear and Treasury reaffirmed this, that it is likely to be a transition process to optimise rating levels given the complexities of health vs. say the IRD. I am now on the MOH Technical group coving this and will update the Board regularly. Louise Zacest will update the Board separately on progress to date. Of more immediate concern is the indication by Treasury of an imminent change in Debt to Equity policy requirement. This needs much more discussion as the potential impact on the State Sector and Health in particular, without compensating changes to our capital structural flexibility could be enormously costly.
- Separate self-explanatory papers are included from Sarah Thirlwall in the confidential section in regard to the next investment steps in our Healthy Together Transformation (encompassing SWIFT). Key message are all three of these Business Cases are absolutely aligned to National Health IT Board (NHITB) requirements with two led and funded by CMDHB while the third is budget funded within hA. Sarah will, as part of that request, summarise the history and the steps to date to put them in context of our (former) SWIFT programme, NHITB and regional issues (NEHR time frames/expectations etc.) Capital funding is provisionally provided under the SWIFT annual capital allocation, subject to Board approval. All have been approved by ELT and Audit, Risk and Finance.

- Good progress being made by Kerry Bakkerus, our new Risk Manager. I have asked her to get involved ASAP with Facilities risk management. No concerns here as they have well proven successful processes but important to understand and review given importance of the Mental Health rebuild and other Facilities projects such as Laboratories relocation.
4.0 Strategic Development

Directorate Highlights
There are 6 teams that provide “corporate services” and two direct patient support services (Māori and Pacific cultural support) in the Strategic Development Directorate. The table below summarises Directorate highlights and risks as at end March.

<table>
<thead>
<tr>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Planning</strong></td>
</tr>
<tr>
<td>• 14/15 Pacific and Asian Health Annual Plan development in progress</td>
</tr>
<tr>
<td>• 2016/17 Annual Plan and Māori Health Plan first drafts submitted to the NHB 31 March; 2nd drafts will be submitted to ELT 26 April; 2016/17 Pacific Health &amp; Asian Health Plans first drafts to 10 May ELT.</td>
</tr>
<tr>
<td><strong>Māori Health Development</strong></td>
</tr>
<tr>
<td>• New internal Whānau Ora model of care implemented. Change proposal to strengthen capability and improve wider integration from 1 July 2016 is in progress.</td>
</tr>
<tr>
<td>• Grow Our Own initiatives:</td>
</tr>
<tr>
<td>o Scholarships process implemented for 2016. Cadets program successfully implemented.</td>
</tr>
<tr>
<td>o Māori HSA launched and underway with first cohort of 15 students enrolled. Tindall funding confirmed. Strengthened regional commitment to Māori Workforce Development has been supported by the Regional Clinical Leaders Group for implementation in 16/17.</td>
</tr>
<tr>
<td><strong>Pacific Health Development – focus on Regional Pacific Development</strong></td>
</tr>
<tr>
<td>• Cook Islands – Training completed. Quarterly reporting completed.</td>
</tr>
<tr>
<td>• Samoa – The 3 month extension worth $250K signed off by MFAT to 30 June 2016 to allow for the development and consultation of the 5 year ILP.</td>
</tr>
<tr>
<td>• Kiribati – Extension to work plan for a further 12 months designed in agreement with stakeholders and submitted to MFAT for approval of contract</td>
</tr>
<tr>
<td>• Fiji - INFANTS programme now being implemented by local trainers. Programme outputs achieved. Identified nurses/doctors/(8) completed placements in NZ hospitals - neonatal and paediatric units.</td>
</tr>
<tr>
<td>• MFAT – Tenders for 5 other Pacific countries scheduled for May 2016 now deferred to September 2016.</td>
</tr>
<tr>
<td>• NZMAT – deployed to Fiji in response to TC Winston 22 February to 17 March 2016. This deployment was the largest to date with 23 people deployed. The clinical teams were deployed to the worst hit islands in northern Lau supported by HMNZS Canterbury and NZDF. Total of 101 surgeries were completed at CWM Hospital and 430 other cases managed through the community clinics.</td>
</tr>
<tr>
<td><strong>Communications Channels</strong></td>
</tr>
<tr>
<td>• Highlight of campaigns in progress:</td>
</tr>
<tr>
<td>• Creation of a year round wellness communication campaign/strategy for staff and the community (with a particular focus on winter) has been completed and due to be actioned April onwards.</td>
</tr>
<tr>
<td>• Education campaign in association with Suburban Newspapers promoting a smoke free campus for MSC and MMH has been extended through to April.</td>
</tr>
<tr>
<td>• Branding guidelines for the new values and strategy on-going through to April.</td>
</tr>
<tr>
<td>• Communications plan for proposed rehabilitation facility at MSC in development.</td>
</tr>
<tr>
<td>• Developing an internal promotion campaign for the new Patient Learning Centre at MMH.</td>
</tr>
<tr>
<td>• Corporate website updated with design changes.</td>
</tr>
</tbody>
</table>
| • New photo assets being collected for photo library with a new tracking system being looked
• Launch of Ask Me Anything Initiative (for CEO) has had great response from staff.
• Influenza vaccination campaign starts end of March aimed at encouraging staff to be vaccinated.
• Social Media statistics for March attached.

**Population Health**

- Population Health Grand Round – Prof Tony Blakely on Achieving Smokefree Aotearoa 2025 Goal.
- Analysis of survey to quantify housing need among people accessing mental health services completed.
- Family outcomes from family interventions literature review completed for website publishing and results discussed in relation to SIB planning.
- Action plan developed for increasing <5 year of flu vaccination coverage.
- Media interview for TV 3 story on Smokefree grounds and buildings policy issues.
- PBFF review technical report published.
- Presentation to PHARMAC on potential application of TestSafe analyses for their work.
- Documents for sector consultation as part of group revising national ethnicity data protocols near completion.
- CM Health Maternity Quality & Safety report distributed as an exemplar for other DHBs.

**Strategic PMO**

- A Strategic Portfolio Delivery Structure has been defined as an input into the improvement plan for Healthy Together. The structure identifies the existing initiatives that would be components of a transformation programme and the inter-relationships between projects, programmes and portfolios. It is envisaged that a P3M3 Improvement Plan would address the operational improvements to enable the delivery structure.
- Transformation: Consultation with SPMO has progressed on possible transfer to the Transformation Directorate to support David Lenihan.
- Priority portfolios include:
  - On-going support to the hospital portfolio to improve efficiency and effectiveness in theatre and procedural areas (ie) gastroenterology and radiology.
  - 12 practices have been confirmed to participate in a Diabetes collaborative scheduled to commence early May. The collaborative will build on the experiences of the Safety in Practice and Mannaki Hauora Manukau Diabetes Project collaboratives.
  - Social investment - further refinement of the business case is being progressed. See deep dive report.
SOCIAL MEDIA AT CM HEALTH

SPOTLIGHT ON TWITTER @CMDHB

- Graphs (right) show 1 January – 31 March 2106
- Likes, clicks, retweets, replies and engagement have all increased this year.
- In March we had over 58,000 impressions, nearly 200 retweets and doubled our engagement compared to December.
- @CMDHB is used for sharing health research, health promotion content, media stories about South Auckland and recruitment information.
- We also interact with the public when appropriate, to offer health info and to respond to complaints, and to live tweet at events.
- 63% of our followers are in New Zealand, followed by 6% each in the UK and US.

POPULAR THIS MONTH: FOOD & RECIPES

Top media Tweet earned 942 impressions
#Healthy and yum #dessert? Yes please! @HeartNZ ow.ly/Zhimo pic.twitter.com/bnLJcx94CU

Top Tweet earned 1,086 impressions
Fijian Fish Curry | A simple, healthy dinner idea @HeartNZ ow.ly/Ze185 pic.twitter.com/O0SxDSNwv0
FINANCIAL POSITION at March 2016

Summary:

March Month

Month / Year to date

Three quarters of the year is now gone with a year to date favourable variance of $641k. The result for the month was a positive variance of $76k, with the actual result was actual $(2,390)k v’s budget $(2,466)k. The YTD result as stated above is favourable by $641k with the actual result $3,069k v’s budget $2,428k. As noted in previous months the full year’s financial/ budgeted result includes the additional MOH advised revenue ($2.7m) and this is accounted for in the final month of the financial year, both in actual and budget reconciliation.

The Funder Arm was $136k favourable to budget with a Year to Date favourable variance of $920k. Slow Mental Health spending benefits continued in the month ($776). This is now being offset by an expected increase in Residential Care (Hospitals and Rest Homes) expenditure to more ‘normal’ levels $(487).

The Provider Arm Consolidated produced a result that was $29k favourable to budget and a YTD favourable variance of $571k. The Hospital side of the provider arm was unfavourable for the month by 233k and has a YTD unfavourable variance of $(382)k. (See HAC report for more details)

Governance was unfavourable for the month of $89k and an YTD unfavourable variance of $850k.

We have re-affirmed to MOH (as at March 2016) that the forecast year end position remains as budgeted although there are clear and increasing signs of pressure within most DHB provider arms and we have/are taking further very active steps to manage this exposure to ensure budget achievement.

Sector report:

As at February the Sector is now forecasting to be unfavourable to budget by $27.0m. This is been driven by nine DHB’s with the largest forecast variance being Capital and Coast $(12.0)m, $5.0m worse than the previous month and MidCentral $(4.1)m,. The Northern region is the only region favourable to budget $543k, Midland $(6.7)m, Central $(19.6)m and Southern $(1.2)m.

The Provider Arms of all but five (Counties is one of the five) are unfavourable to budget causing the sector provider arm view to be $39.2m over budget, Actual $(111.6)m v’s Budget $(72.4)m with the two largest negative variances again being from Capital and Coast ($7.2m) and MidCentral ($5.5m). Note this excludes the fact that most DHB Provider Arm Budgets were for significant deficits hence the actual total dollar position is significantly worse than the Year to date variance highlighted above.
## Statement of Performance by Operating Arm

<table>
<thead>
<tr>
<th>Month</th>
<th>Net Result</th>
<th>YTD</th>
<th>Full year</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2016</td>
<td>$000</td>
<td>Act Bud Var. Last year Bud Forecast</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>(396)</td>
<td>(163)</td>
<td>(233)</td>
<td>22,750</td>
</tr>
<tr>
<td>(1,780)</td>
<td>(2,005)</td>
<td>225</td>
<td>(18,099)</td>
</tr>
<tr>
<td>(1,295)</td>
<td>(1,332)</td>
<td>37</td>
<td>(10,960)</td>
</tr>
<tr>
<td><strong>(3,471)</strong></td>
<td><strong>(3,500)</strong></td>
<td><strong>29</strong></td>
<td><strong>(6,309)</strong></td>
</tr>
<tr>
<td>1,151</td>
<td>1,015</td>
<td>136</td>
<td>10,059</td>
</tr>
<tr>
<td>(70)</td>
<td>19</td>
<td>(89)</td>
<td>(681)</td>
</tr>
<tr>
<td><strong>(2,390)</strong></td>
<td><strong>(2,466)</strong></td>
<td><strong>76</strong></td>
<td><strong>3,069</strong></td>
</tr>
</tbody>
</table>

**Monthly Result** (not cumulative)

![Surplus Graph](image-url)
Volume Summary March 2016

<table>
<thead>
<tr>
<th>Month</th>
<th>Total WIES</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
</tr>
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<td></td>
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<td></td>
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<tr>
<td>Acute</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5,626</td>
<td>5,929</td>
</tr>
<tr>
<td></td>
<td>1,328</td>
<td>1,610</td>
</tr>
<tr>
<td></td>
<td>6,954</td>
<td>7,539</td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>52,622</td>
<td>51,021</td>
</tr>
<tr>
<td></td>
<td>13,294</td>
<td>13,383</td>
</tr>
<tr>
<td></td>
<td>65,016</td>
<td>64,404</td>
</tr>
</tbody>
</table>

Note: Elective WIES numbers remain behind budget despite being well over discharge budget levels, a separate paper from Phillip Balmer was presented to the Audit, Risk and Finance Committee in March reflecting the agreed Plan to correct this by year end. Note nearly 40% of the shortfall is generated by the national change in WIES calculation which has been accepted by MOH. The balance however will be recovered via 3rd party outsourcing primarily.

Discharges
(note we don’t budget for discharges)

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to date</th>
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<tbody>
<tr>
<td></td>
<td>Act</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>8,715</td>
</tr>
<tr>
<td></td>
<td>1,624</td>
</tr>
<tr>
<td></td>
<td>10,339</td>
</tr>
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<td></td>
<td>0.67</td>
</tr>
</tbody>
</table>

Volumes Other

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>603</td>
</tr>
<tr>
<td></td>
<td>9,467</td>
</tr>
<tr>
<td></td>
<td>4,795</td>
</tr>
<tr>
<td></td>
<td>55,011</td>
</tr>
<tr>
<td></td>
<td>2.9</td>
</tr>
</tbody>
</table>

Note: Elective WIES numbers remain behind budget despite being well over discharge budget levels, a separate paper from Phillip Balmer was presented to the Audit, Risk and Finance Committee in March reflecting the agreed Plan to correct this by year end. Note nearly 40% of the shortfall is generated by the national change in WIES calculation which has been accepted by MOH. The balance however will be recovered via 3rd party outsourcing primarily.
## Statement of Performance

### Revenue

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>124,011</td>
<td>123,408</td>
<td>603</td>
</tr>
<tr>
<td>4,030</td>
<td>3,210</td>
<td>820</td>
</tr>
<tr>
<td>128,041</td>
<td>126,618</td>
<td>1,423</td>
</tr>
</tbody>
</table>

### Expenses

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>$000</td>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td>49,048</td>
<td>48,927</td>
<td>(121)</td>
<td></td>
</tr>
<tr>
<td>1,293</td>
<td>672</td>
<td>(621)</td>
<td></td>
</tr>
<tr>
<td>4,497</td>
<td>4,669</td>
<td>172</td>
<td></td>
</tr>
<tr>
<td>54,939</td>
<td>55,054</td>
<td>115</td>
<td></td>
</tr>
<tr>
<td>10,049</td>
<td>9,036</td>
<td>(1,013)</td>
<td></td>
</tr>
<tr>
<td>5,284</td>
<td>5,721</td>
<td>437</td>
<td></td>
</tr>
<tr>
<td>125,110</td>
<td>124,079</td>
<td>(1,031)</td>
<td></td>
</tr>
<tr>
<td>2,931</td>
<td>2,539</td>
<td>392</td>
<td></td>
</tr>
<tr>
<td>2,653</td>
<td>2,730</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>1,059</td>
<td>1,097</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>1,609</td>
<td>1,178</td>
<td>(431)</td>
<td></td>
</tr>
<tr>
<td>(2,390)</td>
<td>(2,466)</td>
<td>76</td>
<td></td>
</tr>
</tbody>
</table>

### Operating Surplus

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>1,088,564</td>
<td>1,091,949</td>
<td>3,385</td>
</tr>
</tbody>
</table>

### Better or Worse than 5%

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>603</td>
<td>1,106,686</td>
<td>1,110,101</td>
</tr>
<tr>
<td>820</td>
<td>32,226</td>
<td>29,391</td>
</tr>
<tr>
<td>1,423</td>
<td>1,138,912</td>
<td>1,139,492</td>
</tr>
</tbody>
</table>

**Revenue**

- **Crown**
  - Act: $1,106,686
  - Bud: $1,110,101
  - Var.: $(3,415)$
  - Last year: $1,086,836
  - Full year: $1,482,736

- **Other**
  - Act: $32,226
  - Bud: $29,391
  - Var.: $2,835
  - Last year: $28,169
  - Full year: $38,662

**Expenses**

- **Personnel**
  - Act: $417,230
  - Bud: $419,538
  - Var.: $2,308
  - Last year: $403,549
  - Full year: $557,441

- **O/S Personnel**
  - Act: $11,492
  - Bud: $5,993
  - Var.: $(5,499)$
  - Last year: $10,810
  - Full year: $17,655

- **O/S services**
  - Act: $41,300
  - Bud: $41,210
  - Var.: $(90)$
  - Last year: $38,849
  - Full year: $53,670

- **Funder Provider payments**
  - Act: $487,288
  - Bud: $495,488
  - Var.: $8,200
  - Last year: $483,476
  - Full year: $651,294

- **Clinical Sup.**
  - Act: $82,276
  - Bud: $79,116
  - Var.: $(3,160)$
  - Last year: $78,667
  - Full year: $110,156

- **Infrastructure**
  - Act: $48,978
  - Bud: $50,604
  - Var.: $1,626
  - Last year: $51,828
  - Full year: $66,219

**Operating Surplus**

- Surplus after operating Exp.
  - Act: $50,348
  - Bud: $47,543
  - Var.: $2,805
  - Full year: $64,963

- Depn.
  - Act: $24,358
  - Bud: $24,568
  - Var.: $210
  - Full year: $32,293

- Interest
  - Act: $9,361
  - Bud: $9,873
  - Var.: $512
  - Full year: $12,572

- Capital Chg.
  - Act: $13,560
  - Bud: $10,674
  - Var.: $(2,886)$
  - Full year: $17,396

- Gain on Sale
  - Act: $0
  - Bud: $0
  - Var.: $0
  - Full year: $0

**Net Surplus**

- Act: $3,069
  - Bud: $2,428
  - Var.: $641
  - Full year: $2,702

Better than 5% | Worse than 5%
Both the months and YTDs actual operating position result look satisfactory but given that there is additional revenue to cover the Capital Charge negative variance (month $431k YTD $2,886k) and Interest received favourable variance (month $75k YTD $1,467k) thereby giving the true Operating position as a negative variance for the month of $114k and YTD a negative variance of $1,548k which is putting considerable pressure on the hospital arm in particular, offset fortuitously by lower depreciation. The capital charge variance relates primary to Revaluations.
Revenue

<table>
<thead>
<tr>
<th>Month</th>
<th>$000</th>
<th>Full Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td>70,792</td>
<td>69,444</td>
<td>1,348</td>
</tr>
<tr>
<td>119,476</td>
<td>119,106</td>
<td>370</td>
</tr>
<tr>
<td>(63,386)</td>
<td>(63,037)</td>
<td>(349)</td>
</tr>
<tr>
<td>1,159</td>
<td>1,105</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>128,041</strong></td>
<td><strong>126,618</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider</th>
<th>YTD</th>
<th>Full Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td>631,708</td>
<td>624,924</td>
<td>6,784</td>
</tr>
<tr>
<td>1,066,667</td>
<td>1,071,954</td>
<td>(5,287)</td>
</tr>
<tr>
<td>(569,320)</td>
<td>(567,327)</td>
<td>(1,993)</td>
</tr>
<tr>
<td>9,857</td>
<td>9,941</td>
<td>(84)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,138,912</strong></td>
<td><strong>1,139,492</strong></td>
</tr>
</tbody>
</table>

Provider favourable for the month of March. The main drivers for the current month’s variance are:

- **Government Revenue**: MoH revenue compensation for capital cost increase (offset by capital cost); ACC arrears initiative; CTA revenue delay in invoicing; funded gastro procedures.
- **Patient/Consumer Sourced**: Non-resident favourable billings (offset by bad debts); Patient co-payments.
- **Other Income**: Interest received; Donation revenue reflects budget phasing variance due to timing of claims. A review of outstanding projects/claims is currently underway.
- **Funder Payments** from Funder (internal transfers) for contracts outside base funding. i.e.: 20k days and localities.

Note that revenue includes additional unbudgeted project revenue (offset by cost).

Staff Costs (including Outsourced)

<table>
<thead>
<tr>
<th>Month</th>
<th>$000</th>
<th>Full Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td>49,425</td>
<td>48,835</td>
<td>(590)</td>
</tr>
<tr>
<td>916</td>
<td>764</td>
<td>(152)</td>
</tr>
<tr>
<td>50,341</td>
<td>49,599</td>
<td>(742)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15,597</strong></td>
<td><strong>15,975</strong></td>
</tr>
<tr>
<td>421,594</td>
<td>418,655</td>
<td>(2,939)</td>
</tr>
<tr>
<td>7,128</td>
<td>6,876</td>
<td>(252)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>421,594</strong></td>
<td><strong>418,655</strong></td>
</tr>
<tr>
<td>568,794</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical

| Outsources | 6,408  | 3,339  | (3,069)  |
| Outsources | 2,203  | 412    | (1,791)  |
| Outsources | 156,024| 155,038| (986)    |
| Outsources | 2,203  | 412    | (1,791)  |
| Outsources | 156,024| 155,038| (986)    |
| Outsources | 2,203  | 412    | (1,791)  |
| Outsources | 156,024| 155,038| (986)    |

Allied Health

| Outsources | 274    | 284    | 10       |
| Outsources | 58,991 | 61,330  | 2,339    |
| Outsources | 274    | 284    | 10       |
| Outsources | 58,991 | 61,330  | 2,339    |

Support Personnel

| Outsources | 323    | 243    | (80)     |
| Outsources | 19,562 | 18,083  | (1,479)  |
| Outsources | 323    | 243    | (80)     |
| Outsources | 19,562 | 18,083  | (1,479)  |
### Internal: Hospital personnel costs are $31k favourable for the month reflecting vacancies mainly in the Nursing and Allied Health Group’s. This includes a leave revaluation provision and higher clinical demand in cleaning and orderly services (discharge lounge, ICU, SAU). A level of vacancies exist across the organisation in all personnel categories (including Allied Health) and are partially covered by bureau, overtime and casual staff.

Note that the Personnel cost variance above includes $147k (25FTE) of costs incurred in delivering additional unbudgeted Provider revenue.

Governance: increased cost for the Treasury Investor Confidence Rating, and Healthy Together.

- **External**: Hospital outsourced personnel is unfavourable for March (includes personnel, clinical and other). Outsourcing to cover key vacancies as mentioned above (e.g. Mental Health) and to meet MoH targets (e.g. gastro, renal, MRI).

### Outsourced Services

<table>
<thead>
<tr>
<th>Month</th>
<th>$000</th>
<th>YTD</th>
<th>Full Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td><strong>Corporate &amp; Funder Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td>2,783</td>
<td>2,917</td>
<td>134</td>
<td></td>
</tr>
<tr>
<td>1,714</td>
<td>1,752</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,497</td>
<td>4,669</td>
<td>172</td>
</tr>
</tbody>
</table>

Provider: Offset by ha YTD cost benefit and savings in other expenses.

Note that the Outsourced cost variance above includes of costs incurred in delivering additional unbudgeted revenue.

### Independent Service Provider *(Demand driven expenditure)*

<table>
<thead>
<tr>
<th>Month</th>
<th>$000</th>
<th>YTD</th>
<th>Full Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td><strong>Personal Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IDF Personal Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21,040</td>
<td>20,991</td>
<td>(49)</td>
<td></td>
</tr>
<tr>
<td>8,546</td>
<td>8,547</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Practice Services – Capitated</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7,705</td>
<td>7,100</td>
<td>(605)</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Youth</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>603</td>
<td>579</td>
<td>(24)</td>
<td></td>
</tr>
<tr>
<td><strong>Adolescent Dental Benefit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>468</td>
<td>470</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
For the third month in a row we have seen the underspend cease and increased spending for new beds and new facilities. Pressure for aged population beds in the district is growing and we have seen an increase investment by the NGO sector in supplying those beds. The increased costs of home support have been offset by increased revenue for this service.
### Clinical Supplies

<table>
<thead>
<tr>
<th>Month</th>
<th>Act</th>
<th>Bud</th>
<th>Var.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Disposables</td>
<td>3,914</td>
<td>3,644</td>
<td>(270)</td>
</tr>
<tr>
<td>Diagnostic Supplies &amp; Other Clinical Supplies</td>
<td>809</td>
<td>702</td>
<td>(107)</td>
</tr>
<tr>
<td>Instruments &amp; Equipment</td>
<td>1,327</td>
<td>1,184</td>
<td>(143)</td>
</tr>
<tr>
<td>Patient Appliances</td>
<td>353</td>
<td>312</td>
<td>(41)</td>
</tr>
<tr>
<td>Implants &amp; Prostheses</td>
<td>1,556</td>
<td>1,498</td>
<td>(58)</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>1,653</td>
<td>1,371</td>
<td>(282)</td>
</tr>
<tr>
<td>Other Clinical Supplies</td>
<td>437</td>
<td>325</td>
<td>(112)</td>
</tr>
<tr>
<td>Total</td>
<td>10,049</td>
<td>9,036</td>
<td>(1,013)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>$000</th>
<th>YTD</th>
<th>Full Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act</td>
<td>Bud</td>
<td>Var.</td>
</tr>
<tr>
<td>32,730</td>
<td>31,861</td>
<td>(869)</td>
</tr>
<tr>
<td>7,352</td>
<td>6,282</td>
<td>(1,070)</td>
</tr>
<tr>
<td>10,557</td>
<td>10,333</td>
<td>(224)</td>
</tr>
<tr>
<td>2,844</td>
<td>2,687</td>
<td>(157)</td>
</tr>
<tr>
<td>12,799</td>
<td>12,619</td>
<td>(180)</td>
</tr>
<tr>
<td>12,969</td>
<td>12,413</td>
<td>(556)</td>
</tr>
<tr>
<td>3,025</td>
<td>2,921</td>
<td>(104)</td>
</tr>
<tr>
<td>82,276</td>
<td>79,116</td>
<td>(3,160)</td>
</tr>
</tbody>
</table>

- **Provider**: unfavourable for the month.

  **Clinical Support.** Drug overspend was driven by infection and cancer drugs (offset by PCT revenue); Blood costs include high cost patients with Guillain-Barre Syndrome and antibody mediated vasculitis; Lab costs were driven by a 3% volume increase (on March 2015).

  **Surgical.** Overspend driven by high complexity acute work, particularly implant costs.

- Note that the Clinical Supplies cost variance above includes costs incurred in delivering additional unbudgeted revenue.

---

### Clinical Supplies Chart

![Clinical Supplies Chart](chart.png)
### Non-Clinical / Infrastructure (excluding Interest and Capital Charge)

<table>
<thead>
<tr>
<th>Month</th>
<th>Act</th>
<th>Bud</th>
<th>Var.</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>YTD</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Act</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5,108</td>
</tr>
<tr>
<td></td>
<td>176</td>
<td>264</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5,284</td>
<td>5,721</td>
<td>437</td>
<td></td>
</tr>
</tbody>
</table>

| Provider | 46,290 | 48,222 | 1,932 | 62,749 |
| Governance | 2,688 | 2,382 | (306) | 265 |
| **Total** | 48,978 | 50,604 | 1,626 | 63,014 |

### Interest and Capital Charge

<table>
<thead>
<tr>
<th>Month</th>
<th>Act</th>
<th>Bud</th>
<th>Var.</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>YTD</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Act</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>217</td>
</tr>
<tr>
<td></td>
<td>1,059</td>
<td>1,097</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td></td>
<td>842</td>
<td>955</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,609</td>
<td>1,178</td>
<td>(431)</td>
<td></td>
</tr>
</tbody>
</table>

| Interest - Received | 2,745 | 1,278 | 1,467 | 1,699 |
| Interest Paid - Debt | 9,361 | 9,873 | 512 | 14,712 |
| **Net Interest Paid** | 6,616 | 8,595 | 1,979 | 13,013 |
| Capital Charge | 13,560 | 10,674 | (2,886) | 14,136 |

**Interest cost:** Interest received; **significantly improved** cash position.

**Capital Charge:** Unfavourable variance reflects the actual cost of capital charged by MoH (increase in the revaluation of land) against budget matched against additional revenue. Timing of top up payments expected but not confirmed until April.
## Ratios

### Provider Arm (only)

**Costs to Revenue (%) last six months**

<table>
<thead>
<tr>
<th></th>
<th>Mar 16</th>
<th>Feb 16</th>
<th>Jan 16</th>
<th>Dec 15</th>
<th>Nov 15</th>
<th>Oct 15</th>
<th>Sep 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>25.49</td>
<td>24.67</td>
<td>25.05</td>
<td>25.09</td>
<td>23.70</td>
<td>24.97</td>
<td>24.29</td>
</tr>
<tr>
<td>Allied</td>
<td>9.87</td>
<td>9.29</td>
<td>8.95</td>
<td>9.43</td>
<td>8.95</td>
<td>9.31</td>
<td>9.23</td>
</tr>
<tr>
<td>Support</td>
<td>3.25</td>
<td>2.75</td>
<td>3.38</td>
<td>3.21</td>
<td>2.96</td>
<td>3.12</td>
<td>3.05</td>
</tr>
<tr>
<td>Management</td>
<td>7.42</td>
<td>7.17</td>
<td>6.92</td>
<td>7.33</td>
<td>6.96</td>
<td>6.91</td>
<td>7.01</td>
</tr>
<tr>
<td><strong>Personnel</strong></td>
<td><strong>67.99</strong></td>
<td><strong>63.81</strong></td>
<td><strong>64.92</strong></td>
<td><strong>66.24</strong></td>
<td><strong>63.16</strong></td>
<td><strong>65.44</strong></td>
<td><strong>63.95</strong></td>
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<tr>
<td>Outsourced Pers.</td>
<td>1.89</td>
<td>1.73</td>
<td>1.79</td>
<td>1.90</td>
<td>2.24</td>
<td>1.93</td>
<td>2.52</td>
</tr>
<tr>
<td><strong>Total Personnel</strong></td>
<td><strong>69.88</strong></td>
<td><strong>65.54</strong></td>
<td><strong>66.71</strong></td>
<td><strong>68.14</strong></td>
<td><strong>65.39</strong></td>
<td><strong>67.37</strong></td>
<td><strong>66.47</strong></td>
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<tr>
<td>Outsourced Clinical Services</td>
<td>2.42</td>
<td>2.77</td>
<td>2.44</td>
<td>2.40</td>
<td>2.94</td>
<td>3.25</td>
<td>2.44</td>
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<tr>
<td>Outsourced Corp (hA)</td>
<td>3.68</td>
<td>3.75</td>
<td>3.73</td>
<td>3.37</td>
<td>3.97</td>
<td>3.82</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>104.90</strong></td>
<td><strong>99.39</strong></td>
<td><strong>100.26</strong></td>
<td><strong>101.77</strong></td>
<td><strong>100.52</strong></td>
<td><strong>102.26</strong></td>
<td><strong>100.29</strong></td>
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</table>

### Provider cost as a percentage of revenue over the last four years and year to date

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>20.8</td>
<td>20.9</td>
<td>20.7</td>
<td>21.2</td>
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<td>Nursing</td>
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<td>24.8</td>
<td>25.1</td>
<td>25.5</td>
<td>24.7</td>
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<td>Allied Health</td>
<td>9.3</td>
<td>9.3</td>
<td>9.7</td>
<td>9.7</td>
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<td>Support</td>
<td>3.1</td>
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<td>2.7</td>
</tr>
<tr>
<td>Man/Admin</td>
<td>7.1</td>
<td>6.9</td>
<td>6.8</td>
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<td>Personnel</td>
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<tr>
<td>Outsourced Personnel</td>
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<td>2.0</td>
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<td>1.8</td>
<td>1.7</td>
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<tr>
<td><strong>Total Personnel</strong></td>
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<td><strong>67.0</strong></td>
<td><strong>67.0</strong></td>
<td><strong>68.1</strong></td>
<td><strong>66.9</strong></td>
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<tr>
<td>Outsourced Clinical Supplies</td>
<td>2.5</td>
<td>2.5</td>
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<tr>
<td>Outsourced Corporate</td>
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<td>3.7</td>
<td>3.7</td>
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<td>3.3</td>
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<tr>
<td>Clinical supplies</td>
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<td>14.4</td>
<td>14.0</td>
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<tr>
<td>Infrastructure</td>
<td>13.5</td>
<td>13.2</td>
<td>13.0</td>
<td>12.4</td>
<td>13.2</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>101.0</strong></td>
<td><strong>100.8</strong></td>
<td><strong>100.4</strong></td>
<td><strong>101.2</strong></td>
<td><strong>100.9</strong></td>
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<td>Depn</td>
<td>3.9</td>
<td>3.6</td>
<td>3.8</td>
<td>3.1</td>
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<tr>
<td>Interest</td>
<td>1.5</td>
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<td>1.1</td>
<td>1.5</td>
<td>1.3</td>
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<td>Capital Charge</td>
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<td>1.7</td>
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### Balance Sheet

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Opening 1st July 15</th>
<th>YTD Movement</th>
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<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Cash</td>
<td>10</td>
<td>10</td>
<td>-</td>
<td>10</td>
<td>-</td>
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<tr>
<td>Bank</td>
<td>55,372</td>
<td>30,037</td>
<td>25,335</td>
<td>55,246</td>
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<tr>
<td>Trust</td>
<td>896</td>
<td>895</td>
<td>1</td>
<td>886</td>
<td>10</td>
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<tr>
<td>Prepayments</td>
<td>146</td>
<td>878</td>
<td>(732)</td>
<td>945</td>
<td>(799)</td>
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<tr>
<td>Debtors</td>
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<td>50,074</td>
<td>(3,410)</td>
<td>45,074</td>
<td>1,590</td>
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<td>Inventory</td>
<td>1,145</td>
<td>1,320</td>
<td>(175)</td>
<td>1,320</td>
<td>(175)</td>
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<tr>
<td>Assets Held for Sale</td>
<td>12,503</td>
<td>12,503</td>
<td>-</td>
<td>12,503</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current Assets</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>144,683</td>
<td>144,683</td>
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<td>144,683</td>
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<tr>
<td>Buildings &amp; Plant</td>
<td>659,723</td>
<td>660,560</td>
<td>(837)</td>
<td>625,018</td>
<td>34,705</td>
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<td>Investment Property</td>
<td>1,449</td>
<td>1,449</td>
<td>-</td>
<td>1,449</td>
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<tr>
<td>Information Technology</td>
<td>5,406</td>
<td>5,422</td>
<td>(16)</td>
<td>5,332</td>
<td>74</td>
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<td>Information Software</td>
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<td>5,467</td>
<td>(252)</td>
<td>5,008</td>
<td>207</td>
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<tr>
<td>Motor Vehicles</td>
<td>4,320</td>
<td>4,480</td>
<td>(160)</td>
<td>4,291</td>
<td>29</td>
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<tr>
<td><strong>Total Cost</strong></td>
<td>820,796</td>
<td>822,061</td>
<td>(1,265)</td>
<td>785,781</td>
<td>35,015</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>614,971</td>
<td>641,808</td>
<td>(26,837)</td>
<td>630,096</td>
<td>(15,125)</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>15,985</td>
<td>5,234</td>
<td>10,751</td>
<td>5,234</td>
<td>10,751</td>
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<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>630,956</td>
<td>647,042</td>
<td>(16,086)</td>
<td>635,330</td>
<td>(4,374)</td>
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<td>Investments (hA IT / HBL)</td>
<td>35,025</td>
<td>37,940</td>
<td>(2,915)</td>
<td>29,390</td>
<td>5,635</td>
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<tr>
<td><strong>Total Assets</strong></td>
<td>782,717</td>
<td>780,699</td>
<td>2,018</td>
<td>780,704</td>
<td>2,013</td>
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<tr>
<td><strong>Current Liabilities</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Creditors</td>
<td>87,144</td>
<td>89,115</td>
<td>(1,971)</td>
<td>92,005</td>
<td>(4,861)</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>8,204</td>
<td>-</td>
<td>8,204</td>
<td>1,920</td>
<td>6,284</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>14,627</td>
<td>15,442</td>
<td>(815)</td>
<td>12,929</td>
<td>1,698</td>
</tr>
<tr>
<td>Loans (short term less than one year)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>32,719</td>
<td>36,702</td>
<td>(3,983)</td>
<td>36,861</td>
<td>(4,142)</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>85,400</td>
<td>85,235</td>
<td>165</td>
<td>85,225</td>
<td>175</td>
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<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>228,094</td>
<td>226,494</td>
<td>1,600</td>
<td>228,940</td>
<td>(846)</td>
</tr>
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<td>Working Capital</td>
<td>(111,358)</td>
<td>(130,777)</td>
<td>19,419</td>
<td>(112,956)</td>
<td>1,598</td>
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<tr>
<td><strong>Net Funds Employed</strong></td>
<td>$554,623</td>
<td>$554,205</td>
<td>$418</td>
<td>$551,764</td>
<td>$2,859</td>
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<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Term Loans</td>
<td>292,500</td>
<td>292,500</td>
<td>-</td>
<td>292,500</td>
<td>-</td>
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<td>Employee Provisions (non-current)</td>
<td>19,916</td>
<td>20,283</td>
<td>(367)</td>
<td>20,283</td>
<td>(367)</td>
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<tr>
<td>Trust and Special Funds</td>
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<td>895</td>
<td>(8)</td>
<td>882</td>
<td>5</td>
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<td>Insurance Liability - Non Current</td>
<td>1,489</td>
<td>1,337</td>
<td>152</td>
<td>1,337</td>
<td>152</td>
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<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>314,792</td>
<td>315,015</td>
<td>(223)</td>
<td>315,002</td>
<td>(210)</td>
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<tr>
<td><strong>Crown Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Equity</td>
<td>124,078</td>
<td>124,078</td>
<td>-</td>
<td>124,078</td>
<td>-</td>
</tr>
</tbody>
</table>
Revaluation Reserve | 173,729 | 173,729 | - | 173,729 | -
Retained Earnings | (57,976) | (58,617) | 641 | (61,045) | 3,069
Total Crown Equity | 239,831 | 239,190 | 641 | 236,762 | 3,069
Net Funds Employed | $554,623 | $554,205 | $418 | $551,764 | $2,859

Commentary:

Net borrowings: Long and short term debt less bank balance better than budget $25.3m but in line with last year.

Debtors: $3.4m lower than budget, $1.6m higher than June 15, due to payments outstanding with the Crown (see table below).

<table>
<thead>
<tr>
<th>MOH Debtors $000</th>
<th>Total</th>
<th>Current</th>
<th>30 day +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invoiced</td>
<td>5,016</td>
<td>1,436</td>
<td>3,580</td>
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<tr>
<td>Accrued</td>
<td>345</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$ 5,361</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last month</td>
<td>$ 9,600</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: $7,300k received 6 March

Accounts payable: $1.9m lower than budget and $4.8m lower than June 2015.

Net Fixed Assets: Are $16.1m lower than budget (timing of capital spends see cash flow).

Investments in Associates:
New Zealand Health Partners $ 5.8m

Note: we will need to continue to ensure that these investments have underlying value through the future success of NZHP.

healthAlliance $29.2m for ICT capital investment.
The first payment of $3.027m was made in March, with two more payment in April and June scheduled.

Payroll Accrual & Clearing: due to timing of payroll cut offs.

There are no other significant issues regarding the Balance Sheet.
### Cash flow

<table>
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<tr>
<th></th>
<th>Month</th>
<th></th>
<th></th>
<th>YTD</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td><strong>Cash flows from operating activities:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>127,785</td>
<td>123,551</td>
<td>4,234</td>
<td>1,111,587</td>
<td>1,104,398</td>
<td>7,189</td>
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<tr>
<td>Other</td>
<td>3,813</td>
<td>2,925</td>
<td>888</td>
<td>29,481</td>
<td>26,896</td>
<td>2,585</td>
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<td>Interest rec.</td>
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<td>142</td>
<td>75</td>
<td>2,745</td>
<td>1,278</td>
<td>1,467</td>
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<td>Expenses</td>
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<td></td>
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<tr>
<td>Suppliers</td>
<td>70,961</td>
<td>74,807</td>
<td>3,846</td>
<td>669,045</td>
<td>668,755</td>
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<td>GST refund</td>
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<td>8,900</td>
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<td>8,900</td>
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<tr>
<td>Employees</td>
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<td>48,927</td>
<td>445</td>
<td>421,564</td>
<td>425,528</td>
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<tr>
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<td>1,226</td>
<td>167</td>
<td>9,361</td>
<td>11,034</td>
<td>1,673</td>
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<td>Capital charge</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9,193</td>
<td>7,644</td>
<td>(1,549)</td>
</tr>
<tr>
<td><strong>Net cash from Operations</strong></td>
<td>20,213</td>
<td>1,658</td>
<td>18,555</td>
<td>25,750</td>
<td>19,611</td>
<td>6,139</td>
</tr>
<tr>
<td>Fixed Assets</td>
<td>(1,833)</td>
<td>(2,320)</td>
<td>487</td>
<td>(19,984)</td>
<td>(36,280)</td>
<td>16,296</td>
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<td>Sale of Asset</td>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Investments (hA &amp; HBL)</td>
<td>(3,027)</td>
<td>(948)</td>
<td>(2,079)</td>
<td>(5,635)</td>
<td>(8,538)</td>
<td>2,903</td>
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<td>(1)</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>4</td>
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<tr>
<td><strong>Net cash from Investing</strong></td>
<td>(4,859)</td>
<td>(3,269)</td>
<td>(1,590)</td>
<td>(25,614)</td>
<td>(44,817)</td>
<td>19,203</td>
</tr>
<tr>
<td>Debt</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other non-current liability</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash from Financing</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net increase / (decrease)</strong></td>
<td>15,354</td>
<td>(1,611)</td>
<td>16,965</td>
<td>136</td>
<td>(25,206)</td>
<td>25,342</td>
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<tr>
<td>Opening cash</td>
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<td>32,553</td>
<td>8,371</td>
<td>56,142</td>
<td>56,148</td>
<td>(6)</td>
</tr>
<tr>
<td>Closing cash</td>
<td>56,278</td>
<td>30,942</td>
<td>25,336</td>
<td>56,278</td>
<td>30,942</td>
<td>25,336</td>
</tr>
</tbody>
</table>

### Summary

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th></th>
<th></th>
<th>YTD</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>Opening cash</td>
<td>40,924</td>
<td>32,553</td>
<td>8,371</td>
<td>56,142</td>
<td>56,148</td>
<td>(6)</td>
</tr>
<tr>
<td>Operating</td>
<td>20,213</td>
<td>1,658</td>
<td>18,555</td>
<td>25,750</td>
<td>19,611</td>
<td>6,139</td>
</tr>
<tr>
<td>Investing</td>
<td>(4,859)</td>
<td>(3,269)</td>
<td>(1,590)</td>
<td>(25,614)</td>
<td>(44,817)</td>
<td>19,203</td>
</tr>
<tr>
<td>Financing</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Closing cash</td>
<td>56,278</td>
<td>30,942</td>
<td>25,336</td>
<td>56,278</td>
<td>30,942</td>
<td>25,336</td>
</tr>
</tbody>
</table>

### Commentary:

**Operating:** The GST refund was paid March for $8.9m. $7.3m was received in March which has put the YTD variance back into a positive position.

Fixed Asset spending continues to be slow around the budgeted Mental Health building and the laboratories move to the Haley Gray building.

Payment for 6,054k C class shares in healthAlliance will be paid in three amounts with the first paid in March $3.027m, and the balance paid in April and June.
Treasury
All term debt facilities are now through the MOH, with interest rates “locked in” at fixed rates. Working capital facilities remain with Westpac via Health Benefits Ltd ($64.4m). Both ASB/Commonwealth Bank ($10.0m) and Westpac ($10.0m) lease facilities are allowable by the Crown.

<table>
<thead>
<tr>
<th>Drawn ($ millions)</th>
<th>Date of Advance</th>
<th>Maturity</th>
<th>Interest rate</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0</td>
<td>16-Jul-12</td>
<td>15-Apr-17</td>
<td>3.32%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>15.0</td>
<td>15-Jul-08</td>
<td>15-Dec-17</td>
<td>6.36%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>10.0</td>
<td>28-Jan-09</td>
<td>15-Dec-17</td>
<td>4.41%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>5.0</td>
<td>03-Feb-09</td>
<td>15-Dec-17</td>
<td>4.41%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>5.0</td>
<td>20-May-09</td>
<td>15-Dec-17</td>
<td>5.65%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>10.0</td>
<td>30-Apr-10</td>
<td>15-Dec-18</td>
<td>5.88%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>20.0</td>
<td>20-Mar-13</td>
<td>15-Dec-18</td>
<td>3.30%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>5.0</td>
<td>15-Nov-11</td>
<td>15-Mar-19</td>
<td>5.13%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>13.0</td>
<td>27-Oct-09</td>
<td>15-Dec-19</td>
<td>6.10%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>7.0</td>
<td>27-Oct-09</td>
<td>15-Dec-19</td>
<td>6.10%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>5.0</td>
<td>20-Jun-12</td>
<td>15-May-21</td>
<td>3.45%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>42.6</td>
<td>29-Jun-12</td>
<td>15-May-21</td>
<td>4.22%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>20.0</td>
<td>18-Dec-12</td>
<td>15-May-21</td>
<td>3.56%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>30.0</td>
<td>15-Apr-13</td>
<td>15-Apr-22</td>
<td>3.45%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>30.0</td>
<td>20-Dec-13</td>
<td>15-Apr-23</td>
<td>4.91%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>5.0</td>
<td>20-May-09</td>
<td>15-Apr-23</td>
<td>4.74%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>24.9</td>
<td>30-Jun-15</td>
<td>15-Apr-23</td>
<td>3.59%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>40.0</td>
<td>15-Apr-15</td>
<td>15-Apr-25</td>
<td>3.40%</td>
<td>Fixed, Semi-Annual</td>
</tr>
<tr>
<td>$292.5</td>
<td></td>
<td></td>
<td>4.26%</td>
<td>Weighted Average</td>
</tr>
</tbody>
</table>

Debt Profile
FTE Reporting
Provider Arm: *(now report in detail to the HAC committee).*

Personnel Costs per FTE
*(Rolling average)*

<table>
<thead>
<tr>
<th></th>
<th>Mar 16</th>
<th>Feb 16</th>
<th>Jan 16</th>
<th>Dec 15</th>
<th>Nov 15</th>
<th>Sep 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>184,917</td>
<td>183,936</td>
<td>183,583</td>
<td>181,921</td>
<td>180,393</td>
<td>178,191</td>
</tr>
<tr>
<td>Nursing</td>
<td>78,539</td>
<td>78,403</td>
<td>78,361</td>
<td>78,273</td>
<td>78,249</td>
<td>78,312</td>
</tr>
<tr>
<td>Allied Health</td>
<td>71,419</td>
<td>71,096</td>
<td>71,046</td>
<td>70,950</td>
<td>70,907</td>
<td>71,025</td>
</tr>
<tr>
<td>Mgmt/Admin/Clerical</td>
<td>74,502</td>
<td>74,298</td>
<td>73,890</td>
<td>73,718</td>
<td>73,390</td>
<td>73,132</td>
</tr>
<tr>
<td>Support</td>
<td>52,026</td>
<td>51,699</td>
<td>52,012</td>
<td>51,742</td>
<td>51,618</td>
<td>51,599</td>
</tr>
</tbody>
</table>

The table below shows the Management Admin cap return to the MoH each month.

<table>
<thead>
<tr>
<th>Counties Manukau</th>
<th>Mar 16</th>
<th>Feb 16</th>
<th>Jan 16</th>
<th>Dec 15</th>
<th>Nov 15</th>
<th>Oct 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrued FTE (as per MOH template)</td>
<td>894.1</td>
<td>901.5</td>
<td>785.8</td>
<td>847.0</td>
<td>870.5</td>
<td>849.1</td>
</tr>
<tr>
<td>Annual Leave loading</td>
<td>(79.1)</td>
<td>(78.0)</td>
<td>(78.1)</td>
<td>(77.0)</td>
<td>(77.0)</td>
<td>(76.2)</td>
</tr>
<tr>
<td>FTE’s on holiday</td>
<td>64.5</td>
<td>43.6</td>
<td>160.1</td>
<td>85.5</td>
<td>62.0</td>
<td>73.2</td>
</tr>
<tr>
<td>Payroll FTE’s</td>
<td>879.4</td>
<td>867.1</td>
<td>867.8</td>
<td>855.5</td>
<td>855.5</td>
<td>846.1</td>
</tr>
<tr>
<td>Contractors / Consultants (FTE equivalent)</td>
<td>10.0</td>
<td>10.0</td>
<td>10.0</td>
<td>10.0</td>
<td>10.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Vacancy</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.0</td>
<td>2.0</td>
<td>11.3</td>
</tr>
<tr>
<td>Total</td>
<td>889.4</td>
<td>877.1</td>
<td>877.8</td>
<td>867.5</td>
<td>867.5</td>
<td>867.5</td>
</tr>
<tr>
<td>Number submitted Jan 09 for 31 Dec 08</td>
<td>867.5</td>
<td>867.5</td>
<td>867.5</td>
<td>867.5</td>
<td>867.5</td>
<td>867.5</td>
</tr>
<tr>
<td>Variance</td>
<td>21.9</td>
<td>9.6</td>
<td>10.3</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
6.0 Ko Awatea

1. **Purpose of report:** Information
2. **Focus:** Alignment between Ko Awatea and CMH Strategic Plan
3. **Recommendation:** Agree high level scorecard approach. *Feedback, or seek more detail as required.*
4. **Strategic alignment - key Ko Awatea led or supported Collaboratives, Programmes & Campaigns**

| Healthy Services | Enhanced Primary Care Collaborative; Technology Enabling Change Programme; Enhanced Recovery After Surgery Collaborative; Faster Cancer Treatment Project; Hand Hygiene Project; Safety in Practice Collaborative; Enhanced Primary Care Collaborative; Community Health System Integration; Care Compass Programme; Early Learning Collaborative; Now We’re Talking Collaborative; National Improvement Network. |
| Healthy People, Whaanau & Families | Diabetes Care Collaborative, At Risk Individuals Programme, Mental Health First Aid Programme. |
| Healthy Communities | Manaaki Hauora; Handle the Jandal; Health Equity Collaborative; Social Sector Collaboration. |

5. **Ko Awatea update**

<table>
<thead>
<tr>
<th>Ko Awatea’s KPIs for FY15-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Core business support for CMH maintained and constantly improved.</td>
</tr>
<tr>
<td>• Capability Building: Clinical, Academic and Community leaders are supported to grow; educational offerings aligned with competencies developed.</td>
</tr>
<tr>
<td>• Successful events delivered: cross-sector focus and drive for sustainability e.g. APAC, TEDx.</td>
</tr>
<tr>
<td>• Equity and safety collaboratives are delivered.</td>
</tr>
<tr>
<td>• Spread the use of e learning platform.</td>
</tr>
<tr>
<td>• National improvement network to be established.</td>
</tr>
<tr>
<td>• KA2 built to address high demand for centre space, driving sustainability, and increase cross-sector and community involvement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Budget:</strong> ON TRACK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APAC Forum</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Sponsorship:</strong> ON TRACK</td>
</tr>
<tr>
<td>• <strong>Speakers &amp; Abstracts:</strong> ON TRACK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internal Capability Building</th>
<th>External Capability Building</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>People Strategy:</strong> ON TRACK</td>
<td></td>
</tr>
<tr>
<td>• <strong>Competency Framework development:</strong> ON TRACK</td>
<td></td>
</tr>
<tr>
<td>• <strong>Improvement Facilitators Network (Enhanced primary care focus):</strong> ON TRACK</td>
<td></td>
</tr>
<tr>
<td>• National and International Capability Building: ON TRACK</td>
<td></td>
</tr>
<tr>
<td>• National Improvement DHB Network: ON TRACK</td>
<td></td>
</tr>
</tbody>
</table>
Utilisation

- **Ko Awatea e-learning**: 750 sessions daily average.
- **Research & Evaluation FY15-16[YTD]**: 39 research projects, 23 evaluations

**Ko Awatea Centre** [people through the door]: ‘14, ‘15, ‘16 YTD. Increasing use, approaching capacity, reconfirms value of Ko Awatea 2.

**Health Intelligence**: automation of reports leading to increased clinical use Dec’15-Mar’16.

**Library**: Total 28,410 searches, 5964 documents delivered Jan, Feb, Mar 2016 - supporting evidence-based practice.
7.0 Compliance

7.1 No compliance issues to report on this month. The Health & Safety and Investor Confidence Rating updates are included below.

7.1.1 Health & Safety

The safety of Community Health workers continues to be an area of priority focus. Activities have progressed with engagement from the Community Health Services Integration team and the CM Health Risk Manager to ensure that a holistic approach is undertaken when reviewing the risks in the community. A workshop with representatives of the community service delivery staff will aim to ensure that potential solutions are identified in an effortless and consultative manner. The work will be underpinned with training and guidance on risk management.

Given that this is an organisational issue, an appropriate and aligned strategic approach is required to ensure engagement and operational consistencies across respective teams and stakeholders. An operational approach will not provide a standardised approach to the management of these risks. The shared learning and feedback from other District Health Boards has been limited, as such we will continue to progress this work.

The planning for the annual Flu Program was completed with the official launch on the 4 April 2016. Vaccinations will be offered both at static pop-up clinics and within working environments.

We are on track to meet the obligations of the new Health and Safety at Work Act 2015 (HSWA) which will come into force on 4 April 2016 and the first phase of supporting regulations have also been finalised.

7.1.2 Investor Confidence Rating

CM Health is one of five DHBs that are being independently assessed in April/May 2016 as part of Cabinet’s requirements that government agencies undergo an Investor Confidence Rating (ICR). This assessment looks at the level of maturity of our portfolio, programme, project, change and asset management practices as well as our long term investment planning and project delivery and asset performance. Feedback from the assessors to date has highlighted the strong strategic alignment we have across the organisation including our decision-making processes, people and demand forecasting. In addition, we have confirmed a number of areas where there is room to enhance our practices. Once the assessment process is complete, we will provide the Board with a detailed report, along with a proposed improvement plan. The ICR process is proving to be a very positive experience as it provides an opportunity to both reflect on our achievements and lift the bar for the future.
Counts Manukau Health Board Meeting
Resolution to Exclude the Public

Resolution:
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

<table>
<thead>
<tr>
<th>General Subject of Items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 1. Minutes of 23 March 2016            | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Confirmation of Minutes
For reasons given in the previous meeting. |
| 2. Minutes of Special Board Meeting – 13 April 2016 | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. |
| 3. Action Items                        | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | For reasons given in the previous meeting. |
| 4. Social Investment Board Update      | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. |
| 5. Healthy Together – Technology Business Cases | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section | Commercial Activities
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. |
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counties Manukau District Health Board Agenda  4 May 2016</strong></td>
<td>9(3)(g)(i)of the Official Information Act 1982.</td>
<td>[Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td><strong>6. IS Projects Update</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.</td>
<td><strong>Commercial Activities</strong> The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td><strong>7. Second Draft Annual Plan &amp; Second Draft Maaori Health Plan</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.</td>
<td><strong>Commercial Activities</strong> The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td><strong>8. MRI Business Case</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.</td>
<td><strong>Commercial Activities</strong> The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td><strong>9. Regional Clinical Pathways Business Case</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.</td>
<td><strong>Commercial Activities</strong> The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td><strong>10. NHC Contract</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.</td>
<td><strong>Commercial Activities</strong> The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
</tbody>
</table>